Preparing for 2019/20 Operational Planning and Contracting

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1 Introduction

The Government announced a five-year funding settlement for the NHS in June 2018. The new settlement provides for an additional £20.5 billion a year in real terms by 2023/24. In response, the NHS has developed a Long Term Plan, which will be published early in the new year. 2019/20 will be the foundation year which will see significant changes proposed to the architecture of the NHS, laying the groundwork for implementation of the Long Term Plan.

To secure the best outcomes for patients and the public from this investment, we will be setting out a bold set of service redesigns to reduce pressure across the NHS and improve care access and quality. We are also conducting a clinically-led review of standards, developing a new financial architecture and introducing a more effective approach to workforce and physical capacity.

The long-term financial settlement will help put the NHS on a sustainable financial footing, moving away from a system in which deficits have become widespread, with the prospect of delivering financial balance for many organisations seemingly unachievable. Instead, the new financial framework will give local organisations and systems the space and support to shape their operational and financial plans to their circumstances, whilst reducing deficits year-by-year. We want to move away as swiftly as possible from individual organisational control totals, to support system working, reward success, and reduce uncertainty.

For 2019/20, every NHS trust, NHS foundation trust and clinical commissioning group (CCG), will need to agree organisation-level operational plans which combine to form a coherent system-level operating plan. This will provide the start point for every Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) to develop five-year Long Term Plan implementation plans now, covering the period to 2023/24.

This is the first part of planning guidance. The full guidance will accompany five-year indicative CCG allocations in early January and will set out the trust financial regime for 2019/20, alongside the service deliverables including those arising from year one of the Long Term Plan, which will also be published in January.

2 System planning

This guidance describes a single operational planning process for commissioners and providers, with clear accountabilities and roles at national, regional, system and organisational level.

2.1 System leadership and system working

All STPs/ICSs will produce a system operating plan for 2019/20 comprising a system overview and system data aggregation. STPs/ICSs should convene local leaders to agree collective priorities and parameters for organisational planning. We expect systems to agree realistic shared capacity and activity assumptions from the outset to provide a single, system-wide framework for the organisational activity plans. These should be based on local trends derived from recent activity within a system. Ambition to contain growth should be collectively agreed and must be realistic. These plans need to be demonstrably aligned across providers and commissioners. Partners should adopt an 'open book' approach, sharing assumptions and plans with each other.

The organisations within each STP/ICS will be expected to take collective responsibility for the delivery of their system operating plan, working together to ensure best use of their collective resources.

The system operating plan will have two elements:

1. an overview setting out how the system will use its financial resources to meet the needs of its population and what the system will deliver in 2019/20, which should include specialised and direct commissioning as well as CCG and provider plans. The plan should make clear the underlying activity assumptions, capacity, efficiency and workforce plans, transformation objectives (including clinical and provider strategy), risks to delivery and mitigations; and

2. a system data aggregation (activity, workforce, finance, contracting), demonstrating how all individual organisational plans align to the system plan. Activity volumes in CCG plans must be matched to the volumes in their STP/ICS provider plans and vice versa. Activity volumes for CCGs with significant out of area flows will also need to be aligned.

We will set out the key features of a high quality system operating plan overview in the supporting technical guidance. We will provide an aggregation tool to support the system data submission, and further details of the options for the aggregated data submission will be described in the technical guidance.

Our joint regional teams will have a key role in ensuring local accountability and will work in partnership with system leaders to jointly review draft and final system operating plan overviews and aggregate submissions, including the alignment of

provider and commissioner plans and realistic phasing of non-elective and elective activity across the year. These should ensure that as much of the annual elective activity – particularly inpatient elective activity – occurs in the first half of the year, before winter. They should also contain effective winter plans, profiling additional winter activity, and the necessary capacity. NHSI/E Regional Directors will assure plans against delivery priorities with the support of the National Director for Emergency and Elective Care.

2.1.1 January checkpoint

Our joint regional teams will work with leaders from all organisations to facilitate the January checkpoint process, taking a collaborative approach that prioritises system-wide alignment and encourages providers and commissioners to work together to solve system challenges.

Prior to the provider and commissioner submissions on 14 January 2019, STPs/ICSs should convene local provider and commissioner leaders to collectively agree planning assumptions on demand and capacity, from which the system can agree how the available resources in 2019/20 will be used to meet the needs of the local population.

