NHS
Merton
Clinical Commissioning Group

REPORT TO MERTON CLINICAL COMMISSIONING GROUP
GOVERNING BODY

Date of Meeting: 26th March 2015

Agenda No: 6.1 **Attachment: 06**

Title of Document: Operating Plan Refresh	**Purpose of Report:** For note and update
Report Author: Adam Doyle, Director of Commissioning and Planning	**Lead Director:** Adam Doyle, Director of Commissioning and Planning
Key sections for particular note (paragraph/page), areas of concern etc: • Summary of Planning Guidance • Draft Operating Plan Refresh	
Recommendation(s): • The Governing Body is asked to note the operating plan refresh and comment on the content.	
Committees which have previously discussed/agreed the report: The Executive Management Team have been contributing to the drafts of the plans	
Financial Implications: Significant - to be factored in as part of the annual financial planning process	
Implications for CCG Governing Body: Significant – Organisational wide impact	
How has the Patient voice been considered in development of this paper: This work builds on feedback from our patient involvement events, sources of information (complaints, PALS)	
Equality Assessment: • JSNA highlights areas of inequality • EDS2 to be continue to applied to areas of the portfolio	
Information Privacy Issues: Nil of note	
Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution) It is expected that the paper will be formally agreed at the Governing Body meeting in May 2015	

NHS
Merton
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Merton CCG Commissioning and Planning 2015/16
March 2015

1. Purpose of Paper

1.1 This paper provides the Merton CCG Governing Body with information about the planning requirements (as they are currently known) of the CCG and offers the Governing Body the opportunity to review the current draft of the Operating Plan.

2. 2015/16 National Planning

2.1 Through its planning guidance, NHS England set out how the NHS budget will be invested so as to drive continuous improvement and to make high quality care for all, now and for future generations a reality. It seeks to ensure that the NHS is on as strong a footing as possible, capable of remaining focused on quality through a period of significant economic challenges and delivering models of care that will be sustainable in the longer term.

2.2 ***Everyone Counts, Planning for Patients 2014/15 – 2018/19*** was published in December 2013. It set out an ambition for high quality care together with details of the planning process to achieve this ambition, including the development of five-year strategic plans and detailed two-year operational plans by CCGs and NHS England's direct commissioning teams for the years 2014/15 – 2015/16.

2.3 Leaders of the NHS in England have published planning guidance for the NHS, setting out the steps to be taken during 2015/16 to start delivering the NHS Five Year Forward View.

2.4 NHS England, Monitor, the NHS Trust Development Authority, the Care Quality Commission, Public Health England and Health Education England have come together to issue the joint guidance called The Forward View into action: planning for 2015/16, coordinating and establishing a firm foundation for longer term transformation of the NHS.

2.5 The guidance is aligned to the recently announced £1.98 billion of additional funding, with specific financial allocations for healthcare commissioners also announced.

2.6 The coordinated guidance includes a new support package for GPs, plans for a radical upgrade in prevention of illness, and new access and treatment standards for mental health services.

2.7 The planning guidance requires leaders of local and national health and care services to take action on five fronts. It:

- Sets outs seven approaches to a radical upgrade in prevention of illness with England becoming the first country to implement a national evidence-based diabetes prevention programme;
- Explains how £480 million of the £1.98 billion additional investment will be used to support transformation in primary care, mental health and local health economies;
- Makes clear the local NHS must work together to ensure patients receive the standards guaranteed by the NHS Constitution;
- Underlines the NHS's commitment to giving doctors, nurses and carers access to all the data, information and knowledge they need to deliver the best possible care;
- Details how the NHS will accelerate innovation to become a world-leader in genomic and genetic testing, medicine optimisation and testing and evaluating new ideas and techniques.

3. 2015/16 Local Planning in Relation to the Guidance

3.1 For this planning round NHS organisations are asked to refresh their operational plans for 2015/16 only, based on the common planning assumptions for NHS commissioners and providers agreed by NHS England, Monitor and the TDA and on their local joint health and wellbeing strategies. There are few new national requirements for planning. The Mandate from the government to the NHS is broadly stable, apart from the introduction of new access standards for mental health. These form part of the wider ambition to achieve a genuine parity of esteem between mental and physical health by 2020. To support that ambition, it is expected each CCG's spending on mental health services in 2015/16 increases in real terms, and grow by at least as much as each CCG's allocation increase. All plans are expected to be aligned, have realistic activity and financial assumptions between NHS commissioners and providers across the country.

