

NHS Operational Planning and Contracting Guidance 2020/21

January 2020

[#NHSLongTermPlan](#)

www.longtermplan.nhs.uk





Publishing Approval Reference 001300

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1. Introduction

The NHS Long Term Plan, published in January 2019, set out the transformation of services and outcomes the NHS will deliver by 2023/24 by investing the long term revenue settlement we have received from the government. The NHS and its partners have used this stability to develop local system-wide strategic plans during 2019 that will put the NHS on a sustainable financial footing whilst expanding and improving the services and care it provides patients and the public.

These plans will be aggregated and published in the National Implementation Plan shortly after the publication of the People Plan in the coming months. In 2020/21 this means the NHS is planning to:

- deliver the 2020/21 elements of the NHS Long Term Plan commitments, which local systems have developed through their strategic plans;
- maintain and improve access to services, specifically:
 - improve Urgent and Emergency Care (UEC) performance and expand the capacity available to meet UEC demand - this includes reducing bed occupancy levels to a maximum of 92% through acute bed expansions, increasing community care, investment in primary care and improvements in length of stay and admission avoidance.
 - stabilise and reduce waiting lists for elective care and eradicate waits of 52 weeks or more, including freeing up capacity through the reduction of face to face outpatient appointments.
 - improve performance against cancer operational standards including the 62 day standard and ensure that at least 70% of people receive a cancer diagnosis within 28 days.
- expand primary and community services by:
 - increasing investment in primary medical and community services in line with the NHS Long Term Plan commitment to lift spend on primary medical and community services by £4.5bn in real terms by 2023/24.
 - increasing the primary care workforce under the Additional Roles Scheme and increasing the number of doctors working in primary care.
 - increasing the number of appointments in general practice to address long waits for routine appointments, and provide 100% of the population with access to online GP consultations.
 - implementing the forthcoming GP contract changes and revised service specifications and develop primary care networks.
- continue to transform the way we provide care by working within systems including both NHS and wider partners to take a far more proactive approach on the prevention of ill-health, including through expansions to smoking cessation, alcohol care and diabetes prevention services, and embracing the opportunities offered by technology to improve care, moderate demand growth and deliver services more efficiently.

- meet the Mental Health Investment Standard with an additional investment of £1.5bn in mental health services. This will fund the service improvements set out in the mental health implementation plan, including expanding access to Improving Access to Psychological Therapies (IAPT) by over 14% so that nearly 1.5 million people are able to benefit.
- continue to improve outcomes and care for people of all ages with a learning disability or autism and delivering against the commitments to reduce the number of adults and children receiving care in an inpatient setting.
- begin to implement the forthcoming People Plan, and in particular within 2020/21 focus on increasing the number of nurses working in the NHS through improved retention and expansion of international recruitment.
- reduce the impact the NHS has on the environment by reducing its carbon footprint, reducing the use of avoidable single-use plastics, and working with partners, including local government, to tackle local air pollution.
- live within agreed financial trajectories. Deliver productivity and efficiency improvements by continuing to maximise opportunities identified through programmes such as RightCare, Model Hospital and Getting it Right First Time (GIRFT) to reduce unwarranted variation.
- embed and strengthen the governance of our systems as we move to a 'system by default' operational model and prepare all systems to become an Integrated Care System (ICS) by April 2021.

2. System planning

In 2019/20 NHS England and NHS Improvement set out and began to implement our new Operating Model for the NHS. During 2020/21 we will continue to strengthen this model so that we:

- work together and with arm's length bodies to provide a single voice for the NHS.
- work with and through our regional offices.
- lead and role model the cultural and behavioural changes we wish to see in the NHS.

As part of this change every part of the country is moving towards becoming an Integrated Care System by April 2021, so 2020/21 will be a critical year in the development of system working as we start working through ICSs and STPs on a “system by default” basis.

2.1 System development

Integrated Care Systems will undertake two core roles: system transformation and collective management of system performance.

Different systems are at different levels of maturity, however, there are some consistent operating arrangements that we expect all systems to agree with regional directors and to put in place during 2020:

- system-wide governance arrangements (including a system partnership board with NHS, Local Government and other partners) to enable a collective model of responsibility and decision-making between system partners.
- a leadership model for the system, including a Sustainability and Transformation Partnership (STP)/ ICS leader with sufficient capacity, and a non-executive chair appointed in line with NHS England and NHS Improvement guidance.
- the system capabilities including population health management, service redesign, workforce transformation, and digitisation required to fulfil the two core roles of an ICS. The system should also agree a sustainable model for resourcing these collective functions or activities. NHS England and NHS Improvement will contribute part-funding for system infrastructure in 2020/21.
- agreed ways of working across the system in respect of financial governance and collaboration (noting that we propose, under the 2020/21 NHS Standard Contract, to require Clinical Commissioning Groups (CCGs) and NHS trusts/NHS foundation trusts to participate in a System Collaboration and Financial Management Agreement – see section 5.8 below).

- streamlining commissioning arrangements, including typically one CCG per system. Formal written applications should be made at the latest by 30 September 2020 for a merger which is proposed for 1 April 2021.
- capital and estates plans at a system level, as the system becomes the main basis for capital planning, including technology.

The wider range of responsibilities for ICSs are described in more detail in the NHS Long Term Plan and the maturity matrix in [Designing ICSs in England](#) (published earlier this year). Further detail will be set out in the National Implementation Plan.

To support this approach, NHS England and NHS Improvement will move to a combined System Oversight Framework for providers and CCGs, on which we will shortly consult.

2.2 System planning

Operational plans will implement the first year of local strategic plans. We ask that:

- system leaders agree individual commissioner and provider plans to ensure they are consistent with the goals, assumptions and financial trajectories in system plans that have been agreed with NHS England and NHS Improvement.
- systems submit a short operational narrative to set out any operational risks or variation from their agreed strategic plan and describe the action that system partners will take to manage this during 2020/21.
- systems set out proposals to use revenue transformation or capital funds where these have been allocated to systems and the benefit they anticipate from the application of those resources.
- NHS and Local Authority partners agree the key elements of the planning for the Better Care Fund and assumptions for increasing health and social care capacity.

2.3 Financial controls and allocations

To support system working, we are proposing some changes to the financial architecture of the NHS (more detail is set out in chapter 5):

- we will continue to operate system control totals across the country. System leaders will be able to agree with regional directors net neutral changes in individual organisational financial trajectories in the planning process and during the year.
- 50% of the Financial Recovery Fund will be tied to system financial performance and not just to individual organisation performance to avoid financial pressures simply being passed, for example, between commissioners and providers.
- some capital funding and revenue transformation funding will be allocated to systems to agree how it is to be used consistently to deliver national frameworks and objectives. We begin this process in this planning round and will seek to

increase the proportion of all national funding that goes through this route. However, continued access to system capital and transformation funding will depend on delivering system financial trajectories.

- the release of the revenue transformation funding will depend upon agreement of system plans with NHS England and NHS Improvement.

Last year we signalled our intention to move towards greater integration of specialised services with local health and care systems. During 2020/21 we will continue to support local systems that express an interest to plan and deliver specialised services as locally as possible to join up care pathways and improve patient outcomes and experience. This will include a review of the underpinning financial architecture for specialised commissioning.

As part of this agenda, from April 2020 NHS England and NHS Improvement are enabling local service providers to join under NHS-led provider collaboratives that will be responsible for managing the budget and patient pathway for specialised mental health, learning disability and autism care. Further detail is included in Annex G of the Technical Guidance.

3. Operational requirements

Local system-wide strategic plans to implement the NHS Long Term Plan already include a set of performance trajectories which should be reflected in operational plans (the list of key metrics is contained in Annex F of the Technical Guidance). We set out some further elements below that will need to be reflected and tested in 2020/21 operational plans.

The Clinically-led Review of NHS Access Standards is currently testing new standards in 70 trusts across the country which will inform final recommendations from the review in the spring of 2020. Existing standards remain in place until a point that new standards are introduced. The approach to implementation for each pathway will be considered individually, any changes will be agreed with government, and further operational guidance will be published in March 2020. More information (including the findings from Interim Report) can be found [here](#).

3.1 Primary care and community health services

[Investment and evolution: A five-year framework for GP contract reform](#) was published in 2019 and sets out a number of reforms including the creation of Primary Care Networks (PCNs) across England and minimum entitlements for general practice to support the development of PCNs. Updated arrangements will be set out in the forthcoming contract.

In 2020/21, PCNs will continue to develop and expand with significant additional funding for workforce growth. The three main priorities for PCN development support in 2020/21 are (i) supporting workforce redesign and team development, (ii) improve patient access and practice waiting times, and (iii) building operational relationships with community providers (including pharmacies) to support integrated care.

PCNs are at various stages of maturity. Systems will be investing their fair share of £45m into PCN development in 2020/21, including support for leadership development. A national prospectus has been developed and this will be updated in early 2020. Systems should continue to work with PCNs and PCN Clinical Directors to support their development on the three priorities.

Specifically, in 2020/21, STPs/ICSs and CCGs must:

- work with PCNs to maximise recruitment under the [Additional Roles Reimbursement Scheme](#) and take action to support them (for example, by running shared recruitment processes or brokering joint / rotational staffing models with community pharmacies or trusts). We will expect every system to

develop a plan, agreed with PCN clinical directors, to spend the available funding.

