



South West London
Merton Clinical Commissioning Group

Report to the Merton Clinical Commissioning Group Governing Body

Date of Meeting: Thursday 21st March 2013

Agenda No: 7.2

ATTACHMENT 12

Title of Document: Everyone Counts: Planning for Patients 2013/14	Purpose of Report: To Receive and Note
Report Author: NHS Commissioning Board	Lead Director: Eleanor Brown, Chief Officer
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<p>Executive Summary: The NHS Commissioning Board (NHSCB) has issued planning guidance to CCG as to the approach they wish CCG's to take in commissioning future services. The guidance sets out principles behind the 'new approach', identifying patient involvement and rights, the movement towards outcomes as part of the NHS Outcomes Framework, how excellent service provision will be rewarded and identifies the information and knowledge require in the new world.</p>	
<p>Key sections for particular note (paragraph/page), areas of concern etc: The document is relevantly short and has been adopted by MCCG in developing our Operating Plan 2013/14.</p>	
<p>Recommendation(s): The Merton Clinical Commissioning Group Governing Body is requested to note the document Everyone Counts: Planning for patients 2013/14</p>	

Committees which have previously discussed/agreed the report: MCCG Board Seminar February 2013.
Financial Implications: N/A
Implications for the Sutton and Merton Board or Joint PCT Boards: N/A
Other Implications: (including patient and public involvement/Legal/Governance/ Risk/ Diversity/ Staffing) N/A
Equality Analysis: N/A
Information Privacy Issues: N/A
Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution) N/A

EVERYONE COUNTS: PLANNING FOR PATIENTS 2013/14

1 NHS SERVICES
7 DAYS
A WEEK

SUNDAY
*every day
health service*

2 MORE
TRANSPARENCY

MORE
CHOICE

3 MORE PATIENT
PARTICIPATION
AND
BETTER
CUSTOMER SERVICE

4 BETTER
DATA
+
INFORMED
COMMISSIONING

IMPROVED
OUTCOMES

5 HIGHER
STANDARDS

SAFER CARE



Sir David Nicholson KCB, CBE
Chief Executive

FOREWORD- A MESSAGE TO ALL NHS STAFF

THE NHS AND ALL OF US WHO WORK IN IT CAN BE JUSTLY PROUD OF THE ACHIEVEMENTS WE HAVE MADE OVER RECENT YEARS.

We have made it possible for the NHS Constitution to set out rights and pledges that were unthinkable not so long ago. We wait less, are diagnosed and referred quicker and our hospitals have fewer infections. Those things have not happened by accident or structural tinkering but by the hard work of NHS staff. I am truly grateful for all you have done. Whether you are a commissioner, provider or partner, thank you.

But we can't rest on our laurels. We must remain committed to improvement while understanding the risks and challenges we now face. The economic situation means that resources are going to be limited for some time. For us that brings about more challenges with an ageing population and greater demand on our services. If we don't get it right then our patients will suffer. That means finding better ways of delivering services – we must get the best possible value in patient outcomes from every pound spent in the NHS. And the appalling standards of care that came to light at Winterbourne View and the Mid Staffordshire NHS Foundation Trust are stark examples of what can happen when we are not all focused on why we work for and with the health service – better and improved standards of care for all.

In our vision of a modern, patient-centred NHS, improvements will be driven by the new clinically-led, local commissioning system. Our job as the NHS Commissioning Board is to support clinical commissioning groups to develop and deliver these improvements.

We must ensure patients' and their families' voices are heard and used to help us develop the insight to improve outcomes and guarantee no community is left behind or disadvantaged. We want to make the NHS the best customer service in the world and throughout the NHS, we must all strive to design and deliver care based on the needs and choices of each individual patient.

Focussing on outcomes to plan NHS services represents a significant opportunity to build on our achievements to date. Across the NHS, we need to work to prevent people from dying prematurely, enhance the quality of life for people with long-term conditions, help people to recover from ill health or injury, ensure that people have a positive experience of care and ensure that people are treated and cared for in a safe environment, protected from avoidable harm. At the same time, we must not fall into the trap of thinking that because we have improved access that the job is done – the rights and pledges in the NHS Constitution must be delivered for everyone who uses the services we commission.

The new system gives pride of place to clinical leaders. From top to bottom and across the country it assumes liberty – freedom for you to take clinical ownership and leadership, and for local communities and commissioners to decide for themselves how best to deliver care.

Although we will retain oversight in order to assure responsibilities are being met, we will not sit above you issuing operating instructions - we will stand with you, helping you to carefully allocate valuable public resources to secure the best possible outcomes for patients.

The NHS Commissioning Board wants to provide the right support and tools to help you design and transform services for patients. The approach set out in this planning framework is aimed at securing three important objectives:

- **balancing change and continuity:** 2013/14 sees widescale organisational change at a time of increasing financial pressures and the best confidence we can provide patients and the public is that local health services are driving change, not reacting to it;
- making **assumed liberty** a reality through creating the time and space for clinical commissioning groups to drive local health priorities within a framework driven by Health and Wellbeing Boards; and
- **balancing annual requirements with the longer term:** the best indicator we have of future quality improvement is current delivery and we need to assure ourselves that the health service is sufficiently robust to deal with the challenges of increasing demand when limited resource growth is likely to be a feature for several years ahead.

We have been successful in our journey so far and I am confident we shall be successful under the new structures.



Sir David Nicholson KCB, CBE
Chief Executive

EXECUTIVE SUMMARY

EMPOWERED LOCAL CLINICIANS DELIVERING BETTER OUTCOMES; INCREASED INFORMATION FOR PATIENTS TO MAKE CHOICES; AND GREATER ACCOUNTABILITY TO THE COMMUNITIES THE NHS SERVES.

These are the principles behind our new approach to planning clinical led-commissioning from April 2013.

As the body charged with overseeing and supporting this new system the NHS Commissioning Board exists to enable excellence in healthcare. The NHS Outcomes Framework and NHS Constitution set out the goals and responsibilities – but the approaches for delivery will vary and local commissioners will have freedom to develop those that work in their community. Healthcare success in the future will be judged on the quality of outcomes.

At a time of significant financial challenge, where we need to ensure all organisations are robust to address the challenges facing them, this document lays out five offers to help commissioners deliver for the public: support for routine NHS care seven days a week; greater transparency on outcomes;

mechanisms to enhance patient feedback; better data collection to drive evidence-based medicine; and for high professional standards. Alongside these are details of the package of guidelines and incentives that demonstrate a new relationship between those directly developing services and those working at a national level. Among the measures covered in this document are:

LISTENING TO PATIENTS

- The rights of patients set out in the NHS Constitution are vital. They must be delivered.
- Customer convenience - the NHS will move to providing seven days a week access to routine healthcare services.
- Real-time experience feedback from patients and carers by 2015.
- A Friends and Family Test to identify whether patients would recommend their hospital to those with whom they are closest.

FOCUSING ON OUTCOMES

- Publication of consultant-level outcome data covering mortality and quality for ten surgical and medical specialties.
- NHS Outcomes Framework will now inform NHS planning. Commissioners will be expected to prioritise and make improvements against all indicators.

REWARDING EXCELLENCE

- Continued financial and related levers and enablers for clinical commissioning groups to use when commissioning for better patient outcomes.
- A Quality Premium for clinical commissioning groups who secure quality improvement against certain measures from the NHS Outcomes Framework
- Support for clinical commissioning groups to define their local QIPP challenge and set milestones.
- CQUIN payments only available to providers who meet the minimum requirements concerning the high-impact innovations, as set out in *Innovation, Health and Wealth*.
- During 2013/14, a fundamental review of the incentives, rewards and sanctions available to commissioners to drive improvements in care quality.

IMPROVING KNOWLEDGE AND DATA

- NHS Standard Contract to require all NHS providers to submit data sets that comply with published information standards.
- *Care.data* - a modern knowledge service for the NHS will provide commissioners with timely and accurate data.

