Technical support for the strategic system plan submission process

NHS England and NHS Improvement

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1 Introduction

The NHS Long Term Plan (LTP) published in January 2019, calls on local health systems - Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) - to create strategic system plans. These are expected to clearly set out the practical actions that each system will take to deliver the LTP commitments.

These strategic system plans should cover the period 2019/20 to 2023/24 and will form the foundation of service and system change over the next five years. All systems will be expected to agree their plans by mid-November 2019 and publish them shortly thereafter.

System plans should clearly describe the population needs and case for change and set out the practical actions they will take to deliver the LTP commitments.

The LTP Implementation Framework published in June 2019, sets out the approach systems are asked to take to create their plans. It includes:

- information to help local system leaders refine their planning and prioritisation;
- detail about where additional funding will be made available to support specific commitments;
- detail about where activities will be paid for or commissioned nationally.

The purpose of this document is to support systems to develop robust and high-quality five-year strategic plans. It describes the principal submissions expected: the Strategic Planning Tool and the Strategic Planning- LTP Collection. This document should be read in conjunction with the LTP and Implementation Framework.

The plan development process should be system-led, system-owned and supported by all constituent organisations. The strategy delivery plan and supporting technical material will provide the framework within which operational planning will take place for 2020/21.

As outlined in the Implementation Framework, systems will be expected to ensure that the plans they submit in November 2019 align with the principles outlined in Chapter 1.

2 Strategic planning into operational planning

For each system your LTP Strategy Delivery Plan, Strategic Planning Tool and Strategic Planning- LTP Collection will subsequently support and inform operational planning in 2020/21. Throughout the strategic planning process, we expect systems to consider how resources and capacity available will be used to deliver the totality of commitments within the LTP, and what this means for each of the commissioners and providers in the system. Therefore, we expect that as far as practicable, strategic plans provide the basis for agreeing indicative contract values for 2020/21 and activity levels. We anticipate that there will be a clear link between the contracts and bottom line figures in strategic plans, and each organisation's eventual operational plan for 2020/21. As a corollary we would not expect material changes in the key underlying assumptions as operational plans and contracts are then developed.

3 Strategic Planning Tool

3.1 Purpose of the tool

The Strategic Planning Tool (the 'tool') sets out the underpinning data requirement for each health system's strategic system plan. The tool will capture the overall finance, activity and workforce articulation of the commitments each system will deliver. The completed tool forms the first part of the supporting technical material systems were asked to provide in the Implementation Framework.

Local system leaders will be at the centre of pulling these plans together. Whilst the tool can be built up from the constituent parts of each system (i.e. the individual organisations), it must be a system led and system owned plan which is fully bought into by all organisations. The tool manifests this most clearly in that there are reciprocal provider/commissioner entries for both finance and activity. System leaders are asked to work with organisations to understand where resources will be best used over the period and construct plans which are, as far as possible, aligned in both finances and assumptions.

The strategic planning process should settle the high-level questions of strategic direction and resource allocation, allowing individual organisations to articulate the detail in the subsequent operational planning submission.

The key assumptions underpinning the finance, activity and workforce plans should be described in the strategy delivery plan (see section 5 of this guidance).

3.2 Strategic Planning Tool description

The final, but non-functional version of the Strategic Planning Tool will be released through the STP finance leaders shortly after the publication of this document.

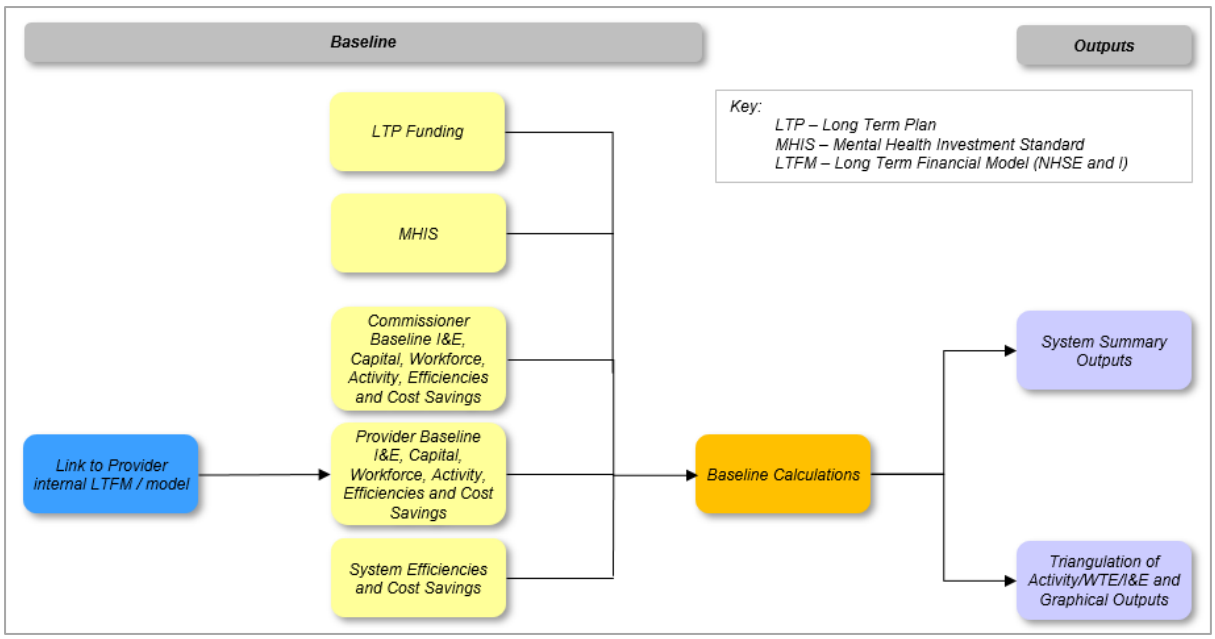
The Strategic Planning Tool is built up by organisation to give an overall system view on an annual basis through to 2023/24. Alongside this guidance you will be provided with a tool which has been customised and prepopulated with the organisations in your system. These will be the same organisations as agreed in the 2019/20 operational planning round.

Each organisation should complete their own individual input tab, however there are multiple areas where organisational positions will need to be aligned, therefore organisations will need to work together across the system to ensure this alignment.

