Regional Commissioning Framework 2012 / 13

This document details the regional requirements for NHS Midlands and East that complement the expectations established in the national Operating Framework and the published SHA Cluster ambitions.

Operations and Performance Directorate
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**Background**

2012/13 is a significant year for the NHS as the service faces multi-faceted challenges of financial constraint, QIPP delivery, organisational transformation for Clinical Commissioning Groups (CCGs), PCT Clusters and SHA Clusters and a strong requirement to maintain or improve service performance levels. During such a period of change, it will be essential to establish across the SHA Cluster a shared understanding of expectations and a consistent set of conditions explaining how we will operate together. This regional commissioning framework is intended to fulfill these requirements.

**National requirements**

The national Operating Framework\(^1\) published on 24 November outlined four areas where focus is required during 2012/13 and this regional commissioning framework complements the requirements made in those areas.

**SHA Cluster ambitions**

The SHA Cluster Board, working in association with PCT Cluster Chief Executives, have agreed a series of SHA ambitions that articulate our regional aspiration of making a difference to patients during 2012/13 despite the challenges we face. These Ambitions are a reflection of our commitment to leave a high quality legacy to the organisations that will be the cornerstones of the NHS delivery system in 2013/14 and beyond. This document will articulate the operational

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\(^1\) Gateway reference 16890
requirements supporting the delivery of the SHA Cluster ambitions in the forthcoming year.

**Integrated planning expectations**
This document confirms the regional expectations of commissioners and providers and should underpin the integrated system plans being developed for 2012/13. It includes regionally mandated transformational QIPP milestones designed to build in consistency as to how the SHA Cluster can track the pace and magnitude of transformational change across individual health systems. PCT Clusters, working with their respective local authorities, are also required to submit, as part of their Integrated Plans, a robust transition plan for local public health that accords with the transition checklist included in the DH technical planning guidance. Additional technical guidance regarding the process of submission for detailed plan indicators will be published separately.

**Our approach to transition in 12/13**
The Operating Framework stated that it will be “imperative that CCGs are supported so that the NHS Commissioning Board is in a strong position to authorise them as ready, willing and able to take on statutory responsibilities from April 2013”

As the PCTs remain the statutory bodies, this document refers to the requirements of PCTs and PCT Clusters, however there is an expectation that CCGs will continue to develop their roles in delivering requirements as this will be an integral part of creating the track record required for authorisation.

**Statutory requirements**
This document cannot and does not intend to comprehensively describe the requirements for each individual organisation. NHS organisations within the SHA Cluster are expected to ensure they remain fully compliant with all statutory obligations including those requirements associated with equality and inclusion and with sustainable development.
SHA Cluster assurance process for National Operating Framework requirements

The Operating Framework contained various requirements for NHS organisations during (and in some cases before) 2012/13. This section of the regional commissioning framework explains how each of the requirements outlined will be monitored by the SHA Cluster. The document will illustrate how the SHA cluster will gain assurance that these requirements will be delivered.

The section will indicate:

- The specific requirement;
- Which NHS organisation is responsible for delivering this requirement;
- The page reference within the national operating framework; and
- The process by which the SHA Cluster will gain assurance.

In specific sections, it may not be possible to identify at this stage how such assurance will be gained. Where this occurs, the SHA Cluster will commit to providing additional guidance through the Operations and Performance monthly bulletin issued to all PCT Cluster Chief Executives on a monthly basis.
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<th>Operating Framework section</th>
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<th>How will assurance be obtained?</th>
<th>Key milestones</th>
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<tr>
<td>Overview</td>
<td>7</td>
<td>Support local authorities in establishing Health and Wellbeing Boards so that they can become effective local system leaders across health, social care and public health</td>
<td>PCT Cluster</td>
<td>Commissioning Development &amp; Public Health</td>
<td>Through regular surveys with local government and understanding of progress in each learning network</td>
<td>n/a</td>
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<td></td>
<td>7</td>
<td>1. Put patients at the centre of decision making in preparing for an outcomes approach to service delivery whilst improving dignity and service to patients and meeting essential standards of care 2. Build capacity of emerging CCGs and support establishment of health and well being boards 3. Increase the pace of delivery of QIPP challenge 4. Maintain a strong grip on service and finance performance</td>
<td>All</td>
<td>Performance, Provider Development &amp; Commissioning Development</td>
<td>Routine performance management and provider development meetings</td>
<td>n/a</td>
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<td></td>
<td>8</td>
<td>Be in a position to publish data when available and certainly from 13/14 on the NHS outcomes framework</td>
<td>PCT Clusters CCGs</td>
<td>Performance</td>
<td>Routine performance management</td>
<td>n/a</td>
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<td></td>
<td>8</td>
<td>Actively promote the NHS Constitution in their localities so that patients can be fully informed when they exercise choice</td>
<td>PCT Clusters</td>
<td>Performance</td>
<td>Specific assurance programme to be scheduled in May 2012 which asks for PCT Clusters to declare that this has happened and provide example materials that support their declaration</td>
<td>May 12</td>
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<td></td>
<td>9</td>
<td>Maintain or improve performance against all existing quality indicators with local accountability required where performance may have slipped or require explanation</td>
<td>All</td>
<td>Performance</td>
<td>Routine performance management and provider development meetings</td>
<td>n/a</td>
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<tr>
<td>Quality Overall</td>
<td>11</td>
<td>Monitor the results of the staff survey</td>
<td>All</td>
<td>Workforce</td>
<td>The staff survey will be incorporated into the performance reviews scheduled in April 12</td>
<td>Apr 12</td>
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<td>11</td>
<td></td>
<td>Comply with the Equality Act 2010 and its associated Public Sector Equality Duty</td>
<td>All</td>
<td>Performance</td>
<td>This will be assessed during the integrated plan review</td>
<td>Feb 12</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>Be ready in 2012 with clinical governance arrangements including appraisals for doctors and public health consultants in place to support responsible officers in fulfilling their duties</td>
<td>All</td>
<td>Clinical and Public Health</td>
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<td>11</td>
<td></td>
<td>Ensure they have arrangements in place to ensure that any person they appoint to a post has the knowledge of English necessary to perform their duties in line with the existing requirements under the Performers List Regulations 2004 and Health Circular 1999/137</td>
<td>All</td>
<td>Clinical</td>
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<tr>
<td>Dementia and care older people</td>
<td>12</td>
<td>Ensure that providers are compliant with relevant NICE quality standards (on dementia and care of older people) and ensure information is published in providers’ quality accounts</td>
<td>PCT Clusters (working with all appropriate partners)</td>
<td>Clinical</td>
<td>A review of the quality accounts will be completed, where this inclusion will be assessed</td>
<td></td>
</tr>
<tr>
<td>Dementia and care older people</td>
<td>12</td>
<td>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 local outcome</td>
<td>PCT Clusters (working with all appropriate partners)</td>
<td>Clinical &amp; Commissioning Development</td>
<td>Link to the SHA Cluster ambition</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>Ensure participation in and publication of national clinical audits that relate to services for older people</td>
<td>All</td>
<td>Clinical</td>
<td></td>
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<tr>
<td>Dementia and care older people</td>
<td>12</td>
<td>Work on 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</td>
<td>All</td>
<td>Clinical</td>
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<td>12</td>
<td></td>
<td>Work on improving diagnosis rates, particularly in the areas with the lowest current performance</td>
<td>All</td>
<td>Clinical</td>
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<tr>
<td>12</td>
<td></td>
<td>Continue to drive to eliminate mixed sex accommodation</td>
<td>All</td>
<td>Clinical</td>
<td>Incorporated into the performance framework as a key headline quality measure</td>
<td>n/a</td>
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<td>12</td>
<td>Use inappropriate emergency admission rates as a performance measure</td>
<td>All</td>
<td>Performance</td>
<td>At the 1st half stock take meeting scheduled for October, a specific section will focus on inappropriate emergency admissions for older people</td>
<td>Oct 12</td>
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<tr>
<td></td>
<td>13</td>
<td>Non payment for emergency readmissions within 30 days of discharge following an elective admission</td>
<td>PCT Clusters</td>
<td>Finance</td>
<td></td>
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<td></td>
<td>13</td>
<td>Ensure that all providers have a systematic approach to improving dignity in care for patients, give staff appropriate training and incorporate learnings from the experience of patients and carers into their work</td>
<td>PCT Clusters</td>
<td>Clinical</td>
<td>Assurance will be through confirm and challenge processes such as the safeguarding adult self assessment (SAAF) and children’s markers of good practice.</td>
<td>n/a</td>
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<tr>
<td></td>
<td>13</td>
<td>Work with their local authorities and publish dementia plans which set out locally the progress they were making on the National Dementia Strategy</td>
<td>PCT Clusters</td>
<td>Performance</td>
<td>Performance will write asking PCT Clusters to send the webpage link to where their dementia plans have been published</td>
<td>Aug 12 performance review</td>
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</tbody>
</table>