SEIZING THE OPPORTUNITY: A NEW APPROACH TO NHS PLANNING

TOWARDS "ASSUMED LIBERTY" FOR LOCAL COMMISSIONING

- 1.1 The challenge facing the NHS is to become truly patient-centred, where patients participate in designing services and are able to exercise choice as customers, whilst seeking always to ensure that no community or part of a community gets left behind. In everything we do, mental health should have equality of esteem with physical health. This section sets out the structure that will create patient-centred services. It provides detail on the support that the NHS Commissioning Board will provide clinical commissioning groups. Commissioners will be offered improved patient satisfaction measures; better comparable clinical data; greater transparency; commitment to improve access to services; and enhanced professional standards.
- 1.2 On 13 November 2012 the Government published its mandate¹ to the NHS Commissioning Board and this set the strategic framework within which we will

discharge our responsibilities. We are committed to deliver all our objectives and this planning guidance is part of how we will work with local commissioners to see that they are met. In doing so, we are mindful that we are facing unprecedented challenges of an ageing population, greater demand and limited resource growth. These challenges mean that all NHS organisations need to play their part in improving services for patients to secure better value from every pound spent on the NHS.

- 1.3 Together, NHS commissioners exist to drive improvements in services to patients. The planning process enables us to define improvement and ensure commissioners have the means to make changes that maximise patient benefit. This document sets out the shared interests of commissioners and how we can work together for the people we serve.
- 1.4 2013/14 is the first year of a reformed health service where greater local control of decision-making leads to better patient

outcomes and service improvements. Our NHS will be driven by local people through greater public participation and transparent access to data. Clinical commissioning groups and local communities are empowered to prioritise on the basis of local needs and patient and public preferences – liberty is assumed rather than granted.

1.5 The NHS Commissioning Board will be one player in securing better services for patients, providing leadership of the NHS commissioning system and support for clinical commissioning groups to help them realise their own ambitions. We will support real action to address variation in the quality of care and health inequalities.

1.6 We are taking an approach to secure better outcomes as defined by the five domains of the NHS Outcomes Framework² and upholding the rights and pledges within the NHS Constitution³ within available resources. In doing so, we will not be asking anything of local commissioners that is not being asked of the NHS Commissioning Board or set out in statute.

1.7 We will use the information we receive from clinical commissioning groups and our own direct commissioning to assure ourselves that:

- each clinical commissioning group and the NHS Commissioning Board itself are maximising quality improvements within their resource allocations;
- commissioning by clinical

commissioning groups and the NHS Commissioning Board is complementary in driving overall improvement;

- we have the information we need for public accountability on the performance of the NHS; and
- NHS organisations are taking the decisions they need to ensure longer term sustainability and success.

1.8 We will support commissioners by ensuring that we all have comparable data. The NHS Standard Contract will include the requirement that all NHS funded providers submit data sets that comply with published information standards. We will work with Healthwatch England to identify national issues of patient interest and with local Healthwatch on areas of direct commissioning. We will expect clinical commissioning groups to do the same when developing their own plans.

PATIENT-CENTRED, CUSTOMER-FOCUSED

1.9 This guidance addresses two key challenges:

- *guaranteeing no community is left behind or disadvantaged* – the commissioning system needs to be focused on reducing health inequalities and advancing equality in its drive to improve outcomes for patients; and
- *treating patients respectfully as customers and putting their interests first* – transforming the service offer of the NHS so that they can take control

and make more informed choices, if they want to.

- 1.10 To meet these challenges, a patient-centred approach and the reformed structures provide three inter-related lenses through which planning can be viewed:
- local area based planning;
 - clinical commissioning group organisational planning; and
 - direct commissioning by the NHS Commissioning Board.
- More detail on each of these is provided later in this section.
- 1.11 We are committed to making time and space for local commissioners to identify and focus where they have identified a real health and wellbeing need for their area.
- 1.12 Rather than set targets, we have been working with clinical commissioning groups to identify what support the NHS Commissioning Board can offer to drive improvements in services to patients. An NHS Commissioning Assembly has been established to bring together leaders across NHS commissioning and organised around a single goal of securing the delivery of better outcomes for patients.
- 1.13 As a first step, the NHS Commissioning Board will provide five offers to NHS commissioners to give them the insights and evidence they need to produce better local health outcomes.

OFFER 1: NHS SERVICES, SEVEN DAYS A WEEK

- 1.14 The NHS will move towards routine services being available seven days a week. This is essential to offer a much more patient-focused service and also offers the opportunity to improve clinical outcomes and reduce costs.
- 1.15 The limited availability of some hospital services at certain times can have a detrimental impact on all five domains of the NHS Outcomes Framework. Our National Medical Director will establish a forum that includes national and local commissioners, providers and regulators to identify how there might be better access to routine services seven days a week and report in the autumn of 2013. As a first stage, the review will focus on improving diagnostics⁴ and urgent and emergency care. It will include the consequences of the non-availability of clinical services across the seven day week and provide proposals for improvements to any shortcomings. Emergency care should not be used when patients would benefit from care in other settings. Through our own direct commissioning and working with clinical commissioning groups, we will ensure that primary and community based services also deliver a high quality, responsive service both in and out of hours.

OFFER 2: MORE TRANSPARENCY, MORE CHOICE

- 1.16 It is critical that patients and commissioners understand the quality of services being delivered within hospitals and other healthcare settings. To enable

this, with oversight from our National Medical Director, the Healthcare Quality Improvement Partnership (HQIP)⁵ will develop methodologies for casemix comparison and, in conjunction with NHS Choices, publish activity, clinical quality measures and survival rates from national clinical audits for every consultant practising in the following specialties:

- adult cardiac surgery;
- interventional cardiology;
- vascular surgery;
- upper gastro-intestinal surgery;
- colorectal surgery;
- orthopaedic surgery;
- bariatric surgery;
- urological surgery;
- head and neck surgery; and
- thyroid and endocrine surgery.

1.17 These data will be published by summer 2013. Commissioners should ensure that each of their providers publishes its own information on these specialties on its website in a format defined by HQIP. Publication will be part of the NHS Standard Contract from 2014/15 to allow for comparisons across hospitals.

1.18 This work is a ground-breaking step towards ensuring the rights and pledges set out in the NHS Constitution, including patients' right to choose the most appropriate setting for care, are delivered. This means choice both at the point of GP referral and along the care pathway. Choice and competition incentives are important insofar as they contribute to achieving better outcomes for patients and local communities. The

NHS Commissioning Board is working in partnership with Monitor to make available the best evidence of how, where and what circumstances choice and competition has the potential to make the biggest positive difference. By March 2013 we will have begun to publish practical, evidence-based guidance and tools to support patients, commissioners and providers.

OFFER 3: LISTENING TO PATIENTS AND INCREASING THEIR PARTICIPATION

1.19 We need to know more about what our patients think of the services we commission and act on that information in designing and delivering services. We recognise a particular responsibility to ensure that the voice and views of currently disadvantaged groups are sought out and listened to.

1.20 We will expect commissioners to work with providers to put in place mechanisms for systematically capturing real-time patient and carer feedback and comment, as well as developing plans to gather public insight on local health services. Our aim is to ensure that all NHS funded patients will have the opportunity to leave feedback in real time on any service by 2015. This will start with a Friends and Family Test which will be introduced for all acute hospital inpatients and Accident and Emergency patients from April 2013 and for women who have used maternity services from October 2013. This will identify whether patients would recommend the hospital to those with whom they are closest and be an important part of the assurance

of clinical commissioning groups by the NHS Commissioning Board. Clinical commissioning groups will need to demonstrate what action they have taken as a consequence of feedback from the Friends and Family Test and work with providers on further roll-out from 2014/15.

