

A photograph of two NHS staff members, a woman and a man, smiling and looking at a document together. The image is overlaid with a semi-transparent blue diamond-patterned grid.

**THE *FORWARD VIEW* INTO ACTION:
PLANNING FOR 2015/16**

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1. Our approach to partnership and planning for 2015/16

- 1.1 This document describes the approach for national and local organisations to make a start in 2015/16 towards fulfilling the vision set out in the *NHS Five Year Forward View*, whilst at the same time delivering the high quality, timely care that the people of England expect today.
- 1.2 The NHS continues to provide a high standard of care for our country's growing population and ageing population - but demand is rising and services are under pressure. The NHS has received an increased financial settlement next year, which will help in managing current pressures and kick start the new ways of providing care as signalled in the *Forward View*. However, the challenge for NHS staff and leaders of delivering high quality care within the available resources is as great as it has ever been.

Planning together with confidence

- 1.3 There are grounds for optimism because as the positive reaction to the *Forward View* revealed, there is a powerful consensus amongst patient groups, clinicians, local communities, frontline NHS leaders and national organisations about how to sustain and improve the NHS over the next five years – and a shared desire to lead and support change.
- 1.4 The future financial gap is challenging but not intrinsically insurmountable, both for 2015/16 and beyond. For 2015/16, the revised Mandate allocated an extra £1.83bn to NHS England, to which NHS England will reallocate a further £150m of its own resources, bringing the total of new money for front line services to £1.98bn. This includes making recurrent money for winter pressures that the NHS has received from time-to-time midway through recent years. Although the financial position will continue to be very challenging in many local health economies, there is now a clear basis on which to commence local planning.
- 1.5 The pace and scale of transformation over the next five years will partly depend on the scale of additional investment in, and uptake of, new care models. We will take our first tangible steps in 2015/16, through a £200m investment fund in new care models, and a further £250m investment in primary care.
- 1.6 Local leaders are already thinking about how to apply the *Forward View*. It is increasingly understood that tackling the causes of ill-health, empowering patients, and engaging communities are all essential components of creating a sustainable NHS. In some parts of the country, clinical commissioning is beginning to drive changes, while in others innovative provider organisations are taking the lead. And providers and commissioners alike are working together on how to dissolve the artificial barriers between prevention and treatment, physical health and mental health, and the historical silos of primary, community, social care and acute care—and the professionals who work across them.

- 1.7 The six national bodies that authored the *Forward View* are committed to acting with greater coherence, and openly with partners in a different kind of national/local dialogue, guided by the spirit of co-creation. To progress the *Forward View*, the chief executives of the six national bodies will serve as a single leadership group, working with a broad coalition of partner bodies. Although each body remains individually accountable for its own statutory responsibilities, we will also take a more joined-up approach to working with local health economies and organisations.

A differentiated national approach

- 1.8 Over the next year we will co-design a programme of support with a small number of selected areas and organisations that have already made good progress and which are on the cusp of being able to introduce the new care models set out in the *Forward View*. Our goal is to make rapid progress in developing new models of promoting health and wellbeing and providing care that can then be replicated much more easily in future years. Achieving this goal involves structured partnership rather than a top-down, compliance-based approach. So we are today extending an open invitation to local and national partner organisations to put themselves forward by the end of January 2015 to work alongside us in creating and implementing these new prototypes.
- 1.9 A minority of local health economies have for some years been in significant difficulty, and have struggled to develop and implement credible plans to recover their position. For these systems NHS England, Monitor and the NHS Trust Development Authority (TDA) will in 2015/16 become more jointly engaged, acting in concert. We will design and apply a new “success regime” intended to help create the conditions for success in the most challenged health economies.
- 1.10 For the majority of geographies and organisations, i.e. neither the first cohort of the leading edge organisations, nor the most challenged systems, we will make it easier for local areas to implement change. We also recognise that some of the vanguard sites for new care models may be part of local systems facing significant difficulties.

Achieving core standards

- 1.11 Planning for tomorrow and delivering for today go hand-in-hand. Next year will not see a relaxation in NHS Constitution standards for providing timely care for patients, or in the requirement set by taxpayers and Parliament that the NHS lives within its means. Given the current pressures that many local health systems are experiencing, we do not underestimate the scale of this challenge. So the 2015/16 planning round will be characterised by building strong partnerships for future transformation, and at the same time an intense focus on achieving performance standards backed by clear, transparent and consistent incentives to do so.

Maximising the value of local planning

- 1.12 For this planning round we are asking NHS organisations to refresh their operational plans for 2015/16 only, based on the common planning assumptions for NHS commissioners and providers agreed by NHS England, Monitor and the TDA and on their local joint health and wellbeing strategies. There are few new national requirements for planning. The Mandate from the government to the NHS is broadly stable, apart from the introduction of new and important access standards for mental health. These form part of our wider ambition to achieve a genuine parity of esteem between mental and physical health by 2020. To support that ambition, we expect each CCG's spending on mental health services in 2015/16 to increase in real terms, and grow by at least as much as each CCG's allocation increase.
- 1.13 Learning from the experiences of 2014/15, it is clear that the NHS now needs to ensure the fundamentals are in place of accurate activity and financial planning, to ensure delivery of NHS Constitution standards, other key outcome and performance measures, and financial balance. We therefore expect aligned, realistic activity and financial assumptions between NHS commissioners and providers, right across the country. We expect providers and commissioners to work with Local Education and Training Boards (LETBs) to ensure that they can secure the right staff to meet future service needs and their workforce plans are affordable and reflect local strategies for transformation.
- 1.14 Rather than imposing a new top-down planning process for transformation we strongly encourage local areas to develop and progress their emerging vision for the future of health and care for their local populations, on the same "units of planning" basis as 2014/15.
- 1.15 We have set out in separate annexes the specific planning requirements for commissioners (in the case of NHS England), NHS Trusts (in the case of the TDA) and NHS Foundation Trusts (in the case of Monitor). These are supported by our respective sets of technical guidance, planning templates and planning resources.

