2021/22 priorities and operational planning guidance: Implementation guidance

25 March 2021

Contents

1. Overview

1.1 Introduction and background

As outlined in the 2021/22 priorities and operational planning guidance this implementation guidance provides further detailed policy and technical information to enable Integrated Care Systems (ICSs) and their constituent organisations to develop and agree operational plans. Plans should summarise how, as systems, the priorities set out in *2021/22 priorities and operational planning guidance* will be delivered, with a focus on the six months to the end of September 2021 for most areas.

This implementation guidance should be read alongside the operational planning guidance and Guidance on finance and contracting arrangements for H1 2021/22

1.2 Timetable

ICSs are expected to work across their partner organisations to produce plans that consider alignment between CCGs and providers, and between activity, workforce and finances.

Key Tasks	Date
Publication. • 2021/22 priorities and operational planning guidance • Guidance on finance and contracting arrangements for H1 2021/22 • Implementation guidance • Technical definitions	Thursday 25 March 2021
Templates issued. • Non-functional activity, workforce • Narrative	Friday 26 March 2021
System financial planning template and SDF schedules issued	Monday 29 March 2021
Organisation (provider) capital and cash plan submission	Monday 12 April 2021
• System finance plan submission. • Mental Health finance submission **Draft plan submission deadline.** • Draft activity, workforce (primary and secondary care) and MH workforce numerical submission • Draft narrative plan submission	Thursday 6 May 2021
Non-mandated provider organisation finance plan submission	w/c 24 May 2021
Final plan submission deadline. • Final activity, workforce and MH workforce numerical submission • Final narrative plan submission	Thursday 3 June 2021

2. System development and ICS establishment

2.1 Introduction

With every part of England now covered by an Integrated Care System, this guidance is aimed at supporting ICSs in delivering their **four core purposes** of:

- **Improving outcomes** in population health and healthcare
- **Tackling inequalities** in outcomes, experience and access
- **Enhancing productivity** and value for money; and
- Helping the NHS to support broader **social and economic development.**

This implementation guidance sets out how ICSs can support that mission through their continued development during 2021/22.

It asks systems to build on the existing consistent operating requirements for ICSs as set out in the April 2020/21 planning guidance and the vision described in *Integrating Care: Next Steps* (November 2020), that has been reinforced in the Government's recent White Paper and proposals for legislative change.

The intention is that legislation and guidance is as permissive as possible and supports the local arrangements many systems have already been so effectively putting in place. ICSs are different in size, demography and local relationships and arrangements.

2.2 Principles

Building on the NHS Long Term Plan, the White Paper and *Integrating care: next steps* confirm the core ICS design principles of subsidiarity and collaboration and the expectations for system progression during 2021/22.

Key expectations informing the approach (subject to relevant legislation) are:

- There will be **one statutory ICS NHS body** and **one statutory ICS health and care partnership** per ICS from April 2022.
- **CCG functions** will be subsumed into the ICS NHS body and some NHS England and Improvement **direct commissioning functions** will be transferred or delegated to ICSs.
- Staff below board level who are directly affected will have an **employment commitment** and local NHS administrative **running costs** will not be cut as a consequence of the organisational changes.
- Through strong place-based partnerships, NHS organisations will continue to forge deep **relationships with local government** and communities to join up health and social care and tackle the wider social and economic determinants of health. To enable this, ICS boundaries will align with upper-tier local authority boundaries by April 2022, unless otherwise agreed by exception. Joint working with local government will be further supported by the **health and care partnership** at ICS level.
- The development of **primary and community services** and implementation of **population health management** will be led at place level, with Primary Care Networks as the building blocks of local healthcare integration.

- Every acute (non-specialist) and mental health NHS trust and FT will be part of at least one **provider collaborative**, allowing them to integrate services appropriately with local partners at place and to strengthen the resilience, efficiency and quality of services delivered at-scale, including across multiple ICSs.
- **Clinical and professional leadership** will be enhanced, connecting the primary care voice that has been a strong feature of PCNs and CCGs, to clinical and professional leadership from community, acute and mental health providers, public health and social care teams.

2.3 Implementation and development in 2021-22

System Development Plans (SDPs) should be updated and agreed between system partners and with NHSEI regional teams by the end of Q1, to set out how each ICS will develop the leadership, capabilities and governance required to take on their anticipated statutory responsibilities from April 2022. SDPs should refer to the core components of system arrangements set out in section 2.4 and should indicate what they expect their arrangements to be from that point, as agreed collaboratively between the NHS, local government and other system partners.

Each system should also have an implementation plan in preparation for managing their organisational and people transition into the future arrangements. This should take into account the anticipated process and timetable for ICS establishment set out in section 2.5, any potential changes to ICS boundaries and the need to streamline commissioning functions across the ICS footprint. They should include public, staff and other stakeholder communications and engagement plans.

