

Report to:	Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin, 2 March 2016
-------------------	---

Title	Developing our Sustainability and Transformation Plan (including the Deficit Reduction Plan)
Purpose	To update the Joint Health Overview and Scrutiny Committee on the development of a Sustainability and Transformation Plan for Shropshire and Telford & Wrekin
Date	24 February 2016
Previously considered by	Not applicable

Introduction to Sustainability and Transformation Plans

The leaders of the national health and care bodies in England have set out steps to help local organisations plan over the next six years to deliver a sustainable, transformed health service and to improve quality of care, wellbeing and NHS finances.

Called “Delivering the Forward View, the NHS planning guidance for 2016/17 – 2020/21” (copy attached) it sets the framework within which £560 billion of NHS funding will be spent over the next five years.

The planning guidance outlines a new approach to help ensure that health and care services are planned by place rather than around individual institutions. As in previous years, NHS organisations will be required to produce individual operational plans for 2016/17. In addition, every health and care system will be required, for the first time, to work together to produce a Sustainability and Transformation Plan, a separate but connected strategic plan covering the period October 2016 to March 2021.

As part of this, local leaders will be required to set out clear plans to pursue the ‘triple aim’ set out in the NHS Five Year Forward View – improved health and wellbeing, transformed quality of care delivery, and sustainable finances.

The guidance also outlines nine ‘must dos’ for every local area in England in 2016/17, agreed by the leading health bodies in England. These include:

- returning the system to financial balance
- introducing a local plan to address the sustainability and quality of general practice
- reducing waiting times for A&E, cancer and mental health
- improving quality – particularly for organisations in special measures.

The guidance is supported by the proposal, currently under consultation from Monitor and NHS England, that hospital trusts make annual efficiency savings of 2%.

Further guidance has been issued by the national health and care bodies setting out the requirements for developing Sustainability and Transformation Plans by June 2016.

The nine “must dos” for 2016/17 for every local system

1. Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.
2. Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.
3. Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.
4. Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.
5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.
6. Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
7. Achieve and maintain the two new mental health access standards: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.
8. Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.
9. Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.

Key requirement for developing Sustainability and Transformation Plans

Key requirements for the development of Sustainability and Transformation Plans by Easter include:

- Agreeing the “transformation footprint” for each Sustainability and Transformation Plan (in other words, the geographical coverage of the plan)
- Clarifying the local governance arrangements and processes for agreeing and implementing the Sustainability and Transformation Plan – including how patients and communities will be engaged
- An understanding within the footprint of:

- The health and wellbeing gap.
 - The care and quality gap.
 - The finance and efficiency gap.
 - Further guidance on assessing these gaps is expected during the week beginning 29 February 2016
- An understanding of the key priorities to address the gaps identified above

Our approach in Shropshire and Telford & Wrekin

Our recommendation that the local transformation footprint should be Shropshire and Telford & Wrekin (rather than a larger geography) has been accepted so we have begun to establish our planning process, building on the work already underway on NHS Future Fit, Community Fit, our Deficit Reduction Plan, Primary Care Strategy and other supporting programmes.

A presentation will be provided to the JHOSC to outline the emerging approach (copy attached).

JHOSC views on the following issues (reflecting on your local intelligence, and on your review and scrutiny of health and care issues in the area, in the context of national policy and guidance) are particularly welcomed:

- The health and wellbeing gap in Shropshire and Telford & Wrekin
- The care and quality gap in Shropshire and Telford & Wrekin
- The finance and efficiency gap in Shropshire and Telford & Wrekin
- Priority actions to address the above.

STP Programmes: Deficit Reduction Plan

As reported to the Joint Health Overview and Scrutiny Committee in February, work to develop the Deficit Reduction Plan is continuing and expected to conclude later in March. An oral update will be provided to the meeting.

Enclosures:

- Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21
- Developing Sustainability and Transformation Plans to 2020/21
- Presentation Slides

Update on Winter Pressures and the Urgent and Emergency Care System

Annex 1

Delivering the Forward View: NHS planning guidance
2016/17 – 2020/21

The background of the cover features a photograph of a woman holding a baby. A healthcare professional, wearing a white coat and glasses, is leaning over to examine the baby. The scene is set in a clinical environment. The entire image is overlaid with a semi-transparent blue geometric pattern of squares and triangles. The title text is centered over this image.

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

Delivering the Forward View: NHS planning guidance

2016/17 – 2020/21

Version number: 2

First published: 22 December 2015

Prepared by: NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE).

This document is for: Commissioners, NHS trusts and NHS foundation trusts.

Publications Gateway Reference: 04437

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England*
- NHS Improvement (Monitor and the NHS Trust Development Authority)
- Health Education England (HEE)
- The National Institute for Health and Care Excellence (NICE)
- Public Health England (PHE)
- Care Quality Commission (CQC)

*The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Introduction

1. The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the [Five Year Forward View](#); second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients.
2. It included an £8.4 billion real terms increase by 2020/21, front-loaded. With these resources, we now need to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.
3. In this document, authored by the six national NHS bodies, we set out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. We reflect the settlement reached with the Government through its new [Mandate to NHS England](#) (annex 2). For the first time, the Mandate is not solely for the commissioning system, but sets objectives for the NHS as a whole.
4. We are requiring the NHS to produce two separate but connected plans:
 - a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
 - a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.
5. The scale of what we need to do in future depends on how well we end the current year. The 2016/17 financial challenge for each trust will be contingent upon its end-of-year financial outturn, and the winter period calls for a relentless focus on maintaining standards in emergency care. It is also the case that local NHS systems will only become sustainable if they accelerate their work on prevention and care redesign. We don't have the luxury of waiting until perfect plans are completed. So we ask local systems, early in the New Year, to go faster on transformation in a few priority areas, as a way of building momentum.

Local health system Sustainability and Transformation Plans

6. We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. STPs will cover the period between October 2016¹ and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016. We are asking the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years.

Place-based planning

7. Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve.
8. System leadership is needed. Producing a STP is not just about writing a document, nor is it a job that can be outsourced or delegated. Instead it involves five things: (i) local leaders coming together as a team; (ii) developing a shared vision with the local community, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting. Where collaborative and capable leadership can't be found, NHS England and NHS Improvement² will need to help secure remedies through more joined-up and effective system oversight.
9. Success also depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.
10. As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including: (i) specialised services, where the planning will be led from the 10 collaborative commissioning hubs; and (ii) primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

¹ For the period October 2016 – March 2017, the STP should set out what actions are planned but it does not need to revisit the activity and financial assumptions in the 2016/17 Operational Plan.

² NHS Improvement will be the combined provider body, bringing together Monitor and the NHS Trust Development Authority (TDA).

Access to future transformation funding

11. For the first time, the local NHS planning process will have significant central money attached. The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.
12. The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). For 2016/17 only, to enable timely allocation, the limited available additional transformation funding will continue to be run through separate processes.
13. The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards. The process will be iterative. We will consider:
 - (i) the quality of plans, particularly the scale of ambition and track record of progress already made. The best plans will have a clear and powerful vision. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically borrow good practice from other geographies, and adopt national frameworks;
 - (ii) the reach and quality of the local process, including community, voluntary sector and local authority engagement;
 - (iii) the strength and unity of local system leadership and partnerships, with clear governance structures to deliver them; and
 - (iv) how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities.