1.21 In 2013/14 commissioners are expected to work with local Health and Wellbeing Boards to assess local population needs and with local Healthwatch to ensure that plans for patient and public involvement match local people's expectations for how they wish to be engaged at both individual and collective level. Commissioners are encouraged to develop local metrics for evaluating the social and economic return on investment and other impacts of their patient and public involvement activities.

1.22 We want to put patients in control and to offer them a world class customer service. For this reason, we will prioritise innovation in developing services around the needs of patients and the public. We will guarantee every patient the opportunity of online access to their own primary care medical record by the spring of 2015 and we will consult, by June 2013, on plans for provision of patient access to interoperable records across the pathway of care.

1.23 In line with the recommendations of *Innovation Health and Wealth: Accelerating adoption and diffusion in the NHS*⁶ we will expect commissioners to promote the benefits of technology in improving outcomes with a particular emphasis on much more rapid take up of telehealth and

telecare in line with patient need. We will support commissioners to provide patients with access to digital tools to help them manage health and care as they choose and shall also support a move to paperless referrals in the NHS by March 2015 so that patients and carers can easily book appointments in primary and secondary care.

OFFER 4: BETTER DATA, INFORMED COMMISSIONING, DRIVING IMPROVED OUTCOMES

1.24 High quality relevant data is a key tool for commissioning – it underpins assumed liberty for clinical commissioning groups. We will work to ensure information systems are improved and integrated where necessary. We will build a modern data service, *care.data*, in health and social care. This will provide timely, accurate data derived from information collected as part of the care process and linked along care pathways. This will require universal adoption of the NHS number as the primary identifier by all providers in 2013/14.

1.25 To ensure that clinical commissioning groups have the information they need to make informed decisions about secondary care and enable commissioning for integrated care, we will collect a core set of clinical data from GP practices for 2013/14. This will support clinical commissioning groups' analysis of outcomes along patient pathways, while maintaining patient confidentiality. This dataset is published alongside this planning framework.

- 1.26 Throughout 2013/14 commissioners must use sanctions within the NHS Standard Contract if they are not satisfied over the completeness and quality of a provider's data on the Secondary Uses Service (SUS).
- 1.27 We will work with clinical commissioning groups and providers to develop comprehensive clinical data for secondary care which we will consult on before development of planning guidance for 2014/15. We will expect secondary care providers to be able to account for the outcomes of all patients they treat and to adopt modern, safe standards of electronic record keeping by 2014/15. In 2013/14 we will expect secondary care providers to comply with data collections that have been approved by the Information Standards Board, including the Systemic Anti-Cancer Therapy dataset and Cancer Outcomes and Services dataset which will help us improve cancer outcomes for patients.
- 1.28 To support clinical commissioning groups develop their capacity to improve data quality, the NHS Commissioning Board's National Director for Patients and Information will produce advice by 31 March 2013 on what a high quality data set should look like and ask each clinical commissioning group to identify its own strategy in the light of our advice by 30 September 2013.

forthcoming report by Robert Francis QC into the Mid Staffordshire NHS foundation trust provide stark reminders of the consequences for patients if their needs are not central to everything we do. All NHS commissioners must work together with their providers to ensure the recommendations in those reports are being addressed. We will include any relevant recommendations from these reports within our assurance of clinical commissioning groups. Specifically, the Winterbourne View report sets out responsibilities for clinical commissioning groups which should lead to a dramatic reduction in hospital placements for people with learning disabilities or autism in NHS funded care who have a mental health condition or challenging behaviour.

1.30 *Compassion in Practice*⁸ sets out a new approach to improving our culture of compassionate care and in particular the actions necessary to maximise the role and expertise of nurses, midwives and care staff to deliver improved patient outcomes. It sets out the necessary values: care, compassion, competence, communication, courage and commitment – the 6Cs. As well as nurses, midwives and care staff, we expect all staff, including doctors, managers and support staff to embrace these values. We all want to see the highest standards of care, from childbirth where women should have choice and personalised care through children's services and adulthood to the end of people's lives.

OFFER 5: HIGHER STANDARDS, SAFER CARE

- 1.29 *Transforming Care: A National response to Winterbourne View Hospital*⁷ and the
- 1.31 Medical revalidation is designed to improve the quality and safety of care for patients

by ensuring that licensed doctors are up to date and fit to practice. Responsible officers must assure the quality and appraisal and clinical governance systems in their organisations to support this process.

- 1.32 In partnership with the NHS Leadership Academy⁹ we will ensure that the professionalism of management within the NHS meets the highest quality standards.

JOINED UP, LOCAL PLANNING

- 1.33 For the first time, local communities will drive NHS planning. The new Health and Wellbeing Boards create a close partnership between the NHS and local authorities and bring a new local accountability to assessing health and care needs. Both clinical commissioning groups and the NHS Commissioning Board Area Teams are members of each Health and Wellbeing Board. Health and Wellbeing Boards will be the key partnership forum for determining local priorities and providing oversight on their delivery. At a time of economic challenge it is vital that all organisations can understand their contribution to joined up working. Making the best use of resources through integration of provision around the needs of the service user should drive local priorities. Health and wellbeing partners have a key role in developing and supporting reconfiguration to ensure safe and sustainable services for patients. We will work with them to identify the parents of children with special educational needs or disabilities who could benefit

from a personal budget based on a single assessment across health, social care and education.

- 1.34 Health and Wellbeing Boards are a dynamic environment where the local health and wider needs of the population can be considered in partnership. The Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy determine locally what needs to be done to support better outcomes and a better service to the public irrespective of organisational boundaries.

- 1.35 We have developed a Clinical Commissioning Group Outcomes Indicator Set, which includes NHS Outcomes Framework indicators that can be measured at clinical commissioning group level and additional indicators developed by NICE and the Health and Social Care Information Centre. These indicators are published alongside this guidance and will provide clear, comparative information for clinical commissioning groups, Health and Wellbeing Boards, local authorities and patients and the public about the quality of health services commissioned by clinical commissioning groups and the associated health outcomes. They will be useful for clinical commissioning groups and Health and Wellbeing Boards in identifying local priorities for quality improvement and to demonstrate progress that local health systems are making on outcomes. The Clinical Commissioning Group Outcomes Indicators have been selected on the basis that they help contribute to better outcomes

across the five domains of the NHS Outcomes Framework.

1.36 The NHS Commissioning Board will not second-guess local priorities because we want local communities to determine what matters for them. To make this happen, we will:

- through clinical commissioning groups, make available to Health and Wellbeing Boards all the information we hold that might support local decision-making;
- provide each clinical commissioning group and Health and Wellbeing Board an outcomes support pack which provides comparative information at clinical commissioning group and local authority level; the packs include benchmarking information relating to the Clinical Commissioning Group Outcomes Indicator Set where data are available; and
- operate on the understanding and expectation that all data are published, whether or not the issue it relates to has been prioritised locally or nationally.

1.37 A robust, joined up approach to planning would cover each of the following steps:

- ensuring that all local partners are contributing – local health and care plus other local authority directors with an interest;
- understanding how your locality compares with other areas against indicators in the outcomes frameworks;
- understanding at a detailed level which groups of people within the locality are getting a raw deal from health and care services;

- engaging in open and creative ways with local communities to identify what matters most to them about their health and care. There is a particular need to seek out and listen to the voice and views of currently disadvantaged groups;
- using this quantitative and qualitative information to develop shared priorities based on outcomes that are in greatest need of improvement and the groups of people who are most disadvantaged;
- considering explicitly where and how commissioning budgets can be integrated whenever this will advance shared priorities, and taking the practical steps to ensure that people who will benefit, including in particular vulnerable groups and those with long-term conditions, receive an integrated experience of care; and
- aligning contracting around the shared priorities and putting in place mutual accountability across the partners.

1.38 The NHS Commissioning Board is committing to being actively engaged in every Health and Wellbeing Board and will expect each clinical commissioning group to be a strong contributor also.