- support the recruitment and retention of extra doctors working in general practice.
- work with PCNs to a particular early focus on supporting improvements in practices with long waits for routine appointments. CCGs must provide monthly data to each PCN showing the number and cost of A&E attendances by that PCN's patient population. During the year this should form an integral part of the PCN dashboard.
- ensure full delivery of online consultation systems to general practices where these are not already in place; learn from the work of the digital first primary care accelerator project; and ensure full delivery of direct booking from 111 to in hours appointments (as per the 2019/20 GP contract).
- lead the transition to the new GPIT Futures Digital Care Services Framework arrangements. CCGs should work collaboratively with their constituent GP Practices and PCNs to develop plans to re-procure the GP systems.
- work with PCNs to deliver national service requirements from 2020/21, details of which will be set out in the final version of the forthcoming GP contract and Network Contract Direct Enhanced Service (DES). Funding invested by CCGs during 2019/20 in local service provision which will be duplicated through delivery of the new service requirements in the Primary Care Network Contract DES in 2020/21 should be reinvested within primary medical care. Further detail will be set out shortly at the conclusion of the GP contract negotiations for 2020/21, including how systems support mobilisation of services and ensure that local community service teams are configured in line with PCN boundaries.
- provide CCG support to implement the NHS's comprehensive model of personalised care and meet 2020/21 system trajectories for personalised care and support planning, Personal Health Budgets and social prescribing.

The role of community health services is crucial and ICSs and STPs should ensure:

- the continued implementation of Lord Carter's recommendations for improving the productivity and efficiency of services delivered in the community.
- that all providers, including third and independent sector providers, submit comprehensive data to the Community Services Data Set.
- progress towards achieving full access to digital mobile services for the community workforce.
- they work to deliver crisis response services within two hours of referral and reablement care within two days of referral to those patients who are judged to need it. Specifically, for 2020/21, every community provider must as a minimum provide an agreed number of guaranteed two-hour home response appointments to be made available to ambulance and other agreed local services for 1 November 2020 to 31 March 2021.

3.2 Mental health

System-wide strategic plans developed by STPs/ICSs have indicated how they plan to transform mental health services by 2023/24. 2020/21 is an important year for mental health, as we complete the improvements outlined in the original Five Year Forward View for Mental Health and see significant baseline and transformation funding increases across key programmes (perinatal, children and young people, adult and older adult and IAPT).

All Mental Health NHS Long Term Plan deliverables are already been outlined in the [Mental Health Implementation Plan](#), so are not repeated here.

As in previous operational planning rounds, STP/ICSs leaders, working in partnership with a lead mental health provider, should assure that finance, activity and workforce plans are triangulated and support the delivery of key transformation programmes. In addition, we ask systems to build upon 1st November 2019 mental health workforce submission to include non-NHS providers.

The NHS Long Term Plan and Mental Health Implementation Plan both highlight the importance of addressing mental health inequalities, as such, operational plans must take into account actions which reduce inequalities within population footprints.

NHS-led Provider Collaboratives will play an increasing role in commissioning whole pathways of care across ICSs, and as indicated in systems' strategic plans, STPs/ ICSs must have plans that recognise these collaboratives and align with the ambition that these will be managing all appropriate specialised mental health, learning disability and autism services by 2023/24.

In 2020/21, CCGs will have ~£135m of NHS Long Term Plan baseline funding to bolster their community mental health provision for adults and older adults. CCGs should refer to the NHS [Long Term Plan Analytical tool](#) to understand the baseline funding available for their respective CCG. Whilst pilots of new integrated primary and community models are being tested in a subset of STPs, all CCGs should increase investment and staffing in core and dedicated (for eating disorders, mental health rehabilitation and “personality disorder”) community mental health services now as well as plan for future community provision, in line with the recently published [Community Mental Health Framework](#). In 2020/21, CCGs will receive 40% of salary support for trainees to support the expansion of IAPT services. In 2020/21 we expect continued improvement in assuring achievement of children and young people access standards through the Mental Health Data Set (MHDS).

In order to facilitate the move towards new integrated primary and community mental health models as set out in the *NHS Mental Health Implementation Plan 2019/20 – 2023/24* and the *Community Mental Health Framework* (see links to documents, above), all providers of community mental health services for adults and older adults

should put in place arrangements with PCNs within their footprints, by March 2021, to organise and begin delivering services in an integrated manner.

3.3 Learning disabilities and autism

In 2020/21, the NHS will continue to improve the health and wellbeing of people of all ages with a learning disability and/or autism and their families: a better start for children with support for families; better health and care; work to tackle health inequalities and reasonable adjustments to ensure people can access services fairly.

There will be an increased emphasis upon ensuring there is the right range of support and care services in the community so that people can lead longer, happier, healthier lives in the community, not hospitals. Working with 'experts by experience' this includes the development of a seven-day specialist multi-disciplinary service and crisis care in each local area; specialist community teams for children and young people so that an admission to hospital is only considered when all alternatives have been exhausted; and community forensic services.

We will work to maximise choice and control for people with a learning disability, autism or both and their families through increased use of Personal Health Budgets; through stimulating health and care provision to offer tailored, effective and safe services that can support people to live the lives they choose in the community; and through supporting access to independent advocacy.

The NHS will also work to address the particular health inequalities experienced by autistic people including an autism-specific health check, work on autism diagnosis, and testing a 'reasonable adjustment' flag in primary care.

The national deliverables for people with a learning disability, autism or both are:

- a reduction in reliance on inpatient care for people with a learning disability, autism or both to meet the NHS Long Term Plan commitments so that by 2023/24 there will be no more than 30 adults with a learning disability, autism or both per million adults in an inpatient setting and no more than 12-15 children and young people per million children in an inpatient setting.
- local areas will align their plans for children and young people across special educational needs and disability, mental health, health and justice and learning disability and autism to ensure that children and young people have a better start.
- engagement with emerging provider collaboratives (from April 2020) which will develop discharge pathways and community alternatives to inpatient provision.
- development of community services that can provide robust and person centred alternatives to hospital admission.
- making full use of Care (Education) and Treatment Reviews (CTRS and CETRS) and independently chaired C(E)TRs to ensure that all those involved in a person's care and treatment are acting to ensure that the person can be

discharged from hospital (using the 12 Point Discharge Plan) as soon as they are well enough to leave.

- 8 week visits for all adults and 6 week visits for all children and young people in inpatient settings out of area.
- establishing arrangements for 'host commissioner' oversight of local inpatient facilities.
- at least 75% of people aged 14 and over with a learning disability on GP learning disability register should have had an annual health check within the last twelve months, and CCGs should also work with PCNs to increase flu vaccinations rates for people with a learning disability.
- a robust CCG plan in place to ensure that Learning Disability Mortality Reviews (LeDeR) are allocated within 3 months and completed within 6 months of the notification of death to the local area. CCGs are expected to be a member of a 'Learning from LeDeR' steering group and have a named person with lead responsibility. An annual report will be submitted to the appropriate board/committee for all statutory partners demonstrating action taken and outcomes from LeDeR reviews.

3.4 Urgent and Emergency Care

In 2020/21 A&E performance must improve, and all providers should plan to deliver a material improvement against a 2019/20 benchmark. To achieve this, systems and organisations will be expected to reduce general and acute bed occupancy levels to a maximum of 92%. This means that the long period of reducing the number of beds across the NHS should not be expected to continue. In addition, local systems should deliver improvements to the responsiveness of community health service via the two-hour crisis response (See 3.1 above).

The default operational assumption is that the peak of open bed capacity achieved through the winter of 2019/20 will be at least maintained through 2020/21, including the 3,000 increase from October 2019 already planned for. Credible plans to release capacity through reductions in length of stay, improvements in Delayed Transfers of Care (DTOCs), and admission avoidance programmes will be required where the increase is not above this level. Where this requires additional staff the agency staff guidance should be implemented alongside a focus on recruitment and retention to deliver sustainable staffing models.

In 2019/20, we set the goal to deliver Same Day Emergency Care (SDEC) for 12 hours per day as well as acute frailty services for 70 hours per week. There has been good progress made with 89% of providers delivering SDEC and 65% of providers delivering acute frailty services. The target is for all providers to achieve the goal by September 2020. In addition, during 2020/21 we are asking all trusts to:

- increase the proportion of patients seen and treated on the same day (or within 12 hours if this spans midnight) to a level agreed regionally.

- ensure that SDEC activity is recorded on the Emergency Care Data Set (ECDS) or Admitted Patient Care (APC) and not as outpatients, to allow activity to be fully counted. Note that, under the rules on counting and coding changes in the NHS Standard Contract, any financial impact of this change must be neutralised through to March 2021.

To end uncertainty amongst patients and improve the range of services, we will finalise the transformation of Type 3 and 4 services to Urgent Treatment Centres (UTCs) in line with the published Principles and Standards by Autumn 2020.

To support local planning to provide better clinical data, there is a requirement to ensure:

- 95% completeness of specified data fields measured within the ECDS for all providers delivering Acute and Urgent Care i.e. Type 1/2 Emergency Departments and UTCs.
- daily submission of ECDS for the previous day (a new requirement to this effect has been added to the NHS Standard Contract for 2020/21).

