Briefing Paper: Planning 19/20

Author: Rachna Vyas Sponsor: Mark Wightman/Paul Traynor **Trust Board paper G**

Executive Summary

Context

This short paper provides a summary of the planning guidance received to date from our regulators and outlines our plans to meet the requirements detailed.

Questions

1. What guidance has the Trust received to date?
2. Are we on track to deliver an integrated business plan for 19/20?
3. What are the key areas for concern?

Conclusion

1. The first part of the NHS shared planning guidance for 2019/20 was published at the end of December 2018. 'Preparing for 2019/20 Operational Planning and Contracting' is preparatory guidance that covers system planning, the financial settlement, operational plan requirements (for primary care, workforce, data and technology) and the process and timescales around the submission of plans.

2. The full guidance, including provider-specific technical guidance, will accompany five-year indicative CCG allocations in early January, and will set out the trust financial regime for 2019/20 and the service deliverables including those arising from year one of the Long Term Plan, which will also be published in January. In the absence of the full guidance, the planning team has been constructing the Annual Operational Plan using local intelligence from CMG's and the information available within the Trust.

3. The anticipated submission of activity and efficiency plans on January 14th 2019 is now just activity focused with the expectation of a covering letter describing how the system will work collectively towards a plan in common.

4. The key area of concern remains the timescales involved in completing this process, at the busiest operational time of the year – this is further compounded by the lack of complete information in the guidance released to date. Whilst the process has been streamlined as per learning from previous years, there remains a significant draw on both managerial and clinical time at CMG level. Corporate teams will be required to complete planning processes in line with the expected guidance between January and February, as well as align with the wider system plans at short notice.

Input Sought

The Board is asked to:

NOTE the progress made to date & the risks outlined;

RECOGNISE the increased requirements from CMG and corporate teams over the next few weeks.

For Reference

The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

This matter relates to the following *governance* initiatives:

Organisational Risk Register	[No]
Board Assurance Framework	[No]

Related **Patient and Public Involvement** actions taken, or to be taken:	[Not Applicable]
Results of any **Equality Impact Assessment**, relating to this matter:	[Comply]
Scheduled date for the **next paper** on this topic:	[Monthly]
Executive Summaries should not exceed **1 page**	[Does not Comply]
Papers should not exceed **7 pages**	[Comply]

Briefing paper: Planning 19/20
January 2019

Introduction

1. This short paper provides a summary of the planning guidance received to date from our regulators and outlines our plans to meet the requirements detailed.

Summary of guidance received to date

2. A summary of the guidance received to date is attached as Appendix A. This 'preparatory guidance' provides an overview of system planning, the financial settlement and operational planning requirements. The guidance does not include the full trust financial regime for next year, performance recovery trajectories, control total, indicative CCG allocations or any other deliverables for 2019/20.

3. Key points:
    a. There is a greater focus on system planning, with system control totals to be set for each Integrated Care System (ICS) and Sustainability and Transformation Partnership (STP). Providers within an ICS will be expected to link a proportion of their Provider Sustainability Fund (PSF) to the system control total. A full financial framework for ICSs will be published separately in the New Year.
    b. The National Tariff Proposals remain largely unchanged from those published in October (3.8% uplift). Subject to the statutory consultation, the blended payment system for urgent and emergency care will go ahead, meaning £1bn from the PSF and 50% of CQUIN being transferred into tariff. The proposals for funding centralised procurement and market forces factor remain.
    c. The Marginal Rate for Emergency Admissions. (MRET, which saw providers paid only 30% of tariff for admissions over baseline) and the 30 day readmissions penalty will be abolished. Albeit this has to be ‘cost neutral’ to the system, which is hard to foresee.
    d. Against that providers will be asked to deliver 1.1% efficiency over the next five years, with the guidance flagging a number of priorities from the Carter reviews that should be prioritised.
    e. NHS England will place an increased emphasis on achievement against the mental health investment standard. STP/ICS leaders will have the opportunity to review CCG investment plans.

f. The proposed changes to the NHS Standard Contract include splitting the sanction for 52-week waits between providers and commissioners.

