

Technical guidance for NHS planning 2019/20

Annex C: NHS Improvement guidance to trusts for operational plans

January 2019

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

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1. How to use this guidance

This technical document is Annex C of *Technical guidance for NHS planning 2019/20*; and supports the main planning guidance *NHS operational planning and contracting guidance* (published 10 January 2019)¹ It should not be read in isolation but alongside, and in the context of, the main planning guidance documents.

Annex C is detailed guidance for all NHS trusts and NHS foundation trusts on their 2019/20 operational plans only. It outlines our objectives and requirements for provider plans, our view of what operational plans should contain and our approach to the review of, and response to, those plans.

Throughout the document we refer to NHS trusts and NHS foundation trusts collectively as ‘trusts’ or ‘providers’, except where we specifically make separate reference to either group.

2. Objectives for providers’ 2019/20 operational plans

NHS operational planning and contracting guidance is the full guidance, replacing the preparatory guidance published in December 2018. It accompanies five-year indicative clinical commissioning group (CCG) allocations and sets out the trust financial regime for 2019/20, alongside the service deliverables, including those arising from year one of the NHS Long Term Plan.² CCGs and trusts should take action from April 2019 to begin implementing the measures set out in the NHS Long Term Plan.

The development of operational plans for 2019/20 will enable the NHS to progress against the overall tests set by the government to:

- improve productivity and efficiency
- eliminate provider deficits
- reduce unwarranted variation in quality of care
- incentivise systems to work together to redesign patient care
- improve how we manage demand effectively
- make better use of capital investment.

¹ <https://www.england.nhs.uk/deliver-forward-view/>

² <https://www.england.nhs.uk/long-term-plan/>

As highlighted in the *Operational planning and contracting guidance 2019/20*, the organisations within each sustainability and transformation partnership (STP) and integrated care system (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 guidance also describes a single operational planning process for commissioners and providers, with clear accountabilities and roles at national, regional, system and organisational level.

The quality standards for patient services are clearly set out in the NHS Constitution³ and in the fundamental quality and safety standards published by the Care Quality Commission (CQC) in *Guidance for providers on meeting the regulations*.⁴ These quality standards continue to define the expectations for provider services.

For providers to achieve and maintain high quality services, those services also need to be underpinned by affordable and sustainable financial plans. Building on the joint financial improvement actions from recent years, it is important that providers plan for and deliver their control totals for 2019/20 to contribute to delivering financial balance across the NHS.

*Technical guidance for NHS planning 2019/20*⁵ sets out the arrangements for NHS commissioners and providers to submit operational plans for 2019/20. This annex outlines our overarching requirements for the 2019/20 operational plans of providers. Please also refer to the suite of technical guidance annexes to support the preparation of plans at <https://www.england.nhs.uk/deliver-forward-view/>. Please read these alongside the provider-specific NHS Improvement supplementary technical guidance for finance, workforce and activity plans available on the [NHS Improvement planning webpage](#). Most the annexes will be published in early January 2019, with the balance by 31 January 2019.

³ www.gov.uk/government/publications/the-nhs-constitution-for-england

⁴ www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf

⁵ <https://www.england.nhs.uk/deliver-forward-view/>

NHS Improvement's overarching objectives for 2019/20 planning

All providers will have robust, integrated operational plans for 2019/20 that demonstrate the delivery of safe, high quality services that meet the NHS Constitution standards or delivery of recovery milestones within available resources.

The development of operational plans for 2019/20 will enable the NHS to progress against the overall tests set by the government to:

- improve productivity and efficiency
- eliminate provider deficits
- reduce unwarranted variation in quality of care
- incentivise systems to work together to redesign patient care
- improve how we manage demand effectively
- make better use of capital investment.

3. Summary of operational plan submissions

The operational plan collections are designed to enable us to test delivery of the requirements articulated in Section 2 above. Table 1 below summarises the plan submission requirements, identifying what needs to be submitted, where and when. This year, for both NHS trusts and NHS foundation trusts, the operational plan submissions will include (both draft and final plans):

- a finance return
- an activity and performance trajectory return:
 - this will contain annualised activity data for the 2018/19 forecast outturn (pre-populated) and 2019/20 operational plan, supporting the alignment process of provider-commissioner activity plans
 - for both NHS trusts and NHS foundation trusts, this submission is required of acute, specialist acute and ambulance trusts only
 - NHS mental health and community trusts do not need to submit activity returns
- a workforce return