**Carers**

<p>|                                   | 13     | Agree policies, plans and budgets with local authorities and voluntary groups to support carers, where possible using direct payments or personal budgets | PCT Clusters |  |  |  |
|                                   | 13     | Explicitly agree and sign off plans in line with Carers’ Strategy with local authorities | PCT Clusters |  |  |  |
|                                   | 13     | 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 | PCT Clusters |  |  |  |
|                                   | 13     | Identify how much of the total is being spent on carers’ breaks | PCT Clusters |  |  |  |</p>
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<td>Military and veterans health</td>
<td>13</td>
<td>Identify an indicative number of breaks that should be available within that funding</td>
<td>PCT Clusters</td>
<td></td>
<td></td>
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<tr>
<td>Military and veterans health</td>
<td>13</td>
<td>Publish the plans on the PCT or PCT Cluster websites by 30 September 2012 at the latest</td>
<td>PCT Clusters</td>
<td>Performance</td>
<td>Performance will write asking PCT Clusters to send the webpage link to where their carer plans have been published</td>
<td>Aug 12 performance review</td>
</tr>
<tr>
<td>Health visitors and Family Nurse Practitioners</td>
<td>13</td>
<td>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</td>
<td>SHA Clusters</td>
<td>Commissioning Development</td>
<td></td>
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<tr>
<td>Health visitors and Family Nurse Practitioners</td>
<td>13</td>
<td>Implement the Ministry of Defence / NHS Transition protocol for those seriously injured in the course of their duty</td>
<td>PCT Clusters</td>
<td>Commissioning Development</td>
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<tr>
<td>Health visitors and Family Nurse Practitioners</td>
<td>14</td>
<td>Work with the SHA Cluster to deliver the number of health visitors as part of the Government commitment to increase the number by 4,200 by April 2015</td>
<td>PCT Clusters</td>
<td>Clinical / Workforce</td>
<td>Routine performance management meetings</td>
<td>n/a</td>
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<tr>
<td>Health visitors and Family Nurse Practitioners</td>
<td>14</td>
<td>Ensure that new health visitors coming through the expanded training pipeline are effectively supported and deployed</td>
<td>PCT Clusters</td>
<td>Clinical</td>
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<tr>
<td>Health visitors and Family Nurse Practitioners</td>
<td>14</td>
<td>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</td>
<td>PCT Clusters (working with Local Government as appropriate)</td>
<td></td>
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<tr>
<td>NHS Outcomes Framework</td>
<td>14</td>
<td>Prepare for the use of the NHS Outcomes Framework as the NHSCB will be held to account using this framework</td>
<td>All</td>
<td>Performance</td>
<td>The performance management cycle will report outcome metrics when these become available</td>
<td>n/a</td>
</tr>
<tr>
<td>NHS Outcomes Framework</td>
<td>14</td>
<td>Continue to work to meet the expectations in service specific outcomes strategies that have been published for mental health services, cancer, chronic obstructive pulmonary disease, asthma and long term conditions</td>
<td>All</td>
<td>Clinical</td>
<td></td>
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<td><strong>Long Term Conditions</strong></td>
<td>16</td>
<td>Spread the benefits of innovations such as telehealth and telecare as part of ongoing transformation of NHS services</td>
<td>PCT Clusters CCGs</td>
<td></td>
<td>See additional regional milestone requirement</td>
<td></td>
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<td></td>
<td>16</td>
<td>Take full consideration of the use of telehealth and telecare as part of any local reconfiguration plans</td>
<td>PCT Clusters</td>
<td></td>
<td>This will be reviewed as part of any reconfiguration process</td>
<td></td>
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<tr>
<td><strong>Mental Health services</strong></td>
<td>16</td>
<td>Improve access to psychological therapies as part of the commitment to full roll out by 2014/15 so that services remain on track to meet at least 15% of disorder prevalence</td>
<td>PCT Clusters</td>
<td>Clinical</td>
<td></td>
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<td></td>
<td>16</td>
<td>Improve physical healthcare of those with mental illness to reduce their excess mortality</td>
<td>PCT Clusters</td>
<td>Clinical</td>
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<td></td>
<td>16</td>
<td>Improve offender health</td>
<td>PCT Clusters</td>
<td>Commissioning development</td>
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<td></td>
<td>16</td>
<td>Improve targeted support for children and young people at particular risk of developing mental health problems such as looked after children</td>
<td>PCT Clusters</td>
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<tr>
<td><strong>Patient experience</strong></td>
<td>17</td>
<td>Actively seek out, respond positively and improve services in line with patient feedback. This includes acting on complaints, patient comments, local and national surveys and results from real time data techniques</td>
<td>All</td>
<td>Policy &amp; Strategy</td>
<td>System patient revolution plans</td>
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<td>18</td>
<td>Ensure their contracts allow for providers to complete central returns for mistakes, never events, incidents and complaints and use sanctions if they are not compliant</td>
<td>PCT Clusters</td>
<td>Policy &amp; Strategy</td>
<td>System patient revolution plans</td>
<td></td>
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<tr>
<td></td>
<td>18</td>
<td>Continue to monitor and act upon the national patient experience survey</td>
<td>All</td>
<td>Performance</td>
<td>The national survey is a standard element within the performance review paperwork</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>Carry out more frequent local patient surveys including using real time data techniques, to publish the results – including data on complaints – and to respond appropriately where improvements need to be made</td>
<td>All</td>
<td>Policy &amp; Strategy</td>
<td>System patient revolution plans</td>
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<tr>
<td>Access</td>
<td>18</td>
<td>Publicise the right in the NHS Constitution to treatment within 18 weeks or if not possible offer a range of suitable alternative providers – and publicise the options available to local people if treatment within 18 weeks is at risk.</td>
<td>PCT Clusters</td>
<td>Performance</td>
<td>Specific assurance programme to be scheduled in May 2012 which asks for PCT Clusters to declare that this has happened and provide example materials that support their declaration</td>
<td>May 12</td>
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<tr>
<td></td>
<td>19</td>
<td>Ensure all patients are seen on the basis of clinical need, which means there is no justification for the use of minimum waits</td>
<td>PCT Clusters</td>
<td>Performance</td>
<td>Declaration required as part of the integrated planning process</td>
<td>Jan 12</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>Have reviewed planned waiting, pending or review lists for all specialties and diagnostic services by no later than the end of December 2011</td>
<td>PCT Clusters</td>
<td>Performance</td>
<td>A separate request has been issued as part of the Dec Operations and Performance Bulletin</td>
<td>Dec 11</td>
</tr>
<tr>
<td>NHS 111</td>
<td>20</td>
<td>SHA Clusters should be satisfied that roll out is complete by 2013</td>
<td>SHA Clusters</td>
<td>Operations</td>
<td>PCT Cluster implementation plans will be requested and assurance requested 6 months / 3 months and 2 weeks before go live</td>
<td></td>
</tr>
<tr>
<td>Safeguarding</td>
<td>21</td>
<td>Ensure a sustained focus on robust safeguarding arrangements</td>
<td>PCT Clusters</td>
<td>Clinical</td>
<td>Through monitoring processes such as SAAF and health self assessment (LD)</td>
<td>n/a</td>
</tr>
<tr>
<td>Emergency Preparedness</td>
<td>21</td>
<td>Maintain the current capability and capacity of HART in ambulance trusts</td>
<td>PCT Clusters</td>
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<td></td>
<td>21</td>
<td>Maintain a good standard of preparedness to respond safely and effectively to a full spectrum of threats</td>
<td>All</td>
<td>Public Health</td>
<td>Emergency Planning assurance template based on part 4 of the Shared Operating Model for PCT Clusters; Confirm and Challenge meetings</td>
<td>Confirm and Challenge meetings from January and SHA Board report March 2012</td>
</tr>
<tr>
<td>CCGs</td>
<td>26</td>
<td>Support all CCGs in making progress to full authorisation</td>
<td>PCT Clusters</td>
<td>Commissioning</td>
<td></td>
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<td>26</td>
<td>Support exploration and the development of commissioning support offers from a range of suppliers, which might include the independent sector, voluntary organisations and local authorities</td>
<td>PCT Clusters</td>
<td>Commissioning development</td>