Content of STPs

14. The strategic planning process is intended to be developmental and supportive as well as hard-edged. We set out in annex 1 of this document a list of 'national challenges' to help local systems set out their ambitions for their populations. This list of questions includes the objectives set in the Mandate. Do not over-interpret the list as a narrow template for what constitutes a good local plan: the most important initial task is to create a clear overall vision and plan for your area.
15. Local health systems now need to develop their own system wide local financial sustainability plan as part of their STP. Spanning providers and commissioners, these plans will set out the mixture of demand moderation, allocative efficiency, provider productivity, and income generation required for the NHS locally to balance its books.

Agreeing 'transformation footprints'

16. The STP will be the umbrella plan, holding underneath it a number of different specific delivery plans, some of which will necessarily be on different geographical footprints. For example, planning for urgent and emergency care will range across multiple levels: a locality focus for enhanced primary care right through to major trauma centres.
17. The first critical task is for local health and care systems to consider their transformation footprint – the geographic scope of their STP. They must make proposals to us by Friday 29 January 2016, for national agreement. Local authorities should be engaged with these proposals. Taken together, all the transformation footprints must form a complete national map. The scale of the planning task may point to larger rather than smaller footprints.
18. Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, and how it best fits with other footprints such as local digital roadmaps and learning disability units of planning. In future years we will be open to simplifying some of these arrangements. Where geographies are already involved in the Success Regime, or devolution bids, we would expect these to determine the transformation footprint. Although it is important to get this right, there is no single right answer. The footprints may well adapt over time. We want people to focus their energies on the content of plans rather than have lengthy debates about boundaries.

19. We will issue further brief guidance on the STP process in January. This will set out the timetable and early phasing of national products and engagement events that are intended to make it much easier to answer the challenges we have posed, and include how local areas can best involve their local communities in creating their STPs, building on the [‘six principles’ created to support the delivery of the Five Year Forward View](#). By spring 2016, we intend to develop and make available roadmaps for national transformation initiatives.

20. We would welcome any early reactions, by Friday 29 January 2016, as to what additional material you would find most helpful in developing your STP. Please email england.fiveyearview@nhs.net, with the subject title ‘STP feedback’. We would also like to work with a few local systems to develop exemplar, fast-tracked plans, and would welcome expressions of interest to the above inbox.

National 'must dos' for 2016/17

21. Whilst developing long-term plans for 2020/21, the NHS has a clear set of plans and priorities for 2016/17 that reflect the Mandate to the NHS and the next steps on Forward View implementation.
22. Some of our most important jobs for 2016/17 involve partial roll-out rather than full national coverage. Our ambition is that by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care. There are three distinct challenges under the banner of seven day services:
 - (i) reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;
 - (ii) improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital; and
 - (iii) improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.
23. Where relevant, local systems need to reflect this in their 2016/17 Operational Plans, and all areas will need to set out their ambitions for seven day services as part of their STPs.

The nine 'must dos' for 2016/17 for every local system:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.
2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.
3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.
5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.
6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.
8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.
9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

24. We expect the development of new care models will feature prominently within STPs. In addition to existing approaches, in 2016/17 we are interested in trialing two new specific approaches with local volunteers:
- secondary mental health providers managing care budgets for tertiary mental health services; and
 - the reinvention of the acute medical model in small district general hospitals.

Organisations interested in working with us on either of these approaches should let us know by 29 January 2016 by emailing england.fiveyearview@nhs.net

Operational Plans for 2016/17

25. An early task for local system leaders is to run a shared and open-book operational planning process for 2016/17. This will cover activity, capacity, finance and 2016/17 deliverables from the emerging STP. By April 2016, commissioner and provider plans for 2016/17 will need to be agreed by NHS England and NHS Improvement, based on local contracts that must be signed by March 2016.
26. The detailed requirements for commissioner and provider plans are set out in the technical guidance that will accompany this document. All plans will need to demonstrate:
- how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);
 - their planned contribution to the efficiency savings;
 - their plans to deliver the key must-dos;
 - how quality and safety will be maintained and improved for patients;
 - how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
 - how they link with and support with local emerging STPs.

The 2016/17 Operational Plan should be regarded as year one of the five year STP, and we expect significant progress on transformation through the 2016/17 Operational Plan.

27. Building credible plans for 2016/17 will rely on a clear understanding of demand and capacity, alignment between commissioners and providers, and the skills to plan effectively. A support programme is being developed jointly by national partners to help local health economies in preparing robust activity plans for 2016/17 and beyond.

Allocations

28. NHS England's allocations to commissioners are intended to achieve:

- greater equity of access through pace of change, both for CCG allocations and on a place-based basis;
- closer alignment with population need through improved allocation formulae including a new inequalities adjustment for specialised care, more sensitive adjustments for CCGs and primary care, and a new sparsity adjustment for remote areas; and
- faster progress with our strategic goals through higher funding growth for GP services and mental health, and the introduction of the Sustainability and Transformation Fund.

29. In line with our strategic priorities, overall primary medical care spend will rise by 4-5 percent each year. Specialised services funding will rise by 7 percent in 2016/17, with growth of at least 4.5 percent in each subsequent year. The relatively high level of funding reflects forecast pressures from new NICE legally mandated drugs and treatments.

30. To support long-term planning, NHS England has set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations will rise by an average of 3.4 percent, and we will make good on our commitment that no CCG will be more than 5 percent below its target funding level. To provide CCGs with a total place-based understanding of all commissioned spend, alongside allocations for CCG commissioned activities, we will also publish allocations for primary care and specialized commissioned activity.

NHS England will in principle support any proposals from groups of CCGs, particularly in areas working towards devolution who wish to implement a more accelerated cross-area pace-of-change policy by mutual agreement.

31. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign off of a robust STP during 2016/17.

Returning the NHS provider sector to balance

32. During 2016/17 the NHS trust and foundation trust sector will, in aggregate, be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund will replace direct Department of Health (DH) funding. The distribution of this funding will be calculated on a trust by trust basis by NHS Improvement and then agreed with NHS England.
33. NHS England and NHS Improvement are working together to ensure greater alignment between commissioner and provider financial levers. Providers who are eligible for sustainability and transformation funding in 2016/17 will not face a double jeopardy scenario whereby they incur penalties as well as losing access to funding; a single penalty will be imposed.
34. Quarterly release of these Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. The three conditions attached to the transitional NHS provider fund have to be hard-edged. Where trusts default on the conditions access to the fund will be denied and sanctions will be applied.
35. Deficit reduction in providers will require a forensic examination of every pound spent on delivering healthcare and embedding a culture of relentless cost containment. Trusts need to focus on cost reduction not income growth; there needs to be far greater consistency between trusts' financial plans and their workforce plans in 2016/17. Workforce productivity will therefore be a particular priority as just a 1 percent improvement represents £400 million of savings. All providers will be expected to evidence the effective use of e-rostering for nurses, midwives, Health Care Assistants (HCAs) and other clinicians to make sure the right staff are in the right place at the right time to ensure patients get the right hours of care and minimum time is wasted on bureaucracy. This approach will enable providers to reduce their reliance on agency staffing whilst compliance with the agency staffing rules will also reduce the rates paid. In addition, providers will need to adopt tightly controlled procurement practices with compliance incentives and sanctions to drive down price and unwarranted variation. For example, all providers will be expected to report and share data on what they are paying for the top 100 most common non-pay items, and be required to only pay the best price available for the NHS.