4. Key deadlines

Action	Completion target	Status
National contracting and planning guidance published for 19/20	October/November 2018	Delayed
Summary of approach and planning requirements for the coming year/s considered at ESB/TB	Through October/November 2018	Complete
Set up internal Planning Group	*Ongoing from 18/19*	Complete
Identify membership in the LLR wide Planning Operational Group	October 2018	Complete
Set up CMG-level planning workshops, to be held in Nov 2018	October 2018	Complete
Draft annual priorities agreed & Planning progress briefing to ESB & IFPIC	Through November 2018	Complete
Approach to planning v2 at ESB	November 13th	Complete
Approach to planning agreed at HoOps	November 16th	Complete
Preparation of UHL organisational plan	Through Nov-Jan	On track
Initial draft of UHL plan approved for submission by COO, CEX & DoF	January 12th	On track
Submit 2019/20 Initial UHL plan (NHSI)	January 14th	On track
Approval of Draft UHL and system operational plans at Trust Board for submission on 12th/19th	February 7th	
Submit draft 2019/20 organisation operating plans	February 12th	
Submit aggregate system 2019/20 operating plan submissions & system operational plan narrative	February 19th	
2019/20 contract/plan alignment submission	March 5th	
2019/20 national tariff published	March 11th	
Deadline for 2019/20 contract signature	March 21st	
Approval of UHL and system operating plans by Extraordinary Trust Board	March 28th	
Final 2019/20 organisation operating plan submission	April 4th	
Aggregated 2019/20 system operating plan submissions & system operational plan narrative	April 11th	

5. **Conclusion:**

Full planning guidance is expected later in January along with the NHS 10 Year Plan, the deadlines above will be adapted as and when the guidance is updated. In the meantime the UHL corporate and CMG teams are working hard on the Trust's 19/20 plan as part of the wider LLR system.

NOTE: Should there be further guidance issued between the time of writing and the Trust Board a verbal update will be provided.

Input Sought

The Board is asked to:

NOTE the progress made to date & the risks outlined;

RECOGNISE the increased requirements from CMG and corporate teams over the next few weeks.

Appendix 1: Full summary of guidance

Appendix 2: Full guidance

on the day BRIEFING

NHS Providers

2019/20 preparatory planning guidance

NHS England (NHSE) and NHS Improvement (NHSI) published the first part of the 2019/20 operational planning guidance on Friday 21 December 2019. This 'preparatory guidance' provides an overview of system planning, the financial settlement and operational planning requirements. The guidance is unusually late this year and does not include the full trust financial regime for next year, performance recovery trajectories, control totals, indicative CCG allocations or any other deliverables for 2019/20. Full planning guidance is expected in January along with the long awaited NHS long term plan and we will brief fully and publicly comment on these documents when they are published.

Alongside the first part of the planning guidance, NHS England has launched a consultation on the draft NHS Standard Contract 2019/20 as well as proposals on the use of a standard activity and finance report (Aggregate Contract Monitoring report).

The documents published in December include:

- Preparing for 2019/20 Operational Planning and Contracting (first part of the planning guidance)
- 2019/20 NHS Standard Contract documentation (covering both the consultation and contract reporting proposals)
- 2019/20 draft tariff planning prices

Key points

- There is a greater focus on system planning, with system control totals to be set for each Integrated Care System (ICS) and Sustainability and Transformation Partnership (STP). Providers within an ICS will be expected to link a proportion of their Provider Sustainability Fund (PSF) to the system control total. A full financial framework for ICSs will be published separately in the new year.
- The National Tariff Proposals remain largely unchanged from those published in October. Subject to the statutory consultation, the blended payments system for urgent and emergency care will go ahead, with £1bn from the PSF being transferred into emergency care prices. The proposals for funding centralised procurement and market forces factor remain.
- NHS England will place an increased emphasis on achievement against the mental health investment standard. STP/ICS leaders will have the opportunity to review CCG investment plans.
- Providers will be asked to deliver 1.1% efficiency over the next five years, with the guidance flagging a number of priorities from the Carter reviews that should be prioritised.
- The proposed changes to the NHS Standard Contract include splitting the sanction for 52-week waits between providers and commissioners.