SDPs should be agreed with NHSEI regional teams and regularly reviewed and updated throughout the year. By the end of Q4, we expect each ICS's operating plans to be included in an ICS "Memorandum of Understanding" (MoU) for 2022/23.

Alongside national and regional partners, NHSEI will work with each ICS to support their ongoing development and to ensure that they are in a position to discharge their statutory duties and functions (as well as having the necessary technical infrastructure in place, notably data and financial systems) to operate once the new ICS NHS body is established. This will include a peer review and co-development process during Q1 to take stock of initial plans, share good practice and identify support needs.

In line with previous guidance, all ICSs should confirm plans to ensure that commissioning functions are organised across the ICS footprint during 2021/22. Where an ICS has multiple CCGs they must confirm governance and resourcing arrangements that ensure that a single commissioning decisions can be made (where appropriate) and that they operate effectively as a single management team at ICS-level. By Q3 CCG teams should only operate at sub-ICS level where the System Development Plan confirms that the ICS plans to establish a significant place-based function at that footprint.

A new System Oversight Framework is being published for 2021/22. It will set consistent expectations of systems and their constituent organisations and match accountability for results with improvement support. There will be a partnership approach between regional teams and ICSs in the oversight process and in support of individual organisations, linked to system development.

All ICSs should implement the arrangements described in the System Oversight Framework. This will include agreeing, and reviewing on a quarterly basis, an oversight MOU with regional teams that sets out:

- the delivery and governance arrangements, including financial governance across the ICS and the role of place-based partnerships and provider collaboratives in delivering the priorities set out in the 2021/22 planning guidance
- the oversight mechanisms and structures that reflect these delivery and governance arrangements, including the respective roles of the ICS and regional NHSEI team
- the local strategic priorities that the ICS has committed to deliver in 2021/22 as a partnership that complements the national priorities set out in the 2021/22 planning guidance and align to the four fundamental purposes of an ICS.

NHSEI is preparing to shift some of its direct commissioning functions to ICS bodies and we are currently developing the details of these plans. Subject to the proposed changes in legislation, discussions with systems and regions and further work on HR, our initial intention is to enable ICSs to take on responsibility as soon as they are ready to do so from 1st April 2022 onwards.

Commissioning of primary medical services is currently delegated to CCGs and will move automatically into ICS NHS bodies when they are established. We anticipate that ICSs will also take on dental services, general ophthalmic and community pharmacy commissioning from this point onwards.

Further work is taking place at the national and regional levels to explore how the commissioning model for specialised services could evolve in the context of ICSs becoming statutory bodies, in line with the safeguards and four principles set out in Integrating Care: Next steps to building strong and effective integrated care systems across England.

NHSEI has a range of other direct commissioning functions including health and justice, armed forces and aspects of public health, and we will continue to engage with ICSs as we consider how they could take on greater responsibility for these services in future.

2.4 Planning for implementing new statutory arrangements

If, as expected, legislation is introduced into Parliament later this year, we expect to ask systems to start formally preparing to establish these statutory arrangements during Q1 2021/22. Preparations, informed by guidance, may include:

- running a process to appoint an ICS chair, accountable officer and chief financial officer
- development of an ICS NHS body constitution, involving system partners, to be agreed by NHSEI (the constitution will be formally agreed by the Board of the ICS NHS body upon establishment)
- establishing shadow arrangements for the system's ICS NHS body and health and care partnership, including related governance arrangements (such as joint committees and other arrangements for the exercise of functions) that they wish to deploy locally as and when legislation permits
- agreeing an ICS "MOU" for 2022/23 and the associated regional support offer.

The indicative process to be undertaken in every ICS over the course of 2021/22 is set out below. This is subject to legislation and other factors (including pending decisions on ICS boundaries in some areas) and must be viewed as indicative at this stage.

Accountability for managing this process will remain with the current ICS leadership until such time as the new leaders (designated chair, chief executive and others at Board level) may be appointed (subject to legislation). Implementation plans should be agreed with regional teams.

By end Q1	Update SDPs and confirm proposed boundaries, constituent partner organisations and place-based arrangements.
By end Q2	Confirm designate appointments to ICS chair and chief executive positions (following the second reading of the Bill and in line with senior appointments guidance to be issued by NHSEI). Confirm proposed governance arrangements for health and care partnership and NHS ICS body.
By end Q3	Confirm designate appointments to other ICS NHS body executive leadership roles, including place-level leaders, and non-executive roles.
By end Q4	Confirm designate appointments to any remaining senior ICS roles. Complete due diligence and preparations for staff and property (assets and liabilities) transfers from CCGs to new ICS bodies. Submit ICS NHS body Constitution for approval and agree “MOU” with NHS England and NHS Improvement
1 April	Establish new ICS NHS body; with staff and property (assets and liabilities) transferred and boards in place.

