

NHS Operational Planning and Contracting Guidance 2019/20

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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. 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, have developed a new financial architecture and will introduce 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 the norm, 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.

By allocating extra funds up-front the majority of providers will return to balance. The quid pro quo is that next year no national reserves are being held to cover unauthorised deficits, so each NHS organisation in 2019/20 must deliver its agreed financial position during 2019/20. Capital expenditure will also be able subject to additional controls to ensure the NHS budget overall is balanced.

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, covering the period to 2023/24.

This is the full guidance, building on the first part published in December 2018. It accompanies five-year indicative CCG allocations and sets out the trust financial regime for 2019/20, alongside the service deliverables including those arising from year one of the Long Term Plan. CCGs and trusts should take action from April 2019 to begin implementing the measures set out in the LTP.

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. NHS England/Improvement Regional Directors will assure plans against delivery priorities.

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 of Health and Social Care (DHSC) has issued 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 providers

We want financially sustainable services to be the norm; for quality, efficiency and effectiveness to continue to improve; and for health inequalities to be addressed, through NHS providers being able to deliver financial balance. This aim supports the Government's requirement to bring the NHS, including providers, back into balance by reducing unwarranted variation in performance across the country and improving health outcomes for the population we serve.

We intend 2019/20 to be the first year of a re-set of the financial framework for NHS providers. The measures outlined are all part of reforms which encourage system working and build towards the removal of financial control totals from 2020/21. In 2019/20 we are

- taking steps to reduce the difference between national costs and prices including a £1bn transfer from the PSF
- simplifying urgent care payment arrangements,
- rebasing control totals for all providers
- creating a new £1.05bn fund to support the sustainability of essential NHS services
- working with the Department of Health and Social Care to reform the capital and cash regime
- setting stretching, but achievable, tariff efficiency requirements of 1.1%, a material reduction in the tariff efficiency from 2% since 2016/17. All trusts with

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a deficit control total will be expected to deliver additional efficiency of 0.5% which will be retained by the trust to support financial recovery.

We will start this process by reforming the Provider Sustainability Fund (PSF), with £1bn transferring into urgent and emergency care prices and the £200m targeted element of the PSF transferring into a financial recovery fund as detailed below. These two changes reduce the value of the PSF from £2.45bn in 2018/19 to £1.25bn in 2019/20 with the transfer of resource into prices helping to reduce the national tariff scaling factor, the difference between average costs and national tariff prices. In 2019/20 we will allocate a total of £155m of the PSF to the non-acute sector, as we have in 2018/19 with the remaining £1.1bn allocated to acute and specialist trusts using the same methodology as 2018/19 acute and specialist providers will be eligible to earn their allocated PSF if they sign up to control totals, quarterly payments will be made in arrears subject to delivering the planned year to date financial performance only.

In 2019/20, the contract value agreed via the blended payment approach will be reduced by the agreed 2017/18 value of both the MRET and 30-day readmission rules. Providers will be eligible to receive additional central income equal to the MRET value confirmed by providers and commissioners as part of the Autumn 2018 exercise. Control totals will be set on the basis that for every £1 in MRET funding the provider must improve its bottom line position by £1. MRET funding will be paid quarterly in advance subject to providers agreeing their control total.

The financial impact on the removal of the 30-day readmissions rule will form part of the activity and financial baseline for the blended payment approach. Providers and commissioners should have due regard to the values in the Autumn 2018 exercise combined with any subsequent actions when agreeing the appropriate volume and value of activity included in the blended payment baseline.

Financial Recovery Fund

In 2019/20 we will create a new Financial Recovery Fund (FRF) initially of £1.05bn, including £200m transferred from PSF, to support efforts to secure the financial sustainability of essential NHS services, with trusts able to cover current day-to-day running costs whilst they tackle unwarranted variation. We acknowledge that trusts in deficit face a significant range of additional challenges, impacting on their ability to provide services including organisational morale, recruitment and retention of staff and the burden of cash management pressures.

The FRF will be allocated on a non-recurring basis so that we can secure financially sustainable, essential NHS services in as many ICSs/STPs as possible. In 2019/20 the FRF can only be accessed by trusts in deficit who sign up to their control totals. From 2020/21 the fund can only be accessed by those trusts in deficit where they have an agreed financial recovery plan in place. Any FRF funds released by over-delivery

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against plans will where possible be deployed for investment in transformation and further cost reduction.