36. Capital investments proposed by providers should be consistent with their clinical strategy and clearly demonstrate the delivery of safe, productive services with a business case that describes affordability and value for money. Given the constrained level of capital resource available from 2016/17, there will be very limited levels of financing available and the repayment of existing and new borrowing related to capital investment will need to be funded from within the trust's own internally generated capital resource in all but the most exceptionally pre-agreed cases. Trusts will need to procure capital assets more efficiently, consider alternative methods of securing assets such as managed equipment services, maximize disposals and extend asset lives. In January, the DH will be issuing some revisions to how the PDC dividend will be calculated and a number of other changes to the capital financing regime.

Efficiency assumptions and business rules

37. The consultation on the tariff will propose a 2 percent efficiency deflator and 3.1 percent inflation uplift for 2016/17 (the latter reflecting a step change in pension-related costs). This reflects Monitor and NHS England's assessment of cost inflation including the effect of pension changes. To support system stability, we plan to remain on HRG4 for a further year and there will also be no changes to specialist top-ups in 2016/17; the specialised service risk share is also being suspended for 2016/17. We will work with stakeholders to better understand the impact of the move to HRG4+ and other related changes in 2017/18. For planning purposes, an indicative price list is being made available on the Monitor website. The consultation on the tariff will also include the timetable for implementing new payment approaches for mental health.
38. As notified in [Commissioning Intentions 2016/2017 for Prescribed Specialised Services](#), NHS England is developing a single national purchasing and supply chain arrangement for specialised commissioning high cost tariff excluded devices with effect from April 2016. Transition plans will be put in place prior to this date with each provider to transition from local to national procurement arrangements.
39. The 2 percent efficiency requirement is predicated upon the provider system meeting a forecast deficit of £1.8 billion at the end of 2015/16. Any further deterioration of this position will require the relevant providers to deliver higher efficiency levels to achieve the control totals to be set by NHS Improvement.
40. For 2016/17 the business rules for commissioners will remain similar to those for last year. Commissioners (excluding public health and specialised commissioning) will be required to deliver a cumulative reserve (surplus) of 1 percent. At the very least, commissioners who are unable to meet the cumulative reserve (surplus) requirement must deliver an in-year break-even position. Commissioners with a cumulative deficit will be expected to apply their increase in allocation to improving their bottom line position, other than the amount necessary to fund nationally recognised new policy requirements. Drawdown will be available to commissioners in line with the process for the previous financial year. CCGs should plan to drawdown all cumulative surpluses in excess of 1 percent over the next three years, enabling drawdown to become a more fluid mechanism for managing financial pressures across the year-end boundary.

41. Commissioners are required to plan to spend 1 percent of their allocations non-recurrently, consistent with previous years. In order to provide funds to insulate the health economy from financial risks, the 1 percent non-recurrent expenditure should be uncommitted at the start of the year, to enable progressive release in agreement with NHS England as evidence emerges of risks not arising or being effectively mitigated through other means. Commissioners will also be required to hold an additional contingency of 0.5 percent, again consistent with previous years.
42. CCGs and councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. The plan should build on the 2015/16 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care; further guidance on the BCF will be forthcoming in the New Year.
43. Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase. Where CCGs collaborate with specialised commissioning to improve service efficiency, they will be eligible for a share of the benefits.
44. NHS England and NHS Improvement continue to be open to new approaches to contracting and business rules, as part of these agreements. For example, we are willing to explore applying a single financial control total across local commissioners and providers with a few local systems.

Measuring progress

45. We will measure progress through a new CCG Assessment Framework. NHS England will consult on this in January 2016, and it will be aligned with this planning guidance. The framework is referred in the Mandate as a CCG scorecard. It is our new version of the CCG assurance framework, and it will apply from 2016/17. Its relevance reaches beyond CCGs, because it's about how local health and care systems and communities can assess their own progress.

Timetable

Timetable	Date
Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials	By 29 January 2016
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

Please note that we will announce the timetable for consultation and issuing of the standard contract separately. A more detailed timetable and milestones is included in the technical guidance that will accompany this document.

Annex 1: Indicative 'national challenges' for STPs

STPs are about the holistic pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances. They also need to set out how local systems will play their part in delivering the Mandate (annex 2).

We will publish further guidance early in 2016 to help areas construct the strongest possible process and plan.

We will also make available aids (e.g. exemplar plans) and some hands-on support for areas as they develop their plans.

The questions below give an early sense of what you will need to address to gain sign-off and attract additional national investment.

We are asking local systems first to focus on creating an overall local vision, and the three overarching questions – rather than attempting to answer all of the specifics right from the start. We will be developing a process to offer feedback on these first, prior to development of the first draft of the detailed plans.

A. How will you close the health and wellbeing gap?

This section should include your plans for a 'radical upgrade' in prevention, patient activation, choice and control, and community engagement.

Questions your plan should answer:

1. How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government?
 - How rapidly could you achieve full local implementation of the national Diabetes Prevention Programme? Why should Public Health England (PHE) and NHS England prioritise your geographical area (e.g. with national funding to support the programme)?
 - What action will you take to address obesity, including childhood obesity?
 - How will you achieve a step-change in patient activation and self-care? How will this help you moderate demand and achieve financial balance? How will you embed the six principles of engagement and involvement of local patients, carers, and communities developed to help deliver the Five Year Forward View?

2. How will you make real the aspiration to design person-centred coordinated care, including plans to ensure patients have access to named, responsible consultants?
3. How will a major expansion of integrated personal health budgets and implementation of choice – particularly in maternity, end-of-life and elective care – be an integral part of your programme to hand power to patients?
4. How are NHS and other employers in your area going to improve the health of their own workforce – for example by participating in the national roll out the Healthy NHS programme?

B. How will you drive transformation to close the care and quality gap?

This section should include plans for new care model development, improving against clinical priorities, and rollout of digital healthcare.

Questions your plan should answer:

1. What is your plan for sustainable general practice and wider primary care? How will you improve primary care infrastructure, supported in part through access to national primary care transformation funding?
2. How rapidly can you implement enhanced access to primary care in evenings and weekends and using technology? Why should NHS England prioritise your area for additional funding?
3. What are your plans to adopt new models of out-of-hospital care, e.g Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)? Why should NHS England prioritise your area for transformation funding? And when are you planning to adopt forthcoming best practice from the enhanced health in care homes vanguards?
4. How will you adopt new models of acute care collaboration (accountable clinical networks, specialty franchises, and Foundation Groups)? How will you work with organisations outside your area and learn from best practice from abroad, other sectors and industry?
5. What is your plan for transforming urgent and emergency care in your area? How will you simplify the current confusing array of entry points? What's your agreed recovery plan to achieve and maintain A&E and ambulance access standards?
6. What's your plan to maintain the elective care referral to treatment standard? Are you buying sufficient activity, tackling unwarranted variation in demand, proactively offering patient choice of alternatives, and increasing provider productivity?