- a triangulation return:
 - a linked file detailing the required triangulation checks between finance, activity and workforce plans and a requirement to provide commentary where plans do not appear to be aligned
 - a pilot finance/workforce bridge comparison
 - a pilot finance/activity bridge comparison
- an operational plan narrative (maximum 19 pages), which should take forward the local health and care system's STP and outline the provider's approach to activity, quality, workforce and financial planning for 2019/20; see Section 4 for further details
- assurance statements from all NHS trusts and NHS foundation trusts; submissions should be made in accordance with the national planning timetable
- an STP-led contract and plan alignment template, to be submitted to both regional NHS England and NHS Improvement planning email addresses as outlined in *Technical guidance for NHS planning 2019/20* on 19 February, 5 March and 11 April 2019 by ICSs/STPs supported by organisations within their area to arrive at an aligned position.

Relevant providers' initial draft activity plans should be submitted to NHS Improvement by 12 noon on Monday 14 January 2019.

Providers' full draft plans should be submitted to NHS Improvement by 12 noon on Tuesday 12 February 2019.

Providers' final 2019/20 plans should be submitted to NHS Improvement by 12 noon on 4 April 2019. The final operational plan should include updated versions of:

- finance return
- activity and performance trajectory return (acute, specialist acute and ambulance providers only)
- workforce return
- triangulation return
- operational plan narrative
- assurance statements.

Table 1: NHS Improvement plan submission requirements

Submission requirement	Technical annex	Deadlines	Submission method
Plan narrative including quality	Annex C	12 February 2019 4 April 2019	Through online portal
Financial plan	Annex C and NHS Improvement technical guidance	12 February 2019 4 April 2019	Through online portal
Activity plan and performance trajectories	Annex C and NHS Improvement technical guidance	14 January 2019 <i>(acute and specialist acute trusts only, waterfall, activity and commissioner allocation tabs only)</i> 12 February 2019 4 April 2019	Through online portal
Workforce plan	Annex C and NHS Improvement technical guidance	12 February 2019 4 April 2019	Through online portal
Triangulation form	Annex C and in form	12 February 2019 4 April 2019	Through online portal
Assurance statements	Annex C and NHS Improvement technical guidance	4 April 2019	Through online portal

4. Requirements of operational plans

In line with the overarching objectives for operational planning above and underpinned by the expectations for the NHS summarised in the main planning guidance, NHS Improvement expects provider operational plans for 2019/20 to:

- be realistic and deliverable:
 - based on reasonable assumptions for activity, that the provider has sufficient capacity to deliver

- supported by contracts with commissioners, signed by 21 March 2019, that reflect this level of activity and balance risk appropriately
- underpinned by coherent and well-modelled financial projections
- supported by agreed contingency plans wherever risks across local health system plans have been jointly identified
- be stretching, representing the maximum that each provider can reasonably be expected to deliver
- confirm agreement to their financial control totals for 2019/20 to qualify for the receipt of Provider Sustainability Fund (PSF), Financial Recovery Fund (FRF) and marginal rate emergency tariff (MRET) funding. Delivery of control totals for 2019/20 to contribute to financial balance across the NHS will form a core part of the financial oversight regime and the provider oversight arrangements:
 - currently set out in the Single Oversight Framework⁶ that NHS Improvement has put in place and which may develop over the period of the guidance
 - providers should take advantage of the opportunities identified in the Carter reviews for improved productivity⁷ and the Getting It Right First Time (GIRFT) reports,⁸ using the Model Hospital where available to gain visibility of opportunities
 - providers should continue to apply the rules on agency spend⁹ introduced by NHS Improvement and restrictions on the growth of their pay bill; information is available in the guidance on rules for all agency staff working in the NHS
 - providers should engage with commissioners to ensure alignment with local adoption of the NHS RightCare programme
- be consistent with sustainability and transformation plans:
 - the position of each provider (on finance, activity and workforce) should be consistent with the ICS/STP footprint financial plan for 2019/20 to be submitted on 19 February 2019 and with the system control for that ICS/STP area
 - the aggregate of all operational plans in a footprint will need to reconcile with the ICS/STP position