Prevention

3.2 CCGs should work with local government partners to set and share in 2015/16 quantifiable levels of ambition to reduce local health and healthcare inequalities and improve outcomes for health and wellbeing. These should be supported by agreed actions to achieve these, such as specifying behavioural interventions for patients and staff, in line with NICE guidance, with respect to smoking, alcohol and obesity, with appropriate metrics for monitoring progress.

3.3 The Local Government Association (LGA) and NHSE will develop and publish proposals for actions that local areas could take to go further and faster in tackling health risks from alcohol, fast food, tobacco and other issues.

3.4 There is the aspiration to become the first country to implement at scale a national evidence-based diabetes prevention programme, based on proven UK and international models, and linked where appropriate to the NHS Health Check. NHSE have invited local areas that have made greatest strides in developing preventative diabetes programmes to register their interest by the

end of January 2015 to co-design a new national programme led by Public Health England, NHS England and Diabetes UK.

3.5 By Autumn 2015 NHSE will have developed proposals for improving NHS services for helping individuals stay in work, or return to employment, while saving downstream costs at the Department for Work and Pensions

3.6 By Autumn 2015 NHSE will have examined and published their findings on the potential to extend incentives for employers in England who provide effective NICE recommended workplace health programmes for employees.

3.7 All NHS employers should take significant additional actions in 2015/16 to improve the physical and mental health and wellbeing of their staff - for example by providing support to help them keep to a healthy weight, active travel schemes and ensuring NICE guidance on promoting healthy workplaces is implemented.

Empowering Patients

3.8 From next year providers are required in the NHS Standard Contract to show demonstrable progress towards achieving fully interoperable digital health records from 2018.

3.9 From April 2015, patients will have online access to their GP records.

3.10 CCGs are expected to lead a major expansion in 2015/16 in the offer and delivery of personal health budgets to people, where evidence indicates they could benefit. As part of this, by April 2016, it is expected that personal health budgets or integrated personal budgets across health and social care should be an option for people with learning disabilities

3.11 CCGs will need to continue to work alongside local authorities and schools on the implementation of integrated education, health and care plans, and the offer of personal budgets.

3.12 CCGs should engage widely and fully with their local communities and patients, including with their local Healthwatch, and include clear goals on expanding personal health budgets within their published local Joint Health and Wellbeing Strategy. The CCG will need to ensure that integrated personalised commissioning is included here.

3.13 Commissioners and providers should work together and with patient groups to understand current delivery, and make significant further strides to honour patients' entitlements to choose.

3.14 CCGs are expected to work with GPs and providers to ensure that patients are aware of their rights and are offered choice in mental health services, and are able to make well-informed, meaningful choices at appropriate points along the pathway.

3.15 For 2015/16 commissioners should review the choices that are locally available for women accessing maternity services and, working together with service users and the public, consider what more can be done to offer meaningful choice. This may include choice of how to access maternity care, the type of care women receive, where they give birth (taking account of

recent NICE recommendations) and where they receive their antenatal and postnatal care. Within 2016/17 it is expected that tariff-based NHS funding will support the choices women make rather than constrain them and, as a result, make it easier for groups of midwives to set up their own NHS-funded midwifery services.

Engaging Communities

3.16 CCGs must focus on how they will meet their statutory duties on public and patient involvement in their commissioning decisions. In support of this NHSE are continuing to further develop the NHS Citizen approach (www.nhscitizen.org.uk). Commissioners should also consult the voluntary and community sector at local or national level for more strategic advice on this.

3.17 CCGs alongside local authorities to draw up plans to identify and support carers and, in particular, working with voluntary sector organisations and GP practices, to identify young carers and carers who themselves are over 85, and provide better support. In developing plans, CCGs should be mindful of the significant changes to local authority powers and duties from April 2015 under the Care Act 2013. Plans should focus on supporting young carers and working carers through the provision of accessible services, and services for carers from vulnerable groups.

3.18 All NHS employers must review in 2015/16 their own flexible working arrangements and support for staff with unpaid caring responsibilities.

3.19 NHSE will lead improving community volunteering and encourage new roles for volunteers, working with NHS and volunteer supporting organisations

3.20 NHSE will create a short model grant agreement we will reduce the time and complexity for charitable and voluntary sector partners to secure local NHS funding.