7. How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?
8. How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?
9. What steps will your local area take to improve dementia services?
10. As part of the Transforming Care programme, how will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support?
11. How fast are you aspiring to improve the quality of care and safety in your organisations as judged by the Care Quality Commission (CQC)? What is your trajectory for no NHS trust and no GP practice to have an overall inadequate rating from the Care Quality Commission (CQC)?
12. What are you doing to embed an open, learning and safety culture locally that is ambitious enough? What steps are you taking to improving reporting, investigations and supporting patients, their families and carers, as well as staff who have been involved in an incident?
13. What plans do you have in place to reduce antimicrobial resistance and ensure responsible prescribing of antibiotics in all care settings? How are you supporting prescribers to enable them issue the right drugs responsibly? At the same time, how rapidly will you achieve full implementation of good practice in reducing avoidable mortality from sepsis?
14. How will you achieve by 2020 the full-roll out of seven day services for the four priority clinical standards?
15. How will you implement the forthcoming national maternity review, including progress towards new national ambitions for improving safety and increased personalisation and choice?
16. How will you put your Children and Young People Mental Health Plan into practice?
17. How quickly will you implement your local digital roadmap, taking the steps needed to deliver a fully interoperable health and care system by 2020 that is paper-free at the point of care? How will you make sure that every patient has access to digital health records that they can share with their families, carers and clinical teams? How will you increase your online offer to patients beyond repeat prescriptions and GP appointments?

18. What is your plan to develop, retrain and retain a workforce with the right skills, values and behaviours in sufficient numbers and in the right locations to deliver your vision for transformed care? How will you build the multidisciplinary teams to underpin new models of care? How ambitious are your plans to implement new workforce roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice?
19. What is your plan to improve commissioning? How rapidly will the CCGs in your system move to place-based commissioning? If you are a devolution area, how will implementation delivery real improvements for patients?
20. How will your system be at the forefront of science, research and innovation? How are you implementing combinatorial innovation, learning from the forthcoming test bed programme? How will services changes over the next five years embrace breakthroughs in genomics, precision medicine and diagnostics?

C. How will you close the finance and efficiency gap?

This section should describe how you will achieve financial balance across your local health system and improve the efficiency of NHS services.

Questions your plan should answer:

1. How will you deliver the necessary per annum efficiency across the total NHS funding base in your local area by 2020/21?
2. What is your comprehensive and credible plan to moderate demand growth? What are the respective contributions in your local system of: (i) tackling unwarranted variation in care utilisation, e.g. through RightCare; (ii) patient activation and self-care; (iii) new models of care; and (iv) urgent and emergency care reform implementation?
3. How will you reduce costs (as opposed to growing income) and how will you get the most out of your existing workforce? What savings will you make from financial controls on agency, whilst ensuring appropriate staffing levels? What are your plans for improving workforce productivity, e.g. through e-rostering of nurses and HCAs? How are you planning to reduce cost through better purchasing and medicines management? What efficiency improvements are you planning to make across primary care and specialised care delivery?

4. What capital investments do you plan to unlock additional efficiency? How will they be affordable and how will they be financed?
5. What actions will you take as a system to utilise NHS estate better, disposing of unneeded assets or monetising those that could create longer-term income streams? How does this local system estates plan support the plans you're taking to redesign care models in your area?

Annex 2: The Government's mandate to NHS England 2016/17

The table below shows NHS England's objectives with an overall measurable goal for this Parliament and clear priority deliverables for 2016-17. The majority of these goals will be achieved in partnership with the Department of Health (DH), NHS Improvement and other health bodies such as Public Health England (PHE), Health Education England (HEE) and the Care Quality Commission (CQC). It also sets out requirements for NHS England to comply with in paragraph 6.2.

Read the full [Mandate to NHS England](#)

1. Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.	
1.1 CCG performance	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Consistent improvement in performance of CCGs against new CCG assessment framework. <hr/> <p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • By June, publish results of the CCG assessment framework for 2015-16, which provides CCGs with an aggregated Ofsted style assessment of performance and allows them to benchmark against other CCGs and informs whether NHS England intervention is needed. • Ensure new Ofsted-style CCG framework for 2016-17 includes health economy metrics to measure progress on priorities set out in the mandate and the NHS planning guidance including overall Ofsted-style assessment for each of cancer, dementia, maternity, mental health, learning disabilities and diabetes, as well as metrics on efficiency, core performance, technology and prevention. • By the end of Q1 of 2016-17, publish the first overall assessment for each of the six clinical areas above.

2. To help create the safest, highest quality health and care service.

2.1 Avoidable deaths and seven-day services

Overall 2020 goals:

- Roll out of seven-day services in hospital to 100 percent of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week.
- Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements.
- Support NHS Improvement to significantly increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures.
- Measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50 percent by 2030 with a measurable reduction by 2020.
- Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes, including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients.
- Measurable improvement in antimicrobial prescribing and resistance rates.

2016-17 deliverables:

- Publish avoidable deaths per trust annually and support NHS Improvement to help trusts to implement programme to improve from March 2016 baseline.
- Rollout of four clinical priority standards in all relevant specialties to 25 percent of population.
- Implement agreed recommendations of the National Maternity Review in relation to safety, and support progress on delivering Sign up to Safety.
- Support the Government's goal to establish global and UK baseline and ambition for antimicrobial prescribing and resistance rates.

2.2 Patient experience	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96 percent), and ensure its effectiveness, alongside other sources of feedback to improve services. • 50-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 4,000). • Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home.
	<p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • Produce a plan with specific milestones for improving patient choice by 2020, particularly in maternity, end-of-life care (including to ensure more people are able to achieve their preferred place of care and death), and personal health budgets. • Building on the FFT, develop proposals about how feedback, particularly in maternity services, could be enhanced to drive improvements to services at clinical and ward levels.
2.3 Cancer	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Deliver recommendations of the Independent Cancer Taskforce, including: <ul style="list-style-type: none"> ○ significantly improving one-year survival to achieve 75 percent by 2020 for all cancers combined (up from 69 percent currently); and ○ patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.
	<p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • Achieve 62-day cancer waiting time standard. • Support NHS Improvement to achieve measurable progress towards the national diagnostic standard of patients waiting no more than six weeks from referral to test. • Agree trajectory for increases in diagnostic capacity required to 2020 and achieve it for year one. • Invest £340 million in providing cancer treatments not routinely provided on the NHS through the Cancer Drugs Fund, and ensure effective transition to the agreed operating model to improve its effectiveness within its existing budget.

3. To balance the NHS budget and improve efficiency and productivity

3.1 Balancing the NHS budget

Overall 2020 goals:

- With NHS Improvement, ensure the NHS balances its budget in each financial year.
- With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3 percent each year), including from reducing growth in activity and maximising cost recovery.

