# 2 Year Planning Process Guidance

Author: Gino DiStefano Sponsor: Paul Traynor **Trust Board paper J**

## Executive Summary

## Context

This paper summarises the recently published national planning guidance and what it means for our internal planning over the coming weeks and months.

Our integrated operational plan (sometimes referred to as our Annual Plan) describes how we will meet the expectations of our patients, the regulator, commissioners and other stakeholders on our journey to sustainability, whilst also focusing on tackling immediate performance issues and ensuring short-term resilience.

We must also ensure our plan (and priorities for the coming year/s) reflects national planning requirements and the local / emerging sustainability and transformation plan (STP).

## Questions

What are the key messages within the national planning guidance for 2016/17 to 2020/21?
How are the key risks and mitigations / next steps?

## Conclusion

Some of the key messages from the planning guidance include:

- Organisations must produce a two year plan covering 17/18 and 18/19
- Like last year, a notable theme running throughout the guidance is one of partnerships / collaboration (system-wide working)
- Our operational plan must reflect the local STP and directly form part of the delivery mechanism
- There needs to be significant focus on new models of care at both a system level and within provider organisations.
- The timetable is much, much shorter than usual.
- There are 9 national must dos that build on those we saw last year.
- For the first time, there will be a 2 year tariff. Subject to consultation, cost uplifts will be set at 2.1% for 17/18 and 18/19 with an efficiency deflator of 2% in both years. The main changes – at the headlines level – see prices for emergency work ‘improve’ and prices for planned care worsen.

There are several risks, including:

- Collaboration and STP delivery will need to feature heavily in all plans (system and organisational) so strengthening arrangements for this will be critical, particularly as capital and STF monies will be less forthcoming if progress isn’t made across the system. There is also a significant ask of all partners in the STP on things like demand management, which we need to see delivered in full and on time if we are to restore balance between demand and capacity.

- Due to the nature of the STP (a 'system' plan), the assumptions are often described at a macro level - translating these high level / macro assumptions into operational / micro assumptions internally (at a specialty level) will not be without its challenges.
- Full alignment (of operational plans to the STP) would see the Trust reduce its capacity – or maintain it at this year's levels at most – which potentially undermines our ability to deliver access standards if demand exceeds the STP assumptions.
- The expectations on providers are unrelenting - to deliver all core standards and return to finance balance fast, which for some may feel contradictory in the current environment.
- The timetable is extremely tight, which will potentially impact on the accuracy of plans / assumptions, including triangulation.
- Tariff erosion for our planned business that we often 'try to grow'

## Input Sought

The Trust Board is asked to:

1. Note the headlines from the national planning guidance and associated risks
2. Note the format / structure of our operational plan (and executive leads for each component) at appendix A
3. Due to the national planning deadlines, consideration is being given to the governance arrangements (and process for sign off)

## For Reference

The following objectives were considered when preparing this report:

| | |
|---|---|
| Safe, high quality, patient centred healthcare | [Yes] |
| Effective, integrated emergency care | [Yes] |
| Consistently meeting national access standards | [Yes] |
| Integrated care in partnership with others | [Yes] |
| Enhanced delivery in research, innovation & ed' | [Yes] |
| A caring, professional, engaged workforce | [Yes] |
| Clinically sustainable services with excellent facilities | [Yes] |
| Financially sustainable NHS organisation | [Yes] |
| Enabled by excellent IM&T | [Yes] |

This matter relates to the following governance initiatives:

| | |
|---|---|
| Organisational Risk Register | [N/A] |
| Board Assurance Framework | [N/A] |

Related Patient and Public Involvement actions taken, or to be taken: Yes, PPI representatives attended a planning masterclass in October, planning leads and executives also attended the quarterly patient / public forum (hosted by the Chairman) and PPI reps will be involved in CMG planning.