For the 20% of patients who arrive in Emergency Departments by ambulance, we will continue to work with ambulance services and commissioners on safely reducing avoidable conveyance to emergency departments. Further work is needed to ensure ambulances are swiftly available to respond to other incidents and calls, therefore continued focus with acute trusts on avoiding ambulance handover delays at hospital is required, as well as to eliminate 'corridor care'.

The Integrated Urgent Care Clinical Assessment Services (CAS), accessed via NHS 111, ensures more than 50% of calls have an appropriate clinical assessment and will be able to book at least 40% of people that have been triaged into a face-to-face appointment where needed. To support the reduction of pressure on emergency hospital services, commissioners should explore how low acuity ambulance dispositions originating in either 999 or 111 can be clinically assessed by local Integrated Urgent Care CAS services. All providers will continue to improve the data quality of submissions into the national 111 data set (the 'Aggregate Data Collection') until fully compliant.

Ambulance services should ensure they meet the ambulance response time constitutional standards.

Further guidance for systems and organisations including examples of good practice can be found [here](#) which will help with the development and assurance of plans.

3.5 Referral to Treatment Time (RTT) including 26 week choice

Waiting lists should reduce in 2020/21. Specifically, the waiting list on 31st January 2021 should be lower than that at 31 January 2020. Delivery of this requirement may be managed at STP/ICS level, in agreement with the regional team, with every provider expected to make a significant contribution.

Providers should ensure appropriate planning and profiling of elective and non-elective activity throughout the year, taking into consideration expected peaks in non-elective performance over winter months in order to avoid risk of unplanned cancellations.

Waits of 52 weeks or more for treatment should be eradicated. Systems should plan to utilise capacity flexibly across their systems to reduce long waits in specific providers and work with regions to do so where specialised services are concerned. All providers are expected to monitor and manage these long waiting patients very closely and to submit timely and accurate data via weekly Patient Tracking Lists (PTL). Financial sanctions on providers will remain in place and will continue to be applied for any patient who breaches 52 weeks.

Further activities to enable the NHS to deliver these headline objectives are described below.

The NHS Long Term Plan reaffirmed and extended the NHS commitment to patient choice. As well as continuing to provide patients with choice at point of referral, Capacity Alerts should be implemented on the electronic referral system to give clinicians and patients additional information to make meaningful choices about where their care can be provided.

A number of pilot sites across the country are now putting in place practical solutions to offer patients who have been waiting for 26 weeks on an RTT pathway a meaningful choice of an alternative provider. During 2020/21, all providers and systems should be implementing supplementary choice at 26 weeks with reference to the *26 Week Choice Rules and Guidance* and the best practice models emerging from the pilot programme. In preparation, providers should ensure they have robust validation arrangements in place, so that waiting list data are as accurate as possible.

3.6 Outpatient transformation

The fundamental re-design of the outpatient model of care is a key goal of the NHS Long Term Plan so that we improve patient convenience and access to services, avoid unnecessary travel to appointments, enable more productive use of clinicians' time and more efficient use of outpatient clinics. Many face-to-face outpatient appointments could be dealt with through the use of technology or are not clinically necessary. By expanding alternatives to face-to-face appointments, and not bringing patients in for

appointments that are not needed, the NHS will avoid a third of face-to-face outpatient attendances by 2023/24. We therefore expect tangible progress to be made in 2020/21.

Systems should plan to use outpatient capacity released from this transformation to undertake other value-adding activity (first outpatients, diagnostic consultations and clock stopping treatment) to deliver improvements to the size of the elective waiting list and elective waiting times, in line with the elective service planning requirements.

To help systems act on the opportunities to reduce unnecessary outpatient activity in 2020/21, we are proposing reforms to the payment system to ensure providers do not lose income from doing so. This means providers can gain by ensuring only patients who need in-person outpatient care are asked to travel in for an appointment. This means that it will also be easier for providers to adopt remote monitoring, group consultations and patient initiated follow ups. Under the local pricing rules, the proposals will not stop areas that are moving further and faster from implementing new payment approaches but are designed to accelerate the pace of adoption for areas where more progress is needed. Under the proposed 2020/21 National Tariff Payment System, commissioners and providers will be expected to agree blended payments for outpatients that include advice and guidance and the uptake of non-face to face consultations.

Systems should ensure that advice and guidance arrangements/agreements are in place between secondary and primary care providers and in line with the 2020/21 national specification which will be published in January 2020. We expect to see a significant volume of unnecessary hospital outpatient attendances avoided in 2020/21 through expanded uptake of advice and guidance across the country.

A national programme of clinically led pathway redesign has begun and will provide practical help to support systems to adopt optimal pathways with lower in-person outpatient activity. A national trajectory for delivery of outpatient transformation will be published in the National Implementation Plan. Based on systems' NHS Long Term Plan returns, the 2020 national support offer will start with ophthalmology and musculoskeletal, dermatology and cardiology. We expect systems actively to engage with this work and plan to roll out best practice models as they emerge.

Over the next four years we expect major expansion in video, phone and online consultations. For 2020/21, systems should begin the implementation of video consultation in major outpatient specialties so that all patients can access outpatient care without travelling to hospital. We will provide materials and guidance to support this based on the national video consultation pilot.

We also expect systems to accelerate patient-initiated follow up in outpatient specialties and to be able to demonstrate progress against their 2018/19 position. These plans should be aligned to the local STP/ICS personalisation strategy and reflect the national expectation of personalised stratified follow-up pathways for colorectal, prostate and breast cancer (see 3.7).

We would also expect systems to:

- engage with the development and mobilisation of elective High Impact Interventions which will be developed during 2020/21.
- continue to embed First Contact Practitioner (FCP) services, participate in the national evaluation process, and roll out FCP services more widely. By March 2023, FCP services will be available to the whole adult England population. In 2020/21 coverage will increase to 50%, with planned rises to 75% in 2021/22 and 100% in 2022/23.
- ensure that all hospital eye services can report compliance with the Portfolio of Indicators for Eye Health and Care follow-up performance standard.

3.7 Cancer

The NHS Long Term Plan sets two ambitions for cancer:

- by 2028, 55,000 more people will survive cancer for five years or more each year.
- by 2028, 75% of people will be diagnosed at an early stage (stage one or two).

[Cancer Alliances](#), as the cancer arm of their constituent STPs/ICSs, have set out a single system-wide strategic plan for delivering these ambitions for cancer to 2023/24.

In 2020/21, Cancer Alliances will be supported by nearly £90m of funding allocated on a fair shares basis. Additional targeted funding will support the roll out of Rapid Diagnostic Centres and the Targeted Lung Health Checks Programme. New funding will also be available to support testing, evaluation and rapid roll out of prioritised innovations.

Cancer Alliances are accountable to their STPs/ICSs for providing clinical and operational leadership for the delivery of these plans across their local cancer system. Every partner within that alliance – including commissioners, acute trusts, and primary and community providers– has a responsibility to contribute to effective system-level working, and the focus of national and regional oversight will shift increasingly to system-level performance.

We are asking each Cancer Alliance to set out a plan for improvement in the operational standards for cancer in 2020/21 which should, as a minimum, cover:

- improvement against the cancer 62 standard and delivery of the 28-day [Faster Diagnosis Standard](#) (FDS), which will be introduced from 1 April 2020. From April, every alliance and trust should be delivering data completeness of at least 80% and should be meeting the FDS at the proposed initial threshold of at least 70%.

- ensuring all trusts within the alliance have in place appropriate processes, systems and capacity for supporting patients to navigate cancer pathways and robust PTL management.
- implementing optimal timed pathways (see below) and identifying challenged pathways and prioritising these for operational improvement.
- evidence of the impact of funded NHS Long Term Plan projects on operational performance.

Cancer Alliance plans should prioritise the following actions, which will support both operational performance as well as the delivery of the ambitions in the NHS Long Term Plan:

- implementation of agreed Cancer Alliance plans for 2020-21 for the Rapid Diagnostic Centre Programme in line with the Rapid Diagnostic Centres Vision and 2019/20 Implementation Specification. This should build on the minimum requirements in the current year to create a new referral pathway for at least 20% of people with non-specific symptoms and one challenged two-week wait pathway.
- ensure optimal timed pathways (lung, prostate, colorectal and oesophago-gastric) are fully implemented to show demonstrable improvement in operational performance for these pathways. The adoption of the four optimal timed diagnosis pathways, along with increase of PTL management will lead to a significant increase in overall 62 day performance. Full implementation of these pathways is an operational requirement for 2020/21.
- support the implementation of Faecal Immunochemical Test (FIT) in the bowel screening programme by leading the adoption of new guidance on polyp surveillance, with a demonstrable reduction in the number of surveillance colonoscopies undertaken, and the implementation of a new lynch syndrome best practice testing pathway, which will be published in the autumn.
- implementation of new or revised service specifications, including children's cancer and teenager and young adult cancer, and proton beam therapy.
- implementation of personalised stratified follow up pathways for colorectal and prostate cancer by April 2021 and ensure that at least two thirds of breast cancer patients benefit from stratified follow up. Use new patient level data to track delivery of the personalised care commitments for cancer patients.
- improve the recruitment and retention of Clinical Nurse Specialists and cancer support workers, and implement agreed local plans to support the NHS Long Term Plan target to recruit additional clinical and diagnostic staff by 2021; and,
- support improved uptake and performance in the other cancer screening programmes including cervical and breast screening.