3.21 All NHS employers and their boards must examine themselves against the Race Equality standard to ensure that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve.

Models of Care

3.22 NHSE will start by prototyping four different types of care models outlined in the *Forward View* as follows:

- Multispecialty community providers (MCPs),
- Integrated primary and acute care systems (PACS);
- Additional approaches to creating viable smaller hospitals. This may include implementing new organisational forms advocated by the Dalton Review, such as;
- Specialist franchises and management chains; and
- Models of enhanced health in care homes.

3.24 For each of these care and organisational models, NHSE will co-design a structured programme of support to accelerate change, assess progress and demonstrate proof of concept. The purpose of becoming an initial site is not

simply to address local needs, but to become a successful prototype that can be adapted elsewhere, designed from the outset to be replicated by subsequent cohorts. The support programmes across the different care models will be inter-linked or share common elements and will be co-ordinated by a national New Models of Care Board. This will also be implemented at greater pace where new urban development is planned.

3.25 GPs will also be able to bid against the £250m fund intended to improve primary care and out-of-hospital infrastructure. The same amount will be available nationally for each of four years, allowing longer-term planning.

3.26 Health and social care economies should be looking afresh at their medium-term strategies, and choosing to take actions in 2015/16 that create the conditions for rapid early adoption. For example, rather than proceed with a stand-alone re-procurement of community services, one option CCGs may want to consider is how best to integrate these within a new MCP model. These conversations should take place on the same "units of planning" basis as 2014/15 unless otherwise locally agreed.

3.27 Local health economies will have the option, during the year, of coming together as one and inviting in the national bodies for a joined-up conversation about their emerging local system-wide plan.

New Care Models - Urgent and Emergency Care, Maternity, Cancer and Specialised Services

3.28 Commissioners and providers should prioritise the major strategic and operational task of how they will be implementing the urgent and emergency care review. This will be reinforced in 2015/16 by incentives in both the CCG quality premium and the CQUIN framework for providers. Urgent and emergency care networks, which will build upon existing System Resilience Groups, should be established by April 2015, and oversee the planning and delivery of a regional or sub-regional urgent care system. This will include designating and then assuring the quality of urgent care facilities, in line with guidance planned for summer 2015.

3.29 NHS England will complete a review of maternity services – including perinatal mental health - by autumn 2015. This will make recommendations on how best to develop and sustain maternity services for the future, and in a way that gives mothers more choice without compromising on safety

3.30 The *Forward View* explained the need for combined action on three fronts to improve cancer services:

- Better prevention
- Swifter access to diagnosis
- Better treatment, care and aftercare for all those diagnosed with cancer

These actions will be developed, with national cancer charities, in a new national cancer strategy.

3.31 For specialised care where quality and patient volumes are strongly related, such as trauma, stroke and some surgery, the NHS will continue to move towards consolidated centres of excellence. By summer 2015, NHS England

will initiate a first round of service reviews, working with local partners. 2015/16 will involve current providers preparing to implement the new standards for congenital heart disease services for children and adults, for example through new collaborations. In the light of the current consultation, NHS England will finalise the standards, and implement in full from April 2016.

A Regime for Challenged Systems

3.32 In 2015/16 NHSE will create a new regime that will seek to create the conditions for success in these most challenged areas. This "success regime" will focus on addressing current performance challenges, while creating the conditions for future transformation, including stronger relationships between local bodies and more effective and aligned medium-term plans. The regime will seek to build rather than supplement local capacity and capability; to create strong and durable local leadership arrangements; and to address deep-rooted barriers to improvement, such as clinical configuration and workforce shortages.

3.33 NHSE will develop the new regime in a small number of the most challenged areas during 2015/16. The system will learn by doing, and NHSE will set out more detailed guidance on the regime in early 2015. It is likely to include:

- the creation of a single, aligned accountability mechanism for the national bodies to oversee the process and to ensure that all relevant local parties are held to account
- the agreement of a single, collective short-term plan for the health economy setting out what needs to be achieved during the period of intervention;
- access to external support to address the particular issues facing the health economy, including clinical, financial and performance expertise;
- support from high-performing health economies and organisations to accelerate progress and build capacity in the challenged health economy;
- the development of a clear medium-term plan for transformation across the health economy;
- conditionality for any transitional financial support

New Deal for Primary Care

3.34 CCGs that choose to take on co-commissioning responsibilities will also have greater freedom to take local action. In addition to the actions and investment in this plan, an extra £100 million is available to improve access to general practice through the Prime Minister's Challenge Fund.

