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To: CCG Clinical Leads
CCG Accountable Officers
Chief Executives of NHS Trusts
Chief Executives of NHS Foundation Trusts
Chief Executives of Local Authorities
Directors of Adult Social Services
CSU Managing Directors

cc: NHS England Regional and Area Directors
Monitor Regional Directors
NHS TDA Directors of Delivery and Development

1 November 2013

Dear Colleagues

Strategic and operational planning in the NHS

The NHS faces an unprecedented level of future pressure. This is the definitive conclusion of the recent 'Call to Action' and 'Closing the Gap' reports issued by NHS England and Monitor respectively, which warns of substantial impending challenges driven by an ageing population; increase in long-term conditions; and rising costs and public expectations within a challenging financial environment.

In order to respond to these significant challenges the NHS is likely to have to change; all parties - CCGs, foundation and non-foundation trusts - need to play a leading role. They must develop and implement bold and transformative long-term strategies and plans for their services, otherwise many will become financially unsustainable and the safety and quality of patient care will decline.

This long-term transformation will only be achieved through our commitment to create a fully integrated service between the NHS and local government. NHS England and the Local Government Association have recently written to outline the next steps for implementing the £3.8bn Integration Transformation Fund for 2015/16, which will have significant implications for commissioners and providers alike. But changing services and spending patterns will take time. The plan for 2015/16 needs to start in 2014 and form part of a five year strategy for health and care. This is why Health and Wellbeing Boards must also play a leading role in developing local strategic plans and why the LGA is a co-signatory of this letter.

All four bodies, NHS England, NHS Trust Development Authority, Monitor and LGA consider robust planning to be of paramount importance to both providers and commissioners. Robust plans should be coherent long term strategic plans,

underpinned by medium-term detailed operational plans that are consistent in their intentions across local health economies and are developed applying consistent ground rules as articulated in national policy e.g. standard national contract and Payment by Results. Given the scale of the challenges we are facing, we are moving away from incremental one year planning and instead asking bodies to develop bold and ambitious plans which cover the next five years, with the first two years mapped out in the form of detailed operating plans. This is crucial to enabling us to take a longer term, strategic perspective of the direction of travel across the health and social care landscape.

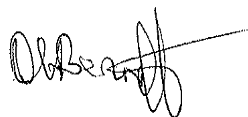
We recognise it is our role and responsibility to provide the right framework for this to happen. We have recently engaged with a range of stakeholders to understand the needs of the sector. We have heard the importance of making the planning process as rigorous and consistent as possible, to ensure alignment and agreement to the key dates across all parties and to release information and guidance as early as possible.

We have taken this feedback on board and we have taken, or will take, the following actions:

- provide draft guidance now as to the process and expectations (as set out in Appendix 1) and full guidance in December, including a joint set of assumptions agreed by all parties;
- align our respective timelines in regards to the planning process. The detail of this joint timetable is set out in appendix 2;
- each body is revisiting their own process to consider how these can be adapted to better facilitate operational and strategic planning; and
- further support will be provided and this will be communicated separately by each body as appropriate.

The initial guidance gives some of detail of the planning process so that commissioners, providers and local authorities know the expectations of them and can start working together over the coming months before final guidance is issued in December.

Sir David Nicholson
Chief Executive
NHS England



David Bennett
Chair and Chief Executive
Monitor

David Flory CBE
Chief Executive
NHS Trust Development Authority

Carolyn Downs
Chief Executive
Local Government Association

Appendix 1: Initial guidance – key objectives of planning process and changes made

1. **Improving outcomes –** improved outcomes must be at the heart of the strategic and operational planning process. All bodies should prioritise an approach to planning which combines transparency with detailed patient and public participation*.*

   We need to construct, from the bottom up, quantifiable and deliverable ambitions for each domain of the NHS Outcomes Framework. We will, therefore, be asking providers and commissioners to work together to determine local levels of ambition, based on evidence of local patient and public benefit, against a common set of indicators.

   Setting levels of ambition against the NHS Outcomes Framework is intended to galvanise the whole commissioning system around a clear and common purpose, aligning the development of our long term strategy and the *Call to Action* with the development of our 5 year strategic and 2 year operating plans and allowing us to articulate the improvements we are collectively aiming to deliver for patients across the seven ambitions.

2. **Quality, Expectations and Sustainability –** while we want the five year plans to reflect local need and be ambitious we are keen to ensure that actions are taken as early as possible in order to deliver the maximum benefit over the period. With that in mind we shall expect more granular detail covering the first two years that set out the measures that will be used to demonstrate progress against improving outcomes while delivering patients' rights and pledges under the NHS Constitution and operating with robust financial control.

