NHS 2021/22 priorities and operational planning guidance

NHS England and NHS Improvement (NHSE/I) published priorities and operational planning guidance for 2021/22 on 25 March 2021. This overarching document sets out six priorities for the year ahead, and asks systems to develop fully triangulated plans across activity, workforce and money for the next six months. These arrangements are supported by an additional £8.1bn of funding to reflect the ongoing impact of COVID-19. For any questions on this briefing, please contact amelia.chong@nhsproviders.org and isabel.lawicka@nhsproviders.org.

Key points

- In the context of responding to the ongoing challenges presented by COVID-19, while also restoring services, meeting new care demands and tackling health inequalities, the planning guidance sets out six priorities (and 17 sub-priorities) for the year ahead:
  1. supporting the health and wellbeing of staff, and taking action on recruitment and retention
  2. delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
  3. 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
  4. expanding primary care capacity to improve access, local health outcomes and address health inequalities
  5. transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
  6. working collaboratively across systems to deliver on these priorities.
- The government has so far committed £8.1bn to cover COVID-19 costs in 2021/22, of which £7.4bn is available over the first half of the year. A further £1.5bn has been allocated for elective recovery, mental health and workforce development. The full settlement for months 7-12 will be agreed once there is greater certainty around the circumstances facing the NHS in the second half of the year.
- Systems are asked to develop fully triangulated plans across activity, workforce and money for the first half of the financial year. Mental health plans are expected to cover the next 12 months. Draft plans are due by 6 May 2021 and final plans are due by 3 June 2021.

Summary of priorities

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

The workforce elements of the guidance note the extraordinary efforts made by trusts and frontline staff in adapting and innovating to confront COVID-19, while continuing to deliver other essential services. The emphasis on the need for staff recovery at the heart of service delivery and transformation is notable and welcome. There will naturally be activity and financial implications in supporting staff with wellbeing offers and time off to recuperate, which are considered in later sections of the guidance.

Systems are asked to review their people plans in first half of 2021/22, and give additional focus to equality, diversity and inclusion, creating compassionate and inclusive cultures, and increasing workforce supply. These areas were highlighted as part of the review of local plans in September 2020.

Looking after our people and helping them to recover

The guidance acknowledges the individualised nature of recovery and gives some suggestions as to how trusts can enable this for staff:

- Left over annual leave from 2020/21 is to be carried over and used by staff in 2021/22. To support this, system financial performance assessments will exclude higher accruals for annual leave in 2020/21.
- Individual health and wellbeing conversations (as per the People Plan 2020/21) are to become a regular aspect of staff management, resulting in annually agreed plans for staff, undertaken in the first half of this financial year. Plans should include risk assessment, flexible working options, compliance with infection prevention and control policy, and testing policy. The guidance encourages managers to draw on the range of preventative health and wellbeing support available in formulating these plans.
- Occupational health, wellbeing support, and psychological and specialist support should all be made available to staff. To facilitate this, national investment will be provided to roll out mental health hubs in each Integrated Care System (ICS).

Belonging in the NHS and addressing inequalities

This work is highlighted as an urgent priority, which is welcome and necessary but feels underdeveloped, as there are no clear actions or next steps listed. Instead, systems are asked to

develop improvement plans based on recent WRES data (with attention given to recruitment and promotion practices), and to accelerate delivery of model employer goals. NHS Providers will continue to support and share the action which trusts have been taking on this issue.

Embed new ways of working and delivering care

The guidance notes significant changes to ways of working that have been accelerated by the pandemic and gives a steer as to which changes should be embedded going forwards. NHS Providers have also published analysis of this area, which is wider reaching. The guidance focusses on:

- e-rostering, which should be utilised more widely and accompanied by providers demonstrating how they will meet the highest level of attainment in NHSE/I's meaningful use standards for e-job planning and e-rostering
- facilitating the continuation of staff movement within systems with remote working plans, technology-enhanced learning, and utilising staff digital passports.