⁶ <https://improvement.nhs.uk/resources/single-oversight-framework/>

⁷ www.gov.uk/government/publications/productivity-in-nhs-hospitals

⁸ <http://gettingitrightfirsttime.co.uk/>

⁹ www.gov.uk/guidance/rules-for-all-agency-staff-working-in-the-nhs

- they should reflect the strategic intent of the ICS/STP and the organisational impact of the key issues agreed as critical to their locality
- provide for a reasonable and realistic level of activity:
 - plans should demonstrate the capacity to meet this through the provision of bed numbers
 - activity should be profiled to take account of seasonality plans and should be in line with the currency, definitions and criteria set out in the technical guidance, irrespective of locally agreed currency and definitions for contracted activity volumes
- demonstrate, through the performance trajectory section of the activity return, improvement in the delivery of core access standards as set out in the NHS Constitution and national planning guidance (accident and emergency (A&E), and ambulance response times, referral to treatment (RTT), cancer, and diagnostic waiting times)
- be internally consistent; individual activity, workforce and finance elements of the plans should be cross-checked and internally consistent.

In relation to capital, providers are expected to:

- continue to work with STPs/ICSs to deliver their estates strategies, including land disposals, with these strategies continuing to be a key to accessing capital for all sectors going forward. NHS capital is very constrained and therefore it is vital that capital plans are realistic and based only on self-funding and funding that has already received approval. Provider capital plans for 2019/20 should be based on self-funding plus agreed STP capital or specific programme capital. Providers should not assume new funding from sources such as the Independent Trust Financing Facility (ITFF) or emergency financing applications unless these already have approval, or if not already approved, have been agreed for inclusion within financial plans by the NHS Improvement capital and cash team
- explain in their narratives how their proposed capital investments are consistent with their clinical strategies and how they demonstrate the delivery of safe, productive services
- given the constrained level of capital resource identified in the Spending Review from 2016/17 to 2020/21, demonstrate that the highest priority

schemes are being assessed and taken forward within plans that are affordable to the organisation

- where they are required to submit business cases for NHS Improvement, Department of Health and Social Care (DHSC) or HM Treasury approval, present robust strategic, economic, commercial, management and financial cases, including clear links between the investment case and activity and financial projections as well as workforce and productivity assumptions
- follow the key business case documentation requirements which may require the approval of strategic outline cases, outline business cases and full business cases
- outline how they plan to make better use of the NHS estate including maximising and accelerating disposals of surplus land and property.

In relation to quality and workforce, it will be important that providers can demonstrate:

- development and implementation of an affordable plan to make improvements in quality, particularly for providers in special measures
- application of a robust quality improvement methodology
- a plan for achieving the four priority standards for seven-day hospital services in an affordable way
- the application and monitoring of an effective quality impact assessment approach for all cost improvement programmes (CIPs)
- workforce productivity, particularly through effective use of e-rostering and less reliance on agency staffing
- triangulation of quality, workforce and finance indicators.

In short, trusts' operational plans must:

- provide for a reasonable and realistic level of activity profiled to take account of seasonality
- demonstrate the capacity to meet this
- provide adequate assurance on the robustness of workforce plans and the approach to quality
- be stretching from a financial perspective, planning to deliver (or exceed) the financial control total agreed with NHS Improvement, thus qualifying the provider for receipt of PSF, FRF and MRET funding
- take full advantage of efficiency opportunities (including those identified by the Carter reviews, GIRFT reports and the Model Hospital)
- demonstrate improvement in the delivery of core access and NHS Constitution standards
- contain affordable, value-for-money capital plans that are consistent with the clinical strategy and clearly demonstrate the delivery of safe, productive services
- be aligned with commissioner plans and underpinned by contracts that balance risk appropriately
- be consistent with and reflect the strategic intent of STPs, including the specific service changes, quality improvements and increased productivity and efficiency identified in the STPs, and with the system control total for the STP/ICS area
- be internally consistent between activity, workforce and finance plans.

Financial framework for providers

Section 3.3 of the *NHS operational planning and contracting guidance 2019/20* sets out details of the financial framework for providers. We have summarised the changes to the framework for 2019/20:

1. Provider Sustainability Fund (PSF)

- £1 billion will transfer into urgent and emergency care prices
- the £200 million targeted element of the PSF will be transferred into a financial recovery fund as detailed below
- the value of the PSF therefore reduces from £2.45 billion in 2018/19 to £1.25 billion in 2019/20
- £155 million of the PSF will be allocated to the non-acute sector, as we have in 2018/19 with £1.095 billion available to support the provision of emergency services in acute and specialist trusts
- control totals will be set on the basis that for every £1 in PSF the provider must improve its bottom line position by £1
 - providers will be eligible to earn their allocated PSF if they sign up to control totals
 - quarterly payments of PSF will be made in arrears subject to delivering the planned year-to-date financial performance only.