2. Creating a new relationship with patients and communities

Getting serious about prevention

- 2.1 The sustainability of the NHS, and the country's future economic prosperity, depend on a radical upgrade in prevention and public health. In 2015/16 we will advocate and lead six different approaches to improving health and wellbeing.
- 2.2 First, Clinical Commissioning Groups (CCGs) should work with local government partners to set and share in 2015/16 quantifiable levels of ambition to reduce local health and healthcare inequalities and improve outcomes for health and wellbeing. These should be supported by agreed actions to achieve these, such as specifying behavioural interventions for patients and staff, in line with NICE guidance, with respect to smoking, alcohol and obesity, with appropriate metrics for monitoring progress.
- 2.3 Second, we reiterate our support for comprehensive, hard-hitting, and broad-based national action on prevention. With the Local Government Association (LGA), we will develop and publish proposals for actions that local areas could take to go further and faster in tackling health risks from alcohol, fast food, tobacco and other issues.
- 2.4 Third, we will take action to become the first country to implement at scale a national evidence-based diabetes prevention programme, based on proven UK and international models, and linked where appropriate to the NHS Health Check. We are today inviting those local areas that have made greatest strides in developing preventative diabetes programmes to register their interest at england.fiveyearview@nhs.net by the end of January 2015 in joining with us as partners to co-design a new national programme led by Public Health England, NHS England and Diabetes UK. By March 2015 we will publish our agreed approach, and a nationwide implementation plan from 2016/17 onwards. A national Prevention Board, chaired by PHE and bringing together NHS, local government and other stakeholders will oversee delivery of these commitments.
- 2.5 Fourth, by autumn 2015 we will have developed proposals for improving NHS services for helping individuals stay in work, or return to employment, while saving downstream costs at the Department for Work and Pensions.
- 2.6 Fifth, in the same timeframe, we will have examined and published our findings on the potential to extend incentives for employers in England who provide effective NICE recommended workplace health programmes for employees.
- 2.7 And sixth, all NHS employers should take significant additional actions in 2015/16 to improve the physical and mental health and wellbeing of their staff - for example by providing support to help them keep to a healthy weight, active travel schemes and ensuring NICE guidance on promoting healthy workplaces is implemented. To reinforce local action, by March 2015 we will have established and launched a new broad-based task force charged with achieving a healthier NHS workforce. To support early progress, the 2015/16 NHS standard contract now requires providers to develop and maintain a food and drink strategy in accordance with the Hospital Food Standards Report ([available here](#)).

Empowering patients

- 2.8 We will continue to work to improve the information to which people have access. Next year providers are required in the NHS Standard Contract to show demonstrable progress towards achieving fully interoperable digital health records from 2018. From April 2015, patients will have online access to their GP records.
- 2.9 To give patients more direct control, we expect CCGs to lead a major expansion in 2015/16 in the offer and delivery of personal health budgets to people, where evidence indicates they could benefit. As part of this, by April 2016, we expect that personal health budgets or integrated personal budgets across health and social care should be an option for people with learning disabilities, in line with the Sir Stephen Bubb's review ([available here](#)). To improve the lives of children with special educational needs, CCGs will need to continue to work alongside local authorities and schools on the implementation of integrated education, health and care plans, and the offer of personal budgets. CCGs should engage widely and fully with their local communities and patients, including with their local Healthwatch, and include clear goals on expanding personal health budgets within their published local Joint Health and Wellbeing Strategy.
- 2.10 2015/16 will see the first steps towards integrated personalised commissioning (IPC) in national demonstrator sites. For the first time, IPC brings together health and social care budgets for individuals and enables them to exercise more clout over how their own care and support is provided. As well as care planning and voluntary sector advocacy and support, IPC will provide an integrated 'year of care' budget that will be managed by people themselves, supported, where required, by councils, the NHS or a voluntary sector organisation.
- 2.11 The *Forward View* promised to make good the NHS's longstanding promise to give patients choice over where and how they receive care, in line with their legal rights set out in the NHS Constitution and the statutory duties of NHS England and CCGs to promote choice. Commissioners and providers should work together and with patient groups to understand current delivery, and make significant further strides to honour patients' entitlements to choose.
- 2.12 A particular priority for choice next year will be mental health. We expect CCGs to work with GPs and providers to ensure that patients are aware of their rights and are offered choice in mental health services, and are able to make well-informed, meaningful choices at appropriate points along the pathway.
- 2.13 We will work with the Royal College of Midwives and others to develop plans so that, from 2016/17, tariff-based NHS funding will support the choices women make rather than constrain them and, as a result, make it easier for groups of midwives to set up their own NHS-funded midwifery services. For 2015/16 commissioners should review the choices that are locally available for women accessing maternity services and, working together with service users and the public, consider what more can be done to offer meaningful choice. This may include choice of how to access maternity care, the type of care women receive, where they give birth (taking account of recent NICE recommendations) and where they receive their antenatal and postnatal care.

Engaging communities

- 2.14 In 2015/16 we will focus on actions to improve the way that the NHS engages with communities and citizens, including with local Healthwatch, involving them in decisions about the future of health and care services. It is essential that CCGs focus on how they will meet their statutory duties on public and patient involvement in their commissioning decisions. In support of this we are continuing to further develop the NHS Citizen approach (www.nhscitizen.org.uk). Commissioners should also consult the voluntary and community sector at local or national level for more strategic advice on this. We will also progress four further specific actions.
- 2.15 First, we expect CCGs alongside local authorities to draw up plans to identify and support carers and, in particular, working with voluntary sector organisations and GP practices, to identify young carers and carers who themselves are over 85, and provide better support. In developing plans, CCGs should be mindful of the significant changes to local authority powers and duties from April 2015 under the Care Act 2013. Plans should focus on supporting young carers and working carers through the provision of accessible services, and services for carers from vulnerable groups. Linked to this, we expect all NHS employers to review in 2015/16 their own flexible working arrangements and support for staff with unpaid caring responsibilities.
- 2.16 Second, we will energise community volunteering and encourage new roles for volunteers, working with NHS and volunteer supporting organisations. Since the following publication of the *Forward View*, voluntary and community sector groups have welcomed its proposals on volunteers and have expressed a strong desire to play a key role in delivering its commitments. Working with this group of partners, in 2015/16 we will develop arrangements for enhancing the impact of volunteers and lay people, including by strengthening support and training, better matching of people to opportunities and steps to raise the status of volunteering.
- 2.17 Third, we will reduce the time and complexity for charitable and voluntary sector partners to secure local NHS funding. Grant agreements can sometimes provide a more appropriate means for NHS commissioners to fund voluntary organisations, rather than burdensome contracts. As promised in the *Forward View*, we will shortly publish a short model grant agreement.
- 2.18 And fourth, we expect NHS employers to lead the way as progressive employers. The introduction from April 2015 of the first NHS workforce race equality standard in the NHS contract is a major step to ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve. All NHS employers and their boards must examine themselves against this standard. A new joint taskforce will challenge and support better and faster progress. The national NHS Equality and Diversity Council will develop a wider programme to promote equality for other protected characteristics during 2015.

