The Integrated Approach to Planning and Assurance between DH and the NHS for 2012/13

Department of Health

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The Integrated Approach to Planning and Assurance between DH and the NHS for 2012/13

Prepared by Performance Delivery Team

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THE INTEGRATED APPROACH TO PLANNING AND ASSURANCE BETWEEN DH AND THE NHS FOR 2012/13

INTRODUCTION

This paper supports the accountability arrangements set out in section 5 of the NHS Operating Framework for 2012/13. By the end of March 2012, all PCT clusters should have an integrated plan as required by the NHS Operating Framework 2012/13 and described in this document. The plan must be assured by SHA clusters, through a process overseen by the Department of Health. There will be two stages of submissions by SHA clusters, with the first set of submissions on 27 January 2012 and the final submission on 5 April 2012. From each SHA cluster, the Department will require:

- data trajectories for all PCTs for the relevant indicators set out in the Annex to the NHS Operating Framework 2012/13;
- milestones for each PCT cluster (drawn from their integrated plan), covering transformational change elements of QIPP and reform;
- milestones for each SHA cluster about the transition of the functions within the SHA to new bodies; and
- a short narrative outlining the SHA cluster's assurance process of PCT cluster integrated plans, including the process of signoff of material changes in the plan (including size of financial challenge) and the SHA cluster's assessment of key risks and mitigating action within the region (both geographical and programme based).

The single point of contact in DH for the integrated planning process is the Performance Delivery Team, with leads for each SHA cluster set out below:

Table of SHA clusters and PDT contacts

SHA	Lead PDT contact	Email address
North of England	Rachel Swallow	Rachel.swallow@dh.gsi.gov.uk
Midlands & East	Gillian Donachie	Gillian.donachie@dh.gsi.gov.uk
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This paper sets out:

1. The indicative planning timetable
2. Content of the submission
3. Overview of the indicators process
4. Overview of the milestones process
5. Overview of assurance narrative and RAG rating on each PCT cluster plan

Annex 1. Indicators, as set out in the NHS Operating Framework 2012/13
Annex 2. National minimum expectations for key milestones
Annex 3. Questions to support narrative assurance
Annex 4. Requirements set out in the NHS Operating Framework 2012/13 for key issues
Annex 5. Workforce key lines of enquiry
Annex 6. Public health checklist for local use

1. INDICATIVE PLANNING TIMETABLE

Date in 2012	Action
Fri 27 Jan	SHA clusters make initial submissions for 2012/13 to David Flory cc Performance Delivery Team contact at DH
Mon 31 Jan – Wed 8 Feb	First cut analysis of data and submissions by DH & internal DH meetings to discuss plans
Thurs 9 Feb – Fri 30 Mar	DH and SHA cluster discussions and feedback on progress of plans
31 Mar	All contracts expected to be signed off
Thurs 5 Apr	SHA clusters make final submissions for 2012/13
Tues 10 Apr – Fri 20 Apr	Analysis of plans by DH & internal DH meetings to discuss plans
Wed 25 Apr – Fri 4 May	David Flory meetings with SHA clusters to sign off plans with formal sign off letters being issued shortly afterwards. Meetings will combine a look back at 2011/12 together with forward look

2. CONTENT OF THE SUBMISSION

The submission should include the following components and it is expected that all parts are consistent.

Content		Format	Guidance – date and title
By PCT (and trust where appropriate)	Trajectories on the relevant quality and reform indicators set out in the Annex to the NHS Operating Framework 2012/13 (Annex 1 to this paper).	Unify	Technical guidance
	Trajectories on financial indicators set out in the Annex to the NHS Operating Framework 2012/13 (Annex 1 to this paper).	FIMS	Financial planning guidance
	Trajectories on the relevant workforce indicators set out in the Annex to the NHS Operating Framework 2012/13, including HV trajectories (Annex 1 to this paper).	Workforce template & HV modified MDS template	Workforce planning guidance
For each PCT cluster	Milestones for each PCT cluster (drawn from their integrated plan), covering transformational change elements of QIPP and reform. QIPP milestones must relate to specific end states that comprise the most important and scaled transformational changes.	Excel milestone template	This document
	Narrative by SHA cluster on each PCT cluster plan covering assurance of the plan, risks and mitigating actions and including a RAG rating assessment of the PCT cluster plan and associated products (trajectories and milestones).	Word template below and RAG excel template	This document
For each SHA cluster	Milestones for each SHA cluster about the transition of the functions within the SHA to new bodies.	Excel milestone template	This document
	Short narrative by each SHA cluster on the approach to assurance.	No specified format	This document

3. OVERVIEW OF THE INDICATORS PROCESS

Trajectories for each PCT should be submitted for each relevant indicator of the national performance indicators set out in the Annex to the NHS Operating Framework 2012/13 (**Annex 1** to this paper). Information is required at PCT level, as the PCT remains the statutory body. However, for in year performance management purposes, the Department of Health will work through SHA clusters to hold PCT clusters to account for delivery of the requirements set out in the NHS Operating Framework 2012/13.

4. OVERVIEW OF MILESTONES PROCESS

Each PCT cluster and SHA cluster is asked to make a return of their planned milestones covering QIPP and reform for 2012/13 and, for QIPP only, also for 2013/14 and 2014/15.