2.1.2 System control totals

We will set a system control total for each STP/ICS which will be the sum of individual organisation control totals. All STPs/ICSs will have the opportunity to propose net-neutral changes, agreed by all parties, to organisation control totals ahead of the draft and final planning submissions. These proposals will be subject to approval by Regional Directors. This flexibility is intended to support service improvement and collective financial management; we will not accept proposals designed to exploit technicalities in the flexibility offered. Systems that intend to propose any control total changes should engage with their regional team at an early stage, as these will need to be finalised in line with the timetable.

ICSs will be expected to link a proportion of their Provider Sustainability Fund (PSF) and any applicable Commissioner Sustainability Fund (CSF) to delivery of their system control total. The full financial framework for ICSs will be communicated separately. STPs will also be allowed to do this if all parties agree to manage their finances in this way. This will be an important marker of system maturity and readiness to develop as an ICS.

2.1.3 Inclusion of providers and commissioners in a system control total

All NHS providers and CCGs must be included in a system operating plan and system control total. We expect all CCGs and most providers to be included in only one system. Ambulance trusts should be included in the system with their host commissioner. Where a significant proportion of a provider's clinical income flows from organisations within another STP/ICS it may be included pro-rata in more than one system if agreed by the provider, the relevant STP/ICS leaders and the relevant

Regional Director. Providers and commissioners can still be a partner in an STP/ICS, even if they are not included in the system control total, and are encouraged to do so by agreement where this is appropriate. The organisations to be included in each system must be finalised before final system operating plans are submitted.

Whilst we are not yet in a position to reflect specialised commissioning funding flows in system control totals or system aggregate financial plans, we will still expect system operating plans to include agreed local specialised service priorities.

2.1.4 System efficiency

STPs/ICSs are increasingly finding efficiency opportunities that can only be delivered through their combined efforts. These include providers working together to improve productivity and clinical effectiveness, CCGs commissioning at-scale and sharing corporate services, and providers and commissioners working together to design more effective models of care. STPs/ICSs should focus on the cost-effectiveness of the whole system, not cost-shifting between organisations.

2.2 Brexit

The Department for Health and Social Care (DHSC) is issuing further operational guidance to assist NHS organisations with their business continuity planning for a no-deal EU Exit scenario. NHS organisations should follow the instructions contained in this document, and further guidance will be issued to support operational readiness for EU Exit as the situation develops.

3 Financial settlement

3.1 Financial architecture

The Autumn Budget 2018 confirmed additional funding for the NHS of £20.5 billion more a year in real terms by 2023/24. NHS England will receive rebates to help offset drugs spending growth funded by the Branded Health Service Medicines (Costs) 2018 Regulations deal agreed with the pharmaceutical industry.

The 2018/19 Agenda for Change pay deal funding will form part of NHS England's budget for 2019/20. This is a change in source of the £800m funding which is being paid directly to providers by DHSC in 2018/19 and will form part of the tariff uplift for providers in 2019/20.

3.2 Payment reform and national tariff

In October we published *'Payment system reform proposals for 2019/20'*[1] setting out proposed reforms to the payment system for 2019/20.

Subject to consultation, the uplift in the national tariff will be set at 3.8% for 2019/20. The cost uplifts include the costs of Agenda for Change pay awards that were paid directly to relevant providers in 2018/19. Clinical Negligence Scheme for Trusts contributions for 2019/20 have been updated for the relevant national and local prices. The 3.8% cost uplift excludes the transfer into national prices of a proportion of the PSF and the transfer into national and local prices of 1.25% from CQUIN and the pensions impact. The tariff efficiency factor for 2019/20 will be 1.1%. National and local prices will be reduced to cover the costs of the new centralised procurement arrangements. The transfer from the PSF and CQUIN will reduce the tariff scaling factor.

We intend to set a new default approach for payment of CCG commissioned emergency care activity. This will apply where the expected annual value of a CCG's emergency activity with a provider is above £10m, aimed principally at those systems that are still following a Payment by Results reimbursement model. The 'blended payment' model will cover non-elective admissions, A&E attendances and ambulatory/same day emergency care, and comprise two elements:

- a fixed element based on locally agreed planned activity levels; and
- a variable element, set at 20% of tariff prices.