NHS England and NHS Improvement has committed to increase its contribution to funding both children's hospices and children's palliative and end of life care services. More detail will be released by spring 2020, including arrangements for match-funding CCGs where they commit to increase their local investment.

In addition to the NHS Long Term Plan commitment for the NHS to provide 500,000 whole genome sequences by 2023/24 (as part of one million whole genome sequences by the NHS and UK Biobank), including for children with cancer, the NHS will begin from 2020/21 to offer more extensive genomic testing to patients who are newly diagnosed with cancers so that by 2023 over 100,000 patients a year can access these tests. To deliver this commitment and create a world-leading genomic medicine service, we are transforming the delivery model for cancer genomic testing and the associated funding model.

The procurement of the NHS Genomic Laboratory Hub (GLH) network included the delivery of cancer genetic testing services for an identified geography. Where a trust is a GLH, they will be funded directly for the delivery of genetic testing services. Where trusts are sub-contracted by the lead GLH provider, they will need to engage with their GLH to confirm the scope of services provided and funding. The GLH lead contractors will sub-contract testing services and distribute funding where each of the following requirements are met:

- testing meets the minimum specification of the National Genomic Test Directory;
- tests are accredited;
- NHS England-mandated contract management data is available; and
- tests are delivered by the laboratories agreed by each GLH's Oversight Board.

Where trusts do not perform testing, or previously delivered genetic testing but are not a designated GLH or sub-contracted by the GLH, they will not be funded for any genetic testing and should request tests from their designated GLH. Trusts will not incur any costs associated with the testing performed by their designated GLH. Only those tests stipulated in the National Genomic Test Directory, including the eligibility criteria, will be funded.

To support the implementation of more extensive genomic tests and to ensure equitable access, trusts should work with their designated GLH to implement testing pathways that adhere to the required sample handling and processing standards.

3.8 NHS public health functions and prevention

As part of the NHS Long Term Plan, the NHS will continue to take a more proactive role in helping people to prevent ill-health. CCGs will support this through their responsibility for the health of their populations. In 20/21 the NHS will:

- begin to expand alcohol care teams and roll out smoking cessation support for inpatients (acute and mental health) and maternity services in selected sites. This will be expanded in future years to fully deliver the NHS Long Term Plan commitments.
- support an additional 25,000 people lose weight and reduce their risk of diabetes through the Diabetes Prevention Programme and pilot low-calorie diets at scale

across 10 STPs to support people with existing Type 2 diabetes to achieve remission.

CCGs/ICS/PCNs will work with the public health commissioning teams in NHS England and NHS Improvement regional teams to ensure NHS population cancer screening, non-cancer screening and national immunisation programmes are delivered optimally to their population. This will include delivering agreed recommendations from Sir Mike Richards' [Independent Review of Adult Screening Programmes](#) - published October 2019, the government's Vaccination Strategy (expected publication early 2020), and will be supported by new vaccination incentives embedded in GPs' 2020/21 national contract.

For flu, there is an established national public health annual influenza immunisation programme. Each year a tripartite guidance [letter](#) is published by the Department of Health and Social Care, Public Health England and NHS England and NHS Improvement. This letter includes the nationally agreed ambitions for vaccination uptake to be achieved for each of the agreed patient cohorts covered by the programme. It is anticipated that the letter for the 2020/21 programme will be published in late February 2020. The Department of Health and Social Care is also considering making flu vaccination mandatory for NHS staff, and will be issuing further guidance on this point in due course.

Antimicrobial resistance is a global problem. Although the number of antibiotic prescriptions dispensed in primary care has reduced by 13.2% in five years further progress is needed. In 2020/2021 we expect all providers to reduce Gram-negative blood stream infections (*Escherichia coli* (*E. coli*) *Pseudomonas aeruginosa* (*P. aeruginosa*) *Klebsiella* species (*Klebsiella spp.*) as they work to halve healthcare associated Gram-negative bloodstream infection by 2024. Individual trust targets of circa three to five percent in 2020/21 will be agreed with regions. Targets for future years will be set later in 2020/21.

It is estimated that up to 40,000 people die prematurely every year linked to poor air quality. The NHS Long Term Plan seeks to reduce the impact the NHS has on the environment by reducing its carbon footprint, reducing the use of avoidable single-use plastics, and working with partners, including local government, to tackle local air pollution. The NHS will develop a national de-carbonisation and climate change plan during 2020 in the runup to COP26, the UN Climate Change Conference. Whilst many already do, in the meantime all systems should have a Green Plan (also known as the Sustainable Development Management Plan or SDMP) and a plan to deliver the sustainable development related NHS Long Term Plan commitments.

Deliverables for sustainable development include:

- cut business mileages and NHS fleet air pollutant emissions by 20% by 2023/24. In 2020/21 organisations should:

- consider signing up for a free Green Fleet Review which can be booked via this [link](#).
- reduce air pollution from fleet vehicles, by ensuring all fleet vehicles purchased or leased by the organisation after 1 April 2020 support the transition to low and ultra-low emission (ULEV) in line with Long Term Plan Commitments. Using the Sustainable Development Unit's [Health Outcomes of Travel Tool \(HOTT\)](#) can help organisations to measure the impact their travel and transport has in environmental, financial and health terms.
- ensure that any car leasing schemes restrict the availability of high-emission vehicles.
- end business travel reimbursement for any domestic flights within England, Wales and Scotland.
- all NHS organisations should move to purchasing 100% renewable electricity from their energy suppliers by April 2021.
- providers should replace lighting with LED alternatives during routine maintenance activities.
- all NHS organisations must ensure all new builds and refurbishment projects are delivered to net zero carbon standards.
- all organisations are expected to implement the Estates and Facilities Management Stretch programme which will be published by NHS England and NHS Improvement in 2020. This will set out key activity's organisations can take to reduce the environmental impact of their estates.
- reduce the use of single use plastics in the NHS, beginning by signing up to and delivering the NHS [Plastics Pledge](#) which commits organisations to phase out avoidable single-use plastic items.
- reduce the carbon impact of Metered Dose Inhalers in line with long term plan commitments, including by:
 - decreasing the percentage of inhaler prescriptions that are for Metered Dose Inhalers where clinically appropriate.
 - reducing the overall carbon impact of all inhalers dispensed at pharmacy.
 - encouraging patients to return spent devices for green disposal in pharmacy medicines waste.
- reduce the carbon footprint associated with anaesthetic gases in line with long term plan commitments by:
 - appropriately reducing the proportion of desflurane to sevoflurane used in surgery to less than 20% by volume, and
 - local systems and providers assessing the potential to reduce unnecessary emissions of nitrous oxide to atmosphere.

4. People

Delivering the improvements set out in the NHS Long Term Plan requires urgent and sustained action to improve working cultures and staff experience and to achieve workforce transformation and growth. As the demands and expectations on the NHS grow year on year, we need to take much more concerted and collaborative action to ensure we have the right numbers of staff with the right skills, working in well-led and motivated teams, to provide high-quality care for patients.

The interim People Plan published in June 2019, set out a strategy for better supporting the 1.4 million people working in the NHS to deliver the NHS Long Term Plan, with a focus on immediate action to address the most pressing workforce shortages. The full NHS People Plan when published, will set out a comprehensive programme of action across the NHS for 2020/21 and beyond to:

- grow the future workforce, supported by reforms to education and training;
- make the NHS the best place to work and improve retention;
- improve the leadership culture;
- release time for care; and
- redesign workforce models, including changes in skill mix.

The government has committed to ensuring 50,000 more full time equivalent (FTE) nurses by 2025, together with 6,000 more doctors working in primary care and a 26,000 increase in the wider primary care workforce under the PCN additional roles scheme. We expect to see progress towards these goals with an increase in nurse numbers across the NHS in 2020/21. This will be supported through a significant expansion of ethical international recruitment of high-quality nurses, driven by a new national programme which will be established early in 2020. All providers should proactively engage with the national programme, and regions will play a key role in implementation.

The work to develop the People Plan has reinforced the need for a much more integrated approach to service, financial and workforce planning. Providers and CCGs should incorporate this approach in their operational planning for 2020/21.

This means local system and organisational workforce plans that are well-modelled, aligned with both service plans (i.e. providing the right numbers of staff to provide planned services safely and effectively) and financial plans, and that they are based on realistic projections for improvements in recruitment, retention and skill mix.

To be a model employer, the NHS needs to be more inclusive – embodying a diverse workforce at all levels. In 2020/21 NHS trusts and commissioners should work towards their bespoke targets for black and minority ethnic (BME) representation at Very Senior Manager (VSM) levels – and across the workforce pipeline – as outlined in the NHS

Long Term Plan and in the Workforce Race Equality Standard (WRES) [Model Employer strategy](#).

4.1 Hospital and community health service workforce

Providers should re-confirm or, where necessary, update the plans for 2020/21 they have submitted through the strategic planning process for the total number of planned FTE staff (including both substantive and temporary staff).

NHS England and NHS Improvement, Health Education England and STPs/ICSs will continue to work together to develop a more iterative and improved approach to future workforce planning.