Beyond individual commissioner or provider organisational tabs, there are additional tabs to be completed on:

- **LTP funding** – outlining how the additional indicative 'fair shares' funding outlined in the LTP is to be used by the system.
- **Mental Health Investment Standard (MHIS)** – more detail on how the system intends to meet the MHIS over the period to 2023/24.

- **System Efficiencies and Cost Savings –** detail on work being taken at a system level to deliver financial improvement and sustainability.



The tool is aligned at an aggregated level with the operational planning forms with which systems will be familiar but asks for information on an annual basis through to 2023/24. There are sections for systems to complete on a more granular level for workforce if this would be useful as part of overall planning, however this information is not part of the mandatory collection and will not be collected nationally.

The tool will aggregate this data to system level and includes other functionalities for systems to sense check their inputs, such as completion checks, triangulation tools and graphical outputs.

Throughout the template we have added information boxes to help with completion.

i	Information pop up - these cells contain specific information or guidance on completing the adjacent cells or table. The information will only appear when the cell is selected.

When preparing your submission please use this guidance, you must click on the 'i' pop up box itself as shown on the right to see the information message pop up. The information boxes are supplemented with a mapping table to the operational plans which will accompany the strategic planning tool.

3.3 Sections within the Strategic Planning Tool

3.3.1 Organisational input tabs – Commissioner / Provider

Finance: All financial inputs are to be entered including inflation and all organisational and system efficiencies (there is no counter-factual within the tool).

The tool should be completed before the application of the Provider Sustainability Fund (PSF) (which will not exist from 2020/21 onwards), the Financial Recovery Fund (FRF), or the Commissioner Sustainability Fund (CSF). These figures should only be entered for the baseline year, 2019/20.

Each system template is pre-populated with the organisations within your STP and CCG allocations.

For the baseline year (2019/20) there are two columns. Figures should be entered as per operational plan, and as per forecast outturn at month three for the draft submission and as at month five for the final submission. The forecast outturn should be that as signed off through internal governance procedures and reported to NHS England and NHS Improvement through the regular reporting routes.

The template includes reciprocal lines for commissioner expenditure/provider income for the organisations as specified as being within your system. Therefore, organisations will need to work together to come to an aligned view of activity and resource allocation over the period.

Systems will also work with regional teams and specialised commissioning hubs to agree positions where services are commissioned directly by NHS England as these form part of the return. Further guidance on the basis on which to plan for Specialised Income was distributed in July 2019 along with indicative contract envelopes.

Capital: Systems are asked to draw up capital investment plans and associated capital cash management plans in line with local investment priorities, agreed strategic plans and affordability. These system plans should consider all capital spending (including both routine and backlog maintenance, depreciation and other self-financed investments, loan-financed schemes and more significant transformational schemes) within the system which scores within capital limits set by HM Treasury. The Government has not set a capital budget for DHSC for the period of the Long Term Plan. We will provide systems with an indicative baseline assumption against which system plans should set out prioritised investments.

Workforce: The template collects high-level information on the total planned number of staff needed to deliver STP/ICS service plans, with a breakdown for 12 staff groups. These workforce numbers should take account of new care models, new ways of working and improvements in productivity. They will need to be affordable within financial plans and consistent with realistic projections for improvements in recruitment and retention.

The 12 staff groups are broken down into two settings:

Staff Working in Trusts

- Medical and dental staff - Total
- Registered nursing, midwifery and health visiting staff - Total
- Qualified ambulance staff - Total
- Allied health professionals - Total
- Health care scientists - Total
- Other qualified scientific, therapeutic and technical staff - Total
- Support to clinical staff - Total
- Managerial, estates, and other support staff - Total Staff Working for Trusts

Staff Working in General Practice

- GP and GP Registrars - Total
- Registered nursing staff – Total Nurses

- Other Qualified staff providing direct patient care – Total Clinical Direct Patient Care staff
- Other practice staff – Total Other practice staff

The high-level workforce information from trusts will need to be derived from more granular information on different staff groups collected at Trust level via the separate 'e-workforce' platform. Further guidance on the detail on the granular data collection will follow through HEE Regional Directors.

For staff working in General Practice, the intention is to collect more granular information on different staff groups. Further guidance on the detail will follow.

Activity: The activity section of the tool covers referrals, outpatient attendances, elective spells, non-elective spells and A&E attendances, as well as primary care GP appointments. Where possible the definitions used are consistent with those used in operational planning – full definitions are provided in Annex A of this document.

Systems are asked to provide provider and commissioner level plans for the next 5 years. In addition, systems are asked to complete alignment information to ensure that provider and commissioner activity is aligned within the system. For each point of delivery systems are asked to identify:

- The total CCG activity
    a) Of which the volume of activity provided by NHS acute providers within the system and;
    b) The volume of activity provided by NHS acute providers outside the system

Note: it is acknowledged that CCGs will also commission activity from non-acute providers and the independent sector. This activity should also be included in the total, but not included in a) or b).

- The total provider activity
    a) Of which the volume of activity is commissioned by CCGs in system and;
    b) The volume of activity commissioned by CCGs outside the system and;
    c) The volume of activity commissioned by specialised commissioning

Note: it is acknowledged that Providers will also include activity commissioned through other routes such as overseas visitors or devolved authorities. This activity should be included in the total but not included in a), b) or c)

The within system totals for providers and commissioners must align for the submission to be accepted.

The activity lines will be prepopulated with 2018/19 actual and 2019/20 plan data- these values cannot be amended. The template will also provide expected shares of activity to aid in alignment, based on historic data- this will also be prepopulated but can be amended as needed to ensure plans are fully aligned.

Organisational Efficiencies and Cost Savings: Within this section organisations can provide an overview of any regulatory or other financial support they have in place. There are also sections to describe any governance arrangements in place for any financial recovery programme, and also to give an overview of financial improvement opportunities and efficiency opportunities. Where appropriate, this section should link to the system efficiencies and cost savings tabs.

Organisations in financial deficit may wish to include more detail on support and governance arrangements, as well as more detail on savings opportunities. For organisations in surplus, the focus will likely be on further productivity opportunities, and some questions may not be applicable.

LTP Funding: The LTP funding tab sets out the "fair shares" LTP funding for the system for the delivery of LTP and Five Year Forward commitments, as set out in Annex A of the Implementation Framework. This funding is additional to CCG allocations and is assumed to operate at system level only in the planning process (i.e. this funding is not reflected in any CCG positions).

