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2021/22 priorities and operational planning guidance: October 2021 to March 2022

30 September 2021

Dear colleague

This updated planning guidance for the second half of the year reflects a positive financial settlement for the NHS that allows us to continue to deliver on the priorities for the year that we set out in March.

As I wrote in my recent message, we have achieved a huge amount over the last six months and I want to thank you all again for the work you have done, and continue to do, in what have been very challenging circumstances.

There are, of course, new challenges that we must meet over next six months, in particular the seasonal pressures over winter that are likely to be intensified by the ongoing impact of the COVID-19 pandemic. We have seen sustained pressure on urgent and emergency care services throughout the summer and managing this is going to continue to be a key focus across the second half of the year.

Looking after staff over this period will be crucial as we also strive to keep up the momentum on recovering services and addressing care backlogs.

Taking a longer term view, the government has announced significant additional funding for the NHS over the next three years. We will spend every pound we have been given wisely and to best effect to deliver for patients, continuing to recover and transform services. While the pandemic has inevitably impacted some delivery trajectories – including speeding some up - we remain determined to deliver the ambitions for improvements in care, treatment and population health set out in the NHS Long Term Plan (LTP), which have stood the test of time well. Our shared goals set out in the LTP continue to be the right priorities over the coming years.

On behalf of myself and the whole of the NHS leadership team I want to say thank you for the way you are rising to the challenges we face.

With best wishes

Amanda

Amanda Pritchard
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In March we published the 2021/22 priorities and operational guidance setting out our priorities for the year. Since then the NHS has risen to the challenge of restoring and transforming services while continuing to meet the needs of patients with COVID-19 and dealing with increases in urgent and emergency care (UEC), primary and community care and mental health demand. At the time of writing, the NHS has delivered more than 78 million COVID-19 vaccinations to people across England and, as a direct result, there has been a very significant fall in the rate of severe illness and hospitalisation. Thank you to you and your teams for your extraordinary efforts over the last six months that have made all of this possible.

As we look ahead to the second half of the year, the six areas set out in March remain our priorities:

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

We will also continue the focus on the five priority areas for tackling health inequalities and redouble our efforts to see sustained progress across the areas detailed in the NHS Long Term Plan, including early cancer diagnosis, hypertension detection, respiratory disease, annual health checks for people with severe mental illness, continuity of maternity carer, and improvements in the care of children and young people. To support this, we are improving the quality and presentation of health inequalities data and will shortly set out further details of our approach. We are also asking that all NHS Board performance reports include reporting by deprivation and ethnicity.

Government has agreed an overall financial settlement for the NHS for the second half of the year which provides an additional £5.4bn above the original mandate. This includes, £1.5bn funding (£1bn revenue and £500m capital) to support the continued recovery of elective activity and of cancer services. This reflects the challenges that we must meet over the next six months: managing COVID-19 (currently over 5,000 patients with COVID-19 are in our hospitals), the growing backlog of care, and the significant UEC pressures areas are experiencing ahead of the usual seasonal peaks over winter.

Meeting both planned and unplanned patient demand, including that from COVID-19 and seasonal viral illnesses will require a robust whole system plan. It is in this context that we are asking systems to pay particular attention to the areas outlined below.

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

People continue to be at the heart of all plans for recovery and transformation for the second half of 2021/22. The priorities, based on the pillars of the People Plan, therefore remain as set out in March. Systems are asked to continue to deliver on these commitments as well as those made in local people plans, recognising the pressures on each and every member of staff, line manager and senior leader. The way we honour this commitment to look after staff and keep the 'People Promise' during the winter months will be crucial and will be remembered by them. In this context systems are asked to:

- focus on the delivery of workforce plans that support elective recovery in the second half of the year and winter resilience through increasing workforce availability, and putting in place or scaling up new and more productive ways of working and transformation opportunities
- continue to move to whole system workforce planning to support sustainable delivery against the priorities for the NHS and preparations for the transition to statutory integrated care boards (ICBs) from April 2022.