3. Co-creating new models of care

- 3.1 This chapter sets out how in 2015/16 local and national organisations can work together to accelerate the design and implementation of the new models of care, set out in the *Forward View*.
- 3.2 We recognise the different starting points of different local health and care economies. The taxonomy of models in the *Forward View* is not an exhaustive list; it provides a menu of additional, voluntary, options. We will avoid imposing a single rigid national blueprint, as well as the inefficiency of stimulating the development of hundreds of different solutions to what are common problems and opportunities. Our approach to new care models combines three distinct elements: first, focused support for vanguard sites; second, a more permissive approach to change right across the country; and third, intervening to create the conditions for success in the most challenged systems.

The leading cohorts

- 3.3 Working with a small initial cohort of sites, we will start by prototyping four different types of care models outlined in the *Forward View*:
- multispecialty community providers (MCPs), which may include a number of variants;
 - integrated primary and acute care systems (PACS);
 - additional approaches to creating viable smaller hospitals. This may include implementing new organisational forms advocated by the Dalton Review, such as specialist franchises and management chains; and
 - models of enhanced health in care homes.
- 3.4 For each of these care and organisational models, we will co-design a structured programme of support to accelerate change, assess progress and demonstrate proof of concept. The purpose of becoming an initial site is not simply to address local needs, but to become a successful prototype that can be adapted elsewhere, designed from the outset to be replicated by subsequent cohorts. The support programmes across the different care models will be inter-linked or share common elements and will be co-ordinated by a national New Models of Care Board.
- 3.5 The first cohort of sites will be ones that are in the vanguard, making the strongest progress. They will already have in place:
- an ambitious vision of what change they want to achieve to the model of care, in order to meet clear identified needs and preferences of their local population;
 - a record of already having made tangible progress towards new ways of working in 2014;
 - a credible plan to make move at serious pace and make rapid change in 2015;

- funded local investment in transformation that is already agreed;
- effective managerial and clinical leadership, and the capacity and capability to succeed;
- strong, diverse and active delivery partners, such as voluntary and community sector organisations;
- positive local relationships, for example the support of local commissioners and communities.

3.6 The initial cohort will also need to show:

- the appetite to engage intensively with other sites across the country, and with national bodies, in a co-designed and structured programme of support aimed at (a) identifying, prioritising and tackling national barriers experienced locally; (b) developing common rather than unique local solutions that can easily be replicated by subsequent sites; and (c) assessing progress, through a staged development process;
- a commitment to richer, standardised data to enable real-time monitoring and evaluation of health and care quality outcomes, the costs of change, and the benefits that accrue. NHS England is establishing a new operational research and evaluation capability to support this activity.

3.7 A support programme will be co-developed rapidly with the initial sites. It will blend the provision of technical expertise with peer learning, and removal of barriers to change. Practical support could be developed across a number of areas such as designing patient-centred care, and increasing community involvement; clinical workforce redesign; using digital technology to rethink care delivery; the optimal use of infrastructure; devising organisational legal forms; new contractual models; procurement routes; and, capitated payment arrangements.

3.8 We will begin making investments in these leading sites in 2015/16, drawing on the transformation funding announced in the Autumn Statement. It will be closely targeted on the costs of implementing new care models, with some investment contingent both on progress made and giving support to the next wave of early adopters. GPs will also be able to bid against the £250m fund intended to improve primary care and out-of-hospital infrastructure. The same amount will be available nationally for each of four years, allowing longer-term planning.

3.9 Local organisations or areas wishing to become first cohort sites are asked to express their interest by Monday 2 February to the new care models team (england.fiveyearview@nhs.net). We will provide further information on the core requirements of each of the models in early January. Where possible, we will use existing information to inform site selection, rather than rely on long written applications. Some of the first sites will be agreed by February, in a process overseen by the New Models of Care Board, co-chaired by NHS England and Monitor; and the first support programmes will be developed by the end of March.

- 3.10 In addition, the government has recently announced the new garden cities of Ebbsfleet and Bicester, where an extra 28,000 houses will be built by 2020. There are also a number of fast-growing population centres typically in urban areas; for example, around the former Olympic village in east London. In 2015, NHS England, working together with the LGA, will develop proposals for establishing a health and care garden city in one or more of these areas as part of the New Models of Care programme. These areas would take a ‘first principles’ approach to designing how health and wellbeing should be promoted, and how services should be delivered, from rethinking the physical design of the infrastructure, to embracing new technologies and encouraging the deep integration of health and care with supported housing and other public services.
- 3.11 Next year we will invite UK and international innovators to bid to develop a small number of test-bed sites to sit alongside and enable new models of care. These innovators will work in collaboration—for example, Academic Health Science Networks/Centres in partnership with statutory, voluntary and private sector organisations. They will focus on deploying and evaluating the impact of different technologies and innovations working in combination. These test-beds will be important opportunities for the life science and health technology industries to partner with the NHS to demonstrate how multiple innovations can deliver significant improvements in outcomes, patient experience and cost-effectiveness. This could range from online primary care; digital mental health support; whole area digital population health management; 21st century remote and assistive technologies. We will explore establishing these sites on a match-funding basis with interested consortia, and reimbursed on a payment-for-outcomes basis. More details will be published by March 2015.

Building the foundations for early adoption

- 3.12 We recognise that strategic change cannot be mandated nationally. The future direction for a CCG or NHS provider can only be developed and implemented by its own leadership, in conjunction with partner organisations, patients, communities and staff. We are strongly encouraging all local areas to develop a shared vision of health and care for their populations in the context of the strategic choices outlined by the *Forward View*. They should be looking afresh at their medium-term strategies, and choosing to take actions in 2015/16 that create the conditions for rapid early adoption. For example, rather than proceed with a stand-alone re-procurement of community services, one option CCGs may want to consider is how best to integrate these within a new MCP model. These conversations should take place on the same “units of planning” basis as 2014/15 unless otherwise locally agreed.
- 3.13 A local health economy will have the option, during the year, of coming together as one and inviting in the national bodies for a joined-up conversation about their emerging local system-wide plan.

3.14 In order to target our support effectively, we need to understand and create the conditions for successful transformation across local health economies. Some of the key conditions for future transformation are likely to include:

- stable, ambitious and collective leadership to oversee and drive the transformation process;
- commissioners, providers, local authorities, local education and training boards (LETBs), health and wellbeing boards and other relevant organisations work collaboratively within a defined local health economy – with shared boundaries and an understanding of organisational interdependencies;
- high levels of patient and community engagement, with consideration of how to empower people and patients still further;
- strong clinical leadership and engagement;
- current healthcare services are satisfactory or better in respect of quality and outcomes, safety and patient experience. Strategic planning is clear and realistic about how outcomes can be improved;
- a sound financial position across the health economy with headroom to support transformation. Financial planning is resilient and long-term;
- a strong primary and out-of-hospital care system, with well-developed planning about how to provide care for people with long term conditions in primary care settings and in their own homes, with a focus on prevention, promoting independence and support to stay well;
- plans to invest in and make better use of the current workforce, since the provision of health and care is mainly about people, not buildings or infrastructure;
- partners work together to develop a vision for strategic estates/capital planning across the LHE and identify efficiencies in procurement, IT systems and estate management;
- the development of fully interoperable information and technology systems.

