Healthier Futures
Black Country and West Birmingham

Black Country & West Birmingham ICS

Operational Planning 2022/23

27.12.21

Building Healthier, Happier Communities

Introduction

Key ambitions for 2022/2023 are to continue to restore services, meet new care demands, reduce care backlogs as a result of pandemic:

- **accelerate plans to grow the substantive workforc**e 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.

Objectives for 2022/23 based on COVID-19 returning to a low level

Effective partnership & four strategic purposes of ICS is critical to achieving the priorities set out:

- 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

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. 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 updated transition timeline.

NHS 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**.

One year revenue allocations for 2022/23 and **three year capital allocations to 2024/25** to be issued shortly. Remaining **two-year revenue allocations to 2024/25** will be **published in the first half of 2022/23**

2022/23 National Planning priorities

A – **Invest in our workforce** - **with more people** (e.g. 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 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 model**s, 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 resources** – **moving back to & beyond pre pandemic levels of productivity** when the context allows this

J - **Establish ICBs and collaborative system working** – work together with local authorities & other partners across their ICS to develop **a five-year strategic plan** for their system and places

2022/23 National Planning priorities

Maintain focus on reducing **preventing ill-health and tackling health inequalities** by redoubling our efforts on the **five priority areas**:

1. Restore NHS services inclusively
2. Mitigate against digital exclusion
3. Ensure datasets are complete & timely
4. Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
5. Strengthen leadership & accountability

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. ICBs, once established, and **trust board performance packs** are therefore expected to be **disaggregated by deprivation and ethnicity**

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's need to develop plans that reflect these priorities & ensure triangulation across activity, finance & workforce. **Immediate focus** should remain **priorities** set out in **Preparing NHS for the potential impact of the Omicron variant**, planning timetable been amended to reflect this with **draft plans due in mid-march 2022.**

A. Invest in Our Workforce

Whole system workforce plans & **local people plans** should reflect ambition 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.

A. Invest in Our Workforce

Grow for the future

- **expand international recruitment** through ongoing ethical recruitment of high quality nurses and midwifes
- **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 and NHS Improvement Regional teams will support systems to develop and deliver workforce plans 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. Responding to COVID-19 ever more effectively

Vaccinations

- 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
- Continue to **prioritise roll out 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.
- 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, NHSE/I will **develop plans for wider access to antivirals from the spring**.

Long Covid

Due to **variation** in **referral rates**, **waiting times & access** to clinics 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.

C1. Elective Recovery – Maximise elective activity & reduce long waits taking full advantage of opportunities to transform the 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
- 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 prioritise**d.
- Wherever possible over winter, we need systems 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.
- 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.
- 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 week**s as a priority and **maintain this position through 2022/23** (except where patients choose to wait longer)
- **reduce waits of over 78 weeks** 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 w**aits where possible
- 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. Specific targets will be agreed with systems through the planning process.

C1. Elective Recovery – Maximise elective activity & reduce long waits taking full advantage of opportunities to transform the delivery of services

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.

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. Further details will be shared 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**, e.g. 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.

C1. Elective Recovery – Maximise elective activity & reduce long waits taking full advantage of opportunities to transform the delivery of services

Systems are asked to rapidly draw up **delivery plans across elective inpatient, outpatient and diagnostic services for adults and children (including specialised services) for April 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. Elective Recovery – Complete recovery and improve performance against cancer waiting time standards

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 low**er

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.

C2. Elective Recovery – Complete recovery and improve performance against cancer waiting time standards

- **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.**

Plans will form 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. Elective Recovery – Diagnostics

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 planned to facilitate training & supply staff of workforce. 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 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

C3. Elective Recovery – Diagnostics

Pathology & Imaging Networks

- Pathology and imaging networks 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 innovatio**n, 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. Delivering Improvements in Maternity Care

- 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

D1. Urgent & Emergency Care

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.

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 >15% of calls received having clinical input

D1. Urgent & Emergency Care

  - 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) pro**vision and increasingly moving to a model where **UTCs act as the front door of ED,** to enable emergency
- 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 & build community services capacity to deliver more care at home & improve hospital discharge

Virtual Wards

- 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 wards 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.

D2. Transform & build community services capacity to deliver more care at home & improve hospital discharge

Urgent Community Response

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

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.

D2. Transform & build community services capacity to deliver more care at home & improve hospital discharge

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

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

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. Improving access to Primary Care – expanding capacity & increasing the number of appointments available

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.

Other key priority areas include:

- 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.
- 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.**
- From **April 2022** there will be a phased introduction of **two new DES services – anticipatory care and personalised care** – and an expanded focus on cardiovascular disease (CVD) diagnosis and prevention.

E. Improving access to Primary Care – expanding capacity & increasing the number of appointments available

- 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 condi**tions, 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.
- 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. 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**

F1. Expand and improve mental health services

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.
- Systems **maintain a focus on improving equalities across all programmes**, noting the actions and resources identified in the Advancing Mental Health Equalities Strategy

F1. Expand & grow mental health services

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 2021/22, as part of this process

F2. Meeting the needs of people with learning disability and autistic people

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 & address health inequalities

- ICSs will take a lead role in tackling health inequalities by building on the **Core20PLUS5 approach introduced in 2021/22**.
- 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.

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

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

- **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.

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

- 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 digital investment plans, funding will be directed towards those services/settings that are the least digitally mature.

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
- Ambition for the **NHS e-Referral Service (e-RS**) to become an any-to-any health sector triage, referral and booking system by **2025**. Mental health and other additional services are being evaluated for inclusion in 2022/23.

I. Making the most effective use of 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 NHSE 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.
- NHSE will shortly issue **one-year revenue allocations to 2022/23** and **three-year capital allocations to 2024/25**. NHSE intend to publish the remaining two-year revenue allocations to 2024/25 **in the first half of 2022/23**.

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.

I. Making the most effective use of resources

Financial Framework

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 NHSE. 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 & Collaborative System Working

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:

- CCGs will remain as statutory organisations
- 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, NHSE will consult with CCGs on changes to their boundaries, to align with the ICS boundary changes decided by the Secretary of State in July 2021. CCG boundary changes coming into effect from 1 April 2022 would support the smooth transition from CCGs to ICBs at the implementation date.

Next Steps

- Continue preparations for closure of CCGs & establishment of ICB's working towards new date, systems should ensure they have **clear & effective plans for local communications** & 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.** 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.**
- **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**.
- 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 ICS**s 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).
- 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 Engla**nd, such as **primary care** and some **specialised serv**ices.