<td></td>
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<td></td>
<td>26</td>
<td>Establish an effective transition to the NHSCB for a common model of commissioning services</td>
<td>PCT Clusters</td>
<td>Commissioning development</td>
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<td></td>
<td>26</td>
<td>Prepare for formal transfer of staff to the new commissioning architecture</td>
<td>PCT Clusters</td>
<td>Commissioning development</td>
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<td></td>
<td>26</td>
<td>Demonstrate that they are allocating both non pay running costs and staff to support emerging CCGs, commensurate with the level of budgets for which emerging CCGs have delegated responsibility</td>
<td>PCT Clusters</td>
<td>Commissioning development</td>
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<td>26</td>
<td>Work with GP practices to undertake a full review of practice registered patient lists, ensuring patient anomalies are identified and corrected by March 2013</td>
<td>PCT Clusters</td>
<td>Commissioning development</td>
<td></td>
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<tr>
<td>CCGs</td>
<td></td>
<td>SHA Clusters will be held to account for the delivery of plans to support the development of the new commissioning architecture whether for the establishment of CCGs, commissioning support or transfer of commissioning responsibilities to the New Commissioning Board</td>
<td>SHA Clusters</td>
<td>Commissioning development</td>
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<tr>
<td>Health and well being boards</td>
<td>27</td>
<td>SHA and PCT Clusters should support shadow health and well being boards and encourage CCGs to play an active part in their formation including participation in the programme of accelerated learning sets</td>
<td>PCT Clusters</td>
<td>Public Health &amp; Commissioning development</td>
<td>Integrated Plans; regional visits; regional networks and discussions with PCT Cluster CExs and LA CExs; involvement in national work on HWBs (with LGA) and accelerated learning sets.</td>
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</tr>
<tr>
<td>CCG development</td>
<td>27</td>
<td>SHA Clusters should be working to support practices and emerging CCGs to resolve configuration issues. By 31 Jan, SHA Clusters need to be confident that any outstanding configuration issues can be resolved by 31 March 12</td>
<td></td>
<td>Commissioning development</td>
<td></td>
<td>Jan 12</td>
</tr>
</tbody>
</table>
| CCG Authorisation           | 27     | Build a track record  
  o Manage budgets well and play an active role in the planning round for 12/13, taking ownership of those parts of a PCT Cluster plans which it will inherit  
  o Develop relationships with local partners  
  o Deliver the relevant share of the QIPP agenda for the PCT Cluster | CCGs                | Performance and Commissioning Development                                                                                                                  |                                |               |
| CCG Authorisation           | 28     | Prepare for establishment  
  o Address any issues arising from the configuration risk assessment  
  o Prepare an application in line with forthcoming guidance  
  o Identify how they wish to secure commissioning support | CCGs                | Commissioning Development                                                                                                                                 |                                |               |
<p>|                             | 28     | Undertake the development plan agreed with the PCT Cluster in 11/12                                                                                                                                         | CCGs                | Commissioning Development                                                                                                                                  |                                |               |
|                             | 28     | Facilitate opportunities to aggregate demand from CCGs in aspects of commissioning support                                                                                                                    | PCT Clusters        | Commissioning development                                                                                                                                    |                                |               |
| Public Health               | 29     | Develop the vision and strategy for the new public health role, working closely with local authority partners as the future lead local public health organisations                                                                 | PCT Clusters        | Public Health          | PH Local Transition Plans; regional visits; regional networks including DPH meetings                                                                | June 12        |</p>
<table>
<thead>
<tr>
<th>Operating Framework section</th>
<th>Pg ref</th>
<th>Requirement</th>
<th>Applicable to whom?</th>
<th>Lead SHA Directorate</th>
<th>How will assurance be obtained?</th>
<th>Key milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29</td>
<td>Prepare local systems for new commissioning arrangements</td>
<td>PCT Clusters</td>
<td>Public Health</td>
<td>PH Local Transition Plans; regional visits; regional networks including DPH meetings; discussions with PCT Cluster CEs and LA CEs.</td>
<td>Oct 12</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>Ensure new clinical governance systems are in place</td>
<td>PCT Clusters</td>
<td>Public Health</td>
<td>PH Local Transition Plans; regional visits; regional networks including DPH meetings; discussions with PCT Cluster CEs and LA CEs.</td>
<td>Oct 12</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>Prepare for formal transfer of staff</td>
<td>PCT Clusters</td>
<td>Public Health</td>
<td>PH local transition plans</td>
<td>Oct 12</td>
</tr>
<tr>
<td></td>
<td>29</td>
<td>Test the new arrangements for Emergency Planning</td>
<td>PCT Clusters</td>
<td>Public Health</td>
<td>Emergency Planning assurance template (based on part 4 of the Shared Operating Model for PCT Clusters); Confirm and Challenge meetings; regional and local exercises; national Olympics exercises</td>
<td></td>
</tr>
<tr>
<td>AQP</td>
<td>29</td>
<td>Start to offer patients a choice of AQP in at least three services which are local priorities</td>
<td>PCT Clusters</td>
<td>Policy &amp; Strategy</td>
<td>PCT Cluster implementation plans</td>
<td>Sept 12</td>
</tr>
<tr>
<td>Choice and personal health budgets</td>
<td>30</td>
<td>Work collaboratively with GP practices to establish outer areas to enable patients who move house locally to stay with their existing practice</td>
<td>PCT Clusters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>30</td>
<td>Providers to list their services on Choose and Book in a way that allows users to book appointments with named consultant-led teams</td>
<td>Providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>31</td>
<td>Prepare for wider roll out of personal health budgets</td>
<td>PCT Clusters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pg ref</td>
<td>Requirement</td>
<td>Applicable to whom?</td>
<td>Lead SHA Directorate</td>
<td>How will assurance be obtained?</td>
<td>Key milestones</td>
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<td></td>
</tr>
<tr>
<td>31</td>
<td>Use the NHS Number consistently</td>
<td>All</td>
<td>Policy &amp; Strategy</td>
<td>PCT Clusters to provide evidence of their approach to providers for achieving and monitoring NHS Number usage including use of contractual mechanisms. The Information Centre reports on data quality within contractual datasets. The SHA Cluster expects % completeness of NHS Number in datasets to be above 98% and to rise to near 100% by Mar 13</td>
<td>Mar 13</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>A number of key NHS datasets have been identified for public release. NHS organisations must ensure the availability and quality of these datasets</td>
<td>All</td>
<td>Policy &amp; Strategy</td>
<td>PCT Cluster plans for publication and ensuring Provider compliance</td>
<td>PCT plans due by Mar 12</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Patients who have been written to about the Summary Care Record should have a record created by March 2013 at the latest</td>
<td>PCT Clusters</td>
<td>Policy &amp; Strategy</td>
<td>National reports illustrating the % of patient records created where GP systems are capable will be reviewed</td>
<td>PCT cluster implementation plan submitted by March 12</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>The protection of sensitive patient information remains a top priority – all organisations to be vigilant at all times and to ensure that appropriate governance policies and guidelines are implemented and followed in practice</td>
<td>All</td>
<td>Policy &amp; Strategy</td>
<td>Reduction of number of data loss incident through SI process</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Embedding the SHA Cluster Ambitions**

At its meeting on 24 November 2011, the NHS Midlands and East Board agreed that five ambitions were to be implemented across the SHA Cluster.

