Agenda item 9(i)
Appendix 1

Refreshing NHS Plans

for 2018/19

Published by NHS England and NHS Improvement

Refreshing NHS plans for 2018/19

Version number: 1.0

First published: February 2018

Prepared by: NHS England and NHS Improvement

This document is for: Foundation Trusts, NHS Trusts, Direct Commissioners and CCGs and should be read in conjunction with the NHS Operational Planning and Contracting Guidance

Publications Gateway Reference: 07705 and 07706

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net

Contents

1 Introduction

1.1 The NHS already has two-year contracts and improvement priorities set for the period 2017/19. These were based on the NHS Operational Planning and Contracting Guidance 2017-2019 published in September 2016 and reflected in the March 2017 document *Next Steps on the NHS Five Year Forward View*.

1.2 The November 2017 budget announced additional NHS revenue funding of £1.6 billion for 2018/19, which will increase funding for emergency & urgent care and elective surgery. In addition, for other core frontline services such as mental health and primary care, the Department of Health & Social Care (DHSC) is making a further £540 million available through the Mandate over the coming financial year. It is now our collective responsibility to ensure we deliver the best possible health service within the funds available. This joint NHS England and NHS Improvement updated guidance sets out how these funds will be distributed and the expectations for commissioners and providers in updating their operational plans for 2018/19.

1.3 In line with the priorities set out by the NHS England Board on 30 November 2017, for 2018/19 we will build on the progress made in 2017/18 and protect investment in mental health, cancer services and primary care in line with the available resources and agreed plans. Recognising the scale of unmet need in mental health, the importance of cancer services and the intense pressures on primary care we believe it would be unacceptable to compromise progress on these services. This means a continued commitment to deliver the cancer waiting time standards, achievement by each and every CCG of the Mental Health Investment Standard, service expansions set out by the Mental Health Taskforce and General Practice Forward View commitments, consistent with the expectations already set out in the 2017-19 planning guidance.

1.4 Given that two-year contracts are in place, 2018/19 will be a refresh of plans already prepared. This will enable organisations to continue to work together through STPs to develop system-wide plans that reconcile and explain how providers and commissioners will collaborate to improve services and manage within their collective budgets. Additional freedoms and flexibilities, described in this guidance, will support the most advanced Integrated Care Systems to lead this process.

1.5 Our energies must remain focused on improving the quality of care for patients and maintaining financial balance, whilst working in partnership to strengthen the sustainability of services for the future.

2 Financial Framework

Financial Framework for CCGs

2.1 The resources available to CCGs will be increased by £1.4 billion, principally to fund realistic levels of emergency activity in plans, the additional elective activity

necessary to tackle waiting lists, universal adherence to the Mental Health Investment Standard and transformation commitments for cancer services and primary care. This additional investment will be made available in the following ways:

- the requirement for CCGs to underspend 0.5% of their allocations has been lifted for 2018/19, releasing £370 million of CCGs' resources to fund local pressures and transformation priorities. The requirement to use a further 0.5% of CCGs' allocations solely for non-recurrent purposes has also been lifted;
- £600 million will be added to CCG allocations for 2018/19 (which otherwise remain unchanged), distributed in proportion to CCGs' target allocations (which have been updated to reflect the latest population estimates and other data)[1]; and
- a new £400 million Commissioner Sustainability Fund (CSF) will be created, partly mirroring the financial framework for providers, to enable CCGs to return to in-year financial balance, whilst supporting and incentivising CCGs to deliver against their financial control totals.

2.2 CCGs will be expected to plan against financial control totals communicated at the outset of the planning process[2] alongside revised allocations. CCGs collectively will be expected to deliver financial balance after the deployment of the Commissioner Sustainability Fund, and control totals will be set on this basis. Drawdown of cumulative underspends will be available subject to affordability, and where agreed with the relevant NHS England regional team.

2.3 CCGs' control totals will take into account each CCG's financial performance in 2017/18. Any CCG that is overspending in 2017/18 will be expected to improve its in-year financial performance by at least 1% of its overall allocation, and those with longer standing and/or larger cumulative deficits will be given a more accelerated recovery trajectory.

Commissioner Sustainability Fund

2.4 Where it is agreed that a CCG is unable to operate within its recurrent allocation for 2018/19 it will be required to commit to a credible plan, agreed and aligned at STP level, to deliver a stretching but realistic deficit control total set by NHS England and it will then qualify to access the Commissioner Sustainability Fund provided it delivers its financial control total.

2.5 All CCGs will be expected to achieve a minimum of financial balance with zero deficits, following deployment of any CSF allocations. Full details on the operation of the CSF will be published shortly.

[1] Revised CCG allocations have been published alongside this document on a provisional basis and for planning purposes, subject to confirmation at the NHS England public Board meeting on 8 February 2018.
[2] CCGs will be informed of their control total by NHS England in writing, shortly after this guidance is published.

Provider Sustainability Fund and Financial Framework for NHS Providers

2.6 £650 million will be added to the £1.8 billion Sustainability and Transformation Fund to create an enhanced £2.45 billion Provider Sustainability Fund, targeted at the same objectives as the existing Sustainability and Transformation Fund. The additional £650 million must deliver at least a pound-for-pound improvement in the aggregate provider financial position and will be reflected in 2018/19 provider control totals[3]. As in 2017/18, 30% of the total £2.45 billion fund will be linked to A&E performance. Full details will be published separately via an update to the existing Sustainability and Transformation Fund guidance. To access the performance element, each provider will need to achieve A&E performance in 2018/19 that is the better of either 90% or the equivalent quarter for 2017/18. The provider sector will plan and deliver a balanced income and expenditure position for 2018/19 after deployment of the £2.45 billion Provider Sustainability Fund.

2.7 Providers will be expected to plan on the basis of their 2018/19 control totals. Provider plans must make clear whether the Board has confirmed acceptance of its control total. NHS Improvement will use the completed financial planning template to capture this decision. If the control total has not been accepted, this is likely to trigger action under the Single Oversight Framework.

2.8 Providers who accept their control totals and so have access to the Provider Sustainability Fund for 2018/19 will continue to be exempt from the application of an agreed range of contractual performance sanctions, as set out in the existing NHS Standard Contract. NHS England will shortly consult on changes to the Contract to extend this exemption to all national contractual performance sanctions except those relating to mixed sex accommodation, cancelled operations, Healthcare Associated Infections and the duty of candour, on the basis that continuing NHS Improvement oversight, including the NHS Improvement Single Oversight Framework, will ensure that NHS providers continue to perform to acceptable levels against all national standards. Neither providers nor commissioners should include the expected impact of contractual sanctions in their plans, whether or not the provider has accepted its control total and so has access to the Provider Sustainability Fund. Providers who accept control totals (and associated conditions) will also be eligible to be considered for any discretionary capital allocations.