3. **Joint assumptions –** a number of planning assumptions are included under the relevant headings in this document, and further joint planning assumptions will be published in December. NHS England, Monitor and the NHS TDA also have planning expectations that relate to the organisations which each of us oversee and these are set out in Appendix 3.

4. **Tariff –** Monitor and NHS England plan to publish the 2014/15 tariff in December.

   The 2014/15 tariff guidance has been strengthened to confirm that where a Trust is being reimbursed at less than 100% of the national tariff, both the provider and commissioner will be jointly engaged in the reinvestment decision. The scope of this improved arrangement includes the non-payment for emergency readmissions and the marginal rate emergency tariff and we would expect to see plans that demonstrate how this funding has been transparently re-invested in appropriate demand management and improved discharge schemes.

5. **Allocations –** we will be able to notify CCGs of their financial allocations for both 14/15 and 15/16 in the week commencing 16 December and will also provide broad assumptions regarding allocations for years 3 – 5 to the same timescale.

6. **Efficiencies**

	2014/15	2015/16 – 2019/20
Efficiencies -	4.0%*	Published in December

* Subject to consultation

7. **Cost Inflation**

	2014/15	2015/16 – 2019/20
Weighted average cost inflation	2.1%*	Published in December

* Subject to consultation

8. **Price deflation – tariff**

	2014/15	2015/16 – 2019/20
Average tariff deflation	1.9%*	Published in December

* Subject to consultation

Any further forward guidance provided in December will be indicative only and will not represent a commitment to future tariff pricing beyond 2014/15, which will be subject to consultation in future years.

9. **CQUIN –** NHS England is refreshing the CQUIN scheme and associated guidance for 2014/2015. It is proposed that the final CQUIN scheme will be agreed and published in December 2013.

10. **Integration Transformation Fund –** the Local Government Association and NHS England published further guidance on 17 October 2013 on how CCGs and councils should work together to develop their plans for the pooling of £3.8 billion of funding, announced by the Government in the June spending round, to ensure a transformation in integrated health and social care.

The 'Integration Transformation Fund' is a single pooled budget to support health and social care services to work more closely together in local areas. The publication provides further advice, ahead of the formal planning guidance in December, on how the Fund will operate. The publication also includes a draft plan submission template.

Whilst the fund itself does not address the financial pressures faced by local authorities and CCGs, it can act as a catalyst for developing a new shared approach to delivering services and setting priorities.

It is essential, therefore, that CCGs and Local Authorities engage from the outset with all providers likely to be affected by the use of the Integration Transformation Fund so that plans are developed in a way that achieves the best outcomes for

local people. Commissioner and provider plans should have a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. CCGs and Local Authorities should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services.

This new shared approach to delivering services needs to be reflected in the planning units chosen for the development of 5 year strategic plans.

11. **Joint working –** it will be essential for all health (commissioners and providers) and social care practitioners to work together with other partners to develop locally owned and agreed plans. We expect the shape of size of planning units to depend on local arrangements, but all relevant parties should be included and national coverage is required.

    To support mutual working between commissioners and providers, we expect local organisations to share their own assumptions with each other. For commissioners, this will mean ensuring plans reflect the local Health and Wellbeing Strategy and have been discussed with providers. Providers will need to be satisfied that their plans reflect the commissioning intentions of CCGs and NHS England's Area Teams.

12. **Unit of planning –** as CCG sizes and local configurations differ, a larger unit of planning is required for the development of consistent and integrated long-term strategic plans**.** Each statutory body (CCG, Trust, FT) must produce its own operational plan that reflects the wider strategic plan. For the five year strategic plans CCGs will work with Trusts and local government to identify and communicate the larger footprint within which they will sit. The guidance is that each CCG should only sit in one larger footprint. This unit of planning will consist of at least one CCG and CCGs will contribute to a larger footprint where one CCG is too small. CCGs will be required to nominate their choice of planning unit to NHS England by 8 November 2013 through Area Team Directors of Operations and Delivery.

    Table 1 – unit of planning guidance

Each commissioner is asked to cast its strategic plan in a wider footprint that meets the following characteristics:
• each CCG to belong to one unit only; • the unit has been locally agreed and has clear clinical ownership and leadership; • it is based on existing health economies that reflect patient flows across Health & Wellbeing Board(s) and local provider footprints with no CCG to be split across boundaries; • it includes significant local trusts (e.g. where CCG spend is > 25%) and some trusts may participate in more than 1 unit of planning;

• it has sufficient scale to deliver geography wide clinical improvements; • it enables the pooling of resources to reduce risk associated with large investments; • it does not cut across existing locally agreed collaboration agreements; and • engagement has been secured from Local Authorities.
The Integration Transformation Fund will need to be identified within each plan so that the CCG can identify its contribution to the amount and approach to be agreed by its Health & Wellbeing Board(s).