The LTP funding tab requires the system to set out how this funding will be applied across the given categories and allows this funding to be directed both to NHS providers within the system and to other providers (NHS providers in other systems, NHS Primary Care, and non-NHS providers). There are corresponding income lines on provider tabs to reflect this funding within the system (NB these must reconcile in total to the distributions given in the LTP funding tab).

The system is free to deploy this funding as required to deliver the associated commitments, including changing the distribution of the expenditure from that given, within the following constraints:

(i) Mental health- the funding set out must solely be used to fund mental health services in line with the LTP commitments to grow the share of national funding used for this purpose (see section B23 of the Implementation Framework). This funding is categorised in greater detail to support planning decisions, but this funding distribution within mental health services is not mandatory.

(ii) Cancer funding- Cancer Alliances will work with their constituent STPs / ICS to lead the development of a system wide plan for cancer. It is expected that as part of this process, where relevant, STPs/ ICS will agree their planned proportion of the total 'fair-share' allocation notified to Alliances. This value should be used to overwrite the pre-populated values for 'Cancer' in the planning tool under 'LTP Planning Allocation summary' and form the basis for the associated split of 'LTP Planning expenditure in System' by category of provider. Separately, Alliances will submit a summary by STP/ICS to allow reconciliation.

(iii) Primary medical and community services- the funding for Primary Care and Ageing Well programmes should be allocated in line with the requirements set out in sections B24-B25 of the Implementation Framework. There is a separate schedule detailing the extended access funding by CCG (as included within the Primary Care allocation) to support planning decisions.

Mental Health Investment Standard: The MHIS tab asks all CCGs within the system to outline spending plans against the MHIS over the period to 2023/24. This should be completed in the same way as the 2019/20 operational planning round, but using updated definitions and categories to reflect the LTP. The template should be completed with reference to the MHIS LTP definition guidance together with guidance for completion of CCG finance templates, which details the row by row completion of MHIS tab (available on the CCG SharePoint site).

System Efficiencies and Cost Savings: This section asks systems to outline any financial support or scrutiny they have in place and asks for the governance arrangements around system financial reporting and monitoring. This section also gives systems an opportunity to describe financial improvement activities and efficiency opportunities being pursued at the system level.

3.3.2 Output and summary tabs

Summary tabs There is a summary tab for both CCGs and providers, as well as for the system as a whole. These tabs aggregate the inputs from all the individual organisations and present the system wide CCG view, the system wide provider view, and an overall system surplus/deficit view.

Triangulation tabs Provides an indicative triangulation between the following data points in the model:

- Income against Activity
- Staff expenditure against Workforce
- Patient Care Activity against Workforce
- CCG expenditure versus provider income (alignment)

Output Graphs: The graphs tab shows a bridge between each year in the plan, as well as other graphs showing changes over time in finance, activity, workforce, and capital expenditure.

3.3.3 Other important information

Assumptions: National financial assumptions to aide planning, which should be tailored for local circumstances, have been published in Annex B of the Implementation Framework.

Ambulance Trusts: For the purposes of finance data in the strategic planning tool, ambulance trusts should be split across the various systems they support (they will appear as a provider tab on all relevant systems). This split will be as per the 2019/20 planning process.

For the purposes of activity and workforce data in the strategic planning tool, ambulance trusts data should be included only on the system related to their host commissioner (although there will be a tab for the ambulance provider on all relevant systems the activity data items will be hidden – data will only be able to be entered for the lead STP). Workforce data should only be entered in the tool relating to their host commissioner.

Within the LTP Performance Measure template, where ambulance trust data is required, this should also be allocated to the STP of the host commissioner.

Organisational Mergers: The tool will be customised to include the organisations within each system as for the 2019/20 planning round. This will enable the 2019/20 baseline to be accurately presented within the tool. Where organisations will merge they should use one of the tabs of the legacy organisations and mark clearly as such.

Split providers: Providers, including ambulance services, have been split as per the 2019/20 planning process. For each split organisation (including ambulance providers) we will provide a reconciliation template that should be completed to show the entire

position of the split organisation. This template should be submitted alongside the strategic planning tool.

3.4 Next steps

The strategic planning tool accompanying this guidance represents the final (pre-populated with the organisations within your local system) version. The core content and structure of this tool will not change. However, this version of the tool cannot be submitted. The final, functional version of the template will be released via the Strategic Data Collection Service (SDCS) portal when the submission window opens. The collection portal will only accept the final functional version of the template for submission. Further guidance on the collection portal is available on the NHS Digital website

If you have any questions on the content of the tool, please contact your local NHS England and NHS Improvement contacts in the first instance.

4 Strategic Planning- LTP Collection

Following on from the publication of the Implementation Framework, we have agreed a list of metrics that will be used to evaluate progress against the LTP, to cover the headline areas outlined in Annex C of the Implementation Framework. This list has been agreed with government and will be used regularly to provide updates on progress. The list can be found here: https://www.longtermplan.nhs.uk/headline-metrics/

We are asking systems to provide a planned trajectory over the next 5 years, against a number of these metrics and a limited number of additional measures to provide additional context and assurance through the Strategic Planning- LTP Collection template, to be submitted through SDCS. These measures will develop over the course of the next 5 years as additional measures become available and can be forecast at system level.

For each measure included in this collection Systems are asked to provide annual projections over 5 years. Although each measure will be aggregated to an STP level within the template, for a number of measures more granular data is required (e.g. CCG level data), and systems are asked to provide trajectories for all relevant organisations (as listed in the template). Each organisation has been assigned to only one system – plan data for an organisation (e.g. ambulance trusts) should only be included in the submission for the STP they have been assigned to.

A non-functional template and supporting definitions document will be released to systems in August 2019- the definitions document will also identify the required level of granularity plans should be provided at for each measure. The final functional version of the collection template will then be released alongside the Strategic Planning Tool via SDCS when the collection portal opens. This template should be submitted alongside the Strategic Planning Tool, to the same timescales.

5 Strategy Delivery Plan

The narrative in the strategy delivery plan is an opportunity for each ICS/STP to describe the system's strategy for 2019/20 to 2023/24, forming the basis for continued engagement with local partners and stakeholders throughout the period of the plan. The plan should also show how the system will deliver the finance, activity and workforce components of the supporting technical material, as well as setting out the major milestones and risks to achieving the plan and will therefore be used for reference as part of the plan review process with NHS England and NHS Improvement.