A 'break glass' clause will apply if actual activity is significantly different from the planned level. Should this level be reached, providers and commissioners will need to agree how to revise the fixed payment.

[1] https://improvement.nhs.uk/resources/201920-payment-reform-proposals/

The marginal rate emergency tariff (MRET) and the 30-day readmission rule will be abolished as national rules for 2019/20, on a financially neutral basis between providers and commissioners.

We intend to implement an updated Market Forces Factor (MFF) for 2019/20. The MFF has not been updated for almost 10 years and is currently based on Primary Care Trust (PCT) boundaries, and out-of-date underlying data. The updated MFF would mean a significant change in income for some providers, so we are planning to implement the changes over five years. We will reflect the revenue impact in provider control totals for 2019/20. Commissioner target allocations will also be updated for the updated MFF values (phased over five years), with actual allocations subject to pace of change rules.

The sector largely sets local prices based on the local cost of services, already taking account of unavoidable cost differences, therefore we would not expect the full impact of changes to the MFF to immediately or automatically affect local prices.

We propose to make the maternity pathway tariffs non-mandatory, but we still expect these prices to be used for contracting in 2019/20.

Further details of the changes outlined above can be found in the technical guidance.

3.3 Financial framework for CCGs

Allocations for 2019/20 are being set to fund a stretching but reasonable level of activity, the impact of the 2018/19 pay awards and the changes to national tariff. Allocations will also ensure CCGs are able to meet commitments to the mental health investment standard, and the Prime Minister's commitment that funding for primary medical and community health services should grow faster than the overall NHS revenue funding settlement.

We are making a number of improvements to the formulae which determine target allocations. This includes changes to the way population data is used, new need-indices for community, and mental health and learning disability services, and changes to our approach to health inequalities, making the formula more responsive to extremes of health inequalities and un-met need, and increasing the fair share of resources targeted at those areas.

The Commissioner Sustainability Fund (CSF) was established in 2018/19 to support those CCGs that would otherwise be unable to live within their means to achieve in-year financial balance. The changes to the financial framework including to CCG allocations mean that in future we expect that all CCGs will be able to balance their financial position each year without additional support, and therefore the CSF will be phased out. We are taking the first step towards this in 2019/20 by reducing the CSF from £400m to £300m.

CCGs will be expected to plan against financial control totals communicated during the planning process. CCGs collectively will be expected to deliver a breakeven position after the deployment of the CSF, and control totals will be set on this basis. Therefore, it is essential that CCGs plan for and deliver their control totals for 2019/20 to contribute to delivering financial balance across the NHS.

Any CCG that is overspending in 2018/19 will be expected to improve its in-year financial performance; those with longer standing and/or larger cumulative deficits will be set a more accelerated recovery trajectory.

In line with the 2018/19 financial framework for commissioners, CCGs will not be required to contribute to a national risk reserve, nor to spend any element of their recurrent allocation non-recurrently. Decisions on how allocations are committed are for local prioritisation and must, in line with best practice, include an assessment of the risks to plan delivery alongside a robust risk mitigation strategy, and must deliver the Mental Health Investment Standard.

3.4 CCG administration costs

2019/20 running cost limits will be issued as part of CCG allocations. CCGs must ensure that they do not exceed their management costs allowance in 2019/20.

CCGs are asked to deliver a 20% real terms reduction against their 2017/18 running cost allocation in 2020/21, adjusted for the recent pay award. To ensure that full, recurrent savings can be made from the beginning of 2020/21, CCGs must ensure they are planning for and taking actions to achieve these reductions during 2019/20. CCG admin allowances will therefore be maintained in cash terms in 2019/20, using savings achieved during the year to fund any necessary restructuring costs.

NHS England will support CCGs that want to work collaboratively with their local system or with each other to make faster progress on improving our collective efficiency and effectiveness. We would like to hear from CCGs that want to pilot new approaches or have already achieved efficiencies that they think could be adopted more broadly across England.

