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2022/23 priorities and operational planning guidance

Version 3, 22 February 2022

updates from previous versions are highlighted throughout the document

Version Number	Date	Details of change
V1	24 December 2021	Initial version
V2	14 January 2022	Page 22 under community care models, a sentence about those living with frailty has been amended. The change is highlighted.
		Page 22 community care models- information about virtual wards has been amended to read 40-50 virtual <u>beds</u> per 100,000 population. The change is highlighted.
		Page 29, a date has been corrected and the change is highlighted.
V3	22 February 2022	Page 13 Elective care ambitions updated to reflect the 'Delivery plan for tackling the Covid-19 backlog of elective care' (Feb 2022). Three changes are highlighted.
		Page 21 NHS111 clinical capacity within the clinical assessment service has been amended to read > <u>50%</u> of calls received having clinical input. The change is highlighted.

Dear colleague

Thank you to you and your teams for your continued extraordinary efforts for all our patients.

At the end of January, we will mark two years since paramedics from Yorkshire Ambulance Service and hospital teams in Hull and Newcastle started to treat this country's first patients with COVID-19, and earlier this month we marked the anniversary of the first COVID-19 vaccine dose – and the milestone of 100 million doses – delivered in the biggest and fastest vaccination programme in NHS history.

The last two years have been the most challenging in the history of the NHS, and staff across the service – and many thousands of volunteers – have stepped up time and time again:

- expanding and flexing services to meet the changing demands of the pandemic
- developing and rolling out new treatments, new services and new pathways to respond to the needs of patients with COVID-19 and those without
- pulling out all the stops to recover services that have been disrupted.

At the time of writing, we are again operating within a [Level 4 National Incident](#) in response to the emergence of the Omicron variant. Teams from across the NHS and our partners are:

- significantly increasing vaccination capacity to provide the maximum level of immunity for the maximum number of people
- rolling out new antiviral and monoclonal antibody treatments through COVID medicines delivery units
- preparing for a potentially significant increase in those requiring life-saving care.

This concrete and rapid action in the face of uncertainty has characterised the NHS response to the pandemic. We face that uncertainty again now – in terms of the potential impact of Omicron over the coming weeks and months and the development of the pandemic as we look ahead to 2022/23. Despite this, the clear message I have had from colleagues across the NHS is that it is important to provide certainty and clarity where we can by now setting out the priorities and financial arrangements for the whole of 2022/23, recognising that they will have to be kept under review.

The objectives set out in this document are based on a scenario where COVID-19 returns to a low level and we are able to make significant progress in the first part of next year as we continue to rise to the challenge of restoring services and reducing the COVID backlogs.

Building on the excellent progress seen during 2021/22, this means significantly increasing the number of people we can diagnose, treat and care for in a timely way. This will depend on us doing things differently, accelerating partnership working through integrated care systems (ICSs) to make the most effective use of the resources available to us across health and social care, and ensure reducing inequalities in access is embedded in our approach. As part of this, and when the context allows it, we will need to find ways to eliminate the loss in non-COVID output caused by the pandemic.

Securing a sustainable recovery will depend on a continued focus on the health, wellbeing and safety of our staff. ICSs will also need to look beyond the immediate operational priorities and drive the shift to managing the health of populations by targeting interventions at those groups most at risk and focusing on prevention as well as treatment. Thank you for the significant progress that has been made in preparing for the proposed establishment of statutory Integrated Care Systems. To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for statutory arrangements to take effect and ICBs to be legally and operationally established.

Our ability to fully realise the objectives set out in this document is linked to the ongoing level of healthcare demand from COVID-19. Given the immediate priorities and anticipated pressures, we are not expecting you or your teams to engage with specific planning asks now. The planning timetable will be extended to the end of April 2022, and we will keep this under review.

On behalf of myself and the whole NHS leadership team I want to thank you for the way you are continuing to support staff, put patients first and rise to the challenges we face.

With best wishes

Amanda Pritchard
NHS Chief Executive

Introduction

In 2022/23 we will continue to rise to the challenges of restoring services, meeting the new care demands and reducing the care backlogs that are a direct consequence of the pandemic. While the future pattern of COVID-19 transmission and the resulting demands on the NHS remain uncertain, we know we need to continue to increase our capacity and resilience to deliver safe, high quality services that meet the full range of people's health and care needs. We will:

- accelerate plans to grow the substantive workforce and work differently as we keep our focus on the health, wellbeing and safety of our staff
- use what we have learnt through the pandemic to rapidly and consistently adopt new models of care that exploit the full potential of digital technologies
- work in partnership as systems to make the most effective use of the resources available to us across acute, community, primary and social care settings, to get above pre-pandemic levels of productivity as the context allows
- use the additional funding government has made available to us to increase our capacity and invest in our buildings and equipment to support staff to deliver safe, effective and efficient care.

Our goal is that these actions will support a significant increase in the number of people we are able to treat and care for in a timely way. Our ability to fully realise this goal is linked to the ongoing level of healthcare demand from COVID-19. The new Omicron variant reminds us that we will need to remain ready to rise to new vaccination challenges and significant increases in COVID-19 cases. We are not able to predict the timing or impact of new variants and must develop ambitious plans for what we can achieve for patients and local populations in a more favourable context. The objectives for 2022/23 set out in this document are therefore based on COVID-19 returning to a low level. We will keep these objectives under review as the pandemic evolves.

Effective partnership is critical to achieving the priorities set out in this document. After several years of local development, we have established 42 integrated care systems (ICSs) across England with four strategic purposes:

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

- enhancing productivity and value for money
- supporting broader social and economic development.

To underpin these arrangements, the Health and Care Bill, which intends to put ICSs on a statutory footing and create integrated care boards (ICBs) as new NHS bodies, is currently being considered by Parliament.

To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for new statutory arrangements to take effect and ICBs to be legally and operationally established. This replaces the previously stated target date of 1 April 2022. This new target date will provide some extra flexibility for systems preparing for the new statutory arrangements and managing the immediate priorities in the pandemic response, while maintaining our momentum towards more effective system working.

The establishment of statutory ICSs, and timing of this, remains subject to the passage of the Bill through Parliament. An implementation date of 1 July would mean the current statutory arrangements would remain in place until then, with the first quarter of 2022/23 serving as a continued preparatory period.

Joint working arrangements have been in place at system level for some time, and there has already been significant progress in preparing for the proposed establishment of statutory ICSs, including recruitment of designate ICB chairs and chief executives. Designate ICB leaders should continue to develop system-level plans for 2022/23 and prepare for the formal establishment of ICBs in line with the guidance previously set out by NHS England and NHS Improvement and the updated transition timeline (this is set out more fully in section J).

The NHS's financial arrangements for 2022/23 will continue to support a system-based approach to planning and delivery and will align to the new ICS boundaries agreed during 2021/22. We will shortly issue one-year revenue allocations for 2022/23 and three-year capital allocations to 2024/25. We intend to publish the remaining two-year revenue allocations to 2024/25 in the first half of 2022/23. It is in this context that we are asking systems to focus on the following priorities for 2022/23:

- A. Invest in our workforce – with more people (for example, the additional roles in primary care, expansion of mental health and community services, and tackling

substantive gaps in acute care) and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.