We expect that plans will set out the strategic transformation priorities that the system has agreed with local stakeholders based on an analysis of population health needs, as well as the phasing for delivering LTP commitments. We expect that the strategic system plan will refer to all of the commitments in the Implementation Framework. There will be some LTP commitments and metrics that cannot be included in the supporting technical material, and where this is the case, we expect that the system delivery plan will qualitatively address how this commitment will be delivered locally. The plan should also describe how the system will develop its approach to collaboration (e.g. governance, streamlined commissioning), and the expected timeline and activities required for the system to become an ICS.

There is no set template for the strategy delivery plans. Systems may wish to consider the following topics when developing their strategy delivery plan:

Outline and plan for achieving key transformation priorities	Describe local transformation and major service change priorities. This should include plans for integrated care models and service change at place and neighbourhood levels Overview of approach to delivering LTP foundational commitments (Chapters 2 and 3 of Implementation Framework) Plans for improving prevention and addressing health inequalities Plans to develop both the provider and commissioner landscape e.g. provider collaboration, arrangements to streamline commissioning System approaches to key enablers including workforce, digital and estates Major milestones and plans for monitoring achievement of plans

System development activities	Outline of expected trajectory to become an ICS (see Designing Integrated Care Systems recently published) and key activities to support ICS development Plans to build local partnership coalition and to ensure ongoing engagement including with patients and public System governance and arrangements for collective decision-making
Key assumptions and supporting narrative for finance, activity and workforce plans	Outline of key assumptions underpinning finance, activity and workforce plans Confirmation that system partners have agreed the finance, activity and workforce plans and have a shared commitment to deliver them Key risks to the delivery of the five-year plan and mitigating actions (including service quality, operational performance, transformation, finance) Approach to workforce planning
System financial management	System approach and actions to achieve financial recovery. Plans to embed system financial management, including arrangements to support management of collective financial resources. The following link will take you to the FutureNHS platform for which a login is required: management of collective financial resources Approach to payment reform and description of any planned contractual changes Plans to agree and drive system-wide efficiency programmes, including how system partners will work together to deliver them

ICS/STP systems should work with NHS England and NHS Improvement regional teams to ensure that their strategic plan sufficiently demonstrates how the system will meet all LTP commitments locally.

5.1 Submission of Strategy Delivery Plan

Strategy Delivery Plans should be submitted to the regional mailboxes listed in section 10.

6 Information Governance

Data will obviously need to be shared between organisations to enable the development of safe and sustainable plans and to support financial, activity, workforce and quality planning. Corresponding information governance guidance on data sharing is included in the strategic planning tool and strategic planning- LTP collection template for system plans. Details on the questions that need to be asked in respect of system plan data sharing are contained in Annex 2 and should be considered alongside relevant legislation. Further support and information on information governance can be provided by: england.ig-corporate@nhs.net

7 Timetable

Milestone	Date
Interim People Plan published	3 June 2019
Publication of the Implementation Framework	27 June 2019
Main technical and supporting guidance issued	July 2019
Initial system planning submission	By 27 September 2019
System plans agreed with system leaders and regional teams are submitted	By 15 November 2019
Further operational and technical guidance issued	December 2019
Publication of the national implementation programme for the LTP	December 2019
First submission of draft operational plans	Early February 2020
Final submission of operational plans	By end March 2020

8 Support

To support systems with planning a series of webinars led by national policy and clinical leads has been held. These were an opportunity for relevant leads within local systems to ask practical and operational questions and seek clarity on specific elements of the framework. The webinars have been recorded, and a link to them can be requested via england.ltp@nhs.net.

The Implementation Framework system support offer signposts the national and regional support systems can draw on to develop their five-year strategic plans:

https://www.longtermplan.nhs.uk/publication/implementation-framework-support-offer/

A summary of the additional support and assurance tools for the strategic planning process is set out below:

Type of support	Support and assurance tools
Awareness and training	• Key documents published on the NHS England and NHS Improvement websites • LTP cascade events including WebEx sessions for system planning leads during July 2019
Guidance	• Guidance and technical documents as outlined in 'Technical support for the LTP submission process'
Tools	• 'Built-in' assurance as part of the strategic planning tool and key LTP metrics • Tableau tools for analysis of activity, workforce and finance submissions
Planning and assurance support	• Support from regional teams and Commissioning Support Units • National summaries of plans for activity, workforce and finance, and trajectories for LTP metrics to support regional assurance
Improvement support	• Support from each national policy team • Transformation support from NHS England and NHS Improvement • Specific improvement tools e.g. UEC demand tool; an RTT planning tool; outpatient transformation

Arrangements are being made for Commissioning Support Units to provide targeted support for strategic planning in line with the priorities identified by NHS England and NHS Improvement regional teams.

9 Assurance

NHS England and NHS Improvement regional teams will undertake both support and assurance roles with the aim of ensuring high quality plans that deliver the commitments in the LTP.

Regional and national teams will work together to support systems to develop their plans throughout the summer and autumn of 2019, in line with the Implementation Framework.

In addition to working alongside systems during the preparation of strategic plans, regional teams will lead the assurance of system plans during October 2019. The regional teams will work with the system leaders to review the draft strategic plans shortly after submission and provide feedback to inform the final plans. Where ICS systems have agreed oversight arrangements with NHS England and NHS Improvement, the regional team will work with the system leadership to review the five-year system strategic plan in accordance with the principles agreed in these oversight arrangements.

The LTP commitments and planning assumptions set out the expectations for strategic plans. The assurance process will, therefore, include a comparison of the plans and trajectories against the national planning assumptions and LTP commitments.

The assurance process will ask a number of key questions to establish whether submissions:

- Define how all the commitments in the LTP will be met, with a particular focus on the delivery of foundational commitments **(**see chapters 2 and 3 of the

Implementation Framework) and showing key underpinning assumptions (e.g. levels of activity)?

- Reflect realistic assumptions for workforce planning based on the interim NHS People Plan, including the steps to improve recruitment and retention?
- Are financially balanced based on the assumptions and financial allocations in the Implementation Framework and with appropriate 'stretch' to take up the efficiency and productivity opportunities?
- Demonstrate that the implications for individual organisations are coherent for the system as a whole?
- Reflect system-wide working**,** delivering for patients across the whole system of care with strong engagement and agreement from all of the system partners?