Regarding staff movement across organisations, our view is that whilst there is a need to avoid command and control, and respect the role of leadership in systems, it would be useful for colleagues at a national level to be sighted overall on emerging risks from this approach. This would enable insight and issues to be shared at the earliest opportunity across systems through regional teams. We are aware of plans for System Quality Groups, which will have a role in identifying risks within a system, but it is not yet clear if they will be responsible for escalating insight upwards and sharing it with other systems. Further detail in this area would be useful.

Grow for the future

The NHS workforce has grown during the pandemic, due to innovative measures to increase staff numbers at pace. The guidance states that this growth needs to be made sustainable and deployed to meet measures set out in the NHS long term plan (LTP). Systems are asked to produce local workforce supply plans, though the guidance does not give a deadline for this work. The plans should cover recruitment and retention, collaboration between organisations, and wider labour participation in health and care system.

Ensuring that there are enough staff to cover existing workforce gaps and build flexibility into the system, is vital to ensure more realistic workloads and better work life balance for staff. However, the ask for systems to develop local workforce supply plans will not be effective without national funding for recruitment and retention initiatives, underpinned by a fully costed and funded national workforce plan. In addition, it is unclear how much weight will be given to the request for system workforce supply plans to support economic recovery, which could transpire to be quite a significant ask.

In addition to local workforce supply plans, the guidance sets out that:

- National investment should be utilised to increase numbers of Maternity Support Workers, and national interventions to bolster Health Care Support Workers and international nursing recruitment should also be engaged with.
- Clinical placement capacity should be planned for as a priority, to help students qualify as close to their intended dates are possible, and postgraduate training recovery plans are to be developed and implemented to integrate local training needs to service delivery. Both of these asks will require collaboration with education bodies and institutions.
- Workforce plans should cover all sectors, and support the expansion and development of integrated teams in the community. The guidance stated that primary care networks (PCNs) will be the foundation for this as they have Additional Roles Reimbursement Scheme funding, which should be utilised widely through the options of rotational or joint employment.

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

The COVID-19 vaccine will continue to be delivered through implementing a mixed model of vaccine delivery. This includes vaccination centres, hospital hubs, general practice and community pharmacy capacity. The model will vary depending on the needs of the local population. There will also be targeted approaches where required to drive uptake, particularly in underserved populations. Primary care will continue to play a key part in the roll out of the vaccine, with PCNs having the option to vaccinate those aged between 18 and 49 (cohorts 10-12).

Due to the lack of information about how long protection lasts once somebody has received a vaccine and given the possibility of new variants emerging, the Joint Committee on Vaccination and Immunisation (JCVI) will issue further advice in due course. Systems need to be prepared for a COVID-19 re-vaccination programme from autumn and the possibility of COVID-19 vaccination of children (should vaccines be authorised for use in under 18s and recommended by the JCVI).

PCNs will have an important, ongoing role in response to the pandemic that will involve the use of hospital-led 'virtual wards'. NHSE/I hope that COVID virtual wards may be able to support some COVID patients who would otherwise be admitted to hospital. Furthermore, NHSE/I confirm that national funding to maintain dedicated post-COVID assessment clinics will continue. NHSE/I will also conduct a stocktake of both physical critical care capacity and workforce, which will inform next steps in creating a resilient and sustainable service. This will include critical care transfer services.

NHS organisations are asked to ensure reliable application of the recommendations in the UK Infection Prevention and Control guidance.

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, taking full advantage of the opportunities to transform the delivery of services

In order to increase activity across elective inpatient, outpatient and diagnostic services, systems are asked to rapidly draw up delivery plans for the next six months that:

- maximise available physical and workforce capacity: this will range from adapting wards to segregate patients, improving elective care flow, and utilising the independent sector (IS)
- prioritise the clinically most urgent patients
- manage clinical risk by incorporating patient focused reviews and validating waiting lists
- proactively reach out to the clinically most vulnerable;
- provide analysis of waiting times by ethnicity and deprivation;
- safeguard the health and wellbeing of staff, allowing people to recover.