The milestones should be set out using the agreed Excel template. Milestones should be SMART and high level – about critical success factors rather than every stage along a pathway. Although some transactional milestones, as opposed to transformational milestones, may be appropriate (e.g. Common approach for GP pathology requests agreed by CCGs), milestones relating to everyday activities or repetitive events should be avoided (e.g. Quarterly review completed).

As in 2011/12, progress against the planned milestones will be reported on a monthly basis to DH, with the addition of a quarterly commentary covering an assessment of progress by the SHA cluster. Once agreed, progress against the milestones should be submitted to DH by SHA clusters on a monthly basis on the 16th of each month (or the Friday before if this falls at the weekend). Progress against the milestones will form part of regular performance discussions and will be reported as part of the performance overview in the dashboard to the NHS Operations Executive.

The minimum national expectations for milestones for commissioning, health and wellbeing boards and public health transition are set out at **Annex 2**. PCT clusters and SHA clusters must reflect all relevant milestones in their local milestone set. Organisations may choose to plan for a milestone before the date indicated below, but milestones should be completed by the date indicated below at the latest. Minimum national expectations for milestones for CCGs aiming for establishment without conditions by April 2013 are included below for use locally.

PCT clusters and SHA clusters should supplement the minimum national expectations for milestones with the milestones agreed as part of the Tripartite Formal Agreement process for the FT pipeline, locally agreed milestones on QIPP (as set out below) and any additional locally agreed milestones to reflect local plans.

In recognising the importance of 2012/13 as a transition year, when firm foundations will be built for a new system architecture, reform milestones across all areas of reform including public health, will be supplemented by additional checkpoints during the year. For example, in relation to Commissioning Development the details of function specific checkpoints have already been published, for example, Commissioning Support Business Development checkpoints and Emerging CCG configuration risk assessment. However in addition to this it is proposed that there could be a checklist for CCGs in moving to authorisation and periodic assessment of SHAs in delivering the development of the new commissioning

architecture, including the state of readiness of CCGs for authorisation. This approach will be developed by DH reform, policy and performance teams with SHA clusters and other key stakeholders including emerging clinical commissioning groups over coming months.

QIPP milestones
Each PCT cluster needs to report on their key 5-7 transformational QIPP programmes through robust milestones toward an overall goal or end states for each of the key programmes for the next three years to 2014/15. The impact of each key programme, in terms of planned quality, savings, activity, workforce and Key Performance Indicators, and the expected timescale for these impacts should be clearly stated.

In some cases, the end states will be past 2014/15 but over-arching objectives for the Spending Review period need to be defined to make the milestone progress meaningful. The aggregate savings from these key programmes or big ticket items should represent a meaningful amount of the planned savings - we would expect this to exceed 50%.

5. OVERVIEW OF NARRATIVE AND RAG RATING ON EACH PCT CLUSTER PLAN

SHA clusters should assure PCT clusters' plans and provide assurance to DH through a narrative, covering each key domain, describing issues by exception and also by RAG rating each key domain of the PCT cluster plan, using the agreed Excel template. The template for the narrative is set out below.

Annex 3 sets out key questions to support this narrative assurance, although SHA clusters should supplement these questions and their narrative with any additional information they think is relevant.

The key domains covered by the assurance narrative and the RAG rating template, supported by the questions in **Annex 3** are:

- Overarching assurance
- Engagement
- Performance and quality
- Finance
- QIPP
- Workforce
- Informatics
- Transition and reform:
    - Commissioning development – CCGs
    - Commissioning development – commissioning support
    - Commissioning development – direct commissioning
    - Health and wellbeing boards
    - Public health
    - Provider development

Template for narrative assurance return on each PCT cluster plan

Commentary	**Key Risks and mitigating action** (Only required in April submission)
Overarching assurance	
Engagement	
Performance and quality	
Finance	
QIPP	

Commentary	**Key Risks and mitigating action** (Only required in April submission)
Workforce	
Informatics	
Transition and reform: Commissioning development – CCGs	
Transition and reform: Commissioning development – commissioning support	
Transition and reform: Commissioning development – direct commissioning	
Transition and reform: Health and wellbeing boards	
Transition and reform: Public health	

Commentary	**Key Risks and mitigating action** (Only required in April submission)
Transition and reform: Provider development	

ANNEX 1 - INDICATORS

National Performance Measures

Quality

1 Preventing people from dying prematurely

- Ambulance quality (Category A response times)
- Cancer 31 day, 62 day waits

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

- Mental health measures (Early intervention; Crisis resolution; CPA follow up, IAPT)
- Long term condition measures (Proportion of people feeling supported to manage their condition; Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults); Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s)

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

- Emergency admissions for acute conditions that should not usually require hospital admission

4 Ensuring that people have a positive experience of care

- Patient experience of hospital care
- Referral to Treatment and diagnostic waits (incl incomplete pathways)
- A&E total time
- Cancer 2 week waits
- MSA breaches

5 Treating and caring for people in a safe environment and protect them from avoidable harm

- Incidence of MRSA
- Incidence of *C. difficile*
- Risk assessment of hospital-related venous thromboembolism (VTE)