Systems are expected to ensure that their plans align with the principles set out in the Implementation Framework.

10 Key planning advice contacts

Systems should initially contact their region for advice on planning, with technical queries specifically about submissions being addressed to the SDCS mailbox data.collections@nhs.net and wider technical queries to the strategic planning mailbox england.nhs-planning@nhs.net

Location	**NHS England and NHS Improvement**
North West	england.nhs-northplanning@nhs.net
North East and Yorkshire	england.nhs-northplanning@nhs.net
Midlands	england.midlandsplanning@nhs.net
East of England	england.eoest@nhs.net
London	england.london-co-planning@nhs.net
South East	england.planning-south@nhs.net
South West	england.southwestplanning@nhs.net

Annex 1 Part A: Technical definitions for activity measures in the strategic planning tool

The technical definitions described for activity measures follow the same principles and definitions as the 2019/20 operational planning round. For more information, please refer to

https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/

1.1 Referrals

Referrals made for a First Outpatient Appointment (General & Acute)

DEFINITIONS

Detailed descriptor: The sum of the total number of written referrals from General Practitioners and "other" referrals, for first consultant outpatient appointment, in general and acute specialties.

Lines Within Indicator (Units):

GP: The total number of written referrals made from GPs, for first consultant outpatient appointment, in general and acute specialties.

Other: The total number of other (non-GP) referrals requests made for first consultant outpatient appointment in general and acute specialties. See below for exclusions.

Total: The total number of GPs and other (non-GP) referrals requests made for first consultant outpatient appointment in general and acute specialties (GP + Other).

Data definition: The sum of the total number of written referrals made from GPs and the total number of other (non GP) referrals made, for first consultant outpatient appointment, in general and acute specialties.

For GP referrals:

It is the total number of general and acute GP written referrals where:

11 Referral Request Type = National Code 01 'GP referral request'.
12 Written Referral Request Indicator = classification 'Yes'.

All written GP referral requests to a Consultant whether directed to a specific consultant or not, should be recorded, regardless of whether they result in an outpatient attendance.

An electronic message should be counted as written, as should a verbal request which is subsequently confirmed by a written request.

The referral request received date of the GP referral request should be used to identify referrals to be included in the return.

For other referrals:

It is the total number of general and acute other referrals requests excluding:

a. GP written referrals; these are where the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 01 'GP referral request' and the WRITTEN REFERRAL REQUEST INDICATOR of the REFERRAL REQUEST is classification 'Yes'

b. Self-referrals; these are where the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 04 'Patient self-referral request'

c. Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode referrals; these are where the SOURCE OF REFERRAL FOR OUT-PATIENTS of the REFERRAL REQUEST is National Code 01 'following an emergency admission' or 02 'following a domiciliary visit' or 10 'following an Accident And Emergency Attendance' or 11 'other'

d. Referrals initiated by attendance at drop-in clinic without prior appointment; these are where the OUT-PATIENT CLINIC REFERRING INDICATOR of the REFERRAL REQUEST is classification 'Attended referring Out-Patient Clinic without prior appointment'

For general and acute main specialties:

- **include: 100-192, 300-460, 502, 504, 800-834, 900 and 901**
- **exclude: 501, 700-715**

MONITORING

Monitoring Frequency: Monthly.

Monitoring Data Source: Monthly Activity Return (MAR) - Both providers and commissioners should ensure that their referrals information submitted through the Monthly Activity Return (MAR) is of good quality. Commissioners are required to check and sign-off their MAR data on SDCS each month.

1.2 Activity

Consultant Led Outpatient Attendances

DEFINITIONS

Detailed descriptor: All Specific Acute consultant-led first outpatient attendances.

Lines within indicator (Units)

- Consultant-led first outpatient attendances
- Consultant-led follow-up outpatient attendances
- Total consultant-led outpatient attendances (A + B)

Data definition: A count of all outpatient attendances taking place within the period, whether taking place within a consultant clinic session or outside a session.

The patient must have been seen by a consultant, or a clinician acting for the consultant, for examination or treatment.

Specifically, the number of consultant outpatient attendances for which:

- Der_(Derived SUS Fields) Attendance_Type = ‘Attend’
- StaffType = ‘Cons’ i.e. main speciality is not ‘560’, ‘950’ or ‘960’
- Treatment function maps to Specific Acute

For first outpatient attendances:

- Der_Appointment_Type = ‘New’

For follow up outpatient attendances:

- Der_Appointment_Type = ‘FUp’

This includes outpatient attendance for all consultant outpatient episodes for all sources of referral.

Activity delivered in a primary care setting should also be included.

MONITORING

Monitoring frequency: Monthly.

Monitoring Data Source: Secondary Uses Service NCDR (SEM) - SUS NCDRNCDR is derived from SUS (SEM) and not the SUS PbR Mart.

CCGs: Commissioners should plan by using the new identification rules (IR) to identify CCG-commissioned activity – https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-psp-planning-tool-2019-20

1.2.1 Total Elective Spells

DEFINITIONS

Detailed Descriptor: Number of Specific Acute elective spells.

Lines within indicator (Units)

Elective Spells – Day cases: Total number of Specific Acute elective day case spells in the period.

Elective Spells – Ordinary spells: Total number of Specific Acute elective ordinary spells in the period.

Total elective spells: Total number of Specific Acute elective spells in the period (Day cases + Ordinary spells)

Data definition: An Elective Admission is one that has been arranged in advance. It is not an emergency admission, a maternity admission or a transfer from a hospital bed in another health care provider. The period the patient has to wait for admission depends on the demand on hospital resources and the facilities available to meet this demand.

Elective Spells – Day cases: A day case admission must be an elective admission, for which a 'Decision To Admit' has been made by someone with the 'Right Of Admission'. Any patient admitted electively during the course of a day with the intention of receiving care, who does not require the use of a hospital bed overnight and who returns home as scheduled, should be counted as a day case. If this original intention is not fulfilled and the patient stays overnight, such a patient should be counted as an ordinary admission. Where clinical care is provided as a series of day case activities (for example chemotherapy or radiotherapy) this should be recorded as regular day / night activity (and therefore not be included in the day case count).