Summary of proposals

System planning

All STPs and ICSs will be expected to produce system plans for 2019/20. These shared capacity and activity plans should be realistic and based on local trends, with both providers and commissioners operating an 'open book' approach during planning. System plans should set out an overview of how financial resources will be used, including specialised and direct commissioning as well as CCG and provider plans. The plans will also need to include a 'system data aggregation' that sets out how individual organisational plans (including for activity, workforce, finance, and contracting) align with system plans. Further detail on this, including an 'aggregation tool', will be included in the technical guidance expected in January. The new joint NHSE/I regional directors will likely play a role in these plans.

A system control total will be set for each STP/ICS. This will amount to the sum of individual organisational control totals, but all STP/ICSs will have the opportunity to propose net-neutral changes as long as these are agreed by all organisations. Regional directors will approve any proposals. ICSs will be expected to link a proportion of their Provider Sustainability Fund (PSF) and any applicable Commissioner Sustainability Fund (CSF) to the delivery of a system control total. A full financial framework for ICSs will be communicated separately. STPs will be offered the opportunity to do link PSF/CSF as well, which indicates this will be an important indicator of system maturity.

Ambulance trusts will be expected to be included in the system of their host commissioner, while any provider with a significant proportion of income flowing from outside their STP/ICS may be included pro-rata in more than one system (if agreed by the provider, relevant STP/ICS leaders and relevant regional director). Specialised commissioning will not be reflected in system control totals.

Financial requirements

National tariff proposals

The guidance gives details on the 2019/20 national tariff, following feedback on the October payment system reform policy paper. These details are still subject to the statutory consultation expected in January, with further details expected in the technical guidance still to be published:

- The uplift in the national tariff will be set at 3.8%. This will include the costs of the Agenda for Change pay award for 2019/20. It excludes the £1bn of PSF and half of the money previously set aside for CQUIN, both of which will be transferred into prices.
- The tariff efficiency factor will be set at 1.1%.
- The new centralised procurement scheme will be funded by a top slice to the tariff.
- The blended payments system for emergency activity is going ahead. This will include a fixed element based on locally agreed planned activity levels as well as the variable element, set at 20% of prices. It will cover non-elective admissions, A&E attendances and ambulatory/same day emergency care.
- The marginal rate emergency tariff (MRET) and 30-day readmission rule will be abolished but on a 'financially neutral basis' between providers and commissioners.

- The updated market forces factor (MFF) will be implemented next year, phased over a five year period

CCG funding

Indicative CCG funding allocations will be published in January, but these are expected to be set to fund a 'stretching but reasonable' level of activity. The national bodies intend to improve the funding formula so that it is more responsive to health inequalities and unmet need. The CSF will be phased out over the next few years, and will reduce from £400m to £300m in 2019/20. CCGs will still be expected to break even in 2019/20. They will not be required to contribute to a national risk reserve but will be expected to deliver a 20% real terms reduction in their running costs by 2020/21 (against 2017/18 levels).

Mental health investment

As part of the new CCG funding formula, there will be renewed focus on the mental health investment standard (MHIS). In 2019/20 the standard requires CCGs to increase spend by at least as much as the increase in their overall programme allocation growth, plus an additional percentage increment. The minimum percentage uplift in mental health spend for each CCG will be shown in the financial planning template, to be published in January.

STP/ICS leaders will have the opportunity to review each CCG's investment plan underpinning the MHIS, with any concerns escalated to the regional teams. Where a commissioner fails to achieve its MHIS, NHSE will consider appropriate action, which may include imposing directions on the CCG. As part of a national assessment of MHIS, NHSE will review mental health spend per head, as a percentage of CCG allocations.

Productivity and efficiency

The 2018 autumn budget set out the minimum efficiency requirement for the NHS in the next five years of 1.1% per year. The planning guidance states this will require focus on greater staff productivity, investment in new digital technology and wider infrastructure, and through service transformation.

In 2019/20 CCGs, STPs and ICSs will be asked to implement the Evidence-Based Interventions guidance published earlier this year, with national performance monitoring being launched from April 2019.