Results of any Equality Impact Assessment, relating to this matter: [N/A at this stage]

Scheduled date for the next paper on this topic: Planning Updates to be shared with the executive throughout the planning cycle

**NHS OPERATIONAL PLANNING AND CONTRACTING GUIDANCE 2017/18 & 2018/19**

**Summary Paper for Trust Board – October 2016**

## Introduction and Context

1. This summary paper provides an overview of the key messages within the national planning guidance for 2017/18 and 2018/19, which was published on 22nd September 2016.

2. Our shared tasks are clear: implement the Five Year Forward View to drive improvements in health and care; restore and maintain financial balance; and deliver core access and quality standards.

3. NHS organisations within a given system are required to produce:

   - ✓ A sustainability and transformation plan (STP), jointly developed by local health and care systems, covering the period October 2016 to March 2021.
   - ✓ Two year (organisational) operational plans for 2017-19.

4. The planning guidance therefore outlines the expectations of the national bodies for planning over the next two years, focussing on contracting and STPs as well as introducing a range of new national business rules.

5. System and organisational control totals will be in place from April 2017 to encourage 'better balance, integration and planning between organisations'. These are very challenging to say the least. But the message is clear, organisations are being encouraged to work more closely and balance risk across the system.

6. The deadlines for both planning and contracting have been concentrated – everything should be agreed and signed off by the 23rd December.

## Contracts and the contracting round

7. The 2017-19 planning and contracting round "will be built out from STPs", which we will submit at the end of October BEFORE we have done any detailed planning work and/or fully understood the implications for acute demand and capacity. This is important because our two-year contract will need to reflect the two-year activity, workforce and performance assumptions that are referenced (and deemed affordable) within the STP.

8. On that note, our internal / operational plans must explain how we will support delivery of the STP, including clear and credible milestones and deliverables. This will not be without its challenges given much within the STP is high level and many of the emerging solutions have yet to articulate what the potential impact will be in activity terms. Planning and contracting leads are working on this to find a sensible way forward.

## Sustainability and transformation funding (STF)

9. As in 2016/17, the payment of STF will depend on providers meeting their financial control totals and meeting the core access standards. Going forward, the guidance states streams of STF will increasingly be targeted towards "the STPs making most progress", which is another nod towards the importance of system working.

10. The baseline for 2017/18 trajectories will be the agreed trajectories for 2016/17. Any provider whose plan for 2016/17 did not deliver one or more of the national standards for

operational performance will not be able to reduce this baseline, and will have a trajectory to reach the national standards during 2017/18.

11. If we do not deliver our performance trajectory during 2016/17 as a result of exceptional circumstances outside of our control (i.e. unprecedented demand), we can use the appeals process to NHS England and NHS Improvement and, if successful, NHS England and NHS Improvement may jointly agree to adjust our trajectory, but this will only very rarely be the case.

**Nine 'must dos' for 2017-19**

12. The guidance lists a number of national must dos, which are similar to those published last year. They can be summarised as follows:

- ✓ Implement agreed **STP milestones**, moderate growth, increase efficiency etc.
- ✓ Deliver system and organisational **financial control totals**
- ✓ Implement the GP Forward View and deliver new care models
- ✓ Deliver the **4 hour A&E standards**, the four **7 day service standards** for urgent network specialist services and implement the Urgent and Emergency Care Review
- ✓ Deliver NHS constitution standards for **RTT** and achieve 100% use of e-referral by April 2018
- ✓ Deliver NHS constitution standards for **cancer** 62, improve one-year survival rates implement the cancer taskforce report
- ✓ Deliver the **Mental Health** Forward View
- ✓ Deliver Transforming Care Partnership plans for **learning disabilities**
- ✓ Improve **quality** of care

13. So, it seems there is no let up on the ask of providers to deliver core standards despite the expectations to balance the books fast.

**National Tariff**

14. National Tariff prices for the next two years have been published and the key movements, broadly speaking, see prices 'improve' for emergency activity and degrade for planned activity.