2016-17 deliverables:

- With NHS Improvement ensure the NHS balances its budget, with commissioners and providers living within their budgets, and support NHS Improvement in:
 - securing £1.3 billion of efficiency savings through implementing Lord Carter's recommendations and collaborating with local authorities on Continuing Healthcare spending;
 - delivering year one of trust deficit reduction plans and ensuring a balanced financial position across the trust sector, supported by effective deployment of the Sustainability and Transformation Fund; and
 - reducing spend on agency staff by at least £0.8 billion on a path to further reductions over the Parliament.
- Roll-out of second cohort of RightCare methodology to a further 60 CCGs.
- Measurable improvement in primary care productivity, including through supporting community pharmacy reform.
- Work with CCGs to support Government's goal to increase NHS cost recovery up to £500 million by 2017-18 from overseas patients.
- Ensure CCGs' local estates strategies support the overall goal of releasing £2 billion and land for 26,000 homes by 2020.

4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.

<p>4.1 Obesity and diabetes</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Measurable reduction in child obesity as part of the Government’s childhood obesity strategy. • 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme. • Measurable reduction in variation in management and care for people with diabetes. <hr/> <p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • Contribute to the agreed child obesity implementation plan, including wider action to achieve year on year improvement trajectory for the percentage of children who are overweight or obese. • 10,000 people referred to the Diabetes Prevention Programme.
<p>4.2 Dementia</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Measurable improvement on all areas of Prime Minister’s challenge on dementia 2020, including: <ul style="list-style-type: none"> ○ maintain a diagnosis rate of at least two thirds; ○ increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral; and ○ improve quality of post-diagnosis treatment and support for people with dementia and their carers. <hr/> <p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • Maintain a minimum of two thirds diagnosis rates for people with dementia. • Work with National Institute for Health Research on location of Dementia Institute. • Agree an affordable implementation plan for the Prime Minister’s challenge on dementia 2020, including to improve the quality of post-diagnosis treatment and support.

5. To maintain and improve performance against core standards

5.1 A&E, ambulances and Referral to Treatment (RTT)

Overall 2020 goals:

- 95 percent of people attending A&E seen within four hours; Urgent and Emergency Care Networks rolled out to 100 percent of the population.
- 75 percent of Category A ambulance calls responded to within 8 minutes.
- At least 92% of patients on incomplete non-emergency pathways to have been waiting no more than 18 weeks from referral; no-one waits more than 52 weeks.

2016-17 deliverables:

- With NHS Improvement, agree improvement trajectory and deliver the plan for year one for A&E.
- Implement Urgent and Emergency Care Networks in 20 percent of the country designated as transformation areas, including clear steps towards a single point of contact.
- With NHS Improvement, agree improvement trajectory and deliver the plan for year one for ambulance responses; complete Red 2 pilots and decide on full roll-out.
- With NHS Improvement, meet the 18-week referral-to-treatment standard, including implementing patient choice in line with the NHS Constitution; and reduce unwarranted variation between CCG referral rates to better manage demand.

6. To improve out-of-hospital care.

6.1 New models of care and general practice

Overall 2020 goals:

- 100 percent of population has access to weekend/evening routine GP appointments.
- Measurable reduction in age standardised emergency admission rates and emergency inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50 percent of population.
- Significant measurable progress in health and social care integration, urgent and emergency care (including ensuring a single point of contact), and electronic health record sharing, in areas covered by the New Care Model programme.
- 5,000 extra doctors in general practice.

	<p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • New models of care covering the 20 percent of the population designated as being in a transformation area to: <ul style="list-style-type: none"> ○ provide access to enhanced GP services, including evening and weekend access and same-day GP appointments for all over 75s who need them; and ○ make progress on integration of health and social care, integrated urgent and emergency care, and electronic record sharing. • Publish practice-level metrics on quality of and access to GP services and, with the Health and Social Care Information Centre, provide GPs with benchmarking information for named patient lists. • Develop new voluntary contract for GPs (Multidisciplinary Community Provider contract) ready for implementation in 2017-18.
<p>6.2 Health and social care integration</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Achieve better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the government's key criteria for devolution. • Ensure the NHS plays its part in significantly reducing delayed transfers of care, including through developing and applying new incentives. <p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • Implement the Better Care Fund (BCF) in line with the BCF Policy Framework for 2016-17. • Every area to have an agreed plan by March 2017 for better integrating health and social care. • Working with partners, achieve accelerated implementation of health and social care integration in the 20 percent of the country designated as transformation areas, by sharing electronic health records and making measurable progress towards integrated assessment and provision. • Work with the Department of Health, other national partners and local areas to agree and support implementation of local devolution deals. • Agree a system-wide plan for reducing delayed transfers of care with overall goal and trajectory for improvement, and with local government and NHS partners implement year one of this plan.

	<p>2016-17 requirements:</p> <ul style="list-style-type: none"> • NHS England is required to: <ul style="list-style-type: none"> ○ ring-fence £3.519 billion within its allocation to CCGs to establish the Better Care Fund, to be used for the purposes of integrated care; ○ consult the Department of Health and the Department for Communities and Local Government before approving spending plans drawn up by each local area; and ○ consult the Department of Health and the Department for Communities and Local Government before exercising its powers in relation to failure to meet specified conditions attached to the Better Care Fund as set out in the BCF Policy Framework.
<p>6.3 Mental health, learning disabilities and autism</p>	<p>Overall 2020 goal:</p> <ul style="list-style-type: none"> • To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce). • Access and waiting time standards for mental health services embedded, including: <ul style="list-style-type: none"> ○ 50 percent of people experiencing first episode of psychosis to access treatment within two weeks; and ○ 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks. <p>2016-17 deliverables:</p> <ul style="list-style-type: none"> • 50 percent of people experiencing first episode of psychosis to access treatment within two weeks. • 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks. • Increase in people with learning disabilities/autism being cared for by community not inpatient services, including implementing the 2016-17 actions for Transforming Care. • Agree and implement a plan to improve crisis care for all ages, including investing in places of safety. • Oversee the implementation of locally led transformation plans for children and young people’s mental health, which improve prevention and early intervention activity, and be on track to deliver national coverage of the children and young people’s Improving Access to Psychological Therapies (IAPT) programme by 2018. • Implement agreed actions from the Mental Health Taskforce.

7. To support research, innovation and growth.

7.1 Research and growth

Overall 2020 goals:

- Support the Department of Health and the Health Research Authority in their ambition to improve the UK's international ranking for health research.
- Implement research proposals and initiatives in the NHS England research plan.
- Measurable improvement in NHS uptake of affordable and cost-effective new innovations.
- To assure and monitor NHS Genomic Medicine Centre performance to deliver the 100,000 genomes commitment.

2016-17 deliverables:

- Implement the agreed recommendations of the Accelerated Access Review including developing ambition and trajectory on NHS uptake of affordable and cost-effective new innovations.