Provider plans should set out:

- actions to make the NHS the best place to work and improve retention, as set out in the interim People Plan, specifically on:
 - creating a positive, inclusive and compassionate working culture.
 - providing a safe and healthy working environment.
 - giving staff an ability to learn, develop and fulfil their potential (including use of the new £150m Continuing Professional Development budget).
 - ensuring staff can have a predictable and flexible working pattern.
- actions that the provider is taking to release time for care and improve workforce productivity – providers should work towards full implementation and effective use of e-rostering and e-job planning. Meaningful use [standards](#) can be found on the NHS England and NHS Improvement website. The Model Hospital portal contains the ‘Levels of Attainment’ for effective software use. NHS provider organisations are expected to reach level one of the e-rostering and e-job planning ‘levels of attainment’ for all clinical workforce groups by March 2021 and should strive towards level four, which will be a future requirement.
- immediate action to increase recruitment and retention of the registered nursing workforce, including how providers are collaborating across systems to make more effective use of international recruitment; reduced attrition from training; increase numbers of trainee nursing associates; and support those nursing associates who wish to go on to become registered nurses.
- action to ensure suitable, high-quality clinical placement capacity is in place for September 2020 and January 2021 intakes to support growth in undergraduate entry to key professions of nursing, midwifery and Allied Health Professionals (AHP), supported by the new investment in student maintenance grants announced by the government.

The government has announced £150 million of new investment in continuing professional development (CPD) for all nurses, midwives and AHPs in trusts and general practice. Final confirmation of provider allocations will be made by the end of January 2020. This funding enables employers to provide a £1,000 training budget over the next three years for each nurse, midwife and AHP in addition to current provider

investment in CPD, supporting staff to ensure they continue to be able to develop the skills to deliver high quality care for patients.

CPD allocations have been set against NHS Digital's September 2019 workforce data and will be issued through the Learning Development Agreement process in two stages:

- providers will receive 50% of their confirmed allocation in April 2020 and will be required to submit investment plans to HEE by July 2020.
- subject to approval of those plans, the remaining 50% of the allocation will be issued in Quarter 3 of 2020/21.

Providers will need to ensure this investment is in addition to current CPD investment levels. The financial planning guidance returns will be used to set a baseline for 2019/20. Providers will also need to ensure they release sufficient time for staff to undertake CPD. Providers will support the investment by covering the costs of backfilling staff time during this training.

4.2 Primary care workforce

STPs/ICSs and CCGs will be expected to ensure an STP/ICS primary care workforce plan is in place, which considers local multi-disciplinary workforce needs. The forthcoming national GP contract update will set out arrangements for the plan, to be developed jointly with PCN Clinical Directors. It must:

- set out how the Additional Roles Reimbursement Scheme will be fully used, indicating firm intentions for 2020/21 and indicative intentions for the subsequent three years. CCGs should actively support PCNs who are unable to recruit to the additional roles specified in the PCN DES, through the following specific actions in 2020/21:
 - facilitate work across organisations to develop rotational posts and lead employer models, where there is local appetite.
 - support PCNs to advertise posts, including through batch recruitment;
 - working with local stakeholders to match people to unfilled roles.
 - supporting and driving conversations with training hubs and higher education institutions to influence workforce supply.
- be designed specifically to retain as many GP trainees as possible at an STP/ICS level after completing specialist training; with as many of these as possible taking up substantive roles in the local primary care workforce by 31 March 2021 (including portfolio roles offered through the *General Practice Fellowships programme for newly qualified GPs and nurses*).
- include an action plan to maximise the retention of experienced, effective staff (doctors, nurses and other health professionals), with specific focus in areas which have greatest workforce challenges and with roles where attrition is highest. This includes:

- essential actions which are shown to have positive impact on the retention of GPs as set through national guidance.
- offering the national GP Retention Scheme to support all eligible GPs who require additional support to remain in the workforce.
- targeted action to retain as many general practice nurses as possible in the workforce reflecting the specific needs of this staff group. The update to the GP contract will set out further plans to roll out national schemes to support recruitment and retention.

5. Financial settlement

5.1 Overview

The five financial tests require each system and the organisations in it to:

- meet its trajectory for 2020/21 and the following three years;
- achieve cash-releasing productivity growth of at least 1.1% each year;
- reduce the growth in demand for care via integration and prevention;
- reduce unwarranted variation in performance; and
- make better use of capital investment and existing assets.

Operational plans for 2020/21 should now set out the detail of how the financial trajectories, agreed by systems with NHS England and NHS Improvement as part of the system-wide strategic plans, will be delivered to improve care for patients and the public. Cost improvement plans need to be fully developed before the start of the financial year and agreed between commissioners and providers. Combined with consistent growth assumptions, this should allow no room for provider and commissioner plan mis-alignment. We also ask that system leaders confirm that activity, finance, performance and workforce assumptions are mutually consistent and therefore affordable.

Commissioner allocations

Additional recurrent [CCG allocations](#) have been published alongside the planning guidance. These take account of 2020/21 tariff inflation above the previously assumed level including the impact of 2019/20 pay settlements for doctors, Clinical Negligence Scheme for Trusts (CNST) increases, and also the impact of adjustments to tariff such as removal of cancer genomic testing. Separate adjustments have been made between CCGs to reflect movements in registered population resulting from new digital primary care models.

Similar additional allocations will also be made for specialised and direct commissioners where applicable.

CCG running cost allocations for 2020/21 were published in January 2019 and are unchanged.

Service development funding allocations have already been made for all systems on a fair shares basis. In 2020/21 arrangements for release of this funding will be as follows:

- allocations will be the same as those used at system strategic planning (i.e. the published fair shares funding amounts and methodology will not be reopened except for technical changes e.g. CCGs changing STP).

- funding will be aggregated at system level and released as a single allocation sent to a nominated CCG in each system. Exceptions to this will be cancer funding flowing to Cancer Alliances (via lead CCGs) and GP Extended Access funding to individual CCGs. Cancer Alliances are accountable to their ICSs/STPs and must agree with them how they will deliver and be held to account for doing so.
- regional teams will work with national programmes to approve the release of the funding for 2020/21 where the following conditions have been met:
 - an agreed and signed off system-wide strategic plan is in place.
 - there are appropriate system arrangements for decision making which include all partners in the system.
 - there is appropriate system level oversight and reporting to track expenditure and measure outcomes.
 - there is agreement that system plans are acceptable from a finance perspective.
- as part of the operational planning process systems will be supplied with a statement of their NHS Long Term Plan funding for 2020/21 providing the details of their allocation. This statement will also include any additional targeted NHS Long Term Plan funding allocations where these have been agreed.

Assuming systems continue to meet points (c) i-iv above, in 2021/22 Regional Directors, working with national programmes, will approve the release of funding after consideration of the extent to which systems have met the trajectories for 2020/21 set out in their approved system plan. Where a system falls short of its approved plan, Regional Directors will work with them to improve performance and may choose to link release of Service Development Fund (SDF) fair shares funding to satisfactory progress on recovery plans.

5.2 Payment reform and national tariff

In support of the planning process, the statutory consultation for the national tariff has been published setting out the proposals for the 2020/21 National Tariff Payment System (NTPS).

The consultation proposes that the 2020/21 tariff cost uplift factor would be set at 2.5% and the tariff efficiency factor at 1.1%. CNST contributions for 2020/21 would be updated for the relevant national and local prices. A proposed inflationary increase for medical pay has been included to cover the increase in costs that providers are expected to incur in 2020/21. For local price-setting, the proposals would require commissioners to have due regard for the impact of the Agenda for Change reforms on actual cost inflation, where this can be shown to have a significant differential impact (for example on ambulance services).

Building on the introduction of blended payment contracts for CCG-commissioned emergency care activity in 2019/20, we are proposing to introduce blended payments for outpatient attendances and maternity services in 2020/21.

The outpatient attendances blended payment would cover all first and follow-up attendances, and advice and guidance services related to this activity. It would exclude diagnostic imaging and most outpatient procedures. It would apply where the expected annual value of a CCG's relevant activity with any one provider is above £4m and also to all NHS England Specialised Commissioning contracts. The 'blended payment' would comprise:

- a fixed element based on locally agreed planned activity levels and any agreed advice and guidance services.
- a quality-based element agreed locally and aligned to the successful delivery of those advice and guidance services.

It is also proposed that a risk share can be included within the blended payment but would not be mandatory. Systems who wanted to go further and develop more quality-based or outcome elements are free to do so.

The blended payment approach for maternity services would include all care commissioned by CCGs and provided to women and their babies as part of antenatal care, the birth episode and postnatal care prior to discharge to primary care. It also includes relevant screening tests. However, any activity, commissioned by Specialised Commissioning, such as specialised foetal medicine, is excluded. Any locally agreed transformation funding from CCGs is also excluded. We are also proposing that areas can choose to continue using the maternity pathway payment for 2020/21.

On the adult mental health and emergency care blended payment arrangements which were introduced in the 2019/20 NTPS, we are not looking to make any changes, including the reimbursement arrangements for any legacy Marginal Rate Emergency Tariff (MRET) payments.

We are asking all CCGs to complete and return the national tariff local variations template, which will record local variations and departures from the national tariff rules and prices and details of how the blended payment models have been implemented. We are collecting this information to get a comprehensive picture of how local areas are agreeing reimbursement for their services so that any future national tariff changes can be considered against this baseline.

In 2019/20 we introduced a change to the Market Forces Factor calculation methodology and updated the data used to the latest available. We are not proposing to carry out further changes and therefore the statutory consultation proposes we move to year two of the five-year implementation path published last year.

