

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	12 April 2021	Action	Receive
Item No	10.2	Confidential / Freedom of Information Status	No
Title	NHS 2021/22 Priorities and Operational Planning Guidance		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning, Bury Council and NHS Bury CCG Pat Crawford, Interim Chief Financial Officer, NHS Bury CCG		
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Clinical Lead	-		
Council Lead	-		

Executive Summary
<p>The attached guidance issued on the 25<sup>th</sup> March 2021 sets out the priorities for the year ahead against a backdrop of the challenge to restore services, meet new care demands and reduce the back logs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes.</p>
Recommendations
<p>It is recommended that the Strategic Commissioning Board:</p> <ul style="list-style-type: none"> <li>Notes the NHS 2021/22 Priorities and Operational Planning Guidance.</li> </ul>

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	N/A
Add details here.	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
Have any departments/organisations who	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>

Implications						
will be affected been consulted?						
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
Are there any financial implications?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
Are there any legal implications?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
Are there any health and safety issues?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
How do proposals align with Health & Wellbeing Strategy?	N/A					
How do proposals align with Locality Plan?	N/A					
How do proposals align with the Commissioning Strategy?	N/A					
Are there any Public, Patient and Service User Implications?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
How do the proposals help to reduce health inequalities?	N/A					
Is there any scrutiny interest?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
What are the Information Governance/ Access to Information implications?	N/A					
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>

Implications	
Additional details	

Governance and Reporting		
Meeting	Date	Outcome



# 2021/22 priorities and operational planning guidance

25 March 2021

Thank you to you and your teams for your extraordinary efforts over the last year. On 29 January we marked 12 months since we started to treat this country's first patients with COVID-19 and began to see the impact of the pandemic on our health services. Since then, with thanks to the whole NHS team, we have treated over 390,000 people with COVID-19 in hospitals, and many more in primary, community and mental health care. We have continued to deliver other essential services, treating over 275,000 people with cancer and dealing with increases in urgent and emergency demand.

At the time of writing, the NHS has delivered more than 26 million COVID-19 vaccinations to people across England, and is on course to hit its target of offering a first dose of the vaccine to all people in the top nine priority groups by 15 April. Data shows that the vaccination programme is having a significant impact on transmission rates and, coupled with the public's adherence to social restrictions, this means that hospitalisation rates have been falling across all regions and local areas.

While this gives us cause for optimism, we do not yet know what the pattern of COVID-19 transmission will look like over the next 12 months and it is clear that the impact of the last year will be felt throughout 2021/22 and beyond. As we rise to the challenge of restoring services, meeting the new care demands and reducing the care back logs that are a direct consequence of the pandemic, we know that it has also taken its toll on our people. By supporting staff recovery, their health and wellbeing and improving workforce supply we can restore services in a sustainable way.

The pandemic has shone a brighter light on health inequalities. We will need to take further steps to develop population health management approaches that address inequalities in access, experience and outcomes, working with local partners across health, social care, and beyond. To support this, we have set out five priority areas for tackling health inequalities that systems are asked to give particular focus to in the first half of 2021/22 (see accompanying guidance). Tackling inequalities of outcome is also central to the investments we will make this year to improve outcomes on cancer, cardiovascular disease, mental health and maternity services as well as to expand smoking cessation and weight management services.

To achieve these goals, while restoring services and recovering backlogs, will require us to do things differently, accelerating delivery against and redoubling our commitment to strategic goals we all agreed in the Long Term Plan (LTP). The NHS has shown this year it's ability to adapt, develop new services at scale and pace and has, for example, made real strides in embedding digital approaches to patient care. We now need to build on these improvements alongside the development of system working and collaboration.

Effective partnership working across systems will be at the heart of this and the financial framework arrangements for 2021/22 will therefore continue to support a system-based approach to funding and planning.

It is within this context that we are setting out our priorities for the year ahead:

- A. Supporting the health and wellbeing of staff and taking action on recruitment and retention
- B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
- C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
- D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities
- E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
- F. Working collaboratively across systems to deliver on these priorities.

The Government has agreed an overall financial settlement for the NHS for the first half of the year which provides an additional £6.6bn + £1.5bn for COVID-19 costs above the original mandate. The financial settlement for months 7-12 will be agreed once there is greater certainty around the circumstances facing the NHS going into the second half of the year. In addition, £1.5bn funding has been allocated for elective recovery, mental health and workforce development.