7.2 Technology

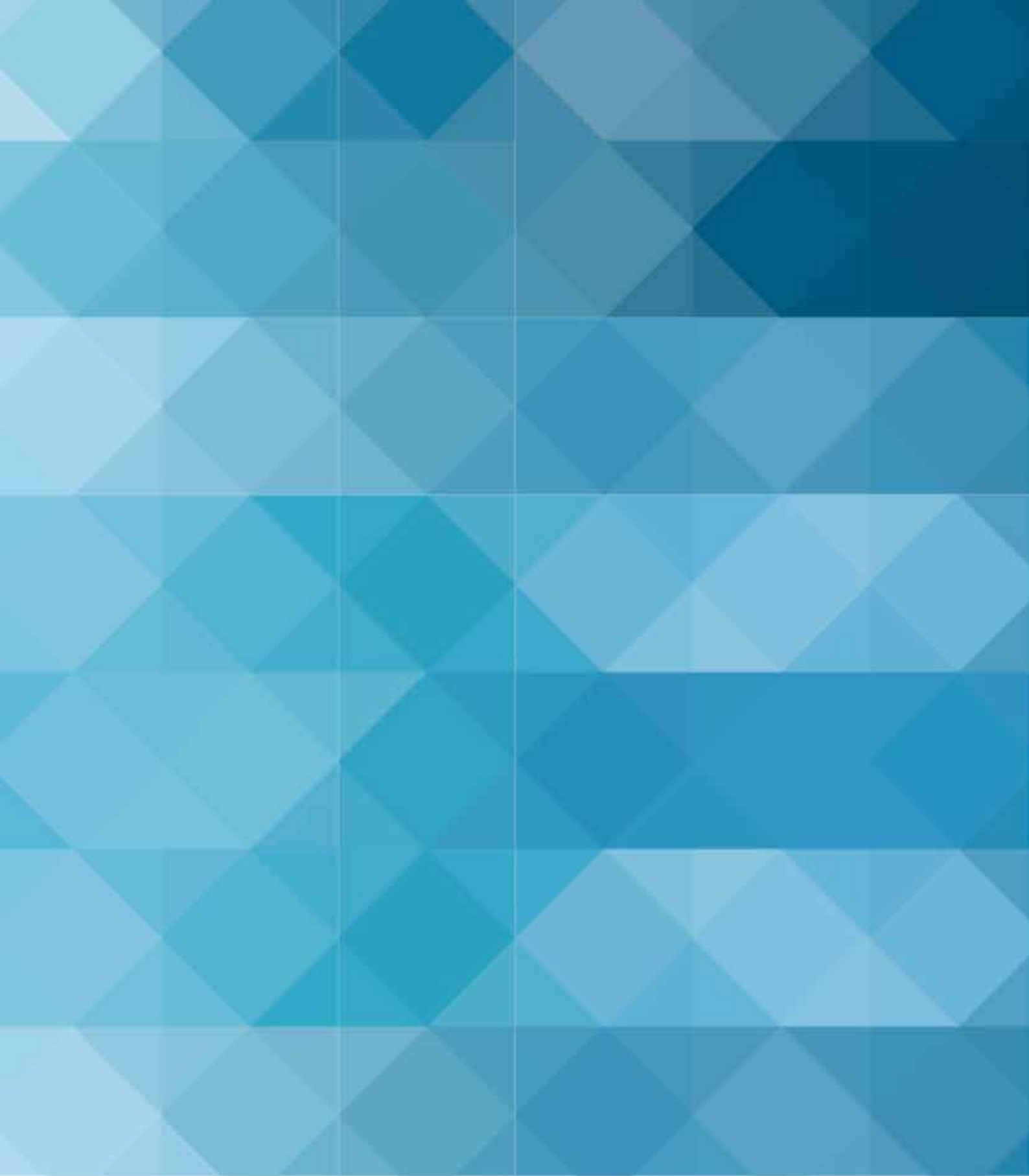
Overall 2020 goals:

- Support delivery of the National Information Board Framework 'Personalised Health and Care 2020' including local digital roadmaps, leading to measurable improvement on the new digital maturity index and achievement of an NHS which is paper-free at the point of care.
- 95 percent of GP patients to be offered e-consultation and other digital services; and 95 percent of tests to be digitally transferred between organisations.

2016-17 deliverables:

- Minimum of 10 percent of patients actively accessing primary care services online or through apps, and set trajectory and plan for achieving a significant increase by 2020.
- Ensure high quality appointment booking app with access to full medical record and agreed data sharing opt-out available from April 2016.
- Robust data security standards in place and being enforced for patient confidential data.
- Make progress in delivering new consent-based data services to enable effective data sharing for commissioning and other purposes for the benefit of health and care.
- Significant increase in patient access to and use of the electronic health record.

7.3 Health and work	Overall 2020 goal: <ul style="list-style-type: none">• Contribute to reducing the disability employment gap.• Contribute to the Government's goal of increasing the use of Fit for Work.
	2016-17 deliverables: <ul style="list-style-type: none">• Continue to deliver and evaluate NHS England's plan to improve the health and wellbeing of the NHS workforce.• Work with Government to develop proposals to expand and trial promising interventions to support people with long-term health conditions and disabilities back into employment.



#FutureNHS

Update on Winter Pressures and the Urgent and Emergency Care System

Annex 2

Developing Sustainability and Transformation Plans to 2020/21



To: CCG Accountable Officers,
Chief Executives of NHS trusts,
NHS foundation trusts and Local
Authorities and LETB Geographical
Directors

By email

16 February 2016

Dear colleague

Re: Developing Sustainability and Transformation Plans to 2020/21

The [NHS Shared Planning Guidance](#) asked every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the Five Year Forward View (5YFV). Sustainability and Transformation Plans (STPs) will be place-based, multi-year plans built around the needs of local populations. They will help ensure that the investment secured in the Spending Review does not just prop up individual institutions for another year, but is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term. STPs are not an end in themselves, but a means to build and strengthen local relationships, enabling a shared understanding of where we are now, our ambition for 2020 and the concrete steps needed to get us there.

We have been encouraged by the speed and enthusiasm with which most areas have already come together to agree their footprints and start the conversations. The boundaries used for STPs will not cover all planning eventualities. As with the current arrangements for planning and delivery, there are layers of plans which sit above and below STPs, with shared links and dependencies. For example, neighbouring STP areas will need to work together when planning specialised or ambulance services or working with multiple local government authorities and, for areas within a proposed devolution footprint that cross STP boundaries, further discussion will be required in working through the implications. Other issues will be best planned at Clinical Commissioning Group (CCG) level.

If we get this right, then together we will:

- engage patients, staff and communities from the start, developing priorities through the eyes of those who use and pay for the NHS;
- develop services that reflect the needs of patients and improve outcomes by 2020/21 and, in doing so, help close the three gaps across the health and care system that were highlighted in the 5YFV (health and wellbeing, care and quality, and finance and efficiency);
- mobilise local energy and enthusiasm around place-based systems of health and care, and develop the partnerships, governance and capacity to deliver;
- provide a better way of spreading and connecting successful local initiatives, providing a platform for investment from the Sustainability and Transformation Fund; and



- develop a coherent national picture that will help national bodies support what local areas are trying to achieve.

This will require a different type of planning process – one that releases energy and ambition and that focusses the right conversations and decisions. It will require the NHS, at both the local and national level, to work in partnership across organisational boundaries and sectors.