**CQUINS**

15. There are two key changes to the scheme:

- Continuing the arrangement of the current year, 1.5% of the 2.5% will be linked to delivery of nationally identified indicators. The indicator set has been streamlined, and with different indicator sets for different provider types.

- The remaining 1% will be assigned to support providers locally. 0.5% of this will be available subject to full provider engagement and commitment to the STP process. To support the introduction of system-wide risk pooling at STP level, the remaining 0.5% will be held as a reserve to cover risks in delivery of the relevant system control total. Where the system as a whole is on track to deliver within its system control total, this 0.5% will be payable to providers.

16. For specialised services, CQUIN scheme will remain as now with 2% of contract value for all acute providers.

## National Planning Timeline

| Key deadlines for planning and contracting processes and information publication dates | Date |
|---|---|
| **Planning Guidance published** + Technical Guidance issued | **22 September** |
| Draft NHS Standard Contract, national CQUIN scheme guidance and National Tariff draft prices issued | 22 September |
| Initial STF 2017/2018 guidance issued to providers | 30 September |
| Commissioner allocations, provider control totals and STF allocations published | 21 October |
| NHS Standard Contract consultation closes | 21 October |
| **Submission of STPs** | **21 October** |
| National Tariff section 118 consultation issued | 31 October |
| Final CCG and specialised services CQUIN scheme guidance issued | 31 October |
| Commissioners (CCGs and direct commissioners) to issue initial contract offers that form a reasonable basis for negotiations to providers | 4 November |
| **Final NHS Standard Contract published** | **4 November** |
| Providers to respond to initial offers from commissioners (CCGs and direct commissioners) | 11 November |
| **Submission of full draft 2017/18 to 2018/19 operational plans** | **24 November** |
| National Tariff section 118 consultation closes | 28 November |
| Where contract signature deadline of 23 December at risk local decisions to enter mediation | 5 December |
| Contract mediation | 5 – 23 December |
| National Tariff section 118 consultation results announced | w/c 12 December |
| **Final National Tariff published** | **20 December** |
| **National deadline for signing of contracts, submission of final approved 2017/18 to 2018/19 operational plans, aligned with contracts** (Final contract signature date for avoiding arbitration) | **23 December** |

**Provider Operational Plans – Requirements, Content and Format**

17. This section of the paper is more focused on what the above means for our internal planning, what we are doing now and what we need to do going forward.

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

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

19. The national planning guidance provides technical guidance that suggests a format for our plan – shown at appendix A with associated exec leads - for provider operational plans; the requirements are similar to the 2016/17 plan and will involve an overarching narrative and various returns. National templates for the (numerical) returns will be published on 1st November. Therefore, our plan for 17/18 and 18/19 will contain:

    1. A finance return*
    2. An activity return (acute and specialist providers only)*
    3. A workforce return*
    4. A triangulation return
    5. The operational plan narrative*
    6. Assurance statements and, where necessary, improvement trajectories.

    * Supported by central planning leads / teams, CMGs produce these at a service level each year and an accompanying narrative – this year we propose the CMG narrative follows a similar format, albeit less detailed, to that required of the Trust. This will allow for better alignment and transparency.

20. In terms of what our plan needs to actually say / demonstrate, we must:

    - ✓ Show how we will support delivery of the nine 'must-dos', including how we will directly support delivery of the local STP, including clear and credible milestones and deliverables;
    - ✓ Provide for a reasonable and realistic level of activity, directly derived from the STP, reflective of the impact that the STP's "well-implemented transformation and efficiency schemes" will have on growth rates;
    - ✓ Demonstrate the capacity to meet this, including how local independent sector capacity will be factored into demand and capacity planning;
    - ✓ Provide adequate assurance on the robustness of workforce plans and the approach to quality
    - ✓ Be stretching from a financial perspective: planning to deliver (or exceed) the financial control total agreed with NHS Improvement, thus qualifying us for STF; taking full advantage of efficiency opportunities (including those identified by the Carter review and the agency rules) etc.
    - ✓ Be internally consistent between activity, workforce and finance plans (as well as consistent with the STP).
    - ✓ Demonstrate improvement in the delivery of core access and NHS Constitution standards (or, if applicable, performance improvement trajectories) and not just those subject to the STF
    - ✓ Contain affordable, value-for-money capital plans that are consistent with the clinical strategy and clearly demonstrate the delivery of safe, productive services
    - ✓ Be aligned with commissioner plans, and underpinned by contracts that balance risk appropriately with jointly agreed contingency plans; and