3.35 A core component of this ten point plan is the £1bn fund, over four years, made available in the Autumn Statement to improve premises and infrastructure. We will provide further details in January

3.36 Early in 2015 NHSE will take into account of the best ideas in how we implement new models of care in dentistry, eye services and community pharmacy.

4. Priorities for Operational Delivery in 2015/16

Improving Quality and Outcomes

4.1 CCG's are expected to continue delivering improvement against the indicators in the NHS Outcomes Framework, as set out in the government's Mandate to NHS England. Last year, each local area set out their own five-year ambitions on seven sentinel indicators, quantifying the level of improvement they could achieve for their local populations. CCGs must refresh, and make further progress to deliver, those ambitions for 2015/16.

4.2 The National Quality Board (NQB) will bring together system leaders and other national stakeholders. It will provide collective leadership for quality across the system, initially to review the current state of quality of care in the NHS, as assessed by the Care Quality Commission (CQC), and barriers to delivery of high quality care; to identify priorities for quality improvement, and; based on this assessment, develop new system-wide approaches for quality improvement.

4.3 Commissioners and providers should use CQC's inspection reports and ratings, as they roll these out during 2015 and 2016, to assure themselves of the quality of care in their area. They should learn from where care is good or outstanding. Where care requires improvement or is inadequate, local organisations and areas should urgently agree joint plans

4.4 During 2015/16, commissioners and providers should work together to embed the practice of clear clinical accountability, with a named doctor responsible for a patient's care, within and across different care settings.

Improving Patient Safety

4.5 Commissioners and providers should continue to drive and embed improvements in safe and compassionate care in response to the Francis Report, the failings at Winterbourne View and the Berwick Review. They are expected to take an active part in their local Patient Safety Collaborative and encouraged to join the 'Sign up to Safety' campaign, aligning safety improvement plans with their local Patient Safety Collaborative activity where appropriate.

4.6 NHS England has identified tackling sepsis and acute kidney injury as two specific clinical priorities for improving patient outcomes for 2015/16. Over a five year timeframe, improving care in these areas would have the biggest potential impact in reducing premature mortality. Sepsis and acute kidney injury will therefore form the basis of new national indicators for the 2015/16 commissioning for quality and innovation (CQUIN) incentive framework.

4.7 In 2015/16 CCGs together with providers should develop plans to improve antibiotic prescribing in primary and secondary care. CCGs should ensure that secondary care providers validate their antibiotic prescribing data following the Public Health England (PHE) validation protocol. This forms the basis of a new national quality premium measure for CCGs in 2015/16.

4.8 All providers of acute care should agree service delivery and improvement plans (SDIPs) with commissioners, setting out how they will make further progress in 2015/16 to implement at least five of the ten clinical standards for seven day services, within the resources available. It is recognised that the tariff for 2015/16 does not include specific additional resources for seven day working.

Meeting NHS Constitution Standards

4.9 NHS England, Monitor and the TDA will focus on achieving minimum performance standards for timely access to care that patients rightly expect and are entitled to receive. The challenges which many areas have experienced in meeting these standards during 2014/15 demonstrate the need for better working between commissioners and providers.

4.10 As part of the Operating Plan's assessment and assurance, NHS England, Monitor and the TDA will require CCGs and providers to make realistic and aligned assumptions about the likely activity levels for both elective and emergency care, including diagnostics, necessary to meet demand and delivering waiting time standards. This includes having realistic ambitions for activity diversion initiatives, using past and current performance as a relevant guide alongside future plans.

4.11 Unless and until it is clear that demand has reduced, CCGs have been strongly advised that system resilience groups should not to switch off additional winter capacity for urgent and emergency care

Achieving Parity for Mental Health

4.12 The recently published Mandate to NHS England remains largely unchanged. Commissioners will need to develop revised plans where they are not on track to deliver against pre-existing Mandate objectives, and to sustain those that are, for example on dementia diagnosis or delivery of improving access to psychological therapies (IAPT) service standards.