2. Financial Recovery Fund (FRF)

- created to support efforts to secure the financial sustainability of essential NHS services, with providers able to cover current day-to-day running costs while they tackle unwarranted variation
- allocated so that we can secure financially sustainable, essential NHS services within as many ICSs/STPs as possible
- in 2019/20 can only be accessed by providers in deficit who sign up to their control totals
- control totals will be set on the basis that for every £1 in FRF the provider must improve its bottom line position by £1

3. Marginal rate emergency tariff (MRET) funding

- 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, if they sign up to their control totals
- 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.

4. Provider financial management

- all providers will be expected to plan against rebased control totals which will be communicated in early January 2019
- 2019/20 control totals for trusts 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
- at a national level we have assumed a level of non-recurring benefit from gains on disposal of assets. We will work with providers to identify these opportunities and have adopted a revised approach to the treatment of these financial gains in the control total regime; providers will not be able to use any of these gains to deliver their original 2019/20 control total
- providers that sign up to their control totals and are therefore eligible to earn PSF will be exempt from most contract sanctions; the sanction for 52-week waits applies to all providers and commissioners; where a commissioner applies contract sanctions, the use of the resultant funding will be subject to sign-off by the joint NHS England/NHS Improvement regional teams
- NHS Improvement 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 historic debt on a case-by-case basis once a recovery plan has been agreed.

5. Operational plan narrative (both draft and final plans)

As outlined above in Section 4, as part of their draft and final operational plans, all providers are required to submit a narrative that supports the finance, activity and workforce returns alongside quality. This narrative should address NHS Improvement's key requirements of provider plans, as set out in Section 4. The supporting narrative submitted at 12 February 2019, although 'draft', should represent a full account of the operational plan at that date.

Although there are no templates for the narrative element of operational plans, we set out below what the plans need to demonstrate. We recommend providers use this structure as far as possible to help with the consistency of plans.

Structure, format and length

Based on the guide below, the operational plan narrative should not be longer than 20 pages. Quality is far more important than quantity: we want to be able to understand each plan. Inability to summarise coherently and concisely will itself be considered as part of the assessment of risk.

It should be easy for us to reconcile the content in the written narrative with data in the finance, activity and workforce templates.

Activity planning (maximum two pages)

A fundamental requirement of the 2019/20 operational planning round is for providers and commissioners to have realistic and aligned activity plans. It is therefore essential they work together transparently to promote robust demand and capacity planning.

In the operational plan narrative, providers should support their activity returns with a written assessment of activity over the next year, based on robust demand and capacity modelling and lessons from previous years' winter and system resilience planning.

They should provide assurance to NHS Improvement that:

- activity returns are underpinned by agreed planning assumptions, with explanation about how these assumptions compare with expected growth rates in 2019/20

- they have sufficient capacity to deliver the level of activity that has been agreed with commissioners, indicating plans for using the independent sector to deliver activity, highlighting volumes and type of activity if possible and describing assumptions about length of stay
- activity plans are sufficient to deliver, or achieve recovery milestones for, all key operational standards, in particular A&E, RTT, incomplete pathways, cancer, and diagnostics waiting times
- extra capacity can be mobilised if needed as part of winter resilience plans – for instance, extra escalation beds arrangements are in place for managing unplanned changes in demand.

Quality planning (maximum four pages)

Quality standards for patient services are clearly set out in the NHS Constitution and in the CQC quality and safety standards. They continue to define the expectations for the services of providers. Providers should have a series of quality priorities for 2019/20 set out in a quality improvement plan. This plan needs to be underpinned by the local STP, the provider quality account, the needs of the local population and national planning guidance. To create these priorities, providers need to consider:

- national and local commissioning priorities
- the provider's quality goals, as defined by its strategy and quality account, and any key milestones and performance indicators attached to these goals to measure improvements in care
- key risks to quality and how these will be managed.

For the 2019/20 operational plan narrative, providers should outline their approach to quality in a narrative with three sections:

- approach to quality improvement, leadership and governance
- summary of the quality improvement plan (including compliance with national quality priorities)
- summary of the quality impact assessment process and oversight of implementation.

We will use this narrative to seek assurance that the approach to quality is sound and robust. Where appropriate, we may ask individual providers for more information, such as their detailed quality improvement plan.