3.5 Mental Health Investment

CCGs must continue to increase investment in mental health services, in line with the Mental Health Investment Standard (MHIS). For 2019/20 the standard requires CCGs to increase spend by at least their overall programme allocation growth plus an additional percentage increment to reflect the additional mental health funding included in CCG allocations for 2019/20. The minimum percentage uplift in mental health spend for each CCG will be shown in the financial planning template. CCGs will also need to increase the percentage of their total mental health spend that is spent with frontline mental health provision. As in 2018/19, each CCG's achievement of the mental health investment standard will require governing body attestation and be subject to independent auditor review.

The level of investment required by CCGs in mental health will be significant. It is important that commissioners achieve value for money for this investment, and so contracts must include clear deliverables supported by realistic workforce planning. Commissioners and providers will need to work together, supported by STPs/ICSs, to make sure that these deliverables are met and to agree appropriate action where they are not.

STP/ICS leaders, including a nominated 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 concerns that proposed investments will be inadequate to meet the programme requirements should be escalated to the regional teams.

Where a commissioner fails to achieve the mental health investment requirements, NHS England will consider appropriate regulatory action, including in exceptional circumstances imposing directions on the CCG.

To support the assessment of mental health investment plans, NHS England will also look at mental health spend per head, and as a percentage of CCG allocations.

We will continue to develop prevalence indicators and performance data to measure outcomes that can be monitored alongside financial investment levels to give a more rounded picture of improvements in mental health. Providers should make full and timely returns to the Mental Health Services Data Set to support this.

Spend on Children's and Young People's (CYP) mental health must also increase as a percentage of each CCG's overall mental health spend. In addition, any CCGs that have historically underspent their additional CYP allocation must continue to make good on this shortfall.

3.6 Underlying Financial Assumptions

3.6.1 Productivity and Efficiency

The NHS has consistently improved productivity over time and in recent years these improvements have outpaced the wider economy. However, both commissioners and providers have the opportunity to go further. The minimum efficiency ask of the NHS in the next five years is 1.1% per year. We expect that efficiency plans are appropriately phased and not back-loaded.

There remains significant variation in efficiency both within and across the different types of services that the NHS provides. Delivering at least 1.1% efficiency per year will require a renewed and intensified focus on enabling greater staff productivity, including through investment in new digital technology and wider infrastructure and through transformative models of delivering services to patients.

Systems should work together to support the improvement of the NHS estate through the development and delivery of robust, affordable local estates strategies that include delivery of agreed surplus land disposal ambitions across all STP and ICS areas.

All systems will work with the NHS RightCare programme to implement national priority initiatives for cardiovascular and respiratory conditions in 2019/20. They will also be expected to address variation and improve care in at least one additional pathway outside of the national priority initiatives. CCGs yet to implement a High Intensity User support offer for demand management in urgent and emergency care will be required to establish a service in 2019/20. CCGs have made great progress working with GPs to reduce unnecessary referrals into hospital. They will continue this work using RightCare data to identify opportunities and outliers and increase the focus on the development of primary care service to further reduce referrals and follow-ups.

In December 2017, NHS England and NHS Clinical Commissioners (NHSCC) issued guidance for CCGs on 18 items which should not be routinely prescribed in primary care. We expect this to save CCGs up to £114 million per year by 2020/21 compared to 2017/18.

In March 2018 NHS England and NHSCC published further guidance for CCGs on conditions for which over the counter items should not be routinely prescribed in primary care. We expect this to save CCGs £93 million per year compared to 2017/18.

In November 2018, NHS England – in partnership with Academy of Royal Medical Colleges, NICE, NHS Improvement and NHS Clinical Commissioners – published '*Evidence-Based Interventions: Consultation response'* which includes statutory guidance on 17 clinical interventions that are divided into two categories:

- Four Category 1 interventions not to be commissioned by CCGs or performed unless a successful Individual Funding Request (IFR) is made because they have been shown to be appropriate only in exceptional circumstances e.g. adult snoring surgery (in the absence of obstructive sleep apnoea);
- Thirteen Category 2 interventions not to be commissioned by CCGs or performed unless specific clinical criteria are met because they have been shown to be appropriate in certain circumstances e.g. ganglion excision.

CCGs and STPs/ICSs should consider how to implement this guidance by 1 April 2019, when national performance monitoring will begin. Activity reduction numbers by CCG and ICS were included in the consultation response document.