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

The Joint Committee on Vaccination and Immunisation (JCVI) has published their advice on booster vaccinations and systems should proceed with vaccinating eligible individuals no earlier than six months after they complete their primary vaccination course. This will continue to be delivered through implementing a mixed model of vaccine delivery using vaccination centre, hospital hub, general practice and community pharmacy capacity. The precise local model will vary according to the needs of the local population and include targeted approaches where these are required to increase uptake, particularly in under-served populations. Primary Care Network (PCN)-led local vaccination services are asked to prioritise older adult care home residents and care home staff. We are asking that all eligible people in this cohort be offered a vaccination by 1 November 2021, and therefore delivery plans should be designed to meet this target.

The JCVI guidance states that “where operationally expedient, COVID-19 and influenza vaccines may be co-administered”. Therefore, systems should consider co-administration wherever eligibility for both programmes, supply and regulation allow. In particular, systems should seek to co-administer in any circumstances where this improves patient experience and uptake of both vaccines, reduces administrative burdens on services or reduces health inequalities (eg in hospital hubs, residential care homes and roving models).

An ‘evergreen offer’ of a first and second dose to those who are unvaccinated or not fully vaccinated remains key to saving lives, reducing the likelihood of increased pressure on the NHS and the spread of COVID-19. The booster campaign will be delivered alongside existing requirements to administer an evergreen offer, a two-dose schedule of vaccinations for at-risk 12 to 15 year olds, and third doses as part of the primary vaccination course for immunosuppressed individuals.

Following the government’s acceptance of the UK Chief Medical Officers’ recommendation to extend the offer of universal vaccination with a first dose of the Pfizer vaccine to all 12 to 15 year olds (who are not already covered by existing JCVI advice), we have asked systems to formally engage with their local school-aged immunisation service (SAIS) providers to operationalise delivery of COVID-19

vaccinations in school settings and make specific provision available for children aged 12 to 15 who are not in mainstream education.

Systems are asked to ensure that all existing SAIS providers are offered the opportunity to provide the COVID-19 vaccination service. They should be supported to work with all local providers to bolster and supplement capacity using existing staff sharing arrangements through lead employers or sub-contracting with partners, if required.

Our objective is to vaccinate children as quickly as is safe and practical, with the majority of school visits completed and vaccinations administered before the October half-term.

Over the last year the NHS has rapidly established 90 specialist post COVID clinics and 14 paediatric hubs. £94 million has been invested in specialist assessment and treatment services and £30 million in an enhanced service to equip primary care to support people with long COVID. From this autumn data on waiting times and activity by provider will be added to the activity data first published in September 2021. Using the additional funding, post COVID commissioning guidance and learning resources, systems are asked to address variation in referrals against expected need and take action to minimise long waits for assessment.

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

Maximise elective activity and eliminate waits of over 104 weeks, taking full advantage of opportunities to transform the delivery of services

During the first half of the year elective activity started to rapidly recover towards pre-pandemic levels. More recently, non-elective pressures, including a rise in COVID-19 admissions as well as workforce supply constraints due to staff needing to isolate, have slowed this progress.

Children, young people and adults should continue to be treated according to clinical priority. The aim is to return to – or exceed – pre-pandemic levels of activity

across the second half of the year to reduce long waits and prevent further lengthening of waiting lists. The ambition is for systems to:

- eliminate waits of over 104 weeks by March 2022 except where patients choose to wait longer ('P5' and 'P6' patients)
- hold or where possible reduce the number of patients waiting over 52 weeks. We will work with systems and providers to agree individual trajectories through the planning process
- stabilise waiting lists around the level seen at the end of September 2021.

To support delivery of these objectives, systems are asked to take full advantage of the elective high-impact changes and transformation opportunities set out in the 2021/22 priorities and operational guidance. In particular, systems are asked to:

- establish and maintain ring-fenced elective capacity at system level for high volume, low complexity (HVLC) procedures, adopting 'hub' models where appropriate
- engage fully in the national clinical validation and prioritisation programme to ensure continued improvement in waiting list data quality with a regular cycle of clinical validation and prioritisation
- work closely with independent sector (IS) providers to maximise the capacity and services available via the IS, including for cancer and over winter
- ensure that approved early adopter community diagnostic hubs (CDHs) deliver against agreed activity trajectories and continue to submit activity returns to the national CDH programme team
- deliver planned capital investments by March 2022 where business cases for Year 1 CDH sites have been approved
- continue to work collaboratively to optimise referrals and avoid asking patients to attend outpatient services unnecessarily. A minimum of 12 advice and guidance requests should be delivered per 100 outpatient first attendances, or equivalent via other triage approaches, by March 2022. All systems are asked to demonstrate monthly increases in referral optimisation, with assessments to monitor the impact on avoiding referrals, and on improving patient experience and outcomes. This should be

evidenced in returns to the Elective Recovery Outpatient Collection (EROC) dataset