1. *Approach to quality improvement, leadership and governance*

Providers should outline their approach to quality improvement including:

- a named executive lead for quality improvement
- a description of the organisation-wide improvement approach to achieving a good or outstanding CQC rating (or maintaining an outstanding rating) including the well-led domain, and the governance processes underpinning the improvement approach
- details of the quality improvement governance system, from the front line to the board, with details of how assurance and progress against quality improvement priorities are monitored
- how quality improvement capacity and capability will be built in the organisation to implement and sustain change
- measures being used to demonstrate and evidence the impact of the investment in quality improvement.

2. *Summary of the quality improvement plan*

Providers should detail their quality improvement plans in relation to local and national initiatives to be implemented during 2019/20. Providers must ensure their plans for quality are affordable and, in particular, that quality plans are triangulated with plans for finance, activity and workforce. Quality plans should include (but are not limited to):

- existing quality concerns (from internal intelligence, variations in care highlighted through initiatives such as GIRFT and RightCare, CQC, the quality account or other parties) and plans to address them
- the top three risks to quality and how the trust is mitigating these
- how learning from relevant national investigations has or will be implemented, including the Gosport Independent Panel (<https://www.gosportpanel.independent.gov.uk/panel-report/>)

- for providers of acute services, the degree of compliance with the four priority standards for seven-day hospital services as demonstrated through the new board assessment framework; this should include the date by which they expect to achieve compliance if they have not already done so, and how links are being made between seven-day hospital services and improvements to patient flow, length of stay and patient outcomes
- how the provider is learning from deaths in line with the National Quality Board guidance [/www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf](http://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf) (all trusts except ambulance – guidance for ambulance trusts will be published during 2019/20)
- plans to reduce Gram-negative bloodstream infections by 50% by 2021, which are aligned with wider health economy plans
- confirmation that a national early warning score (NEWS2) is fully embedded within acute and ambulance trusts, and that the recognition, response and appropriate escalation of patients who deteriorate are measured and improved.
<https://improvement.nhs.uk/news-alerts/safe-adoption-of-NEWS2/>
www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2

Trusts should also consider the Long Term Plan and reflect relevant initiatives in their narrative.

3. *Summary of quality impact assessment process and oversight of implementation*

Each provider should have an effective quality impact assessment (QIA) process for service developments and efficiency plans in line with National Quality Board guidance¹⁰ (examples include seven-day services and cost improvement programmes). Providers must complete QIAs for all CIPs which are developed before and during the financial year, and trust medical directors and nursing directors must sign off the QIA, to confirm that quality of care will not be adversely affected. This section should include:

- a description of the governance structure for creating CIPs, including acceptance and monitoring of implementation and scheme impact (whether positive or negative)

¹⁰https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/212819/How-to-Quality-Impact-Assess-Provider-Cost-Improvement-Plans-.pdf

- a narrative setting out how the governance structure operates, including:
 - how frontline/business unit-level clinicians create schemes
 - how potential risks are considered and how schemes are challenged before they are accepted, including whether there are different approaches based on risk thresholds, such as monetary value, risk score, etc
 - how key metrics are aligned to specific schemes and monitored through the year during and after implementing CIPs, to provide early warning of any adverse impact on the quality of care; metrics should measure impact on outcomes including patient experience
 - how intelligence is triangulated, particularly quality, workforce, activity and financial indicators; this should include the key indicators used in triangulation, how the trust board will use this information, and how this information will be used to improve the quality of care and enhance productivity
 - the QIA process and whether this is assessed against three core quality domains (safety, effectiveness and experience) or the five CQC domains (safe, effective, responsive, caring and well-led), and whether impact on staff is also considered
 - how QIAs receive sign-off by the trust medical director and nursing director
- a description of the process for board oversight of implementing CIPs, including how the board will identify and address potential deterioration in the quality of care. This should include how baseline data has been recorded before implementation of the change, including the duration of this data: eg to capture seasonal variations where the provider does not define specific metrics but uses generic quality measures.

The process for overseeing implementation should also enable the provider board to identify the cumulative impact of multiple CIPs on a particular pathway, service, team or professional group. This is important for all trusts but particularly for providers experiencing transactions, mergers or in special measures.