Public Health

- Smoking quitters
- Health checks

Resources

- Financial forecast outturn & performance against plan
- Financial performance score for NHS Trusts
- Delivery of running cost targets
- Progress on financial aspect of QIPP
- Acute bed capacity
- Activity (eg elective and non-elective consultant episodes, Outpatients; Referrals)
- Numbers waiting on an incomplete Referral to Treatment pathway
- Health visitor numbers
- Workforce productivity
- Total pay costs
- Workforce numbers (clinical staff and non-clinical)

Reform

- **Commissioning Development**
  - % delegated budgets
  - Measure of £ per head devolved running costs
  - % authorisation of Clinical Commissioning Groups
  - % of General Practice lists reviewed and ‘cleaned’
- **Public Health**
  - Completed transfers of public health functions to local authorities
- **FT pipeline**
  - Progress against TFA milestones
- **Choice**
  - Bookings to services where named consultant led team was available (even if not selected)
  - Proportion of GP referrals to first outpatient appointments booked using Choose and Book
  - Trend in value/volume of patients being treated at non-NHS hospitals
- **Information to Patients**
  - % of patients with electronic access to their medical records

ANNEX 2 - NATIONAL MINIMUM EXPECTATIONS FOR KEY MILESTONES

	COMMISSIONING
Q4 11/ 12	**SHA CLUSTERS WILL NEED TO** **Commissioning development:** • Be confident that any outstanding configuration issues can be resolved by end March 2012. Where this is not the case, the timetable for authorisation means that discussions on alternatives will need to take place **Direct commissioning :** • Have divested themselves or have a clear plan in place to divest of any SHA commissioned PMS/PDS **Commissioning support:** • Have identified local leads who will contribute to the development on the national scale offers by end January 2012 • Flag to the BDU by January 2012 any intentions from CCGs to host commissioning support so that they can form part of the national assurance process or where CCGs intend to exercise an alternative choice of NHS or non-NHS commissioning support provider by end January 2012 • Have defined the process locally for checkpoint two of the business review so that emerging NHS CSS outline business plans are with the BDU before end March 2012
	PCT CLUSTERS WILL NEED TO **Development of CCGs**: • Build on delegation in 11/12 and delegate 100% of their relevant commissioning budget to emerging CCGs by end March 2012 (unless exceptional circumstances apply and in agreement with SHA cluster) • Ensure that emerging CCGs with delegated authority are able/continue to access their share of the running costs allowance in relation to their population (in cash or people) and their delegated commissioning budget by end March 2012 • Enable emerging CCGs to review management information including finance, quality, performance and activity, at the emerging CCG level by end March 2012 and ensure arrangements to regularly provide this information at least monthly in 12/13 • Enable emerging CCGs to play a key role in leading the local health system, eg part of 12/13 planning development and sign off • Have development plans in place to support emerging CCGs to become authorised by end March 2013, including a refreshed OD plan • Finalise a transition plan by end March 2012 to emerging CCGs for staff and infrastructure support as necessary, in agreement with the local CCG **Commissioning support:** • Support all prospective emerging CCGs in identifying how they will secure commissioning support and agreeing do/buy/share by end January 2012 • Support the development of commissioning support services, working closely with emerging CCGs to ensure that the emerging offer meets the needs of CCGs • Ensure that discreet commissioning support services are established which are able to operate on an arms length type arrangement clearly distinguishable from relevant PCT clusters • Have identified experienced transitional leaders focussed specifically on the development of NHS CCS by end March 2012, subject to leadership assessment processes that BDU will put in place • Build on the work done for checkpoint one of the business review process, by supporting commissioning support services in developing an outline business plan for checkpoint two before end March 2012 • Ensure that shadow SLA arrangements are developed and ready to be put In place between emerging CCGs and their choice of NHS commissioning support service from April 2012 **Direct commissioning:** • Have completed contract and premises stocktake and risk assessment for stabilisation for all areas by end March 2012 • Identified an implementation lead for primary care commissioning by end January 2012

