Annex B

Guidance for operational and activity plans: assurance statements

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Contents

1 Introduction and context

1.1 Introduction

The *NHS England commissioner guidance for operational and activity plans: SDCS submissions* sets out the deliverables for which 2019/20 operational plans will be collected through SDCS from commissioners and the *NHS Improvement Guidance for Completion of Provider Activity Template* covers the 2019/20 deliverables collected from providers via the NHS Improvement collection portal.

For the deliverables not covered by the SDCS operational plan collection or the NHS Improvement collection portal, NHS England/NHS Improvement Regional Directors will be asked to complete assurance statements to confirm that regional plans will be put in place to ensure delivery. This annex details the deliverables to be covered by those assurance statements.

1.2 Context

Assurance statements were first collected from NHS England Regional Directors in 2018/19, to gain assurance against deliverables which were either qualitative in nature, or were otherwise unsuited to operational plan collections through the former UNIFY2 system.

In order to maintain a focus on deliverables which are not covered by the SDCS operational plan collection or the NHS Improvement collection portal, the assurance statement process is being retained and strengthened for 2019/20. This annex contains an overview for NHS England/NHS Improvement regions and systems of the assurance statement deliverables for which NHS England/NHS Improvement Regional Directors will be required to ensure that regional delivery plans are in place.

2 Assurance statements

2.1 Process and guidance

NHS England/NHS Improvement Regional Directors are asked to provide assurance that regional plans will be put in place to ensure delivery in 2019/20 of the ambitions contained in this annex. National programme teams will provide support to regions where full assurance cannot be provided.

Each NHS England/NHS Improvement Regional Director is requested to submit two assurance statement returns – an interim draft return on 19 February 2019 and a final return on 11 April 2019. These dates align with the aggregate 2019/20 system operating plan submissions, as detailed in the main *NHS Operational Planning and Contracting Guidance 2019/20.*

Further guidance for Regions on the process for submitting assurance statement returns will be provided to NHS England/NHS Improvement Regional Directors later in January 2019.

Any queries from Regions can be addressed to england.ops-planning@nhs.net.

2.2 The assurance statement deliverables

Assurance will be requested from NHS England/NHS Improvement Regional Directors against the deliverables shown below.

2.2.1 Mental health

- Additional CCG baseline funding should be used for its intended purpose to deliver commitments as set out in Implementing the Five Year Forward View for Mental Health and in all guidance related to mental health finances for this 2019/20 planning round.

- All CCGs must meet the Mental Health Investment Standard (MHIS). Full information is in section 3.6 of the *NHS Operational Planning and Contracting Guidance 2019/20*.

- STP/ICS leaders, including an identified lead mental health provider, will review each CCG's investment plan underpinning the MHIS to ensure it covers all of the priority areas for the programme and the related workforce requirements. Any outstanding concerns will be escalated to the NHS England/NHS Improvement regional teams.

- Each CCG should work closely with their NHS and non-NHS provider partners and ALBs locally to deliver against workforce plans, including expansion and

enabling of training and retention schemes. Workforce requirements should form part of finance and mental health investment plan discussions to ensure alignment with CCG financial submissions.

- Continue work to deliver expansion in the capacity and capability of the CYP workforce building towards 1,700 new staff and 3,400 existing staff trained to deliver evidence-based interventions by 2020/21.

- Continue to show evidence of local progress to transform children and young people's mental health services through publication of refreshed joint agency Local Transformation Plans aligned to STPs. This will support the requirement to increase access to 34% of estimated 2004 CYP prevalence (measured via SDCS). Additional funding will be provided to support the delivery of staff trained in CYP IAPT interventions. STPs as part of their workforce planning are expected to work with partners to ensure that staff trained by HEE through the 'recruit to train' programme are offered contracts by providers to maintain momentum in improving access in line with *FYFVMH* commitments. Further funding will be provided to specific CCGs to support the delivery of mental health support teams in schools and colleges and 4-week pilots in 2019/20.