Workforce planning (maximum four pages)

To support the numeric workforce plan, providers must include the following in their operational plan narratives:

- demonstration that providers have a board-approved workforce plan and a robust approach to workforce planning, sign-off, monitoring and reporting that ensures sufficient staffing capacity and capability throughout the year to support the provision of safe, high quality services
- demonstration that the workforce plans are well-modelled and integrated with both financial, quality and activity plans to ensure the proposed workforce levels are affordable, sufficient and able to deliver efficient and safe care to patients
- the current workforce challenges at both a local and STP/ICS level, including their impact. Please include the challenges within specific staff groups (eg adult nursing) and challenges such as, but not limited to, supply, retention, Long Term Plan, the impact of Brexit, overseas recruitment, changes to NHS nursing and allied health professional bursaries. Please use the table below as a template for capturing this information.

Description of workforce challenge	Impact on workforce	Initiatives in place
<i>For example:</i> Shortage of adult nurses	Difficulty in recruiting to establishment; difficulty in rostering, reliance on bank and agency	Plans to recruit 10 whole-time equivalent nurses from Philippines. Due to start February 2019. Scoping out new roles/ ways of working, to include nurse associate role.

- An outline of the current workforce risks, issues and mitigations in place to address them, capturing the impact on patient safety, service quality and national guidelines (for example, the documents on the NHS Improvement website around [safer staffing and developing workforce safeguards](#)).

Please use the table below as a template for capturing this information.

Description of workforce risk	Impact of risk (high, medium, low)	Risk response strategy	Timescales and progress to date
<p><i>For example:</i></p> <p>50% turnover of Band 5 nurses within ICU within 12 months</p>	High	Using bank staff as a temporary solution to cover gap. Identifying reasons for leaving through exit interviews and engagement with staff through focus groups. Implementing 'itchy feet' conversations.	Exit interview feedback analysed and identified main reason for leaving was limited career development and expectations of working in this area not met. Developing a career on a page document to identify the career pathway within ICU and also rotation working. This element is to be completed by January 2019.

- An outline of your long-term vacancies (hard-to-fill posts over six months) and how you are planning to fill these vacancies: for example, use of bank, agency, workforce transformational roles. Please use the table below to capture this information and provide numbers where available.

Description of long-term vacancy, including the time this has been a vacancy post	Whole-time equivalent (WTE) impact	Impact on service delivery	Initiatives in place, along with timescales
<p><i>For example:</i></p> <p>Band 6 midwife. We started recruitment to this post in January 2018 and recruited two WTEs in March 2018 but have been unable to recruit to the additional five WTEs we require.</p>	5 WTE	Impact on rostering and patient safety	We are developing our maternity support worker workforce, upskilling three WTE Band 3 healthcare assistants who are due to complete their training in March 2019. We will continue to advertise for the Band 6 midwife post and work with our STP to address this gap.

- engagement with commissioners and collaborative working to ensure alignment with the future workforce strategy of their local health system, ICS/STPs
- the required workforce transformation and support to the current workforce, underpinned by new care models and redesigned pathways (responding to known supply issues), detailing specific staff group issues and how new roles/new ways of working are being used: eg advanced clinical practitioners, apprenticeships, new and extended roles
- plans for any new workforce initiatives agreed with partners and funded specifically for 2019/20 as part of the Five Year Forward View and Long Term Plan demonstrating the following:
 - a link with the STP/ICS approach to workforce planning and how this will be supported through the operational plan, including an overview of the transformation activities which will impact on the organisation
 - how a balance in workforce supply and demand will be achieved
 - the right skill mix, maximising the potential of current skills and providing the workforce with developmental opportunities underpinning strategies to manage agency and locum use including spend avoidance.

Approaches may include, but are not limited to, strengthening bank

staffing arrangements and using the flexible workforce by developing shared banks with other providers in the STP/ICS footprint. Providers should also consider the effective use of technology, including e-rostering and job planning systems, to enable more effective rota management and staff utilisation, focused on flexibility around patient need.

Operational plans should consider the impact of legislative changes and policy developments including (but not limited to) the opportunities identified in the Carter review for improved productivity, Long Term Plan, changes to the apprenticeship levy, the supply of staff from Europe and beyond, the immigration health surcharge and changes to NHS nursing and allied health professional bursaries, all of which should be taken into account in developing the workforce plan.

Financial planning (maximum six pages)

NHS operational planning and contracting guidance 2019/20 established the clear expectation that all providers will be expected to plan for and deliver against rebased control totals for 2019/20, to contribute to delivering financial balance across the NHS. Delivery of this expectation will require providers' plans to be stretching from a financial perspective, implementing transformational change through the STPs, and taking full advantage of efficiency opportunities to ensure the control totals for 2019/20 can be delivered.