Welsh commissioners will pay full tariff prices for activity commissioned from English providers including the tariff inflation increase in 2020/21 and the 1.25% element of 2019/20 inflation related to the transfer of CQUIN into core prices which was excluded as a transitional measure in 2019/20. It is expected that Welsh providers will apply tariff inflation for 2020/21 to their contracts with English commissioners. This does not affect historic arrangements in respect of the remaining value of CQUIN and/or other issues.

Full details of all the changes can be found in the consultation package.

5.3 Key financial commitments

Mental Health Investment Standard

CCGs must continue to increase investment in mental health services as outlined in their system-wide strategic plans and in line with the Mental Health Investment Standard (MHIS). For 2020/21 the standard requires every CCG to increase spend by at least their overall programme allocation growth plus an additional percentage increment to reflect the additional funding included in CCG allocations. The percentage increase agreed in their strategic plan will be shown in the financial planning template.

The new investment should be prioritised to deliver the activity commitments set out in strategic plans and consistent with the Mental Health Implementation Plan. To deliver the service expansions planned for 2020/21, CCGs need to increase the share of their total mental health expenditure that is spent with: mental health providers; and, the share spent on Children's and Young People's (CYP) mental health.

As in 2018/19 and 2019/20, each CCG's achievement of the mental health investment standard must be attested to by the governing body and subject to independent verification. Where the 2019/20 audit demonstrates that a commissioner has not met the MHIS the commissioner will need to recover the shortfall and plan for the 2020/21 increase.

Local system leaders, including a nominated lead mental health provider, will review each CCG's investment plan underpinning the MHIS to ensure it represents a credible plan to deliver the mental health activity commitments and the related workforce. Any concerns on credibility of plans should first be discussed and agreed between system partners with any escalation to the regional teams only taking place after this. Where a commissioner fails to deliver the mental health investment requirements, NHS England will consider appropriate regulatory action, including in exceptional circumstances imposing directions on the CCG.

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.

Primary medical and community health services funding guarantee

The NHS Long Term Plan committed to an increase of £4.5 billion in real terms expenditure on primary medical and community health services by 2023/24. Systems and commissioners should continue planning to:

- spend the primary care medical (GP) [allocations](#) in full to increase the number of GPs.
- increase overall spending from CCG (core services) [allocations](#) on the aggregate of: primary medical care, community services and Continuing Healthcare services taken together so that by 2023/24 they deliver the STP targets set through system planning. This includes meeting the commitment to provide £1.50 per registered patient to Primary Care Networks (PCNs).

We will ask systems to support PCN planning for employment of the 26,000 additional roles through the Additional Roles Reimbursement Scheme (ARRS), with PCNs indicating their employment intentions. Systems and CCGs will need to work with PCNs to help them develop indicative plans, to support them to recruit people to roles, and to ensure PCN needs are factored into wider system workforce planning. We will break down the additional roles for 2020/21 into an indicative share for each region. All PCNs will be shown their allotted maximum sums of ARRS.

Historic commissioner overspends

Under the current financial rules, where a CCG spends more than its allocation for a given financial year, the overspend is carried forward to future years in a similar way to provider loans and is required to be repaid. However, in some cases the level of historic debt is such that the amount cannot be repaid in a reasonable timeframe, and this is becoming a barrier to system transformation.

Therefore, from 2020/21 we will write-off historic CCG debt subject to the following:

- the level of the total overspend is such that repayment over 4 years is not feasible, i.e. the total cumulative debt is more than 4% of the CCG allocation.
- the CCG will agree a repayment profile with NHS England and NHS Improvement showing the element of the cumulative debt that will be repaid, which will take account of historic funding levels - typically this will be 50% of the cumulative debt but will be assessed case by case.
- the CCG must address the underlying issues that caused the overspends such that it delivers in-year financial balance, and the agreed repayment profile achieved.

This may be applied retrospectively where a CCG has already satisfied the conditions. If the CCG overspends its allocation during the two years following the point of write-off, the historic liability may be reinstated.

Better Care Fund (BCF)

The BCF Planning Requirements for 2020/21 will be published in February 2020 alongside the policy framework from the Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG). The CCG minimum contribution to the BCF and within that the minimum contribution to social

care will grow by an average of 5.3% in cash terms, consistent with the cash growth in the NHS mandate funding overall. Since this is a real term increase, the expectation is that this will fund more social care packages than in 2019/20. To support local planning in the meantime, we are publishing CCG minimum contributions to the BCF and within that minimum contributions to adult social care.

NHS and Local Authority partners should agree the key elements of the planning for the BCF and assumptions for health and social care capacity alongside final operational plan submissions.

The total contribution to the BCF in 2020/21 will be £4.084bn. The non-recurrent allocation made to CCGs in 2019/20 to fund the late change in planning assumption will not be repeated in 2020/21.

5.4 Financial framework for providers and CCGs

Financial improvement trajectories

Financial improvement trajectories establishing the level of financial performance required of CCGs and NHS providers between 2020/21 and 2023/24 were issued in October 2019 to inform the strategic planning process. Trajectories will be updated shortly to reflect the impact of material changes to costs and the national tariff. The updates will ensure that the efficiency requirements for organisations remain consistent with the original goals. Any system net-neutral changes financial improvement trajectories need to be agreed with regional directors two weeks prior to the submission date detailed in the timetable, at the latest. Access to the Financial Recovery Fund (FRF), capital and revenue funds allocated to systems, the suspension of some sanctions for providers, and the process for writing off historic debts incurred through interim revenue support pre-2019/20, will be dependent upon agreement with NHS England and NHS Improvement and delivery of those trajectories.

Financial Recovery Fund

For 2020/21, the Financial Recovery Fund (FRF), as previously signalled, will be the sole source of financial support for NHS providers and CCGs that are otherwise unable to live within their means. The majority of sustainability funding is expected to continue to flow to NHS providers.

To improve cashflow, we will be phasing payments equally (25% per quarter) and paying FRF as soon as possible during the quarter to which the payments relate, rather than after the quarter-end as now. Payments will be calculated using planned financial performance for the first quarter and the latest reported YTD and FOT financial performance for subsequent quarters. Organisations' entitlement to FRF will depend on full-year financial performance and, where they do not deliver financial trajectories, any FRF that has been paid but not earned will be converted to DHSC financing (for

providers) or recouped by adjusting allocations (for CCGs). The DHSC financing guidance will be updated to provide more detail of the arrangements for providers.

50% of the FRF allocation will be paid based on the performance of the organisation; to encourage system working the other 50% will be linked to the achievement of the system trajectory (the sum of the financial improvement trajectories of the organisations within a system). Systems may agree to link a higher proportion of their FRF allocations to system performance if they wish. In exceptional circumstances we will also consider, with the agreement of the organisations and systems involved, and the relevant regional team, requests to change the composition of the systems to which FRF payments are linked. Any such proposals need to be agreed with regional directors two weeks prior to the submission date detailed in the timetable, at the latest.

We are introducing a taper, which means a proportion of the available FRF may still be earned even if trajectories are not met. This will incentivise all eligible organisations to achieve the best financial position they can. The taper will apply to the system and the organisational element. Organisations will lose £1 of FRF from the organisational element of their FRF allocations (up to its total value) for every £1 of organisational underperformance. In addition, systems will lose £1 of FRF from the system element of their constituent organisations' FRF allocations (up to its total value) for every £1 of system underperformance.

Organisations that miss their trajectory will not automatically be entitled to the system element of their FRF allocation. Systems may agree with the relevant regional teams how these amounts are distributed.

From 2020/21, we will simplify the 'offset' mechanism currently available to ICSs and expand it to all systems. Systems that meet their financial improvement trajectories will automatically be entitled to all of the FRF allocated to their constituent organisations. Systems may agree with the relevant regional team the distribution of any elements of organisations' FRF allocations that are only earned by virtue of this commitment (i.e. because an organisation has missed its trajectory).

Breakeven and surplus trust scheme

In our letters setting out trajectories, we also announced a scheme for providers that deliver breakeven and surplus financial improvement trajectories. The scheme, which will be available to NHS providers, and 50% of which is contingent on aggregate system performance has two components:

- for providers that deliver a breakeven or surplus control total (before sustainability funding) in 2019/20 and that deliver a breakeven or surplus position again in 2020/21, a one-year transitional reward payment worth 0.5% of relevant income; and
- for providers with a deficit control total in 2019/20 (before sustainability funding) reaching breakeven by 2023/24, a reward payment of 0.5% of relevant income

at the end of the year in which breakeven is achieved and at the end of the subsequent year, provided financial performance is maintained.

No tapering will apply to this scheme, and providers should not record any income from this scheme in their operating plan submissions.

Cash regime

We are considering whether reforms to the cash regime might be appropriate, and will provide further detail on this in due course.

5.5 Additional financial planning assumptions

Marginal Rate Emergency Tariff (MRET)

Arrangements for MRET payments in 2020/21 will remain the same as in 2019/20; NHS providers will be eligible to receive additional central income equal to the MRET value previously confirmed. Funding will be paid quarterly in advance subject to those providers submitting an operating plan consistent with their 2020/21 trajectory. The MRET payment will not be subject to tapering. This income has been reflected in financial improvement trajectories.