Elective Spells – Ordinary spells: Any patient admitted electively with the expectation that they will remain in hospital for at least one night, including a patient admitted with this intention who leaves hospital for any reason without staying overnight, should be counted as an ordinary admission. A patient admitted electively with the intent of not staying overnight, but who does not return home as scheduled, should also be counted as an ordinary admission.

It is the number of day case and ordinary (as defined above) elective spells relating to hospital provider spells for which:

- Der_Management_Type is either ‘DC’ or ‘EL’
- Treatment function on the date of discharge maps to Specific Acute

Where ‘DC’ = Day Case and ‘EL’ = Ordinary Elective

MONITORING

Monitoring frequency: Monthly.

Monitoring data source: Secondary Uses Service NCDR (SEM) - SUS NCDR is derived from SUS (SEM) and not the SUS PbR Mart.

CCGs: Commissioners should plan by using the new identification rules (IR) to identify CCG-commissioned activity – https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-psp-planning-tool-2019-20

1.2.2 Total Non-Elective Spells

DEFINITIONS

Detailed descriptor: Total number of Specific Acute non-elective spells.

Lines within indicator (Units)

Zero length of stay spells: Number of Specific Acute non-elective spells in the period with a length of stay of zero.

1+ day length of stay spells: Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more.

Total non-elective spells: Number of Specific Acute non-elective spells in the period (Zero LoS spells + 1+ LoS spells).

Data definition: A Non-Elective Admission is one that has not been arranged in advance. Specific Acute Non-Elective Admissions may be an emergency admission or a transfer from a Hospital Bed in another Health Care Provider other than in an emergency.

It is the number of hospital provider spells for which:

- Der_Management_Type is 'EM' or 'NE'
- Treatment function maps to Specific Acute

Where 'EM' = Emergency and 'NE' = Non-Elective

Zero length of stay spells: spells where the date of admission is the same as the discharge date (i.e. the episode does not span midnight).

1+ day length of stay spells: spells where the date of admission is **not** the same as the discharge date.

MONITORING

Monitoring frequency: Monthly.

Monitoring Data Source: Secondary Uses Service NCDR (SEM) - SUS NCDR is derived from SUS (SEM) and not the SUS PbR Mart.

CCGs: Commissioners should plan by using the new identification rules (IR) to identify CCG-commissioned activity – https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-psp-planning-tool-2019-20

1.2.3 A&E attendances

DEFINITIONS

Detailed descriptor: Number of attendances at A&E departments, excluding planned follow-up attendances.

Lines within indicator (Units)

A&E Attendances – Type 1 & 2 attendances: Total number of attendances at all Type 1 and Type 2 A&E departments, excluding planned follow-up attendances.

A&E Attendances – Other attendances: Total number of attendances at all A&E departments other than Type 1 and Type 2, excluding planned follow-up attendances.

A&E attendances: Total number of attendances at all A&E departments, excluding planned follow-up attendances (Types 1&2 + Other).

Data Definition:

Total A&E attendances are taken directly from SUS with the additional restriction of:

A AND E ATTENDANCE CATEGORY <> 2 (Planned follow up attendance)

For type 1 and type 2:

ACCIDENT AND EMERGENCY DEPARTMENT TYPE in ('01', '02')

For Other:

ACCIDENT AND EMERGENCY DEPARTMENT TYPE not in ('01', '02')

Total A&E attendances are taken directly from SUS, with no further restrictions other than the above.

MONITORING

Monitoring Frequency: Monthly.

Monitoring Data Source: Secondary Uses Service NCDR (SEM) - SUS NCDR is derived from SUS (SEM) and not the SUS PbR Mart.

CCGs: Commissioners should plan by using the new identification rules (IR) to identify CCG-commissioned activity – https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-psp-planning-tool-2019-20

1.2.4 Ambulance – total count of incidents (Ambulance providers only)

DEFINITIONS

Detailed descriptor: Incidents comprise not only calls that receive a face-to-face response from the ambulance service at the scene of the incident, but also calls that are successfully resolved with telephone advice with any appropriate action agreed with the patient.

Lines within indicator (Units)

Total count of incidents: All incidents (A7) The count of all incidents. This includes C1-C4 plus incidents referred from HCPs and incidents that do not result in face to face contact. This maps to reference code A7 within NHS England's ambulance quality indicator guidance.

Data definition: There are no additional filters on this indicator. Ambulance trusts should include all activity within their host STP.

MONITORING

Monitoring frequency: Monthly.

Monitoring data source: NHS England ambulance quality indicators. Further information on data available to support this metric can be found on the ambulance quality indicators landing page.

1.3 Primary Care Activity

Appointments in General Practice

DEFINITIONS

Detailed descriptor: Estimated number of General practice appointments.

Lines within indicator (Units)

Estimated Total number of appointments

Data Definition:

Each appointment in the dataset has an “appointment status”. Many of the appointments with status of “available” are thought to be spurious and represent time reserved for breaks, training, admin etc. It is not currently possible to distinguish this time from potentially patient facing slots that go unused. For this reason, only appointments with a status of “Booked, Attended or Did Not Attend” are included in this total. Cancelled appointments are typically reallocated to other patients and so are not included in the total to avoid double counting. The total represents the number of appointments that took place rather than those that were offered.

Currently not all GP Practices are included in the GP appointments data. An estimate of the total number of appointments is calculated by dividing the reported number of appointments by the proportion of the GP registered population that are registered in included practices.

MONITORING

Monitoring Frequency: Monthly

Monitoring Data Source: Appointments in General Practice collection published by NHS Digital. The data can be found here along with the data quality note.

1.4 SUS Methodology

APC and OP activity is restricted to specific acute.

Specific acute replaces what was previously known as general and acute (G&A). The spell treatment function code (TFC) and main specialty (MS) are as at discharge.

Firstly, APC and OP activity is grouped by TFC into the categories:

- TFC Specific Acute (previously G&A)
- TFC Maternity – TFC 501 + 560
- TFC Mental Health & Learning Disabilities – TFC 700 to 727
- TFC Well Babies – TFC 424 only
- TFC Other – largely therapies
- TFC Unknown – data quality inadequate to categorise

The full breakdown of TFCs into the categories is given in the table below.