- B. Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.
- C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
- D. Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by creating the equivalent of 5,000 additional beds, in particular through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays.
- E. Improve timely access to primary care – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.
- F. Improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access.
- G. Continue to develop our approach to population health management, prevent ill-health and address health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.
- H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems.
- I. Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.
- J. Establish ICBs and collaborative system working – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places.

Across all these areas we will maintain our focus on preventing ill-health and tackling health inequalities by redoubling our efforts on the five priority areas for tackling health

inequalities set out in [guidance](#) in March 2021. ICSs will take a lead role in tackling health inequalities, building on the [Core20PLUS5](#) approach introduced in 2021/22 to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level.

Improved data collection and reporting will drive a better understanding of local health inequalities in access to, experience of and outcomes from healthcare services, by informing the development of action plans to narrow the health inequalities gap. ICBs, once established, and trust board performance packs are therefore expected to be disaggregated by deprivation and ethnicity.

We will also continue to embed the response to climate change into core NHS business. Trusts and ICBs, once established, are expected to have a board-level Net Zero lead and a Green Plan, and are asked to deliver carbon reductions against this, throughout 2022/23.

ICS footprints represent the basis of strategic and operational plans for 2022/23 and beyond. Designate ICB leadership teams are asked to work with partners in their ICS to develop plans that reflect these priorities and are triangulated across activity, workforce and money. The immediate focus should remain on the priorities set out in [Preparing the NHS for the potential impact of the Omicron variant](#) and we have extended the planning timetable to reflect this.

A. Invest in our workforce – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care

During the pandemic the focus has rightly been on the health, wellbeing and safety of our staff; this will continue. To support the restoration and recovery of services we need more people, working differently in a compassionate and inclusive culture where leaders at all levels inspire, empower and enable them to deliver high quality care in the most effective and efficient way.

We are therefore asking systems to accelerate work to transform and grow the substantive workforce and make the NHS a better place to work for all our staff. The actions to achieve this should be set out in whole system workforce plans that build on the progress made in delivering local people plans and reflect the ambitions to:

Look after our people:

- improve retention by delivering the NHS People Promise to improve the experience of our staff, through a focus on flexible working, early/mid/late career conversations and enabling staff to understand their pensions
- continue to support the health and wellbeing of our staff, including through effective health and wellbeing conversations and the mental health hubs
- improve attendance by addressing the root causes of non COVID-related sickness absence and, where appropriate, supporting staff to return to work.

Improve belonging in the NHS:

- improve the Black, Asian and minority ethnic disparity ratio, delivering the six high impact actions to overhaul recruitment and promotion practices
- implement plans to promote equality across all protected characteristics.

Work differently:

- accelerate the introduction of new roles, such as anaesthetic associates and first contact practitioners, and expanding advanced clinical practitioners
- develop the workforce required to deliver multidisciplinary care closer to home, including supporting the rollout of virtual wards and discharge to assess models
- ensure the highest level of attainment set out by the [‘meaningful use standards’](#) for e-job planning and e-rostering is met to optimise the capacity of the current workforce
- establish, or become part of, volunteer services such as the NHS cadets and NHS reservists.

Grow for the future:

- expand international recruitment through ongoing ethical recruitment of high quality nurses and midwives

- leverage the role of NHS organisations as anchor institutions/networks to widen participation and create training and employment opportunities, including through expanding apprenticeships as a route into working in health and care
- make the most effective use of temporary staffing, including by expanding collaborative system banks and reducing reliance on high-cost agency staff
- ensure training of postgraduate doctors continues, with adequate time in the job plans of supervisors to maintain education and training pipelines
- ensure sufficient clinical placement capacity to enable students to qualify and register as close to their initial expected date as possible.

Health Education England (HEE) and NHS England and NHS Improvement regional teams will support systems to develop and deliver their workforce plans. We will support systems to deliver through:

- investment to expand the national nursing international recruitment programme and support to recruit more allied health professionals
- the national healthcare support worker (HCSW) recruitment and retention programme
- continued funding of mental health hubs to enable staff access to enhanced occupational health and wellbeing and psychological support
- a suite of national GP recruitment and retention initiatives to enable systems to support their PCNs to expand the GP workforce and make full use of the digital locum pool
- the Additional Roles Reimbursement Scheme (ARRS) to deliver 26,000 roles in primary care, to support the creation of multidisciplinary teams.

B. Respond to COVID-19 ever more effectively – delivering the NHS COVID vaccination programme and meeting the needs of patients with COVID-19

The NHS has been asked to offer every eligible adult over the age of 18 a booster vaccination by 31 December 2021 and the immediate next steps for deployment were set out in the recent [letter](#) to services. Delivery of the vaccine programme is expected

to remain a key priority as we look ahead to 2022/23 and systems are asked to plan to maintain the infrastructure that underpins our ability to respond as needed. We will set out further details as future requirements become clearer.

A number of new treatment options, including neutralising monoclonal antibodies and oral antivirals, are now available for non-hospitalised NHS patients at greater risk from COVID-19. These treatments are in addition to COVID-19 vaccines, which remain the most important intervention for protecting people from COVID-19 infection.

These new treatments, which reduce the risk of hospitalisation and death, are being rolled out initially for a targeted cohort of highest-risk patients and should continue to be prioritised. In parallel, the government has also launched a study to assess the efficacy of antivirals in the UK's predominately vaccinated population. Dependent on the results of that study, we will develop plans for wider access to antivirals from the spring.

The Office for National Statistics (ONS) estimates around one million people are living with post-COVID syndrome (long COVID) in England. The NHS in England has responded by establishing 90 specialist post-COVID clinics to assess, diagnose and help people recover from long COVID, as well as 14 paediatric hubs to provide expert advice to local services treating children and young people.

While good progress has been made, there is still wide local variation in referral rates, waiting times and access to the clinics across diverse demographic groups. Systems are asked to:

- increase the number of patients referred to post-COVID services and seen within six weeks of referral
- decrease the number of patients waiting longer than 15 weeks, to enable their timely placement on the appropriate management or rehabilitation pathway.

£90 million is being made available to support this work in 2022/23.

C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards

C1: Maximise elective activity and reduce long waits, taking full advantage of 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. Over the next three years, we will rise to the challenge of addressing the elective backlogs that have grown during the pandemic through a combination of expanding capacity, prioritising treatment and transforming delivery of services. Every system is required to develop an elective care recovery plan for 2022/23, setting out how the first full year of longer-term recovery plans will be achieved.

As in the COVID-19 wave last winter, it is crucial that we continue to deliver elective care and ensure that the highest clinical priority patients – including patients on cancer pathways and those with the longest waits – are prioritised. Once again, clinical leadership and judgement about prioritisation and risk will be essential. Wherever possible over winter, we need systems and providers to continue to separate services and to maintain maximum possible levels of inpatient, day case, outpatient and diagnostic activity, recognising the requirement to release staff to support the vaccination programme and respond to the potential increase in COVID-19 cases. This should include the independent sector as separate green pathway capacity.