- Each CCG, as part of an STP footprint, should ensure increased access to NICE concordant community-based specialist perinatal mental health services (in secondary care settings) for at least 4.5% of their population birth rate, equating to an additional 20,000 women nationally. This means:

    - Ensuring effective use of additional CCG baseline investment for these services to continue and expand further following transformation funding in 2017/18 and 2018/19, as set out for 2019/20 in Chapter 3 of Implementing the Five Year Forward View for Mental Health.

    - Ensuring this expansion includes timely access to psychological therapies as recommended in the published care pathway

- Ensure continued focus on improving access to psychology therapies (IAPT) services through meeting core IAPT offer requirements, all areas commissioning IAPT-LTC (psychological therapies for people with Long Term Conditions) services, and co-location of therapists in primary care. This requires CCGs to expand access, including for underrepresented groups like older people and BAME. For IAPT-LTC, this means CCGs should ensure they issue a contract variation to their local IAPT provider for the delivery of IAPT-LTC, and increase funding to the provider to achieve 22% access, whereby two thirds of the increase in access should be delivered within the IAPT-LTC service.

- Use additional 2019/20 baseline funding to stabilise and bolster core adult and older adult community mental health teams and services for people with the most complex needs, including people with diagnoses of personality disorder and eating disorders. Alongside this, undertake preparatory work for the mobilisation of a new integrated primary and community model as part of the Long Term Plan. This preparation should include strengthening local relationships between primary care, secondary care, local authorities and VCS services, developing understanding of local need through information and data (such as the NHS England and NHS Benchmarking Network community mental health services stocktake), and early workforce planning.

- All CCGs are encouraged to work with regional teams to develop plans to establish baselines and track access to PT-SMI (psychological therapies for people with severe mental illness, defined in the Five Year Forward View for Mental Health as Psychosis, Bipolar Disorder and Personality Disorder). For psychosis, this includes working with providers on delivering required training.

- For Crisis Resolution Home Treatment Teams (CRHTTs), CCGs must ensure that by the end of 2019/20 all populations have access to services for adults and older adults that are commissioned to meet the minimum functions of: (i) urgent and emergency community mental health assessment, and (ii) intensive home treatment as an alternative to inpatient admission, 24 hours a day, 7 days per week. This means that the services providing these functions can:
    - be accessed directly by telephone on a 24/7 basis, by new and known patients, with the contact details made clearly and publicly available to the local population;
    - be accessed 24/7 by all system partners (including police, ambulance, NHS111, GPs, members of the public);
    - visit people in their homes (or wherever they present in the community) on a 24/7 basis to conduct face to face assessments for people with urgent/emergency mental health needs; and
    - visit people under the care of the intensive home treatment function, as many times per day as needed, on a 24/7 basis.

  Commissioners should work with providers to assess local levels of demand and capacity in these functions, with a view to increasing capacity to achieve the above, and further increasing capacity as necessary by 2020/21, to enable robust provision in line with the UCL CORE Crisis Resolution Team Fidelity Scale.

- Spread coverage of liaison mental health teams through sustained commissioning of Core24 teams to reach 50% of acute hospitals by 2020/21. Alongside this, 100% of areas should be progressing plans for their general acute hospitals to have mental health liaison services that can meet the

specific needs of people of all ages, including children and young people and older adults by 2020/21.

- CCGs should ensure there is a crisis response that meets the needs of under 18 year olds. These should be staffed by practitioners who are trained and competent in meeting the specific mental health needs of children and young people. CCGs should then work towards delivering age-appropriate 24/7 crisis provision for children and young people (CYP) which combine crisis, liaison and intensive community support functions. This should apply whether or not the model selected by the CCG is a dedicated CYPMH service for 24/7 or extended hours, or a blended model that relies on Core24 to support CYP at some point during the 24 hours.

- As per the second part of the national standard for Early Intervention in Psychosis (EIP), CCGs are to ensure the 2018/19 commitment for NICE concordance for EIP from the implementation plan is met; then deliver against the further ambition for 50% of services to be graded at level 3 by the end of 2019/20. The first part of the standard (56% accessing in 2 weeks) is to be measured via SDCS.

- Ensure 60% national increase in access to Individual Placement and Support (IPS) services in 2019/20 through delivery against STP trajectories in line with best practice.