NHS Midlands and East is an ambitious organisation. Maintaining the status quo of service delivery is not good enough and we are determined to show this driving ambition until 31 March 2013, particularly in the area of safeguarding patient safety and enhancing quality.

The ambitions were consulted on during the ‘Ambition for Transition and Organisation Design’ consultation in September 2011. Since then they have been developed further by lead SHA Cluster Directors with particular support from PCT Cluster Chief Executives.

This section of the Commissioning Framework outlines the focus of the five ambitions, their respective reporting and monitoring intentions for each and the support to be provided by the respective ambitions’ project groups.

**SECTION THREE: SHA CLUSTER AMBITIONS**

1. **Eliminating** avoidable pressure ulcers
2. **Making every** contact count
3. **Significantly** improve quality and safety in Primary Care
4. **Ensuring radically** strengthened partnership between the NHS and Local Government
5. **Create a revolution** in patient and customer experience
Ambition One- Eliminating avoidable Grade Two, Three and Four pressure ulcers

Background
Avoidable pressure ulcers are a key indicator of the quality of nursing care. Elimination of avoidable Grade Two, Three and Four pressure ulcers is being taken as an outcome measure for nursing care which includes: hydration, nutrition, pressure area management, medication management and individualised care for patients in acute and community providers.

Pressure ulcers can be unpleasant, upsetting and challenging to treat. Therefore, healthcare professionals use a range of techniques that are designed to prevent pressure ulcers developing in the first place. These include:

- Regularly changing a person’s position
- Using equipment, such as specially designed mattresses and cushions, to protect vulnerable parts of the body

Between January and October 2011 NHS Midlands and East reported 3,325 Grade Three & Four pressure ulcers.

How success will be monitored
Data on pressure ulcers will be reported using the NHS Safety Thermometer and accessed via the Quality Observatory.

Further information
The collection of census data is incentivised through the national CQUIN scheme. The achievement of the elimination goal will also require monthly monitoring of the adequacy of assessment, prevention and treatment activities within provider organisations. For this reason commissioners will need to make the provision of this data a contractual requirement.
A standard clause for inclusion in contracts will be produced by mid-January to support local negotiations.

The implementation programme will include a series of intensive support visits to each cluster to review progress and facilitate intervention as appropriate. It is planned to procure a programme to engage staff and embed the clinical protocols and care bundles that have recently been completed by the expert working group. This will support a commitment approach to the ambition in parallel to monitoring compliance.

The third strand of the implementation programme is to build a communications plan that promotes the key messages of the ambition to the public at large and highlights the trends in numbers reported at the current time.

PCT clusters will need to reserve approximately £90k of their 2% transformation fund to support these activities. Further details will follow in January.
**Ambition Two – making every patient contact count through systematic healthy lifestyle advice delivered through front line staff**

**Background**

The Making Every Contact Count (MECC) ambition aims to utilise the human resources of the NHS in the Midlands and East to inform and enable people to make positive changes to their life. This will be achieved through the systematic delivery of health improvement using consistent and simple healthy lifestyle advice combined with appropriate signposting to lifestyle services.

Initially this work will focus on interventions within NHS organisations, given the large number of patients and staff involved in these organisations and the need to deliver this aspect of the NHS Midlands and East ambition by March 2013. However, it is intended to develop this project in such a way that it could also be rolled out to all other relevant organisations.

**How success will be monitored**

Success will be measured by evidence of the organisational readiness of NHS organisations and partner organisations. This will be assessed through the following:

- Evidence of board level commitment to implementation;
- Board level lead / champion in place;
- Evidence of organisational policies and procedures in place, for example organisational health and wellbeing development strategy, suitable data collection and reporting mechanisms, use of induction;
- Evidence of activity to support employees’ own health and wellbeing;
- Number of NHS staff completing locally agreed training in delivering brief lifestyle advice; and
- Increased number of referrals from NHS organisations to local stop smoking services, as a key indicator for delivery of brief lifestyle advice from NHS staff.
PCT Clusters will be asked to submit MECC implementation plans, utilising an MECC implementation toolkit and guidance, to be developed by the MECC Project Group. Progress will be monitored by the Project Group quarterly against plan.

Data collection and reporting requirements will be developed by the MECC Project Group during Q4 2011/12 and incorporated within the implementation guidance.
Ambition Three - Significantly improve quality and safety in Primary Care

Background
NHS Midlands and East’s third ambition identifies significant improvements in quality and safety in primary care. Primary medical care is the cornerstone of the NHS, providing the majority of patient contacts, access, coordination and continuity are the key offers of effective and efficient services. However, quality and safety can be variable and there is currently no single defining set of measures for quality in primary care. In order to deliver significant improvements in this area the SHA Cluster board has agreed four objectives for this ambition:

- Develop emerging clinical commissioning groups to undertake quality assessments of their practices, and to support quality improvement;
- Significantly reduce prescribing of quinolones and cephalosporins, broad spectrum antibiotics associated with C. difficile;
- Improve management of patients taking the anticoagulant Warfarin; and
- Ensure patients receive the best quality in care for managing their diabetes.

This ambition will be clinically led and take an educational and developmental approach. Using existing data sources and defined best practice the projects will work with emerging clinical commissioning groups, PCT clusters and general practices to deliver improvements.

Developing clinical commissioning groups to undertake quality assessment of practices
We will develop a standard benchmarking tool for primary care quality, focused on the following domains:

1. Clinical Effectiveness and Outcomes
2. Patient Experience
3. Organisational Effectiveness
4. Patient Safety

The tool will make use of existing data collections, such as: data on workforce numbers and list sizes; participation in DES and LES; clinical governance information; referral and admission rates; QOF attainment; access levels; child protection; public health protection; and sound practice management. The standards will be defined in partnership with CCGs and PCT clusters and will align to priorities within the NHS Outcomes Framework.

A small number of CCGs will be identified to work with the project to undertake the baseline assessment of member practices and support them to produce practice development plans to address any quality issues and to develop a “train the trainer” approach to spread the methodology.

*Antibiotic prescribing related to C. difficile*

Broad spectrum antibiotics, such as quinolones and cephalosporins, are associated with an increased risk of *C. difficile*, MRSA and resistant UTIs. National guidance recommends that they be reserved to treat resistant disease, and should be used only when standard antibiotics are ineffective.

We will work to experts from primary care, pharmacy and public health to define when these antibiotics should be used. We will audit all practices against these criteria, and implement a programme of peer audit to support improvement.

This data will be publically available from December 2011. We will need to agree the approach but will develop an improvement approach where practices are out with guideline by more than a tolerance of 15%.

*Management of patients on Warfarin*

Warfarin is used in the management of increasing numbers of patients and conditions including patients’ post-myocardial infarction, atrial fibrillation, DVTs and other disorders.

Patients taking Warfarin should be monitored and managed within primary care, with the aim
of stabilising the INR helping to prevent serious side effects and maximising effective
treatment.

Anecdotal evidence suggests that patients taking Warfarin are often poorly managed in
primary care, leading to deterioration in their condition and sometimes acute admission.