While we are setting out priorities for the full year, we are therefore asking systems to develop fully triangulated plans across activity, workforce and money for the first half of the year. For mental health we can provide funding for the full year and these plans should therefore extend to 12 months (see accompanying guidance).

## A. Supporting the health and wellbeing of staff and taking action on recruitment and retention

Our people need to be at the heart of plans for recovery and transformation and those plans should reflect the need for staff to get the support, rest and recuperation that they need. For

the first half of 2021/22, we are asking systems to review and refresh their people plans to reflect the progress made in 2020/21, as well as to show: greater progress on equality, diversity and inclusion; progress on compassionate and inclusive cultures; and increasing workforce supply. These themes were highlighted as part of the review of local plans in September 2020.

### **A1 Looking after our people and helping them to recover**

Different people will need to recover from the demands of the pandemic in different ways, and staff safety remains a priority. Employers need to put support in place to help staff given what they have been through over the last 12 months.

- We encourage trusts to allow staff to carry over all unused annual leave and offer flexibility for staff to take or buyback unused leave. System financial performance assessment will exclude higher accruals for annual leave in 2020/21. All staff should be encouraged to take time off to recover, making use of annual leave which may be carried over from 2020/21.
- Individual health and wellbeing conversations should be a regular part of supporting all staff with an expectation that a plan is agreed at least annually and should take place over the course of first half of the year. Staff safety remains a priority and these plans should include risk assessment, flexible working, compliance with infection prevention and control policy, and testing policy, as well as drawing on the range of preventative health and wellbeing support available.
- Occupational health and wellbeing support should be available to all staff, including rapid access to psychological and specialist support. We will provide national investment to roll out mental health hubs in each ICS and to expand.

### **A2 Belonging in the NHS and addressing inequalities**

COVID-19 has surfaced inequalities that can be harmful to our people and addressing this remains an urgent priority. We expect systems to:

- develop improvement plans based on the latest WRES findings, including to improve diversity through recruitment and promotion practices
- accelerate the delivery of the model employer goals.

### **A3 Embed new ways of working and delivering care**

During the pandemic, our people adopted innovative ways of working to make best use of their skills and experience to benefit our patients. Now is the time to embed those workforce transformations to support recovery and longer-term changes:

- Providers should maximise the use of and potential benefits of e-rostering, giving staff better control and visibility of their working patterns, supporting service improvements and the most effective deployment of staff. Providers are asked to show how they intend to meet the highest level of attainment as set out by our 'meaningful use standards' for e-job planning and e-rostering.
- Local systems are also encouraged make use of interventions to facilitate flexibility and staff movement across systems, including remote working plans, technology-enhanced learning and the option of staff digital passports.

## **A4 Grow for the future**

During the pandemic we were able to grow our workforce through a range of innovative measures that helped us to successfully deal with COVID-19 while treating patients with a range of other conditions. Now we need to take steps to sustainably increase the size of our workforce in line with measures set out in the NHS Long Term Plan. Systems are asked to:

- Develop and deliver a local workforce supply plan with a focus on both recruitment and retention, demonstrating effective collaboration between employers to increase overall supply, widen labour participation in the health and care system, and support economic recovery.
- Ensure system plans draw on national interventions to introduce medical support workers (MSWs), and make use of associated national funding, increase health care support workers (HCSWs) and international recruitment of nursing staff.
- Support the recovery of the education and training pipeline by putting in place the right amount of clinical placement capacity to allow students to qualify and register as close to their initial expected date as possible.
- Develop and implement robust postgraduate (medical and dental) training recovery plans that integrate local training needs into service delivery planning.
- Ensure that workforce plans cover all sectors – mental health, community health, primary care and hospital services. The plans should support the major expansion and development of integrated teams in the community, with primary care networks (PCNs) serving as the foundation, assisted to make full use of their Additional Roles Reimbursement Scheme funding, including through the options of rotational or joint employment.



## B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19

Offering a first dose to the adult population by the end of July remains key to saving lives, reducing the likelihood of increased pressure on the NHS, and reducing the spread of COVID-19 as social distancing is eased. This will continue to be delivered through implementing a mixed model of vaccine delivery through vaccination centres, hospital hubs, general practice and community pharmacy capacity. The precise local model will vary according to the needs of the local population and include targeted approaches where these are required to increase uptake, particularly in under-served populations.