There should be a particular focus on restoring diagnostic activity volumes. Additional capacity and efficiencies should be delivered via community diagnostic hubs, and pathology and imaging networks. Systems should note how they will adhere to the recommendations of the Richards review.

Following the additional £1bn for elective recovery announced at the 2020 Spending Review, the Elective Recovery Fund (ERF) will be made available to systems that achieve activity levels above set thresholds (the levels funded from system envelopes). The threshold is set against a baseline value of all elective activity delivered in 2019/20 – for April 2021 it will be 70%, rising by 5% each month to 85% from July. Further information can be found in the accompanying implementation guidance.

The planning guidance makes it clear that trusts should continue to collaborate with the IS to ensure there is enough capacity across systems to deliver elective recovery plans. More work will be carried out over the next two months to explore how IS capacity can be most effectively utilised.
No specific timelines have been established for systems to restore activity to meet or exceed pre-pandemic levels. However, the guidance states that systems should identify approaches to tackle the backlog and (when feasible) to move beyond the 2019/20 baselines.

Providers are encouraged to demonstrate learning from other systems, and to take advantage of high impact changes and transformation opportunities to increase activity, in particular: clear accountability for elective recovery at system level; implementing high impact service models; implementing whole pathway transformations with support via the National Pathway Improvement Programme; and embedding outpatient transformation.

Restore full operation of cancer services

There is concern for people who have not contacted their GP with symptoms. To address this, systems should draw on advice from their Cancer Alliance to return the number of people waiting longer than 62 days to pre-pandemic levels, and to address the shortfall in the number of first treatments by March 2022.

In terms of operational performance, systems are expected to deliver against the new 28 day faster diagnosis standard from Q3 2021/22, with data being collected and published from Q1. Systems should also focus on improving performance against the existing cancer waiting time standards.

On behalf of their ICS(s), Cancer Alliances must establish delivery plans for April to September 2021 covering the following areas:

- Getting patients to come forward – the guidance recommends providers collaborate with public health commissioning teams to restore all cancer screening: an additional £50m investment has been made available for breast cancer screening, and NHSE/I will begin to extend bowel cancer screening to include 50-60 year olds.
- Investigate and diagnose – providers should extend the centralised clinical prioritisation and hub model to patients on cancer diagnostic pathways (starting with endoscopy where appropriate).
- Treat – embed the collaborative approaches of system working demonstrated throughout the pandemic (like the centralised clinical triage and surgical hubs), and agree personalised stratified follow-up pathways.

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

The guidance recognises how COVID-19 has caused a significant increase in demand for mental health services. NHSE/I has outlined how systems might expand capacity and transform mental health services, and support people with learning disabilities, autism or both.

NHS long term plan commitments on mental health

Systems are expected to meet the mental health ambitions outlined in the LTP, transforming core mental health services, and ensure services can implement the recommendations from the clinical review of standards for mental health. Key expectations include:

- increasing children and young people's access to NHS-funded community mental health services
- delivering physical health checks for people with Serious Mental Illness (SMI), particularly given that the Quality Outcomes Framework (QOF) indicators have changed
- delivering the scale of workforce growth needed to meet the LTP ambitions
- investing fully in community mental health (funding will be provided to create new integrated models for SMI, SDF funding will allow the expansion of services, and co-funding requirements across the NHS contract and GP contract will deliver additional PCN posts. New metrics will also be introduced assessing people who access community mental health services.)
- improving equalities across all programmes, noting actions and resources identified in the *Advancing mental health equalities strategy*.

Providers are also encouraged to advance the beneficial changes made throughout the pandemic, including (where clinically appropriate) 24/7 open access, staff wellbeing hubs, and crisis lines.

An additional £500m was announced at the 2020 Spending Review to address the impact of COVID-19. We welcomed the news last month that £79m will be allocated to children and young people's mental health services, but we still do not know the precise allocations of the total sum going forward.