All providers, working with their systems, will develop robust efficiency plans taking account of the opportunities identified in the Model Hospital and outlined in published Getting It Right First Time (GIRFT) reports and Lord Carter's reviews *'Operational productivity and performance in English NHS acute hospitals: unwarranted variations'*; '*Operational Productivity: unwarranted variations in mental health and community*

health services'; and *'Operational Productivity and performance in England NHS ambulance trusts: unwarranted variations*.'

We expect a particular focus on key areas where the reviews identify that further savings should be generated across all sectors.

Category 1 – transformative action required from providers in 2019/20:

- Work across the STPs/ICSs to develop proposals to transform outpatient services by introducing digitally-enabled operating models to substantially reduce the number of patient visits.
- Improve quality and productivity of services delivered in the community, across physical and mental health, by making mobile devices and digital services available to a significant proportion of staff.

Category 2 – action required from providers to accelerate ongoing opportunities

- Focus on concrete steps to improve the availability and deployment of clinical workforce to improve productivity, including a significant increase in effective implementation of e-rostering and e-job planning standards.
- Accelerate the pace of procurement savings by increasing standardisation and aggregation, making use of the NHS's collective purchasing powers. Providers should make regular use of the NHS Benchmarking tool (PPIB) to support this work.
- Make best use of the estate including improvements to energy efficiency, clinical space utilisation in hospitals and implementation of modern operating models for community services.
- Improve corporate services, including commissioners and providers working together to simplify the contracting processes and reducing the costs of transactional services, for example through automation.
- Support and accelerate rollout of pathology and imaging networks.
- Secure value from medicines and pharmacy, including implementation of electronic prescribing, removal of low value prescribing and greater use of biosimilars.

In addition to efficiency savings, providers have opportunities to grow their external (non-NHS) income. This provides extra revenue and benefits for local patients and services. It is expected that the NHS will work towards securing the benchmarked potential for commercial income growth and overseas visitor cost recovery identified in the Model Hospital.

3.6.2 Specialised Services and other Direct Commissioning

The direct commissioning of specialised services will focus on delivering the following priorities over the next two years:

- Helping people with **cancer** to benefit from innovative, specialised cancer treatments that will extend and improve quality of life, including the latest NICE-approved drugs, new genomic testing, cutting-edge radiotherapy techniques such as proton beam therapy, implementation of eleven new radiotherapy networks, and new service specifications for children, teenagers and young adults. We will also look to streamline cancer pathways across specialised and non-specialised services.
- Providing high quality specialised **mental health** services that are integrated with local health systems and are delivered as close to home as possible, driving further reductions in inappropriate out-of-area placements.
- Reducing the number of people with **learning disability and autism** who are treated in inpatient settings and supporting local health systems to manage the learning disability and autism care of their whole population.
- Improving **cardiovascular** services by ensuring that specialised vascular services are meeting national standards 24 hours a day, seven days a week, expanding access to mechanical thrombectomy for certain types of stroke, and improving access to non-surgical specialised cardiac interventions for those patients who could benefit.
- Improving outcomes and reducing mortality rates for **babies, children and young people** who are critically ill, and ensuring they are treated in the most appropriate environment for their needs.
- Supporting patients with a range of **long term conditions**, including those with Hepatitis C, where we aim to eliminate this disease ahead of World Health Organisation goals, and those accessing specialised neurosciences services, where we aim to reduce variation.
- Improving **equity of access** to services, including, for example, delivering faster access to high quality gender dysphoria services.
- Enabling patients to benefit from the latest advances in **genomics and personalised medicine**, including reducing the time it takes to receive a diagnosis for a rare disease and improving survival outcomes for those with aggressive cancers, as well as embedding whole genome sequencing as part of routine care.

In addition, the development of ICSs presents further opportunities to integrate the planning and delivery of specialised services into locally-commissioned services and move to a whole pathway-based approach to planning care for our populations. Further detail is contained in the technical guidance.

Specialised commissioning budgets are currently set on a provider rather than a population basis. NHS England and NHS Improvement will work with local systems in 2019/20 to explore how integration of specialised services within local systems could create greater opportunity and incentive for joint service planning, and what supporting governance arrangements would be required. Specialised commissioning budgets will therefore not be reflected formally in system control totals in 2019/20, but it is important that income and expenditure assumptions between specialised commissioners and

providers align at a system level to give a complete view of the resources available to the system. We will therefore again be including specialised commissioning in the plan and contract alignment process (on a provider level) supported by STP/ICS leaders.