Capital and Estates

2.9 The 2017 Autumn Budget provided an extra £354 million of public capital in 2018/19 and set out the Government's commitment to delivering its share of the NHS property and estates investment recommended in the Naylor review. NHS England and NHS Improvement are working together with DHSC and HMT to prioritise the allocation of additional STP capital. In updating 2018/19 operational plans, STPs and providers should not assume any capital resource

[3]Providers will receive a letter from NHS Improvement informing them of changes to their previously notified 2018/19 control totals shortly after this guidance is published

above the level in the current 2018/19 operating plans unless NHS England and NHS Improvement have given written confirmation of additional resource.

2.10 The approval of additional STP capital will be contingent on the STP having a compelling estates and capital plan. The STP plan must be fully aligned with the overarching strategy for service transformation and financial sustainability. This plan must set out how the individual organisations in the STP will work together to deploy capital funding to support integrated service models, maximise the sharing of assets and dispose of unused or underutilised estate. In addition, plans will need to demonstrate both value for money and savings to the STP over a reasonable payback period, taking full account of the life cycle costs associated with any new asset. STPs will also be expected to ensure that they maximise opportunities for self-funding of schemes using their own capital and receipts from land disposals and are fully considering the use of private finance where this provides value for money. Further information on the next steps regarding STP capital will be communicated separately.

2.11 Providers are asked to actively consider the requirement for funding critical estate backlog within their capital plan and explain their strategy for investment in backlog work and risk mitigation including how they will reduce operational expenditure relating to estate and facilities.

National Tariff

2.12 The two-year National Tariff Payment System which came into effect from 1 April 2017 remains in place for next year. Local systems are encouraged to consider local payment reform, in particular to complement the introduction of ‘advice and guidance’ services. Local systems are also encouraged to introduce appropriate local tariffs for emergency ambulatory care where they have not already done so, to replace the current A&E and non-elective tariffs for appropriate conditions. The next round of interventions eligible for direct reimbursement through the Innovation and Technology Payments, a programme designed to incentivise take-up of the latest innovations across the NHS, will be published by 31 March.

Underlying Assumptions

2.13 Local systems are expected to continue to implement the priority efficiency programmes within the 10 Point Efficiency Plan. This includes taking every opportunity to maximise provider operational productivity, guided by the Model Hospital portal, and to participate fully in associated programmes. It also includes the implementation of *Getting It Right First Time* recommendations; participation in networked arrangements for procurement, corporate services and diagnostic services; achieving best practice in clinical and other workforce productivity standards (including reducing agency staff usage); and improving the safety and efficiency of providers’ estate and facilities. Providers and STPs should also consider how to make best use of the digital and technological systems and innovations available to them. In addition to the moderation of emergency demand discussed below, the use of RightCare, elective care

redesign, urgent and emergency care reform, medicines optimisation, and more integrated primary and community services are also key areas of focus.

2.14 CCGs should assume that the current high level of discretionary prices for generic drugs in short supply will not persist in 2018/19. In 2018/19, CCGs will receive the remaining period of temporary benefit from changes made to Category M generic drug prices designed to recover excess community pharmacy margin from previous years (i.e. the Cat M clawback will not continue beyond 2017/18). Beyond this, no assessment has yet been made of whether upward or downward adjustments to generic drugs prices will be needed in 2018/19 to reflect under or over-delivery of community pharmacy margin delivered in 2016/17 and 2017/18. So no allowance for this should be included in CCG plans.

2.15 In December 2017, NHS England issued guidance on *Items that should not routinely be prescribed in primary care: Guidance for CCGs*. This guidance is aimed at reducing the routine prescribing of 18 ineffective and low clinical value medicines, such as some dietary supplements, herbal treatments and homeopathy. It is assumed CCGs will save up to £141 million a year from this programme. NHS England has also launched a public consultation (closing 20 March 2018) on reducing prescribing of over-the-counter medicines for 33 minor, short-term health concerns, as well as vitamins and probiotics. Depending on the outcome of the consultation, it is assumed this could save the NHS up to £136 million a year. CCGs should consider how to locally implement guidance on the 18 ineffective and low clinical value medicines and consider the potential impact of any developments concerning over the counter medications following the consultation.

2.16 It is assumed that all CCGs continue to work with the NHS England Continuing Healthcare strategic improvement and QIPP programmes to increase standardisation of processes and adopt best practice to deliver the targeted reduction in growth, thus mitigating cost and volume pressures, including the impact of any increases to Funded Nursing Care rates.

2.17 Where the activity, cost and efficiency assumptions made by an STP do not enable each of its organisations to meet the control totals set by NHS England and NHS Improvement, the STP will need to agree additional cost containment measures and highlight any implications. This includes potential impacts on the range or level of services to be provided, and where surpluses will be created to offset any unavoidable deficits within the STP. When considering options to deliver control totals, STPs must ensure the alignment of commissioner and provider assumptions. They must also ensure that plans continue to meet the requirements for A&E, RTT and cancer set out in this letter and that patients are able to exercise choice as set out in the NHS Constitution.

2.18 We are working through the implications of the Government's commitment on NHS pay described in the 2017 Autumn Budget and will publish further guidance in due course. Until this is available the impact of any changes to NHS pay beyond the 2017-19 published assumptions should be excluded from

plans. It is essential that the 2018/19 pay costs in financial planning returns are an accurate reflection of the cost of the current, published pay assumptions.

2.19 Further details about CQUIN, Quality Premium, national contract and winter planning are set out in section 6.

Specialised Commissioning

2.20 The contracting approach for specialised services continues into 2018/19, aligned to implementation of the Carter review. Specialised commissioners and providers will need to review the 2018/19 activity plans and agree any contract variations required in accordance with the contractual process and to the national timetable. Activity plans for 2018/19 will be reviewed as part of routine in-year contract management, incorporating delivery of QIPP planning and appropriate CQUIN benefit realisation. Locally priced services reform to reduce cost per weighted activity unit, multi-year medicines optimisation approach underpinned by CQUIN, and further reforms to the medical device supply chain, will continue. It remains a priority to have robust and high quality data flows to support accurate reimbursement, in particular of tariff-excluded high cost drugs and devices.