CLINICAL COMMISSIONING: PLANNING TO MEET RESPONSIBILITIES

1.39 As well as being a strong contributor to the Health and Wellbeing Board process, each clinical commissioning group will need to satisfy itself that it is maintaining its statutory duties to improve the quality of services, in particular to:

- reduce inequalities;
- obtain appropriate professional advice;
- ensure public involvement;
- meet financial duties; and
- take account of the local Joint Health and Wellbeing Strategy.

1.40 For its part, as the oversight body charged with assessing clinical commissioning groups against their statutory duties, the NHS Commissioning Board will provide a single consistent approach to each of these areas. What clinical commissioning groups are asked to do, will be consistent with how they are held to account, how they are assessed and how they are rewarded.

1.43 As the national commissioning body, we will be positioning ourselves as a system leader and develop exemplar models of direct commissioning. We will act in a transparent and collaborative way and be as challenging on ourselves about quality improvement and the effective use of resources, as we are on other parts of the healthcare system.

1.44 The NHS Commissioning Board is accountable for ensuring the delivery of GP IT services and will devolve to clinical commissioning groups, the responsibility for operational management of these services. Clinical commissioning groups should commission appropriate GP information services, in line with the published operating model¹². These services will be expected to provide clinical assurance and safety, ensuring practices are supplied with appropriate clinical systems, integration with national systems and IT support services.

DIRECT COMMISSIONING BY THE NHS COMMISSIONING BOARD

1.41 We will directly commission services in five areas:

- primary medical, dental, pharmacy and optical services as well as all other dental services¹⁰;
- specialised services¹¹;
- some specific public health screening and immunisation services;
- services for members of the armed forces; and
- services for offenders in institutional settings.

1.42 In doing so, we will aim to use a single operating model for each of these services to secure consistency of approach. We will adopt the same principles that we would expect clinical commissioning groups and other partners in the Health and Wellbeing Board to adopt around the transparency

EMERGENCY PREPAREDNESS

1.45 There are some areas where national determination is required. Emergency preparedness, resilience and response (EPRR)¹³ across the NHS remains a core function of the NHS, required in line with the Civil Contingencies Act 2004. All NHS organisations will identify accountable emergency officers to assume executive responsibility and leadership at service

and ensure compliance with published guidance.

1.46 All NHS organisations are required to maintain preparedness to respond safely and effectively to a full spectrum of significant incidents and emergencies that could impact upon health or patient care, such as pandemic ‘flu, mass casualty, potential terrorist incidents, severe weather, chemical, biological, radiological and nuclear incidents, and public health incidents. Trusts must also be resilient to maintain continuity of key services in the face of disruption from identified local risks such as adverse weather, fuel supply shortages and industrial action.

1.47 From April 2013, all NHS organisations are required to contribute to the coordinated planning for both emergency preparedness and service resilience through their local health resilience partnerships. These partnerships will form the basis for all strategic joint work in this area, with Public Health England and with all our local partners. It is important that the NHS engages proactively at all levels as these new ways of working will form the basis for future decision-making.

1.48 Commissioners must ensure that they maintain the current capability and capacity of existing Hazardous Area Response Teams (HARTs) in ambulance trusts.

PROTECTING PATIENTS: CONTINUITY OF CARE

1.49 Commissioner Requested Services are services that will be considered for

protection should a provider fail. Monitor will publish guidance for commissioners to follow to ensure that key NHS services remain available for patients if a provider experiences serious financial difficulty. They will form part of Monitor’s Continuity of Service framework¹⁴, which aims to make sure patients continue to have access to the services they need in their local area.

1.50 As part of the Continuity of Service framework, commissioners will decide which services should be designated Commissioner Requested Services. Providers of Commissioner Requested Services will be subject to additional licence conditions in the proposed NHS provider licence.

1.51 Initially, all services offered by NHS foundation trusts that were previously identified in their terms of authorisation as “mandatory services” will automatically be classified as Commissioner Requested Services. During 2013/14, commissioners should begin to review this automatic classification, in line with Monitor’s guidance.

SEIZING THE OPPORTUNITY

1.52 The NHS belongs to us all. We are unashamedly ambitious for patients and will work relentlessly to empower them, putting them at the heart of the NHS, ensuring their voices are heard and that their choices drive the improvements that will shape our services. We will be realistic in our ambitions. We will support planning, providing oversight and assurance, helping

balance immediate and long-term improvement, and guiding careful use of resources to ensure current delivery is not put at risk. In doing so, we need to be focused on the wider economic and financial situation, where our push for improvement will be at a time of increasing demand for services within tight financial constraints.

¹ <https://www.wp.dh.gov.uk/publications/files/2012/11/mandate.pdf>

² <http://www.dh.gov.uk/health/2012/11/nhs-outcomes-framework/>

³ <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx>

⁴ See Implementing 7 Day working in Imaging Departments : Good Practice Guidance. A Report from the National Imaging Clinical Advisory Group. DH 2011.

⁵ <http://www.hqip.org.uk/>

⁶ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_134597.pdf

⁷ <http://www.dh.gov.uk/health/2012/12/final-winterbourne/>

⁸ <http://www.commissioningboard.nhs.uk/nursingvision>

⁹ <http://www.leadershipacademy.nhs.uk/>

¹⁰ <http://www.commissioningboard.nhs.uk/files/2012/06/ex-comm-pc.pdf>

¹¹ <http://www.commissioningboard.nhs.uk/files/2012/11/op-model.pdf>

¹² GP IT Services operating model v027 final

¹³ <http://www.commissioningboard.nhs.uk/ourwork/gov/epr/>

¹⁴ <http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/our-publications/consultations/consultations-and-engagement-monito-1>

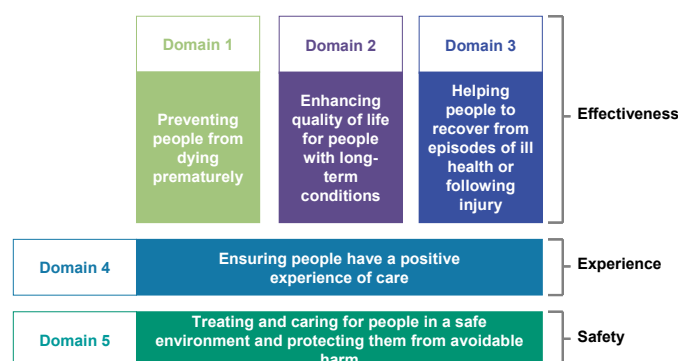
IMPROVING OUTCOMES, REDUCING INEQUALITIES: OUR RESPONSIBILITIES

2.1 We are committed to improving outcomes for patients with all mental and physical conditions that are amenable to health and care treatment. In supporting clinical commissioning groups and our own commissioning to improve outcomes, we have identified a number of outcome and delivery measures that commissioners can use to assure themselves that progress is being made. These are informed by our mandate, will help us to deliver it and will support our accountability to the Department of Health. The mandate asks us to oversee improvements against the NHS Outcomes Framework, ensure patients' rights and pledges under the NHS Constitution are maintained within allocated resources and with a view to meeting the QIPP challenge.

IMPROVING OUTCOMES

2.2 Improving the quality of care that patients receive and the outcomes we achieve for the people of England is what unites NHS commissioners in a common purpose.

2.3 The five domains of the NHS Outcomes Framework help shape what we are striving to achieve for the patients and populations we serve:



Equality and addressing health inequalities

2.4 Within each of these domains, tackling health inequalities and being focused on advancing equality will drive everything we do. Each domain will address inequalities so that those most in need have most to gain from the interventions we make. The outcomes for people with mental health are as important to us as those for physical health. Using outcomes in NHS planning is a radical departure from the pursuance of process targets. As such, we are at the beginning of a journey and 2013/14 will be a test-bed year as we develop an

understanding of how an outcomes-based approach will work in practice.