During 2021/22 we will also update guidance on provider governance (to support providers to work collaboratively), including:

- Updated FT Code of Governance
- Updated guidance on the duties of FT council of governors
- Updated memorandums for accounting officers of FTs and NHS trusts
- New guidance issued under the NHS Provider Licence that good governance for NHS providers includes a requirement to collaborate.

3. Elective recovery framework

Systems will coordinate the production of plans for elective activity, including cancer, that can be delivered through core funding and the extended funding that is available via the Elective Recovery Fund (ERF). Plans should make full use of available NHS and Independent Sector (IS) capacity through the new IS contract framework (the 'NHS Increasing Capacity Framework'), while demonstrating the steps being taken to eliminate unnecessary activity.

The ERF is designed to ensure that systems receive appropriate funding to deliver the highest possible levels of recovery activity. Systems will be paid through the ERF for activity delivered above nationally set thresholds as compared to 2019/20 activity levels, which will be an aggregate of inpatient and outpatient activity delivered by both NHS and IS providers and will include both CCG and specialised activity.

The baseline will be calculated using a £ value based on tariff prices. Activity delivered will be calculated on the same basis to ensure that more complex activity is given full value and there is no incentive to deliver higher volumes of simpler activity to achieve the baseline. The baseline and value of activity delivered will be calculated using data submitted to SUS+.

The scheme will operate on an individual month basis, rather than cumulatively, to provide a continued incentive for systems that do not achieve the baseline in the first part of the year.

Systems will need to decide how to allocate additional funding to providers and commissioners and how this will operate alongside the variable payment for elective activity in the aligned payment model for 2021/22 when the national tariff becomes operational.

For activity delivered between the target thresholds and the estimated funded activity within envelopes (set at 85%), systems will receive an additional payment at 100% of tariff. Additional activity above 85% will receive the equivalent of 120% of tariff to take into account additional pathway costs that are not funded by published tariff prices (for example, critical care costs for some elective procedures).

There are no downside adjustments; activity delivered below the lower thresholds will not result in any adjustments to system envelopes.

To access the additional funding, systems will need to demonstrate that their elective recovery plan is consistent with some wider objectives, described in section 3.3.

Thresholds

Thresholds have been set nationally, measured against the value of total activity delivered in 2019/20, and taking into account productivity constraints due to infection prevention and control (IPC) measures.

There will be a staged increased in thresholds, recognising the ongoing challenges in re-establishing affected services and workforce recovery. The thresholds, as a percentage of the value of the 2019/20 activity, will be:

- 70% for April 2021
- 75% for May 2021
- 80% for June 2021
- then 85% from July to September 2021

These thresholds will be applied to all NHS-commissioned activity, whether delivered in the NHS, the IS or insourced). Each provider's activity will count towards their system threshold, irrespective of the patient's CCG. Activity delivered by IS providers will count towards the system threshold of the patient's CCG.

The scope of the activity covered is:

- elective activity (ordinary or day case), including cancer, with a published tariff price
- outpatient procedures with a published tariff price
- outpatient attendances for all treatment function codes (TFCs) apart from mental health, maternity and diagnostic imaging, whether consultant-led, non-consultant-led or non-face-to-face.

The threshold will be calculated using a £ value based on tariff prices based on the 2021/22 tariff consultation, specifically:

- published tariff prices for elective and outpatient procedures
- published consultant led tariff prices for outpatient attendances with a published price. For these TFCs, non-consultant led and non-face to face will be given the consultant led price
- the average of the published consultant-led tariff prices for outpatient attendances that do not have a published price. For these TFCs, non-consultant-led and non-face-to-face will be given the consultant-led price
- other tariff adjustments such as market forces factor (MFF), specialist top-ups and excess bed days will be applied as per the 2021/22 tariff consultation.

Actual activity delivered will be calculated on the same basis. An adjustment will be made to thresholds to reflect any differences in the number of working days between 2019/20 and 2021/22.

Where there are likely to be systematic differences to the counting and coding of activity in 2021/22 compared to the baseline activity from 2019/20, we will be asking systems to provide us with that information in order to adjust the threshold values. The only categories of change we will implement are:

- where a service has shifted across system boundaries, an adjustment will be made to both systems on a net neutral (apart from MFF) basis
- where a service has shifted to a provider that cannot submit the data to SUS+
- *significant* counting and coding changes (for example where an SDEC service was coded as an outpatient service in 2019/20 but as an emergency service in 2021/22)
- where an error has been identified in the 2019/20 data (for example incorrect coding leading to the activity having been rejected)