3 Planning Assumptions for Emergency Care and Referral to Treatment Times

Emergency Care

3.1 The combination of clarity on control totals for providers and commissioners, underpinned by the increased provider sustainability fund and the new commissioner sustainability fund, paid for using additional budget funding, should enable health systems to fund and plan for this year's activity in a way that enables improved A&E performance in 2018/19. In addition, the allocations for 2018/19 allow for 2.3% growth in non-elective admissions and ambulance activity and 1.1% growth in A&E attendances. This is in aggregate for England and reflects recent trends, but activity growth patterns to be reflected in plans will in practice vary by commissioner and provider.

3.2 Our expectation is that the Government will roll forward the goal of ensuring that aggregate performance against the four-hour A&E standard is above 90% for the month of September 2018, that the majority of providers are achieving the 95% standard for the month of March 2019, and that the NHS returns to 95% overall performance within the course of 2019. STPs, commissioner and providers should review assumptions for levels of A&E attendances and non-elective admissions to ensure they reflect recent trends, adjusting as appropriate for demand management and other efficiency schemes that have been agreed between CCGs and providers. Given the differential implications for both bed capacity and cost, organisations will be required to plan and report non-elective admissions of less than one day separately from those of one day or more. Plans will also be collected on planned bed numbers to ensure

sufficient capacity is available throughout the year to meet anticipated demand for emergency and elective care.

3.3 Commissioner and provider plans will be expected to demonstrate how they will complete the implementation of the integrated urgent care strategy that was commenced this year, and how sufficient capacity will be available to meet planned activity growth through a combination of additional beds and/or:

- reductions in delayed transfers of care (DTOCs), both through reducing NHS-driven DTOCs and through continuing to work with local authorities to reduce social care DTOCs, with the aim of reducing the proportion of beds occupied by DTOC patients to 3.5%;
- reductions in average length of stay, including a focus on those patients with the longest length of stay as identified in the stranded patients metrics.

3.4 It is clear that there is significant variation in length of stay between providers, particularly in the number of patients with a length of stay over seven days (stranded patients) and a length of stay over 21 days (super stranded patients). We expect all providers and commissioners to work together to focus on reducing their length of stay, and particularly the very long lengths of stay, to release capacity for patients who are legitimately waiting for a hospital bed.

3.5 To further support progress in these areas and free-up capacity, providers of community services will be invited to participate in a new local incentive scheme in conjunction with their CCG whereby they will be able to reinvest savings from acute excess bed day costs to expand community and intermediate care services. This will benefit ‘stranded’ and ‘super-stranded’ patients in particular.

3.6 A total of £210 million of CCG Quality Premium incentive funding will be contingent on performance on moderating demand for emergency care. This payment will be conditional on the CCG meeting or improving on the levels jointly planned with providers. The principal metric for this purpose will be the level of growth in non-elective activity compared to the agreed plan.

Referral to Treatment Times

3.7 The 2018/19 allocations now allow for improvements in the volume of elective surgery being funded next year, and improvements in the number of patients waiting over 52 weeks. A more significant annual increase in the number of elective procedures compared with recent years means commissioners and providers should plan on the basis that their RTT waiting list, measured as the number of patients on an incomplete pathway, will be no higher in March 2019 than in March 2018 and, where possible, they should aim for it to be reduced. Numbers nationally of patients waiting more than 52 weeks for treatment should be halved by March 2019, and locally eliminated wherever possible. The planning assumption for England as a whole is for 4.9% growth in total outpatient attendances (4.0% per working day) and up to 3.6% growth in elective admissions (2.7% per working day). It is also assumed that GP referrals will increase by 0.8% (i.e. no change per working day). The planned growth levels required will vary locally and therefore activity plans should be reviewed

to ensure delivery of these objectives, adjusting as appropriate for demand management and other efficiency schemes which have been jointly agreed between commissioners and providers. Systems will be expected to plan and report separately on day case and inpatient elective activity, based on their trend performance, the profile of expected referrals and the composition of their existing waiting list. Systems will be expected to demonstrate to regional teams that their RTT plans are robust and realistic, and that they make best and flexible use of available capacity across their STP footprint in order to optimise delivery against the objectives above.

3.8 Provider plans will need to consider the capacity required to deliver the growth in non-elective and elective activity and the impact on workforce, finance and productivity. Alongside these capacity considerations it remains essential that providers manage within their agency ceilings.

4 Delivery of Next Steps Priorities

4.1 The NHS is already working to two-year priorities as set out in last year's planning guidance and the March 2017 *Next Steps on the Five Year Forward View*. This document confirms the deliverables for 2018/19. These are set out in Annex 1, together with the progress made against 2017/18 deliverables.

5 Integrated System Working

5.1 In 2018/19, we expect all STPs to take an increasingly prominent role in planning and managing system-wide efforts to improve services. STPs should:

- ensure a system-wide approach to operating plans that aligns key assumptions between providers and commissioners which are credible in the round;
- work with local clinical leaders to implement service improvements that require a system-wide effort; for example, implementing primary care networks or increasing system-wide resilience ahead of next winter;
- identify system-wide efficiency opportunities such as reducing avoidable demand and unwarranted variation, or sharing clinical support and back office functions;
- undertake a strategic, system-wide review of estates, developing a plan that supports investment in integrated care models, maximises the sharing of assets, and the disposal of unused or underutilised estate; and
- take further steps to enhance the capability of the system including stronger governance and aligned decision-making, and greater engagement with communities and other partners, including where appropriate, local authorities. STPs should also take steps to resource their own 'infrastructure'. Although these should be mainly drawn from their constituent organisations, NHS England will be making a further non-recurrent allocation within each STP to support its leadership in 2018/19 on the same basis as last year.

Integrated Care Systems

5.2 We will reinforce the move towards system working in 2018/19 through STPs and the voluntary roll-out of Integrated Care Systems. Integrated Care Systems are those in which commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations.

5.3 We are now using the term 'Integrated Care System' as a collective term for both devolved health and care systems and for those areas previously designated as 'shadow accountable care systems'. An Integrated Care System is where health and care organisations voluntarily come together to provide integrated services for a defined population.

5.4 We see Integrated Care Systems as key to sustainable improvements in health and care by:

- creating more robust cross-organisational arrangements to tackle the systemic challenges facing the NHS;
- supporting population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation;
- delivering more care through re-designed community-based and home-based services, including in partnership with social care, the voluntary and community sector; and
- allowing systems to take collective responsibility for financial and operational performance and health outcomes.

5.5 There are currently eight areas designated as 'shadow' accountable care systems, plus the two devolved health and care systems based on STP footprints (Greater Manchester and Surrey Heartlands). These systems should prepare a single system operating plan narrative that encompasses CCGs and NHS providers, rather than individual organisation plan narratives. The system operating plan should align key assumptions on income, expenditure, activity and workforce between commissioners and providers. System leaders should take an active role in this process, ensuring that organisational plans underpin and together express the system's priorities. All Integrated Care Systems are expected to produce together a credible plan that delivers the system control total, resolving any disputes themselves, and no 'shadow' Integrated Care System will be considered ready to go fully operational if it is unable to produce such a plan.

