Briefing Paper: NHS England Priorities and Operational Planning Guidance: October 2021 – March 2022

Key documents

NHSE Priorities and Operational Planning Guidance: Oct 21 – March 22 - full document

Related documents

NHSE Priorities and Operations Planning Guidance: 2021/22 - full document

NHSE Priorities and Operational Planning Guidance homepage - link

Neuro Alliance News, additional funding for NHS and social care - link

Introduction

This update to the NHSE priorities and operational planning guidance for 2021/22 reaffirms many of the priorities set out in the March guidance. It also reflects the new financial settlement for the NHS and the additional challenges in the six months ahead including winter pressures and the ongoing impact of the COVID-19 pandemic.

Briefing

The guidance reaffirms NHSEs commitment to the six priority areas set on in March alongside the recently announced additional funding for the health service. Priorities are:

A. Supporting staff health and wellbeing, recruitment and retention

B. Delivering COVID-19 vaccination programme and meeting the needs of COVID patients

C. Implementing pandemic learnings in delivery of service, restoration of elective and cancer services and manging demands on mental health services

D. Expanding primary care capacity improving access, outcomes and health inequalities

E. Prevent inappropriate emergency department (ED) attendance, reduce length of stay

F. Collaboration across systems to deliver the above.

Overarching commitment to improving the quality and presentation of health inequalities data including an ask of NHS Board performance reports to include reporting by deprivation and ethnicity.

Additional £5.4bn for second half of the year on top of the original mandate agreed by government including £1.5bn funding for elective recovery and cancer service recovery.

A. **Supporting staff** - The guidance urges systems to recognise the ongoing pressures on staff. Focus is on delivery of workforce plans to support elective recovery and winter resilience and moves towards whole system workforce planning to meet NHS priorities and prepare for transition to statutory integrated care boards (ICBs) from April 2022.

B. **Delivering COVID-19 vaccinations** - Plan to deliver on JCVI advice on booster vaccinations – ask that all eligible people are offered a booster vaccination by 1 November 2021 with delivery plans in place to meet target. Deliver on CMO's recommendations to offer first dose Pfizer vaccine to all 12- to 15-year-olds as quickly as is safe and practical. Investment in support for long COVID including 90 specialist clinics and 14 paediatric hubs. From Autumn long COVID waiting times and provider activity data will be made available. Focus on addressing variation in referrals and minimising long waits for assessments.

C. **Restoration of elective services** - Acknowledges elective recovery during the first half of the year has slowed due to non-elective pressures, rising COVID admissions and workforce constraints. Aim is to reach or exceed pre-pandemic levels of activity in the second half of the year, specifically:

    - Eliminate waits of over 104 weeks by March 2022 except by patient choice
    - Hold or reduce waits of over 52 weeks. Agree specifics through planning process.
    - Stabilise waiting lists around level seen at end of September 2021.

    Systems should utilise "elective high-impact changes and transformation opportunities" as set out in the March guidance (linked above) including:

- Referral optimisation and avoidance of unnecessary outpatient appointments. A minimum of 12 advice and guidance requests expected per 100 outpatient first attendances or equivalent via other triage approaches by March 2022. Demonstrable monthly increases in referral optimisation with assessments to monitor impact on patient experience and outcomes through Elective Recovery Outpatient Collection (EROC) dataset.
- Ensuring patient-initiated follow-up (PIFU) in place for at least 5 major outpatient specialities with 1.5% of all outpatient attendances moved to PIFU or discharged by December 21 and 2% by March 22. Monthly increases in proportion of outpatients moved to PIFU evidenced through EROC data set.
- Increasing remote consultations in outpatients where clinically appropriate with an overall share of 25% minimum.
- Considering digital-first elective care pathways with NHSX support.

Request for systems to propose targeted investments to increase activity focussed on highest priority elective recovery areas by 14 October.

Systems should continue to deliver on 21/22 Mental Health plans including ICS workforce plans, recovery of face-to-face community MH services, reducing lengths and stay and waits alongside progress on NHS Long Term Plan commitments.

D. **Primary care** - Focus on support for general practice and primary care networks (PCNs) specifically GP recruitment and retention and patient access. Asked to optimise the use of remote consultations and improve patient and staff experience.

E. **ED attendance and discharge** - Government will continue to fund first four weeks of post-discharge recovery and support services for those with new and additional care needed before 31 March 22. Joint planning across CCGs, local authorities and providers within the Better Care Fund to improve post-rehab outcomes, reduce long term care needs and length of hospital stays. Seasonal flu and ongoing impact of the pandemic are likely to exacerbate

winter pressures facing urgent and emergency care (UEC). Systems should embed UEC Action Plan.

F. **System collaboration** - Integrated Care Systems (ICSs) should continue to plan for statutory integrated care boards (ICBs) operational from 1 April 22. Systems and providers should submit elective recovery plans for October – March 22 and targeted investment plans (see above) by 14 October. Submit final plans for October- March 22 including key actions set out in this Operational Planning guidance by 16 November as per submission guidance.

Alliance thoughts

Given the ongoing challenges facing neurology and neurosurgery including around recovery of elective services and waiting times it is disappointing that neither speciality is not explicitly referenced in the updated Operational Planning Guidance.

The allocation of additional funding is welcome and necessary, particularly in relation to elective recovery. As part of the implementation guidance accompanying the March Operational Planning Guidance for specialised services, ICSs were asked to submit summaries of their recovery plans for elective activity. Key specialties were identified for additional focus in these plans, including neurology and neurosurgery.

Despite additional funding for elective recovery and an apparent increased focus on key specialties including neurology and neurosurgery, we are yet to see the material benefits in terms of reductions in numbers of people or waiting times to start treatment. We are also increasingly concerned about additional pressures and expectation being put on an already overstretched and under resourced neurology workforce.

What next?

We will continue to engage with NHSE/I, DHSC and other parts of the system at all levels on issues including elective recovery, specialised commissioning, neuroscience transformation and

outpatient transformation. Going forward we will continue to make the case for the necessary prioritisation of neurology and neurosurgery and hold the system and system leaders to account.

More specifically:

- We will continue to work with NHSE/I to develop guidance related to outpatient transformation, including the use of triage, advice and guidance, remote consultations and patient-initiated Follow-Up (PIFU)
- We remain on the NHSE/I elective care recovery taskforce, ensuring neuroscience has representation at the highest levels of NHSE/I strategy formulation
- We will continue to work with the National Neuroscience Advisory Group (NNAG) to design optimum pathways of care
- We will support the development of the neuroscience transformation programme, which will set out the future funding model for specialised neuroscience services in the coming months. This model is being developed ahead of ICS' being placed on a statutory footing in April 2022.

This will be even more vital as we move into winter with the addition of seasonal pressures, the ongoing impact of the pandemic and seasonal influenza likely to make a challenging situation even more difficult. It is vital that access to services and care for people with neurological conditions is maintained in the face of these challenges and staff are supported.

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