This guidance and the approach outlined in recent contracting intentions letters sent to providers separately, will also apply to health and justice services, and services for the armed forces, which are also the responsibility of NHS England.

3.7 NHS Standard Contract

NHS England is publishing a draft NHS Standard Contract for 2019/20 for consultation. The final version of the Contract will be published in February 2019. NHS commissioners must use the NHS Standard Contract when commissioning any healthcare services other than core primary care.

The national deadline for signature of new contracts for 2019/20 (or agreement of variations to update existing non-expiring contracts) is 21 March 2019. Where NHS commissioners and providers cannot reach agreement by this date, they will enter a nationally coordinated process for dispute resolution. Details of this process will be covered in the '*Joint Contract Dispute Resolution'* guidance. Given the focus on closer system working, NHS England and NHS Improvement will view any requirement to enter these national dispute resolution processes as a failure of local system relationships and leadership.

Extremely long waiting times for elective treatment lead to poorer quality of care, are frustrating for patients, and present patient safety risks. Subject to the outcome of the Standard Contract consultation, we propose that new arrangements would apply for 2019/20 in respect of sanctions for 52-week breaches. The new approach would involve 'mirroring' financial sanctions for providers and commissioners of £2,500 per breach from each organisation. Alongside other contract sanctions, the use of withheld funding will be determined by regional teams. Further details will be set out in the Contract and technical guidance.

3.8 Incentives: Commissioning for Quality and innovation (CQUIN), Quality Premium

3.8.1 CQUIN

From 1 April 2019, both the CCG and Prescribed Specialised Services (PSS) CQUIN schemes will be reduced in value by 50% to 1.25% with a corresponding increase in core prices through a change in the tariff uplift. The CQUIN scheme will also be simplified, focusing on a small number of indicators aligned to key policy objectives drawn from the Long Term Plan.

In recent years CQUIN has secured improvements across a diverse range of goals, including treatment of sepsis, venous thromboembolism management, Hepatitis C

treatment and staff flu vaccinations. It has worked well where used to accelerate the uptake of known interventions which are clearly defined and widely supported.

Recognising that some areas have not been suitable for in-year incentivisation through CQUIN, there will be a renewed focus on the types of change where CQUIN has consistently demonstrated success. Each proposal has been subjected to five tests. The indicator must: support proven delivery methods; cover relatively simple interventions; not add separate cost requirements; be aided by explicit national implementation support; and command stakeholder confidence.

A portion of the CQUIN monies will be dedicated to sustain and expand the work of Operational Delivery Networks (ODNs) in ensuring consistency of care quality across the country. In addition, recognising the ongoing commitment to the elimination of Hepatitis C, ODN leads for Hepatitis C will, alongside mental health providers, continue to be eligible for a higher CQUIN allocation when compared to other acute providers of specialised services. Across both CCG and specialised commissioning CQUIN schemes, local indicators will be developed for providers for which national indicators are not available.

The tests to which CQUIN proposals have been subjected will ensure that those interventions supported by the scheme will deliver real benefits to patients and providers. They will be straightforward to implement, aligning with our goal that CQUIN is ‘realistically earnable’, and therefore deliverable for a significant majority of providers. Where the total value of CQUIN has not been earnt, the use of the resultant funding will be subject to sign off by the joint NHS England/Improvement regional teams.

Full details of the 2019/20 indicators will be published in separate CQUIN guidance.

3.8.2 Quality Premium

The 2019/20 Quality Premium scheme will retain a similar structure to the 2018/19 scheme, including a significant incentive for non-elective demand management, and a set of clinical quality indicators.

Earnings through the scheme will continue to be moderated through the ‘gateways’. However the gateway criteria will be reviewed with a view to simplifying them, addressing concerns over low ‘earnability’ of the scheme for some CCGs. Further details of changes to the scheme will be published shortly.

3.8.3 NHS Resolution (NHSR) Maternity Incentive Scheme

NHSR has confirmed that for the second year running it will be collecting an additional 10% of the maternity contribution from providers that provide maternity services to create a fund for the Maternity Incentive Scheme. We encourage providers to review the relevant detailed guidance and consider how they can deliver the 10 safety actions. The 2019/20 scheme will operate in the same way as the 2018/19 scheme, providers

will be required to meet all 10 safety actions by the deadlines set to earn the maternity incentive.