We propose to establish a small review group to define best practice on the basis of existing
national guidance for the management of Warfarin, and to audit all practices against the
defined best practice standard.
Having identified areas below standard, we will focus intensive support to improve
management in these practices and bring them up to the agreed standard.

**Best quality in care for managing diabetes**
To ensure patients receive the best quality care for managing their diabetes and reducing
the risk of complications, all patients with diabetes should be offered the 9 key tests/care
processes in their consultation within primary care (as recommended by NICE).

Figures from the 2008/09 Atlas of Variation show there is a 35-fold variation in the
percentage of patients receiving all 9 key care processes. From the 2009/10 national
diabetes audit, around half of people with type 2 diabetes and two thirds of people with
Type1 diabetes did not achieve this basic standard of care.

We propose to audit practices against the nine care processes (all are recorded through the
Quality and Outcomes Framework). Having identified areas below standard, we will focus
intensive support to improve management in these practices and bring them up to the
agreed standard.
**Ambition Four - Ensuring radically strengthened partnership between the NHS and Local Government**

NHS Midlands and East’s fourth ambition is to ensure we radically strengthen partnerships between the NHS and local Government across the cluster. This ambition acknowledges the excellent work that has already taken place and seeks to develop our partner relations to a new and strengthened level.

The project will:

- Build on the established relationships and existing structures – strengthening what has previously existed and supporting local solutions to develop further;
- Identify an engagement process with local Government to jointly determine the key deliverables;
- Outline the expectations of the SHA, and in its oversight of PCTs, and developing Clinical Commissioning Groups (CCGs) what it can support and enable in local systems; and
- Establish task and finish groups to determine KPI’s or KLOEs with representation from LG networks, CCG chief officers and PCT Clusters, DsPH and Patient Voice leads.

Within the wider context of NHS Reform, CCG authorisation processes require evidence of good partnership working. This project will provide support to CCG development to embrace partnerships with Local Government. This project will deliver key measurable outcomes for PCTs and CCGs including evidence of engagement to deliver integrated commissioning.
Ambition Five - Create a revolution in patient and customer experience

NHS Midlands and East’s fifth ambition sets out its intention to deliver a ‘Patient Revolution’. Commissioners and providers are being asked to deliver a transformation across the three Cs that define the ‘Patient Revolution’ through:

- Driving greater Co-production between patients and professionals, e.g. through shared decision making and involvement in the management of long term conditions;
- Delivering greater Community participation between the public and the service, e.g. by involving the public in the future planning and reconfiguration and making even better use of Foundation Trust members; and
- Improving the Customer experience of patients and carers.

PCT Clusters are asked to identify the key prioritised actions that they are taking to deliver a patient revolution and submit a system action plan as part of their response to this document.

How success will be monitored

Whilst the SHA will be non-prescriptive about how the ‘Patient Revolution’ is driven forward locally, a standardised monitoring framework will be developed, to ensure that boards and wards can benchmark themselves against the best and prioritise improving the patient and carer experience.

PCTs are asked to ensure that the standardised ‘Net Promoter’ question and methodology is asked in all existing patient surveys from April 1\textsuperscript{st} 2012, i.e. “How likely is it that you would recommend this service to friends and family? Extremely Likely? Likely? Unsure? Unlikely? Not at all? Don’t Know?”. 

Regional Commissioning Framework 2012/13
From the 1st April 2012 all acute hospitals must ensure that a minimum 10% of their weekly footfall of patients are asked the ‘Net Promoter’ question and the results reported to wards, boards, commissioners and the SHA weekly. The SHA will publish the results on NHS Local and in our Board Reports.

Commissioners are expected to set a contractual trajectory to improve their acute provider ‘Net Promoter’ scores by 10 points over the next year using Month 1 of Financial Year 2012-13 as the baseline for improvement. PCTs must ensure that at a minimum 10% of their weekly footfall of acute patients are asked the ‘Net Promoter’ question. Further guidance will be developed in January 2012 to ensure that the sample is consistent and representative through the year.

CQUINs should be used to incentivise this improvement.
**Regional QIPP & Reform milestones**

Section 1.11 in the national Operating Framework makes reference to the QIPP transformational milestones that will be required as part of the national planning cycle for 2012/13. This section also specifies that SHA and PCT Clusters can and should supplement national milestones with additional measures that reflect their own local circumstances and ambitions.

This section of the regional commissioning framework will outline the regionally mandated transformational QIPP milestones that should be incorporated into the integrated plan for each health system.

**Additional QIPP milestones**

The experience of monitoring QIPP in 11/12 has shown that it is comparatively easy to count financial savings or cost reductions on an organisational basis but it is much harder to demonstrate the magnitude of transformation that has occurred within a health system.

The following milestones have been developed to provide some consistency across all 17 PCT Clusters in tracking QIPP transformation during 2012/13. It is expected that all PCT Cluster critical paths submitted as part of the Integrated Planning process will incorporate these milestones into their critical paths or explain why these milestones are not applicable to their health system in the narrative submission.
<table>
<thead>
<tr>
<th>Due Date</th>
<th>Milestone</th>
<th>Category</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar 13</td>
<td>All acute trusts with an obstetric unit to have a midwifery led birthing unit</td>
<td>QIPP</td>
<td>All acute providers are expected to have a midwifery led birthing unit operational by the end of the financial year. Providers with midwifery led units already operational are not expected to add this milestone to their QIPP and reform plans.</td>
</tr>
<tr>
<td>Mar 13</td>
<td>Annual survey of tele care completed providing an indication of the number of service users with long term conditions who use assistive technology including simple tele-health</td>
<td>QIPP</td>
<td>The SHA Cluster expects to see an increase in the numbers of people with LTCs using assistive tele-health to support self management.</td>
</tr>
<tr>
<td>Mar 13</td>
<td>100% of organisations within each trauma network have implemented integrated trauma systems with formally adopted policies, procedures and protocols</td>
<td>QIPP</td>
<td>This supports the effective co-ordination of integrated trauma systems across England.</td>
</tr>
<tr>
<td>Mar 13</td>
<td>100% of major trauma patients receive tranexamic acid within 3 hours (excl isolated head injury)</td>
<td>QIPP</td>
<td>This is expected to reduce all cause mortality (DH Guidance issued 24 November 2011).</td>
</tr>
<tr>
<td>Mar 13</td>
<td>All providers to have implemented Enhanced Recovery for the 4 clinical specialties identified by the national programme (part of Right Care work stream)</td>
<td>QIPP</td>
<td>All commissioners to have included Enhanced Recovery in contractual agreements with providers. The 4 specialties are colorectal, gynaecology, hips and knees, urology. SHAs are required to update the national Programme Board on which acute trusts have implemented in each specialty – partially or completely.</td>
</tr>
<tr>
<td>Mar 12</td>
<td>Each commissioner to agree a plan for 12/13 for implementation of the high impact innovations as set out in Innovation Health and Wealth</td>
<td>QIPP</td>
<td>This will be used as a pre qualification criterion for CQUIN in 2013/14 and during 2012/13 commissioners and providers should be preparing for this.</td>
</tr>
<tr>
<td>Mar 12</td>
<td>95% patients requiring access to carotid endarterectomy surgery receive access within 14 days of referral</td>
<td>QIPP</td>
<td>This supports delivery of domain 1 in the Outcomes Framework.</td>
</tr>
<tr>
<td>Mar 12</td>
<td>Submit an agreed plan for the transition of Information Governance and RA functions which meets the requirements of the assurance framework and Information Governance Toolkit (IGT)</td>
<td>Reform</td>
<td>A PCT Cluster plan is required by Mar 12.</td>
</tr>
</tbody>
</table>
**CQUINs**

In the Operating Framework, commissioners were reminded that CQUIN is a quality increment that applies to a level of service over and above the standard contract. Commissioners and providers were also reminded to have due regard to the Innovation Review\(^2\) when developing their local CQUIN schemes for 2012/13. This will be used as a pre qualification criterion for CQUIN in 2013/14 and during 2012/13 commissioners and providers should be preparing for this.