The ongoing uncertainties and challenges of COVID-19 and demand make it particularly hard to predict how quickly we will be able to recover elective services, but we have set an ambitious goal to deliver around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and specialist advice, including advice and guidance. We will continue to work to return to pre-pandemic performance as soon as possible with an ambition in 2022/23 for systems to deliver over 10% more elective activity than before the pandemic and reduce long waits. Treatment should continue to be prioritised based on clinical urgency and steps should be taken to address health

inequalities. Systems should make use of alternative providers if people have been waiting a long time for treatment. Systems are asked to:

- eliminate waits of over 104 weeks as a priority **by July 2022** and maintain this position through 2022/23 (except where patients choose to wait longer)
- **eliminate** waits of over 78 weeks **by April 2023, except where patients choose to wait longer or in specific specialties**, and conduct three-monthly reviews for this cohort of patients, extending the three-monthly reviews to patients waiting over 52 weeks from 1 July 2022
- develop plans that support an overall reduction in 52-week waits where possible, **in line with ambition to eliminate them by March 2025, except where patients choose to wait longer or in specific specialties**
- accelerate the progress we have already made towards a more personalised approach to follow-up care in hospitals or clinics, reducing outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023 and going further where possible. We will agree specific targets with systems through the planning process.

Our ability to fully deliver on the objectives is linked to the ongoing level of healthcare demand from COVID-19 and will depend on:

- holding elective activity through the winter
- systems eliminating the loss in productivity caused by the operating constraints resulting from the pandemic.

A more personalised approach to outpatient follow-up appointments will ensure people who require a follow-up appointment receive one in a timely manner – protecting clinical time for the most value adding activity. The opportunity to reduce outpatient follow-ups will differ by trust and specialty and local planning should inform how the ambition will be delivered across the system, supported through a combination of:

- patient initiated follow-up (PIFU) – expanding the uptake of PIFU to all major outpatient specialties, moving or discharging 5% of outpatient attendances to PIFU pathways by March 2023
- effective discharge, particularly of those patients for whom clinical interventions have been exhausted
- more streamlined diagnostic pathways

- referral optimisation, including through use of specialist advice services to enhance patient pathways – delivering 16 specialist advice requests, including advice and guidance (A&G), per 100 outpatient first attendances by March 2023.

Systems are asked to plan how the redeployment of the released capacity (including staff) is used to increase elective clock-stops or reduce clock-starts proactively.

£2.3 billion of elective recovery funding has been allocated to systems to support the recovery of elective services in 2022/23. We will set out further details in additional guidance.

£1.5 billion of capital above that funded within core envelopes has been made available to the NHS over three years to support new surgical hubs, increased bed capacity and equipment to help elective services recover. Systems are asked to demonstrate how their capital proposals support a material quantified increase in elective activity, eg through schemes that enable the separation of elective and non-elective activity, the setting up or expansion of elective hub sites, day case units or increased bed capacity. Further detail on these requirements and the process will be set out in additional guidance.

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 2022 to March 2023. These plans should set out how:

- systems will meet the ambitions set out above, reflecting the additional revenue and capital funding being made available. We will set out further details in additional guidance
- services will be organised and delivered to maximise productivity opportunities and secure the best possible outcomes for patients
- local independent sector capacity is incorporated as a core element to deliver improved outcomes for patients and reduce waiting times sustainably
- the updated UK Health Security Agency (UKHSA) guidance will be implemented, ensuring safety concerns are appropriately balanced.
- systems will ensure inclusive recovery and reduce health inequalities where they are identified
- elective care, UEC, social care and mental health will be managed in a way that ensures elective recovery can be protected and any disruptions minimised.

C2: Complete recovery and improve performance against cancer waiting times standards

The number of patients seen following an urgent suspected cancer referral has remained at a record high since March 2021. However, backlogs remain for those who have been referred for treatment, and we would have expected at least 36,000 more patients to have come forward to start treatment during the pandemic than have done so. Systems should therefore, as a priority, complete any outstanding work on the post-pandemic cancer recovery objectives set out in the 2021/22 H2 planning guidance, to:

- return the number of people waiting for longer than 62 days to the level in February 2020 (based on the national average in February 2020)
- meet the increased level of referrals and treatment required to reduce the shortfall in number of first treatments.

Priority actions should centre on ensuring there is sufficient diagnostic and treatment capacity to meet recovering levels of demand, with a particular focus on the three cancers making up two-thirds of the national backlog (lower GI, prostate and skin), including:

- provision of sufficient commissioned capacity so that every urgent suspected lower GI cancer referral is accompanied by a faecal immunochemical test (FIT) result
- delivery of the optimal timed pathway for prostate cancer, including ensuring mpMRI prior to biopsy to eliminate the need for biopsy wherever possible
- making teledermatology available as an option for clinicians in all providers receiving urgent cancer referrals.

Systems are asked to work with Cancer Alliances to develop and implement a plan to:

- improve performance against all cancer standards, with a focus on the 62-day urgent referral to first treatment standard, the 28-day faster diagnosis standard and the 31-day decision-to-treat to first treatment standard
- make progress against the ambition in the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas where rates of early diagnosis are lower.

Delivery of these plans is expected to support:

- Timely presentation and effective primary care pathways including:
 - working with PCNs to support implementation of cancer early diagnosis as set out in the Network Contract Directed Enhanced Service (DES)
 - running local campaigns to complement national advertising to raise public awareness of cancer symptoms and encourage timely presentation.
- Faster diagnosis, including:
 - extending coverage of non-specific symptom pathways – with at least 75% population coverage by March 2023
 - ensuring at least 65% of urgent cancer referrals for suspected prostate, colorectal, lung, oesophago-gastric, gynaecology and head and neck cancer meet timed pathway milestones.
- Targeted case finding and surveillance, including:
 - maximising the uptake of targeted lung health checks (TLHC) and the effective delivery of follow-up low dose CT scans, to meet trajectories agreed with the national team. From 2022/23, all Cancer Alliances will have at least one TLHC project
 - ensuring that every person diagnosed with colorectal and endometrial cancer is tested for Lynch syndrome (with cascade testing offered to family members), and patients who qualify for liver surveillance under National Institute for Health and Care Excellence (NICE) guidance are identified and invited to surveillance.

The national cancer team will provide data and guidance to Cancer Alliances to support the development of their plans. Plans will form the basis of Cancer Alliance funding agreements.

ICBs and Cancer Alliances are also asked to work with trusts to:

- ensure they have fully operational and sustainable patient stratified follow-up (PSFU) pathways for breast, prostate, colorectal and one other cancer by the end of the first quarter of 2022/23; and for two further cancers (one of which should be endometrial cancer) by March 2023
- for systems participating in colon capsule endoscopy and cytosponge projects, deliver agreed levels of activity

- increase the recruitment and retention of clinical nurse specialists, cancer support workers and pathway navigators, and promote take up of clinical training opportunities for the cancer workforce.

Maintaining and restoring cancer screening programmes is critical to our efforts to fully restore cancer services. For breast cancer screening in particular, any systems that have not restored compliance with the three-year cycle by the end of March 2022 are expected to have done so by the end of June 2022.

C3: Diagnostics

Recovery of the highest possible diagnostic activity volumes is critical to providing responsive, high quality services and supporting elective recovery and early cancer diagnosis. This will be supported by the timely implementation of new community diagnostic centres (CDCs). Systems are asked to:

- increase diagnostic activity to a minimum of 120% of pre-pandemic levels across 2022/23 to support these ambitions and meet local need
- develop investment plans that lay the foundations for further expansion of capacity through CDCs in 2023/24 and 2024/25.