	COMMISSIONING
	• Engaged with functions analysis for prison and military by end March 2012 • Have divested themselves of or have a clear plan to divest of any PCTMS, PCTDS • Agreement on specialised commissioning group (CCG) cluster board arrangements within respective clusters by end December 2011
	CCGS AIMING FOR ESTABLISHMENT WITHOUT CONDITIONS BY APR 13 WILL NEED TO • Have delegated authority from the PCT cluster and 100% of relevant commissioning budget, with staff allocated to manage the budgets and support the development of the emerging CCG • Be leading the local health system actively reviewing finance, performance and activity for commissioned services on a regular basis and taking action as necessary from beginning of April 2012 • Have an updated development plan in place by end March 2012 • Have discussed and agreed with PCT clusters the preparation and implementation of a transition plan for staff and infrastructure support as necessary by end March 2012 • Ensure that they actively engage in the development and design of local and national commissioning support offers • Understand their emerging do/buy/share intentions by end January 2012 and flag as quickly as possible to SHA clusters any plans to host commissioning support • Ensure that their development plans explicitly describe how they intend to source and manage their external commissioning support service • Have agreed their SLAs with their chosen NHS CSS by end March 2012 and identified a corporate lead to manage the SLA and have identified whether they require access to specialist procurement advice where they wish to secure alternative or additional commissioning support
Q1 12/ 13	**SHA CLUSTERS WILL NEED TO** **Direct commissioning functions where applicable to the SHA:** • Adopt the common contract compliance performance framework by end June 2012 • Support roll out of common operating processes for direct commissioning by end June 2012 • Take action to stabilise all current contracts for primary care, prison/offender health, military health and specialised services by June 2012 • Agree management of Cancer Drug Fund arrangements for 2012/13 with SCG clusters
	PCT CLUSTERS WILL NEED TO **Commissioning support:** • Ensure that shadow SLA arrangements are in place between emerging CCGs and their choice of NHS commissioning support service from the beginning of April 2012 • Support emerging commissioning support services in developing and refining outline business plns ahead of submitting the final plan in Q3 • Consider where opportunities to work with other NHS and non-NHS partners will optimise CS offers and where bringing together functions locally has potential to develop critical mass to bring greater efficiencies **Direct commissioning:** • Adopt the common contract compliance performance framework by end June 2012 • Support the design, development and subsequent adoption of structures and common operating processes for direct commissioning by end June 2012 • Stabilise all current contracts for primary care, prison/offender health, military health and specialised services by June 2012 • Separate CCG contract with providers established and signed for 2012/13 for specialised services (incorporating minimum take services across all PCT clusters) • Agree the approach to work with GP practices to undertake a full review of practice registered patient lists ensuring patient anomalies are identified

	COMMISSIONING
	and corrected (e.g. ghost patients) by end March 2012
	CCGS AIMING FOR ESTABLISHMENT WITHOUT CONDITIONS BY APR 13 WILL NEED TO • Be preparing for authorisation, including implementing the development plan agreed by end March and prepare authorisation application, pending view of the NHS CB Authority, between April and July 2012 (subject to passage of the Bill) • Have determined and agreed commissioning support option and be agreeing SLAs • Have confirmed the identification of senior leaders either through local or national processes • Have delegated authority from the PCT cluster and 100% of relevant commissioning budget, with staff allocated to manage the budgets and support the development of the emerging CCG • Be leading the local health system actively reviewing finance, performance, quality and activity for commissioned services on a regular basis and taking action as necessary from beginning of April 2012 • Continue to work with the NHS CSUs to ensure that local and national offers reflect their needs • Continue to reflect in their development plans how they intend to secure commissioning support
Q2 12/ 13	**SHA CLUSTERS WILL NEED TO** **Commissioning support:** • Work with BDU to address any necessary reorganisation of NHS CSSs as a result of assurance and CSSs failing to meet the necessary criteria **Direct commissioning functions where applicable to the SHA:** • Divest themselves of any remaining SHA commissioned PMS/PDS contracts by August 2012 • Support the testing and refinement of structures and common operating processes, policies and procedures so that by September, all units are operating to a common set of procedures and frameworks • Support process to ensure all direct commissioning contracts are stabilised ahead of transfer
	PCT CLUSTERS WILL NEED TO **Development of CCGs:** • Support all emerging CCGs to put in place their interim governance and leadership arrangements • Work with emerging CCGs enabling those that are willing to bring forward initial applications for authorisation by end July 2012 **Commissioning support:** • Ensure emerging CCGs have the necessary commissioning support services to support them through authorisation and consider where emerging CCGs may want or need additional support beyond the scope of their existing NHS CSS • Support CSS in develoing trajectories and refine externalisation plans to show when and how they will move to freestanding status • Support CSS in further developing their OBPs to prepare for checkpoint three of the business review in order to submit NHS CSS full business plans by end August 2012 • Work with SHAs to address the outcomes of the business review checkpoints, including where offers fail to meet the necessary criteria **Direct commissioning:** • Divest themselves of any remaining PCTMS or PCTDS contracts by August 2012 • Support the testing and refinement of structures and common operating processes, policies and procedures so that by September all units are operating to a common set of procedures and frameworks • Ensure all direct commissioning contracts are stabilised ahead of transfer **Any qualified provider:**