5.6 To reinforce this approach to system planning, NHS England and NHS Improvement will focus on the assurance of system plans for Integrated Care Systems rather than organisation-level plans. We expect that Integrated Care Systems will assure and track progress against organisation-level plans within their system, ensuring that they underpin delivery of agreed system objectives.

NHS England and NHS Improvement will support system leaders in this task. We have developed a new approach to oversight and support for Integrated Care Systems, based on the principles of setting system-wide goals, streamlining the oversight and support provided by NHS England and NHS Improvement (supported by an integrated framework that brings together the separate frameworks for trusts and CCGs), and working with and through the local system leadership to provide any support or interventions in individual providers or localities.

5.7 Integrated Care Systems will be supported by new financial arrangements:

- all Integrated Care Systems will work within a system control total, the aggregate required income and expenditure position for trusts and CCGs within the system, as communicated by NHS England and NHS Improvement[4]. They will be given the flexibility, on a net neutral basis, and in agreement with NHS England and NHS Improvement, to vary individual control totals during the planning process and agree in-year offsets of financial over-performance in one organisation against financial under-performance in another;
- in 2018/19, systems are encouraged to adopt a fully system-based approach to the PSF and CSF under which no payment will be made unless the system as a whole has delivered against its system control total. If the system achieves its control total, but individual trusts or CCGs do not, the system will still retain its full share of the PSF (£2.45 billion in aggregate) and any applicable CSF awards, but NHS England and NHS Improvement will agree with the leadership how those trusts' and CCGs' shares will be apportioned between local organisations;
- systems adopting this full incentive structure will operate under a more autonomous regulatory relationship with NHS England and NHS Improvement. NHS England and NHS Improvement will also support fully authorised Integrated Care Systems by exercising their intervention powers alongside the system leadership. For example, where there is a case for regulatory intervention in a trust or CCG to address financial underperformance or issues of quality, the leadership of the Integrated Care System will play a key role in agreeing what remedial action needs to be taken; and
- all approved Integrated Care Systems will be required to operate under these fully-developed system control total incentive structures by 2019/20. However, in 2018/19 systems that are not ready to proceed with full system incentives and shared intervention arrangements will alternatively be allowed to adopt an interim approach under which only the additional funding that has been put into the PSF (£650 million in aggregate) will be linked to system financial performance. On this option, no payment will be made from this enhanced funding unless the system as a whole meets its control total. If individual trusts or CCGs miss their organisational control totals, but the system still achieves overall, their share will be apportioned in consultation with the system leadership. However, on this interim option

[4] Integrated Care Systems will be informed of their system control total by NHS England and NHS Improvement in writing, shortly after this this guidance is published

if the individual trusts or CCGs meet their organisational control totals, but the system does not overall, they will retain access to the relevant share of the existing £1.8 billion PSF and any applicable CSF awards.

New Integrated Care Systems

5.8 There is strong appetite amongst other systems to join the Integrated Care System development programme and we anticipate that additional systems will wish to join during 2018/19 as they demonstrate their ability to take collective responsibility for financial and operational performance and health outcomes. STPs that can demonstrate their readiness to join the programme should speak to their regional teams to confirm expressions of interest from all organisations in the STP. We will aim to review any applications to join the programme by March 2018. We envisage that over time Integrated Care Systems will replace STPs.

5.9 The next cohort of Integrated Care Systems will be selected from STPs with:

- strong leadership, with mature relationships including with local government. The leadership team should have effective ways of involving clinicians and staff, the third sector, service users and the public. It should also have the right capability and infrastructure to execute on priorities;
- a track record of delivery, with evidence of tangible progress towards delivering the priorities in *Next Steps on the Five Year Forward View*. These systems should be meeting NHS Constitution standards or provide confidence that by working as an integrated system they are more likely to be recovered;
- strong financial management, with a collective commitment from CCGs and providers to system planning and shared financial risk management, supported by a system control total and system operating plan;
- a coherent and defined population that reflects patient flows and, where possible, is contiguous with local government boundaries; and
- compelling plans to integrate primary care, mental health, social care and hospital services using population health approaches to redesign care around people at risk of becoming acutely unwell. These models will necessarily require the widespread involvement of primary care, through incipient networks.

Public Engagement

5.10 As systems make shifts towards more integrated care, we expect them to involve and engage with patients and the public, their democratic representatives and other community partners. Engagement plans should reflect the five principles for public engagement identified by Healthwatch and highlighted in the *Next Steps on the Five Year Forward View*.

6 Process and Timetable

6.1 The task for commissioners and providers is to update the 2018/19 year of existing two-year plans to take account of the points set out above and to ensure that operating plans:

- are stretching and realistic, and show a bottom line position consistent with the control totals set by NHS England and NHS Improvement;
- are the product of partnership working across STPs, with clear triangulation between commissioner and provider plans and related contracts to ensure alignment in activity, workforce and income and expenditure assumptions – and with assurance from STP leaders that this is the case whilst ensuring the updated plans and contracts are aligned between commissioners and providers. As a result of the activity moderation incentives in the new Commissioner Sustainability Fund and the revised Quality Premium scheme, it is now more critical than ever that activity and finance plans are aligned between commissioners and providers; and
- include appropriate phasing profiles to reflect seasonal changes in demand, especially related to winter, and ensuring efficiency savings are not back-loaded into the later part of the financial year.

Contract Variations

6.2 Where the 2018/19 plans have changed and these changes need to be reflected in the finance, activity or other schedules for the second year of two-year contracts, a contract variation should be agreed to this effect, and signed no later than 23 March 2018.

6.3 The NHS Standard Contract sets out clear rules relating to the updating of a contract for a second year, and our expectation is therefore that there should be no disputes between commissioners and providers about these variations.

6.4 Where commissioners and providers fail to reach timely agreement the dispute resolution process in the contract should be followed. Starting with escalated negotiation, the process then moves into mediation. Mediation may be undertaken within STPs if both parties are in agreement, or where this is not possible, it may be arranged with a third party. Where, exceptionally, agreement is not reached through mediation, organisations will be expected to follow the Expert Determination process set in the dispute resolution guidance, which will be published shortly. NHS England and NHS Improvement will view use of mediation, and in particular determination, as a failure of local system relationships and leadership. This guidance also provides detailed advice about the rules within the Contract on varying a contract for its second year.