Additionally, a subset of TFCs classified as other have been excluded for the following reasons:

- They tend to be therapies undertaken in a hospital setting
- A large proportion of the activity is considered to be non-consultant
- They represent a small proportion of the overall total

It was also agreed that outpatient activity should be further restricted to consultant led by applying a filter based on main specialty:

- Non-consultant – MS 560 Midwife episode
- Non-consultant – MS 950 Nursing episode
- Non-consultant – MS 960 Allied Health Professional episode
  Consultant – All other MS including not known

A number of additional derivations applied to SUS data are used throughout this annex. For the following derivations, information can be found on the corresponding links.

Der_Attendance_Type:

https://data.england.nhs.uk/ncdr/database/NHSE_SUSPlus_Reporting/column/96193/

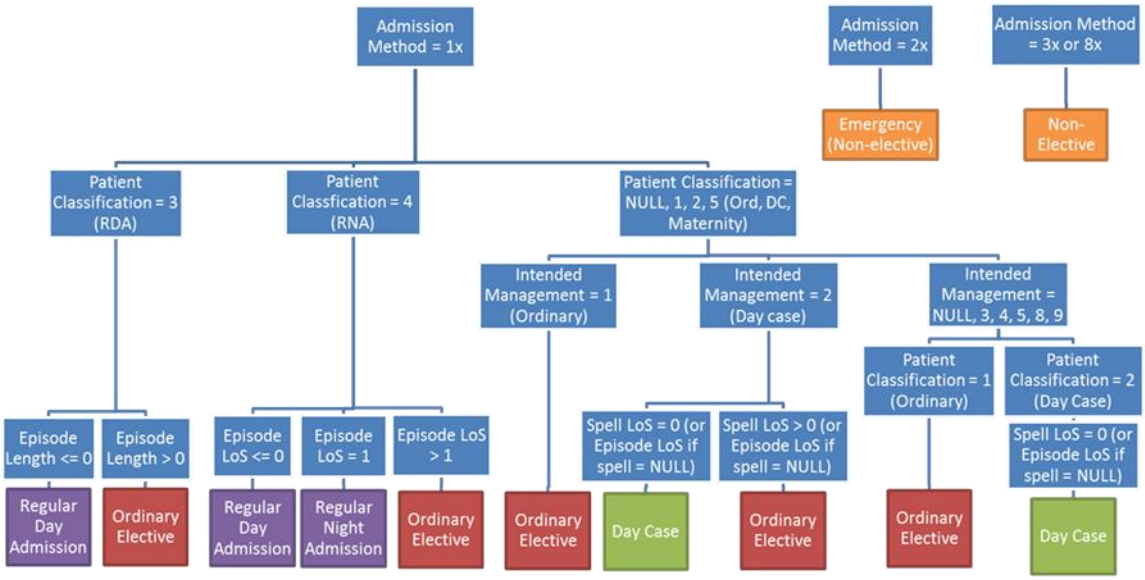
Staff Type

https://data.england.nhs.uk/ncdr/database/NHSE_SUSPlus_Reporting/column/111416/

Der_Appointment_Type

https://data.england.nhs.uk/ncdr/database/NHSE_SUSPlus_Reporting/column/96072/

For the Der_Management_Type derived field, the following logic is used to identify the appropriate activity type based on the Admission Method, Patient Classification; Intended Management and Length of Stay (i.e. difference between Admission Date and Discharge Date) fields:



Code	Description	Grouping
100	General Surgery	Acute
101	Urology	Acute
102	Transplantation Surgery	Acute
103	Breast Surgery	Acute
104	Colorectal Surgery	Acute
105	Hepatobiliary & Pancreatic Surgery	Acute
106	Upper Gastrointestinal Surgery	Acute
107	Vascular Surgery	Acute
108	Spinal Surgery Service	Acute
110	Trauma & Orthopaedics	Acute
120	ENT	Acute
130	Ophthalmology	Acute
140	Oral Surgery	Acute
141	Restorative Dentistry	Acute
142	Paediatric Dentistry	Acute
143	Orthodontics	Acute
144	Maxillo-Facial Surgery	Acute
150	Neurosurgery	Acute
160	Plastic Surgery	Acute
161	Burns Care	Acute
170	Cardiothoracic Surgery	Acute
171	Paediatric Surgery	Acute
172	Cardiac Surgery	Acute
173	Thoracic Surgery	Acute
174	Cardiothoracic Transplantation	Acute
180	Accident & Emergency	Acute
190	Anaesthetics	Acute
191	Pain Management	Acute
192	Critical Care Medicine	Acute
199	Non-UK provider; Treatment Function not known, treatment mainly surgical	Other
211	Paediatric Urology	Acute
212	Paediatric Transplantation Surgery	Acute
213	Paediatric Gastrointestinal Surgery	Acute
214	Paediatric Trauma and Orthopaedics	Acute
215	Paediatric Ear Nose and Throat	Acute
216	Paediatric Ophthalmology	Acute
217	Paediatric Maxillo-Facial Surgery	Acute
218	Paediatric Neurosurgery	Acute
219	Paediatric Plastic Surgery	Acute
220	Paediatric Burns Care	Acute
221	Paediatric Cardiac Surgery	Acute
222	Paediatric Thoracic Surgery	Acute
223	Paediatric Epilepsy	Other
241	Paediatric Pain Management	Acute
242	Paediatric Intensive Care	Acute
251	Paediatric Gastroenterology	Acute

252	Paediatric Endocrinology	Acute
253	Paediatric Clinical Haematology	Acute
254	Paediatric Audiological Medicine	Acute
255	Paediatric Clinical Immunology and Allergy	Acute
256	Paediatric Infectious Diseases	Acute
257	Paediatric Dermatology	Acute
258	Paediatric Respiratory Medicine	Acute
259	Paediatric Nephrology	Acute
260	Paediatric Medical Oncology	Acute
261	Paediatric Metabolic Disease	Acute
262	Paediatric Rheumatology	Acute
263	Paediatric Diabetic Medicine	Acute
264	Paediatric Cystic Fibrosis	Acute
280	Paediatric Interventional Radiology	Acute
290	Community Paediatrics	Other
291	Paediatric Neuro-Disability	Other
300	General Medicine	Acute
301	Gastroenterology	Acute
302	Endocrinology	Acute
303	Clinical Haematology	Acute
304	Clinical Physiology	Acute
305	Clinical Pharmacology	Acute
306	Hepatology	Acute
307	Diabetic Medicine	Acute
308	Blood and Marrow Transplantation	Acute
309	Haemophilia	Acute
310	Audiological Medicine	Acute
311	Clinical Genetics	Acute
313	Clinical Immunology and Allergy	Acute
314	Rehabilitation	Acute
315	Palliative Medicine	Acute
316	Clinical Immunology	Acute
317	Allergy	Acute
318	Intermediate Care	Acute
319	Respite Care	Acute
320	Cardiology	Acute
321	Paediatric Cardiology	Acute
322	Clinical Microbiology	Acute
323	Spinal Injuries	Acute
324	Anticoagulant Service	Acute
325	Sport and Exercise Medicine	Acute
327	Cardiac Rehabilitation	Acute
328	Stroke Medicine	Acute
329	Transient Ischaemic Attack	Acute
330	Dermatology	Acute
331	Congenital Heart Disease Service	Other
340	Thoracic Medicine	Acute