3.15 By April 2015, the six national partners working together aim to have developed a better understanding of how far these and other critical conditions for transformation are present in each part of the NHS.

A new regime for challenged systems

3.16 In some areas, these conditions for success do not yet exist. Problems faced in these health systems often include challenges on quality and finance, geographical isolation, poor relationships between local bodies, or the absence of a clear future strategy. In these health economies, the national bodies will increasingly intervene together to secure a better way forward, acting in concert.

- 3.17 In 2015/16 we will create a new regime that will seek to create the conditions for success in these most challenged areas. This “success regime” will focus on addressing current performance challenges, while creating the conditions for future transformation, including stronger relationships between local bodies and more effective and aligned medium-term plans. The regime will seek to build rather than supplement local capacity and capability; to create strong and durable local leadership arrangements; and to address deep-rooted barriers to improvement, such as clinical configuration and workforce shortages.
- 3.18 The intervention process will be overseen by the relevant national oversight bodies - which will most often be NHS England, the TDA and Monitor – with the involvement of other bodies such as the LGA and CQC.
- 3.19 We will develop the new regime in a small number of the most challenged areas during 2015/16. We will learn by doing, and set out more detailed guidance on the regime in early 2015. It is likely to include:
- the creation of a single, aligned accountability mechanism for the national bodies to oversee the process and to ensure that all relevant local parties are held to account
 - the agreement of a single, collective short-term plan for the health economy setting out what needs to be achieved during the period of intervention;
 - access to external support to address the particular issues facing the health economy, including clinical, financial and performance expertise;
 - support from high-performing health economies and organisations to accelerate progress and build capacity in the challenged health economy;
 - the development of a clear medium-term plan for transformation across the health economy;
 - conditionality for any transitional financial support.

Delivering a new deal for primary care

- 3.20 Primary care is central to the new population-based health care models described in the Forward View. But general practice is under a great deal of pressure. To tackle some of the immediate workforce issues, NHS England and Health Education England (HEE) have been developing a plan working alongside the Royal College of GPs and the General Practitioners’ Committee, to attract more training doctors into general practice, make better use of the wider clinical workforce in primary care, target measures to support retention and to support clinicians who have left general practice to return. We will publish the plan in January. Those CCGs that choose to take on co-commissioning responsibilities will also have greater freedom to take local action. In addition to the actions and investment in this plan, an extra £100 million is available to improve access to general practice through the Prime Minister’s Challenge Fund.
- 3.21 A core component of this ten point plan is the £1bn fund, over four years, made available in the Autumn Statement to improve premises and infrastructure. We will provide further details in January.

- 3.22 Primary care is not just about general practice. During 2014, we heard hundreds of views about how community pharmacy, dentistry and aspects of eye healthcare could develop to support better outcomes. Early in 2015 we will set out our response, taking account of the best ideas in how we implement new models of care.

New care models - urgency and emergency care, maternity, cancer and specialised services

- 3.23 Commissioners and providers should prioritise the major strategic and operational task of how they will be implementing the urgent and emergency care review. This will be reinforced in 2015/16 by incentives in both the CCG quality premium and the CQUIN framework for providers. Urgent and emergency care networks, which will build upon existing System Resilience Groups, should be established by April 2015, and oversee the planning and delivery of a regional or sub-regional urgent care system. This will include designating and then assuring the quality of urgent care facilities, in line with guidance planned for summer 2015.
- 3.24 NHS England will complete a review of maternity services – including perinatal mental health - by autumn 2015. This will make recommendations on how best to develop and sustain maternity services for the future, and in a way that gives mothers more choice without compromising on safety.
- 3.25 The *Forward View* explained the need for combined action on three fronts to improve cancer services: (i) better prevention, (ii) swifter access to diagnosis, and (iii) better treatment, care and aftercare for all those diagnosed with cancer. These actions will be developed, with national cancer charities, in a new national cancer strategy.
- 3.26 For specialised care where quality and patient volumes are strongly related, such as trauma, stroke and some surgery, the NHS will continue to move towards consolidated centres of excellence. By summer 2015, NHS England will initiate a first round of service reviews, working with local partners. 2015/16 will involve current providers preparing to implement the new standards for congenital heart disease services for children and adults, for example through new collaborations. In the light of the current consultation, NHS England will finalise the standards, and implement in full from April 2016.

4. Priorities for operational delivery in 2015/16

Improving quality and outcomes

- 4.1 The only purpose of developing the new models of care described in chapter 3 is to improve outcomes: better health for the whole population, increased quality of care for all patients, and better value for the taxpayer. That means delivering improvement against the indicators in the NHS Outcomes Framework, as set out in the government's Mandate to NHS England. Last year, each local area set out their own five-year ambitions on seven sentinel indicators, quantifying the level of improvement they could achieve for their local populations. We encourage CCGs to refresh, and make further progress to deliver, those ambitions for 2015/16.
- 4.2 A revitalised National Quality Board (NQB) will bring together system leaders and other national stakeholders. It will provide collective leadership for quality across the system, initially to review the current state of quality of care in the NHS, as assessed by the Care Quality Commission (CQC), and barriers to delivery of high quality care; to identify priorities for quality improvement, and; based on this assessment, develop new system-wide approaches for quality improvement. By summer 2015, the NQB will publish its priorities and work programme, taking steps towards building a single framework for consistently measuring quality across providers, commissioners and regulators.
- 4.3 Commissioners and providers should use CQC's inspection reports and ratings, as they roll these out during 2015 and 2016, to assure themselves of the quality of care in their area. They should learn from where care is good or outstanding. Where care requires improvement or is inadequate, local organisations and areas should urgently agree joint plans – including with stakeholders from social care, where appropriate – to improve.
- 4.4 We commend the Academy of Medical Royal Colleges' *Guidance for taking responsibility: accountable clinicians and informed patients*. During 2015/16, we expect commissioners and providers to work together to embed the practice of clear clinical accountability, with a named doctor responsible for a patient's care, within and across different care settings.
- 4.5 By the end of this year, the NHS will have become the first health system to publish outcome data for thirteen medical and surgical specialities, down to the level of individual consultant surgeons - around 5,000 individual surgeons in total. In 2015/16 we will go further.