As the sustainability of services improves, we expect the number of trusts in deficit to reduce. After application of this funding, we expect the number of trusts reporting a deficit in 2019/20 to be reduced by more than half, and by 2023/24 no trust to be reporting a deficit. We also expect the size of the FRF to reduce over time with funding replaced by recurrent efficiency improvements delivered through multi-year recovery plans.

We recognise the need to give trusts and systems time to develop their medium term financial recovery plans. Initially, the distribution of the FRF will therefore be set nationally, with the aim of maximising the sustainability of NHS services in 2019/20. However, we expect recovery plans to be agreed during 2019/20 as a condition of receipt of the fund, and for all systems with deficit trusts to have recovery plans in place as part of the five-year system level strategic plans by December 2019. STPs/ICSs will need to demonstrate that their capital plans are an investable proposition.

From 2020/21 providers will only have access to this funding where financial recovery plans, agreed with NHS Improvement and NHS England regional teams, are in place to deliver significant year-on-year improvement. The recovery plan must set out how financial recovery will be delivered over a number of years. The fund will be paid on successful delivery of key milestones. Financial recovery plans will need to establish the drivers of financial performance, the actions required to make services sustainable at both trust and system level and agreed responsibilities to make this happen within the ICS/STP. These plans should draw on local understanding of the health system, but we expect that all systems and trusts will implement proven initiatives, including the Model Hospital, RightCare and GIRFT, and the big opportunities identified within the Long Term Plan, such as redesigning outdated and unsustainable outpatients model to eliminate up to a third of face-to-face outpatient visits.

Trusts that are in financial surplus will play an active role in the development and delivery of recovery plans of organisations within their STP/ICS, including sharing of management expertise and active engagement in reducing the total cost of service provision across an STP/ICS. Where appropriate, recovery plans and access to FRF funding will be agreed with new management teams as part of integration plans between organisations.

In 2019/20 all trusts will continue to receive their allocation of the PSF linked to acceptance and delivery of their control totals. Our ambition is that FRF will mean the end of the control total regime and associated PSF for all trusts from 2020/21. The remaining PSF funds will be transferred to increase the value of the FRF from 2020/21. We will consider amending the financial regime for providers to require delivery of a minimum surplus standard as our definition of sustainability.

National guidance and templates will be issued to ensure that there is a consistent approach to the development of recovery plans in line with the wider planning timetable. Trust boards will need to own, sign up to and be accountable for delivery of the Recovery Plans, which must be fully aligned with system level five-year Long Term Plan implementation plans. Trusts in deficit will need to achieve agreed financial performance trajectories that deliver significant year-on-year improvement in the sustainability of services and financial performance to receive the FRF. If the agreed trajectory is missed, then the regional team will intervene. The intervention will take account of the particular circumstances of the provider, and the level of operational changes delivered, with the potential to draw on the full range of statutory and regulatory powers. NHSI will be writing out shortly to confirm details of the new accountability regime.

Provider financial management

All providers will be expected to plan against rebased control totals which will be communicated in January 2019. The 2019/20 control totals for providers in deficit will reflect a further 0.5% efficiency requirement on top of the 1.1% efficiency factor included in the tariff. It is important that providers plan for and deliver their control totals for 2019/20 to contribute to delivering financial balance across the NHS.

Providers that sign up to their control totals and are therefore eligible to earn PSF will be exempt from most contract financial sanctions. The sanction for 52-week waits applies to all providers and commissioners; see section 3.8 below. Where a commissioner applies contract sanctions, the use of the resultant funding will be subject to sign off by the joint NHSE/I regional teams.

NHSI is working with DHSC to develop changes to the cash regime for providers including reviewing the rate of interest payable on both historic debt and on all new loans. We are also considering a process for restructuring of historic debt on a case-by-case basis once a recovery plan has been agreed.

3.4 Financial framework for CCGs

Allocations for 2019/20 have been 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 increase investment in primary medical and community services, sufficient to meet the Long Term Plan commitments.

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.

3.5 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. This is their contribution to the overall £700m administrative savings requirement for commissioners and providers by 2023/24. 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. In November 2018 a letter was sent to CCGs outlining local actions to deliver running cost savings.

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.

3.6 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. In order to deliver the service expansions planned for 2019/20, CCGs will (other than by local exception requiring prior agreement with NHS England) also need to increase the share of their total mental health expenditure that is spent with mental health providers. As in 2018/19, each CCG's achievement of the mental health investment standard will require governing body attestation and in every case will 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.