**Current Status & Key Risks**

21. Planning leads are looking at the requirements above in an attempt to shape an early draft (narrative) and ensure CMGs are sighted to the various requirements. However, the assumptions underpinning the STP continue to move on an almost daily basis, making this quite challenging.

22. Moreover, the scale and pace of the changes described in the STP reflect a level of ambition not seen before locally, making this an extremely challenging planning and contracting round.

23. Operationally, there is a potential disconnect between the STP assumptions and the work our CMGs are doing given the nature of how the STP is being developed. The STP assumptions are also very high level i.e. not service specific. However, much of this may become clearer over the coming weeks as our mutual thinking progresses and the STP takes final shape.

24. Therefore, while aware of the ambitions within the STP, it's fair to say CMGs are not fully sighted on the STP and the potential impact of various initiatives, partly due to the fact much remains 'work in progress', certainly true when it comes to articulating things at a service level. If plans are to align, bottom up operational plans that are being developed by CMGs may need to be centrally 'adjusted' to ensure alignment. Whatever approach we take to this alignment exercise, we risk setting our capacity too low if STP delivery slips or demand is more than planned.

25. CMGs have been engaged through a variety of forums in order to ensure planning starts at the earliest opportunity – activity, finance and workforce planning has already commenced across all CMGs supported by central guidance. This is not without its challenges; we are making judgements about this year's outturn (on which we add growth to and adjust plans down against) much sooner than we are used to. This adds a level of risk to our demand and capacity assumptions.

26. We will translate our internal workings into the national templates once they are published.

27. In terms of planning narrative at the CMG level, as mentioned above at para 19, we intend to keep this simple and consistent with the Trust level plan (shown at appendix A) to ensure messages align and so that the plans inform each other.

28. Like last year, we intend to hold a confirm and challenge session with each CMG – this requires executive (and patient partner) support. These sessions provide CMGs with an opportunity to describe their emerging plans, priorities and risks, to the execs and planning leads who in turn will seek to ensure all relevant Trust (and STP) priorities are suitably reflected in CMG plans.

29. An internal planning timetable has been agreed (by the Strategic Planning Group) and discussed with and circulated to Heads of Operations. This is shown at appendix B. While challenging for all involved, this shows how we intend to ensure we promote transparency throughput the process and ensure relevant boards and committees see the plan for governance and assurance purposes.

**Next Steps**

30. Our draft annual priorities for 17/18 will be considered at a forthcoming Trust Board Thinking Day.

31. Work on translating the STP assumptions into operational planning assumptions continues at some pace, overseen by a task and finish group (chaired by John Adler)

32. Initial planning confirm and challenge sessions with each CMG to commence in November ahead of the first draft submission, with further engagement sessions due in December.

**Appendix A – Operational Plan Narrative & Exec Leads**

## RICHARD MITCHELL Activity planning (2 pages)

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

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

They should provide assurance to NHS Improvement that:

- the activity plans for 2017/18 to 2018/19 are based on outputs from:
    - the demand and capacity approach for 2016/17
    - demand and capacity modelling tools that have been jointly prepared and agreed with commissioners
- activity returns are underpinned by agreed planning assumptions, with explanation about how these assumptions compare with expected growth rates in 2016/17
- they have sufficient capacity to deliver the level of activity that has been agreed with commissioners, indicating plans for using the independent sector to deliver activity, highlighting volumes and type of activity if possible
- activity plans are sufficient to deliver, or achieve recovery milestones for, all key operational standards, in particular accident and emergency (A&E), referral to treatment (RTT), incomplete, cancer, diagnostics and mental health waiting times
- they should also refer to any explicit plans agreed with commissioners around:
    - extra capacity as part of winter resilience plans, for instance extra beds
    - arrangements for managing unplanned changes in demand.