Capital resources are constrained and will require prioritisation, so plans should only include schemes that are essential to the provision of safe, sustainable services, are affordable and offer value for money. Plans should be underpinned by robust financial forecasts and modelling and should be consistent with the strategic intent of the STP.

We therefore recommend providers divide their financial narratives as follows:

- financial forecasts and modelling
- efficiency savings for 2019/20
- agency rules
- capital planning.

1: Financial forecasts and modelling

Provider plans and priorities for quality, workforce and activity should align with the financial forecasts in their draft and final operational plans. The operational plan narrative should clearly set out how they make sure their plans are internally consistent.

To help providers demonstrate this, we will make available for mandatory submission a triangulation file that will include both reconciliation points and reasonableness tests between the differing elements of the operational plan. This file includes pilot bridge comparisons for the first time to help organisations assess whether the workforce and finance, and finance and activity, plans have been prepared on the same basis.

The plans will comprise financial projections based on robust local modelling and reasonable planning assumptions aligned with national expectations and local circumstances.

The forecasts should also be supported by clear financial commentary in the operational plan narrative.

Collectively the financial forecasts and commentary should explain how the control totals will be delivered and outline the key movements that bridge 2018/19 forecasts and plans for 2019/20, and clearly set out:

- the financial impact of implementing the new financial framework for providers and the planning assumptions set out in the *NHS operational planning and contracting guidance 2019/20* plus the impact of the 2019/20 national tariff; NHS Standard Contract and Commissioning for Quality and Innovation (CQUIN) guidance; it should also highlight any significant deviations from national assumptions
- the impact of activity changes, relating to underlying demand, quality, efficiency programmes, and the impact of other commissioning intent
- the provider should confirm that the agreed contract values are the same as those included in the plan; where there are differences, these should be disclosed and align with commissioner planning assumptions
- other key movements, including other changes in income expectations, revenue impact of any capital plans, or in-year non-recurrent income or expenditure

- the impact of initiatives, such as, but not limited to, CIPs, revenue-generation schemes, service developments and transactions.

The PSF, FRF and MRET funding are contingent on acceptance of the control total (receipt of which should only be included in plans where providers have agreed their financial control totals).

The narrative financial commentary should address:

- the assumptions underpinning these drivers
- the impact of these drivers on the overall financial forecasts – in particular, on performance against the Single Oversight Framework finance metrics
- the outcomes of any sensitivity analysis.

Operational plans will be developed before a final 2018/19 year-end financial position is known, so providers should use a projected year-end outturn for 2018/19 based on the most up-to-date and relevant information available. For the 12 February 2019 submission, the forecast outturn position used should agree with the Month 9 returns, and for the 4 April 2019 submission this should be updated to agree with the Month 11 position.

2: Efficiency savings for 2019/20

All providers should ensure they have a robust efficiency plan to enable them to deliver the control totals set for 2019/20 by NHS Improvement, with an emphasis on recurrent savings.

To achieve this, they should focus on the development and delivery of robust multi-year efficiency plans focusing primarily on increasing the productivity of the trust but also reflecting a growth in contribution from commercial income and overseas visitor cost recovery. Operational plan narratives should outline the key areas identified for operational efficiency including, but not limited to the areas within the joint NHS England and NHS Improvement efficiency plan (staff costs, procurement, pathology and imaging, community health and mental health services, medicines and pharmacy, corporate overhead reduction, estates infrastructure, reduced inappropriate interventions, patient safety, counter-fraud).

The efficiency plans should also reflect savings arising from collaboration and consolidation both within STP areas and wider networks, together with any opportunities identified through the commissioner-led programme.

The level of engagement with NHS Improvement operational productivity workstreams should be evident in the narrative.

Providers should set out their approach to identifying, quality assurance and monitoring the delivery of efficiency savings, including PMO arrangements.

3: Agency rules

Providers should outline how they will continue to make effective use of the agency rules and what they will do to ensure they will be able to contain spend within their annual agency ceiling. Providers should correctly analyse their paybill plan between substantive, bank and agency based on their best forecast of where they expect the spend to fall.