Improving patient safety

- 4.6 2015/16 will see a major national and local focus on improving patient safety. First, we expect all commissioners and providers to continue to drive and embed improvements in safe and compassionate care in response to the Francis Report, the

failings at Winterbourne View and the Berwick Review. They are expected to take an active part in their local Patient Safety Collaborative and encouraged to join the 'Sign up to Safety' campaign, aligning safety improvement plans with their local Patient Safety Collaborative activity where appropriate.

- 4.7 Second, based on analysis of the evidence and the unmet potential for improved outcomes, NHS England has identified tackling sepsis and acute kidney injury as two specific clinical priorities for improving patient safety in 2015/16. Over a five year timeframe, improving care in these areas would have the biggest potential impact in reducing premature mortality. Sepsis and acute kidney infection will therefore form the basis of new national indicators for the 2015/16 commissioning for quality and innovation (CQUIN) incentive framework.
- 4.8 Third, resistance to antibiotics is spreading, and now constitutes a major threat to the delivery of safe and effective healthcare. AMR and antibiotic prescribing are inextricably linked; overuse and incorrect use of antibiotics are major drivers of resistance. In 2015/16 CCGs together with providers should develop plans to improve antibiotic prescribing in primary and secondary care. CCGs should ensure that secondary care providers validate their antibiotic prescribing data following the Public Health England (PHE) validation protocol. This forms the basis of a new national quality premium measure for CCGs in 2015/16.
- 4.9 And fourth, all providers of acute care should agree service delivery and improvement plans (SDIPs) with commissioners, setting out how they will make further progress in 2015/16 to implement at least five of the ten clinical standards for seven day services, within the resources available. We recognise that the tariff for 2015/16 does not include specific additional resources for seven day working.

Meeting NHS Constitution standards

- 4.10 NHS England, Monitor and the TDA will focus on achieving minimum performance standards for timely access to care that patients rightly expect and are entitled to receive. The challenges which many areas have experienced in meeting these standards during 2014/15 demonstrate the need for better working between commissioners and providers.
- 4.11 Learning from the experiences of 2014/15, NHS England, Monitor and the TDA will, as part of plan assessment and assurance, require CCGs and providers to make realistic and aligned assumptions about the likely activity levels for both elective and emergency care, including diagnostics, necessary to meet demand and delivering waiting times standards. This includes having realistic ambitions for activity diversion initiatives, using past and current performance as a relevant guide alongside future plans. Unless and until it is clear that demand has reduced, we strongly advise system resilience groups not to switch off additional winter capacity for urgent and emergency care.

Achieving parity for mental health

- 4.12 The recently published Mandate to NHS England remains largely unchanged. Commissioners will need to develop revised plans where they are not on track to deliver against pre-existing Mandate objectives, and to sustain those that are, for example on dementia diagnosis or delivery of improving access to psychological therapies (IAPT) service standards.
- 4.13 2015/16 will see the introduction of access and waiting time standards in mental health services for the first time. As part of the 2015/16 contracting round, mental health commissioners will need to develop and agree service development and improvement plans with mental health providers, setting out how providers will prepare for and implement the standards during 2015/16 and achieve these on an ongoing basis from 1 April 2016.
- 4.14 By April 2016, it is expected that more than 50% of people experiencing a first episode of psychosis will receive treatment within two weeks. This will require dedicated specialist early intervention-in-psychosis services, working with local secondary mental health providers. A further £40 million is being made available in 2015/16 through the tariff inflator to support the introduction of this standard.
- 4.15 Commissioners and providers will also need to work together to achieve new waiting time standards for people entering a course of treatment in adult IAPT services. At least 75% of adults should have had their first treatment session within six weeks of referral, with a minimum of 95% treated within 18 weeks. A £10m additional investment is being made available to support these standards.
- 4.16 There is a clear local invest-to-save case for developing adequate and effective levels of liaison psychiatry for all ages in a greater number of acute hospitals. Savings from reduced repeat attendees and four-hour breaches can be as high as £4 for every £1 invested. A £30m targeted investment will also be made available in 2015/16. Commissioners are expected to agree SDIPs with appropriate providers, setting out how providers will ensure there are adequate and effective levels of liaison psychiatry services in acute settings.
- 4.17 The Crisis Care Concordat describes the actions required of commissioners and providers to ensure that those experiencing a mental health crisis are properly supported. This includes the provision of mental health support as an integral part of NHS 111 services; 24/7 Crisis Care Home Treatment Teams; and the need to ensure that there is enough capacity to prevent children, young people or vulnerable adults, undergoing mental health assessments in police cells.
- 4.18 CCGs should work with other local commissioners to invest in community child and adolescent mental health services. Investing in children and young people's mental health and good transition planning improves outcomes for patients and families and generates economic benefits. Investing in effective community services will minimise the use of expensive and often out-of-area tier four services, and the incidence of young people being admitted to inappropriate settings.

- 4.19 NHS England will coordinate a programme using the £30m investment identified in the Autumn Statement to establish community based specialist teams for children and young people with eating disorders.

Transforming care of people with learning disabilities

- 4.20 The Winterbourne View Concordat charged NHS commissioners with achieving a substantial reduction in reliance on inpatient care for people with learning disabilities or autism. Progress since the Concordat has been insufficient. There is a moral as well as practical imperative for us to do better during 2015/16. CCGs working jointly with specialised commissioning and local authorities will have to make demonstrable progress in improving the system of care and reducing reliance on inpatient care for this group: ensuring that nobody becomes an inpatient inappropriately and those who are currently inpatients are supported back into the community. Progress will be monitored through the measures set out at Annex B, and enhanced data collections in future. Following Sir Stephen Bubb's independent report of November 2014 (*Winterbourne View – Time for Change*), NHS England will by spring set out further guidance on transforming care.

5. Enabling change

Harnessing the information revolution and transparency

- 5.1 The new National Information Board (NIB) brings national health and care organisations together with clinical leaders, local government and civil society. It has recently published *Personalised Health and Care 2020: a Framework for Action* which builds on commitments in the Forward View to use data and technology more effectively to transform outcomes for patients and citizens. Technology can help people use care services less by supporting healthier lives and it can transform the cost of services when they are needed. From April 2015, all citizens will have online access to their GP records and a number of related steps are planned by the NIB for 2015/16 which will contribute significantly towards our aim of achieving a 'paperless NHS'.
- 5.2 First, the NHS number will be used as the primary identifier in all settings when sharing information. Commissioners will need explicitly to include this change within their plans. To enforce this change, commissioners will be able, under additional powers proposed through the NHS Standard Contract for 2015/16, to withhold funding from providers unless these conditions are met
- 5.3 Second, patients should have access to an easy-to-use electronic prescription service. We expect that at least 60% of practices will be transmitting prescriptions electronically to the pharmacy electronically by March 2016. Full uptake of the Electronic Prescribing Service is an important precursor to delivering a fully electronic 'click and collect' or 'click and deliver' service for prescriptions.
- 5.4 Third, the 2015/16 GMS contract contains a further commitment to expand and improve the provision of online services for patients, including extending online access to medical records and the availability of online appointments.
- 5.5 Fourth, structured, coded discharge summaries should be available to health professionals electronically everywhere, as required. This will be a legally binding requirement by October 2015.
- 5.6 Fifth, electronic referrals between GPs and other services should become the norm. We expect at least 80% of elective referrals to be made electronically by March 2016, in line with the 2015/16 GMS standard contract. To achieve this, providers will be required to publish all relevant services and appointment slots as part of standard contract obligation.
- 5.7 Sixth, to deliver the NIB's framework *Personalised Health and Care 2020*, local commissioners will be expected to develop a roadmap for the introduction of fully interoperable digital records, including for specialised and primary care. Although not due for publication until April 2016, it will be important to make progress on this key enabler next year. Further guidance on those roadmaps will be published in June 2015, although work can usefully start immediately.