341	Respiratory Physiology	Acute
342	Programmed Pulmonary Rehabilitation	Acute
343	Adult Cystic Fibrosis	Acute
344	Complex Specialised Rehabilitation Service	Other
345	Specialist Rehabilitation Service	Other
346	Local Specialist Rehabilitation Service	Other
350	Infectious Diseases	Acute
352	Tropical Medicine	Acute
360	Genitourinary Medicine	Other
361	Nephrology	Acute
370	Medical Oncology	Acute
371	Nuclear Medicine	Acute
400	Neurology	Acute
401	Clinical Neurophysiology	Acute
410	Rheumatology	Acute
420	Paediatrics	Acute
421	Paediatric Neurology	Acute
422	Neonatology	Acute
424	Well Babies	Well Babies
430	Geriatric Medicine	Acute
450	Dental Medicine Specialties	Acute
460	Medical Ophthalmology	Acute
499	Non-UK provider; Treatment Function not known, treatment mainly medical	Other
501	Obstetrics	Maternity
502	Gynaecology	Acute
503	Gynaecological Oncology	Acute
560	Midwife Episode	Maternity
650	Physiotherapy	Other
651	Occupational Therapy	Other
652	Speech and Language Therapy	Other
653	Podiatry	Other
654	Dietetics	Other
655	Orthoptics	Other
656	Clinical Psychology	Other
657	Prosthetics	Other
658	Orthotics	Other
659	Drama Therapy	Other
660	Art Therapy	Other
661	Music Therapy	Other
662	Optometry	Other
663	Podiatric Surgery	Acute
700	Learning Disability	MH and LD
710	Adult Mental Illness	MH and LD
711	Child and Adolescent Psychiatry	MH and LD
712	Forensic Psychiatry	MH and LD
713	Psychotherapy	MH and LD
715	Old Age Psychiatry	MH and LD

720	Eating Disorders	MH and LD
721	Addiction Services	MH and LD
722	Liaison Psychiatry	MH and LD
723	Psychiatric Intensive Care	MH and LD
724	Perinatal Psychiatry	MH and LD
725	Mental Health Recovery and Rehabilitation Service	MH and LD
726	Mental Health Dual Diagnosis Service	MH and LD
727	Dementia Assessment Service	MH and LD
800	Clinical Oncology (Previously Radiotherapy)	Acute
811	Interventional Radiology	Acute
812	Diagnostic Imaging	Acute
822	Chemical Pathology	Acute
834	Medical Virology	Acute
840	Audiology	Other
920	Diabetic Education Service	Other

Annex 2 Information Governance

In engaging with constituent organisations, the ICS/STP need to consider the following when receiving, storing and sharing data and when establishing any data sharing agreements.

What data is and is not being collected:

Patient-level data (including NHS number) is **not** required for this data collection exercise. What is being requested is as set out in the national planning and technical guidance documents, which includes finance, activity, performance and planning data. Any fields that would potentially allow an identification of a patient or staff member MUST be excluded

Why is the data is being collected, and what it's being used for:

Both STPs and ICS will need to work with their constituent organisations, NHS England and NHS Improvement staff, in partnership Health Education England, to collate and undertake analysis of the plan submissions to assess, align and assure plans. It should be acknowledged that part of the analysis may involve triangulating submitted data with other data or information held by the ICS/STP, NHS England and NHS Improvement or Health Education England (HEE) to provide more in depth understanding of planning positions across commissioner/provider or ICS/STP level.

Who is going to share or have access to the data: Sharing the data with other partner organisations and arm's length bodies (ALBs):

If data will be shared with other partner organisations and arm's length bodies (ALBs) to facilitate the ICS/STP system plans and joint working arrangements and to provide support where needed this needs to be advised to any relevant organisations providing data. Sharing with a third party should always be done securely and in accordance with the guidance. The organisations that data will be shared with should be listed and information provided on how the data sharing will support the ICS/STP and NHS England and NHS Improvement and HEE as part of a jointly agreed collection to enable all to fulfil their statutory functions in support of the system as follows. Some but not all of the statutory functions that this requirement may fall under are set out below; this is not an exhaustive list and will be dependent on how the ICS/STP is constituted:

- at system, national and regional level to understand and comment on plans individually and in aggregate;
- some aggregate analysis will also be deployed in the development of workforce and service level programmes;
- to inform broader strategic planning requirements;
- at ICS/STP level the data will be deployed locally in joint endeavours which will be determined by local factors and relationships. It is understood that individual organisational level data is not to be shared with any other organisations unless the organisations that comprise an individual ICS/STP agree to this.

Any organisations whose data may be shared should be advised so they can provide consent.

Where will the data be stored, for how long and what is their destruction policy (how will they delete it when it's no longer needed)?

Data is collected and processed via our secure collection platform the strategic data collection service (SDCS) and transferred using the NHS digital accredited secure file transfer system (SEFT). Once received the data is stored and processed within secure servers based in the UK via our internal secure network.

Data made available to other partner organisations or ALBs will be required to be held securely by them in line with the security and confidentiality requirements including those set out in any data sharing agreements.

All data will be regularly backed up and will be securely held for a minimum of 6 years, at which point they will be reviewed to see if they need to be retained for a longer period or deleted if no longer required.

This data will be shared with other partner organisations and arm's length bodies (ALBs) to facilitate joint working arrangements and support individual providers (where necessary). Sharing with a third party will always be done securely and in accordance with the guidance set out in this document.

Sharing of historical planning round data already collected

Advice should be given to organisations if it necessary to also share historic data already collected for planning and information must be provided on who this will be shared with and for what purpose/reason.