	COMMISSIONING
	• Have implemented patient choice of AQP for relevant services by September 2012
	CCGS AIMING FOR ESTABLISHMENT WITHOUT CONDITIONS BY APR 13 WILL NEED TO • Prepare authorisation application, pending views of the NHS CB Authority, between April and July 2012 [subject to passage of the Bill] • Continue to work with SHA and PCT clusters to further shape and refine the NHS CSS offers ahead of the final business review checkpoint in August 2012 • Signal their intentions for commissioning support for 2013/14 to enable NHS CSS to complete their full business plans by August 2012
Q3 12/ 13	**SHA CLUSTERS WILL NEED TO** **Commissioning development:** • Work with the 'field force' to put in place arrangements by end March 2013 for CCGs who are established with conditions **Commissioning support:** • Work with the BDU to help manage any local reorganisation and HR issues following NHS CB hosting decision • Support CCGs, PCT clusters and emerging NHS CSSs to put in place final commissioning support arrangements
	PCT CLUSTERS WILL NEED TO **Development of CCGs:** • Ensure all CCGs have completed authorisation assessment process **Commissioning support:** • Support CCGs to agree and adopt final commissioning support arrangements for taking on full statutory duties in April 2012 • Review and refine exisiting CSS/CCG SLAs to prepare for more formal contracting arrangements from April 2013 • Put in place appropriate HR plans for any CSS arrangements that will not move to and NHS hosted arrangement **Direct commissioning:** • Support process of ensuring all contracts are ready to be electronically or physically transferred by end December 2012 or earlier
	CCGS AIMING FOR ESTABLISHMENT WITHOUT CONDITIONS BY APR 13 WILL NEED TO • Have completed the formal CCG authorisation process [subject to Health and Social Care Bill passage] • Work with chosen NHS CSS to articulate full commissioning support requirements for when they take on full statutory duties from April 2013
Q4 12/ 13	**SHA CLUSTERS WILL NEED TO** **Commissioning development:** • Work with the NHS CBA and then the NHS CB to put in place arrangements by 31 March for CCGs who are established with conditions **Commissioning support:** • Oversee and support contracting arrangements between CCGs and their chosen NHS CSS • Support and oversee transfer of commissioning support staff to relevant hosted option **Direct commissioning functions where applicable to the SHA:** • Support PCT Clusters in ensuring all contracts are transferred to new arrangements by the end of March 2013 • Support the full review of practice registered patient lists, ensuring anomalies are identified and corrected (e.g. ghost patients) by end of March 2013
	PCT CLUSTERS WILL NEED TO

	COMMISSIONING
	Direct commissioning: • Ensure all contracts are transferred to new arrangements by end March 2013 • Work with GP practices to have completed a full review of practice registerd patient lists, ensuring patient anomalies are identified and corrected (e.g. ghost patients) by end March 2013
	CCGS AIMING FOR ESTABLISHMENT WITHOUT CONDITIONS BY APR 13 WILL NEED TO • Be operating and preparing to take on full statutory responsibilities from 1 April 2013 • Put in place SLA arrangements with NHS hosted CSS ahead of taking on full statutory responsibilities from 1 April 2013

	HEALTH & WELLBEING BOARDS
Q4 11/12	**PCT CLUSTERS WILL NEED TO (with CCGs leading where possible)** • Enable their emerging CCGs to work with their local authority to establish their local HWB in shadow form by end March 2012 and begin refreshing their Joint Strategic Needs Assessment (JSNA)
Q1 12/13	**PCT CLUSTERS WILL NEED TO (with CCGs leading where possible)** • Enable emerging CCGs to jointly lead their local HWB. Identify high level priorities from JSNA as basis for joint health and wellbeing strategy (JHWS), and begin developing JHWS by April 2012
Q2 12/13	**PCT CLUSTERS WILL NEED TO (with CCGs leading where possible)** • Enable their emerging CCGs to use their JSNA and JHWS as evidence for the authorisation process by July 2012 • By September 2012, use agreed JHWS as foundation for 2013/14 planning process. Involve partners in HWB in the planning process. Begin developing JSNA for 2014/15
Q3 12/13	**PCT CLUSTERS WILL NEED TO (with CCGs leading where possible)** • Begin developing JHWS for 2014/15 by December 2012. Continue to work with partners in HWB to develop commissioning plans
Q4 12/13	**PCT CLUSTERS WILL NEED TO (with CCGs leading where possible)** • Enable their emerging CCGs to work with partners in HWB to ensure that commissioning plans fully reflect the local priorities in the JHWS by February 2013

	PUBLIC HEALTH
Q4 11/12	**PCT CLUSTERS WILL NEED TO (working with Local Authorities)** • Agree local transition plan for public health as part of the overall integrated plan, taking account of the checklist in **Annex 6**, by March 2012 • Develop a communication and engagement plan, first draft produced by March 2012
Q1 12/13	**PCT CLUSTERS WILL NEED TO (working with Local Authorities)** • Agree approach to the development and delivery of the local public health vision by June 2012
Q2 12/13	**PCT CLUSTERS WILL NEED TO (working with Local Authorities)** • Agree arrangements on public health information requirements and information governance by September 2012
Q3 12/13	**PCT CLUSTERS WILL NEED TO (working with Local Authorities)** • Test arrangements for the delivery of specific PH services, in particular screening and immunisation by October 2012 • Test arrangements for the role of PH in Emergency Planning, in particular the role of the DPH and LA based PH by October 2012 • Ensure early draft of legacy and handover documents produced by October 2012
Q4 12/13	**PCT CLUSTERS WILL NEED TO (working with Local Authorities)** • Ensure final legacy and handover documents produced by January 2013
In 12/13	**SHA CLUSTERS WILL NEED TO (working with shadow PHE)** • Agree arrangements for the transfer of public health functions, staff and contracts/legal agreements currently held in SHAs that are expected to transfer to Public Health England – date for local determination
	PCT CLUSTERS WILL NEED TO (working with Local Authorities) • Agree arrangements for LAs to take on public health functions – date for local determination