## JULIE SMITH & ANDREW FURLONG Quality planning (4 pages)

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

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

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

Providers should self-assess and outline their approach to quality as follows:

*Section 1: Approach to quality improvement*

Providers should outline their approach to quality improvement including:

- a named executive lead for quality improvement

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

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

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

- national clinical audits
- the four priority standards for seven-day hospital services
- safe staffing
- care hours per patient day
- mental health standards(Early Intervention in Psychosis and Improving Access to Psychological Therapies)
- actions from the Better Births review
- improving the quality of mortality review and Serious Incident investigation and subsequent learning and action
- anti-microbial resistance
- infection prevention and control
- falls
- sepsis
- pressure ulcers
- end of life care
- patient experience
- national CQUINs
- confirmation that the provider's quality priorities are consistent with STPs.

*Section 3: Summary of quality impact assessment process*

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

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

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

- how appropriate baseline data have been recorded before implementation of the change, including the duration of this data, eg to capture seasonal variations
- where the provider does not define specific metrics but use generic quality measures, how they interrogate and challenge poor performance to make sure the efficiency plans do not drive any deterioration
- how the board receives oversight of any potential cumulative impact of several schemes on a particular pathway, service, team or professional group.

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

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

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

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

**LOUISE TIBBERT Workforce planning (2 pages)**

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

- articulation of a workforce planning methodology linked to the strategic aims of the provider, informed by financial and service objectives and contributing to the integrated operational plan
- an underpinning workforce strategy developed with staff involvement (also linked to clinical and wider STP strategies)
- a robust governance process to offer assurance and approval and act as a means of assessing performance against plan in year
- well-modelled alignment with both financial and service activity plans to ensure the proposed workforce levels are affordable, sufficient and able to deliver efficient and safe care to patients
- achievement of workforce efficiency, capitalising on collaboration opportunities to increase workforce productivity within STPs and inform subsequent CIP development (taking into account any impact on quality and safety, with ongoing measurement to identify adverse outcomes and ensure effective mitigating actions where necessary.)
- detail the required workforce transformation and support to the current workforce, underpinned by new care models and redesigned pathways (responding to known supply issues), detailing specific staff group issues
- plans for any new workforce initiatives agreed with partners and funded specifically for 2017/18 to 2018/19 as part of the Five Year Forward View demonstrating the following:
    - a link with the STP approach to workforce resourcing and how this will be supported through the operational plan
    - how a balance in workforce supply and demand will be achieved
    - the right skill mix, maximising the potential of current skills and providing the workforce with developmental opportunities
    - underpinning strategies to manage agency and locum use including spend avoidance. (Approaches may include, but are not limited to, strengthening bank

staffing arrangements and utilisation of the flexible workforce by developing shared banks with other providers in the STP footprint. Providers should also consider the effective use of technology including e-rostering and job planning systems to enable more effective rota management and staff utilisation, focused on flexibility around patient need.)

- activity to support delivery of workforce plans in conjunction with local workforce advisory boards
- engagement with commissioners to ensure alignment with the future workforce strategy of their local health system
- affordable plans for implementing the four priority standards for seven-day hospital services by March 2018 for providers in the second tranche of roll-out and by March 2020 for providers not in the first or second tranches.