- 5.8 We will bring together hospital, GP, administrative and audit data in initiatives like care.data that support quality improvement, commissioning and research during 2015/16. Individuals will be able to opt out of their data being used in this way.

A modern health and care workforce

- 5.9 The new models of care described in the *Forward View* will only become a reality if we have enough staff with the right skills, values and behaviours to deliver them. We need to develop a workforce able to work across acute and community boundaries and beyond traditional professional demarcations, with flexible skills and with the ability to adapt and innovate.
- 5.10 We expect each health economy to engage with their LETB to work together to identify their current and future workforce needs. For those economies that wish to put themselves forward to co-create the new care models, we expect to see plans to develop the existing and future workforce to deliver these models. In challenged health care economies, a plan to deliver workforce needs will also be a crucial ingredient of success.
- 5.11 At a national level, a new Workforce Advisory Board, chaired by HEE with senior membership from across the system, will be established, to develop a health and care workforce with the skills to support the implementation of new models of care. The Workforce Advisory Board will initially focus on four areas:
- additional actions to retain existing staff and attract returners in roles experiencing shortages such as Emergency Medicine, nursing and GPs;
 - provide support to challenged economies where workforce shortages are impeding improvement;
 - identify the flexibilities that will need to be developed in order to deliver new care models as well as opportunities to reskill the existing workforce;
 - identify new roles that may need to be commissioned to deliver on the aspirations of the *Forward View*.
- 5.12 Commissioners and providers must prepare for the introduction of nursing and midwifery revalidation from the end of December 2015. This will set new requirements for nurses and midwives when they renew their registration every three years.

Accelerating useful innovation

- 5.13 In 2015/16 we will take a number of new steps to accelerate innovation in new treatments and diagnostics. We will be inviting interested manufacturers that are prepared to contribute to the expansion of the 'Commissioning through Evaluation' programme and the related Early Access to Medicines programme. We will aim to accelerate the cost-effective and affordable deployment of technologies and drugs, in the light of the Government's Medicines and Medical Technology Review. At the same time, we will increase the ability of local commissioners to shape their own priorities for investment through place-based commissioning.

5.14 NHS England and NICE will develop a deployment model for new technologies in 2015. This will include consideration of the process and criteria used to identify topics for NICE assessment that relate to NHS England-commissioned services. One goal will be to develop a structured method for introducing new technologies following NICE approval—for example, operational pilots to generate real world evidence about how to most effectively to introduce new therapies or diagnostics. This deployment model should enable the decommissioning of outmoded legacy technologies that are no longer delivering sufficient value for patients and taxpayers.

5.15 The Prime Minister announced in 2014 that by 2017 the NHS would seek to sequence 100,000 whole genomes working through its NHS Genomic Medicine Centres. This project will act as a catalyst for the wider transformation of the NHS in relation to diagnostics, pathology and functional genomics. To support this transformation, commissioners should:

- realign to commission pathology services from Genomics Local Laboratory Hubs (that are being re-procured by NHS England during 2015/16);
- ensure that diagnostic and scientific services are accredited and part of a quality assurance scheme;
- provide data to enable performance and outcomes of diagnostic services to be monitored;
- work towards integration of all diagnostic test results with clinical data, registries and appropriate clinical audit.

6. Driving efficiency

A more productive and efficient NHS

- 6.1 The Forward View describes how we need to achieve 2-3% efficiency per year across total NHS expenditure over the next Parliament in return for the increased public investment, enabling us to absorb future demand with more modest increases in expenditure.
- 6.2 In recent years the NHS has been able to achieve 2% efficiency. However, perhaps 40% of this has been down to pay restraint and other top-down initiatives, such as the national drug-pricing scheme. We do not believe we can rely solely on these initiatives in the next Parliament.
- 6.3 However, there are other opportunities that we have so far failed to capture. One is the potential to close the gap between the least and most efficient providers. For example, recent analysis for Monitor and NHS England calculated that by closing the gap an average acute provider could raise its efficiency by a total of 5.6%.
- 6.4 Another source of opportunity is from productivity gains through technological advancement or improvements to service delivery. Analysis suggests that 1.2-1.3% of this type of efficiency has been achieved in the acute sector over the past four years. This had not been a result of pay restraint or other top-down initiatives; it has been a result of delivering care in better ways. The NHS needs to continue and accelerate these gains in future years.
- 6.5 Closing the gap between the least and most efficient and introducing new and more efficient ways of delivering services offer the opportunity to continue achieving 2% efficiency over the next Parliament. However, we believe overall efficiency (including limiting activity growth to below historic rates) could rise as high as 3% by the end of the five-year period if we move with pace in implementing preventative approaches and new care models.
- 6.6 Our staff are our most precious and expensive resource, accounting for around two thirds of provider expenditure. There are opportunities to improve efficiency and the quality of care through better retention of our existing staff, including by promoting their health and wellbeing, rather than relying on costly short-term responses to vacancies such as agency staff and international recruitment.
- 6.7 Although many prevention programmes are likely to pay off only in the longer term, some have more immediate impacts. These include diabetes prevention, which evidence suggests could begin to show returns in as little as three years. Helping pregnant women to quit smoking produces impact within months, including reduced costs of complex deliveries, still births etc. Action on alcohol could also produce fairly immediate savings, particularly for harmful drinkers and dependent drinkers. We need to combine these actions with a more immediate payback together with those that are nevertheless worth doing but have a longer period of return.

- 6.8 Evidence from leading areas and from international examples suggests we can capture additional opportunities from implementing the new models of care described in the *Forward View*. A critical enabler will be the development of total cost data for individual patients across multiple health and care settings. In the new year we will be doing more work to quantify the additional initial costs of transformation, and the benefits.