3.7 Underlying Financial Assumptions

3.7.1 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.

All CCGs should ensure the availability of the innovations approved as part of the Innovation and Technology fund. From 2019/20 all CCGs will be expected to offer flash blood glucose monitoring devices to people with type 1 diabetes who meet relevant clinical criteria. Funding has been held back from overall CCG allocations to create a time-limited national budget to meet these costs.

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 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 in line with the goal of reducing the number of outpatient visits by a third over the next five years.
- 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 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.

3.7.2 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 planning 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.

3.8 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.

3.9 Incentives: Commissioning for Quality and innovation (CQUIN),

3.9.1 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.

For the PSS Scheme, as in previous years 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 PSS 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 earned, 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.

3.9.2 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

The Long Term Plan highlights a number of key priorities that are fundamental to achieving further progress in transforming the provision of urgent and elective care, for example around delivery of Same Day Emergency Care (SDEC) and the transformation of outpatient services. The Long Term Plan also notes that we will begin to test and implement the recommendations of the NHS Clinical Standards Review during 2019/20.

The deliverables referenced in sections 4.1 to 4.9 include those that require trajectories to be submitted. This is not an exhaustive list and for planning purposes, systems and organisations should ensure that they refer to the full list of 2019/20 deliverables contained within the relevant annexes.

4.1 Emergency Care

Every acute hospital with a type 1 A&E department will move to a comprehensive model of Same Day Emergency Care (SDEC). This will increase the proportion of acute admissions discharged on the day of attendance from a fifth to a third. We would not expect the proportion of non-SDEC zero-day length of stay admissions to rise. Hospitals should also specifically reduce avoidable admissions through the establishment of acute frailty services, so that such patients can be assessed, treated and supported by skilled multidisciplinary teams delivering comprehensive geriatric assessments in A&E and acute receiving units. The SDEC model should be embedded in every hospital, in both medical and surgical specialities, with all Type 1 Emergency Department (ED) providers expected to deliver SDEC at least 12 hours per day, seven days a week, by September 2019.

Building on the system-wide adoption of Emergency Care Data Set (ECDS) in 2018/19 to record A&E department case mix, in 2019/20 we will require all providers to record their SDEC activity via the same core dataset, adapted specifically for this purpose. This will capture and code all SDEC activity ('A&E type 5'). Further guidance on identification of SDEC activity and coding will follow early in 2019.

As part of the clinical standards review, we will also develop new ways to focus on patients with the most serious illness and injury, ensuring that they receive the best possible care in the shortest possible timeframe. We are working with clinical experts and patient groups nationally to ensure that these pathways deliver improvements in patient outcomes, so that the NHS continues to lead the world in the quality of care that it provides for those with the greatest need.

STPs/ICSs, commissioners and providers should review assumptions for demand growth to ensure they reflect recent local trends, adjusting as appropriate for demand management and other efficiency schemes that have been agreed within the system, and to reflect delivery of national priorities.

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Long stay patients (those in hospital for 21 days or more) account for 7.3% of admissions and 20.4% of bed-days (as at October 2018). In 2018/19, we set the goal to reduce bed occupancy by long stay patients by 25%, to release at least 4,000 beds compared to 2017/18 figures. Once local goals have been delivered, the aim should then be to reduce the proportion of beds occupied by long stay patients by 40% against the original 2017/18 baseline. Providers should also focus attention on shorter lengths of stay to reduce the time for which patients are hospitalised and should set local targets for reduction in 7-day or more and 14-day or more lengths of stay in 2019/20.

CCGs and Health and Well Being Boards (HWBs) should plan to continue to deliver the reductions in the Delayed Transfers of Care (DToc) rate (set out in Annex 3 to the Better Care Fund Operating Guidance for 2017-19) or to maintain their performance if these targets have been achieved already.

The Clinical Assessment Service (CAS) within NHS 111 enables healthcare professionals and patients to access the right care in the right place, first time. All areas will have a CAS by April 2019, and over the next year we will work with CCGs to enhance the CAS to support admissions avoidance, discharge support and mental health services. The NHS 111 service will continue to provide 50% of calls with clinical assessment and will be able to book at least 40% of people that have been triaged into a face-to-face appointment where needed.