6.5 On 3 January 2018, NHS England published a National Variation to the Standard Contract. This was principally to give effect to changes to the ambulance response standards, but took the opportunity to incorporate other national policy requirements which had been announced since the 2017-19 planning round. In particular, these related to: prohibiting the sale of sugary

drinks on NHS provider premises; prohibiting the provision or promotion of certain legal services from NHS provider premises; and mandating participation by NHS providers in the Nationally Contracted Products Programme. Commissioners and providers are legally bound to incorporate these changes into local contracts.

Plan Submissions

6.6 All commissioners (CCGs and direct commissioning including specialised) and all providers are required to submit a full suite of operating plan returns to the deadlines in the national timetable (see below); and also adhere to the contract variation deadlines and processes. We will update technical planning guidance to support the submission of templates to ensure plans are completed on a consistent basis and to a high standard. The data collected will be used to inform decision making and will also form the plan against which 2018/19 delivery is judged. All organisations must ensure submissions are accurate, detailed and consistent with their Board approved plans.

6.7 For providers the first and final plan submission will include finance, activity, workforce and triangulation returns alongside an update to the existing two-year plan narrative. For providers that are part of an Integrated Care System the provider plan narrative will be updated with a system plan narrative that describes the key changes to the existing plan, which will be assured jointly by NHS England and NHS Improvement.

6.8 Provider workforce plans will need to consider the significant workforce supply and retention challenges in the NHS. For 2018/19, providers are expected to update their workforce plans to reflect latest projections of supply and retention, taking into account the supply of staff from Europe and beyond, changes to NHS nursing and allied health professional bursaries, improvements expected in agency and locum use. Plans should also be updated to take account of the strengthening of bank arrangements and opportunities identified for improved productivity and workforce transformation through new roles and/or new ways of working. It is important that workforce plans are detailed and well-modelled – and align with both financial and service activity plans – to ensure the proposed workforce levels are affordable, efficient and sufficient to deliver safe care to patients. The workforce plans submitted will be used nationally for pay modelling during the year.

6.9 Commissioners will need to submit draft and final commissioner operating plan updates, using the financial, performance activity and milestone plan templates. These and the supporting guidance will be issued separately. Draft and final finance, performance and activity plans must be consistent, and triangulated with provider expectations.

6.10 For STPs, para 2.17 sets out the requirement to ensure alignment in activity, income and expenditure assumptions across STPs. Building on the 2017/18 in year contract alignment approach, we will be asking STP leaders to return a contract and plan alignment template to demonstrate that updated plans and contracts are aligned financially between commissioners and providers.

CQUIN and Quality Premium

6.11 NHS England will shortly be publishing an update to the 2017/19 CQUIN guidance. This update is required to provide indicator thresholds for some indicators for year 2 of the scheme. As part of the update, NHS England will clarify the requirements around the influenza vaccination indicator. In addition, NHS England has made some changes to the anti-microbial resistance indicator to take account of supply issues. The sepsis indicator will also be updated to require providers to replace locally devised protocols with a National Early Warning Score (NEWS) by March 2019. In September 2017, the National Quality Board strongly endorsed NEWS as a standardised system between clinicians in the acute setting to help early detection of deterioration/ identification of sepsis. Organisations will also be required to make a one-off data return in relation to the healthy food and drink indicator at the end of Q4.

6.12 In addition, in light of the specific challenges around delivering provider side balance, NHS England has agreed with NHS Improvement to offer a temporary relaxation of an element of the scheme for acute providers. Our shared position is that this concession is being made in 2018/19 only. On the basis that there are multiple initiatives supporting the discharge agenda, we have agreed to suspend the 'proactive and safe discharge' indicator for acute providers, with the remaining five indicators in the scheme increasing their weighting from 0.25% to 0.3% as a temporary measure for 2018/19.

6.13 This change will have implications for the linked indicators in Community and Care Home settings. We are issuing an updated indicator for Care Home providers. For Community providers, we expect CCGs to either take this opportunity to include a local CQUIN indicator in their contracts, or increase the weights of the remaining five indicators in the scheme to 0.3%.

6.14 The 0.5% risk reserve CQUIN will be withdrawn in 2018/19. The 0.5% will be added to the engagement CQUIN, which will increase as a result to 1%.

6.15 Our collective expectation is that the degree of conditionality in CQUIN will return to its 2017/18 levels from 2019/20. These temporary suspensions are not an indication of our future intentions for the CQUIN scheme, in respect of the quantum, the number of indicators, or their respective weightings.

6.16 In line with our policy intent that CQUIN is 'realistically earnable', NHS England and NHS Improvement will be trialling a new triangulated provider/ commissioner finance return, to confirm whether CQUIN awards have been earned during the year.

6.17 As previously indicated, the 2018/19 Quality Premium scheme will be restructured to include an incentive on non-elective demand management. Given the significant emphasis we wish CCGs to give to this issue, the non-elective measure will make up the majority of the Quality Premium scheme, with a potential award of £210 million nationally. We will retain a number of the existing quality measures, which will be linked to the remainder of the potential

Quality Premium funding, and we will continue to moderate payment through the operation of the existing Finance and Quality gateways. We will shortly publish updated guidance which will set out the full details of the revised scheme.

Winter Demand & Capacity Plans

6.18 There will be no additional winter funding in 2018/19. To ensure that winter preparation has been undertaken well in advance and using existing funds, systems will need to demonstrate that winter plans are embedded both in their system plans and in individual organisations' operating plans, including realistic phasing of non-elective and elective activity across the year.

6.19 To support this there is a requirement for each system to produce a separate winter demand and capacity plan, triangulating the finance and activity implications along with the actions and proposed outcomes. Guidance on submitting these winter plans will be available by March 2018.

Timetable

Item	Date
ICS system control total changes and assurance statement submitted	By 1 March 2018
Local decision to enter into mediation for 2018/19 contract variations	2 March 2018
Draft 2018/19 Organisational Operating Plans submitted	**8 March 2018**
Draft 2018/19 STP Contract and Plan Alignment template submitted	8 March 2018
National deadline for signing 2018/19 contract variations and contracts	23 March 2018
2018/19 Expert Determination paperwork completed and shared by all parties	27 April 2018
Final Board or Governing Body approved Organisation Operating Plans submitted	**30 April 2018**
2018/19 Winter Demand & Capacity Plans submitted	30 April 2018
Final 2018/19 STP Contract and Plan Alignment template submitted	30 April 2018
Final date for experts to notify outcome of determinations for 2018/19 update	8 June 2018

Annex 1: 2018/19 Deliverables

Reminder of 2018/19 deliverables – drawn from 'Next Steps on the NHS Five Year Forward View' published in March 2017

The NHS already has two-year priorities, set out in last year's Planning Guidance and the March 2017 publication of the *Next Steps on the NHS Five Year Forward View.* This Annex confirms these deliverables for 2018/19.