Learning disabilities and autism

There is a recognised need to deliver the LTP commitments for those with a learning disability, autism or both. There are a range of actions outlined in the guidance, including:

- reducing reliance on inpatient care for adults and children with learning disability, autism or both, supported by improved community capacity to expand personalised care, closer to home
- improving accuracy of GP learning disability registers (with a particular focus on ensuring under-represented groups are recorded)
- continuing pilots and early adopter sites for keyworkers for children and young people with most complex needs
- implementing the actions coming out of the Learning Disability Mortality (death) Review (LeDeR) programme to tackle inequalities.

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

This year NHSE/I are committing to improving maternity safety. Their most recent board papers detail a £95m investment to meet the immediate and essential actions from the Ockenden report. The planning guidance stated that this figure would be 'more than £80m', so the £95m amount is extremely welcome. To support this work, local maternity systems (LMSs) will be accountable to ICSs for their safety. LMSs must also oversee the implementation of the seven immediate and essential actions from the Ockenden report across their local trusts.

Systems are asked to continue to strive towards the maternity transformation measures set out in the LTP. This requires a personalised care and support plan to be offered to every woman, implementing the Saving Babies' Lives Care Bundle, and working towards implementing the continuity of carer model of midwifery.

In February, NHS Providers wrote to the Health and Social Care committee, noting that more than £400m is needed in extra annual recurrent funding in order to increase numbers of maternity service staff, in line with the Ockenden report's findings. Whilst a fully costed and funded workforce plan is vital more generally, it is particularly key to improving maternity service safety.

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

Restoring and increasing access to primary care services

The commitment to a significant real-terms expenditure increase on primary and community health services will be met again in 2021/22. It is expected to support:

- restoring and increasing access to primary care services
- implementing health population management and personalised care approaches to improve health outcomes and address health inequalities
- transforming community services and avoiding unnecessary hospital admissions and improving flow, in particular on the emergency pathway.

Systems will be expected to prioritise local investment and support for PCNs to enable stronger integration with community services, helping their PCNs to:

- achieve their share of 15,000 FTE PCN roles to be in place by the end of the financial year, in line with the target of 26,000 by 2023/24
- expand the number of GPs towards the 6,000 target

- continue to make progress towards delivering 50 million more appointments in general practice by 2024.

Systems are also asked to support general practices to improve access for patients, enable all practices to deliver pre-pandemic appointment levels and offer face-to-face consultations. Systems should continue to support practices to increase online consultations, as part of embedding total triage. Systems will be expected to support their PCNs and general practices to work with local communities to address health inequalities. QOF indicators on long term condition management reviews, medication reviews and routine vaccinations will be re-introduced from April 2021.

Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities

Systems are encouraged to adopt population health management techniques as part of their targeted recovery strategies. NHSE/I will work with systems to develop the data tools needed to support this work, applying lessons from the COVID-19 vaccination programme. This includes risk stratification to identify those facing the greatest health inequalities. Systems should provide multi-disciplinary support in line with the NHS comprehensive model for personalised care. More information on tackling health inequalities can be found in the accompanying implementation guidance.

NHSE/I asks systems to develop robust plans for the prevention of ill health, covering both primary and secondary prevention deliverables as outlined in the LTP. Plans should set out how ICS allocations will be deployed in support of the expansion of smoking cessation services, improved uptake of the diabetes prevention programme and cardiovascular disease prevention. Systems should continue and where possible accelerate the delivery of personal health budgets, social prescribing referrals, and personalised care and support plans. Recruitment to three additional roles will support this: social prescribing link workers, health and wellbeing coaches, and care coordinators.

Transforming community and urgent and emergency care to prevent inappropriate attendance at ED improve timely admission to hospital for ED patients and reduce length of stay

Transforming community services and improve discharge

Every system is asked to set out plans to accelerate the roll out of the two-hour crisis community health response at home to provide consistent national cover (8am-8pm, seven days a week) by April 2022.