To assist PCT Clusters in meeting this requirement, the SHA Cluster proposes to review draft local CQUIN schemes and to provide feedback to PCT Clusters to ensure the CQUIN schemes are:

- Applying to a level of service over and above the standard contract; and
- In alignment with the innovation review, including a review of high impact innovation compliance where this is possible.

To enable this review to take place, PCT Clusters are requested to send through copies of their proposed local CQUIN schemes in draft form to submissions@eoe.nhs.uk by Friday 03 February 2012. The SHA Cluster will then commit to providing feedback on these schemes by no later than 24 February 2012.

\(^2\) Gateway reference 16978
For clarity, it will be the responsibility of the local health system to agree the final form of their local CQUIN schemes.

To enable further regional consistency, there is a recommendation from the national specialised services CQUIN scheme that CQUIN payments should be calculated on trust outturn minus any “pass through payments”. The rationale behind this is that pass through payments such as pass through drug costs in specialised services are cost neutral reimbursements rather than trust income.

**Regionally proposed CQUIN schemes**

There are four national CQUIN goals that must continue to be linked to around one fifth of 2.5 percent value of schemes. In addition, the SHA Cluster is proposing to add to this list additional CQUIN schemes that help drive forward delivery of our SHA Cluster ambitions.

The teams working on developing the SHA Cluster ambitions are currently considering what regional CQUINs may be appropriate for 2012/13. There is an expectation that any regionally proposed CQUIN schemes, supporting the SHA Cluster ambitions will be cascaded to PCT Clusters by 16 January 2012.
Detailed operating requirements

Operational contracting expectations
As the deadline for commissioning and contracting to pass from PCTs to Clinical Commissioning Groups rapidly approaches, there is a significant amount of work that needs to be undertaken by PCTs to ensure a smooth transition. Whilst there has been progress on the contract transition work, which is being led by colleagues in the Commissioning Development directorate, there is a continuing need to ensure that operational contracting remains robust. This assurance process will be led by the Operations and Performance directorate.

‘Operational Contracting’ is an umbrella term which covers:

- the annual contracting round for acute, community, mental health and learning disability, integrated and ambulance services (referred to as ‘secondary and community care services’);
- the procurement of NHS funded continuing care services via the Care Homes standard contract;
- the procurement of new secondary and community care clinical services; and,
- the procurement of some primary care services via an APMS contract (it does not include the procurement of primary care services via the GMS, PMS, GDS, pharmacy and optometry contracts).
A new NHS standard contract for secondary and community care services has also been introduced, which will replace the existing acute, community, mental health and learning disability, integrated and ambulance services contracts (4.41). The structure of this contract will vary significantly from those provided in previous years.

During 2011 the Cooperation and Competition Panel issued recommendations which, together with the Department of Health’s responses to those recommendations, clarified the interpretation by PCTs of the principles and rules for cooperation and competition (4.51, 4.52). The NHS standard contract provisions have been amended to reflect the CCP recommendations.

As with 2011/12, the 2012/13 contract will be for a default period of 12 months, in preparation for a further round of amendments in 2013/14. A longer contract period will be available by exception and the SHA is required to put in place an approvals process to deal with requests (4.45).

NHS Midlands and East has produced detailed Operation Contracting Assurance guidance. The aims of this guidance are to:

1. to ensure a consistency in approach to operational contracting across the SHA cluster;

2. to ensure that operational contracting is carried in accordance with the finance and business rules laid out in the Operating Framework 2012/13 and the Payment by Results Guidance and Rules; and,

3. to ensure that contracts meet minimum good practice standards and are able to go forward into the Contract Transition process without further amendment or assurance.
The Operational Contracting Assurance guidance will be published in the new year and commissioners are requested to follow this guidance (which may be updated from time to time) when undertaking any operational contracting activities.

**Implementing payment by results (PbR) in mental health**

2012/13 will be the introductory year for Mental Health PbR implementation. The implementation of payment by results in mental health is a key focus of government policy. During 2012/13 commissioners will need to ensure the delivery of a plan of work which will include:

- defining quality outcome metrics;
- a data improvement plan;
- assessing current delivery models against effectiveness measures;
- a timed programme for full delivery of NICE guidance; and
- rework contract structures to reflect development.

Progress will be reviewed against the plan developed in Q1 2012/13.

**Implementation of Integrated Major Trauma Networks**

During 2012/13, the Specialised Commissioning Group (SCG) will coordinate delivery of an effective integrated trauma system across the Midlands and East cluster in line with NCEPOD recommendations “Trauma: Who Cares?” Working with stakeholders, this work will define the best appropriate clinical management, reducing delays in accessing elements of care and ensuring optimal bed management. Plans are at variable stages across the SCG cluster. Implementation should be addressed in 2012/13, where not already progressed. In those parts of the region, where implementation is more advanced, the SCG will ensure effective tracking and planning of the pathway for the major trauma patient throughout the system.
**SCG minimum take algorithm**

To support a nationally consistent approach towards the commissioning of specialised services, it has been agreed that all SCGs will commission a consistent sub set of the Specialised Services National Definitions Set (SSNDS) – the “Minimum Take” services.

The Midlands and East Specialised Commissioning Teams (SCTs) have agreed a cluster wide coding algorithm which has been distributed to providers and identifies the services that will be commissioned within the Minimum Take services. Services requiring transfer between SCTs and PCTs will be agreed as part of national Transition Controls Project

This work will aim for consistency of charging arrangements across the Cluster and introduces clear rules on responsible commissioner and supports the managed transition of specialised commissioning into the NHSCB.

Services requiring transfer between SCTs and PCTs will be agreed as part of national Transition Controls Project. Successful local implementation will be indicated by those PAMs specified by the agreed algorithm during 2012/13 and will require tripartite agreements between SCT / PCT / Provider responsible officers.

Progress will be monitored through monthly contract monitoring, based on SCTs Finance & Information Teams
**Planning Timeline & Guidance**

This annex provides an overview of the planning timetable that the SHA Cluster will operate to ensure that each PCT Cluster and health system has submitted an appropriate integrated business plan.

The PCT Cluster will be required to submit the following component parts:

1. An integrated plan narrative – which should be built upon the first submission made on 25 November incorporating any previously received feedback. It would also be helpful to ensure the key lines of enquiry identified later in this document will be addressed within the narrative and to reference the additional checklists included in the DH planning guidance on public health transition and workforce.

2. Data trajectories for all performance areas where plans are required (the specific plans required will be listed as part of the technical guidance released by DH). These will be required at PCT level not just PCT Cluster level.

3. Trajectories on financial indicators as set out in DH guidance.

4. Workforce indicators as required by DH guidance, this may be covered by the financial indicators in point 4.

5. Milestones for each PCT Cluster covering the 5 – 7 transformational QIPP programmes, and reform. The
milestone plan should be accompanied by narrative explaining:

- If any of the regional QIPP and reform milestones have not been incorporated, the rationale behind this; and
- How the QIPP transformational milestones selected relate to delivery of the 14/15 end state.

6. A refreshed triangulation toolkit, which has been reviewed by the PCT Cluster to ensure consistency between sections 2, 3, 4 and 5 highlighted above.

The specific details of where items 2, 3 and 4 should be submitted will be found in the DH technical guidance and supported by any local guidance from the info teams.

Additional guidance on QIPP milestones is provided within the DH technical guidance. All other component parts should be submitted to submissions@eoe.nhs.uk in the first instance.