- Alongside the 66.7% Dementia Diagnosis Rate (measured via SDCS), improve post-diagnostic dementia care in line with published guidance.

- Deliver against multi-agency suicide prevention plans, working towards a national 10% reduction in suicides by 2020/21. This includes working closely with mental health providers to ensure plans are in place for a zero-suicide ambition for mental health inpatients.

- Commissioners should ensure all providers, including third sector and independent sector providers, submit comprehensive data to the Mental Health Services Data Set (MHSDS) and Improving Access to Psychological Therapies Data set. Commissioners should work with providers to ensure data quality is proactively reviewed, national guidance is adhered to and the breadth of data submitted to the MHSDS accurately reflects local activity. Commissioners should routinely monitor MHSDS data and are encouraged to use MHSDS commissioner extracts to inform local discussions with providers. A mid-year review will be undertaken, and CCGs will be expected to ensure appropriate contract penalties are applied where providers have failed to meet data reporting and data quality standards.

- Evidence plans and preparation to partner with Provider Collaboratives to manage care for patients from the area needing specialised services.

- Deliver liaison and diversion services to 100% of the population.

- Deliver against regional implementation plans to ensure that by 2020/21, inpatient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements, within a context of 150-180 additional beds by 2020/21.

2.2.2 Transforming care for people with learning disabilities

- CCGs to work with local partners to plan for and invest in appropriate community provision to support people to live in their local communities, in line with the *Building the right support service* model.

- Ensure more children and young people with a learning disability, autism or both get a community Care, Education and Treatment Review (CETR), such that 90% of under-18s admitted to hospital have either had a community CETR or a CETR post-admission.

- CCGs to ensure that they are represented at CETRs for Children and Young People who are inpatients; and can demonstrate an increase in compliance and quality of C(E)TRs in line with national policy.

- CCGs to have a dynamic risk stratification process in place with a clear function of identifying those at risk of admission and to ensure that this is reviewed and updated on a regular basis.

- CCGs are a member of a Learning from Deaths report (LeDeR) steering group and have a named person with lead responsibility.

- There is a robust CCG plan in place to ensure that LeDeR reviews are undertaken within 6 months of the notification of death to the local area.

- CCGs have systems in place to analyse and address the themes and recommendations from completed LeDeR reviews.

- An annual report is submitted to the appropriate board/committee for all statutory partners, demonstrating action taken and outcomes from LeDeR reviews.

- There is a process in place to proactively identify children and young people and adults who are subject to regular and or prolonged restrictive practices including the use of seclusion/long term segregation and ensure that appropriate safeguarding and review measures are followed.

2.2.3 Maternity

- Continue against trajectory to deliver improvements in safety towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025.

- Deliver full implementation of the Saving Babies' Lives Care Bundle (v2) by 31st March 2020.

- Increase the number of women receiving continuity of the person caring for them during pregnancy, birth and postnatally so that by March 2020, 35% of women are booked on to a continuity of carer pathway. All reasonable endeavours must be undertaken to ensure that continuity of carer is provided to groups that experience the poorest outcomes, such as women from ethnic minorities and the most deprived socio-economic groups. Continuity of carer should be delivered alongside ensuring high quality care maternity for all women.

- Continue against trajectory to deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 all women have a personalised care plan.

- Continue against trajectory to deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 more women can give birth in midwifery settings.

2.2.4 Cancer

- All providers must start collecting mandatory data items for the 28-day faster diagnosis standard cohorts and, working through their Cancer Alliance, use the data to improve time to diagnosis, in particular for lung, prostate and colorectal cancers, before the standard is introduced in 2020. All Cancer Alliances should implement the national timed pathway for oesophago-gastric (OG) cancer by the end of 2019/20.

- Show improvement in the proportion of cancers diagnosed at stage 1 and 2, as progress towards the ambition of 75% cancers diagnosed at stage 1 and 2 by 2028/29, and reduce the proportion of cancers diagnosed following an emergency admission. All Alliances should work with the national programme to begin the roll out of Rapid Diagnostic Centres (RDCs) – starting with one RDC in each Alliance geography – and to transform diagnostic provision in their area. Where relevant, CCGs should participate in the national targeted

lung health checks programme.