For national targets we will, where appropriate, provide disaggregated STP and CCG-level improvement targets and templates to ensure plans are completed on a consistent basis.

1. Mental Health

<table>
<tr><td colspan="2">Overall Goals for 2017-2019
We published Implementing the Mental Health Forward View in July 2016 to set out clear deliverables for putting the recommendations of the independent Mental Health Taskforce Report into action by 2020/21. The publication of Stepping Forward to 2020/21[5] in July 2017 provides a roadmap to increase the mental health workforce needed to deliver this. Making parity a reality will take time, but this a major step on the journey towards providing equal status for mental and physical health. These ambitions are underpinned by significant additional funding for mental health care, which should not be used to supplant existing spend or balance reductions elsewhere.</td></tr>
<tr><td>Progress in 2017/18
On track to ensure an extra 35,000 children and young people are able to access services this year.
70 new or extended community eating disorder services funded and commissioned.
81 new beds for Children and Adolescent Mental Health Services (Tier 4) and at least another 50 beds will open by</td><td>Deliverables for 2018/19
Additional funding has now been built into CCG 2018/19 allocations to support the expansion of services outlined in this planning guidance and the specific trajectories set for 2018/19 to deliver the Five Year Forward View for Mental Health. Progress to be made against all deliverables in the Next Steps on the NHS Five Year Forward View and the Implementing the Mental</td></tr>
</table>

[5] Stepping Forward to 2020/21: Mental Health Workforce Plan for England (Health Education England).

end of March 2018. • Expanded **specialist perinatal care** with over 5,000 additional women accessing these services between April and December 2017. Contracts awarded for four new Mother and Baby Units. • Continued to meet the waiting time standard for **early intervention in psychosis.** • **Physical health checks and interventions** for patients with severe mental illness in secondary care, with 60% of people in inpatient settings and 42% in community mental health teams receiving this to date. • Health Education England (HEE) expects to provide over 600 training places for Improving Access to Psychological Therapies (IAPT) practitioners. At least **800 practitioners in primary care** settings by March 2018. • 10 mental health **new care models** up and running and an additional 7 go live by April 2018. • CCGs have continued to meet the **dementia diagnosis standard**, which was at 68.3% by December 2017. • Seven **Global Digital Exemplar** Mental Health Trusts, funded to identify trusts which they will partner with as 'fast followers'.	*Health Forward View* in 2018/19 with all CCGs and STPs required to: • Each CCG must meet the **Mental Health Investment Standard** (MHIS) by which their 2018/19 investment in mental health rises at a faster rate than their overall programme funding. CCGs' auditors will be required to validate their 2018/19 year-end position on meeting the MHIS. • Ensure that an additional 49,000 **children and young people** receive treatment from NHS-commissioned community services (32% above the 2014/15 baseline) nationally, towards the 2020/21 objective of an additional 70,000 additional children and young people. Ensure evidence of local progress to transform children and young people's mental health services is published in refreshed joint agency Local Transformation Plans aligned to STPs. • Make further progress towards delivering the 2020/21 waiting time standards for **children and young people's eating disorder services** of 95% of patient receiving first definitive treatment within four weeks for routine cases and within one week for urgent cases. • Deliver against regional implementation plans to ensure that by 2020/21, **inpatient stays for children and young people** will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements, within a context of 150-180 additional beds. • Continue to increase access to **specialist perinatal mental health services,** ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%.

	• Continue to improve access to **psychology therapies** (IAPT) services with, maintaining the increase of 60,000 people accessing treatment achieved in 2017/18 and increase by a further 140,000 delivering a national access rate of 19% for people with common mental health conditions. Do so by supporting HEE's commissioning of 1,000 replacement practitioners and a further 1,000 trainees to expand services. This will release 1,500 mental health therapists to work in primary care. Approximately two-thirds of the increase to psychological therapies should be in new integrated services focused on people with co-morbid **long term physical health conditions** and/or medically unexplained symptoms, delivered in primary care. Continue to ensure that access, waiting time and recovery standards are met. • Continue to work towards the 2020/21 ambition of all acute hospitals having **mental health crisis and liaison services** that can meet the specific needs of people of all ages including children and young people and older adults; and deliver Core 24 mental health liaison standards for adults in 50% of acute hospitals subject to hospitals being able to successfully recruit. • Ensure that 53% of patients requiring **early intervention for psychosis** receive NICE concordant care within two weeks. • Support delivery of STP-level plans to reduce all inappropriate adult acute **out of area placements** by 2020/21, including increasing investment for Crisis Resolution Home Treatment Teams (CRHTTs) to meet the ambition of all areas providing CRHTTs resourced to operate in line with recognised best practice by 2020/21. Review all patients who are placed out of area to ensure that have appropriate packages of care.

	• Deliver annual **physical health checks** and interventions, in line with guidance, to at least 280,000 people with a severe mental health illness. • Provide a 25% increase nationally on 2017/18 baseline in access to **Individual Placement and Support** services. • Maintain the **dementia** diagnosis rate of two thirds (66.7%) of prevalence and improve post diagnostic care. • Deliver their contribution to the **mental health workforce** expansion as set out in the HEE workforce plan, supported by STP-level plans. At national level, this should also specifically include an increase of 1,500 mental health therapists in primary care in 2018/19 and an expansion in the capacity and capability of the children and young people's workforce building towards 1,700 new staff and 3,400 existing staff trained to deliver evidence based interventions by 2020/21. • Deliver against multi-agency **suicide prevention** plans, working towards a national 10% reduction in suicide rate by 2020/21. • Deliver **liaison and diversion** services to 83% of the population. • Ensure all commissioned activity is recorded and reported through the Mental Health Services **Dataset**.

2. Cancer

Overall Goals for 2017-2019 Advance delivery of the National Cancer Strategy to promote better prevention and earlier diagnosis and deliver innovative and timely treatments to improve survival, quality of life and patient experience by 2020/21.