4.13 2015/16 will see the introduction of access and waiting time standards in mental health services for the first time. As part of the 2015/16 contracting round, mental health commissioners will need to develop and agree service development and improvement plans with mental health providers, setting out how providers will prepare for and implement the standards during 2015/16 and achieve these on an ongoing basis from 1 April 2016.

4.14 By April 2016, it is expected that more than 50% of people experiencing a first episode of psychosis will receive treatment within two weeks. This will require dedicated specialist early intervention-in-psychosis services, working with local secondary mental health providers. A further £40 million is being made available in 2015/16 through the tariff inflator to support the introduction of this standard.

4.15 Commissioners and providers will also need to work together to achieve new waiting time standards for people entering a course of treatment in adult IAPT services. At least 75% of adults should have had their first treatment session within six weeks of referral, with a minimum of 95% treated within 18 weeks

4.16 There is a clear local invest-to-save case for developing adequate and effective levels of liaison psychiatry for all ages in a greater number of acute hospitals. Commissioners are expected to agree SDIPs with appropriate providers, setting out how providers will ensure there are adequate and effective levels of liaison psychiatry services in acute settings.

4.17 The Crisis Care Concordat describes the actions required of commissioners and providers to ensure that those experiencing a mental health crisis are properly supported. This includes the provision of mental health support as an integral part of NHS 111 services; 24/7 Crisis Care Home Treatment Teams

4.18 CCGs should work with other local commissioners to invest in community child and adolescent mental health services.

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

Transforming Care of People with Learning Disabilities

4.20 CCGs working jointly with specialised commissioning and local authorities will have to make demonstrable progress in improving the system of care and reducing reliance on inpatient care for people with learning disabilities or autism as part of the Winterbourne View Concordat.

5. Enabling Change

Harnessing the Information Revolution and Transparency

5.1 The NHS number will be used as the primary identifier in all settings when sharing information. Commissioners will need explicitly to include this change within their plans. To enforce this change, commissioners will be able, under additional powers proposed through the NHS Standard Contract for 2015/16, to withhold funding from providers unless these conditions are met.

5.2 It is expected that at least 60% of practices will be transmitting prescriptions electronically to the pharmacy electronically by March 2016.

5.3 The 2015/16 GMS contract contains a further commitment to expand and improve the provision of online services for patients, including extending online access to medical records and the availability of online appointments.

5.4 Structured and coded discharge summaries should be available to health professionals electronically everywhere, as required. This will be a legally binding requirement by October 2015.

5.5 It is expected that electronic referrals between GPs and other services should become the norm. At least 80% of elective referrals should be made electronically by March 2016, in line with the 2015/16 GMS standard contract. To achieve this, providers will be required to publish all relevant services and appointment slots as part of standard contract obligation.

5.6 To deliver the NIB's framework Personalised Health and Care 2020, local commissioners will be expected to develop a roadmap for the introduction of fully interoperable digital records, including for specialised and primary care. Although not due for publication until April 2016, it will be important to make progress on this key enabler next year. Further guidance on those roadmaps will be published in June 2015, although work can usefully start immediately.

A Modern Health and Care Workforce

5.7 Each health economy should engage with their LETB to work together to identify their current and future workforce needs. For those economies that wish to put themselves forward to co-create the new care models, we expect to see plans to develop the existing and future workforce to deliver these models. In challenged health care economies, a plan to deliver workforce needs will also be a crucial ingredient of success.

5.8 Commissioners and providers must prepare for the introduction of nursing and midwifery revalidation from the end of December 2015. This will set new requirements for nurses and midwives when they renew their registration every three years.

Driving Efficiency

5.9 The guidance is particularly clear that further efficiency within the provision of service is possible. Commissioners should ensure the providers are driving efficiency through technology and other efficient measures.

6. NHS Funding

6.1 In deploying the additional funding NHS England is seeking to:

Create momentum in the implementation of the *Forward View* by providing a £200m investment fund to promote transformation in local health economies, with a particular focus on investment in the new models of care;

- Deliver on the promise of a new deal for primary care, ensuring that the overall level of total funding growth for primary care is in line with that provided for other local services;
- Ensure that mental health spend will rise in real terms in every CCG and grow at least in line with each CCG's overall allocation growth;
- Accelerate progress towards bringing all CCGs receiving less than their target funding to within 5% of target by 2016/17 whilst also directing funding towards distressed health economies; provide full cover for expected cost growth for each commissioning stream,
- Eliminating the structural deficit in specialised commissioning, and reflecting the rapid growth in these services;
- Enable earlier and more effective planning for operational resilience;
- Reconfirm plans to deliver 10% cash savings in CCG and NHS England administration costs for redeployment to the front line, and;
- To give CCGs priority access to the £400m drawdown available.