- Improve uptake of screening for bowel, cervical and breast cancers. Support the rollout of FIT in the bowel cancer screening programme and HPV in the cervical cancer screening programme.

- Implement the new radiotherapy service specification, including the establishment of Radiotherapy Networks.

- All providers should work with their designated Genomic Laboratory Hub to implement the national genomic test directory, the patient choice offer and fresh-frozen pathways.

- Ensure full implementation of breast cancer personalised (stratified) follow-up protocols by the end of 2019/20, so that from April 2020 approximately two-thirds of patients who finish treatment for breast cancer are on a supported self-management follow-up pathway. All Cancer Alliances should have in place clinically-agreed protocols for stratifying prostate and colorectal cancer patients and systems for remote monitoring by the end of 2019/20.

- Support delivery of regional plans for implementation of Phase 1 of the Cancer Workforce Plan.

2.2.5 Primary care

- Actively support the establishment of Primary Care Networks (PCNs) within the geographical area to ensure that every practice in England is a part of a local PCN (serving populations of around 30,000 to 50,000) as soon as is possible, to achieve 100% coverage by 30 June 2019 at the latest.

- Support the introduction of any nationally-agreed contract arrangements for PCNs, ensuring that community services are configured in line with PCN boundaries.

- Provide a minimum of £1.50 per head of financial support to PCNs for their management and organisational development. This investment should start in 2019/20 and continue each year until 31 March 2024.

- Support PCNs in their development and ensure they are practically supported to access the PCN Development Programme by 31 March 2020.

- Ensure that PCNs are provided with primary care data analytics for population segmentation and risk stratification based on national data, complemented with local flows, to allow them to understand in depth their populations' health and care needs for symptomatic and prevention programmes including

screening and immunisation services by 1 July 2019 at the latest, and then on an ongoing basis at regular intervals as agreed locally.

- Ensure that PCNs work together including at place level to ensure they play a full role in improving services commissioned and provided at that level, including urgent and emergency care services, and ensure every PCN is working to implement the comprehensive model for personalised care.

- Ensure that the delegated budgets received are used to support the development of all practices in the context of PCN development, with a detailed local plan published by 1 July 2019 showing that every practice is actively engaged and all activity is completed by 31 March 2020 (ensuring delivery of at least two high-impact actions set out in the GPFV including Online consultations; Reception and clerical training; and Time for Care), to be determined through a diagnostic/evidence-based approach that enables deployment of targeted development offers in the most effective way to support, strengthen and transform services for the benefits of staff and patients locally.

- Ensure that the local practice development plans continue to identify those practices who need more intensive and immediate support to stabilise, build their resilience and become sustainable. 75% of 2019/20 sustainability and resilience funding (allocated by NHS England) must be spent by 31 December 2019, with 100% of the allocation spent by 31 March 2020.

- Recruit the share of the additional 5000 doctors and maximise the impact of the over 5000 other health professionals already recruited since the GPFV was published as part of the multidisciplinary workforce, using all available channels and initiatives. This must include development of a detailed STP/ICS workforce plan with trajectories detailed by role type, taking into account local multi-disciplinary workforce needs (based on capacity and demand), working with PCNs as they develop to recruit an expanded range of clinicians and other professionals. As part of this, plan specifically to retain as many GP trainees as possible at an STP/ICS level after completing specialist training; with as many of these as possible taking up substantive roles in the local primary care workforce by 31 March 2020.

- Maximise retention of experienced, effective staff (doctors, nurses and other health professionals), with specific actions/focus in areas which have greatest workforce challenges and with roles where attrition is highest. This includes actions which are shown to have positive impact, (identified by the GP Retention Intensive Support Sites and wider retention programmes) and are tailored to local circumstances. The national GP Retention Scheme should also be offered to support all eligible GPs who cannot work a regular part-time position (up to 4 sessions per week) to remain in practice.

- Continue planned investment in upgrading local primary care facilities, ensuring completion of the pipeline of Estates and Technology Transformation schemes and other STP primary care capital schemes (that support the interoperability with other clinical and administrative systems).