ANNEX 3 – QUESTIONS TO SUPPORT NARRATIVE ASSURANCE

Overarching
1. Does the plan clearly identify how the health system will be different in 2014/15, from that of 2011/12, with clear, supporting milestones to outline the actions required to deliver the end states? 2. Is the plan clear on how the system will achieve sustainable service and financial performance alongside quality and productivity improvements to deliver QIPP? 3. Is the plan clear on the role CCGs have taken in determining the end state and the level of accountability for delivery they will take in 2012/13? 4. Do the reform milestones cover the key steps to enable authorisations of CCGs, development of a Commissioning support function, transition of direct commissioning functions to NHS CB and delivery of the Public Health reforms? 5. Does the plan provide sufficient linkages between finance, activity and workforce plans, and do these align with the QIPP transformational milestones for 2012/13, 2013/14 and 2014/15? 6. Does the plan provide sufficient linkages between organisations within the health economy, e.g. TFA actions are consistent with other areas of the plan? 7. Are there sufficient governance and performance management processes in place to track delivery and take effective mitigating actions as appropriate? 8. Are high level risks identified that represent the most significant threats to the system that would prevent successful delivery of the 'end state'? 9. Does the PCT cluster have processes in place to identify and track risk? 10. Does the plan give due regard to the public sector Equality Duty (PSED), and are equality objectives integrated into the plan?
Engagement
1. Does the plan clearly describes what steps have been taken to engage with stakeholders, including CCGs, Providers, HWBs, LA, in developing the plan for 2012/13? 2. Is it clear from the plan how the system has engaged with and agreed the 'end state' with both primary and secondary care clinicians? 3. Does the narrative describe the steps for the system to ensure they retain engagement with Patients and Public on planned developments?
Performance and quality
1. Is the plan clear about what was delivered in 2011/12? 2. Has the PCT cluster identified whether there is a need to take recovery action based on delivery in 2011/12 and if so is the recovery plan sufficient? 3. Does the plan, including trajectories, cover delivery on the key performance and quality areas for 2012/13? 4. Do plans address the key areas set out in the Operating Framework? In particular, as set out in **Annex 4** on 1) dementia and care of older people, 2) Carers, 3) Military and Veterans Health and 4) Health visitors and family nurse partnerships? 5. Is the PCT cluster preparing to implement the Innovation Review?
Finance
1. Does the plan reflect the expected level of SHA/PCT surplus drawdown (to be agreed)? 2. Does the plan include any NHS Trust deficits? If so, are they in formal, agreed recovery, consistent with their NHS Foundation Trust pipeline plan and their TFA? If not, why?

3. Does the plan resolve all PCT legacy debt by the end of 2012/13?
4. Has every PCT set aside 2% of their recurrent funding with the SHA for non-recurrent expenditure purposes? Is there a process in place to approve appropriate business cases for proposed expenditure?
5. Is the value of QIPP savings forecast for 2012/13 (and the full Spending Review period, ending in 2014/15) materially consistent with the four year integrated plan? If not, what steps are being taken to ensure the regions share of the QIPP challenge will be delivered?
6. What assurance processes are in place to monitor and manage changes to planned QIPP savings and variances from plan?
7. Does the QIPP plan include sufficient headroom between the size of the challenge and the savings identified? If not, what is the reason, and how will slippage and underperformance be managed?
8. Does the plan reflect delivery of target running cost savings (to be agreed)?

QIPP

1. Has the refreshed PCT cluster integrated plan, in particular the identified opportunities and QIPP programmes, materially changed in relation to the four year integrated plan that was signed off last year and if so, why?
2. Does the plan include recovery action on QIPP if required, in case of slippage?
3. Does the plan outline the size of the opportunities in 2012/13, 2013/14 and 2014/15, and provide evidence within the narrative as to how this will be delivered ?
4. Is there a clear explanation of how the planned 'future state' will ensure that the LHE is sustainable both in terms of improvements in quality and outcomes and also financial affordability?
5. Does the plan have sufficient in year actions to deliver change that will only see benefits in later years?
6. Does the plan outline the process for successful adoption and spread of QIPP initiatives ?

Workforce

1. Has workforce assurance been completed using the safety and quality assurance framework and Key Lines of Enquiry at **Annex 5** and what was the outcome?
2. Does the narrative clearly set out what 'system wide' changes are expected in activity and patient flows and the subsequent impact of the shape of the workforce?
3. Does the plan include sickness absence, skill mix changes, productivity and agency costs?

Informatics

1. Does the plan include consideration of informatics capability and capacity necessary to support the transition?
2. Does the plan include a credible proposal for giving patients on-line access to their medical records, starting with their GP record?
3. Is there an achievable trajectory for providing Summary Care Records by March 2013 to all residents who have been written to?

Transition and Reform

Commissioning development – CCGs

1. How has the CCG leadership team and the delegated sub committee of the PCT cluster board signed off the plan?
2. Can relevant aspects of the plan be disaggregated to CCG level?
3. Is there CCG ownership of relevant aspects of the plan?
4. How does the plan reflect how the PCT cluster will deliver commissioning development milestones in relation to CCGs and particularly
   i) does the plan enable CCGs to:
   - progress to full authorisation

- ‘build a track record’, ‘prepare for establishment’ and ‘become a successful organisation’ as outlined in the OF?
ii) does the plan clearly set out the approach to delegation including eligible commissioning budgets, allocating non pay running costs and staff?