Three-year capital funding allocations will be included in system envelopes for this purpose. National investment through HEE is planned to facilitate training and supply of the workforce to support these goals. Systems will be able to access dedicated revenue funding to support set up and running of CDCs, subject to the necessary business case approvals. Revenue will be allocated to align with the programmes of work or agreed capital business cases.

Systems are asked to utilise targeted capital allocations to:

- increase the number of endoscopy rooms, levelling up to a guide level of 3.5 rooms per 100,000 population over 50 years of age. Systems should consider using this funding to locate endoscopy services in CDCs and supplement available CDC funding allocations, seeking to co-locate endoscopy and imaging services where possible. Funding will also be available to units that have yet to meet Joint Advisory Group (JAG) on Gastrointestinal Endoscopy Endoscopy accreditation to upgrade their services

- invest in CT capacity to support expansion the Target Lung Health Checks programme from 2023/24, with target coverage to be agreed between Cancer Alliances and the National Cancer Programme team. Cancer Alliances will receive this targeted funding on the basis of their remaining unscreened population and existing CT capacity and should coordinate with ICSs.
- develop additional digitally connected imaging capacity and ensure that acute sites have a minimum of two CT scanners
- procure new breast screening units to deliver the 36-month cycle.

Operational capital resources should continue to be used to reduce the backlog of diagnostic equipment replacement over 10 years old.

Pathology and imaging networks are asked to complete the delivery of their diagnostic digital roadmaps as part of their digital investment plans. National funding will be provided that is broadly consistent with these roadmaps, taking account of progress to date. Refreshed roadmaps need to include specific plans setting out how pathology and imaging networks and CDCs will with their systems support artificial intelligence (AI) research and innovation, and the scalable and sustainable integration of AI-driven diagnostics. The implementation of digital diagnostic investments is expected to deliver at least a 10% improvement in productivity by 2024/25, in line with the best early adopters.

Systems should ensure that pathology networks reach, as a minimum, the 'maturing' status for delivery of pathology services on the pathology network maturity framework by 2024/25. They should also meet the requirements of all national data collections for diagnostic services and support the work to scope creation of endoscopy and clinical physiology networks.

Programme funding of £21 million is available to support pathology and imaging networks to deliver on these priorities in 2022/23 alongside the implementation of CDCs.

C4 Deliver improvements in maternity care

Systems working through local maternity systems (LMSs) are asked to continue to work towards delivering a range of transformation objectives to make maternity and neonatal care safer, more personalised and more equitable. ICSs should undertake

formal, structured and systematic oversight of how their LMS delivers its functions and there should be a direct line of sight to the LMS board.

Providers are asked to continue to embed and deliver the seven immediate and essential actions identified in the interim Ockenden report, along with any future learning shared in the second Ockenden report and East Kent review (when published). LMSs should continue to oversee quality in line with [Implementing a revised perinatal quality surveillance model](#).

LMSs are asked to support providers to prioritise reopening any services suspended due to the pandemic, ensuring women can take somebody with them to all maternity appointments and supporting work to increase vaccination against COVID-19 in pregnancy. LMSs should implement local maternity equity and equality action plans in line with [Equity and equality: Guidance for local maternity systems](#).

LMSs are also asked to continue to work with providers to implement local plans to deliver Better Births, the report of the national maternity review, including:

- delivering local plans for midwifery continuity of carer (MCoC) in line with [Delivering midwifery continuity of carer at full scale](#), prioritising MCoC so that most Black, Asian and mixed ethnicity women and most women from the most deprived areas receive it once the building blocks are in place
- offering every woman a personalised care and support plan in line with the [Personalised care and support planning guidance](#)
- fully implement Saving Babies' Lives. Providers should have a preterm birth clinic and act so that at least 85% of women who are expected to give birth at less than 27 weeks' gestation are able to do so in a hospital with appropriate on-site neonatal care.

Funding of c£93 million to support the implementation of Ockenden actions through investment in workforce will go into baselines from 2022/23. Programme funding will also be made available to support the delivery of the Better Births priorities.

D. Improve the responsiveness of urgent and emergency care and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting

Sustaining UEC performance has been very challenging due to the pandemic. We need to continue reforms to community and urgent and emergency care to deliver safe, high quality care by preventing inappropriate attendance at EDs, improving timely admission to hospital for ED patients, reducing length of stay and restoring ambulance response times. An essential requirement is to increase the capacity of the NHS by the equivalent of at least 5,000 G&A beds and return, as a minimum, to pre-pandemic levels of bed availability through a combination of:

- national funding for the further development of virtual wards (including hospital at home)
- system capital plans to increase physical bed capacity as part of elective recovery plans
- re-establishing bed capacity consistent with latest UKHSA IPC guidance.

D1: Urgent and emergency care

The urgent and emergency care system continues to be under significant pressure ahead of what is expected to be an extremely challenging winter. These pressures are exacerbated by delayed ambulance handovers and ambulance response times. A longer term improvement approach is required for the full recovery of urgent and emergency care services. Expected performance levels in 2022/23 therefore represent a first step towards recovery.

Systems are therefore asked to:

- reduce 12-hour waits in EDs towards zero and no more than 2%
- improve against all Ambulance Response Standards, with plans to achieve Category 1 and Category 2 mean and 90th percentile standards

- minimise handover delays between ambulance and hospital, allowing crews to get back on the road and contribute to achieving the ambulance response standards. This includes:
 - eliminating handover delays of over 60 minutes
 - ensuring 95% of handovers take place within 30 minutes
 - ensuring 65% of handovers take place within 15 minutes
- ensure stability of services and have planned contingency in advance of next winter.

Systems are asked to build on the work already commenced, as indicated in the UEC 10 Point Action Recovery Plan. This should incorporate:

- Increasing capacity within NHS 111 to ensure the service is the credible first option for patients, enabling their referral to the most appropriate care setting, including:
 - call handling capacity to meet growing demand
 - clinical capacity within the clinical assessment service to support decision-making, with >50% of calls received having clinical input
 - ensuring there is a full range of available options in the Directory of Services to meet local need
 - adopting the new regional/national route calling technology.
- Expanding urgent treatment centre (UTC) provision and increasingly moving to a model where UTCs act as the front door of ED, to enable emergency medicine specialists to focus on higher acuity need within the ED.

Systems are asked to put in place integrated health and care plans for children and young people's services that include a focus on urgent care; building on learning from pilots placing paediatric staff within NHS 111 services; better connections between paediatric health services; joining up children's services across the NHS and local authorities; improving transitions to adult services; and supporting young people with physical and mental health needs within acute and urgent care settings.

Systems are asked to consistently submit timely Emergency Care Data Set (ECDS) data, now seven days a week.

D2: Transform and build community services capacity to deliver more care at home and improve hospital discharge

The transformation of out-of-hospital services is a key element of the NHS recovery. National funding, alongside additional growth within core allocations for community services funding, will support systems to increase overall capacity of community services to provide care for more patients at home and address waiting lists, develop and expand new models of community care and support timely hospital discharge.