This letter sets out our initial thinking on STPs – please see **Annex A** for further detail. We recognise that you and your teams are also working hard on operational plans, so over the next few weeks and months we will develop an active programme of support for our local and national teams, based on what you tell us you need.

We look forward to continuing to work closely with you to deliver this important work.

Yours faithfully

David Behan, Chief Executive, Care Quality Commission

Ian Cumming, Chief Executive, Health Education England

Sir Andrew Dillon, Chief Executive, National Institute for Health and Care Excellence

Jim Mackey, Chief Executive - Designate, NHS Improvement

Duncan Selbie, Chief Executive, Public Health England

Simon Stevens, Chief Executive, NHS England



Annex A

Stage 1: Before Easter – developing local leadership and collaboration

1. To have a realistic prospect of developing good plans by the summer, we will need to have agreed three things for each of the STP footprints by Easter:
 - (i) the governance arrangements and processes needed to produce an agreed STP and then to implement it;
 - (ii) the scale of the challenge locally for each of the three gaps; and
 - (iii) key priorities identified to address each gap.
2. **Governance arrangements:** Building the relationships and collective leadership needed to make STPs real will take dedicated time, effort and resource. Different areas will be at different starting points. In some areas, local leaders are already working together on established transformation projects. In other areas, relationships and strategies are less mature, requiring intensive focus in the early stages.
3. Each footprint will need to set out governance arrangements for agreeing and implementing a plan. This should include the nomination of a named person who will be responsible for overseeing and coordinating their STP process – a senior and credible leader who can command the trust and confidence of the system, such as a CCG Chief Officer, a provider Chief Executive or a Local Authority Chief Executive. They will be responsible for convening and chairing system-wide meetings and facilitating open and honest conversations that will be necessary to secure sign-up to a shared vision and plan. We would expect to see time and resource dedicated to this system leadership role.
4. STPs will need to be developed with, and based on the needs of, local patients and communities and command the support of clinicians, staff and wider partners. We therefore anticipate robust plans for genuine engagement as part of the decision making process. This doesn't mean beginning from scratch. Where relevant, areas should build on existing engagement through Health and Wellbeing Boards and other existing local arrangements. Health Education England has agreed that they will establish a local Workforce Advisory Board to coordinate and support the workforce requirements for each STP footprint.
5. **The scale of the challenge:** Partners in each footprint area will need to quickly get a sense of the scale of the forecast challenge in their local area, by working out the extent of the three gaps. To accelerate this process, we will provide a method with data to enable local partners to diagnose current and projected gaps in health and wellbeing, care and quality and finance and efficiency, including current and expected delivery on key service priorities such as cancer and seven day services. We will publish more detail on this during the week commencing **29 February 2016**.
6. **Identify key priorities:** An assessment of the three gaps, alongside a consideration of local challenges where patients and populations need to see most improvement, will help each area to identify the key priorities they need to tackle over the next five years to achieve sustainable transformation. Where, for example, Vanguards and



Integrated Care Pioneers are leading the transition to new care models, local leaders will want to set out how the learning from these can be applied in the coming years.

7. There is clearly a lot to do in a short space of time. To help support local and national learning, each footprint will be asked to attend one of four regional 'development days' to share their emerging thinking with one other and with the Chief Executives of the national bodies. This will help us to identify further areas for support and shape the next stage of the process. Ahead of these regional 'development days' we will ask each planning footprint to make a short return on the above three issues (governance, gap analysis and key issues).
8. **National support until Easter:** By March, we will provide each local system with:
 - **Input into assessing each of their three gaps** – this will set out the key health and well-being outcomes the NHS and partners need to improve by preventing illness, diagnosing disease earlier and treating it more effectively; the quality improvement and service change priorities by 2020, such as moving to seven day services and (by the end of March) provide each area with analytical support to help assess its financial gap.
 - **Share information and provide support** – based on what you tell us you need and using some of the tools that Vanguard and other collaborations have found useful as they have developed new systems and relationships. This will include using logic models as a basis for longer-term planning, and information about the core components of the different care models (e.g. multi-speciality community providers (MCPs) and primary and acute care systems (PACS) or devolved arrangements).
 - **Publish advice on engaging individuals, communities and staff** – drawing on exemplar practice from the service and partners and the ['six principles'](#) developed by the People and Communities 5YFV Board.

In addition we will:

- ask our regional teams and partners to support the process of building local leadership and effective decision-making, sharing what we've learned from working with, for example, Vanguard sites and others through communities of practice;
- work with you to identify and enlist a group of respected individuals who have the experience and credibility to mentor and catalyse system leadership where it is needed. This could include people with experience of health leadership roles, as well as local government and the voluntary sector. We will make this offer to all local areas that would benefit from individual support to accelerate progress; and
- share some further tools, templates and guidance along with some exemplars to support local development of returns. For example we will work quickly with a small number of leading systems as they develop their plans to provide models for what good Easter returns and June plans look like and make these available to everyone.

Stage 2: after Easter – developing the STP



9. After Easter, local area partners will be able to focus on more of the detail of their plans and the actions required to close the three gaps over the next five years. To do this, they should consider their response to the set of questions outlined in the annex to the Shared Planning Guidance, given the results of their gap analysis and continuing engagement with local communities, staff and other partners.
10. The Shared Planning Guidance sets out nine 'must dos'. Many, if not all, of these will require action beyond 2016/17. A good STP will therefore set out how areas will maintain and deepen the progress they will make by implementing their operational plans. This is one tangible way in which 2016/17 operational plans need to be closely linked to STPs, and conceived as the first steps on the way to wider transformation.
11. Strong STPs will set out a broader platform for transforming local health and care services. We will work with the footprints to help us develop the detailed requirements. However, as a minimum, we expect that all plans will:
 - describe a local cross-partner prevention plan, with particular action on national priorities of obesity and diabetes and locally identified priorities to reduce demand and improve the health of local people;
 - increase investment in the out-of-hospital sector, including considering how to deliver primary care at scale;
 - set out local ambitions to deliver seven day services. In particular: (i) improving access and better integrating 111, minor injuries, urgent care and out-of-hours GP services; (ii) improving access to primary care at weekends and evenings; and (iii) implementing the four priority clinical standards for hospital services every day of the week;
 - support the accelerated delivery of new care models in existing Vanguard sites; or in systems without Vanguards, set out plans for implementing new models of care with partners;
 - set out collective action on quality improvement, particularly where services are rated inadequate or are in special measures;
 - set out collective action on key national clinical priorities such as improving cancer outcomes; increasing investment in mental health services and parity of esteem for mental health patients; transforming learning disabilities services; and improving maternity services;
 - ensuring these and other changes return local systems to financial balance, together with the increased investment that will come on-stream as set out in NHS England's allocations to CCGs; and
 - be underpinned by a strategic commitment to engagement at all levels, informed by the 'six principles'.
12. We must avoid creating distinct plans for each specialty or initiative, and instead grasp the opportunity to achieve greater alignment and coherence between programmes and priorities. Local leaders will also want to ensure that their plans are underpinned by action on the key enablers of change, including harnessing technology and workforce redesign, working closely with their Local Education and Training Boards (LETBs). Local areas should also have considered the fit between



their STP footprint and their local plans for integrated health and social care more broadly, and decided on the high-level model of person-centred, coordinated care that they would look to develop.