Worked example

	April	May	June	July
2019/20 activity baseline	£ 30,000,000	£ 30,000,000	£ 30,000,000	£ 30,000,000
Basline adjustments (70%/75%/80%/85%)	£ 21,000,000	£ 22,500,000	£ 24,000,000	£ 25,500,000
WD adjustment	100%	90%	110%	96%
Counting and Coding (example)	£ 500,000	£ 500,000	£ 500,000	£ 500,000
Threshold value of activity (LOWER THRESHOLD)	**£ 20,500,000**	**£ 19,857,143**	**£ 25,900,000**	**£ 23,891,304**
Threshold value of activity at 85% (UPPER THRESHOLD)	**£ 25,000,000**	**£ 22,571,429**	**£ 27,550,000**	**£ 23,891,304**
Actual Activity (Example 1 - System delivers activity below LOWER THRESHOLD)	£ 20,000,000	£ 20,000,000	£ 20,000,000	£ 20,000,000
Actual Activity (Example 2 - System delivers activity above UPPER THRESHOLD)	£ 26,000,000	£ 26,000,000	£ 28,000,000	£ 25,000,000
Actual Activity (Example 3 - System delivers activity between LOWER and UPPER THRESHOLDS)	£ 23,000,000	£ 22,000,000	£ 28,000,000	£ 20,000,000
(Example 1 - System delivers activity below LOWER THRESHOLD)				
Amount above UPPER THRESHOLD	£ -	£ -	£ -	£ -
Amount above LOWER THRESHOLD but below UPPER THRESHOLD	£ -	£ -	£ -	£ -
Total Additional Funding	**£ -**	**£ -**	**£ -**	**£ -**
(Example 2 - System delivers activity above UPPER THRESHOLD)				
Amount above UPPER THRESHOLD	£ 1,000,000	£ 3,428,571	£ 450,000	£ 1,108,696
Amount above LOWER THRESHOLD but below UPPER THRESHOLD	£ 4,500,000	£ 2,714,286	£ 1,650,000	£ -
Total Additional Funding	**£ 5,700,000**	**£ 6,828,571**	**£ 2,190,000**	**£ 1,330,435**
(Example 3 - System delivers activity between LOWER and UPPER THRESHOLDS)				
Amount above UPPER THRESHOLD	£ -	£ -	£ 450,000	£ -
Amount above LOWER THRESHOLD but below UPPER THRESHOLD	£ 2,500,000	£ 2,142,857	£ 1,650,000	£ -
Total Additional Funding	**£ 2,500,000**	**£ 2,142,857**	**£ 2,190,000**	**£ -**

3.2 Gateway criteria and monitoring

To qualify for ERF funding, systems are required to demonstrate their elective recovery plan supports the requirements set out in sections C1 and C2 of the planning guidance and the five objectives listed below, with tangible deliverables and milestones where possible. Regional teams will review progress against the agreed deliverables on a monthly basis to determine if the gateway criteria are being met.

1. Addressing health inequalities

Systems are required to demonstrate that plans for elective recovery will:

- Use waiting list data (pre and during pandemic), including for clinically prioritised cohorts, to identify disparities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and black and minority ethnic populations
- Prioritise service delivery by taking account of the bottom 20% by IMD and black and minority ethnic populations for patients on the waiting list and not on the waiting list, including through proactive case finding
- Use system performance frameworks to measure access, experience and outcomes for black and minority ethnic populations and those in the bottom 20% of IMD scores
- Evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic-related disparities in waiting lists, including for clinically prioritised cohorts
- Demonstrate how the ICS's SRO for health inequalities will work with the Board and partner organisations to use local population data to identify the needs of communities experiencing inequalities in access, experience and outcomes and ensure that performance reporting allows monitoring of progress in addressing these inequalities.

2. Transforming outpatient services

Systems are expected to take all possible steps to avoid outpatient attendances of low clinical value and redeploy that capacity where it is needed. Where outpatient attendances are clinically necessary, at least 25% should be delivered remotely by telephone or video consultation.

Systems are required to demonstrate progress in the following, with routine data capture in place by the end of Q2:

- introducing Patient-Initiated Follow-up (PIFU), or similar alternative, in at least three major outpatient specialties per provider; including personalised stratified follow up for cancer patients, avoiding unnecessary follow up attendances, and providing faster access to follow up appointments where clinically necessary
- collaborating across primary and secondary care to treat more patients without the need for an onward referral, including increasing the uptake of Advice and Guidance or other measures such as referral triage to avoid unnecessary first attendances.

3. System-led recovery

Systems are required to set out how management of Patient Tracking Lists (PTLs), including for cancer patients, will be undertaken at a system level and how NHS and IS capacity will be used to the benefit of the whole system population. This will be supported through the ongoing mobilisation of Elective Activity Coordination Hubs.

4. Clinical validation, waiting list data quality and reducing long waits

Plans should be built on robust, system-level processes, including:

- shared decision making and treatment reviews between patients and clinicians, keeping waiting patients informed of next steps in their treatment, including discussion of alternative treatment options.
- maintaining waiting list data quality through close interrogation of patient-level PTL data and the application of system-wide data review processes, including close partnership working with primary care and adherence to guidance on Evidence Based Interventions.
- detailed validation, by providers, of the weekly Waiting List Minimum Dataset (MDS) uploads, to ensure waiting list data are complete and accurate.
- clinical validation, focusing on diagnostic and non-admitted pathways, providing evidence of how long-waiting patients will be regularly reviewed and risk assessed.