General practice will retain an important role in the COVID-19 vaccination programme, with PCN groupings having the option to vaccinate cohorts 10-12 (18-49 year olds) (when the national supply availability means those groups can begin to be vaccinated) if they can also fulfil the requirements of the GMS contract.

It is not currently known for how long people who receive a COVID-19 vaccine will be protected. This is because, as is the case with many vaccines, the protection they confer may weaken over time. It is also possible that new variants of the virus may emerge against which current vaccines are less effective. The Joint Committee on Vaccination and Immunisation (JCVI) will issue advice in due course and systems will need to consider:

- being prepared for a COVID-19 re-vaccination programme from autumn, with high uptake ambitions for seasonal flu vaccination, alongside:
- the possibility of COVID-19 vaccination of children, should vaccines be authorised for use in under 18s and recommended by the JCVI in this population.

PCNs will also have an important ongoing role in response to the pandemic that will involve the continued use of home oximetry, alongside hospital-led 'virtual wards', proactive care pathways delivered virtually in people's homes. As well as enabling safe and more timely discharge, COVID Virtual Wards have the potential to support some COVID patients who would otherwise be admitted to hospital. Systems are encouraged take this into account as they continue to prepare for any future potential surge requirements for COVID patients.

We will continue national funding to maintain the dedicated Post COVID Assessment clinics that have been established and all systems are asked to ensure that they provide timely and equitable access to Post COVID Syndrome ('Long COVID') assessment services.

We will also conduct a stocktake of both physical critical care capacity and workforce, which will inform next steps in creating a resilient and sustainable service. This will include critical care transfer services.

All NHS organisations should ensure continued reliable application of the recommendations in the UK [Infection Prevention and Control guidance](#) updated by Public Health England to reflect the most up-to-date scientific understanding of how to prevent and control COVID-19 infection.

## C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services

The pandemic has had a significant impact on NHS activity, and while the majority of care and activity has been maintained through the winter and the second wave, elective care has been disrupted and there are new demands on mental health services.

During the pandemic collaboration across providers helped ensure that every COVID-19 patient requiring hospital treatment received it and staff could work where they were most needed. In addition, pathway changes were rapidly implemented, helping ensure patients were only in hospital if they needed to be. This same approach will now help us transform the design and delivery of services across systems, to reduce unwarranted variation in access and outcomes, redesign clinical pathways to increase productivity, and accelerate progress on digitally-enabled care. In 2021/22 we will:

### **C1 Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services**

The pandemic has had a significant impact on the delivery of elective care and, as a result, on the lives of many patients who are waiting for treatment. We need to be ambitious and plan to recover towards previous levels of activity and beyond where possible over the next few years. An additional £1bn funding has been made available to the NHS in 2021/22 to support the start of this recovery of elective activity, and the recovery of cancer services. Systems are asked to rapidly draw up delivery plans across elective inpatient, outpatient and diagnostic services for adults and children (including specialised services) for April 2021 to September 2021 that:

- maximise available physical and workforce capacity across each system (including via the Independent Sector- IS), learning from other systems and taking into account the high-impact changes including adapting the ward environment to enhance flow

and physical segregation of patients,<sup>1</sup> segregating elective care flow through the hospital and developing service transformation initiatives to drive elective recovery

- prioritise the clinically most urgent patients, eg for cancer and P1/P2 surgical treatments
- incorporate clinically led, patient focused reviews and validation of the waiting list on an ongoing basis, to ensure effective prioritisation and manage clinical risk (drawing on both primary and secondary care)
- include actions to maintain effective communication with patients including proactively reaching out to those who are clinically vulnerable
- address the longest waiters and ensure health inequalities are tackled throughout the plan, with a particular focus on analysis of waiting times by ethnicity and deprivation
- safeguard the health and wellbeing of staff, taking account of the need for people to recover from what they have been through

Given these factors, systems are asked to plan for the highest possible level of activity. We understand that current restrictions affect output. The Government has made additional funding available to allow systems to step activity back up and so systems that achieve activity levels above set thresholds, ie the levels funded from core system envelopes, will be able to draw down from the additional £1bn Elective Recovery Fund (ERF) for 2021/22. The threshold level is set against a baseline value of all elective activity delivered in 2019/20, allowing for available funding, workforce recovery and negative productivity impacts of the pandemic through 2021/22. For April 2021 it will be set at 70%, rising by 5 percentage points in subsequent months to 85% from July.