- ensure that patient-initiated follow-up (PIFU) is in place for at least five major outpatient specialties, moving or discharging 1.5% of all outpatient attendances to PIFU pathways by December 2021, and 2% by March 2022. All providers are asked to increase the proportion of outpatient attendances they move to PIFU month-on-month, evidenced through returns to the EROC dataset
- continue to grow remote outpatient attendances where clinically appropriate with an overall share of at least 25%
- consider options for digital-first elective care pathways that reduce demand and manage activity differently. NHSX is supporting systems to do this, with digital playbooks and targeted funding for roll-out of the most effective opportunities in key specialties
- continue to ensure health inequalities are considered within elective recovery plans and progress is tracked through board level performance reports.

£1bn revenue and £500m capital funding above that funded within core envelopes has been made available to the NHS in the second half of 2021/22 to support the continued recovery of elective activity and cancer services.

We are making a £700m targeted investment fund (including the additional £500m capital funding) available to support elective recovery. We are asking systems to work with NHS England and NHS Improvement regional teams to propose, by 14 October, a shortlist of targeted investments that can deliver in year and have a material impact on activity in their region either in 2021/22 or in future years. Proposals should focus on delivering the highest priority elective recovery reforms, and / or on systems and providers facing the greatest challenges in restoring activity to pre-pandemic levels.

In addition, systems that achieve completed RTT pathway activity above a 2019/20 threshold of 89% will be able to draw down from the Elective Recovery Fund (ERF). Part of the ERF will also be used to centrally fund IS activity above 2019/20 levels. Further details on the operation of the ERF and targeted investment fund are set out in in the accompanying ‘Guidance on finance and contracting arrangements for H2 2021/22’.

Restore full operation of all cancer services

The number of patients seen following an urgent suspected cancer referral has been at a record high since March 2021, helping to recover some, but not all, of the shortfalls seen during the pandemic. However:

- there remain a significant number of patients who we would have expected to have started treatment during the pandemic, but who have not yet come forward
- diagnostic and treatment volumes are not keeping up with restored levels of demand at a national level, meaning more patients are waiting longer.

The priorities for cancer recovery therefore remain the same as in the first half of the year, with a particular focus on:

- continuing to maximise all available capacity, including by extending hub models and ensuring all system plans reflect the IS capacity needed to meet demand for cancer care
- ensuring sufficient diagnostic and treatment capacity to meet the increased level of referrals and treatment required to address the shortfall in number of first treatments, by March 2022. Breast cancer screening accounts for around a quarter of this shortfall and remains a specific priority
- accelerating the development of rapid diagnostic centre (RDC) pathways for those cancer pathways which have been most challenged by COVID-19. Cancer Alliances should accelerate current RDC implementation to achieve 50% population coverage for non site-specific RDCs and work with colleagues to ensure CDHs support and meet the needs of the RDC programme and patients with suspected cancer.

And the objectives to:

- return the number of people waiting for longer than 62 days to the level we saw in February 2020 (based on the overall national average) by March 2022
- meet the Faster Diagnosis Standard (FDS) from Q3, ensuring at least 75% of patients will have cancer ruled out or diagnosed within 28 days of referral for diagnostic testing. Where the lower GI pathway is a barrier to achieving FDS, full implementation of faecal immunochemical tests and, where

appropriate, colon capsule endoscopy is expected (to reduce colonoscopy demand and shorten the pathway).

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

We estimate at least 1.5 million people have been accepted for / are eligible for care but are yet to receive it. The ambitions set out in the NHS Mental Health Implementation Plan 2019/20–2023/24, which expand and transform services, remain the foundation for the mental health response to COVID-19, enabling local systems to expand capacity, improve quality and tackle the treatment gap. Systems should continue to make full use of the additional £500m of funding made available in 2021/22 to address the impact of COVID-19 and must continue to meet the Mental Health Investment Standard (MHIS).