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3 Gateway reference 15476
• PCT Clusters should submit items 1-6 listed above by noon.
• The SHA Cluster will then review the submissions against a consistent set of Key Lines of Enquiry (KLOEs) and rag rate the submission

18 JAN

• SHA Cluster submits the initial plans, PCT Cluster rag ratings and narrative on red areas to DH

27 JAN

• SHA Cluster issues RAG ratings to PCT Clusters with any related feedback
• First cut plans are analysed by DH and feedback is provided to SHAs

31 JAN - 16 FEB

• PCT Clusters to submit draft CQUIN schemes to SHA Cluster

03 FEB

• Operational plan sign off meetings held with all PCT Clusters to discuss outstanding amber and red plan areas
• The meetings will also include a performance element with areas of under performance discussed in more detail

FEB

• SHA Cluster provides feedback on draft CQUIN schemes

24 FEB

• PCT Cluster submit Item 1, integrated plan narrative (unless previously assessed as fully green)

09 MAR

• PCT Clusters submit the remaining component parts of the plan (2-6) to the SHA Cluster

22 MAR

• All contracts expected to be signed off
• PCT Clusters to report status of contracts to SHA Cluster

31 MAR

Figure 2: Planning timeline
**Key Lines of Enquiry (KLOE)**

The plans submitted by the PCT Clusters will be assessed against standard key lines of enquiry (KLOE). These KLOEs will be used to rag rate the submissions received. We have also attached (in attachment 1) a KLOE checklist which contains all the KLOE and a column for which page number in the integrated plan relates to the particular KLOE.

It is intended that the final set of KLOEs will be agreed across all SHA Clusters as we move towards a single operating model for planning and performance, however the domains are likely to include:

### Domain 1: Overarching assurance

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 authorisation of CCGs, development of a Commissioning support function, transition 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?
11. Do the plans provide assurance that robust plans are in place to offer patients choice of Any Qualified Provider?

### Domain 2: Engagement

1. Does the plan clearly describe what steps have been taken to engage with stakeholders, inc CCGs, Providers, HWBs, LA, in developing the 2012/13 plan?
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?

### Domain 3: 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 provided 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 of the planning guidance issued by DH 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?

### Domain 4: 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)?

### Domain 5: 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?

### Domain 6: Workforce

1. Has workforce assurance been completed using the safety and quality assurance framework and Key Lines of Enquiry (outlined below) and what was the outcome?

   - **A) Workforce metrics, benchmarking, trends and plans, with related quality metrics and intelligence, are used to identify and raise concerns about future trends and performance**

   - **B) 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 (e.g. activity / finance etc...)**
C) 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.

D) 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.

E) 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.

F) 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.

G) 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.

H) There is sufficient attention to support staff and wider support groups.

I) Where clinical workforce changes are planned, a communications strategy has been developed.

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?

**Domain 7: 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**

**Domain 8: Commissioning development - CCGs**

1. How have the CCG Leadership team and the delegated subcommittee of the PCT 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 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?

**Domain 9: Commissioning development – commissioning support**
1. Does the plan reflect how the PCT 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?

**Domain 10: Commissioning development - direct commissioning**

1. Does the plan reflect how the PCT 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?

**Domain 11: 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 NHS CB (primary care, specialised services, prison health, military health and relevant aspects of public health)?

**Domain 12: 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 in the DH technical planning guidance)?
2. Is the narrative clear about how Local Authorities have been engaged and the part they have played in refining the plan?

**Domain 13: Provider Development**

1. Does the plan detail the progress being made to continue to develop the new provider landscape across the system?
2. Are the TFA milestones for each aspirant FT accurately reflected in the plan, with an explanation of the agreed escalation process where slippage has occurred?
3. Do the plans provide robust assurance on the specific actions being taken to ensure commissioner convergence is being achieved in order to support TFA timelines and achievement of NHS FT status?

**Domain 14: SHA Cluster ambitions**

1. Do plans confirm the PCT Cluster approach to delivering the SHA Cluster
ambitions?

**Domain 15: Contract signature**

1. Are contracts signed with all providers?

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**Guidance for the Integrated Plan narrative**

The integrated plans for 2012/13 must be built ‘bottom up’. It is expected that each Clinical Commissioning Group will produce an operational plan for the coming year and that these plans, alongside provider plans will be aggregated up to form PCT and PCT cluster level plans. The Midlands and East SHA expect to receive and review PCT Cluster level plans.

The narrative of the plan must set out clear ambitions for the Cluster for the next year underpinned by KPI trajectories, robust workforce, activity and financial plans and milestones for QIPP & Reform. Systems must ensure that all data submissions used to underpin the plan are consistent, including FIMS, Unify, and SuS etc.

The relationship between the narrative and the underlying detailed assumptions should be tested by the PCT Cluster to ensure there is consistency within the plan. The plan must also set the high level strategy for the subsequent two years, through to 2014/15.

The plan must take into consideration the strategy for delivery set out in the integrated plan for 2011/12 and reflect progress made throughout the year. The plan narrative should take into consideration that this is year two of the previous planning submission.

It is important that there is a strong narrative that runs through the document that emphasises the fact that the NHS’s core purpose remains the delivery of improved quality for patients by improving safety, effectiveness and patient experience and that the plan will deliver that.

The following chapter headings should be used in constructing the plan:
1. Executive summary
2. Background/Context across the health system
3. Review of delivery in 2011/12
4. Priorities for 2012/13 (National, SHA and Local)
5. Transition and reform
6. Financial analysis
7. QIPP work programmes
8. Capacity implications
9. Implementation and delivery
10. Engagement
11. Risks

All integrated plans must be formally signed off by all relevant stakeholders in each system, including PCTs, Providers, Clinical Commissioning Groups and the relevant Local Authorities. The plan must include a signature sheet with sign off from the Chief Executive or Lead Accountable officer from each organisation, as well as sign off by the Nurse and Medical Directors of the PCT Cluster. We also expect to see evidence within the plan itself that it has been developed in partnership with key stakeholders.

System plans must be written with the understanding that they are likely to become publicly available documents (not including all appendices).
**Narrative structure**

Systems must ensure that the plan covers the key requirements set out in the Operating Framework, the additional requirements set out in the commissioning framework, addresses the Key Lines of Enquiry for assessment and follows the structure below.

**Section 1: Executive summary**

This should summarise the document, including the financial challenge faced, the quality and productivity improvements that will have been delivered, the impact on workforce, the key changes that will have been made within the system and ‘a picture’ of how the system is envisaged in 2014/15 and potentially beyond.

**Section 2: Background/Context**

A brief explanation of the current health system should be provided, explaining the strategic issues and priorities. It should also put the plan in the context of 2011/12 including any significant activity/financial issues or strategic changes underway.

**Section 3: Review of delivery in 2011/12**

This chapter should outline the system accomplishments during 2011/12, including delivery of QIPP schemes, service, workforce and financial performance. This should be shown against plan to demonstrate achievements. Where delivery has not been sufficient, remedial actions and/or recovery trajectories must be included as appendices to the plan.

Where CCGs have made a significant contribution towards delivery for example in successfully leading on elements of the contract negotiations or QIPP projects, this should be incorporated into this section.

**Section 4: Priorities for 2012/13 (National, SHA and Local)**
This chapter should clearly set out how the cluster intends to deliver the priorities set out in the NHS Operating Framework, particularly relating to:

1. Dementia and care of older people
2. Carers
3. Military and veterans health
4. Health visitors and family nurse partnerships

Systems should ensure that any local priorities are linked, where appropriate, with the NHS Midlands and East Cluster ambitions.