Progress in 2017/18	Deliverables for 2018/19
• **Cancer survival** at its highest ever with latest figures showing that one-year cancer survival is up by over 2,000 people a year. • 95.1% of people seen by a specialist **within two weeks** of an urgent GP referral for suspected cancer, with 5.1% more patients being seen in the 12 months to November 2017 than in the previous 12 months. • Ten **multidisciplinary rapid diagnostic and assessment centres** in place across the country by March 2018, supporting patients with complex symptoms through to diagnosis. • We are on track to deliver the **largest radiotherapy upgrade programme in 15 years modern radiotherapy** have now funded 26 new machines in 21 trusts in 2017/18. • Half of the country's Cancer Alliances have begun to roll out **personalised follow-up** after cancer treatment. • Added 22 more drugs to the Cancer Drugs Fund, which have benefitted nearly 7,500 more patients, taking the total since the reformed CDF launched in July 2016 to 15,700 patients having benefited from 52 drugs treating 81 different cancers.	• Ensure all **eight waiting time standards** for cancer are met, including the 62 day referral-to-treatment cancer standard. The '10 high impact actions' for meeting the 62 day standard should be implemented in all trusts, with oversight and coordination by Cancer Alliances. The release of cancer transformation funding in 2018/19 will continue to be linked to delivery of the 62 day cancer standard. • Support the implementation of the new **radiotherapy** service specification, ensuring that the latest technologies, including the new and upgraded machines being funded through the £130 million Radiotherapy Modernisation Fund, are available for all patients across the country. • Ensure implementation of the nationally agreed **rapid assessment and diagnostic pathways for lung, prostate and colorectal cancers**, ensuring that patients get timely access to the latest diagnosis and treatment. Accelerating the adoption of these innovations helps meet the 62 days standard ahead of the introduction of **the 28 day Faster Diagnosis Standard** in April 2020. • Progress towards the 2020/21 ambition for **62% of cancer patients to be diagnosed at stage 1 or 2**, and reduce the proportion of cancers diagnosed following an emergency admission. • Support the rollout of FIT in the **bowel cancer screening** programme during 2018/19 in line with the agreed national timescales following PHE's procurement of new FIT kit, ensuring that at least 10% of all bowel cancers diagnosed through the screening programme are detected at an early stage, increasing to 12% in 2019/20. • Participate in pilot programmes offering low dose CT scanning based on an assessment of lung cancer risk in

	CCGs with lowest **lung cancer** survival rates. • Progress towards the 2020/21 ambition for **all breast cancer patients to move to a stratified follow-up pathway** after treatment. Around two-thirds of patients should be on a supported self-management pathway, freeing up clinical capacity to see new patients and those with the most complex needs. All Cancer Alliances should have in place clinically agreed protocols for stratifying breast cancer patients and a system for remote monitoring by the end of 2018/19. • Ensure implementation of the **new cancer waiting times system** in April 2018 and begin data collection in preparation for the introduction of the new 28 day Faster Diagnosis standard by 2020.

3. Primary Care

Overall Goals for 2017-2019 Stabilise general practice today and support the transformation of primary care and for tomorrow, by delivering *General Practice Forward View* and *Next Steps on the NHS Five Year Forward View*.	

Progress in 2017/18
• 52% of the country now benefitting from **extended access** including appointments on evenings and weekends, beating the target of 40% for 2017/18.
• **Primary care workforce**:
  ○ Over 770 additional GP trainees started specialist training since 2015 baseline (3,157 in total in 2017/18);
  ○ Begun GP international recruitment, with the first 100 GPs being recruited;
	Deliverables for 2018/19
	Progress against all *Next Steps on the NHS Five Year Forward View* and *General Practice Forward View* commitments. This includes all CCGs:
	• Providing **extended access** to GP services, including at evenings and weekends, for 100% of their population by 1 October 2018. This must include ensuring access is available during peak times of demand, including bank holidays and across the Easter, Christmas and New Year periods.
	• Delivering their contribution to the **workforce commitment**

○ Launched the GP Retention Scheme; ○ Recruitment of an additional 505 clinical pharmacists, in addition to the 494 already in post. • **Investment in general practice** continues to increase on track to deliver the pledged additional £2.4 billion by 2021. • CCGs investing in line with expectations set out in the 2017/18 NHS's Planning Guidance, for **additional primary care transformation investment (£3/head)** over two years. • Invested in **upgrading primary care facilities**, with 844 schemes completed and a further 868 schemes in development.	to have an extra 5,000 doctors and 5,000 other staff working in primary care. CCGs will work with their local NHS England teams to agree their individual contribution and wider workforce planning targets for 2018/19. At national aggregate level we are expecting the following for 2018/19: ○ CCGs to recruit and retain their share of additional doctors via all available national and local initiatives; ○ 600 additional doctors recruited from overseas to work in general practice; ○ 500 additional clinical pharmacists recruited to work in general practice (CCGs whose bids have been successful will be expected to contribute to this increase); ○ An increase in physician associates, contributing to the target of an additional 1000 to be trained by March 2020 (supported by HEE); ○ Deliver increase to 1,500 mental health therapists working in primary care. • I**nvesting** the balance of the £3/head investment for general practice transformation support. • Actively encourage every practice to be part of a local **primary care network**, so that there is complete geographically contiguous population coverage of primary care networks as far as possible by the end of 2018/19, serving populations of at least 30,000 to 50,000. • Investing in upgrading primary care facilities, ensuring completion of the pipeline of **Estates and Technology Transformation schemes**, and that the schemes are delivered within the timescales set out for each project. • Ensuring that 75% of 2018/19 **sustainability and resilience funding** allocated is spent by December 2018, with 100% of the allocation spent by March 2019.

	• Ensuring every practice implements at least two of the **high impact 'time to care' actions**. • In all practices, delivering primary care **provider development initiatives** for which CCGs will receive delegated budgets, including online consultations. • Where primary care commissioning has been **delegated**, providing assurance that statutory primary medical services functions are being discharged effectively. • Lead CCGs expected to commission, with support from NHS England Regional Independent Care Sector Programme Management Offices, **medicines optimisation** for care home residents with the deployment of 180 pharmacists and 60 pharmacy technician posts funded by the Pharmacy Integration Fund for two years.

4. Urgent and Emergency Care

Overall Goals for 2017-2019 Redesign and strengthen the urgent and emergency care system to ensure that patients receive the right care in the right place, first time.	
Progress in 2017/18 • More patients able to **speak to a clinician** about their urgent and emergency care needs when calling NHS 111 – 40% of answered calls now receive clinical input, up from 22% last year. • Piloted and evaluated **NHS 111 Online** in a number of areas, with 27% of the population now able to access urgent and emergency care advice through this online portal.	**Deliverables for 2018/19** • Ensure that **aggregate performance against the four-hour A&E standard** is at or above 90% in September 2018, that the majority of providers are achieving the 95% standard for the month of March 2019. Also Trusts are expected to improve on their performance each quarter compared to their performance in the same quarter the prior year in order to qualify for STF payments.