4: Capital planning

Providers' capital plans should be consistent with their clinical strategy, and clearly provide for the delivery of safe, productive services with business cases that demonstrate affordability and value for money. They should:

- demonstrate that the highest priority schemes are being assessed and taken forward
- continue to ensure that the provider's own internally generated capital resource funds the repayment of existing and new borrowing related to capital investment
- be aware that DHSC financing is likely to be available only in pre-agreed and exceptional cases
- continue to procure capital assets more efficiently and maximise and accelerate disposals of surplus land and property
- highlight where capital investment plans support opportunities for improved productivity identified by Lord Carter's review
- where applicable, also clearly demonstrate which schemes are above their delegated limit and when business cases will be submitted for approval.

Link to the local sustainability and transformation plan (maximum two pages)

Significant progress on transformation is expected in 2019/20 operational plans so all providers are expected to reflect the implementation of the local health and care system's STP. See *NHS operational planning and contracting guidance 2019/20* for more details.

Although we acknowledge that local health and care systems will be at different stages of their strategic development, providers should briefly in their narratives:

- how the vision for their local ICS/STP is being taken forward through the operational plan, including the provider's own role
- how priority transformational programmes articulated in the local system operating plan affect the provider's individual organisational operational plan (for instance, setting out the most locally critical milestones for accelerating progress in 2019/20 and the key improvements in finance/activity/workforce/quality these programmes are planned to deliver).

Membership and elections (NHS foundation trusts only) (maximum one page)

For 2019/20, NHS foundation trusts should provide a high level narrative on memberships and elections, including:

- governor elections in previous years and plans for the coming 12 months
- examples of governor recruitment, training and development, and activities to facilitate engagement between governors, members and the public membership strategy and efforts to engage a diverse range of members from across the constituency over past years
- plans for the next 12 months.

Any NHS foundation trusts that did not have NHS foundation trust status as at 1 April 2018 should also detail the activities of their shadow council of governors and members.

Note on publication of providers' operational plan narratives

NHS Improvement and providers have a mutual duty of candour and transparency.

This is particularly important in the spirit of 'open book' planning encouraged for 2019/20. It is therefore appropriate to make providers' final operational plans accessible to the widest possible audience.

We are therefore asking providers to prepare a separate version of the final operational plan narrative in May/June 2019 suitable for external communication that can then be published online on provider websites. This separate document should be written for a wide audience and exclude any commercially sensitive information but must be consistent with the full version.

6. NHS Improvement review of providers' operational plans

Key criteria on which plans will be assessed

In reviewing providers' operational plans for 2019/20, we will seek assurance that all providers have plans that meet the requirements in Section 4.

Therefore, while recognising the statutory differences between NHS trusts and NHS foundation trusts, we will seek to:

- assess all provider plans against these shared criteria
- be consistent in our responses to common risk and plan characteristics – rather than to NHS trust or NHS foundation trust status.

Methodology for review of draft operational plans

Regional teams from NHS Improvement will work with providers to support the preparation of plans.

Timing of draft plan review

NHS Improvement will undertake risk-based reviews of the initial and draft operational plans for all providers after 14 January (activity only) and 12 February respectively. This work will be concluded before 29 March. We will do most of the review work in this period so that:

- feedback offered to providers on their draft plans can be incorporated into providers' final operational plans for 2019/20
- we can focus more effectively on monitoring and supporting delivery of those plans from April 2019 onwards.

Desk-based review work

Central and regional teams will do some desk-based review for all draft plans as part of the assurance process. This is likely to include review of the:

- operational plan narrative against NHS Improvement requirements of provider plans (see Section 4)
- activity plans to seek assurance on the robustness of demand and capacity planning and key assumptions underpinning the activity and trajectory submissions
- key assumptions underpinning the financial projections, together with an application of tests to each provider's own financial projections
- providers' assurances on quality and workforce to identify any areas for further follow-up
- several areas of joint risk assessment between NHS Improvement and NHS England, in recognition of the need for alignment and the impact of local health and care system interactions on individual organisations (see the joint assurance process outlined in *Operational planning and contracting guidance 2019/20* and *Technical guidance for NHS planning 2019/20*).

Interactions with providers

The draft plan review process in January and February 2019 will often combine desk-based work with face-to-face discussions between providers and their NHS Improvement regional teams.

Methodology for review of final operational plans

We will conduct a high level review of providers' final operational plans following the 4 April 2019 submission. This will largely entail corroboration of the material movements we expect to see based on the discussions and feedback to the provider after the ICS/STP submissions, but we will also identify and follow up unexpected movements.

We will consider the implications for providers of their final operational plans and monitor their delivery during 2019/20 through the routine oversight and assurance processes.

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