**Section 5: Transition and reform**

This section should include a brief statement of the system’s overall approach to the reform agenda, including progress made during 2011/12. Specific sections should be included on:

- Development of the PCT Cluster including progress made on ensuring sustained resource levels whilst delivering running cost savings
- Clinical Commissioning Groups: This should set out the current and likely final number of Clinical Commissioning groups. The stage at which each CCG has developed to and plans for future development, including delivery of milestones as set out in the shared operating model. It should also be clear from this section what the specific delegation will be for 2012/13 – budgets/staff etc.
- Commissioning Support: The systems progress with establishing a model of commissioning support etc
- Direct Commissioning: Outline of how the system will ensure it delivers the milestones set out in the Shared Operating Model
- Arrangements with local authorities: This should include clear statements on the progress made with establishing Health and Wellbeing Boards and joint working arrangements with social services, as well as outlining the transition plan for establishing the new arrangements for Public Health. An understanding of how patient voice systems will link up to Health Watch should also be reflected.
- Provider Development: A brief statement outlining Trusts yet to become Foundation Trusts and their timeline to do so. It would be helpful to also reference progress made on community services and any immediate benefits realised by community providers in 11/12 or expected for 12/13.
- System health: This should include clear statements on plans for developing talent and leadership during the transitional period.
Section 6: Financial analysis

The current financial position of the PCT Cluster and each system providers should be provided. The financial plan for the PCT for 2012/13 should also be set out. This should also, where appropriate, be presented at a CCG level.

The size of the productivity challenge for 2012/13 should be set out. There should be three components to this:

1. The challenge to the system, which is an aggregate of the PCT Cluster and provider challenges
2. The challenge to the PCT Cluster, reflecting the need to deal with pay and price pressures, demand and quality pressures and any impacts from previous years but after allowing for planned increases in income and the impact of contract efficiencies
3. The challenge to each of the providers, reflecting the need to deal with the combination of pay and price pressures, contract efficiencies and any additional net reduction in contract income as a result of agreed activity changes.

Activity projections will be detailed in the Unify submissions however this section should highlight any significant planned activity changes that underpin the financial assumptions across the PCT Cluster.

Section 7: QIPP (Quality, Innovation, Productivity and Prevention) work programmes

This chapter should set out the key opportunities identified to deliver the QIPP challenge for the period 2012/13 – 2014/15, however more detail is expected for 2012/13.

The following details also need to be provided:

- The financial scale of the opportunity for the combined system and the opportunity split by provider;
Clearly identified local quality opportunities and any linkages with the quality opportunities and ambitions identified by the Midlands and East SHA cluster;

The quality opportunity should identify the indicator, the baseline and the target or milestones by which to measure delivery;

The likely impact upon activity levels for all relevant providers from the QIPP schemes; and

The high level priorities/QIPP work streams for the system. These should be transformational and by nature should encompass all providers within the system.

Systems must take care to ensure that there is no double counting with Provider Cost Improvement Plans (CIPs).

This chapter should focus on providing high level assurance that the system as a whole and each provider organisation has sufficient plans in place to deliver the financial challenge. Specific areas of priority for the system should be included in this chapter; a full list of schemes will be required as an appendix to the plan providing title, local reference and anticipated financial contribution.

This narrative is expected to align to activity; finance and workforce changes detailed in the triangulation tool and in the submissions to DH and should correlate to the QIPP milestones.

**Section 8: Capacity implications**

The key implications of the proposed changes for the system by 2014/15 should be set out in the narrative form, including:

- The key changes to the shape and structure of the system including any planned service reviews or reconfigurations
- Changes in required activity, capacity and workforce (number and skills) by setting of care
- Changes to % distribution of PCT expenditure
- Headline implications for individual providers including provider income, activity, capacity and workforce
- Identify how issues such as training and skill mix will be addressed across the cluster in order to mitigate risks of planned changes to service delivery.
PCT clusters need to provide assurance that quality and safety for patients is improved or maintained irrespective of capacity changes. PCT clusters should ensure that they have completed adequate assessment of workforce plans (using the Key Lines of Enquiry) and the assessment and evidence should be outlined in the integrated plan.

The PCT Cluster narrative needs to clearly set out what ‘system wide’ changes are expected in activity and patient flows and the subsequent impact on the shape of the workforce. The plan needs to include sickness absence, skill mix changes, productivity and agency costs.

**Section 9: Implementation and delivery**

Plans should describe the governance arrangements and supporting business processes for the delivery of the system-wide plans, including the following information on overall programme management arrangements:

- Agreed programme management approach, responsibilities and reporting and decision making arrangements
- Identification that the leadership capacity is in place to deliver the plan
- Programme funding arrangements, including the application and phasing of the 2% transformation fund.

Any critical milestones relating to implementation and delivery should be included within the QIPP and Reform milestones.

**Section 10: Engagement**

The plans should address the following:

- **Clinical engagement** - How secondary and primary care clinicians have been involved in agreeing the key planning assumptions and how they are engaged in the key work streams;
- **Clinical Commissioning Groups** – The role in which Clinical Commissioning Groups have taken in the development of QIPP schemes, including clear detail on ownership for 2012/13;
- **Local Authority partners** - The process by which Adult Care Services have been involved in the development of the plan and in agreeing key assumptions. This will be particularly important around assumptions which involve a change in care setting,
admission avoidance schemes or length of stay reductions linked to improved community based services;

- **Patient and public involvement** - Assurance that patient and public involvement is integral within the key work streams; and

- **Staff engagement** - Identify what steps have been taken to engage with staff when determining the vision of the ‘future state’, what changes are required to achieve it and the associated impact.

**Section 11: Risks**

Plans should include high level risks, separated out by function, i.e. QIPP, Commissioning Development; Provider Development; Workforce, Finance and Performance. The degree of risk, mitigating action and the risk owner should also be identified.

**Appendix 1 – Recovery trajectories for performance (where appropriate)**

**Appendix 2 - QIPP and Reform Milestone plan**

For 2012/13 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 an agreed Excel template. The Excel template will be circulated separately once received from the DH. 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).

**Reform milestones**

The minimum national expectations for milestones for commissioning, health and wellbeing boards and public health transition are set out in Attachment two. PCT 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 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.

**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%.

Systems must ensure that they have also included the regionally mandated QIPP milestones set out in the Commissioning Framework.

**Appendix 3 – Public Health transition plan**

The final Integrated Plan (due in March 2012) should have the Public Health transition plan as an appendix and the Cluster should be able to demonstrate engagement and discussion
with Local Authorities in the development of this. DH guidance on the development and content of Public Health Transition Plans should be followed.

Appendix 4 – List of QIPP schemes

Each system is expected to submit a complete list of all QIPP schemes as an appendix to the integrated plan. The schemes should be split by PCT and provider and should be submitted using the template attached as Attachment three.
**Yearly planner**

This section will contain a yearly planner that PCT Clusters can use to ensure they are well aware of the requirements contained within this document. When all other sections are completed, this section will provide a useful summary of SHA Cluster expectations as to when key milestones will occur and any supporting submissions required.

This cannot be exhaustive as in year requirements will always arise, but it is intended to be a helpful starting point.
April 2012

- Staff survey results are anticipated and when published will be included in the next performance review meetings
- Standardised net promoter question asked in all existing patient surveys

May 2012

- Assurance process instigated where PCT Clusters will be asked to declare what work has been completed to actively promote the NHS Constitution in their localities
- Assurance process instigated where PCT Clusters will be asked to demonstrate what they have done to publicise the right in the NHS Constitution to treatment within 18 weeks

June 2012

- Annual accountability reviews scheduled
- Milestone for Public Health vision and strategy for the new public health

August 2012

- The Operations & Performance team will request links to the websites where dementia plans are published
- The Operations & Performance team will request links to the websites where carer plans are published
September 2012

- Policy & strategy to review PCT Cluster implementation plans on the choice of AQP

October 2012

- A specific section on inappropriate emergency admission rates for older people will feature in the first half performance reviews
- Prepare local systems for new commissioning support – Public Health milestone due
- Ensure new clinical governance systems in place – Public Health milestone due
- Prepare for formal transfer of staff – Public Health milestone due

March 2013

- Policy & strategy to review use of the NHS number in datasets with an expectation that to will be near 100%
- All acute trusts with an obstetric unit to have a midwifery led birthing unit
- Annual survey of tele-care completed
- 100% of organisations with each trauma network should have implemented integrated trauma systems
- 100% of major trauma patients receive tranexamic acid within three hours excluding isolated head injury
- All providers to have implemented Enhanced Recovery for the 4 clinical specialties identified