NHS funding in 2015/16

- 6.9 £1.98bn of additional investment in the NHS in England was announced by the Chancellor of the Exchequer in the Autumn Statement, including £150m from NHS England through efficiencies and reprioritisation in its central budgets. This implies a real terms funding increases of 1.6%, in line with the funding ambitions outlined in the *Forward View*.
- 6.10 In deploying the additional funding NHS England is seeking to:
- create momentum in the implementation of the *Forward View* by providing a £200m investment fund to promote transformation in local health economies, with a particular focus on investment in the new models of care;
 - deliver on the promise of a new deal for primary care, ensuring that the overall level of total funding growth for primary care is in line with that provided for other local services;
 - ensure that mental health spend will rise in real terms in every CCG and grow at least in line with each CCG's overall allocation growth;
 - accelerate progress towards bringing all CCGs receiving less than their target funding to within 5% of target by 2016/17 whilst also directing funding towards distressed health economies;
 - provide full cover for expected cost growth for each commissioning stream, eliminating the structural deficit in specialised commissioning, and reflecting the rapid growth in these services;
 - enable earlier and more effective planning for operational resilience;
 - reconfirm plans to deliver 10% cash savings in CCG and NHS England administration costs for redeployment to the front line;
 - To give CCGs priority access to the £400m drawdown available. Further details are set out in NHS England's supporting document for commissioners

Joint working between commissioners and providers

- 6.11 For local plans developed by commissioners and providers to be meaningful, and to provide a basis for improvement and transformation, it will be essential for them to be aligned and based on common assumptions. To support this Monitor, the TDA and NHS England have worked together to consider the future pressures and opportunities faced by the health sector as a whole, and agreed a shared set of national planning assumptions which should underpin all local plans.

- 6.12 For key variables, commissioners and providers will need to consider their own circumstances with reference to the national assumptions, and set out robust plans in accordance with these.
- 6.13 We expect greater consistency between the activity and financial trajectories set out in commissioner and provider plans. The extent to which the trajectories are both realistic and sufficiently aligned will be tested through a joined-up process to ensure that all partners have a shared understanding of how local services will be transformed. Significant differences between commissioner and provider finance and activity plans will be reviewed as part of the process. Where these cannot be suitably explained, we may require revised or additional plans.
- 6.14 Each year, activity growth presents a major pressure to the health system, as providers strive to meet the increasing demand for healthcare services with their capacity and resources. Different types of activity – such as elective admissions and A&E attendances – vary by length of stay, care setting, cost, and frequency. Further, they have differential growth rates according to the population’s demand for that particular type of healthcare, and commissioners’ and providers’ ability to manage and reduce that demand.
- 6.15 Commissioners and providers will need to consider the underlying activity pressures specific to them and to their local health economy and type of provision. This should reflect local demographic pressures (nationally, ONS population projections imply roughly 1.3% activity growth per year due to a growing population and changing age mix) while also considering non-demographic trends (for example, new treatments). At a national level, we might expect the overall activity growth pressure, before application of any demand management reduction, to be around 3% per year. We recognise that growth rates will vary for different health economies and encourage providers and commissioners to agree on activity growth assumptions.
- 6.16 Referrals to hospitals in England have been accelerating at a rate higher than demographic pressures. There has been a 4% increase in activity in 2014/15 when compared to the previous year. This trend is significantly above the planned levels agreed between commissioners and providers, with GP referrals and non-elective activity running at 12% and 9% above planned levels respectively. This unplanned growth in demand for care in a hospital setting has been difficult to respond to in a safe and affordable way. It is therefore essential that providers and commissioners work together, with partners in primary and social care, to develop accurate demand and capacity plans that fulfil both the planning requirements and ensure patients have access to high quality services. Commissioners must confirm the level of activity they wish to commission from providers in the 2015/16 standard contract, whilst providers must clearly understand the level of capacity that they have in order to meet demand in a safe and sustainable way.

NHS England and Monitor's proposals on the National Tariff

- 6.17 Input cost inflation is the annual increase in the unit costs of delivering healthcare services. We assume this will be around 3.0% in 2015/16. This assumption incorporates weighted uplifts of components including pay, drugs, general procurement, Clinical Negligence Scheme for Trusts (CNST) and depreciation.
- 6.18 The tariff cost uplift is the corresponding national price uplift associated with these pressures. In the tariff, some costs (particularly CNST) are passed through differentially, as price adjustments for individual services, which means that the national tariff cost uplift is slightly lower than overall cost inflation. Subject to the outcome of NHS England and Monitor's ongoing statutory consultation on the tariff for 2015/16, the uplift should be assumed to be 1.93% in 2015/16. The proposals for the national tariff include a provider efficiency requirement of 3.8% in 2015/16 which means a net decrease of 1.9%. Based on recent analysis for Monitor and NHS England, this efficiency level is realistic although it will require both a large element of "closing the gap" to the level of the best providers, as well as general technological advances and improvements in service delivery.
- 6.19 NHS England and Monitor have proposed that the marginal rate for non-elective activity above the agreed baseline (based on 2008/09 activity levels with baseline revisions in line with national guidance) will be increased from 30% to 50% of tariff for 2015/16. Commissioners and providers must jointly agree plans for spending the 50% balance, which should be targeted towards investment to reduce the level of non-elective admissions. We expect the plans to be published on the commissioners' website by no later than 30 April 2015.

NHS England's requirements for commissioners in key areas

- 6.20 The ambition for the level of improvement agreed by CCGs and Councils in Better Care Fund (BCF) plans should be reviewed if there is a material change in their assessment of the risk to delivery, taking into account:
- actual performance in the year to date, particularly through the winter;
 - the likely outturn for 2014/15;
 - progress with contract negotiations with providers.
- 6.21 Any such review should be undertaken within the partnership underpinning local BCF planning and approved by the Health and Wellbeing Board. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition.
- 6.22 The total additional funding of £1.98bn announced in the 2014 Autumn Statement provides certainty of funding in 2015/16, including for issues such as operational resilience that would previously have been resourced from in-year allocations. As a result, there will be no further in-year allocations during 2015/16. SRGs should

develop local capacity and demand plans that reflect operational resilience funding (including for winter) at the same level received in 2014/15, but funded from baseline allocations.