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

**PAUL TRAYNOR (& RICHARD MITCHELL) Financial planning (6 pages)**

*Strengthening financial performance and accountability in 2016/17* established the clear expectation that the provider sector will achieve financial run rate balance in aggregate by the start of 2017/18. Delivery of this expectation will require providers' plans to be stretching from a financial perspective, delivering (or improving on) the financial control totals agreed with NHS Improvement, implementing transformational change through the STPs, and taking full advantage of efficiency opportunities to ensure that the control totals for 2017/18 and 2018/19 can be delivered.

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

We therefore recommend providers divide their financial narratives as follows:

*Section 1: Financial forecasts and modelling*

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

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

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

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

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

- the financial impact of the planning assumptions set out in Technical Guidance for NHS planning 2017/18 and 2018/19 plus the impact of the 2017/18 and 2018/19 national tariff (including the changes associated with the introduction of HRG4+), NHS Standard Contract and Commissioning for Quality and Innovation (CQUIN) guidance; the narrative should also highlight any significant deviations from national assumptions
- the impact of activity changes, relating to underlying demand, quality, efficiency programmes, and the impact of other commissioning intentions
- other key movements, including other changes in income expectations, revenue impact of any capital plans, or in-year non-recurrent income or expenditure
- the impact of initiatives, such as, but not limited to, CIPs, revenue-generation schemes, service developments and transactions
- the STF contingent on delivery of the control total (receipt of which should only be included in plans where providers have both agreed their financial control totals and submitted assurance statements-and, if applicable, agreed performance improvement trajectories- in relation to selected national standards).

The narrative financial commentary should address:

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

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

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

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

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

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

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

Lord Carter's provider operational productivity work programme

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

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

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

Agency rules

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

Procurement

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

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

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

*Section 3: Capital planning*

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

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

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

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

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

**MARK WIGHTMAN Link to the local STP (2 pages)**

Providers should briefly articulate the following in their operational plan narratives:

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

END

# Appendix B – UHL Planning Timetable and Key Milestones

## DRAFT 2017/18 Integrated Planning Timetable (Finance, Workforce, Activity and Contracting)

Version 2 29th September 2016

- Guidance and consultation
- Contracting milestones
- STP milestones
- Activity, workforce and financial planning
- External Governance
- Internal Governance
- To be timetabled shortly