For the second half of the year systems are therefore asked to continue to deliver on their 2021/22 Mental Health plan, with a specific focus on:

- delivery against in-year ICS workforce plans, making full use of new roles, and development of a multi-year mental health workforce plan
- accelerating the recovery of face-to-face care in community mental health services and submitting the re-categorisation of community mental health spend over autumn
- reducing out-of-area placements, long lengths of stay and long waits in EDs for mental health patients
- continuing to increase access to:
  - children and young people's NHS-funded community mental health services, including eating disorders, crisis and school-based mental health support teams
  - NHS-funded talking therapies, individual placement and support (IPS) and specialist perinatal mental health services
- advancing equalities, including delivering against the target for physical health checks for people with severe mental illness (SMI) and recovering the dementia diagnosis rate
- delivering actions to enable whole pathway commissioning for provider collaborative front runners from April 2022
- ensuring that digital capabilities are in place across mental health services to drive interoperability and improvements in patient safety. Systems are

encouraged to use resources, developed jointly by NHSX and NHS England, to support digitally enabled pathway redesign and the use of digital services to improve access and personalisation in mental health care.

Systems are also asked to continue to make progress on the NHS Long Term Plan commitments for children, young people and adults with a learning disability, autism or both.

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

Systems are asked to continue to prioritise action to make maternity care safer and more personalised in line with the Maternity Transformation Programme, and to implement the emerging findings of the Ockenden review.

In June, NHS England and NHS Improvement and NHSX announced £52m additional funding for 2021/22 to accelerate the transformation of maternity information systems. This will support seamless data sharing and interoperable systems to enable pregnant women to access their own maternity care records digitally. Named digital leads, to work up local plans and guide implementation, should be provided to the NHSX Digital Child Health and Maternity Programme no later than 31 January 2022.

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

Restoring and increasing access to primary care services

Primary care is under intense pressure. Systems are asked to continue to prioritise local investment and support for general practice as well as PCNs, with a particular focus on GP recruitment and retention and ensuring access for patients. This includes supporting the recruitment under the Additional Roles Reimbursement Scheme (ARRS) to ensure that nationally 15,500 additional FTE are in post by the end of 2021/22. Systems are also asked to support their PCNs to work closely with local communities to address health inequalities.

Systems are asked to support practices with access challenges so that all practices are delivering appropriate pre-pandemic appointment levels, including face-to-face

care as part of a blended access model. We will shortly set out details of continued investment in H2 to support general practice capacity and improve access.

Building on the successful deployment of remote consultation systems during the pandemic, systems are asked to continue to support PCNs and practices to optimise the use of these technologies, including by funding advanced telephony, to improve experience for patients and practice staff.

Systems should support the scaling up of minor illness referrals from 111 and general practice to community pharmacy under the Community Pharmacist Consultation Service as part of a system-wide strategy to manage urgent care demand. Hospitals are asked to refer patients leaving hospital with changed medication into the Discharge Medicines Service which is available in every pharmacy in England. As well as reducing incidences of avoidable harm, this evidence-based service can support winter resilience by reducing emergency re-admissions from medication errors.

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

Transforming community services and improving discharge

Government will continue to fund the first four weeks of post-discharge recovery and support services that are provided on or before 31 March 2022 for those with new and additional care needs. The scheme will end on 31 March 2022 and will not fund care delivered after this date - consequently no costs for care delivered in 2022/23 will be funded by this scheme. Working together, health and social care systems are asked to ensure that the Hospital Discharge and Community Support policy and operating model are fully implemented. This will ensure that more people are discharged home and that the length of stay for people in acute care (particularly over 21 days) is reduced.

Joint planning is already taking place across clinical commissioning groups (CCGs), local authorities and providers within the Better Care Fund. The focus on improving people's outcomes following a period of rehabilitation and recovery, reducing the need for long-term care and reducing the time spent in hospital is key. Systems should plan to implement hospital discharge arrangements that are sustainable and

affordable from core NHS and local authority expenditure into April 2022. Further guidance on setting local ambitions for long length of stay is given in the Better Care Fund planning requirements.

Two-hour community crisis response teams are expected to be providing consistent national cover (8am-8pm, seven days a week) by April 2022 across every ICS to prevent avoidable attendance and admissions. Activity must be fully reported into the Community Services Data Set from 1 October 2021.

Managing the increasing pressure within urgent and emergency care and supporting winter resilience

There has been sustained pressure on UEC services throughout the summer because of increasing demand and capacity constraints within non-elective pathways. Seasonal pressures over the second half of the year are likely to be exacerbated by the ongoing impact of the COVID-19 pandemic with the potential for a significant number of COVID hospital admissions.