Acute providers' access to the ERF will be subject to meeting 'gateway criteria' including addressing health inequalities, transformation of outpatient services, implementing system-led elective working, tackling the longest waits and supporting staff.

The remaining national contracts between NHS England and acute independent sector providers end on 31 March and local commissioning will be restored. Targeted collaborative partnerships with IS providers to support delivery of system capacity plans will continue be an important element of elective recovery plans. Over the next 2 months we will explore with system leaders and IS providers evolved mechanisms for effective working, contracting and

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<sup>1</sup> In line with [infection prevention and control guidance](#) published by Public Health England

planning to establish how we can most effectively use IS capacity to support recovery over the next two to three years.

Systems are asked to recover elective activity in a way that takes full advantage of elective high-impact changes and transformation opportunities, and demonstrates learning from other systems, in particular:

- Create clear accountability for elective recovery, and implement key supporting tools, at system level, including common tracking of waiting lists; clinical review and prioritisation; dynamic planning of elective capacity and shared capacity, demand and monitoring data
- Maximise opportunities to implement high impact service models in elective care at system level such as dedicated fast track hubs for high volume, low complexity care with standardised clinical pathways; dedicated elective service pathways within acute sites; elective activity coordination hubs for booking and scheduling across sites to tackle backlogs at system level
- To reduce variation in access and outcomes, systems are expected to implement whole pathway transformations and thereby improve performance in three specialties: cardiac, musculoskeletal (MSK) and eye care with support via the National Pathway Improvement Programme. The aim should be to achieve what was top quartile performance against benchmarks on those pathways, and we will ask the National Pathway Improvement Programme in conjunction with GIRFT to support the development of and accredit plans as part of the national elective recovery programme.
- Embed outpatient transformation, taking all possible steps to avoid outpatient attendances of low clinical value and redeploying that capacity where it is needed, alongside increased mobilisation of Advice & Guidance and Patient Initiated Follow-Up services. Where outpatient attendances are clinically necessary, at least 25% should be delivered remotely by telephone or video consultation (equivalent to c.40% of outpatient appointments that don't involve a procedure). Initial activity goals and the gateway to access ERF have been set to reflect the feedback on not incentivising the avoidance of clinically unnecessary referrals and appointments. For the second half of the year we anticipate a national data collection and counting methodology. In future we will use this to inform the way in which the payment system further supports implementation of these reforms.
- Access available support to help deploy the innovative approaches to optimising workforce capacity that are best suited to local system needs, including system wide

workforce planning, passporting to allow flexible working of employed and bank staff between organisations

Recovery of the highest possible diagnostic activity volumes will be particularly critical to support elective recovery. Capital and revenue funding have been made available to deliver additional capacity and efficiencies through new Community Diagnostic Hubs (CDHs) and pathology and imaging networks. All systems are expected to work with regions to deliver increased capacity to meet the diagnostic needs for their population, in line with the recommendations of the Richards review. System plans should set out their proposals for how this additional capacity will be delivered, including through the development of CDHs.

In order to tackle the backlog, systems will when feasible need to return to, and in time and with support, move above 2019/20 baseline of activity. We will look to support systems who can identify and develop innovative and transformative approaches to restore activity to above pre-pandemic levels, with mechanisms to ensure that the insights generated can be applied across the NHS.

## **C2 Restore full operation of all cancer services**

NHS staff have worked hard to prioritise cancer services during the pandemic, and the overwhelming majority of cancer treatment has continued. However, some people have not contacted their GP with symptoms. Local systems, drawing on advice and analysis from their Cancer Alliance, will ensure that there is sufficient diagnostic and treatment capacity in place to meet the needs of cancer to:

- return the number of people waiting for longer than 62 days to the level we saw in February 2020 (or to the national average in February 2020 where this is lower) and
- meet the increased level of referrals and treatment required to address the shortfall in number of first treatments by March 2022.

The national cancer team will support local systems and Cancer Alliances to learn from each other, and to plan by providing estimates of the level of additional referrals and treatment required to address the shortfall.