4 Operational plan requirements

Detail on operational plan requirements are provided in this section. Further detail on other delivery areas will follow in the new year.

4.1 Primary Care

The continued investment in primary care as set out in the Spending Review and underpinning the commitments in the General Practice Forward View provides local systems with both the means and the focus for delivery over the remaining two years of the transformation programme (2019/20–20/21). This investment enables local systems and providers, wherever they are on their current journey, to increase their resilience and sustainability at a practice level and transform the care and services provided to their local population. Building on the £3/head CCG investment in primary care transformation during 2017/18 and 2018/19, we will be requiring CCGs to commit a recurrent £1.50/head recurrently to developing and maintaining primary care networks so that the target of 100% coverage is achieved as soon as is possible and by 30 June 2019 at the latest. This investment should be planned for recurrently and needs to be provided in cash rather than in kind.

STPs/ICSs must have a Primary Care Strategy in place by 1 April 2019 which sets out how they will ensure the sustainability and transformation of primary care and general practice as part of their overarching strategy to improve population health; and which engages CCGs and primary care providers in its implementation. This must include specific details of their:

- local investment in transformation with the local priorities identified for support;
- PCN development plan; and
- local workforce plan which supports the development of an expanded workforce and multidisciplinary teams and sets out the strategy to recruit and retain staff within primary care and general practice.

Where primary medical care commissioning has been delegated, CCGs are required to undertake a series of internal audits[2] that will provide assurance that this statutory function is being discharged effectively. This in turn will provide aggregate assurance to NHS England and facilitate engagement on improvement, including support through STPs/ICSs, who are expected to have oversight of this function and ensure that delegated CCGs are compliant and effective in discharging their responsibilities for:

- primary care commissioning and procurement activities;
- primary care contract and performance management;
- primary care financial management; and
- governance of all primary medical care delivery.

[2] https://www.england.nhs.uk/publication/internal-audit-framework-for-delegated-clinical-commissioning-groups/

STPs/ICSs must ensure that Primary Care Networks are provided with primary care data analytics for population segmentation and risk stratification, according to a national data set, complemented with local data indicator requirements, to allow Primary Care Networks to understand in depth their populations' needs for symptomatic and prevention programmes including screening and immunisation services.

4.2 Workforce

Provider workforce plans will need to consider the significant workforce supply and retention challenges in the NHS. For 2019/20, providers are expected to update their workforce plans to reflect the latest projections of supply and retention, taking into account the supply of staff from Europe and beyond, pay reforms and expected reductions in agency and locum use.

Plans should specifically detail the steps that providers will take during 2019/20 to move towards a 'bank first' temporary staffing model and identify opportunities for improved productivity and workforce transformation through new roles and/or new ways of working. 'Unnecessary' agency staffing spend should be eliminated – that being shifts procured at above agency price caps or off-framework, unless there is an exceptional patient safety reason to do so. Providers should also demonstrate how they will further bear down on the per shift prices paid to procure all temporary staffing resources, and describe the specific actions that will be taken to secure cost reductions compared to the latest 2018/19 outturn. Financial plans should also include an accurate estimate of the split between substantive, bank and agency spend based on these outturn figures.

Providers should ensure they have systems in place to offer full time employment to all student nurses trained locally, where they are suitably qualified and pass assessment centres. Providers should collaborate to ensure that 100% of qualified nurses are able to find NHS employment where they wish to work.

Workforce plans should include actions to improve retention of staff, linked to the rapid improvement areas identified by the national retention programme being rolled out in 2019/20.

Providers should also include within plans a focus on health and wellbeing, mechanisms to address bullying and harassment, consideration to the improvement of diversity amongst staff, and mitigations to address risks associated with EU Exit.

It is important that workforce plans are detailed and well-modelled, phasing in any workforce changes within the year. Workforce plans must also align with finance and activity plans, ensuring the proposed workforce levels are affordable, efficient and sufficient to deliver safe care to patients.