- Ensure oversight of schemes within the geographical area and work closely to ensure these schemes are delivered as planned within the timescales and budget set out for each project so that the benefits of this investment are realised by the improved facilities being used to support multidisciplinary working and the expansion of the primary care workforce.

- Ensure that all GP practices are technically enabled to provide all the functionality that will be offered through the NHS App, as part of the Digital Primary Care transformation plan to ensure it is available to 100% of the population by 31 July 2019.

- Support connectivity by keeping in touch with all doctors in the locality, whether they are working on a sessional or substantive basis.

- Deliver the GP nursing plan including working with HEE and higher education institutions to support nurses to choose primary care as a first destination and to retain experienced nurses already working in primary care.

- Continue with commissioning and deployment of 180 pharmacists and 60 pharmacy technician posts (funded by the Pharmacy Integration Fund, with support from NHS England Regional Independent Care Sector Programme Management Offices), to improve medicines optimisation for care home residents by 31 March 2020.

- Ensure that clinical pharmacists are recruited into practices in line with approved applications for the clinical pharmacist programme.

- Ensure all staff in primary care settings have access to the support of a training hub and capacity to participate in training programmes (e.g. e-learning resources held by HEE); and that there is a plan to develop the agreed set of required functions by 31 March 2020.

- Work with HEE to ensure robust training programmes are in place to adequately support workforce plans.

- Continue providing extended access to general practice services, including at evenings and weekends, for 100% of the population. This must include ensuring access is available during peak times of demand, including bank holidays and across the Easter, Christmas and New Year periods.

- Integrate extended access with other services at scale to deliver value for money and efficiencies and support compliance with national core requirements to maximise capacity, availability and utilisation of appointments for 100% of the population.

2.2.5.1 Public Heath

For public health services the key aim is to support the commitments within the Cancer Strategy and the Section 7a public health functions agreement in relation to population screening and national immunisation programmes. For CCGs the focus will be on supporting NHS England to improve the quality and access to the diabetic eye and cancer screening programmes, the MMR immunisation programme, as well as the planning and delivery of an adequate cancer workforce covering symptomatic and screening services. To support this, CCGs must:

- have a coherent plan to work with the local Public Health commissioning teams of NHS England to improve the quality, access to screening and immunisation programmes with a requirement to prioritise the public health service needs as part of PCN development and the sustainability and resilience of practices; and

- work with PHE workforce planning team data, NHS England regions and local public health commissioning teams to develop plans supporting the prevention commitments for adequate workforce for the symptomatic and screening programme care pathways.

CCGs need to ensure they have capacity in place to deliver:

- the additional colposcopies and cancer treatment that we expect to result from the conversion to HPV primary screening for cervical cancer in the short to medium term; and

- the treatment of additional bowel cancer cases likely to follow the switch from FOBt to FIT 120ug/g.

CCGs will support the implementation of the flu programme, with particular emphasis on:

- supporting improvement in uptake and reducing variation, and ensuring the recommended vaccines are used;

- ensuring that there are clear arrangements in place to support oversight of the flu programme between October and March every year, which are broadly in line with the operating protocol developed for 2018/19;

- supporting general practices to target at-risk population groups to improve uptake and coverage of the flu vaccination to achieve national uptake ambitions, also having a named flu lead in place whose role is to ensure that practices have ordered sufficient vaccine and that there are mechanisms in place to monitor supply and demand and to drive up uptake of flu vaccines;

- supporting general practices (subject to national funding) to sustain and improve uptake and coverage of the routine childhood vaccination to achieve WHO targets for elimination and eradication of vaccine preventable diseases,

improve cancer screening and immunisation uptake, flu vaccination uptake and other national screening and immunisation programmes; and

- STPs/ICSs and NHS England public health commissioning teams working closely with their respective CCGs, taking a lead role in workforce planning and delivery across their geographical area.

2.2.5.2 Diabetes

- Take action to reduce variation in achievement of the diabetes treatment targets (HbA1c, blood pressure and cholesterol for adults and HbA1c only for children) between GP practices in the CCG, particularly where the treatment target achievement in an individual GP practice is below the England average of 40.8%.