Commissioners and providers will also be expected to support the 'right place, first time' approach by appropriately resourcing the Directory of Service (DOS), ensuring accurate profiling and a reduction in 'A&E by default' selections on the DOS to less than 1% by March 2020. All providers will continue to improve the data quality of submissions into the national 111 data set (the 'Aggregate Data Collection') until fully compliant.

Commissioners should continue to redesign urgent care services outside of A&E, aiming to designate the majority of Urgent Treatment Centres (UTCs) by December 2019, with any exceptions to be agreed with the Regional Director. UTCs should meet previously published standards and ensure that they operate effectively as part of a network of services including primary care, integrated urgent care, ambulance services and A&E. Through increasing commonality of service provision under the UTC name we will end the confusing mix of urgent care centres, minor injury units and walk in centres, and provide more opportunities for patients to be seen without going to A&E. Key standards for UTCs include the ability to book appointments directly from NHS 111, having a multi-disciplinary team with access to patient records and diagnostics, and being open at least 12 hours a day.

Ambulance services are expected to meet response time standards as per the Ambulance Quality Indicators; where these are not being achieved, local trajectories for recovering achievement should be agreed. Ambulance providers are expected to deliver a safe reduction in conveyance to EDs. A national band 6 job description has been agreed, designed to build the enhanced skills so that, where clinically

appropriate, paramedics can support patients at scene. Ambulance lead commissioners will agree individual trajectories for a safe reduction in avoidable conveyance for each ambulance trust.

Delays in handover of patients from ambulance services to ED, or hospital handover delays, result in increased risks to patients, both on site and in the community, and reduced ambulance response performance. Commissioners should work with their acute providers to adopt a zero tolerance approach to delays of over 30 minutes, ensuring that they accept timely handover of all patients arriving by ambulance, with the aim that no one waits more than 15 minutes and that no patient is cared for in a hospital corridor.

The ECDS, also known as Commissioning Data Set type 011, is replacing the Accident & Emergency Commissioning Data Set (CDS type 010) with effect from March 2019. All providers with any type of A&E department should ensure they are reporting daily data into this data set from April 2019.

The deliverables for urgent and emergency care are:

- The existing NHS Constitution standards remain in force until new clinical standards for urgent and emergency care are set out in the Clinical Standards Review, to be published in spring 2019, tested in the first half of the year, and implemented from October 2019.
- Ambulance services should ensure they meet ambulance response time constitutional standards as set out below:
 - Category 1: 7 minutes (mean), 15 minutes (90th centile)
 - Category 2: 18 minutes (mean), 40 minutes (90th centile)
 - Category 3: 120 minutes (90th centile)
 - Category 4: 180 minutes (90th centile)
- No one arriving by ambulance should wait more than 30 minutes from arrival to hospital handover.

4.2 Referral to Treatment Times (RTT)

The ability of patients to choose where they have their treatment remains a powerful tool for improving waiting times and patient experiences of care. The NHS will continue to provide patients with a wide choice of options for quick elective care, including making use of available independent sector capacity. This will be supported by continued roll out of Capacity Alerts as a tool for CCGs to support GPs and patients to make informed decisions about where to have their treatment. Patients will continue to have choice at the point of referral and for 2019/20 new local arrangements must be put in place so that anyone who has been waiting for six months or longer must be specifically contacted by the provider on whose waiting list they appear or by the responsible CCG and given the option of faster treatment at an alternative provider.

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Building on the expectation that providers will deliver March 2019 waiting lists at the March 2018 level, we expect that all providers will further improve their waiting list position during 2019/20 and that their capacity plans will demonstrate how they will increase elective treatment so that the waiting list number will decrease. Delivery of this requirement may be managed at STP/ICS level, in agreement with the regional team, although every provider will be expected to make a significant contribution. Over the first five years of the Long Term Plan, we expect to lock in and improve short waits. Given the purchasing power commissioners will have next year, we expect to see an increase in the volume of elective activity being funded and delivered across the NHS. We will review on a system-by-system basis the expectations for improvement in access to elective services.

Following good progress in 2018/19, we expect no patient to be waiting more than 52 weeks for treatment. Given that over the coming years there will be sufficient funding available to CCGs and providers to avoid long waits, financial sanctions (as detailed in section 3.8 – NHS Standard Contract) must be applied for any patient who breaches 52 weeks.