Commissioning development – commissioning support

1. Does the plan reflect how the PCT cluster will deliver commissioning development milestones in relation to commissioning support and particularly:
- how the PCT cluster is supporting the design and development of commissioning support, for example through the business review process, by creating arms-length operating arrangements and ensuring there is clearly defined transitional leaders in place to drive its development
- what the PCT cluster is doing to identify and secure effective commissioning support through authorisation, and ensuring that there are shadow arrangements (backed by draft SLAs) in place from April 2012
- what are they doing to maximise opportunities to aggregate demand and to develop services across the most appropriate scale?

Commissioning development – direct commissioning

1. Does the plan reflect how the PCT cluster will establish an effective transition to the NHS CB for a common model of commissioning?
2. Does the plan outline how it will deliver commissioning development milestones in relation to direct commissioning in particular;
- Does the plan outline how it will work with GP practices to undertake a full review of practice registered patient lists, ensuring patient anomalies are identified and corrected by March 2013?
- Does the plan describe how PCT clusters will identify which staff are eligible to transfer to the NHS CB direct commissioning functions in line with the PTP published in July 2012?
- Does the plan describe how the PCT cluster will ensure all contracts for services that the NHS CB will directly commission will be ready for transition to the NHS CB in April 2013, in line with contract transition control work?
3. Does the plan identify PCT cluster implementation lead for primary care commissioning transition?
4. Does the plan describe how the PCT cluster will divest itself of any remaining PCTMS and PCTDS contracts?

Health and wellbeing boards

1. Does the plan outline the progress with the establishment of Health and Wellbeing Boards?
2. Is there evidence to suggest sufficient engagement is taking place between the emerging Health and Wellbeing Boards and Clinical Commissioning Groups?
3. Does the plan describe engagement with emerging Health and Wellbeing Boards on the areas covered by direct commissioning functions which will pass from PCTs to the NHSCB (primary care, specialised services, prison health, military health and relevant aspects of public health)?

Public health

1. Are the plans for public health transition robust? (e.g. do they reflect the components of the PH transition checklist, which is included as guidance at **Annex 6**)?
2. Is the narrative clear about how Local Authorities have been engaged and the part they have played in refining the plan?

Provider development

1. Are the actions to support the TFA milestones for each aspirant FT accurately reflected in the plan, with an explanation of the agreed escalation process where slippage has occurred?

Dementia and care of older people

There is a systemic set of things we need to do which will require organisations to work together. These include:

• commissioners should ensure that providers are compliant with relevant NICE quality standards and ensure information is published in providers' quality accounts;
• commissioners should work with GP practices to secure ongoing improvements in the quality of general practice and community services so that patients only go into hospital if that will secure the best clinical outcome;
• ensuring participation in and publication of national clinical audits that relate to services for older people;
• initiatives to reduce inappropriate antipsychotic prescribing for people with dementia to improve quality of life with a view to achieving overall a two-thirds reduction in the use of antipsychotic medicines;
• improving diagnosis rates, particularly in the areas with the lowest current performance;
• the continued drive to eliminate mixed-sex accommodation;
• the use of inappropriate emergency admission rates as a performance measure for national reporting; and
• non-payment for emergency readmissions within 30 days of discharge following an elective admission.

PCT clusters should ensure that all providers have a systematic approach to improving dignity in care for patients, to giving staff appropriate training and to incorporating learning from the experience of patients and carers into their work.
PCTs are asked to work with their local authorities and publish dementia plans which set out locally the progress they were making on the National Dementia Strategy, including any local or national CQUIN goals.

Carers

Following a joint assessment of local needs, which should be published with plans, PCT clusters need to agree policies, plans and budgets with local authorities and voluntary groups to support carers, where possible using direct payments or personal budgets. For 2012/13 this means plans should be in line with the Carers Strategy and:

• be explicitly agreed and signed off by both local authorities and PCT clusters;
• identify the financial contribution made to support carers by both local authorities and PCT clusters and that any transfer of funds from the NHS to local authorities is through a section 256 agreement;
• identify how much of the total is being spent on carers' breaks;
• identify an indicative number of breaks that should be available within that funding; and
• be published on the PCT or PCT cluster's website by 30 September 2012 at the latest.

Military and veterans health

SHAs should maintain and develop their Armed Forces Networks to ensure the principles of the Armed Forces Network Covenant are met for the armed forces, their families and veterans. The Ministry of Defence/NHS Transition Protocol for those who have been

seriously injured in the course of their duty should be implemented, meeting veterans' prosthetic needs and ensuring improvement in mental health services for veterans. NHS employers should be supportive towards those staff who volunteer for reserve duties.

Health Visitors & Family Nurse Partnerships

SHA and PCT clusters should work together to deliver the number of health visitors required as part of the Government commitment to increase the number by 4,200 by April 2015. Commissioners should ensure that new health visitors coming through the expanded training pipeline are effectively supported and deployed. The increased number of health visitors will ensure improved support for families through the delivery of the Healthy Child Programme and the Family Nurse Partnership programme. PCT clusters are expected to maintain existing delivery and continue expansion of the Family Nurse Partnership programme in line with the commitment to double capacity to 13,000 places by April 2015, to improve outcomes for the most vulnerable first time teenage mothers and their children.