13. **Support –** we recognise that producing fully integrated and assured strategic plans is a challenging task and to support this programme NHS England, NHS TDA, Monitor and LGA are exploring the possibility of a joint approach to support packages.

14. **Proposed assurance / challenge process –** the assurance processes used in the 2013/14 planning will be enhanced. For 2014/15 planning we are including an additional step to ensure that commissioner and provider plans are aligned by reconciling activity and revenue figures between CCGs, foundation and non-foundation trusts. The assurance on alignment will be conducted jointly between NHS England, Monitor, NHS TDA and LGA. Please note that every step will be taken not to prejudice the position of any provider or commissioner, no information will be shared without first contacting the appropriate party. This exercise is to highlight risk where parties within the local health economy are planning on a directional inconsistent basis.

15. **Further guidance –** further detailed guidance will be issued in December 2013 and will be tailored to providers and commissioners respectively.

Appendix 2: Key dates

Key dates – NHS England

Planning Units received from CCGs	8 November 2013
Final guidance, templates and tools issued	w/c 16 December 2013
Allocations issued	w/c 16 December 2013
1st Submission	14 February 2014
Contracts signed	28 February 2014
Refresh of plan post contract sign off	5 March 2014
Dispute resolution for 2014/15 with NHS TDA	From 5 March 2014
Plans approved by Boards	31 March 2014
Submission of final 2 year plans and draft 5 year	4 April 2014
Submission of final 5 year plans • Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014	20 June 2014

Key dates – Monitor

Final guidance, templates and tools issued	w/c 16 December 2013
Planned publication date of the 2014/15 National tariff Payment System (subject to the outcome of a statutory consultation process)	December 2013
Contracts signed	28 February 2014
Submission of final 2 year plans	4 April 2014
Submission of final 5 year plans • Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014	20 June 2014

Key dates – NHS TDA

Final Guidance, templates and tools issued	w/c 16 December 2013
Initial, high level plans	13 January 2014
Contracts signed	28 February 2014
Full plan collection	5 March 2014
Dispute resolution for 2014/15 with NHSE	From 5 March 2014
Plans approved by Boards	31 March 2014
Submission of final 2 year plans	4 April 2014
Submission of 5 year LTFMs and IBPs • Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014	20 June 2014

Key dates – LGA

HWBs to return completed template on the ITF	15 February 2014

Appendix 3: Assumptions

Further guidance to commissioners on the feasibility of bringing forward an element of the 15/16 saving requirement into 14/15 to avoid a financial ‘cliff edge’ in 15/16, in order to fund strategic change, will be given by December.

Table 2 – NHS England specific assumptions

CCGs	
Demographic growth	Local determination using ONS age profiled weighted population projections
Non-demographic growth	Local determination based on historic analysis and evidence.
Price inflation - prescribing	Local determination - would expect this to be in a range of 4% to 7% per annum increase
Price inflation – continuing health care	Local determination - would expect this to be in a range of 2% to 5% per annum increase
Business rules	• Minimum 0.5% contingency fund held • 1% surplus carry forward • 2% underlying surplus • 2% non-recurrent spend • Local determination of impact of ITF on plans
Primary care	
Demographic growth	Local determination based on resident population in line with crude population projections
Price increase	1.3% per annum increase
Business rules	• Minimum 0.5% contingency fund held • 1% surplus carry forward • 2% underlying surplus • 2% non-recurrent spend
Direct commissioning (excluding Primary Care and Public Health)	
Demographic growth	Local determination using ONS age profiled weighted population projections for population covered by Area Teams
Non-demographic growth	Local determination based on historic analysis and evidence
Business rules	• Minimum 0.5% contingency fund held • 1% surplus carry forward • 2% underlying surplus • 2% non-recurrent spend

Public health	
Demographic growth	Local determination using ONS age profiled weighted population projections for population covered by Area Teams
Price increase	0% per annum increase
Business rules	• Minimum 0.5% contingency fund held • 0% surplus carry forward • 0% underlying surplus • 0% non-recurrent spend

Table 3 – NHS TDA specific assumptions

Business Rules	• Minimum 0.5% contingency fund held • 1% surplus requirement or for those NHS Trusts in formal recovery the planned outturn should be consistent with the recovery plan signed off by the NHS TDA

Table 4 – Monitor specific assumptions

Business rules	Monitor does not require foundation trusts to deliver a surplus. The provider licence requires foundation trusts to have regard to the desirability of maintaining an acceptable continuity of service risk rating. In practice, a lower risk rating will prompt Monitor to ask whether there is a risk to the continuity of services. Where foundation trusts plan for a lower risk rating, they should explain their rationale to Monitor.

Appendix 4 - Joint Timeline