Providers are already embracing the non-face-to-face redesign of many interactions in outpatients and are redefining access points, for example patient-initiated follow-up. This should be accelerated, as should the alignment of diagnostics with appointments, to provide treatment more efficiently. Providers should use the national outpatient improvement dashboard to target reductions in cancellations and non-attendance at appointments by improving processes and usage of digital booking options. Furthermore, providers should look to release capacity by reducing unnecessary frequent attenders and improving clinic utilisation where it is below the average of Model Hospital peers.

Given that almost four fifths of referral to treatment 'clock stops' are outpatient appointments, the effect of removing up to a third of these will impact how RTT waiting times performance is calculated. This is something the Clinical Standards Review will consider in the spring.

RTT plans should be robust and realistic, making best use of available capacity, informed by rigorous forecasting of demand and activity to ensure that capacity is utilised as effectively and efficiently as possible.

The deliverables for RTT are:

- Building on the expectation that providers will deliver March 2019 waiting lists at the March 2018 level, all providers to reduce their waiting list during 2019/20.
- No patient will wait more than 52 weeks for treatment.

- Every patient waiting 6 months or longer to be contacted and offered the option of care at an alternative provider
- Implement agreed standards as set out in the Clinical Standards Review to be published in spring 2019.
- No more than 1% of patients should wait six weeks or more for a diagnostic test.
- Ensure patients will have direct access to MSK First Contact Practitioners

4.3 Cancer Treatment

STPs/ICSs are responsible for ensuring that the cancer services provided to their populations are of the highest standard. Cancer Alliances provide clinical, operational and transformational leadership to their local cancer system by bringing together their constituent commissioners and providers, on behalf of their STPs/ICSs, to ensure system-wide oversight and transformation of cancer services and outcomes. STPs/ICSs must ensure that commissioners and providers come together as part of their Cancer Alliance to agree and deliver a system-wide plan for cancer covering core operational performance and transformation.

The delivery of all eight cancer waiting times standards remains a priority. Cancer Alliances have a particular leadership role in improving operational performance, and in ensuring that their constituent providers and commissioners take collective responsibility for delivering against the cancer standards. The system-wide plan should include actions to: increase capacity; encourage effective, cross-organisational working; and broker agreements between providers to balance supply and demand more effectively across the system. Our regional teams will work closely with their Alliances to ensure that any support or interventions they undertake in local health systems or providers are co-ordinated with the Alliance activity.

All providers must start to collect the 28-day Faster Diagnosis Standard data items in 2019/20, in preparation for the introduction of the Standard in 2020. Organisations, working through their Alliances, should use the data items to improve time to diagnosis, in particular for lung, prostate and colorectal cancers.

The deliverables for cancer are:

- At least 93% of patients who receive an urgent GP (GMP, GDP or Optometrist) referral for suspected cancer should have their first outpatient attendance within a maximum of two weeks.
- At least 93% of patients with breast symptoms who receive an urgent GP referral for suspected cancer should have their first hospital assessment within a maximum of two weeks.

- At least 96% of patients should wait no more than one month (31 days) for their first definitive treatment, from the date a decision to treat is made, for all cancers.
- At least 94% of patients should wait no more than one month (31 days) for subsequent treatment, from the date a decision to treat is made, where the treatment is surgery.
- At least 98% of patients should wait no more than one month (31 days) for subsequent treatment, from the date a decision to treat is made, where the treatment is drug treatment.
- At least 94% of patients should wait no more than one month (31 days) for subsequent treatment, from the date a decision to treat is made, where the treatment is radiotherapy.
- At least 85% of patients receiving an urgent GP (GMP, GDP or Optometrist) referral for suspected cancer should wait no more than two months (62 days) for their first definitive treatment, for all cancers.
- At least 90% of patients with an urgent referral from an NHS cancer screening programme should wait no more than two months (62 days) for their first definitive treatment.
- Implement human papillomavirus (HPV) primary screening for cervical cancer across England by 2020

4.4 Mental Health

In 2019/20 the Five Year Forward View for Mental Health (FYFVMH) enters its fourth year of implementation, with the programme currently on track to deliver new and improved services to more than a million patients by 2020/21. In 2019/20 additional funding continues to increase in allocations to CCGs. This funding is for transformation and expansion of services, as outlined in Implementing the Mental Health Forward View ('the implementation plan').

In 2019/20 Long term Plan funding for mental health will start to flow into CCG baselines and they must, in association with STPs and ICSs, commission services that deliver improved services set out in the plan such as community mental health teams for people with Severe Mental Illness (SMI), enhanced crisis services for adults and for children and young people, and perinatal mental health services.