Cancer Alliances are asked to draw up a single delivery plan on behalf of their integrated care systems(s) ICSs) for April 2021 to September 2021 to deliver the following actions:

- **Getting patients to come forward**
  - work with GPs and the local population to increase the number of people coming forward and being referred with suspected cancer, with a particular focus on groups under-represented among those who have come forward. Systems should

actively support their practices as they complete the QOF Quality Improvement module on early cancer diagnosis, which has been continued into 2021/22 as part of GP contract arrangements, and

- work with public health commissioning teams to restore all cancer screening programmes. This should include using the additional £50m investment committed funding for breast cancer screening to meet national standards and to recover backlogs by end March 2022. We will also begin to extend bowel cancer screening to include 50-60 year olds, with rollout to 56 year olds from April 2021.

- **Investigate and diagnose**

- extend the centralised clinical prioritisation and hub model established during the pandemic for cancer surgery to patients on cancer diagnostic pathways (starting with endoscopy where appropriate), ensuring a joint approach across cancer screening and symptomatic pathways
- using national service development funding Alliances are encouraged to:
  - increase take up of innovations like colon capsule endoscopy and Cytosponge to support effective clinical prioritisation for diagnostics
  - accelerate the development of Rapid Diagnostic Centre pathways for those cancer pathways which have been most challenged during the pandemic and
  - restore first phase Targeted Lung Health Check projects at the earliest opportunity, and begin planning the launch of the Phase 2 projects.

- **Treat**

- embed the system-first approach to collaboration established during the pandemic
  - including centralised clinical triage and centralised surgical hubs where appropriate – as an enduring legacy of the pandemic
- agree personalised stratified follow up (PSFU) pathways in three additional cancer types and implement one by March 2022, in addition to breast, prostate and colorectal cancer.

Systems will be expected to meet the new Faster Diagnosis Standard from Q3, to be introduced initially at a level of 75%. To support delivery, Faster Diagnosis Standard data will begin to be published from spring 2021. Systems should, as soon as possible, also ensure a renewed focus on improving performance against the existing Cancer Waiting Times standards. Cancer Alliances are asked to draw up on behalf of their ICS(s) an action plan for improving operational performance, with a particular focus on pathways which are most adversely affecting overall performance.

### **C3 Expand and improve mental health services and services for people with a learning disability and/or autism**

Our mental health workforce has continued to provide people with the support they need during the pandemic. We know, however, that COVID-19 has not only affected the delivery of services but is also likely to cause an increase in demand.

The ambitions set out in the Mental Health Implementation Plan 2019/20–2023/24, which expand and transform services, remain the foundation for our mental health response to COVID-19, enabling local systems to expand capacity, improve quality and tackle the treatment gap. An additional £500m of funding has been made available in 2021/22 to address the impact of COVID-19.

In 2021/22 we expect local systems to:

- Deliver the mental health ambitions outlined in the Long Term Plan, expanding and transforming core mental health services (and in doing so prepare for implementation of recommendations for Clinical Review of Standards for mental health). This includes:
  - continuing to increase children and young people’s access to NHS-funded community mental health services, noting the revised metric and importance of continued focus on quality of care
  - delivery of physical health checks for people with Serious Mental Illness (SMI), noting that GPs will be incentivised to deliver the checks in 2021/22 via a significant strengthening of relevant QOF indicators
  - investing fully in community mental health, including funding for new integrated models for Serious Mental Illness (adult and older adult) and SDF funding to expand and transform services. To support this a new metric will measure those accessing community mental health services. To support integration with general practice, the NHS contract and GP contract have introduced new co-funding requirements for embedded additional PCN posts.
- maintain transformations and beneficial changes made as part of COVID-19, where clinically appropriate, including 24/7 open access, freephone all age crisis lines and staff wellbeing hubs
- maintain a focus on improving equalities across all programmes, noting the actions and resources identified in the [Advancing Mental Health Equalities Strategy](#)
- have a workforce strategy and plan that delivers the scale of workforce growth required to meet LTP ambitions



- enable all NHS Led Provider Collaboratives to go live by 1 July 2021
- ensure that all providers, including in scope third sector and independent sector providers, submit comprehensive data to the Mental Health Services Data Set and IAPT Data Set
- have a strategy and effective leadership for digital mental health, and ensure that digitally-enabled models of therapy are rolled out in specific mental health pathways.