13. The aim should be to produce an STP that is based upon strong analysis and insight rather than a glossy brochure. The process of exposing these issues and having real conversations about the potential benefits for patients is as least as important as the final product itself. A robust process will enable STPs to set out the actions that will make a difference for local people rather than abstract principles or vision statements. The examples we publish at Easter will give local areas a better sense of what a good final document looks like, but we are clear that a good process is one that unleashes energy, facilitates real conversations and strengthens local relationships around a shared sense of purpose.

14. National support after Easter:

- In April and May, we will host a programme of regional workshops and webinars with subject matter experts to provide practical help with developing plans. We will continue to make available online collaborative tools so that local areas can share information and examples of emerging best practice, based on what you tell us would be most helpful.
- These will be supplemented by a suite of 'how to' materials so that we can develop a shared understanding of what good looks like on topics including implementing the Cancer and Mental Health Taskforce reports, developing and spreading new models of care, workforce redesign and planning for interoperability and digital services.
- Our regional teams and their partners will continue to work closely with local footprints as they develop the detail of their plans, to enable effective communication and learning across the system.

Sustainability and Transformation Funding

15. There will be tangible benefits for areas with good STPs. The Spending Review settlement enabled us to invest £2.139bn in a Sustainability and Transformation Fund in 2016/17. Of this total, £1.8bn of funding has been allocated to the sustainability element of the fund to bring the NHS provider trust sector back to financial balance.

16. Quarterly release of sustainability funds to NHS trusts and NHS foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. It is not a case of recovery followed by transformation. They are not alternatives; we must do both simultaneously.

17. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign-off of a robust STP during 2016/17.



18. The Sustainability and Transformation Fund will grow from £2.1bn in 2016/17 to £2.9bn in 2017/18, rising to £3.4bn in 2020/21, with an increasing share of the growing fund being deployed on transformation.
19. The STPs will become the single application and approval process for being accepted onto programmes with transformation funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.
20. Recognising that different systems are at different starting points, the most credible and compelling STPs will secure the earliest funding. We will assess plans in July, and – as the Shared Planning Guidance sets out – we will consider:
- the quality of plans, particularly the scale of ambition and track record of progress already made in addressing each of the three gaps. The best plans will have a clear and powerful vision across health, quality and finance, owned by all local partners in the system. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new models of care; trusts in special measures and finance. They will systematically borrow good practice from other geographies and adopt national frameworks;
 - the reach and quality of the local process, including community and voluntary sector engagement;
 - the strength, maturity and unity of local system leadership and partnerships, with clear governance structures to deliver them;
 - how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities; and
 - the extent to which systems can already point to tangible, early progress.
21. Part of this process will involve a second series of regional events hosted by the Chief Executives of the national bodies. Taking place in July, these regional summits will be an opportunity to test the plans that local systems have submitted, and agree the actions we will take to deliver them.

22. Contacts:

For any queries, please contact the Regional Director from the relevant national body in the first instance or please email england.fiveyearview@nhs.net

23. Key Dates:

What	Who	When
Further engagement and support on gap analysis and STP development	National bodies	Week commencing 29 February 2016
Gap analysis / data developed with each footprint	National bodies / Regional Directors / footprints	Throughout March 2016
Short return, including	Each footprint	11 April 2016



priorities, gap analysis and governance arrangements		
Outline STPs presented	Footprints to attend regional events to discuss emerging plans with peers and national bodies	w/c 22 April 2016
Each footprint area to develop plans and build support with their boards and partners	As set out in local governance arrangements	During April/May/early June 2016
Ongoing engagement and support from national policy experts and teams to support priority development	National policy teams and experts	During April and May 2016
Each footprint to submit their STP	To Regional Directors and then the 5YFV Board of national body Chief Executives	30 June 2016
Series of regional conversations between national teams and footprints	The NHS national body Chief Executives, National Directors, partners and footprints	Throughout July 2016

Update on Winter Pressures and the Urgent and Emergency Care System

Annex 3

Presentation Slides

Shropshire and Telford and Wrekin Sustainability and Transformation Plan (STP)

Introduction

The last spending review set out the basis for:

- * Implementation of the “Five Year Forward View”
- * Restoring and maintaining financial balance to the NHS
- * Delivery of core access and quality standards for patients

What we have to do?

- * Following the spending review we now have national guidance outlining the requirement to:
 - Develop a Five Year Sustainability and Transformation Plan (STP), based on local health and social care systems and delivering the Five Year Forward View.
 - Develop a one year operational plan for each organisation, consistent with the STP – a year of stabilisation.
- * STPs are to be submitted by the 30 June 2016 and will be formally assessed in July 2016.

Context of the STPs

- * Planning by individual institutions increasingly supplemented with planning by place for population
- * System leadership will be needed and involve:
 - o Local health and social care leaders coming together as a team
 - o Developing a shared vision with the local community
 - o Setting out a programme of activities to make the STP happen
 - o Implementation of the plan once it is written
 - o Learning and adapting to develop the right solution
- * Engaging and iterative process that harmonises the energies of clinicians, patients, carers and citizens and local community partners.
- * Must cover all areas of CCG and NHS England spend as well as relevant local authority services reflecting health and wellbeing strategies.

Access to Transformation Funding

- * For the first time the planning process will have significant central money attached
- * STP will be the single application and approval process for transformation funding for 2017/18 onward
- * This protected funding is for initiatives such as the spread of new care models, technology roll out, prevention etc
- * The criteria to assess STPs will include:
 - Scale of ambition, track record of progress already made
 - Clear and powerful vision with a coherent story across the system
 - The reach and quality of the local process
 - The strength and unity of the local system leadership and partnerships
 - Confidence that there is a clear sequence of implementation actions

Context of STPs

- * A clear overall vision and plan for the area including system-wide financial sustainability
- * Agreement of the transformation footprint (Shropshire and Telford & Wrekin)
- * Clear plan for the radical upgrade in prevention, patient activation, choice and control and community engagement – how we will close the health and wellbeing gap
- * New care model development, improving against clinical priorities and rollout of digital healthcare – how we will drive transformation to close the care and quality gap
- * Achieving financial balance around the local systems and improve the efficiency of NHS services – how we will close the financial and efficiency gap

What are we doing in Shropshire and Telford and Wrekin?

- * Build on what is already in place (e.g. NHS Future Fit)
- * Putting in place the governance and implementation process for the STP – building on what is in place rather than creating a new bureaucracy
- * Working in partnership across the local health and care system to develop our approach in the context of emerging national guidance
- * Creating a coherent and shared vision across the health and care system

Key questions for the Joint HOSC

Considering your work programme and intelligence:

- * What are the main features of the **Health and Wellbeing Gap** in Shropshire and Telford & Wrekin
- * What are the main features of the **Care and Quality Gap** in Shropshire and Telford & Wrekin
- * What are the main features of the **Finance and Efficiency Gap** in Shropshire and Telford & Wrekin
- * What views do you have on the main priorities to address these gaps?

Questions