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We expect commissioners and providers to work together through STPs/ICSs and proactively prioritise:

- Mental health workforce expansion including training and retention schemes, both to meet existing demand and to provide the additional workforce required to complete implementation of the FYFVMH and deliver the Long Term Plan. STPs/ICSs must fully understand current workforce and required expansion numbers, how this translates into provider-level expansion plans, and where there are key local pressure points for service areas or staff groups, identifying mechanisms to mitigate. They must ensure that funds for training and other workforce requirements are used for that purpose. STPs/ICSs need to ensure workforce information is accurately recorded in the Electronic Staff Record;
- Ensuring all providers, including third and independent sector providers, submit comprehensive data to the Mental Health Services Dataset (MHSDS) / Improving Access to Psychological Therapies (IAPT) dataset. Commissioners should work with providers to ensure data quality is proactively reviewed, national guidance is adhered to and the breadth of data submitted to the MHSDS accurately reflects local activity. Commissioners should routinely monitor MHSDS data and are encouraged to use MHSDS commissioner extracts to inform local discussions with providers;
- Ensuring a comprehensive understanding of data and information on local health inequalities and their impact on service delivery and transformation. Organisations should factor advancing equality into mental health operational plans; and
- Ensuring a clearly defined mental health digital strategy is in place and is supported by a service transformation programme and board-level sign off. This should include processes to achieve future digital record sharing across health and care communities, and the integration of digital tools and digitally-enabled therapies into routine clinical practice.

The deliverables for mental health are:

- By March 2020 IAPT services should be providing timely access to treatment for at least 22% of those who could benefit (people with anxiety disorders and depression).
- At least 50% of people who complete IAPT treatment should recover.
- At least two thirds (66.7%) of people with dementia, aged 65 and over, should receive a formal diagnosis.
- At least 75% of people referred to the IAPT programme should begin treatment within six weeks of referral.
- At least 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral.
- At least 56% of people aged 14-65 experiencing their first episode of psychosis should start treatment within two weeks.

- At least 34% of children and young people with a diagnosable mental health condition should receive treatment from an NHS-funded community mental health service, representing an additional 63,000 receiving treatment each year.
- By March 2021, at least 95% of children and young people with an eating disorder should be seen within one week of an urgent referral.
- By March 2021, at least 95% of children and young people with an eating disorder should be seen within four weeks of a routine referral.
- Continued reduction in out of area placements for acute mental health care for adults, in line with agreed trajectories.
- At least 60% people with a severe mental illness should receive a full annual physical health check.
- Nationally, 3,000 mental health therapists should be co-located in primary care by 2020/21 to support two thirds of the increase in access to be delivered through IAPT-Long Term Conditions services
- Nationally, 4,500 additional mental health therapists should be recruited and trained by 2020/21.
- The further deliverables for mental health outlined in the technical annex must also be delivered during 2019/20, most notably for: perinatal mental health; all age crisis and liaison services; 50% of early intervention in psychosis services graded at level 3; and reducing suicides.

4.5 Learning Disabilities and Autism

Progress has been made in our goal to transform the treatment, care and support available to people of all ages with a learning disability, autism or both so that they can lead longer, happier, healthier lives in homes in the community, not hospitals. The number of people with a learning disability, autistic spectrum condition or both, who are in an inpatient setting, continues to fall and further progress is expected during the remainder of the year. Over 2019/20, more needs to be done to ensure the ambitions set out in *'Building the Right Support'* are met and sustained, ensuring more people are supported to live in the community. Care and Treatment Reviews both pre- and post-admission should be carried out in line with policy. For those who may need to be in hospital for care and treatment, length of stay should be as short as possible, with improved quality of care and reduced use of restraint. Accompanying our ambition to transform care, we will reduce the inequalities faced by people with a learning disability through increased uptake of annual health checks and continued learning and action from Learning Disability Mortality Review reviews.

The national deliverables for transforming care for people with learning disabilities:

- Reduction in reliance on inpatient care for people with a learning disability and/or autism (CCG-funded) to 18.5 inpatients per million adult population by March 2020.