Community care models

Virtual wards

The NHS has already had considerable success in implementing virtual wards, including Hospital at Home services. Over 53 virtual wards are already providing over 2,500 'beds' nationwide, enabled by technology. In addition to managing patients with COVID, they also support patients with acute respiratory infections, urinary tract infections (UTIs), chronic obstructive pulmonary disease (COPD) and complex presentations, such as those living with frailty as well as having a specific medical need.

The scope for virtual wards is far greater. Given the significant pressure on acute beds we must now aim for their full implementation as rapidly as possible. We are therefore asking systems to develop detailed plans to maximise the rollout of virtual wards to deliver care for patients who would otherwise have to be treated in hospital, by enabling earlier supported discharge and providing alternatives to admission. These plans should be developed across systems and provider collaboratives, rather than individual institutions, based on partnership between secondary, community, primary and mental health services. Systems should also consider partnerships with the independent sector where this will help grow capacity.

By December 2023, we expect systems to have completed the comprehensive development of virtual wards towards a national ambition of 40–50 virtual beds per 100,000 population. Successful implementation will require systems to:

- maximise their overall bed capacity to include virtual wards
- prevent virtual wards becoming a new community-based safety netting service; they should only be used for patients who would otherwise be admitted to an NHS acute hospital bed or to facilitate early discharge

- maintain the most efficient safe staffing and caseload model
- manage length of stay in virtual wards through establishing clear criteria to admit and reside for services
- fully exploit remote monitoring technology and wider digital platforms to deliver effective and efficient care.

Up to £200 million will be available in 2022/23 and up to £250 million in 2023/24 (subject to progress of systems) to support the implementation of these plans. We expect plans to cover two years. The scale of funding awarded in 2022/23 will depend on credible ambition for delivery of virtual wards by December 2022 to provide capacity for next winter. Systems will want to consider approaches that address patients with lower intensity and higher intensity needs (ie Hospital at Home services). We will set out further guidance on the virtual ward model, the support available and the funding criteria.

Urgent community response

By April 2022 all parts of England will be covered by 2 hour urgent community response services and over 2022-23 providers and systems will be required to:

- Maintain full geographic rollout and continue to grow services to reach more people extending operating hours where demand necessitates and at a minimum operating 8am to 8pm, 7 days a week in line with national guidance
- Improve outcomes through reaching patients in crisis in under 2 hours where clinically appropriate. Providers will be required to achieve, and ideally exceed in the majority of cases, the minimum threshold of reaching 70% of 2 hour crisis response demand within 2 hours from the end of Q3.
- Increase the number of referrals from all key routes, with a focus on UEC, 111 and 999, and increase care contacts
- Improve capacity in post urgent community response services to support flow and patient outcomes including avoiding deterioration into crisis again or unnecessary admission
- Ensure workforce plans support increasing capacity and development of skills and competencies in line with service development

- Improve data quality and completeness in the Community Services Dataset (CSDS) as this will be the key method to monitor outcomes, system performance and capacity growth

Anticipatory care

Anticipatory care (AC) is a Long-Term Plan commitment focused on provision of proactive care in the community for multimorbid and frail individuals who would benefit most from integrated evidence-based care. ICSs should design, plan for and commission AC for their system. Systems need to work with health and care providers to develop a plan for delivering AC from 2023/24 by Q3 2022, in line with forthcoming national operating model for AC.

Enhanced Health in Care Homes

Ensure consistent and comprehensive coverage of Enhanced Health in Care Homes in line with the national framework.

Community service waiting lists

Systems must develop and agree a plan for reduction of community service waiting lists and ensure compliance of national sitrep reporting. Specifically, systems are asked to:

- develop a trajectory for reducing their community service waiting lists
- significantly reduce the number of patients waiting for community services
- prioritise patients on waiting lists
- consider transforming service pathways and models to improve effectiveness and productivity.

Hospital discharge

As outlined in the H2 2021/22 planning guidance, the additional funding for the Hospital Discharge Programme will end in March 2022. As part of [preparing the NHS for the potential impact of the Omicron variant and other winter pressures](#), we have asked systems to work together with local authorities and partners, including hospices and care homes, to release the maximum number of beds, as a minimum this should be equivalent to half of current delayed discharges. Systems should seek to sustain the improvement in delayed discharges in 2022/23 working with local authority partners and supported by the Better Care Fund and the investment in virtual wards.

Digital

Digital tools and timely, accurate information are key to delivering on these aims and systems are asked to:

- identify digital priorities to support the delivery of out-of-hospital models of care through the development of system digital investment plans, ensuring community health services providers are supported to develop robust digital strategies to support improvements in care delivery
- ensure providers of community health services, including ICS-commissioned independent providers, can access the Local Care Shared Record as a priority in 2022/23, to enable urgent care response and virtual wards
- deliver radical improvements in quality and availability against national data requirements and clinical standards, including the priority areas of urgent care response and musculoskeletal (MSK).

E. Improve timely access to primary care – expanding capacity and increasing the number of appointments available

The NHS Long Term Plan commits to increasing investment in primary medical and community services (PMCS) by £4.5 billion real terms investment growth by 2023/24. We expect systems to maximise the impact of their investment in primary medical care and PCNs with the aim of driving and supporting integrated working at neighbourhood and place level. Systems are asked to look for opportunities to support integration between community services and PCNs, given they are an integral part of solutions to key system challenges that require a whole system response, including elective recovery and supporting more people in their own homes and local communities. Systems should also consider how community pharmacy can play a greater role in local plans as part of these integrated approaches.

Expanding the primary care workforce remains a top priority to increase capacity. Systems are expected to:

- support their PCNs to have in place their share of the 20,500 FTE PCN roles by the end of 2022/23 (in line with the target of 26,000 by the end of 2023/24) and

to work to implement shared employment models, drawing on more than £1 billion of Additional Roles Reimbursement Scheme (ARRS) funding across system development funding (SDF) and allocations

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

In line with the principles outlined in the October 2021 [plan](#), systems are asked to support the continued delivery of good quality access to general practice through increasing and optimising capacity, addressing variation and spreading good practice. Every opportunity to secure universal participation in the Community Pharmacist Consultation Service should be taken. Systems should drive the transfer of lower acuity care from both general practice and NHS 111 under this scheme, supported by a new investment and impact fund indicator for PCNs which incentivises contributions to a minimum of two million appointments in 2022/23. Performance at the rate of the best early implementers of 50 referrals a week would move more than 15 million appointments out of general practice. Systems will need to implement revised arrangements for enhanced access delivered through PCNs from October 2022.

Systems are asked to support practices and PCNs to ensure the commitment that every patient has the right to be offered digital-first primary care by 2023/24 is delivered. By 'digital-first primary care' we mean a full primary care service that patients can access easily and consistently online, that enables them to quickly reach the right service for their needs (whether in person or remotely), that is integrated with the wider health system, and that enables clinicians to provide efficient and appropriate care.

2022/23 will see the implementation of GP contract changes, including those to the DES. In addition to the five services already being delivered by PCNs, from April 2022 there will be a phased introduction of two new services – anticipatory care and personalised care – and an expanded focus on cardiovascular disease (CVD) diagnosis and prevention.