ANNEX 5 – WORKFORCE KEY LINES OF ENQUIRY

1	**Workforce metrics, benchmarking, trends and plans, with related quality metrics and intelligence, are used to identify and raise concerns about future trends and performance.**
2	Where the workforce indicators of a provider raise concerns, the PCT cluster integrated plans are challenged to see if this causes issues for other areas (eg activity / finance etc...)
3	'Deep dives' have been undertaken where there is uncertainty about the safety and quality of workforce plans. CQC and Monitor have been involved as appropriate.
4	Planned and actual reductions in clinical workforce numbers and changes in clinical workforce productivity are monitored and correlated with other workforce and quality data at least quarterly
5	Local workforce plans are discussed at Cluster level with the provider's staff and, where concerns are raised, these have been brought to the attention of the Cluster and Provider Boards and addressed?
6	Local workforce plans are discussed with the provider's staff and, where concerns are raised, these have been brought to the attention of the provider Board and addressed?
7	Clinical ownership of proposed workforce change has been achieved. Medical Directors and Directors of Nursing have agreed to work with HR Directors to implement the plans and protect safety and quality of care in the process.
8	There is sufficient attention to support staff and wider support groups.
9	Where clinical workforce changes are planned, a communications strategy has been developed.

ANNEX 6 – PUBLIC HEALTH CHECKLIST FOR LOCAL USE

The following prompts will help PCT clusters assure themselves that they are working effectively with Local Authorities on the transfer of Public Health functions and ensuring continuity of delivery through 2012/13 and into 2013/14. The Department will seek assurance from SHA clusters that PCT clusters have robust plans in place and this guidance may be helpful to SHA clusters in this assurance.

Ensuring a robust transfer of systems and services	➢ Is there an understood and agreed (PCT cluster/LA) set of arrangements as to how the local public health system will operate during 2012/13 in readiness for the statutory transfer in 2013? ➢ Is there a clear local plan which sets out the main elements of transfer including functions, staff and commissioning contracts for 2013/14 and beyond? ➢ Are there locally agreed transition milestones for the transition year, 2012/13? ➢ Is there a clear local plan for developing the JSNA in order to support the H&WB strategy? ➢ Is there a clearly developed plan for ensuring a smooth transfer of commissioning arrangements for the services described in *Healthy Lives, Healthy People* that Local Authorities will be responsible for commissioning? ➢ Is there a clearly developed plan for ensuring a smooth transfer of those PH functions and commissioning arrangements migrating to NHS CB and PHE? ➢ Is there local agreement on the delivery of a core offer providing LA based public health advice to Clinical Commissioning Groups?
Delivering public health responsibilities during transition and preparing for 2013/14	➢ Is it clear how future mandated services and steps are to be delivered during transition and in the new local public health services: ➢ Appropriate access to sexual health services, ➢ Plans in place to protect the health of the population, ➢ Public health advice to NHS commissioners, ➢ National Child Measurement Programme, ➢ NHS Health check assessment? ➢ Is there clarity around the delivery of critical PH services/programmes locally, specifically: screening programmes; immunisation programmes; drugs & alcohol services and infection prevention & control?
Workforce	➢ Has the workforce elements of the plan been developed in accordance with the principles encapsulated within the Public Health Human Resources Concordat?
Governance	➢ Does the PCT cluster with LA have in place robust internal accountability and performance monitoring arrangements to cover the whole of the transition year, including schemes of delegation agreed as appropriate? ➢ Are there robust arrangements in place for key public health functions during transition and have they been tested e.g. new emergency planning response to include: o Accountability and governance, o Details of how the DPH, on behalf of LA, assures themselves about the arrangements in place, o Lead DPH arrangements for EPRR and how it works across the LRF area? ➢ Are there robust plans for clinical governance arrangements during transition including for example arrangements for the reporting of SUIs/incident reporting and Patient Group Directions? ➢ Has the PCT cluster with the LA agreed a risk sharing based approach to transition? ➢ Is there an agreed approach to sector led improvement? ➢ Is the local authority engaged with the planning and supportive of the PCT cluster approach to PH transition?
Enabling	➢ Has the PCT cluster with LA identified sufficient capability and capacity to ensure delivery of their plan?

infrastructure	➢ Has the PCT cluster with LA identified and resolved significant financial issues? ➢ Has the PCT cluster with LA agreed novation/other arrangements for the handover of all agreed PH contracts? ➢ Are all clinical and non-clinical risk and indemnity issues identified for contracts? ➢ Are there plans in place to ensure access to IT systems, sharing of data and access to health intelligence in line with information governance and business requirements during transition and beyond transfer? ➢ Have all issues in relation to facilities, estates, asset registers been resolved? ➢ Is there a plan in place for the development of a legacy handover document during 2012/13?
Communication and engagement	➢ Is there a robust communications plan? Does it consider relationships with the Health and Well being Board; clinical commissioning groups and NHSCB; Health Watch; local professional networks? ➢ Is there a robust engagement plan involving stakeholders, patients, public, providers of PH services, contractors and PHE?