| Timetable Item<br>NB Weekly / fortnightly planning touchpoints to happen at Heads of Operations Group | Date | Owner | Progress |
|---|---|---|---|
| Internal Coding and Counting email request to CMGs | 12th August | Contracts Team | Done |
| Internal Coding and Counting reponses from CMGs | 31st August | CMG teams | Done |
| NHSI issue planning guidance, draft contract & draft prices | 22nd September | NHSI | Done |
| *For info: CMG Finance & CIP Performance Meetings* | 23rd September | N/A | Done |
| Planning 'launch' to Heads of Operations | 23rd September | Corporate Planning Lead | Done |
| **Demand Plan templates issued** for completion | 23rd September | CMG teams | Done |
| Conclude corporate review of NHSI planning guidance & circulate summary | 28th September | Corporate Planning Leads | |
| Notice Letter issued to Commissioners including MRET | 30th September | Chris Blackburn | |
| NHSI issue control totals (including proposed allocation of STF) | 30th September | NHSI | |
| **STP Activity Baselines confirmed** (excluding STP / QIPP adjustments) | 30th September | STP Leads (BCT PMO) | |
| **Financial Plan & Workforce templates issued** for completion | 3rd October | Corporate Finance Team | |
| Planning Session with CMGs (Finance and HR leads) | 3rd October | Corporate Finance Team | |
| Receipt of commissioning intentions letters (these will be circulated) | 3rd October | CCG & Planning Team | |
| **Operating Plan Narrative** template issued to CMGs and directorates | 5th October | Corporate Planning Lead | |
| **Demand Plan templates returned & reviewed** by ODU Central Team | 7th October | CMG teams & ODU | |
| STP Review by UHL Execs at ESB | 11th October | Corporate Planning Leads | |
| Finalisation of STP for sign off by CFOs | 12th October | STP Leads (BCT PMO) | |
| Planning Masterclass with our Patient Partners | 13th October | Corporate Planning Leads | |
| Trust Board Thinking Day (afternoon) for STP and Planning | 13th October | Corporate Planning Leads | |
| **STP Alignment** - work to adjust draft demand plans commences | 14th October | Corporate Planning Leads | |
| **Demand Plan initial feedback to CMGs** | 14th October | CMG teams & ODU | |
| Public Engagement Forum (hosted by UHL Chairman) | 20th October | Corporate Planning Leads | |
| Theatre & Bed Capacity Plan Produced | 21st October | ODU (with CMG support) | |
| **Submission of STP** | **21st October** | STP Leads (BCT PMO) | |
| *For info: CMG Finance & CIP Performance Meetings* | 21st October | N/A | |
| National Tariff s118 consultation starts | 31st October | NHSI | |
| **Financial Plan & Workforce templates returned** | 31st October | CMGs and directorates | |
| **Operating Plan Narrative** templates returned to inform Trust Narrative | 31st October | CMGs and directorates | |
| NHSI Issue finance, workforce and activity templates & technical guidance | 1st November | NHSI | |
| **Stocktake** - All returns to be reviewed ahead of Confirm and Challenge sessions | 2nd November TBA | Corporate Planning Leads | |
| **Trust Board Update** (needs to delegate authority to IFPIC or JA and KS for sign off) | 3rd November | Corporate Planning Lead | |
| Internal **Confirm and Challenge** with CMGs | 3rd & 7th November TBA | Corporate Planning Leads | |
| Commissioners issue initial contract offers | 4th November | CCG | |
| Final NHS Standard Contract published | 4th November | NHSI | |
| Internal Planning Review Session / **Confirm and Challenge** with directorates | 7th November TBA | Corporate Planning Leads | |
| Work on Final Plan commences (to account for feedback provided) | 8th November | CMGs and directorates | |
| **CUT-OFF FOR DRAFT SUBMISSION (contract, CIP, I&E, workforce)** | **17th November** | | |
| *For info: CMG Finance & CIP Performance Meetings* | 18th November | N/A | |
| EPB Review | 22nd November | Corporate Planning Leads | |
| IFPIC Review & **Sign Off** (needs TB delegated authority) | 24th November | Corporate Planning Leads | |
| **NHSI DRAFT OPERATIONAL PLAN SUBMISSION** | **24th November midday** | **Corporate Planning Leads** | |
| National Tariff s118 consultation closes | 28th November | NHSI | |
| **Final plan returned (finance, workforce and activity templates)** | 30th November | Corporate Planning Leads | |
| Trust Board Review latest plan (needs to delegate authority to IFPIC or JA and KS for final sign off) | 1st December | Corporate Planning Leads | |
| Internal **Confirm and Challenge** with CMGs on Final Plan submissions | 2nd & 5th December TBA | Corporate Planning Leads | |
| Internal Planning Review Session / **Confirm and Challenge** with directorates | 5th December TBA | Corporate Planning Leads | |
| Final Theatre & Bed Demand and Capacity Plan | Final Demand Cut + 2 days | ODU (with CMG support) | |
| **CUT-OFF FOR FINAL SUBMISSION (contract, CIP, I&E, workforce)** | **8th December** | **Corporate Planning Leads** | |
| IFPIC Papers | 15th December | Corporate Planning Leads | |
| Publication of 2017/19 National Tariff Final Prices | 20th December | NHSI | |
| IFPIC Submission sign-off | 22nd December | Corporate Planning Leads | |
| **NHSI FINAL OPERATIONAL PLAN SUBMISSION** | **23rd December** | **Corporate Planning Leads** | |
| Contract Sign-off | 23rd December | Corporate Contracting Team | |

| **TO BE ADDED ABOVE SHORTLY:** | | |
|---|---|---|
| Alliance Governance / Key Milestones for sign off | To be confirmed | Helen Mather |