Systems are asked to support their PCNs to work closely with local communities to address health inequalities. Practices should continue the critical job of catching up on the backlog of care for their registered patients who have ongoing conditions, to

ensure the best outcomes for them and to avoid acute episodes or exacerbations that may otherwise result in avoidable hospital admissions or even premature mortality.

Systems are asked to take every opportunity to use community pharmacy to support this; for example, in the delivery of care processes such as blood pressure measurement under new contract arrangements. This will drive detection of hypertension across our communities, address backlogs in care and deliver longer-term transformation in integrated local primary care approaches. Systems should also optimise use of pharmacy services around smoking cessation on hospital discharge, the expanded new medicines service and the discharge medicines service.

For dental services, the focus is on maximising clinically appropriate activity in the face of ongoing IPC measures, and targeting capacity to meet urgent care demand, minimise deterioration in oral health and reduce health inequalities.

Subject to the passage of the Health and Care Bill, ICBs will become the delegated commissioners for primary medical services and, in some cases, also dental, community pharmacy and optometry services, during 2022/23 – the target date now being 1 July 2022. Once established, ICBs should develop plans, working with NHS England regional commissioning teams to take on effective delegated dental, community pharmacy and optometry commissioning functions from 2023/24.

F. Grow and improve mental health services and services for people with a learning disability and/or autistic people

F1: Expand and improve mental health services

The complexity of needs for those requiring mental health services has risen because of the pandemic. In addition to a pre-existing treatment gap within mental health, this is increasing pressures within community services, mental health UEC and inpatient pathways across all ages. To address these pressures and continue to make progress against the NHS Long Term Plan ambitions, systems are asked to:

- Continue to expand and improve their mental health crisis care provision for all ages. This includes improving the operation of all age 24/7 crisis lines, crisis resolution home treatment teams and mental health liaison services in acute

hospitals. Systems are also asked to increase the provision of alternatives to A&E and admission, and improve the ambulance mental health response. Over the next three years £150 million targeted national capital funding will be made available to support improvements in mental health UEC, including mental health ambulances, extending Section 136 suites, safe spaces in or near A&E.

- Ensure admissions are intervention-focused, therapeutic and supported by a multidisciplinary team, utilising the expansion of mental health provider collaboratives across the whole mental health pathway where systems plan such developments. These collaboratives will support systems to transform services and reduce reliance on hospital-based care delivered away from people's local area.
- Continue the expansion and transformation of mental health services, as set out in the NHS Mental Health Implementation Plan 2019/20–2023/24, to improve the quality of mental healthcare across all ages. The [mental health LTP ambitions tool](#) will support systems to understand their delivery requirements for expanding access, as well as the Mental Health Delivery Plan 2022/23.
- Continue to grow and expand specialist care and treatment for infants, children and young people by increasing the support provided through specialist perinatal teams for infants and their parents up to 24 months and through continuing to expand access to children and young people's mental health services.
- Subject to confirmation, encourage participation in the first phase of the national Quality Improvement programme to support implementation of the Mental Health Act reforms.

We ask that systems maintain a focus on improving equalities across all programmes, noting the actions and resources identified in the Advancing Mental Health Equalities Strategy.

Delivery of the Mental Health Investment Standard (MHIS) remains a mandatory minimum requirement, ensuring appropriate investment of baseline funding and SDF to deliver the mental health NHS Long Term Plan objectives by 2023/24. Where SDF funding supports ongoing services, these will continue to be funded beyond 2023/24. This will support the continued expansion and transformation of the mental health workforce. For this:

- systems are asked to develop a mental health workforce plan to 2023/24 in collaboration with mental health providers, HEE and partners in the voluntary, community and social enterprise (VCSE) and education sectors
- PCNs and mental health trusts are asked to continue to use the mental health practitioner ARRS roles to improve the care and treatment for adults, children and young people in line with NHS Long Term Plan ambitions.

Capital funding made available through system allocations is expected to support urgent patient safety projects for mental health trusts, such as those that address ligature points and other infrastructure concerns that pose immediate risks to patients. Funding to eradicate mental health dormitories will continue in 2022/23 and 2023/24.

Systems are asked to work with the Mental Health Provider Collaboratives to produce a clear plan of requirements for CYPMH general adolescent and psychiatric intensive care in-patient beds to meet the health needs of their population, strengthen local services and eliminate out of area placements for the most vulnerable young people. These bed plans should be an integral part of the overall plan for CYP mental health services to ensure a local, whole patient pathway for patients with mental health, learning disability and/or autism needs. The plans should be complete by the end of Q1 2022/23 and should be funded through system operational capital. Investing in this way is expected to reduce operating costs as a direct result of improving access to local services and reducing out of area patient flows. Further guidance on the development of these plans will be issued before the start of 2022/23.

All NHS commissioned services must flow data to the national datasets and relevant bespoke collections. Provision for this must be included and agreed in commissioning arrangements planned for 2022/23, as part of this process.

F2: Meeting the needs of people with a learning disability and autistic people

The pandemic has highlighted and exacerbated the significant health inequalities experienced by people with a learning disability and autistic people. As we recover from the pandemic, we must ensure that people with a learning disability and autistic people are not further disadvantaged in fair access to healthcare. As digital healthcare develops, this means making sure there are reasonable adjustments and tailored responses, including consideration of the ongoing need for face-to-face appointments. Systems are asked to:

- Increase the rate of annual health checks for people aged 14 and over on a GP learning disability register towards the 75% ambition in 2023/24. Every annual health check should be accompanied by a health action plan to identify actions to improve the person's health.
- Continue to improve the accuracy of GP learning disability registers so that the identification and coding of patients is complete, and particularly for under-represented groups such as children and young people and people from ethnic minority groups.
- Maintain a strong commitment to reducing reliance on inpatient care for both adults and children with a learning disability and/or who are autistic, consistent with the ambition set out in the NHS Long Term Plan, and to develop community services to support admission avoidance and timely discharge.
- Build on the investment made in 2021/22 to develop a range of care and diagnostic services for autistic people delivered by multidisciplinary teams. This includes access to community mental health services; support for autistic children and young people and their families; and access to the right support and housing. Systems should adopt best practice to improve local diagnostic pathways to minimise waiting times for diagnosis, improve patient experience and ensure that there is accurate and complete reporting of diagnostic data.
- Implement the actions coming out of Learning Disability Mortality Reviews (LeDeRs), including following deaths of people who are autistic, to tackle the inequalities experienced by people with a learning disability; these have been exacerbated by the pandemic.

Service development funding support of £75 million is being made available in 2022/23 to achieve the above ambitions.

G. Continue to develop our approach to population health management, prevent ill-health and address health inequalities

Working alongside local authorities and other partners we will continue to develop our approach to population health management and prevention so that people can play a more proactive role in promoting good health. ICSs will drive the shift to population

health, targeting interventions at those groups most at risk, supporting health prevention as well as treatment. ICSs will take a lead role in tackling health inequalities by building on the [Core20PLUS5](#) approach introduced in 2021/22.

The safe and effective use of patient data is key to this. Systems are asked to develop plans by June 2022 to put in place the systems, skills and data safeguards that will act as the foundation for this. By April 2023, every system should have in place the technical capability required for population health management, with longitudinal linked data available to enable population segmentation and risk stratification, using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities. Systems are encouraged to work together to share data and analytic capabilities.