Pensions revaluation – employer contributions

The transitional approach operated in 2019/20 will continue in 2020/21. For 2020/21 an employer rate of 20.6% (20.68% inclusive of the administration charge) will apply; the NHS Business Service Authority will continue to only collect 14.38% from employers which is the basis on which organisations should plan. Employers should also ensure that their payroll provider continues to apply an employer contribution rate of 14.38% from 1 April 2020. Central payments will again be made for the remaining 6.3%.

Non- NHS commissioner funding assumptions

Providers should ensure that the inflationary costs associated with providing services are captured and priced into contracts with non-NHS commissioners, including for public health services commissioned by local authorities. The Department of Health and Social Care will confirm arrangements for the Local Authority Public Health Grant in due course. Providers should ensure these costs are reflected in local contracts as appropriate. Therefore, the non-recurrent funding provided in 2019/20 to fund inflationary pressures in local authority contracts will not be repeated and local contract values need to reflect the value of non-recurrent funding since the pay award and the impact of 2020/21 inflation.

Primary care prescribing

Category M medicines prices were increased in August 2019 to adjust the pharmacy medicines margin in line with regular review processes. For planning purposes, CCGs should assume no further upward or downward margin adjustments in 2019/20 i.e. continuation of the current level of margin adjustments. This does not represent a forecast of underlying medicines prices for which CCGs should make appropriate provision. CCGs should also assume a typical level of cost pressure from price concessions/NCSO.

Identification rules

There are some minor changes to Identification Rules captured in the Prescribed Specialised Services 2020/21 which can be found at this link.

This release is part of an annual business as usual cycle, where revisions to the content of the Identification Rules are undertaken to align the content to published revisions to clinical service specifications. The Planning Tool can be used to generate contract plan projections for 2020/21 commissioned activity.

Commissioning for Quality and Innovation (CQUIN)

Full details of the 2020/21 CQUIN have been published. The simplified approach to both CCG and Prescribed Specialised Services (PSS) CQUIN that was initiated in 2019/20 will continue, targeting the faster uptake of clinical interventions aligned to key policy objectives drawn from the NHS Long Term Plan.

For the PSS Scheme, as in previous years, a portion of the CQUIN monies will be dedicated to sustain and expand the work of Operational Delivery Networks (ODNs) in ensuring consistency of care quality across the country. In addition, recognising the ongoing commitment to the elimination of Hepatitis C, ODN leads for Hepatitis C will, alongside mental health providers, continue to be eligible for a higher PSS CQUIN allocation when compared to other acute providers of specialised services, up to a maximum of 1.25%. Other acute providers of specialised services will be eligible for a similar CQUIN allocation to that which was allocated this year.

5.6 Productivity and efficiency

NHS England and NHS Improvement will continue to provide tools, information and support in aid of systems working together to deliver provider cost improvement plans, commissioner savings plans and to reduce unwarranted variation. Systems should set out in their operational plans the steps they will take to deliver cost savings required to meet agreed financial trajectories, assist staff and improve patient outcomes and experience.

All providers and commissioners should continue to use the data available to them through the Model Hospital, improvement programmes focused outside acute trusts, and transformation programmes to identify their priorities for productivity and efficiency

improvement. A suite of programmes designed to help trusts and systems unlock the opportunities to deliver sustainable productivity improvements has been created under the banner of Releasing Time for Care. It includes:

- help for local systems to agree optimal care pathways that make most efficient use of resources to improve quality and health outcomes, drawing on the work of RightCare, GIRFT and a range of other sources.
- practical support for effective demand/capacity planning, implementation of multi-professional workforce models, optimising scope of practice and better workforce deployment through universal deployment of electronic rostering or electronic job planning and evidence-based rostering.
- support for using digital solutions to remove non-productive tasks and making essential tasks more efficient (see digital section below).
- a range of approaches focused on specific professions or services such as community, mental health or urgent and emergency care which helps to release more time for care.

NHS England and NHS Improvement will provide support for systems to identify and then implement a small number of high impact interventions that will deliver the greatest productivity gain in 2020/21. For acute trusts this will be focus on identifying the highest impact opportunities set out in the Model Hospital.

Alongside any local priorities, we expect each system to prioritise delivery of:

- pathology and imaging networks;
- rostering and job planning;
- digital tools that release time for care; and
- clinical and operational improvements to pathways that improve productivity and efficiency through reducing length of stay and improving flow.

For pathology networks, systems should refer to the Pathology State of the Nation publication and use the pathology network toolkit to support progress. The case for developing Imaging Networks is set out in the National Strategy for Imaging.

Diagnostic services

Diagnostics services will be fundamental to implementation of the NHS Long Term Plan commitments. The immediate focus should be on the diagnostics services that have the largest impact locally on RTT and cancer standards. Systems should, working with and through their Cancer Alliances where appropriate:

- implement networks for imaging and pathology services.
- understand capacity and demand for both endoscopy and physiological measurement at a system level, and close capacity gaps by developing networked provision.

- take full advantage of HEE supported opportunities to increase workforce and support training in diagnostic services that are facing critical workforce constraints.
- understand and implement best practice models for using the existing working differently, for example reporting radiographer.
- continue to upgrade and replace equipment, including through the additional targeted £200m investment for imaging announced last year.

We will also be working with local systems to implement the recommendations of Professor Sir Mike Richard's forthcoming review of diagnostic capacity, including testing new models of provision where waiting time performance, and the consequent impact on emergency, elective and cancer performance is most challenged.

Digital transformation to support system integration

NHSX will work with systems to define 'what good looks like' for a digitised health and care system. Systems and providers will be expected to set out clear plans to work towards the agreed ambitions by 2024. Expectations will be embedded in the CQC inspection framework and the Single Oversight Framework.

Early in 2020/21 NHSX will set out its approach to mandating technology, security and data standards across the health and care system, which all systems and organisations will be expected to comply with.

NHSX, with NHS England and NHS Improvement, will also set out how technology funding should work, including:

- funding for the digitisation of providers will be targeted through a new digital aspirant programme and will not be split equally across all organisations.
- clarity on who pays for what, in particular what technology costs providers will be expected to pay for themselves.
- other programmes to improve outcomes and relieve the frustrations for frontline staff, for example on solutions which will reduce the time that staff spend logging onto different systems.

In the meantime, we expect systems and providers will want to ensure an appropriate level of investment in tech to achieve full use of modern digitised technology in the NHS digitisation of the NHS by 2024. Investment in technology, done in the right way, improves care, increases productivity, reduces the burden on staff freeing up more time to care, helps manage demand by enabling care to take place in the right setting and improving patient experience. It therefore makes sense to invest in technology now, to realise the benefits throughout the period of the NHS Long Term Plan and meet forthcoming standards of interoperability and cyber security.

NHSX, with NHS England and NHS Improvement, will be engaging with systems and providers to determine if there is a minimum and optimal indicative benchmark level of

technology revenue spend linked to digital maturity standards that are under development, what that level might be; and how they might move towards it over time. This does not preclude future bids on central technology and applies to revenue only. This will partly relate to the multi-year capital settlement the government has committed to providing the NHS.

To support productivity improvements in 2020/21 NHSX, with NHS England and NHS Improvement, will identify the high impact productivity enhancing solutions which all relevant NHS organisations should be using. Where appropriate NHSX will negotiate licence agreements to drive best value for the NHS, which NHS organisations may then fund themselves. NHSX will also put in place deployment teams to help organisations effectively implement these applications.

Last year we signalled our intention to move towards greater integration of specialised services with local health and care systems. During 2020/21 we will continue to support local systems that express an interest to plan and deliver specialised services as locally as possible to join up care pathways and improve patient outcomes and experience. This will include a review of the underpinning financial architecture for specialised commissioning.

As part of this agenda, from April 2020 NHS England and NHS Improvement are enabling local service providers to join together under NHS-led Provider Collaboratives that will be responsible for managing the budget and patient pathway for specialised mental health, learning disability and autism care. Further detail is included in Annex G of the Technical Guidance.

Procurement and corporate services

The NHS should continue to work through the Procurement Target Operating Model to improve the efficiency and effectiveness on NHS procurement. By April NHS England and Improvement will identify opportunities for NHS collaboration on ICT solutions to deliver increased value for the NHS.

NHS spend comparison service

NHS Spend Comparison is the national price benchmarking solution. NHS Organisations should regularly use this service to evidence and support price benchmarking, monitoring price inflation and supporting collaboration and aggregation across STPs on common areas of spend.

The NHS should continue to work with Supply Chain Coordination Limited (SCCL) to identify the right, clinically assured, best value products for the NHS. To maximise the value of this model and drive greater efficiencies Providers should work collaboratively with SCCL.

The NHS Long Term Plan identified an additional £400m savings in provider administration costs by 2023/24. Providers should continue to submit their corporate services Cost Improvement Plan delivery programme annually (September) to the regional delivery leads.

Legal

NHS organisations should standardise their legal services operating models and contracts in order to increase collaboration and achieve maximum value for money. Where organisations deliver an ‘in-house’ legal services model (i.e. solicitors are substantively employed by the NHS Trust) organisations are encouraged to review how this expertise may be deployed to bring greater benefit to the wider system. Organisations must not take decisions that prevent collaboration on a regional and/or national scale.

Finance back office

Within health and care systems all finance contracts for functional software/IT systems and financial services should be reviewed to align with other regional providers to ensure: interoperability; standardisation of services; and the better use of technology. Transactional processes should be reviewed for automation opportunities. Trusts must not take decision with regards to systems and contracts in isolation and that prevent system collaboration.