System leaders should embed the actions in the UEC Action Plan to support recovery of services. In particular, systems are asked to take immediate action that will:

- reduce the number and duration of ambulance to hospital handover delays within the system – keeping ambulances on the road is key to ensuring that patients needing an urgent 999 response are seen within national Ambulance Response standards
- eliminate 12-hour waits in EDs – flow out of EDs ensures that expert clinical resource can be directed to those most in need
- ensure safe and timely discharge of those patients without clinical criteria to reside in an acute hospital, especially individuals on Pathway 0. This should be done in partnership with system colleagues, including community and social care, to ensure a focus on Pathway 1-3 discharges.

Systems are asked to develop effective integrated operational delivery plans underpinned by the UEC Action Plan. These plans must ensure that there are robust and effective assurance and escalation processes to rapidly identify and mitigate against bottlenecks and risks from across the system that may add pressure to UEC services.

To assess pressure in UEC systems and monitor their recovery, systems were asked in Q1 to roll out the Emergency Care Data Set (ECDS) to all services. Systems are asked to ensure that by the end of Q3 they are consistently submitting ECDS data seven days per week.

Seasonal influenza and COVID-19 have the potential to add substantially to the winter pressures the NHS usually faces, particularly if infection waves from both viruses coincide. The timing and magnitude of potential influenza and COVID-19 infection waves for winter 2021/22 are currently unknown, but mathematical modelling indicates the 2021/22 influenza season in the UK could be up to 50% larger than typically seen and it may start earlier than usual. The uptake ambitions for this coming season set out in the national flu letter reflect the importance of protecting people against flu this winter and should be regarded as the minimum level to achieve.

Since the lifting of non-pharmaceutical interventions to prevent the spread of COVID-19 in the summer, we have seen earlier than usual increases in a range of respiratory illnesses in children, including respiratory syncytial virus (RSV). Thank you to systems for putting in place paediatric acute care plans to prepare for a rise in demand. Systems are asked to continue to oversee these plans and put in place mitigations as appropriate. We will also support systems to take forward improvements in the management of respiratory conditions in children, such as RSV and asthma, including resources for the workforce and support for families from the voluntary sector.

A response to the consultation on the UEC clinically-led review of standards was published on 26 May 2021. We will work with government to agree next steps.

F. Working collaboratively across systems to deliver on these priorities

Develop ICSs as organisations to meet the expectations set out in Integrating care

ICSs should continue to progress their development and preparation for the statutory establishment of integrated care boards (ICBs), drawing on the guidance on the NHS England website and the ICS Guidance collaboration platform. This guidance includes the ICS design framework and the ICB 'readiness to operate' checklist and assurance process.

Designate ICB CEOs and regional directors will be asked to sign a readiness to operate statement in March 2022, confirming that all relevant preparations and due diligence have been carried out to enable the ICB to fulfil its statutory functions from 1 April 2022.

Financial arrangements

The H2 financial arrangements are broadly consistent with a continuation of the H1 framework. This means that systems will continue to receive a fixed system funding envelope based on the H1 2021/22 envelopes adjusted for additional known pressures, such as the impact of the pay award. H2 envelopes include an increased efficiency requirement from H1 and where systems are able to go further, in preparation for 2022/23, they should take action with any savings re-invested in supporting non-recurrent recovery initiatives.

Block payment arrangements will remain in place for relationships between NHS commissioners (comprising NHS England and CCGs) and NHS providers (comprising NHS foundation trusts and NHS trusts). Signed contracts between NHS commissioners and NHS providers are not required for the 2021/22 financial year.

Further details are set out in the accompanying document Guidance on finance and contracting arrangements for H2 2021/22.

Plan submission

We are asking systems and providers to:

- work with their regional NHS England and NHS Improvement team to rapidly develop and submit by 14 October:
  - elective recovery and capacity plans for the second half of the year
  - a proposed shortlist of investments for the Targeted Investment Fund (TIF) that can be delivered in year
- submit a final set of plans covering the second half of the year by 16 November using the templates issued and covering the key actions set out in this document.

Further details are set out in the accompanying submission guidance.

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This publication can be made available in a number of other formats on request.

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