- Reduction in reliance on inpatient care for people with a learning disability and/or autism (NHS-England funded) to 18.5 inpatients per million adult population by March 2020.
- At least 75% of people on the learning disability register should have had an annual health check.
- CCGs are a member of a Learning from Deaths report (LeDeR) steering group and have a named person with lead responsibility.
- There is a robust CCG plan in place to ensure that LeDeR reviews are undertaken within 6 months of the notification of death to the local area.
- CCGs have systems in place to analyse and address the themes and recommendations from completed LeDeR reviews.
- An annual report is submitted to the appropriate board/committee for all statutory partners, demonstrating action taken and outcomes from LeDeR reviews.

4.6 Primary Care and Community Health Services

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. More guidance on the future direction for primary care networks will be available soon.

As set out in the Long Term Plan, real terms investment in primary medical and community services should grow faster than CCGs overall revenue growth. Further guidance will be issued on how to measure this. In return, CCGs and community providers should, during 2019/20, make progress towards implementing the new service models set out in the LTP, including the urgent response standards for urgent community support.

STPs/ICSs must include a primary care strategy as part of the system strategy that will be developed in Autumn 2019 response to the Long Term Plan 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 audits² 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.

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.

4.7 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

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

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.

4.8 Data and Technology

From April 2019, providers should submit all commissioning datasets to 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 be managed by providers to maintain high quality data and enable accurate reporting, including on available and occupied beds which will be extracted digitally on a daily basis to reduce the reporting burden on Trusts.

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.

4.9 Personal Health Budgets

Personalised care means people have choice and control over the way their care is planned and delivered. One way to provide care in this way is by a personal health budget (PHB).

The deliverable for PHBs is:

- By March 2021, 50,000 to 100,000 people should have a PHB.

4.10 Longer-term deliverables

Further to the deliverables for 2019/20 set out in sections 4.1 to 4.9, a number of areas of relating to long-term transformation will require consideration and preparation during 2019/20. These are set out in appendix 1. More detail has been included in the Long Term Plan.

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: <ul style="list-style-type: none"> 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	7 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

Appendix 1 – Longer-term deliverables

System architecture	Work towards every area of the country being part of an ICS by April 2021
Health inequalities	All local health systems will be expected to set out during 2019 how they will specifically reduce health inequalities by 2023/24 and 2028/29, including clearly setting out how those CCGs benefiting from the health inequalities adjustment are targeting that funding to improve the equity of access and outcomes
Maternity	Start to implement an enhanced and targeted continuity of carer model to help improve outcomes for the most vulnerable mothers and babies
	Offer all women who smoke during their pregnancy, specialist smoking cessation support to help them quit
	Support work to achieve a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025
	By spring 2019, every trust in England with a maternity and neonatal service will be part of the National Maternal and Neonatal Health Safety Collaborative, supported by Local Learning Systems
	Roll out the Saving Babies Lives Care Bundle during 2019
	Maternity digital care records are being offered to 20,000 eligible women in 20 accelerator sites across England, rising to 100,000 by October 2019
	Continue to work with midwives, mothers and their families to implement continuity of carer so that, by March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally
	All maternity services that do not deliver an accredited, evidence-based infant feeding programme, such as the UNICEF Baby Friendly Initiative, will begin the accreditation process in 2019/20
Mental health	By 2020/21, the NHS will ensure that at least 280,000 people living with severe mental health problems have their physical health needs met
	Continue to deliver enhanced access to mental health services for children and young people
	Begin roll out of Mental Health Support Teams working in schools and colleges in trailblazer areas to cover one fifth to a quarter of the country by the end of 2023
	Continue to expand access to IAPT services for adults and older adults with common mental health problems, with a focus on those with long term conditions
	Continue to progress delivery of standards for early intervention in psychosis, IAPT and services for young people with eating disorders by 2021
	Delivering against multi-agency suicide prevention plans, working towards a national 10% reduction in suicides by 2020/21
Learning disability and autism	Expand the STOMP-STAMP programmes to stop the overmedication of people with a learning disability, autism or both by 2023/24

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	Continue to reduce the number of people with a learning disability, autism or both in inpatient care
Cancer	From September 2019, all boys aged 12 and 13 will be offered vaccination against HPV-related diseases, such as oral, throat and anal cancer
	Extend lung health checks (already piloted in Manchester and Liverpool)
	From 2019, we will start the rollout of new Rapid Diagnostic Centres (RDCs) across the country
	Implement a stratified approach for follow up for breast cancer in 2019 and prostate and colorectal cancers in 2020 (expanding to all cancers which are clinically appropriate in 2023). From 2019, we will begin to introduce an innovative quality of life metric – the first on this scale in the world – to track and respond to the long-term impact of cancer