To support this, we will:

- continue to operate national data platforms for key, individually identified clinical data driven national programmes (eg the COVID pass, vaccine registries)
- provide a clear set of technical requirements and standards.

We are asking systems to develop robust plans for the prevention of ill-health, led by a nominated senior responsible officer (SRO). These plans should reflect the primary and secondary prevention deliverables as outlined in the NHS Long Term Plan, and the key local priorities agreed by the ICS. Plans should set out how system allocations will be deployed to:

- Support the rollout of tobacco dependence treatment services in all inpatient and maternity settings, in line with agreed trajectories and utilising £42 million of SDF funding.
- Improve uptake of lifestyle services, the Diabetes Prevention Programme, Low Calorie Diets, the new Digital Weight Management Programme and digitally supported self-management services.
- Restore diagnosis, monitoring and management of hypertension, atrial fibrillation and high cholesterol and diabetes, as well as asthma and COPD registers and spirometry checks for adults and children, to pre-pandemic levels in 2022/23, as per the Quality and Outcomes Framework (QOF), Integrated Investment Fund and Direct Enhanced Service targets.

- Progress against the NHS Long Term Plan high impact actions to support respiratory, stroke and cardiac care, implementing new models of care and rehabilitation, including remote and digital models, and increasing respiratory, hypertension, atrial fibrillation and high cholesterol detection and monitoring/control to pre-pandemic levels. This should include how systems plan to implement national procurements and population health agreements such as those in place for inclisiran and direct oral anticoagulants (DOACs). NHS England's new DOAC framework agreement will make treatment more affordable, allowing the NHS to provide DOACs to 610,000 additional patients. Uptake of DOAC treatment at this level will help prevent an estimated 21,700 strokes and save 5,400 lives over the next three years
- Reduce antibiotic use in primary and secondary care through early identification and treatment of bacterial infections, and support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary, with a switch to oral antibiotics as soon as appropriate.

There is strong evidence that people from socio-economically deprived populations and certain ethnic minority groups experience poorer health than the rest of the population, so it is particularly important to focus preventative services on these groups. Smoking is the single largest driver of health disparities between the most and least affluent quintiles. Obesity is the next biggest preventable risk factor and obesity in children has seen a major increase during the pandemic, especially in the least well off.

Systems are also asked to:

- renew their focus on reducing inequalities in access to and outcomes from NHS public health screening and immunisation services
- continue to adopt culturally competent approaches to increasing vaccination uptake in groups that have a lower than overall average uptake as of March 2022
- continue to deliver on the personalised care commitments set out in the NHS Long Term Plan – social prescribing referrals, personal health budgets, and personalised care and support plans are key enablers of population health and prevention.

H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes

During the pandemic digital technologies transformed the delivery of care. The opportunity now is for the health and care sector to build on this and use the potential of digital to help the NHS address both its long-term challenges and the immediate task of recovering from the pandemic. In practice this means better outcomes for patients, better experience for staff and more effective population health management.

We will support health and care systems to 'level-up' their digital maturity, and ensure they have a core level of infrastructure, digitisation and skills.

A core level of digitisation in every service within a system is essential. Acute, community, mental health and ambulance providers are required to meet a core level of digitisation by March 2025, in line with the NHS Long Term Plan commitment. By March 2022, systems should develop plans that set out their first year's priorities for achieving a core level of digitisation across all these settings (as set out by the Frontline Digitisation minimum viable product, which will be published by 31 December).

Costed three-year digital investment plans should be finalised by June 2022 in line with What Good Looks Like (WGLL). We will fund systems to establish dedicated teams to support the development and delivery of their plans, which should:

- include provisions for robust cyber security across the system. We will continue to provide and further enhance centralised cyber security capabilities systems; however, local organisations are responsible for managing their own cyber risk
- reflect ambitions to consolidate purchasing and deployment of digital capabilities, such as electronic patient records and workforce management systems, at system level where possible
- set out the steps being taken locally to support digital inclusion
- consider how digital services can support the [NHS Net Zero Agenda](#).

Capital will be available to systems for three years from 2022/23, to support digitisation of acute, mental health, ambulance and community services. £250 million will initially

be allocated to systems for 2022/23 while they develop their digital investment plans. This funding will be directed towards those services and settings that are the least digitally mature.

A digitised, interoperable and connected health and care system is a key enabler of delivering more effective, integrated care. Systems are asked to ensure that:

- by March 2023, all systems within a Shared Care Record collaborative can exchange information across the whole collaborative, with a view to national exchange by March 2024. Standards will be published to support this
- local authorities with social service responsibilities within their footprint are connected to their local Shared Care Record solution by March 2023, and that all social care providers can connect within six months of them having an operational digital social care record system
- suppliers comply with interoperability standards as these are finalised by April 2022
- general practice promotes the NHS App and NHS.UK to reach 60% adult registration by March 2023
- plans are developed to support skilling up the workforce to maximise the opportunities of digital solutions.

The ambition is for the NHS e-Referral Service (e-RS) to become an any-to-any health sector triage, referral and booking system by 2025. This will support two-way digital advice and guidance between clinical teams, ensuring patients are managed safely, and the referral is triaged and processed according to clinical priority. We will support systems with adoption as this functionality is made available to support triage, bookings and referrals. Mental health and other additional services are being evaluated for inclusion in 2022/23.

I. Make the most effective use of our resources

The 2021 Spending Review (SR21) provided the NHS with a three-year revenue and capital settlement covering 2022/23 to 2024/25. The government committed to spend an additional £8 billion to support tackling the elective backlog over the next three

years, from 2022/23 to 2024/25. This allows us to prioritise £2.3 billion in 2022/23 to support elective recovery.

SR21 also confirmed that the NHS will receive total capital resources of £23.8 billion over the next three years, including £4.2 billion of funding to support the building of 40 new hospitals and to upgrade more than 70 hospitals; £2.3 billion to transform diagnostic services; £2.1 billion for innovative use of digital technology; and £1.5 billion to support elective recovery.

We will shortly issue one-year revenue allocations to 2022/23 and three-year capital allocations to 2024/25. We intend to publish the remaining two-year revenue allocations to 2024/25 in the first half of 2022/23.

I1: Use of resources

With this funding, the NHS is expected to fully restore core services and make significant in-roads into the elective backlog and NHS Long Term Plan commitments. The SR21 settlement assumes the NHS takes out cost and delivers significant additional efficiencies, on top of the NHS Long Term Plan requirements, to address the excess costs driven by the pandemic response, moving back to and beyond pre-pandemic levels of productivity when the context allows this.

The scale of the efficiency requirement will be sustained throughout the SR21 period and systems should ensure they develop plans that deliver the necessary exit run-rate position to support delivery of future requirements.

We will continue to provide tools, information and support to help systems work together to deliver cost improvement plans that maximise efficiency and productivity opportunities, and reduce unwarranted variation. We will set out additional information on the support programmes available in additional guidance.

I2: Financial framework

The COVID-19 pandemic necessitated simplified finance and contracting arrangements that supported systems to dedicate maximum focus to responding to immediate operational challenges. To support the next phase of service restoration, the financial and contracting frameworks need to evolve to enable systems to take the appropriate funding decisions for their populations.