All CCGs must, as a minimum, invest in mental health services to meet the Mental Health Investment Standard.

It is vital to continue to make progress on our LTP commitments for people with a learning disability, autism or both. We need to make progress on the delivery of annual health checks for people with a learning disability. We also need to improve the accuracy of GP Learning Disability Registers to make sure the identification and coding of patients is complete, in particular for under-represented groups such as children and young people and people from Black, Asian and Minority Ethnic backgrounds.

Systems will be expected to maintain a strong commitment to reducing reliance on inpatient care for both adults and children with a learning disability, autism or both. This will be supported by improved community capacity to enable more people to receive personalised care, closer to home. Pilots and early adopter sites for keyworkers for children and young people with the most complex needs will continue, with remaining areas preparing for delivery in 2022/23.

To tackle the inequalities experienced by people with a learning disability highlighted and exacerbated by the pandemic, systems are asked to implement the actions coming out of LeDeR reviews. The national programme requirement is for 100% of reviews to be completed within six months of notification.

#### **C4 Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review**

Donna Ockenden's interim report has challenged everyone who works in maternity services to redouble efforts to continue to improve outcomes and patient experience and to reduce unwarranted variation. All trusts have completed an assurance assessment tool and reported it though systems as set out in the [14 December letter](#) from Amanda Pritchard, Ruth May and Steve Powis. For 2021/22 we are investing more than £80m of additional funding to improve maternity safety and meet the Immediate and Essential Actions from the [Ockenden report](#).



Local maternity systems (LMSs) should be taking on greater responsibility for ensuring that maternity services are safe for all who access them, and should be accountable to ICSs for doing so. As part of their work to make maternity care safer, more personalised and more equitable, they should oversee local trust actions to implement the seven immediate and essential actions from the [Ockenden report](#).

Systems are expected to continue delivery of the maternity transformation measures set out in the Long Term Plan, including offering every woman a personalised care and support plan, implementing all elements of the Saving Babies' Lives care bundle, and making progress towards the implementation of the continuity of carer model of midwifery.

Further detail on the full set of actions and priorities under these broad headings is set out in the accompanying guidance.

## **D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities**

The Long Term Plan committed to a significant real terms expenditure increase on primary medical and community health services to improve prevention and keep people out of hospital. In 2021/22 this commitment will again be met and will support:

- restoring and increasing access to primary care services
- implementing population health management and personalised care approaches to improve health outcomes and address health inequalities and
- transforming community services and avoiding unnecessary hospital admissions and improving flow, in particular on the emergency pathway.

### **D1 Restoring and increasing access to primary care services**

The success of the COVID vaccination programme has proven beyond doubt the value and potential of PCNs. Systems should continue to prioritise local investment and support for PCN development, including enabling stronger integration of care with community-based services.

PCNs are the critical enabler of workforce expansion in general practice. All systems are expected to support their PCNs to:

- achieve their share of 15,500 FTE PCN roles to be in place by the end of the financial year, in line with the target of 26,000 by 2023/24

- expand the number of GPs towards the 6,000 target, with consistent local delivery of national GP recruitment and retention initiatives and thereby
- continue to make progress towards delivering 50 million more appointments in general practice by 2024.

National funding for general practice capacity also continues through an additional £120m in first half of the year, which will taper in the second quarter as COVID pressures decrease.

Overall appointment volumes in general practices remain high. Systems are asked to support those practices where there are access challenges so that all practices are delivering appropriate pre-pandemic appointment levels. This includes all practices offering face-to-face consultations. Systems are asked to continue to support practices to increase significantly the use of online consultations, as part of embedding total triage.

Practices continue to reach out to clinically vulnerable patients and, as set out in section C. Systems should support their PCNs to work closely with local communities to address health inequalities. The ongoing effort to tackle the backlog of clinically prioritised long-term condition management reviews, including medication reviews and routine vaccinations will be supported via the re-introduction of QOF indicators from April.

The Community Pharmacy Consultation Service (CPCS) has been extended, as part of the existing advanced service, to include the ability to receive referrals from General Practice and support the management of low acuity patients in alternative settings, supporting workload pressures. Local pharmacy contractors, PCNs and GP practices should be working with their local LPC, LMC and regional teams to agree implementation of this service locally prior to being able to receive referrals.