4.3 Data and Technology

From April 2019, providers should submit all commissioning datasets to the Secondary Uses Service (SUS+) on a weekly basis. This will be mandated by NHS Digital in due course, but, in the interim, commissioners should make weekly submission a local requirement within their contracts. More frequent SUS data is a prerequisite for us to move towards a standardised, single version of hospital activity for performance and reconciliation of payments. All providers must also submit the emergency care dataset on a daily basis as currently mandated. In addition, Patient Administration Systems and Electronic Patient Records must enable providers to maintain high quality data to enable accurate reporting, including on available and occupied beds on a daily basis.

We will continue to expand the Global Digital Exemplar and Local Health and Care Record Exemplar programmes with more organisations and localities coming on-stream and in 2019. In addition, in 2019, we will be mandating core standards (across interoperability, cyber security, design, commercial etc.) for all technology across the NHS and introducing additional controls to ensure that all new technology and systems meet these mandated standards.

The NHS App, complemented by NHS Login, will provide a secure way for citizens to access digital NHS services. Initially, it will provide citizens with access to 111 online and their GP record, and the ability to book appointments, set their data sharing preferences and register for organ donation. We ask STPs/ICSs, providers and commissioners to support us to increase uptake, enabling more people to manage their interactions with the health service digitally. By October 2019 100,000 women across 20 accelerator sites will be able to access their maternity records digitally and we expect other organisations to follow their lead on route for universal coverage in future years. We will also enable digital access for all to the successful Diabetes Prevention Programme and ask providers and commissioners to support people to use this.

5 Process and timescale

5.1 Submission of organisational operational plans and system plans

Systems and organisations are asked to develop plans in line with the national timetable below.

These plans need to be the product of partnership working across STPs/ICSs, with clear triangulation between commissioner and provider plans to ensure alignment in activity, workforce and income/expenditure assumptions, evidenced through agreed contracts. System leaders are asked to help ensure plans and contracts are aligned and should convene local leaders as early as possible to agree collective priorities and parameters for organisational planning.

In addition to organisational plan submissions, we request system-level operating plan submissions including an accompanying overview. The detail of what is expected will be set out in the technical guidance.

Boards need to be actively involved in the oversight of operational planning to ensure credible, Board-approved plans, against which in-year performance can be judged.

5.2 Timetable

Milestone	Date
Publication of: • Near final 2019/20 prices • 2019/20 standard contract consultation	21 December 2018
2019/20 deliverables, indicative CCG allocations, trust financial regime and control totals and associated guidance for 2019/20	Early January 2019
NHS Long Term Plan	January 2019
2019/20 CQUIN guidance published	January 2019
2019/20 Initial plan submission – activity focused	14 January 2019
2019/20 National Tariff section 118 consultation starts	17 January 2019
STP/ICS net neutral control total changes agreed by regional teams	By 1 February 2019
Draft 2019/20 organisation operational plans	12 February 2019
Aggregate system 2019/20 operating plan submissions, system operating plan overview and STP led contract / plan alignment submission	19 February 2019
2019/20 STP/ICS led contract / plan alignment submission	19 February 2019
Final 2019/20 NHS Standard Contract published	22 February 2019
Local decision whether to enter mediation and communication to NHSE/I and boards/governing bodies	1 March 2019
2019/20 STP/ICS led contract / plan alignment submission	5 March 2019
2019/20 national tariff published	11 March 2019
Deadline for 2019/20 contract signature	21 March 2019
Parties entering arbitration to present themselves to the Chief Executives of NHS Improvement and England (or their representatives)	22-29 March 2019
STP/ICS net neutral control total changes agreed by regional teams	By 25 March 2019
Organisation Board / Governing body approval of 2019/20 budgets	By 29 March
Submission of appropriate arbitration documentation	1 April 2019
Arbitration panel and/or hearing (with written findings issued to both parties within two working days after panel)	2-19 April 2019
Final 2019/20 organisation operational plan submission	4 April 2019
Aggregated 2019/20 system operating plan submissions, system operating plan overview and STP/ICS led contract / plan alignment submission	11 April 2019
2019/20 STP/ICS led contract / plan alignment submission	11 April 2019
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 30 April 2019
Strategic planning	
Capital funding announcements	Spending Review 2019
Systems to submit 5-year plans signed off by all organisations	Autumn 2019