5. People recovery

Systems are required to demonstrate how they will monitor and safeguard staff health and wellbeing, using an appropriate set of staff experience measures, to ensure people recovery is taken into account when considering available workforce capacity.

3.3 High impact service models

Diagnostic activity volumes are critical to elective recovery, and additional capacity and efficiency should be maximised through new Community Diagnostic Hubs (CDHs) and pathology and imaging networks, as set out in the planning guidance.

Systems will be supported to accelerate high volume low complexity (HVLC) surgery in specialties targeted according to local needs, including orthopaedics, ophthalmology, urology, ENT, gynaecology and general surgery , including theatre productivity, where HVLC typically represents over half of surgical waiting lists, and day case maximisation.

Systems will be required to continue the development of Elective Activity Coordination Hubs, which support patient choice and maximise the available NHS and IS capacity.

4. Health inequalities

COVID-19 has highlighted the urgent need to prevent and manage ill health in groups that experience health inequalities, as outlined in the NHS Long Term Plan

To help achieve this, NHS England and NHS Improvement issued guidance as part of its 'phase 3' response to the COVID-19 pandemic, setting out eight urgent actions for tackling health inequalities. Systems are now asked to focus on **five priority areas** in the first half of 2021/22, distilled from the eight actions.

The effective use of data is central to tackling health inequalities including delineation of our waiting list and performance data by deprivation and ethnicity as set out in section 3.2.

Priority 1: Restore NHS services inclusively

At national level, the decline in access amongst some groups during the first wave of the pandemic broadly recovered in later months. Insight work has, however, highlighted that in some cases pre-existing disparities in access, experience, and outcomes, have been exacerbated by the pandemic. It is therefore critical that systems use their data to plan the inclusive restoration of services, guided by local evidence. This approach should be informed by NHS performance reports that are delineated by ethnicity and deprivation, as evidence suggests these are the areas where heath inequalities have widened during the pandemic.

Priority 2: Mitigate against digital exclusion

Systems are asked to ensure that:

- providers offer face-to-face care to patients who cannot use remote services
- more complete data collection is carried out, to identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups
- they take account of their assessment of the impact of digital consultation channels on patient access.

Priority 3: Ensure datasets are complete and timely

Systems are asked to continue to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning.

NHS England and NHS Improvement will support the improvement of data collection across all settings, including through the development of the Health Inequalities Improvement Dashboard, which will contain expanded datasets where there is currently a relative scarcity of intelligence, e.g. for people experiencing post- COVID syndrome.

Systems should also implement mandatory ethnicity data reporting in primary care, to enable demographic data to be linked with other datasets and support an integrated approach to performance monitoring for improvement.

Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes

Uptake of the COVID and flu vaccination has increased significantly across all groups, but inequality has also widened, particularly by deprivation and ethnicity. Systems and providers should take a culturally competent approach to increasing vaccination uptake in groups that had a lower uptake than the overall average as of March 2021.

Preventative programmes and proactive health management for groups at greatest risk of poor health outcomes should be accelerated, as set out in the main 2021/22 planning guidance, including:

- Ongoing management of long-term conditions
- Annual health checks for people with a learning disability This example from Herefordshire and Worcestershire CCG. shows an approach tailored to the local population.
- Annual health checks for people with serious mental illness, learning from proven delivery models such as the approach taken by City and Hackney CCG.
- In maternity care, implementing continuity of carer for at least 35% of women, with the proportion of Black and Asian women and those from the most deprived neighbourhoods meeting and preferably exceeding the proportion in the population as a whole.

Priority 5: Strengthen leadership and accountability

Systems and providers should have a named executive board-level lead for tackling health inequalities. and should access training made available by the Health Equity Partnership Programme.

5. Maternity and Neonatal transformation priorities

NHS England and NHS Improvement are committed to working with regions, systems and partners to implement the actions from Donna Ockenden's initial report: Emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospitals NHS Trust.

In the letter of 14 December systems were asked to implement the seven Immediate and Essential Actions in the Ockenden Report, identifying 12 clinically urgent priorities. An assurance assessment tool has been used by all trusts, reported to Local Maternity Systems and shared with regional teams. This section sets out the next steps for transforming maternity services in light of the Ockenden report.

5.1 Additional support for systems and providers in 21/22 for improvements to maternity services

For 2021/22, we will invest more than £80m of additional funding in systems to help deliver more midwives, more consultant obstetrician time and more multi-disciplinary training in maternity services. Arrangements are set out in section 5.4 below.