For dental services, the focus is on maximising clinically appropriate activity in the face of ongoing infection prevention control measures, and targeting capacity to minimise deterioration in oral health and reduce health inequalities. We will continue to support dental teams to deliver as comprehensive a service as possible.

## **D2 Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities**

COVID-19 has highlighted the correlation between poorer health outcomes and ethnicity and deprivation, specifically. Systems are encouraged to adopt population health management techniques as part of their targeted recovery strategies, aiming for equitable access, excellent experience and optimal outcomes for all groups. NHS England and NHS Improvement will continue to work with systems to develop the real-time data tools and techniques being used so effectively by the COVID vaccination programme, at a granular

local level. It also includes the use of person-centred segmentation and risk stratification to identify at-risk groups, those with the greatest health inequalities or the most complex needs, and those awaiting multiple appointments. Systems should provide proactive, multi-disciplinary, cross sector support to these patients, in line with the NHS Comprehensive Model for Personalised Care.

The NHS Long Term Plan sets out a path for improvements for people with conditions such as diabetes, CVD and obesity. These are even more important given we now know the clear association with poorer outcomes with COVID-19. We are asking systems to develop robust plans for the prevention of ill-health, led by a nominated SRO, covering both primary and secondary prevention deliverables as outlined in the Long Term Plan. These plans should set out how ICS allocations will be deployed in support of the expansion of smoking cessation services, improved uptake of the NHS diabetes prevention programme and CVD prevention. The NHS digital weight management services will also be made more widely available following additional government investment announced in March. Systems are also asked to review their plans and make progress against the LTP high impact actions to support stroke, cardiac and respiratory care.

Delivering the NHS Comprehensive Model for Personalised Care, thereby giving people more control over their own health, will underpin systems' efforts to recover services and address health inequalities. Systems will continue and, where possible, accelerate the delivery of existing requirements, including personal health budgets, social prescribing referrals and personalised care and support plans. In 2020/21 1 million personalised care interventions were delivered and we expect at least 1.2 million to be delivered in 2021/22 in line with our LTP ambition. Implementation will be supported by recruitment to three additional roles funded through the ARRS: Social Prescribing Link Workers, Health and Wellbeing Coaches, and Care Coordinators.

## **E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments, improve timely admission to hospital for ED patients and reduce length of stay**

### **E1 Transforming community services and improve discharge**

With national transformation funding and the increase in primary and community care services funded through baseline allocations we are asking every system to set out plans to accelerate the rollout of the 2-hour crisis community health response at home to provide consistent national cover (8am-8pm, seven days a week) by April 2022. Additional transformation funding will be released subject to those plans and a commitment by all

community service providers to provide complete and accurate data to the Community Services Dataset (CSDS) in 2021/22.

Systems have achieved significant reductions in long stays during 2020/21 equivalent to freeing up 6,000 beds and 11,000 staff across acute and community settings. All providers should continue to deliver timely and appropriate discharge from hospital inpatient settings and seek to deliver an improvement in average length of stay with a particular focus on stays of more than 14 and 21 days. To support this we will continue to fund the first six weeks of additional care after discharge from an NHS setting during the first quarter and first four weeks from the beginning of July. We will review the position with Government for the second half of the year.

Together, these actions will enable more patients to be cared in the optimal setting and will reduce the pressure on our hospitals by improving flow through the emergency pathway and freeing up capacity to support the restoration of elective care.

## **E2 Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments**

Systems are asked to continue to progress the work already underway through the NHS 111 First and Same Day Emergency Care programmes. Specifically, systems should:

- promote the use of NHS 111 as a primary route into all urgent care services
- maximise the use of booked time slots in A&E with an expectation that at least 70% of all patients referred to an emergency department by NHS 111 receive a booked time slot to attend
- maximise the utilisation of direct referral from NHS 111 to other hospital services (including SDEC and specialty hot clinics) and implement referral pathways from NHS 111 to urgent community and mental health services
- adopt a consistent, expanded, model of SDEC provision, including associated acute frailty services, within all providers with a type 1 emergency department to avoid unnecessary hospital admissions.