The future financial framework will continue to support system collaboration with a focus on financial discipline and management of NHS resources within system financial balance. Partner organisations should work together to deliver the new duties on ICBs and trusts.

Advice and guidance on the establishment of ICB financial management and governance arrangements is available as part of the ongoing support offer for ICB establishment. Regional teams are working with clinical commissioning groups (CCGs) and designate ICB board appointees to ensure that ICBs are ready to operate as statutory bodies from 1 July 2022, subject to the passage of legislation. ICBs and the boards of their constituent partners must be clear on the lines of financial accountability in managing NHS resources. This includes meeting core principles for managing public money, statutory responsibilities and other national expectations.

The 2022/23 financial and contracting arrangements are summarised as:

- A glidepath from current system revenue envelopes to fair share allocations. ICB revenue allocations will be based on current system funding envelopes, which continue to include the funding previously provided to support financial sustainability. In addition to a general efficiency requirement, we will apply a convergence adjustment to bring systems gradually towards their fair share of NHS resources. This will mean a tougher ask for systems consuming more than their relative need.
- Increased clarity and certainty over capital allocations, with multi-year operational capital allocations set at ICB level, building on the approach taken in the last two years, and greater transparency over the allocation of national capital programmes.
- A collective local accountability and responsibility for delivering system and ICB financial balance. The Health and Care Bill includes provisions which are designed to ensure that ICBs and trusts are collectively held responsible for their use of revenue and capital resources. Each ICB and its partner trusts will have a financial objective to deliver a financially balanced system, namely a duty on breakeven.
- A return to signed contracts and local ownership for payment flows under simplified rules. To restore the link between commissioning and funding flows, commissioners and trusts will have local ownership for setting payment values on simplified terms, supported by additional guidance from NHS England and

NHS Improvement. While written contracts between commissioners and all providers (NHS and non-NHS) will be needed to cover the whole of the 2022/23 financial year, systems and organisations should continue to take a partnership approach to establishing payment terms and contract management such that focus on delivery of operational and financial priorities can be maximised. We are separately publishing an updated draft of the NHS Standard Contract for 2022/23 for consultation; the final version of the contract, to be used in practice, will be published in February 2022.

- A commitment to support systems to tackle the elective backlog and deliver the NHS Long Term Plan. Additional revenue and capital funding will be provided to systems to support elective recovery, with access to additional revenue where systems exceed target levels. Provider elective activity plans will be funded as per the aligned payment and incentive approach, with payment linked to the actual level of activity delivered. ICBs will continue to be required to deliver the MHIS, as well as to meet other national investment expectations. We will set these out in additional guidance.
- A continued focus on integration of services to support the transition for future delegations. For those services that continue to be commissioned by NHS England in 2022/23, mechanisms to strengthen joint working with ICBs will be established.

J. Establish ICBs and collaborative system working

The establishment of ICBs, and everything that follows regarding the process and timing for this, remains subject to the passage of the Health and Care Bill through Parliament.

The continued development of ICSs during 2022/23 will help to accelerate local health and care service transformation and improve patient outcomes. As stated in the introduction to this document, a new target date of 1 July 2022 has been agreed for new statutory arrangements for ICSs to take effect and ICBs to be legally and operationally established. National and local plans for ICS implementation will now be adjusted to reflect this timescale, with an extended preparatory phase from 1 April 2022 up to the point of commencement of the new statutory arrangements. During this period:

- CCGs will remain in place as statutory organisations. They will retain all existing duties and functions and will conduct their business (collaboratively in cases where there are multiple CCGs within an ICS footprint) through existing governing bodies.
- CCG leaders will work closely with designate ICB leaders in key decisions that will affect the future ICB, notably commissioning and contracting.
- NHS England and NHS Improvement will retain all direct commissioning responsibilities not already delegated to CCGs.

During Q4 2021/22, NHS England and NHS Improvement will consult a small number of CCGs on changes to their boundaries, to align with the ICS boundary changes decided by the Secretary of State in July 2021. Those CCG boundary changes coming into effect from 1 April 2022 would support the smooth transition from CCGs to ICBs at the implementation date. Arrangements for people affected will be discussed directly with the relevant CCG and designate ICB leaders.

We do not plan to implement any further CCG mergers before the establishment of ICBs.

Next steps

CCG leaders and designate ICB leaders should continue with preparations for the closure of CCGs and the establishment of ICBs, working toward the new target date. NHS England and NHS Improvement will support CCG and designate ICB leaders to reset their implementation plans, to ensure the safe transfer of people, property (in its widest sense) and liabilities from CCGs to ICBs from their establishment. The national programme team will work closely with colleagues in systems and in regional teams to identify what support is needed to manage the new timetable.

We will work with national partners, including trade unions, to communicate the changed target date and any implications for the transfer process. Systems should also ensure they have clear and effective plans for local communications and engagement with the public, staff, trade unions and other stakeholders.

ICB designate chairs and chief executives should continue to progress recruitment to their designate leadership teams, adjusting their timelines as necessary while managing immediate operational demands. Current/planned recruitment activities for designate leadership roles should continue where this is the local preference, but

formal transition to the future leadership arrangements should now be planned for the new target date of 1 July 2022.

Regional teams will work with CCG leaders to agree arrangements that ensure that:

- CCGs remains legally constituted and able to operate effectively, working in partnership with the designate ICB leadership
- individuals' roles and circumstances are clear during the extended preparatory phase.

The employment commitment arrangements for other affected staff and the talent-based approach to people transition [previously set out](#) will be extended to reflect the new target date.

The requirements for ICB Readiness to Operate and System Development Plan submissions currently due in mid-February 2022 will be revised to reflect the extended preparatory period. Further details of these plans along with specific implications for financial, people or legal arrangements during the extended preparatory period will be developed with systems and set out in January 2022.

Designate ICB leaders, CCG accountable officers and NHS England and NHS Improvement regional teams will be asked to agree ways of working for 2022/23 before the end of March 2022. This will include agreeing how they will work together to support ongoing system development during Q1, including the establishment of statutory ICSs and the oversight and quality governance arrangements in their system.

Planning during 2022/23

The Health and Care Bill before Parliament will require each ICB to publish a five-year system plan before April each year. This plan must take account of the strategy produced by the integrated care partnership (ICP), and the joint strategic needs assessments and joint health and wellbeing strategies produced by the relevant health and wellbeing board(s).

We expect to require ICBs' refreshed five-year system plans in March 2023. This will give each ICB and its local authority partners sufficient time to agree a strategy for the ICP that has broad support, and to develop a plan to support its implementation, including the development of place based integration. ICBs will undertake preparatory work through 2022/23 to ensure that their five-year system plans:

- match the ambition for their ICS, including delivering specific objectives under the four purposes to:
 - improve outcomes in population health and healthcare
 - tackle inequalities in outcomes, experience and access
 - enhance productivity and value for money
 - support broader social and economic development
- reflect the national priorities and ambitions for the NHS
- take account of the responsibilities that they will be taking on for commissioning services that are currently directly commissioned by NHS England, such as primary care and some specialised services.

Plan submission

The planning timetable will be extended to the end of April 2022, with draft plans due in mid-March. We will keep this under review and publish further guidance setting out the requirements for plan submission.

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