Providers will be expected to focus on key efficiency areas detailed in Lord Carter's operational productivity reviews. These include:

- Digitally-enabled outpatient operational models
- Improved availability of mobile devices and digital service for staff
- Improved deployment and availability of clinical workforce
- Accelerate the pace of procurement savings
- Making best of use of estates, with a particular focus on energy efficiency, clinical space utilisation and implementation of modern operation models for community services
- Improved use of shared corporate services
- Continued rollout of pathology and imaging networks

- Better value from medicines and pharmacy, including implementation of e-prescribing and removal of low value prescribing

Specialised commissioning

Direct commissioning of specialised services will focus on the following priorities over the next two years:

- Helping more cancer patients benefit from new, innovative specialised cancer treatments
- Providing specialised mental health services that are integrated with local services and delivered as close to home as possible
- Reducing treatment in inpatient facilities for people with learning disability and autism
- Improving cardiovascular services
- Improving outcomes and reducing mortality rates for babies, children and young people
- Supporting patients with a range of long term conditions, including those with Hepatitis C and those accessing neurosciences services
- Improving equity of access to services
- Enabling patients to benefit from the latest advances in genomics and personalised medicine

Commissioning for quality and innovation (CQUIN)

CQUIN schemes will be reduced by 50% to 1.25% from April 2019, with a corresponding increase in core prices through the tariff uplift. The CQUIN scheme itself will also be simplified – the planning guidance emphasises that it should be 'earnable'. Full details are expected in separate CQUIN guidance.

The planning guidance confirms NHS Resolution will continue to collect 10% of the maternity contribution from providers that provide maternity services to support the fund for the Maternity Incentive Scheme.

NHS Standard Contract proposals

A draft 2019/20 NHS Standard Contract has been published for consultation, with a final version set to be launched in February 2019. The deadline for agreeing contracts is 21 March 2019.

A number of changes are proposed to the contract, but potentially the most significant involves a new arrangement around 52-week breaches. For providers that sign up to their control total, the 52-week breach sanction, set at £5,000 in 2018/19, will be suspended. In its place, both providers and commissioners will be sanctioned £2,500 each, ensuring the financial burden for 52-week breaches is shared across local systems. The aggregate sanction may only be used at the express direction of the regional team, which will determine how best it be applied.

The consultation closes on 1 February. NHS Providers will be submitting a response on behalf of our members. Please get in touch with adam.wright@nhsproviders.org and david.williams@nhsproviders.org by January 20th if you would like to comment.

Proposals for the mandated use of a standard activity and finance report, and supporting data flows, have also been published. This follows an engagement exercise carried out in January 2018. A new Information Standards Notice is expected in early 2019 to reflect these changes.

Operational plan requirements

The guidance provides an overview of operational plan requirements, but further detail is expected in the full guidance to be published in January.

CCGs will be asked to commit a recurrent £1.50 per head to continue to develop and maintain primary care networks. STPs/ICSs must have a Primary Care Strategy in place by 1 April 2019, setting out their overall strategy for population health.

Providers will be expected to update workforce plans to reflect the latest projections of supply and retention, pay reforms and planned reductions in bank and locum use. A 'bank first' approach to temporary staffing is encouraged. A national retention programme will also be rolled out next year.

From April 2019 providers will need to submit all commissioning datasets to the Secondary Uses Services (SUS+) on a weekly basis. NHS Digital will eventually mandate this requirement. Emergency care datasets must continue to be submitted daily.

More organisations will join the Global Digital Exemplar and Local Health and Care Record Exemplar programmes next year. Core standards across interoperability, cyber security, design and commercial will be mandated in 2019.

NHS Providers' view

Because this is only the first part of the planning guidance, it will be difficult to understand the full impact on providers until the remainder of the guidance is published alongside the long term plan in January.

The 2019/20 planning round is likely to be more complex than previous years. Providers will need to work with multiple organisations and individuals to complete detailed organisation and system plans. Aligning resource, workforce and capacity/demand projections across systems is the right thing to do. But the submission timescales remain compressed and delays to guidance publications will place further pressure on providers. We look forward to understanding what the 'deliverables' are for next year, including performance recovery trajectories and financial control totals, as these will determine the plausibility of the requirement for 2019/20.

On the surface, system control totals appear to be a step in the right direction, although NHSE and NHSI will need to set out how accountability for their delivery will work. It is disappointing not to see specialised commissioning funding reflected in system controls, not least because it will make it much harder for larger specialised trusts to plan effectively. We look forward to the full financial framework for ICSs that will hopefully clarify some of this.