7 Joint Working between Commissioners and Providers

7.1 For local plans developed by commissioners and providers to be meaningful, and to provide a basis for improvement and transformation, it will be essential for them to be aligned and based on common assumptions. To support this Monitor, the TDA and NHS England have worked together to consider the future pressures and opportunities faced by the health sector as a whole, and agreed a shared set of national planning assumptions which should underpin all local plans. There must be Consistency between the activity and financial trajectories set out in commissioner and provider plans. The extent to which the trajectories are both realistic and sufficiently aligned will be tested through a joined-up process to ensure that all partners have a shared understanding of how local services will be transformed. Significant differences between commissioner and provider finance and activity plans will be reviewed as part of the process.

7.2 Commissioners and providers will need to consider the underlying activity pressures specific to them and to their local health economy and type of provision. This should reflect local demographic pressures (nationally, ONS population projections imply roughly 1.3% activity growth per year due to a growing population and changing agemix) while also considering non-demographic trends (for example, new treatments).At a national level, it is expected the overall activity growth pressure, before application of any demand management reduction, to be around 3% per year.

7.3 It is therefore essential that providers and commissioners work together, with partners in primary and social care, to develop accurate demand and capacity plans that fulfil both the planning requirements and ensure patients have access to high quality services. Commissioners must confirm the level of activity they wish to commission from providers in the 2015/16 standard contract, whilst providers must clearly understand the level of capacity that they have in order to meet demand in a safe and sustainable way.

NHS England's Requirements for Commissioners in Key Areas

7.4 The ambition for the level of improvement agreed by CCGs and Councils in Better Care Fund (BCF) plans should be reviewed if there is a material change in their assessment of the risk to delivery, taking into account:

- Actual performance in the year to date, particularly through the winter;
- The likely outturn for 2014/15;
- Progress with contract negotiations with providers.

7.5 Despite the BCF planning guidance setting an indicative figure aiming at an overall reduction of 3.5% in non-elective admissions, it confirmed that each local area could set *its own level of ambition*, taking into account local circumstances. The ambition for the level of improvement agreed by CCGs and Councils in Better Care Fund plans should now be reviewed in light of the current operational circumstances, taking into account the broad range of planning factors, including:

- Actual performance in the year to date, particularly through the winter;
- The likely outturn for 2014/15;
- Progress with contract negotiations with providers.

7.6 Through this review CCGs will need to be confident, together with Councils and providers, that they have translated their initial ambition to firm and deliverable planning assumptions on which NHS acute capacity provision can be safely based.

7.7 Any such review should be undertaken within the partnership underpinning local BCF planning and approved by the Health and Wellbeing Board. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition.

7.8 The total additional funding of £1.98bn announced in the 2014 Autumn Statement provides certainty of funding in 2015/16, including for issues such as operational resilience that would previously have been resourced from in-year allocations. As a result, there will be no further in-year allocations during 2015/16. SRGs should develop local capacity and demand plans that reflect operational resilience funding (including for winter) at the same level received in 2014/15, but funded from baseline allocations.

7.9 All commissioners must set aside 1% non-recurrent spend in 2015/16. This will be released for investment in strategic plans – for example, the implementation of the new care models discussed in the *Forward View*, subject to risk assessment by NHS England's Regional Teams.

7.10 Commissioners will offer each provider, through the commissioning for quality and innovation payment framework (CQUIN), the opportunity to earn up to 2.5% of its annual contract value (excluding drugs, devices and other items funded on a pass through basis). The 2015/16 CQUIN scheme will feature four national indicators, with an even balance between physical and mental health: two of the current national indicators will remain in place, with limited updating; these cover improving dementia and delirium care and improving the physical health care of patients with mental health conditions. Two new indicators will be introduced, one on the care of patients with acute kidney injury, the other on the identification and early treatment of sepsis.

7.11 There will also be a new national CQUIN theme on improving urgent and emergency care across local health communities, commissioners will select indicators locally from a menu of options.