Payroll

Where NHS Organisations’ payroll contracts are up for renewal within the next 12 months or where organisations are not in contract i.e. stand-alone payroll provision, they should develop plans to collaborate at a minimum as part of the STP/ICS system. NHS organisations should review payroll contracts and arrangements to ensure at every opportunity they are looking to increase collaboration, improve workforce and service resilience. This will improve quality, reduce cost and eliminate risks. Organisations must not take decisions that prevent collaboration on a regional and/or national scale and when reviewing existing service arrangements, should seek to maximise collaborative opportunities to achieve economies of scale.

Consultancy and agency staff

We are taking steps to support NHS providers to reduce their agency staff bills and encourage workers back into substantive and bank roles. This will help ease the financial pressure facing the NHS – guidance on this can be found [here](#). In addition, NHS providers should remind themselves of the processes to follow when commissioning consultancy services: [Consultancy spending approval criteria for providers](#).

Apprenticeship levy

In 2018/19 over 70% of the NHS apprenticeship levy, equivalent to around £150m, is returned to government. NHS organisations should ensure that they are using this levy to support entry level talent into the NHS, senior staff with their continuous professional development and workforce retention.

Organisations are requested to review their workforce plans across the board for entry level talent and then embed apprenticeships within their workforce and recruitment plans to maximise use of the levy.

Evidence based interventions

In November 2018 NHS England and NHS Improvement – in partnership with Academy of Royal Medical Colleges, National Institute of Clinical and Health Excellence and NHS Clinical Commissioners – published statutory guidance on clinical interventions '[Evidence-Based Interventions: Consultation response](#)'. These are interventions that either should not be commissioned by CCGs or only performed where there is a successful individual funding request or where specific clinical criteria are met and so they are shown to be appropriate in the specific, exceptional circumstance. Proposed activity reduction numbers by CCG, provider and ICS/STP will be provided. We will ask systems to develop their own plans with a view to meeting or exceeding these numbers. The system plans will need to be agreed with all providers and commissioners.

Further work is underway with the support of an independent Expert Advisory Committee to build on the list of interventions.

Local, ICS wide, clinical governance arrangements should be in place to oversee the implementation of the existing and new guidance with the support of regional medical directors. Performance against the Evidence-Based Interventions programme is being incorporated into CQC reviews for providers of NHS services.

Specialised commissioning efficiencies

The High Cost Tariff Excluded Devices programme is a key plank for the delivery of required savings within specialised commissioning. A material value is transacted through this programme each month, and many providers have successfully migrated to the single supply route. To ensure that procurement opportunities are maximised at the earliest opportunity, from 1 April 2020 NHS England and NHS Improvement will only reimburse high cost devices through the single supply route, all other reimbursement arrangements will cease, unless with the prior agreement with the local NHS England and NHS Improvement commissioning team. Providers must therefore ensure that all product categories are migrated prior to the end of 2019/20 financial year to ensure that there is no disruption to their reimbursement.

5.7 Capital and estates

Investment in the NHS's buildings, IT and equipment is crucial to delivering the NHS Long Term Plan. The government has committed to providing the NHS with a new multi-year capital settlement at the next Spending Review, including capital to build new hospitals, for mental health and primary care, and to modernise diagnostics and technology.

In the meantime, we therefore ask providers to submit plans taking account of their known funding sources and schemes that have already received DHSC funding approvals including STP capital programmes, 20 hospital upgrades announced by the Prime Minister in August 2019 and the large new hospital building programme set out in the Health Infrastructure Plan in October 2019. This should include revised profiles for future years if those have changed relative to approvals. Trusts should also identify where they will make a request for emergency capital financing. It is critical that all currently funded plans are based on realistic forecasts for expenditure so that we can assess the capacity to fund emergency requests or any other initiative. Individual trust plans should be shared with system partners. We also ask systems to ensure that system-wide estate strategies are up to date so that they can inform future investment decisions.

As set out in the Health Infrastructure Plan, whilst providers remain legally responsible for maintaining their estates and for setting and delivering their organisational level capital investment plans, ICSs/STPs should work together to ensure organisational plans are consistent with system plans.

To strike a better balance between control and delivery, we are proposing two sets of changes – one to offer more assistance for providers in developing their business cases, and the other to streamline the approvals process for submitted cases.

To improve the business case development process, we will:

- roll out the DHSC/NHS England and NHS Improvement Better Business Case training package across the NHS; and
- grant a portion of a scheme's funding earlier in the business case process (i.e. prior to Full Business Case approval), where a convincing case can be made for the benefit of this.

To streamline the approvals process for business cases once they are submitted, we propose to:

- use alternative bid documentation in place of a Strategic Outline Case (subject to completion of current pilot) where organisations have bid for central funding through a competitive process – saving up to 6-12 months;

- formalise an approach where DHSC and NHS England and NHS Improvement triage cases that need extra support (due to high complexity/local sensitivity) or those that can be fast-tracked due to smaller scale/complexity; and
- create a single investment committee process for consideration of major schemes (i.e. one joint committee between DHSC and NHS England and NHS Improvement, to reduce the number of central approval layers.

Disposals and surplus land

Ensuring that each STP/ICS is clear within its estates strategy which estate is surplus to requirements both in the short term and in a future disposal pipeline is key to making efficient use of estates and in maximising land values in the medium to long term.

In previous financial years, profits on disposal were permitted to count towards provider control total delivery or over-achievement, which has encouraged a focus on asset disposals as a method of generating revenue. For the current financial year profits on disposal do not count towards control total achievement - providers that are expected to deliver disposals during 2019/20 were set an additional target as part of their control total, but this doesn't contribute to their PSF/FRF achievement.

Managing the impact of lease accounting standard (IFRS16)

In 2020/21 the NHS will adopt IFRS 16, which for lessee organisations will bring all leases on balance sheet apart from short term and low value leases. Further details on the standard have been provided separately to NHS finance teams, and the impact on reporting is explained in the technical guidance that will accompany the financial planning templates. The changes mean that all leases taken out on or after 1 April 2020 will score to national capital budgets. Using information to be collected from the NHS we expect that the national capital limits will be uplifted for the effect of the new standard in 2020/21: this means that the national capital budget will allow for the effect of leasing, but organisations should be mindful that leased and purchased assets will score to capital budgets in the same way in the future.

5.8 NHS Standard Contract

NHS England and NHS Improvement published the draft NHS Standard Contract for 2020/21 for consultation on 19 December 2019. The final version will be published in February 2020. 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 2020/21 (or agreement of variations to update existing non-expiring contracts) is 27 March 2020. In rare and exceptional circumstances, 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.

To promote collaborative working within local systems and to support implementation of the ICS operating model, we intend that CCGs and providers should be required to agree a System Collaboration and Financial Management Agreement (SCFMA). The SCFMA will:

- describe behaviours expected of a collaborative health system;
- set principles for open book accounting and transparency;
- describe how a consensus view of use of financial and other resources will be reached; and
- set out a mechanism for financial management and risk sharing to support delivery of the system improvement trajectory.

Participation in an SCFMA will be a requirement established through the 2020/21 NHS Standard Contract, for CCGs, NHS England and NHS Improvement regional teams and NHS providers only. A model SCFMA will be made available alongside the NHS Standard Contract. The model agreement is not intended to replace effective approaches which have already been adopted locally, however it will set out minimum arrangements that must be in place in each system. The investment by commissioners of funding withheld through sanctions or of any un-earned element of CQUIN will now fall within scope of the SCFMA.

A provider that submits a financial plan consistent with its financial improvement trajectory will continue to be protected from the impact of certain contractual sanctions, broadly in line with the approach which has applied since 2016. The proposed arrangements have been set out in the draft NHS Standard Contract for 2020/21.

An updated version of the Who Pays? guidance (which describes how the NHS body responsible for commissioning and paying for an individual patient's care is to be established) will be published for implementation from 1 April 2020. This will include additional scenarios to address situations where the rules for determining responsibility are commonly misunderstood, as well as a mandatory national process for resolving any disputes.

6. Process and timetable

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.

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.

Milestone	Date
System plans shared regional teams	November 2019
S118 Tariff Consultation published	December 2019
Operational and technical guidance issued	w/c 27 January 2020
Draft 2020/21 NHS Standard Contract published for consultation	19 December 2019- 31 January 2020
2020/21 CQUIN guidance published	January 2020
National tariff published	January 2020
First submission of draft operational plans	5 March 2020
First submission of system-led narrative plans	5 March 2020
2020/21 STP/ICS led contract/plan alignment submission	12 March 2020
Deadline for 2020/21 contract signature	27 March 2020
2020/21 STP/ICS led contract/plan interim alignment submission	8 April 2020
Parties entering arbitration to present themselves to National Directors of NHS Improvement and England (or their representatives)	6 April – 10 April 2020
Submission of appropriate arbitration documentation	15 April 2020
Final submission of operational plans	29 April 2020
Final submission of system-led narrative plans	29 April 2020
Publication of the People Plan and national implementation plan for the NHS Long Term Plan	March/April 2020
Arbitration panel and/or hearing (with written findings issued to both parties within two working days after panel)	16 April – 1 May 2020
2020/21 STP/ICS led contract/plan final alignment submission	6 May 2020
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	7 May 2020