- Ensure mechanisms are in place to refer individuals identified with Non-Diabetic Hyperglycaemia to the NHS Diabetes Prevention Programme to support them in reducing risk of Type 2 diabetes.

- Ensure referrals are generated in line with agreed targets and local population need.

2.2.6 Urgent and emergency care

- Maintain a 50%+ proportion of NHS 111 calls receiving clinical assessment.
- Increase the percentage of people triaged by NHS 111 that are booked into a face-to-face appointment, where this is needed, to greater than 40% by 31st March 2020.
- By 31st March 2020, reduce ‘A&E by default’ selections on the Directory of Services (DoS) to less than 1% by the commissioning of appropriate services that are accurately recorded on DoS.
- Designate the majority of urgent treatment centres (UTC) by December 2019, with any exceptions to be agreed with the Regional Director.
- Deliver a safe reduction in ambulance conveyance to EDs with trajectories to be agreed between services and their lead commissioners.
- All ambulance services to meet, as a minimum, a baseline level of digital maturity including access to and usage of patient information at scene (e.g. Summary Care Record, Patient Demographic Service, Electronic Patient Record), access to service information at scene (e.g. DoS) and establishing Electronic Prescribing.

- Ensure 100% of ambulance handovers occur within 30 minutes.
- Ensure 100% of trusts are providing Same Day Emergency Care (12 hours day / 7 days week) by September 2019 with the aim of delivering 30% of non-elective admissions via SDEC by March 2020, and are providing a frailty service (70 hours a week) by December 2019.
- Nationally, deliver a 40% reduction in long stay patients (and long stay beds) from the March 2018 baseline by March 2020.
- Continue to make progress on reducing delayed transfers of care (DTOC) to achieve and maintain a national average DTOC position of 4,000 or fewer daily delays, with local targets to be set for 2019/20 through Better Care Fund (BCF) plans. Further detail on these expectations as well as wider requirements for BCF plans will be published later in 2019.

2.2.7 Elective care

- Ensure all local transformation plans reflect the recommendations in the elective care specialty handbooks, where a relevant specialty has been identified as a priority.
- Continue to embed First Contact Practitioner (FCP) services, participate in the national evaluation process, and roll out FCP services more widely where opportunities are identified locally.
- Maintain failsafe prioritisation processes and policies in all areas to manage the risk of harm to ophthalmology patients, and act on the outcomes from the eye health capacity reviews
- Utilise capacity alerts on the NHS e-referral Service as a tool to support shifts in flows of activity identified in local commissioning plans and as a tool to support recovery where referral or activity plans are not being delivered in year.

2.2.8 Seven-day services

- Continue to rollout the seven-day services four priority clinical standards to five specialist services (major trauma, heart attack, paediatric intensive care, vascular and stroke) and the seven-day services four priority clinical standards in hospitals to meet the overall ambition of 100% population coverage by

2020/21.

2.2.9 Continuing healthcare

- Ensure that in more than 80% of cases with a positive NHS Continuing Healthcare (CHC) Checklist, the NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist (or other notification of potential eligibility). In addition, ensure there are no referrals breaching 28 days by more than 12 weeks in each reporting quarter, or by Q4 2019/20.

- Develop plans to incorporate Continuing Healthcare strategic improvement programme opportunities into QIPP for 2019/20 through continued standardisation of process and adoption of best practice including the implementation of digital solutions, use of CHC SIP tools and guidance, and use of the CHAT assurance tools. All CHC QIPP plans greater than £500k or 5% of the total 2019/20 CCG Continuing Care budget must be signed off by the Chief Nurse at the CCG. Detailed QIPP plans outlining how the financial efficiencies will be achieved must be provided to NHSE regional teams by the end of quarter 1 and achievement against these plans should be reviewed at least on a quarterly basis.

- Ensure that less than 15% of all full assessments for NHS CHC funding take place in an acute hospital setting.

2.2.10 Personal health budgets

- Ensure the delivery of all new Continuing Healthcare home-based packages (excluding fast track), using the personal health budgets model as the default delivery process in all CCGs.