7.12 NHS England will publish separate guidance on the 2015/16 CQUIN framework and the Quality Premium in January.

8 Submission and Assurance of 2015/16 Plans

Timetable

8.1 The timetable for submission is set out below in Table 1.

Table 1 – Key Dates and Progress

Activity	Date	Progress Made
High level planning discussions within Commissioning and Planning Directorate	30th August 2014	Delivered
Clinical Directors and Commissioning Managers informed of the commissioning investment and QIPP process. Team are given one month to collate high level plans and high level associated costs	23 September 2014	Delivered
Senior Leaders in Commissioning and Planning Directorate to meet to review plans	17 October 2014	Delivered
Executive Management Team to review the first cut	22nd October 2014	Delivered
Teams to start completing investment and QIPP templates	22nd October 2014	Delivered
Finalised templates to be circulated to scoring group	5th December 2014	Delivered
CFO to present high level financial plan to Finance Committee	11th December 2014	Delivered
Scoring workshop	17th December	Delivered
Publication of Final 2015/16 Planning Guidance, including provisional tariff assumptions, to be followed by: • Standard Contract for 15/16 • Revised Contract Dispute Resolution procedure	w/c 23rd December 2014	Significant issues with the national plans have led to tariff to be differentially applied across SWL
Investments and QIPP to be signed off at EMT	14th January 2015	Delivered
Publication of revised National Tariff	January 2015	Significant issues with the national plans have led to tariff to be differentially applied across SWL

Contract negotiations – including voluntary mediation	January – 11th March 2015	
Submission of initial headline plan data (CCGs, NHS England, NHS Trusts)	13th January 2015	Submitted
Weekly contract tracker to be submitted each Thursday (CCGs, NHS England, NHS Trusts)	From 29th January 2015	Submitted
Checkpoint for progress with planning measures and trajectories (CCGs, NHS England)	13th February 2015	Submitted
National Contract stocktake – to check the status of contracts	20th February	Deadline revised
Submission of full draft plans (CCGs, NHS England, NHS Trusts)	27th Feb 2015	Submitted
Assurance of draft plans (CCGs, NHS England, NHS Trusts)	27th February – 30th March 2015	Awaiting full feedback
Checkpoint for progress with planning measures and trajectories (CCGs, NHS England)	6th March 2015	Deadline revised
Contracts signed post-mediation (CCGs, NHS England, NHS Trusts and Foundation Trusts)	11th March 2015	TBC
Contract arbitration (CCGs, NHS England, NHS Trusts)	12th March – 23th March 2015	TBC
Arbitration outcomes notified to commissioners and providers (CCGs, NHS England, NHS Trusts)	By 25th March 2015	TBC
Plans approved by Boards of CCGs, NHS Trusts and Foundation Trusts	By 31st March 2015	TBC
Submission of full final plans (CCGs, NHS England, NHS Trusts and Foundation Trusts)	10th April 2015	TBC
Assurance and reconciliation of operational plans	From 10th April 2015	TBC

Assurance

8.2 Plans developed by commissioners, NHS Trusts, and NHS Foundation Trusts will be assured by NHS England, the TDA and Monitor respectively, in line with our distinct statutory and regulatory responsibilities.

8.3 In addition we will work together to maximise opportunities for mutual assurance across all health and social care services in a way that does not place additional burdens on local organisations. Our joint approach to the review and triangulation of plans will include a focus on ensuring that operational plans demonstrate:

- The finances to secure delivery of the objectives and compliance with the requirements outlined in the planning guidance;
- That the finance and activity projections are supported by reasonable and deliverable planning assumptions including level of assumed service redesign and underlying activity growth;
- Triangulation of finance and activity;
- Agreed demand and capacity plans;
- Coherence with LETB workforce plans
- A focus on prevention;
- Coherence with the other planning and output assumptions, and;
- Robust local relationships, and good public involvement, which are key to ensuring delivery.

9. Progress to Date

9.1 Taking into consideration the planning guidance, a refresh of the operating that was signed off by the Governing body in March 2014 has been undertaken. It can been seen in draft in appendix 1.

9.2 MCCG is still awaiting feedback from NHSE on our operational plan and cannot finalise elements of it without this feedback.

9.3 The draft plan has been shared with key partners including Merton Health and Wellbeing Board.

10. Summary

10.2 The Merton CCG Governing Body is asked to approve the paper and comment as appropriate.

Adam Doyle
Director of Commissioning and Planning
March 2015