5.2 Pandemic recovery

The NHS in England has put enormous effort into maintaining safe and personalised care for women and their babies despite the challenges of the pandemic. In recovering the full maternity care pathway LMSs are asked to oversee and support trusts to:

- Reopen any services that have been suspended as a result of COVID-19.
- Remove restrictions on women's access to support, on the basis of a risk assessment and in line with Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers.
- Take active steps to help maternity staff recover from the pressures of the pandemic.

Whilst COVID-19 remains a risk to pregnant women and their babies, the NHS in England must continue to implement the four actions to minimise the additional risk of COVID-19 for Black, Asian and minority ethnic women and their babies.

5.3 Transformation – priorities for 2021/22

LMSs are expected to move back to delivering a more complete range of transformation objectives to make maternity care safer, more personalised and more equitable. In light of the variation in implementation highlighted by the Ockenden report, we will be putting a greater emphasis on universal implementation. We will expect LMSs to take responsibility for this, with accountability to ICSs.

We remain committed to women receiving continuity of carer as set out in the NHS Long Term Plan. Some potential barriers need tackling at the outset, including putting adequate staffing in place, ensuring that the model is based on a team approach with a named obstetrician

attached, and capturing the right information electronically so that progress can more easily be measured. We will therefore focus on addressing these issues during 2021/22.

The full range of objectives is:

I. Ensure every woman is offered a **Personalised Care and Support Plan**, underpinned by a risk assessment and in line with national guidance, by March 2022.

II. Implement the five elements of the **Saving Babies' Lives** care bundle, and in particular ensure that:

    a) Every provider has a pre-term birth clinic.

    b) 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.

III. Make new **NHS smoke free pregnancy pathways** available for up to 40% of maternal smokers by March 2022.

IV. Embed **maternal medicine networks** so that women with acute and chronic medical problems have timely access to specialist advice and care at all stages of pregnancy from the start of the 2021/22 planning year.

V. Embed the offer to all women with type 1 diabetes of **continuous glucose monitoring** fully during 2021/22.

VI. Work with neonatal Operational Delivery Networks to implement local **neonatal improvement plans**.

VII. Implement the Core Competency Framework and ensure all maternity staff receive **multi-disciplinary training** – in line with the Ockenden report this must be validated by the LMS three times over the course of the year.

VIII. Put in place the building blocks by March 2022 so that **continuity of carer** is the default model of care offered to all women by March 2023, specifically:

    a) Undertake a Birth-rate Plus assessment to understand the current midwifery workforce required and follow this through with recruitment.

    b) Co-design a plan by July 2021 with local midwives, obstetricians and service users for implementation of continuity of carer teams in compliance with national principles and standards, and phased alongside the fulfilment of required staffing levels. This plan should also take into account the need for maternity staff to be supported to recover from the challenges of the pandemic.

    c) Prioritise those most likely to experience poorer outcomes first, including ensuring most women from Black, Asian and mixed ethnicity backgrounds and also from the most deprived areas are placed by on a continuity of carer pathway by March 2022.

    d) Develop the ability to measure progress electronically and report it to the Maternity Services Dataset

    e) Develop an enhanced model of continuity of carer which provides for extra midwifery time for women from the most deprived areas for implementation from April 2022.

IX. Following the publication of a national **Perinatal Equity Strategy,** LMSs will be asked to submit an equity analysis (covering health outcomes, community assets and staff experience) and a coproduction plan by 30 September 2021. LMSs will then co-produce Equity Action Plans by 31 December 2021.

5.4 Support and funding available

Ockenden Immediate and Essential Actions

Alongside this guidance, Ruth May- Chief Nursing Officer, Jacqueline Dunkley-Bent- Chief Midwifery Officer and Matthew Jolly- National Clinical Director for the Maternity Review and Women's Health, will write to systems to set out the next steps. In parallel to system planning, we are asking systems or providers (with system endorsement) to set out by 6 May their current performance and plan to meet Birth-rate Plus and the Ockenden actions.

Regional teams will review and assure all submissions and confirm funding allocations to systems and providers by the end of May to inform final workforce planning submissions. We will also be strengthening the support available to systems by expanding the team of Maternity Improvement Advisers and providing additional consultant and midwifery leadership to regional teams.

Transformation Funding

As well as continued funding for existing Maternity Transformation Programme priorities we will provide funding on a targeted basis for two new service models included in the NHS Long Term Plan which are still at the pilot stage and not yet suitable for wider rollout: Maternal Mental Health Services (through the Mental Health Programme) and Postnatal Pelvic Health Services. We have also commissioned UNICEF to support trusts that are not accredited with its Baby Friendly Initiative (on infant feeding) to achieve accreditation. We will write to LMSs individually to confirm allocations. Funding will also be made available for Operational Delivery Network and LMS plans to implement the Neonatal Critical Care Review.