2.5 Throughout this planning round we will not second-guess local commissioning by setting improvement requirements but will expect clinical commissioning groups and our own commissioners to prioritise and make most improvement against those indicators where there is greatest local need. For each of the five domains, we have identified the measures from the NHS Outcomes Framework best placed to provide assurance in planning and delivery, where clinical commissioning group data exists and a baseline can be determined for 2013/14. These are set out in Annex A and will be used to inform clinical commissioning groups and ourselves on whether progress is being made. To support local quality improvement and provide transparency, the Clinical Commissioning Group Outcomes Indicators Set published alongside this guidance will provide additional information for commissioners and Health and Wellbeing Boards about the quality of local health services.

Domain 1: Preventing people from dying prematurely

2.6 The NHS Outcomes Framework has identified four key contributions to address premature mortality and the need for better prevention:

- earlier diagnosis;
- improving early management in community settings;
- improving acute services and treatment; and
- preventing recurrence after an acute event.

2.7 NHS commissioners should work with Public Health England, Health and Wellbeing Boards and local government to develop and provide integrated approaches to dealing with these issues, for example through better use of NHS health checks, so that we can become one of the most successful countries in Europe at preventing premature deaths.

Domain 2: Enhancing quality of life for people with long-term conditions

2.8 We have identified three areas for action to support the commissioners in providing person-centred and integrated care for people with long-term conditions:

- improvements in primary care;
- putting patients in charge and giving them ownership of their care, such as through personalised care plans and budgets; and
- coordination and continuity of care.

2.9 There is a critical role for clinical commissioning groups and our direct commissioners to work together under the auspices of the local Health and Wellbeing Boards. For example, if each Health and Wellbeing Board can determine its local expectation for improved diagnosis of dementia, we can commission primary care services in a way that secures improved diagnosis rates while the clinical commissioning group can commission services to reflect the treatment needed. We can aggregate each of the locally determined diagnosis rates to identify the national ambition for 2013/14.

Domain 3: Helping people to recover from episodes of ill-health or following injury

2.10 Avoidable admissions to hospitals need to be addressed, as well as maximising the effectiveness of treatment and providing the right support at the right time. Commissioners will be expected to support an approach that:

- keeps people out of hospital when better care can be delivered in other settings;
- ensures effective joined-up working between primary and secondary care;
- delivers high quality and efficient care for people in hospital; and
- coordinates care and support for people following discharge from hospital.

2.11 The NHS Standard Contract will not allow for hospitals to be reimbursed for admissions within 30 days of discharge following an elective admission. Payments for other readmissions will depend upon locally agreed thresholds. Commissioners should work with providers to invest savings in better reablement and post-discharge support initiatives.

Domain 4: Ensuring people have a positive experience of care

2.12 The final arbiter of the outcome of any NHS interaction is the patient's experience. In developing a more patient-centred approach, we have identified three key issues that require a commissioner response during 2013/14:

- rapid comparable feedback on the experience of patients and carers;
- building a capacity and capability in

both providers and commissioners to act on patient feedback; and

- assessing the experience of people who receive care and treatment from a range of providers in a coordinated package.

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

2.13 Commissioners should use the National Quality Dashboard to identify any potential safety failures in providers. At the same time, the NHS Commissioning Board is introducing a zero tolerance approach to MRSA infections. It will be expected that all cases will involve a Post Infection Review to identify why an infection occurred, and how future cases of infection can be avoided. For *Clostridium difficile*, we will support an approach based on significant reductions in incidence. Reducing the incidence of MRSA and *Clostridium difficile* infections will be one of the national measures used to calculate the Quality Premium for clinical commissioning groups.

PATIENTS RIGHTS: THE NHS CONSTITUTION

2.14 The NHS Constitution sets out the universal rights and pledges for all NHS patients. We all aim to ensure the requirements of the NHS Constitution are met for everyone that uses NHS services. In doing so we wish to see mental and physical health valued equally. Delivery of NHS Constitution rights and pledges on waiting times for its patients will be one of the factors taken into account in determining Quality Premium payments for clinical commissioning

groups. The Department of Health is consulting on strengthening the NHS Constitution. For planning purposes, the NHS Commissioning Board advises clinical commissioning groups to use the consulted position which is as set out in Annex B, together with the thresholds we will use in assessing organisational delivery.

ELIMINATING LONG WAITING TIMES

2.15 NHS staff are to be congratulated for the significant reductions in waiting times achieved over the past few years. That success is now documented as patient rights under the NHS Constitution. Each patient has a right to access non-urgent consultant-led treatment within the maximum waiting time of 18 weeks, or for the NHS to take all reasonable steps to offer a range of alternative providers if this is not possible.

2.16 However, there remains a small number of patients who are waiting too long. It is unfair to provide patients with a right and then not deliver against it. As such, we wish to identify an absolute minimum for all patients. From 2013/14 the following additional safeguard will be in place:

- zero tolerance of any referral to treatment waits of more than 52 weeks, with intervention, including contractual fines when this occurs.

2.17 To ensure treatment takes place as described in the NHS Constitution, we will make progress in four areas aimed at providing patients and commissioners

with the information they need to exercise choice:

- by April 2013 we will publish examples of good practice on where patients have been brought successfully within the maximum limit waiting times, including:
 - i) raising awareness of and responding to patients' requests for treatment at a range of alternative providers where treatment within 18 weeks is at risk; and
 - ii) use of Patient Tracking Lists (PTLs) to manage waiting lists and proactively identify cohorts of patients who must be treated to ensure they do not wait longer than 18 weeks.
- the NHS Standard Contract will make it a requirement for all letters for first outpatient appointments to include standard information on the right to a treatment within a maximum waiting time and what patients can do if they are concerned that they are or will be waiting longer than 18 weeks;
- we will explore how providers can inform patients of their estimated waiting time, as early as possible in their pathway, including whether they are at risk of waiting longer than 18 weeks; and
- we will explore how Choose and Book can be used to raise patients' awareness of their right to treatment within 18 weeks and their expected waiting times and to support them in choosing alternative providers.

MORE RESPONSIVE CARE: URGENT AND EMERGENCY CARE

- 2.18 The response by NHS staff to emergencies has significantly improved over recent years so that the NHS Constitution can provide for minimum response times for patients in Accident and Emergency (A&E) Departments or waiting for an ambulance.
- 2.19 To help support the integration of services at the point a patient arrives at an A&E Department in an ambulance, we are setting the expectation that:
- all handovers between an ambulance and A&E Department must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes; with
 - a contractual fine for all delays over 30 minutes, in both situations, and a further fine for delays over an hour, in both situations.
- 2.20 Neither is it acceptable for patients to be waiting on trolleys in A&E Departments and we will expect that as a minimum no patient experiences a trolley wait of longer than 12 hours.

KEEPING OUR PROMISES: REDUCING CANCELLATIONS

- 2.21 The NHS Constitution also includes a pledge that all patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within

28 days, or the patient's treatment to be funded at the time and hospital of the patient's choosing.

- 2.22 In support of this, and to improve the patient experience, we will also expect that no patient has to tolerate an urgent operation being cancelled for the second time.

MENTAL HEALTH

- 2.23 We wish to see better outcomes from mental health services. Our mandate anticipates the completion of the full roll-out of the access to psychological therapies programme by 2014/15 and the NHS Commissioning Board will expect clinical commissioning groups to commission services with that roll-out in mind and for the recovery rate to reach 50 per cent.

FINANCE

- 2.24 We want to promote strong and autonomous clinical commissioning groups. In doing so, we want them to regard their financial resources as the means to secure better patient outcomes, rather than numbers to feed into technical accounting mechanisms. They should set an annual budget against their plan and ensure that they operate within it throughout the year. As such, we will expect strong clinical commissioning group financial accountability with greater scrutiny in those cases where our approach to risk management has identified that more regular or in depth financial reporting is needed. The key measures are:

- financial forecast outturn and performance against plan;
- an assessment of the range of risk inherent in plans and mitigation strategies;
- underlying financial position after adjusting for non-recurrent items;
- triangulation of spend and activity between commissioning and provider plans; and
- delivery of running cost targets.

QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION (QIPP)

2.25 To ensure that the NHS continues to improve outcomes for patients in years to come, it is important that we are taking the significant actions now that will sustain and safeguard quality in future years. Focusing just on outcomes in the coming year, or waiting until later to tackle foreseeable problems, both fail to live up to our strategic responsibilities. That is why QIPP work remains essential. The creation of clinically-led commissioners comes at a critical time in delivering improved quality at a time of limited resource growth. The first two years of the QIPP challenge have been dominated by central actions such as national pay restraint and efficiency requirements. The health service needs to be locally driven and undergo radical transformational change through clinical service redesign if improvements are going to support modes of delivery that are both sustainable and centred on patients' needs. From 2013/14, this means a step change in the approach to QIPP with full local

ownership of the clinical changes needed to ensure wider service and financial sustainability.

2.26 The National Quality Board¹ has provided a number of guides that commissioners can use in meeting their QIPP challenges. From 2013/14 we will be supporting clinical commissioning groups in meeting their own QIPP challenges and will do so in four ways:

- building on the authorisation process which provided confidence that each clinical commissioning group could articulate its own QIPP challenge and that it had a solid platform for delivery;
- adopting the “assumed liberty” approach rather than performance manage achievement of milestones, we (through our Area Teams) would expect to see assurance from each clinical commissioning group that its governance processes were robust to identify and respond to its own QIPP challenges and milestones over the next two years;
- ensuring that our direct commissioning does not sustain outdated or outmoded service models when clinical commissioning groups have identified the need for improved delivery methods; and
- the triangulation of activity, quality and cost data and intelligence to provide overall system assurance.

2.27 As the NHS continues to face the need to improve efficiency at an increasingly faster rate, it is essential that as providers identify ways to secure cost improvements,

there is no trade-off with the quality of services provided. It is the fundamental responsibility of the Boards of provider organisations to ensure that any decisions to reduce costs do not have a negative impact on the quality of services. To be contracted to receive NHS services, all commissioners will operate on the basis that any cost improvement programmes must be agreed by the Medical and Nursing Directors of the provider as having been assured as clinically safe.

2.28 In addition, the clinical leaders of clinical commissioning groups must make their own assessment of cost improvements and be satisfied that services are safe for patients with no reduction in quality. To support decision making they should use the National Quality Board's "how to" guides, the potential impact on local and nationally accredited tools, such as the National Quality Dashboard, the NHS Safety Thermometer and any likely impact on staff and patient surveys, including the Friends and Family Test. Before making any changes to the thresholds for treatment, clinical commissioning groups must also be satisfied that their clinical leaders have confirmed that they are not contravening NICE guidance.

2.29 To provide assurance on QIPP, commissioners will want to maintain close oversight of patient activity and local plans should include trajectories of how activity will change over the next two years.

2.30 The NHS Commissioning Board will seek assurances from the Boards of clinical

commissioning groups that as a minimum the processes set out above have been followed so that we can be satisfied that each decision to change the cost base of a service has been assessed by clinical experts and identified as being safe and without resulting in the rationing of care on a basis that does not reflect clinical need. Thus, we will receive systemic oversight through assurance by:

- each clinical commissioning group providing confirmation that it has carried out a clinically-led quality impact assessment of all cost improvement schemes undertaken by its providers;
- the use of local metrics and intelligence such as the views of staff and patients, more clinically based tools such as the NHS Safety Thermometer and other resources developed locally to reflect the needs of the local health economy; and
- a line of sight on the clinical assurances that there has been no clinically inappropriate reduction in the availability of local services.

2.31 Implementation of *Innovation Health and Wealth, accelerating adoption and diffusion in the NHS* remains a priority for the development of QIPP. All NHS organisations should demonstrate how they are driving innovation and developing delivery mechanisms for long-term success and sustainability of innovation in their health economy.

2.32 NHS organisations should demonstrate their commitment to implementing each element of the Comply or Explain regime,

and we will set out compliance in the NHS Standard Contract. Where there is deviation from compliance then the same or higher standard must be met. There are four elements to Comply or Explain:

- automatic inclusion of positive NICE Technology Appraisals in local formularies in a planned way that supports safe and clinically appropriate practice;
- publication of local formularies;
- tracking of adoption of NICE Technology Appraisals through the Innovation Scorecard; and
- support to overcome the system barriers to implementation of NICE Technology Appraisal guidance and other guidelines through the NICE Implementation Collaborative.

2.33 The first Academic Health Science Networks (AHSNs) will become operational from April 2013. All clinical commissioning groups and our own direct commissioners should be members of an AHSN. The AHSNs will present a unique opportunity to align education, clinical research, informatics, innovation, training and education and healthcare delivery. Their goal is to improve patient and population health outcomes by translating research into practice and developing and implementing integrated health care services. Working with Academic Health Science Centres, they will identify innovations and spread their use at pace and scale through their networks.

¹ <http://www.dh.gov.uk/health/about-us/public-bodies-2/advisory-bodies/national-quality-board/>

TOOLS AND LEVERS TO SUPPORT COMMISSIONING

- 3.1 To support commissioners to secure better patient outcomes, we are providing a number of financial and related levers that commissioners can use in their overarching strategies.
- 3.2 These levers are structured to support clinical commissioning groups and the NHS Commissioning Board’s direct commissioners to secure quality service improvements which will deliver better outcomes for patients, whilst also, in the first year of reform, maintaining strong financial management while managing change.
- 3.3 Working with stakeholders during 2013/14, the NHS Commissioning Board will oversee a fundamental review of the incentives, rewards and sanctions available to commissioners to inform the 2014/15 planning round.
- 3.4 The NHS Standard Contract is a key enabler for commissioners to secure improvements in the quality of services for patients. It supports the approach set out in this guidance and as such will be the basis on which commissioners should commission NHS-funded services from providers. Commissioners must enforce the standard terms, including the financial consequences for under-performance or failure to provide data on which to assess performance. We will be rigorous in supporting clinical commissioning groups and our direct commissioners to ensure the contract terms are implemented.
- 3.5 The NHS Standard Contract will be revised for 2013/14 to support commissioners to hold providers of NHS funded care to account and to enable innovative commissioning. The final version of the NHS Standard Contract will be an “e-Contract” format, which will enable contracts to be tailored to the specific services commissioned. We will make a wide range of supportive guidance, tools and learning available to commissioners.

CONTRACTING FOR QUALITY: THE NHS STANDARD CONTRACT

REWARDING QUALITY THROUGH PROVISION: COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

- 3.6 CQUIN presents an opportunity for commissioners to secure local quality improvements over and above the norm by agreeing priorities with their providers. It is set at a level of 2.5 per cent of the value of all services commissioned through the NHS Standard Contract.
- 3.7 CQUIN should only be paid by commissioners when providers deliver a level of quality that is over and above the NHS Standard Contract. The 2.5 per cent amount will provide local commissioners with significant freedom to negotiate greater and locally-focused quality from providers. Within the total, one-fifth should be linked to the national CQUIN goals, where these apply, which for 2013/14 will be:
- *Friends and Family Test* – where commissioners will be empowered to incentivise high performing Trusts;
 - improvement against the *NHS Safety Thermometer* - (excluding VTE), particularly pressure sores;
 - improving *dementia* care, including sustained improvement in Finding people with dementia, **A**ssessing and Investigating their symptoms and **R**eferring for support (**FAIR**); and
 - *Venous thromboembolism* - 95 per cent of patients being risk assessed and achievement of a locally agreed goal for the number of VTE admissions that are reviewed through root cause analysis.