It is disappointing to see few changes to the autumn national tariff proposals. Affected trusts will be particularly concerned about the impact of the procurement top slice and the changes to the market forces factor and CCG allocations. They will want to assess what these changes mean for them on an individual basis. Some trusts seem likely to be adversely affected by all three changes, with a potentially significant aggregate negative impact. There is a danger that community and mental health trusts are particularly disadvantaged by the proposed procurement top slice. Providers will however welcome the £1bn transfer from PSF into emergency care prices, as this will mean prices can become more reflective of costs.

Acute trusts will welcome the elimination of the marginal rate for emergency admissions, which NHS Providers has long campaigned for, though they will want to see what a "cost neutral approach" actually means and will want to ensure that the new blended payment doesn't turn into a new marginal rate by default

We welcome the renewed commitment to the mental health investment standard and providers will continue to submit data to support the monitoring of this national priority. The reduction in complicated CQUIN schemes and the transfer of some of this money into tariff is a positive step, as are the changes to the 52-week breach fines set out in the standard contract.

Overall, providers will need to see the full guidance to ensure robust planning for 2019/20 can take place. This should be published as soon as possible.

Annex – planning timetable

- 14 January - initial plan submission (activity focused)
- 12 February – draft 2019/20 organization operational plans
- 19 February – draft aggregate system 2019/20 operation plan submission, system operating plan overview and STP led contract/plan alignment submission
- 21 March – deadline for 2019/20 contract signature
- 29 March – organization board approval of 2019/20 budgets
- 4 April – final 2019/20 organization operational plan submission
- 11 April – final aggregate system 2019/20 operation plan submission, system operating plan overview and STP led contract/plan alignment submission
- Autumn 2019 – 5 year system plans to be signed off by all organisations

Appendix 2

Preparing for 2019/20 Operational Planning and Contracting

December 2018

Preparing for 2019/20 Operational Planning and Contracting

Version number: 1.0

First published: 21 December 2018

Updated:

Prepared by: NHS England and NHS Improvement

NHS England Publications Gateway Reference: 08660

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net

1 Introduction

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

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

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

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

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

2 System planning

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

2.1 System leadership and system working

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

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

The system operating plan will have two elements:

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

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

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

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

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

2.1.1 January checkpoint

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

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

2.1.2 System control totals

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

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

2.1.3 Inclusion of providers and commissioners in a system control total

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

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

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

2.1.4 System efficiency

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

2.2 Brexit

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

3 Financial settlement

3.1 Financial architecture

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

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

3.2 Payment reform and national tariff

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

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

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

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

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

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

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

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

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

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

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

3.3 Financial framework for CCGs

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

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

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

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

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

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

3.4 CCG administration costs

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

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

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

3.5 Mental Health Investment

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

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

STP/ICS leaders, including a nominated lead mental health provider, will review each CCG's investment plan underpinning the MHIS to ensure it covers all of the priority areas for the programme and the related workforce requirements. Any concerns that proposed investments will be inadequate to meet the programme requirements should be escalated to the regional teams.

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

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

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

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

3.6 Underlying Financial Assumptions

3.6.1 Productivity and Efficiency

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Category 2 – action required from providers to accelerate ongoing opportunities

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

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

3.6.2 Specialised Services and other Direct Commissioning

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

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

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

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

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

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

3.7 NHS Standard Contract

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

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

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

3.8 Incentives: Commissioning for Quality and innovation (CQUIN)

3.8.1 CQUIN

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

In recent years CQUIN has secured improvements across a diverse range of goals, including treatment of sepsis, venous thromboembolism management, Hepatitis C treatment and staff flu vaccinations. It has worked well where used to accelerate the uptake of known interventions which are clearly defined and widely supported.

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

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

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

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

3.8.2 NHS Resolution (NHSR) Maternity Incentive Scheme

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

4 Operational plan requirements

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

4.1 Primary Care

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

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

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

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

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

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

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

4.2 Workforce

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

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

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

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

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

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

4.3 Data and Technology

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

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

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

5 Process and timescale

5.1 Submission of organisational operational plans and system plans

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

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

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

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

5.2 Timetable

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