• 110 **Urgent Treatment Centres (UTCs)** designated according to the revised standard specification. • **Ambulance Response Programme** implemented in all English mainland ambulance trusts. • 105 Trusts received capital funding of £96.7 million to implement **front-door clinical streaming**. Over 90% of Trusts now have this in place. • **1,491 beds have been freed up** as a result of **reducing delayed transfers of care (DTOC)**. • £30 million awarded to 74 areas to increase number of acute hospitals meeting the **'Core 24' standard for 24/7 mental health liaison teams**. • 97% of A&Es, 98% of the initial cohort of UTCs and 96% of e-prescribing pharmacies now have **access to primary care records** through either summary care records or local record sharing portals.	• Implementation of the **NHS 111 Online** service to 100% of the population by December 2018. • Access to enhanced **NHS 111** services to 100% of the population, with more than half of callers to NHS 111 receiving clinical input during their call. Every part of the country should be covered by an integrated urgent care Clinical Assessment Service (IUC CAS), bringing together 111 and GP out of hours service provision. This will include direct booking from NHS 111 to other urgent care services. • By March 2019, CCGs should ensure technology is enabled and then ensure that **direct booking from IUC CAS into local GP systems** is delivered wherever technology allows. • Designate remaining **UTCs** in 2018/19 to meet the new standards and operate as part of an integrated approach to urgent and primary care. • Work with local Ambulance Trusts to ensure that the new **ambulance response time standards** that were introduced in 2017/18 are met by September 2018. Handovers between ambulances and hospital A&Es should not exceed 30 minutes. • Deliver a **safe reduction in ambulance conveyance** to emergency departments. • Continue to make progress on **reducing delayed transfers of care** (DTOC), reducing DTOC delayed days to around 4,000 during 2018/19, with the reduction to be split equally between health and social care. • Continue to improve patient flow inside hospitals through implementing the "Improving Patient Flow" guidance[6]. Focus specifically on **reducing inappropriate length of stay for admissions**, including specific attention on 'stranded' and

[6] https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow/

	‘super stranded’ patients who have been in hospital for over 7 days and over 21 days respectively. • Continue to work towards the 2020/21 deliverable of all acute hospitals having **mental health crisis and liaison services** that can meet the specific needs of people of all ages including children and young people and older adults; and deliver **Core 24 mental health liaison standards for adults** in 50% of acute hospitals, subject to hospitals being able to successfully recruit. • Ensure that fewer than 15% of NHS **continuing healthcare full assessments** take place in an acute setting. • Continue to progress **implementation of the Emergency Care Data Set** in all A&Es (Type 1 and Type 2 by June 2018; and Type 3 by the end of 2018/19). • Increase the number of patients who have consented to share their additional information through the **extended summary care record** to 15% and improve the functionality of e-SCR by December 2018. • Implement a **proprietary appointment booking system** at particular GP practices, 50% of integrated urgent care services and 50% of UTCs by May 2018, supported by improved technology and clear appointment booking standards issued by December 2018. • Continue to rollout the **seven-day services four priority clinical standards to five specialist services** (major trauma, heart attack, paediatric intensive care, vascular and stroke) and the **seven-day services four priority clinical standards in hospitals** to 50% of the population.

5. Transforming Care for People with Learning Disabilities

Overall Goals for 2017-2019
Our goal is to transform the treatment, care and support available to people of all ages with a learning disability, autism or both so that they can lead longer, happier, healthier lives in homes not hospitals.

Progress in 2017/18

- 22% increase in the number of **annual health checks** delivered by GPs to improve access to community alternatives to hospital and tackle premature mortality.
- New and expanded **community teams** to support people with a learning disability at risk of admission to hospital, backed by £10 million transformation funding.
- **6% reduction in inappropriate hospitalisation** of people with a learning disability, autism or both, between March and November 2017, totalling a 14% reduction since March 2015. In addition, over 100 people previously in hospital for 5 years or more were discharged between March and November 2017.
- Tackling **premature mortality** by beginning to systematically review and learn from deaths of patients with learning disabilities by March 2018.

Deliverables for 2018/19
All Transforming Care Partnerships (TCPs), CCGs and STPs are expected to:

- Continue to **reduce inappropriate hospitalisation** of people with a learning disability, autism or both, so that the number in hospital reduces at a national aggregate level by 35% to 50% from March 2015 by March 2019. As part of achieving that reduction we expect CCGs and TCPs to place a particular emphasis on making a substantial reduction in the number of long-stay (5 year+ inpatients).
- Continue to improve access to healthcare for people with a learning disability, so that the number of people receiving an **annual health check** from their GP is 64% higher than in 2016/17. CCGs should achieve this by both increasing the number of people with a learning disability recorded on the GP Learning Disability Register, and by improving the proportion of people on that register receiving a health check.
- Make further investment in **community teams** to avoid hospitalisation, including through use of the £10 million transformation fund.
- Ensure more **children with a learning disability**, autism or both get a community Care, Education and Treatment Review (CETR) to consider other options before they are admitted to hospital, such that 75% of under 18s admitted to hospital have either had a pre-admission CETR or a CETR immediately post admission.

	• Continue the work on tackling **premature mortality** by supporting the review of deaths of patients with learning disabilities, as outlined in the National Quality Board 2017 guidance.

6. Maternity

Overall Goals for 2017-2019 Continue to make maternity services in England safer and more personal through the implementation of the *Better Births.*	
Progress in 2017/18 • Continuing the year on year **safety improvements** to maternity services including, since 2010, a 16% reduction in stillbirths, 10% reduction in neonatal mortality and 20% reduction in maternal deaths. • Seven maternity 'early adopters' established covering 125,000 births a year to implement specific elements of *Better Births* and service improvements. Pilots of **continuity of carer** established to over 3,000 women. • 44 **Local Maternity Systems** established bringing together commissioners, providers and service users to lead and deliver transformation of maternity services in every part of the country. • We will exceed the planned goal of 2,000 more women receiving **specialist perinatal care** in 2017/18, with over 5,000 additional women accessing these services between April and December 2017. Four new mother and baby units also funded.	**Deliverables for 2018/19** • Deliver improvements in **safety** towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025, including full implementation of the Saving Babies Lives Care Bundle by March 2019. • Increase the number of women receiving **continuity** of the person caring for them during pregnancy so that by March 2019, 20% of women booking receive continuity. • Continue to increase access to **specialist perinatal mental health services,** ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%. • By June 2018, agree trajectories to improve the **safety, choice and personalisation** of maternity.

N.B. This is not a comprehensive list of ‘Next Steps’ deliverables for 2018/19, simply an ‘aide memoire’ covering these service improvement areas. CCGs and STPs should also continue to work to reduce inequalities in access to services and in people’s experiences of care.