To assess the level of pressure within urgent and emergency care systems and monitor their recovery, systems are asked during Q1 to roll out the Emergency Care Data Set (ECDS) to all services and implement the collection of those measures that are not already in place, including:

- the time to initial assessment for all patients presenting to A&E

- the proportion of patients spending more than 12 hours in A&E from time of arrival
- the proportion of patients spending more than one hour in A&E after they have been declared Clinically Ready to Proceed.

A response to the consultation to the UEC clinically-led review of standards will be published in due course, and with agreement with government on next steps. For the first part of the year, systems are asked to focus on implementing data collection, and UEC recovery.

## F. Working collaboratively across systems to deliver on these priorities

### F1 Effective collaboration and partnership working across systems

The priorities set out in this guidance will only be delivered through effective partnership working across systems, including effective provider collaboration and place-based partnerships with local government. The accompanying guidance sets out the expectations for how ICSs are expected to build on existing arrangements during 2021/22. These requirements include having system-wide governance arrangements to enable a collective model of responsibility and decision-making between system partners.

ICSs will be asked to set out, by the end of Q1, the delivery and governance arrangements that will support delivery of the NHS priorities set out above. These must be set out in a memorandum of understanding (MOU) and agreed with regional NHS England and NHS Improvement teams. In line with the proposed new [NHS System Oversight Framework](#) the MOU will also be expected to set out the oversight mechanisms and structures that reflect these delivery and governance arrangements, including the respective roles of the ICS and regional NHSEI team.

### F2 Develop local priorities that reflect local circumstances and health inequalities

ICSs across the country entered the pandemic with a varying range of circumstances and different health groups with a range of needs. COVID-19 has exacerbated this disparity and, in recovering services, systems now face varying challenges.

In recognition of these challenges, systems are asked to develop their own set of local health and care priorities that reflect the needs of their population, aligned to the four primary purposes of an ICS:

- improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience and access

- enhancing productivity and value for money
- helping the NHS support broader social and economic development.

### **F3 Develop the underpinning digital and data capability to support population-based approaches**

Meeting population need requires smart digital foundations, connected health and care services, locally joined-up person-level data across health and care partners, and robust analytical capability aligned across system partners. This will be described in the forthcoming NHSX What Good Looks Like framework, which will support ICSs to benchmark and enable regional teams to develop an appropriate support offer.

To underpin this, systems should commence their procurement of a shared care record so that a minimum viable product is live in September and roadmap for development to include wider data sources and use for population health is ready for April 2022.

### **F4 Develop ICSs as organisations to meet the expectations set out in Integrating Care**

We expect ICSs to take steps in their development during 2021/22 to ensure they are able to deliver the four core purposes described above. ICSs are asked to set out how they will organise themselves to support this, including through:

- Updating their system development plans, detailing the work they will undertake to ensure their system has the necessary functions, leadership, capabilities and governance
- Preparing for moving to a statutory footing from April 2022, subject to legislation.

### **F5 Implement ICS-level financial arrangements**

The financial framework arrangement for 2021/22 will continue to build on the system-based approach to funding and planning. Systems should ensure that they are continuing to take actions to strengthen their system financial governance arrangements and building collaborative plans to optimise system resources.

For the six-month period to 30 September 2021, we will be issuing system envelopes based on the H2 2020/21 funding envelopes and including a continuation of the system top-up and COVID-19 fixed allocation arrangements. The total quantum will be adjusted to issue additional funding for known pressures and key policy priorities (including inflation, primary care and mental health services).

System envelopes will also be adjusted to reflect an efficiency requirement increasing through the second quarter and with an increased requirement for those systems that had

deficits compared to 19/20 financial trajectories at the end of 2019/20. We will be developing specific system productivity measures to align with the focus on clinical pathway transformation and the reduction in unwarranted variation as part of the national elective recovery programme underpinned by more effective rostering of staff. We will also set goals for outpatient transformation as we approach the second half of the year.

The current block contract payments approach will continue for NHS providers. Further detail on the construction of H1 system funding and organisational plans, the contracting and payments approach for NHS and non-NHS organisations, and the processes to amend plans and access recovery funding, is outlined in the accompanying guidance.

Finally, we are asking local systems to return a draft summary plan by 6 May using the templates issued and covering the key actions set out in this letter, with final plans due by 3 June. These plans need to be the product of partnership working across STPs/ICSs, with clear and transparent triangulation between commissioner and provider activity plans.