5.5 Ockenden report and the role and governance of Local Maternity Systems

The 14 December letter included the expectation that LMSs would oversee implementation of the Ockenden report. LMSs must continue to oversee implementation of the initial report, working in collaboration with the relevant Regional Chief Midwife. The actions regarding the governance of LMSs should be taken forward in a way that positions LMSs as the maternity arm of ICSs in line with Integrating care: Next steps to building strong and effective integrated care systems across England. The actions are:

I. "LMS must be given greater accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them."

Those LMSs that have not already done so should now also take on full and ongoing oversight of quality, ensuring that an understanding of the quality of maternity and neonatal services informs transformation. We are therefore asking all LMSs to review their terms of reference and work programme by 3 June 2021 and to ensure that the LMS purpose specifically includes all of the following:

- To oversee quality in line with Implementing a revised perinatal quality surveillance model.
- To share information and learning in a structured and systematic way, working with partners to turn learning into service improvement.
- To oversee local trust actions to implement the seven immediate and essential actions from the Ockenden report.
- To ensure action is taken to improve the culture of maternity and neonatal services as a building block for safe, personal and more equitable care.

- To co-design and implement a vision for local maternity and neonatal services with local women through Maternity Voices Partnerships.
- To implement shared solutions wherever possible through shared clinical and operational governance.

Alongside this, there must be clear routes of accountability. We are therefore asking existing ICSs to take on formal, structured and systematic oversight of how their LMS delivers its functions. ICSs should set out a plan by 3 June 2021 outlining how this will be delivered with implementation no later than 1 April 2022.

II. "An LMS cannot function as one maternity service only."

Donna Ockenden pointed out that independent scrutiny and challenge through peer review alongside peer support are fundamental to LMS operations and this can only be done when multiple trusts come together. However, providers are moving towards greater collaboration on ICS footprints with shared responsibilities and accountabilities through provider collaboratives. At the same time, as set out above, we need to strengthen LMS accountability through ICSs. In this context a sustainable approach ensuring there is ongoing shared learning and critical challenge is to buddy up LMSs as learning partners to undertake this function. We are therefore asking all LMSs, in consultation with regional teams, to identify a buddy LMS and implement processes for peer review and support by 3 June 2021.

III. "The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda."

To future proof implementation of this recommendation LMS governance must be aligned with ICSs (see section 2). We therefore expect ICSs to ensure the LMS Board is part of governance arrangements for 2021/22, and ensure that future arrangements maintain direct line of sight from the statutory ICS Board to the LMS Board, although there may be a period of transition during 2021/22 where existing arrangements are already planned to come to an end during this period. This will further support accountability and responsibility of the LMS as set out above.

6. Submission Guidance

6.1 Submission requirements

Systems (and where appropriate individual providers) are asked to submit plans covering activity and performance, workforce and finances that reflect the priorities set out in 2021/22 priorities and operational planning guidance. A set of linked collection templates are being made available to support plan submission. The individual elements and submission process for each of these is summarised below. Detailed guidance to support completion of each template can be found on the NHS Planning FutureNHS collaboration platform (see section 7.3) and/or within the collection template itself. The individual collection templates are:

- **Activity and performance**
    - Single system level collection incorporating CCG and provider level breakdowns as appropriate
- **Workforce**
    - Single system level collection across acute, community and primary care, incorporating provider level breakdown
    - Dedicated mental health collection at system and provider level
- **Finance**
    - System financial planning template
    - Provider financial planning template (issued 22 March)
    - Mental health CCG financial planning template
- **Supporting narrative**
    - A single system level template covering:
        - the actions and assumptions that underpin the trajectories within the activity and workforce numerical submission; and
        - other critical actions that systems will take over the next 6 months to address the priorities set out in 2021/22 operational planning guidance and in section 3 (elective recovery), section 4 (health inequalities) and section 5 (maternity) of this document

The collection mechanism for each template is set out in section 6.3

6.2 Planning assumptions

As set out in 2021/22 priorities and operational planning guidance, we do not yet know what the pattern of COVID-19 transmission will look like over the next 6-12 months and there also remains uncertainty over the pattern of non- COVID demand. To provide a consistent basis for planning systems should assume that over the first half of the year:

- Overall non-elective demand from COVID and non- COVID returns to pre-pandemic (2019/20) levels from the beginning of the 2021/22, subject to the impact of any planned service developments.
- COVID general and acute bed occupancy remains <5% between April and September 2021.

- Infection Prevention Control: All NHS organisations should ensure continued reliable application of the recommendations in the UK Infection Prevention and Control guidance. Individual organisations should make an assessment of the productivity impact based on local mitigation plans.

These planning assumptions are not a forecast and are provided as a consistent basis for planning only. As set out in 2021/22 priorities and operational planning guidance, systems should continue to prepare for possible future surge requirements for COVID patients.