3.8 We will provide guidance to commissioners on the methodology to be used to measure performance against each of these indicators.

3.9 CQUIN payments will only be made to those providers that meet the minimum requirements of the high impact innovations as set out in *Innovation, Health and Wealth*. These minimum requirements, including how clinical commissioning groups can identify whether they have been met will be in guidance published by the NHS Commissioning Board.

REWARDING QUALITY THROUGH COMMISSIONING: QUALITY PREMIUM

- 3.10 Subject to Regulations, a Quality Premium will be paid in 2014/15 to clinical commissioning groups that in 2013/14 improve or achieve high standards of quality in the following four measures from the NHS Outcomes Framework (which are also included within the measures at Annex A):
- potential years of life lost from causes considered amenable to healthcare;
 - avoidable emergency admissions (a composite of four NHS Outcome Framework indicators);
 - the Friends and Family Test; and
 - incidence of healthcare associated infections (MRSA and *Clostridium difficile*).
- 3.11 The Quality Premium will also include three locally identified measures. Each clinical commissioning group should agree these measures with the NHS Commissioning

Board after consideration with Health and Wellbeing Boards and key stakeholders, especially patients and local community representatives.

3.17 Templates for the collection of key financial data for both clinical commissioning groups and our direct commissioners have been issued. The templates have been constructed to enable an assessment of the risk inherent in plans and triangulation of plans with providers. Detailed instructions for completion are included with the templates.

PROGRAMME AND RUNNING COSTS

3.18 Income is allocated separately for programme and administrative costs. Expenditure against these allocations will be tracked individually. Commissioners are asked to ensure that plans are in place to ensure administrative costs are not overspent. Underspends on administrative costs may be spent on programme costs. Clinical commissioning groups should plan property costs based upon pro rata share of Primary Care Trust costs collected through the 2012/13 baseline exercise. The total amounts will be communicated to clinical commissioning groups separately.

SURPLUS POLICY

3.19 Each commissioning organisation should plan to make a cumulative surplus at the end of 2013/14 of at least 1 per cent of revenue, including any historic surplus not drawn down. This will be carried forward into 2014/15.

3.20 Ownership of historical surpluses and deficits at 31 March 2013 will see Primary Care Trust accumulated surpluses up to the level of the 2012/13

3.12 These measures should focus on local issues and priorities, especially where the outcomes are poor compared to others and where improvement in these areas will contribute to reducing health inequalities.

3.13 Each measure should be based on robust data and the improvement needed to trigger the reward should be expressly agreed between the clinical commissioning group and our Area Team. Where there is concern about the validity of data, the measures identified in the Clinical Commissioning Group Outcome Indicator Set should be used as a default.

3.14 A significant quality failure in-year will automatically debar a clinical commissioning group from receiving a Quality Premium. A clinical commissioning group will not receive any Quality Premium reward if it has overspent its approved Resource Limit in 2013/14. Payment of the Quality Premium will also be dependent upon achieving NHS Constitution rights and pledges.

3.15 We will publish the methodology to be used for calculation of the Quality Premium.

FINANCIAL PLANNING AND BUSINESS RULES

3.16 The income allocated to clinical commissioning groups has been published alongside this guidance.

operating plans attributed to individual clinical commissioning groups and direct commissioning units in proportion to the final 2012/13 baselines. Strategic Health Authority surpluses will be managed at a national level. Any 2012/13 deficits will also be the responsibility of relevant clinical commissioning groups and direct commissioners.

- 3.21 The maximum expected level of the national surplus drawdown will be finalised with the Department of Health. Any surplus drawdown will be deployed across three areas:
- clinical commissioning group allocated share of drawdown;
 - our direct commissioning; and
 - system requirements including existing Strategic Health Authority commitments.
- 3.22 Commissioners are asked to include proposals for access to historical surpluses, if required, in their operating plans. The plans will be assessed with reference to the impact on outcomes and subject to the maximum drawdown available. Drawdown agreements will be finalised by the end of April 2013.
- 3.23 A key measure of financial resilience of an organisation is the recurrent, or underlying, financial position after stripping out non-recurrent income and expenditure. Commissioners should plan to be in 2 per cent recurrent surplus by the end of 2013/14. We will publish guidance on how this requirement will be defined and measured by the end of January 2013.

MANAGING RISK

- 3.24 It is important to ensure that our approach to risk management provides flexibility whilst providing sufficient mitigations against financial risks. These include:
- risk pooling between clinical commissioning groups;
 - policy for 2 per cent of income to be set aside and spent non-recurrently; and
 - contingencies.
- 3.25 In 2013/14, there is a requirement across all commissioning organisations to set aside 2 per cent of funding for non-recurrent expenditure. Clinical commissioning groups are expected to ringfence these funds and make expenditure commitments against all or part of them only following appropriate approval via NHS Commissioning Board Area Teams. Our own direct commissioners will also ringfence the funds, and release all or part only following approval via the national support centre.
- 3.26 Clinical commissioning groups must demonstrate that appropriate risk management and pooling arrangements are in place internally and between clinical commissioning groups to ensure budgets are achieved. NHS Commissioning Board Area Teams will ensure that effective risk management and pooling across directly commissioned activity are in place to mitigate risk.
- 3.27 Clinical commissioning groups are asked to hold a contingency of at least 0.5 per cent of revenue within their plans to determine locally the contingency required to mitigate

risks within the local health economy. This is in addition to 2 per cent ringfenced non-recurrent funds. Our own direct commissioners will also hold a minimum 0.5 per cent contingency.

undertaken by NHS Commissioning Board Area teams in partnership with clinical commissioning groups.

INTEGRATED CARE

PLANNING ASSUMPTIONS

3.28 Clinical commissioning groups and NHS Commissioning Board direct commissioning units should plan for an underlying growth in demand based upon both demographic and non-demographic changes.

3.29 The running cost allowance for clinical commissioning groups in 2013/14 has already been identified to individual clinical commissioning groups in line with the total overall national allocation of £25 per head of population.

3.30 The national provider efficiency requirement for 2013/14 tariff setting is 4 per cent. This will be offset against estimated provider cost inflation of 2.7 percent. This gives a net tariff adjustment of -1.3 per cent, which will also be the base assumption for discussions on price for services outside the scope of the mandatory tariff.

3.31 The 30 per cent marginal tariff for non-elective admissions will continue. Commissioners should budget for all admissions at 100 per cent tariff. NHS Commissioning Board Area Teams will administer the 70 per cent balance for local investment in relevant demand management schemes, jointly owned by commissioners and providers. Decisions on how to spend this resource will be

3.32 The integration of the provision of services, including the pooling of budgets to reflect local need, should be an explicit consideration in local area planning.

3.33 Clinical commissioning groups will assume responsibility for the management and administration of the £300 million a year reablement provision. Clinical commissioning groups will work with local authorities to agree allocation of the monies to benefit health outcomes in their local population. They will account to their Health and Wellbeing Board and the Area Team on how health and care have benefited from the allocation.