- 6.23 All commissioners must set aside 1% non-recurrent spend in 2015/16. This will be released for investment in strategic plans – for example, the implementation of the new care models discussed in the *Forward View*, subject to risk assessment by NHS England’s Regional Teams.
- 6.24 Commissioners will offer each provider, through the commissioning for quality and innovation payment framework (CQUIN), the opportunity to earn up to 2.5% of its annual contract value (excluding drugs, devices and other items funded on a pass-through basis). The 2015/16 CQUIN scheme will feature four national indicators, with an even balance between physical and mental health:
- two of the current national indicators will remain in place, with limited updating; these cover improving dementia and delirium care and improving the physical health care of patients with mental health conditions;
 - two new indicators will be introduced, one on the care of patients with acute kidney injury, the other on the identification and early treatment of sepsis;
 - there will also be a new national CQUIN theme on improving urgent and emergency care across local health communities, commissioners will select indicators locally from a menu of options;
 - as planned, the other national CQUIN indicators in 2014/15 covering the safety thermometer and the friends and family test will instead be covered from 2015/16 by new requirements within the NHS Standard Contract.
- 6.25 NHS England will publish separate guidance on the 2015/16 CQUIN framework and the Quality Premium in January.

7. Submission and assurance of 2015/16 plans

Partnership working

- 7.1 All health and social care organisations must work together to develop locally owned and agreed plans. To support mutual working between commissioners, providers and LETBs, we expect local organisations to share their own assumptions with each other – in line with their duties of partnership. For commissioners, this will mean ensuring that plans reflect the local Joint Health and Wellbeing Strategy and that providers and the local communities have been fully engaged in this process. For LETBs, this will mean ensuring that their workforce plans reflect local plans to develop the workforce in general and the requirements of the new models of care in particular. Commissioners and providers working across the system in the interests of patients will be evidenced by the production of final, agreed plans reflected in contracts signed by the 2015/16 deadline.

Planning timetable and milestones

- 7.2 The planning timetable, agreed between NHS England, Monitor and the NHS Trust Development Authority is set out in the table below. It is expected that commissioners will have previously advised providers of their commissioning intentions. The timetable will be challenging for everyone; but it is important that we lay strong foundations for delivery during what will be a testing time for all NHS organisations.
- 7.3 NHS England, Monitor and the TDA will work closely together, along with Health Education England, to provide feedback to CCGs and providers and to ensure alignment and deliverability. This will be an iterative process as providers respond to commissioner plans.

By 23 Dec 2014	Publication of 2015/16 planning guidance
Jan 2015	Publication of revised National Tariff, standard contract for 2015/16
Jan – 11 Mar 2015	Contract negotiations – including voluntary mediation
13 Jan 2015	Submission of initial headline plan data (CCGs, NHS England, NHS Trusts)
From 29 Jan 2015	Weekly contract tracker to be submitted each Thursday (CCGs, NHS England, NHS Trusts and NHS FTs)
13 Feb 2015	Checkpoint for progress with planning measures and trajectories (CCGs, NHS England)
20 February	National contract stocktake – to check the status of contracts

27 Feb 2015	Submission of full draft plans (CCGs, NHS England, NHS Trusts, FTs)
27 Feb – 30 Mar 2015	Assurance of draft plans (CCGs, NHS England, NHS Trusts and FTs)
6 Mar 2015	Checkpoint for progress with planning measures and trajectories (CCGs, NHS England)
11 Mar 2015	Contracts signed post-mediation (CCGs, NHS England, NHS Trusts and FTs)
12 – 23 Mar 2015	Contract arbitration (CCGs, NHS England, NHS Trusts and NHS FTs)
By 25 Mar 2015	Arbitration outcomes notified to commissioners and providers (CCGs, NHS England, NHS Trusts and NHS FTs)
By 31 Mar 2015	Plans approved by Boards of CCGs, NHS Trusts and Foundation Trusts
10 Apr 2015	Submission of full final plans (CCGs, NHS England, NHS Trusts and FTs)
From 10 Apr 2015	Assurance and reconciliation of operational plans

Assurance of Plans

- 7.4 Plans developed by commissioners, NHS Trusts, and NHS Foundation Trusts will be assured by NHS England, the TDA and Monitor respectively, in line with our distinct statutory and regulatory responsibilities.
- 7.5 In addition we will work together to maximise opportunities for mutual assurance across all health and social care services in a way that does not place additional burdens on local organisations. Our joint approach to the review and triangulation of plans will include a focus on ensuring that operational plans demonstrate:
- the finances to secure delivery of the objectives and compliance with the requirements outlined in the planning guidance;
 - that the finance and activity projections are supported by reasonable and deliverable planning assumptions including level of assumed service redesign and underlying activity growth;
 - triangulation of finance and activity;
 - agreed demand and capacity plans;
 - coherence with LETB workforce plans;
 - a focus on prevention;
 - coherence with the other planning and output assumptions;
 - robust local relationships, and good public involvement, which are key to ensuring delivery.

- 7.6 Following the initial submission of headline activity and finance data by NHS Trusts, CCGs and NHS England's direct commissioning teams on 13 January, the TDA and NHS England will each assess the extent to which plan data is consistent with national assumptions and requirements. They will then work together to assess the degree of alignment between commissioner and provider plan data and provide feedback on any identified risks or concerns to local areas. Monitor will contribute to this exercise based on their local intelligence on progress with NHS FT plans.
- 7.7 A checkpoint on 13 February will provide an opportunity to repeat this process ahead of the submission of fuller draft plan templates by commissioners and NHS Trusts on 27 February. A national analytical assurance tool will be used by Regional Teams as the basis of a more detailed assessment of these draft plans, allowing for detailed feedback to local organisations during March.
- 7.8 Signed-off local plans, including those of NHS FTs, must be submitted by 10 April. Monitor, NHS England and the NHS TDA will then each undertake their respective assurance reviews and work together to provide a comprehensive assessment of the completeness and degree of alignment of plans at local health economy level. Public Health England will work with NHS England to help assure commissioners' plans to ensure they have a focus on prevention. Ongoing assurance processes during 2015/16 will ensure that progress continues to be made to deliver local plans, in line with the frameworks set out by Monitor, NHS England and the TDA respectively.
- 7.9 HEE will produce its workforce planning guidance in February. LETBs will triangulate workforce plans with commissioners and providers, before submitting them to HEE for national aggregation and triangulation by July.

Dispute resolution

- 7.10 NHS England, the TDA and Monitor consider it to be a major failing of a health economy where parties do not manage to reach agreement prior to the start of the financial year, and we therefore expect that robust, good value contracts are signed between commissioners and all major providers by 11 March 2015. Where this is not achieved, a joint dispute resolution process will apply. This will be available at <http://www.england.nhs.uk/nhs-standard-contract> and <http://www.ntda.nhs.uk>. The key steps in the dispute resolution process are also set out in the overall timetable on page 13 of the document. The process is not mandatory for providers other than NHS Trusts, but Monitor, the TDA and NHS England support its use for disputes between commissioners and other providers, including NHS Foundation Trusts.



NHS
Trust Development Authority

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Making the health sector
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