6.3 Submission portals

Activity and performance

The activity and performance collection will be conducted through SDCS which can be accessed here. Submitters from each system will be contacted and invited to sign up to the SDCS collection system if they do not already have an account. Once the planning collection opens, submitters will be able to download the template from SDCS before completing and resubmitting through SDCS.

Full user guidance for accessing and using the SDCS collection system is available here and any queries regarding the system itself should be directed to the Data Collections team at NHS Digital; data.collections@nhs.net. Any other queries including those regarding the templates themselves should be directed to the NHS planning mailbox; england.nhs-planning@nhs.net.

For mental health there is no requirement to submit activity plans. The focus for this submission is on finance and workforce planning to mitigate risks to LTP delivery. The trajectories communicated in the Mental Health LTP Analytical Tool remain for 2021/22, with the exception of Children and Young People's access, which reflects the additional activity funded through the Spending Review settlement (further information can be found in the Mental Health LTP Analytical Tool). Systems should use the information in the Mental Health LTP Analytical Tool, in conjunction with finance and workforce planning inputs to plan for delivery in 2021/22.

Workforce

The Acute, Primary care and community workforce collection will be conducted through SDCS in the same way as for activity and performance.

The Mental Health Workforce element of the collection will be carried out separately through the HEE eCollections portal. Mental Health Trusts will be responsible for the completion of their Provider-level Mental Health Workforce Collection submission. ICSs will be responsible for the system level Mental Health Workforce Collection submission. The nominated ICS and mental health trust leads will receive access to the tool via an email from HEE providing details to create an account. If you have not received a login by 6th April or if you have any issues accessing the portal, please contact DataService@hee.nhs.uk

Finance

System financial planning templates

System financial planning templates will be issued by email to system leads, along with supporting technical guidance. System leads will then be required to submit their completed system financial planning templates into NHSI.finplan@nhs.net by noon on the submission deadline. All templates should be submitted with all validation errors cleared. Please send any queries regarding the system financial planning collection to NHSI.finplan@nhs.net.

Provider financial planning templates

Provider financial planning templates and supporting technical guidance were issued on 22nd March for the capital and cash collection. After the systems have submitted their system financial plans, a macro fix will be issued to cascade the agreed provider amendments to the

subsequent Provider Income and Expenditure planning collection and there will then be a small window of opportunity for provider's to amend their phasing and breakdown of their H1 plans. These templates, macro fixes and supporting technical guidance are published through the Provider Financial Monitoring System provider portals. The financial planning team will contact regions asking them to cascade to systems when the subsequent macro fixes are available to download from the system. Providers will be required to submit their templates via their portals by noon on the respective submission deadlines for capital and revenue with all validation errors cleared.

If you are a new user requiring log-in details, contact our IT Support team at Itservicedesk@NHSeandi.nhs.uk. Any other queries, including any regarding the template itself should be directed to NHSI.finplan@nhs.net.

Mental Health financial planning templates

Mental Health financial planning templates will be issued through the lead CCG SharePoint portals, along with supporting technical guidance. Systems will then be required to submit their completed mental health financial planning templates into the lead CCG who will upload them onto SharePoint by noon on the submission deadline. All templates should be submitted with all validation errors cleared. Please send any queries regarding the mental health financial planning collection to NHSI.finplan@nhs.net.

Narrative

Plans should be submitted using the template made available on the NHS Planning FutureNHS collaboration platform (see section 7.2) and submitted to the appropriate regional planning mailbox (see section 7.1) in line with the draft and final planning submission dates.

6.4 Sign Off

The templates do not include details of the internal sign off process within each ICS. It is assumed that by submitting the return the ICS confirms that the plan is a reflection of the collective intentions of the system for the rest of the year, that activity and workforce plans align and that the plan is agreed by all ICS partners.

7. Key planning contacts and resources

7.1 Regional contacts

ICSs should initially contact their region for advice on planning, using the contact details below:

Location	Contact information
North East and Yorkshire	england.nhs-NEYplanning@nhs.net
North West	england.nhs-NWplanning@nhs.net
East of England	england.eoe2021operplan@nhs.net
Midlands	england.midlandsplanning@nhs.net
South East	england.planning-south@nhs.net
South West	england.southwestplanning@nhs.net
London	england.london-co-planning@nhs.net

7.2 National and wider technical issues

Subject area	Contact information
SDCS collection portal	data.collections@nhs.net
NHS National Planning Team – activity, workforce MH workforce and general planning queries	england.nhs-planning@nhs.net
Integrated Planning Tool	england.covid-ipt@nhs.net
NHSI.finplan@nhs.net	NHSI.finplan@nhs.net
Capital and Cash	NHSI.CapitalCashQueries@nhs.net

7.3 FutureNHS collaboration platform

General updates and resources will be provided on the NHS Planning FutureNHS collaboration platform throughout the planning round.

You will need a FutureNHS account to access pages, and can get this at: https://future.nhs.uk/connect.ti/system/home following the registration process outlined.

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