PLANNING AND ASSURANCE

- 4.1 We will support clinical commissioning groups to ensure that every plan is as strong as it can be. The approach set out in this guidance aims to strike a balance between local determination of priorities and our responsibility for oversight to ensure that statutory requirements around improving quality and financial duties are being met.
- 4.2 We are not setting any specific targets for improvement of those indicators contained within the NHS Outcomes Framework other than a defined level of continued reduction in *Clostridium difficile* infections. Rather than imposing targets, we expect clinical commissioning groups to develop their own local priorities through their input into the Joint Health and Wellbeing Strategy. However, with assumed liberty comes public responsibility and clinical commissioning groups are expected to set out real ambition in their plans. We will provide support and challenge where we have evidence to suggest greater ambition is needed. In addition to the measures referred to in Section 2 of this guidance, and to support local prioritisation, the
- 4.3 Our planning and assurance approach reflects the three lenses set out in Section 1 of this guidance, namely:
- **Local area based planning:** each Health and Wellbeing Board is expected to determine and oversee delivery of local priorities. Both clinical commissioning groups and the NHS Commissioning Board itself are members of each Health and Wellbeing Board and as such will be strong contributors to and be held to account against, the priorities determined by the Health and Wellbeing Board.
 - **Clinical commissioning group organisational planning:** we will expect each clinical commissioning
- NHS Commissioning Board is asking each clinical commissioning group to identify three local priorities against which it needs to make progress during the year. These priorities will also form part of our assurance of each clinical commissioning group and will be taken into account when determining if the clinical commissioning group should be rewarded through the Quality Premium.

group to monitor progress against each of the measures referred to in Section 2 of this guidance. That will involve reporting to the clinical commissioning group's governing body and to the NHS Commissioning Board's Area Team so that they can both monitor progress. Each clinical commissioning group should also agree with our Area Team, three priorities it has identified for improvement and against which progress can be monitored. These three priorities should be the same that will be used to determine the Quality Premium. Clinical commissioning groups are expected to improve outcomes across the full range of the NHS Outcomes Framework and act proactively, with our support when appropriate, should they identify or anticipate a quality or safety issue in a provider. That includes wider system responses, such as acting on the Winterbourne View and Francis reports.

- **Direct commissioning by the NHS Commissioning Board:** we have set ourselves the goal of being a demonstrable exemplar commissioner. In doing so we will publish assessments of our own performance across the range of our direct commissioning responsibilities and be transparent about any failings and our response to them. We will expect our direct commissioners to account to clinical commissioning groups on our performance so that we can work together to deliver joined up care for patients.

PLANNING TIMETABLE

- 4.4 We will review the local improvement identified by clinical commissioning groups against the measures referred to in Section 2 of this guidance so that we can be satisfied that we are fulfilling our statutory duties to (i) deliver the mandate and (ii) be satisfied that clinical commissioning groups are making sufficient contribution to quality improvement within allocated resources.
- 4.5 We will be taking an "open book" approach where we expect clinical commissioning groups and NHS Commissioning Board Area Teams to share data and planning assumptions on a transparent basis so that both can be satisfied that their plans secure the best possible outcomes for patients within available resources.
- 4.6 We will build on the authorisation process which required clinical commissioning groups to develop clear and credible plans and as such will already have a strong base on which to develop 2013/14 plans. NHS commissioners should develop plans on the basis of the following timetable:

Date	Activity	
	CCG Plans	Direct Commissioning Plans
w/c 17 Dec 12	Allocations published Planning guidance published	
	Draft supporting information published Draft NHS Standard Contract published	
25 Jan 13	CCGs to share first draft of plans with Area Team Directors to include: <ul style="list-style-type: none"> • “Plan on a Page” including <ul style="list-style-type: none"> (i) key elements of transformational change; (ii) key risks; and (iii) confirmation that national requirements will be met; • trajectories on relevant measures in Section 2 plus three local priorities; • activity plans – summary at commissioner level; • financial information 	Area Team Directors to share first draft of plans with Regional Directors to include: <ul style="list-style-type: none"> • “Plan on a Page” for each element of their direct commissioning; including confirmation that national requirements will be met; • key risks; • activity plans; • trajectories on relevant measures; • financial information
By 8 Feb 13	Area Directors to provide feedback to CCGs	Regional Directors to provide feedback to Area Team Directors
11 Feb to 29 Mar 13	Discussions to support Area Team Director assurance of plans	Regional and Area Team Director discussions to support assurance of plans
31 Mar 13	CCG and NHS Commissioning Board contracts signed off	
5 Apr 13	Final CCG plans shared with Area Team Director	Final direct commissioning plans shared with Regional Director
8 Apr to 19 Apr 13	Board analyses CCG plans and plans for direct commissioning with a view to identifying risks to delivery	
22 Apr to 10 May 13	Board confirms that plans add up to a position that delivers the mandate and improves patient outcomes within allocated resources	
By 31 May 2013	Each clinical commissioning group publishes its prospectus for its local population	

4.7 High quality planning is needed to deliver effective improvements for patients. All clinical commissioning groups should use the best available expertise to support them, whether through Commissioning Support Units or secured through other means.

CLINICAL COMMISSIONING GROUP ASSURANCE

4.8 We will use the measures in Section 2 of this guidance to provide assurance that clinical commissioning groups and

the NHS Commissioning Board's direct commissioners are fulfilling statutory duties. This will include:

- ensuring that clinical commissioning groups have taken the appropriate action to allow for authorisation conditions to be lifted at the earliest opportunity;
- an approach to reporting that ensures that the measures referred to in Section 2 are tracked effectively; and

- intervention where clinical commissioning groups are not fulfilling their statutory duties.

before determination of the payment of any Quality Premium.

CLINICAL COMMISSIONING GROUP ANNUAL ASSESSMENT

4.9 We have a statutory duty to carry out an annual assessment of each clinical commissioning group and we will build this into our approach to assurance. Our annual assessment of a clinical commissioning group will be based on it, in particular:

- improving the quality of services;
- reducing inequalities;
- obtaining appropriate professional advice;
- public involvement;
- meeting financial duties; and
- taking account of the local Joint Health & Wellbeing Strategies.

4.10 We will set out the basis on which we will carry out our annual assessment of clinical commissioning groups in 2013/14 by 31 March 2013. In doing so, we will ensure that the assessment is based on meeting the expectations set out in this guidance and meeting wider statutory duties including seeking the views of partners within the local Health and Wellbeing Board. The approach will build on that used in clinical commissioning group authorisation. Annual assessment will build on the six domains of authorisation, with elements updated to take account of learning from the authorisation process. Relevant aspects of the assessment as detailed within the Quality Premium will be taken into account

Annex A

NHS Outcomes Framework measures which the NHS Commissioning Board and Clinical Commissioning Groups will use to track progress (ie data can be generated at Clinical Commissioning Group level and a baseline can be determined against which progress can be considered).

1. Preventing people from dying prematurely
Potential years of life lost (PYLL) from causes considered amendable to healthcare
Under 75 mortality rate from cardiovascular disease
Under 75 mortality rate from respiratory disease
Under 75 mortality rate from liver disease
Under 75 mortality rate from cancer
2. Enhancing quality of life for people with long term conditions
Health-related quality of life for people with long-term conditions
Proportion of people feeling supported to manage their condition
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) ¹
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s ¹
Estimated diagnosis rate for people with dementia
3. Helping people to recover from episodes of ill health or following injury
Emergency admissions for acute conditions that should not usually require hospital admission ¹
Emergency readmissions within 30 days of discharge from hospital
Total health gain assessed by patients i) Hip replacement ii) Knee replacement iii) Groin hernia iv) Varicose veins
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI) ¹
4. Ensuring that people have a positive experience of care
Patient experience of primary care i) GP Services ii) GP Out of Hours services
Patient experience of hospital care
Friends and family test
5. Treating and caring for people in a safe environment and protecting them from avoidable harm
Incidence of healthcare associated infection (HCAI) i) MRSA ii) <i>C.difficile</i>

¹Will be used as part of a composite measure on emergency admissions

Annex B

Expected rights and pledges from the NHS Constitution 2013/14 (subject to current consultation) including the thresholds the NHS Commissioning Board will take when assessing organisational delivery.

Referral To Treatment waiting times for non-urgent consultant-led treatment
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%
Diagnostic test waiting times
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%
A&E waits
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%
Cancer waits – 2 week wait
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%
Cancer waits – 31 days
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%
Cancer waits – 62 days
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set
Category A ambulance calls
Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately)
Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%
Mixed Sex Accommodation Breaches
Minimise breaches
Cancelled Operations
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.
Mental health
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%.