Community services will welcome confirmation of the continuation of the discharge to assess policy, and will now work towards improving length of hospital stays, with a particular focus on stays of between 14 and 21 days. In light of this, the first six weeks of additional care after discharge from an NHS setting will continue to be funded during the first quarter, and the first four weeks from the beginning of July. This position will be reviewed with government for the second half of the year.

Ensuring the use of NHS 111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments

Systems are asked to continue to progress the work already underway through NHS 111 First and Same Day Emergency Care (SDEC) Programmes. Specifically, systems should:

- promote NHS 111 as the primary route into all urgent care
- maximise the use of booked time slots in A&E, with an expectation that at least 70% of all patients referred to an emergency department by NHS 111 receive a booked time slot to attend
- maximise the utilisation of direct referral from NHS 111 to other hospital services (including SDEC and specialty hot clinics) and implement referral pathways from NHS 111 to urgent community and mental health services
- adopt a consistent, expanded, model of SDEC provision, including associated acute frailty services, within all providers with a type 1 emergency department to avoid unnecessary hospital admissions.

To assist the transformation of the urgent and emergency care (UEC) pathway, better understand pressures and monitor recovery, trusts are asked to roll out the Emergency Care Data Set to all services and begin to collect data for a set of new measures tested as part of UEC clinical review of standards. Systems are asked to measure:

- the time to initial assessment for all patients presenting to A&E
- the proportion of patients spending more than 12 hours in A&E from time of arrival
- the proportion of patients spending more than one hour in A&E after they have been declared clinically ready to proceed.

Working collaboratively across systems to deliver on these priorities

Effective collaboration and partnership working across systems

ICSs will be asked to confirm, by the end of Q1, delivery and governance arrangements to support delivery of the 2021/22 priorities. These must be set out in a memorandum of understanding (MoU), agreed with NHSE/I regional teams, and in line with the proposed new NHS system oversight framework. MoUs should also set out the oversight mechanisms and structures that reflect those delivery and governance arrangements, including the respective roles of the ICS and NHSE/I regional team. NHSE/I is currently consulting on the NHS system oversight framework.

Develop local priorities that reflect local circumstances and health inequalities

ICSs are expected to develop their own set of local health and care priorities in recognition of the varying range of circumstances and population health needs, and the challenges systems face in recovering services. These priorities must be aligned to the four primary purposes of an ICS: improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and helping the NHS support broader social and economic development.

Develop the underpinning digital and data capability to support population-based approaches

The guidance highlights the importance of digital innovation in meeting population needs, including joined-up person-level data across health and care partners, and analytical capability aligned across system partners. More detail will be contained in the forthcoming NHSX what good looks like framework. Systems are asked to commence procurement of a shared care record for a minimum viable product to be live by September, developing further to include wider data sources and use for population health by April 2022.

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

ICSs are expected to take steps during 2021/22 to deliver their four core purposes, and are asked to set out how they will organise themselves to support this through updating their system development plans (detailing how they will ensure their system has the necessary functions, leadership, capabilities and governance), as well as preparing to move to a statutory footing from April 2022, subject to legislation.

Implement ICS-level financial arrangements

NHSE/I will shortly issue system funding envelopes for the next six months. These will be based on the H2 2020/21 envelopes, including a continuation of the system top-up and COVID-19 fixed allocation arrangements. Envelopes will be adjusted to reflect a general efficiency requirement of 0.28%, with an increased requirement for systems that had deficits compared to 2019/20 financial trajectories at the end of 2019/20. The current block contract payments approach will continue for NHS providers. More information can be found in the accompanying finance and contracting guidance.

In addition, systems are asked to continue taking actions to strengthen their system financial governance arrangements and build collaborative plans to optimise system resources.

Process and timetable

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

Key tasks	Deadline
Templates issued • Non-functional activity, workforce • Narrative	Friday 26 March 2021
System financial planning template and SDF schedules issued	Monday 29 March 2021
Organisation (provider) capital and cash plan submission	Monday 12 April 2021
Finance plan submission • System finance plan submission • Mental health finance submission Draft plan submission deadline • Draft activity, workforce (primary and secondary care) and mental health workforce numerical submission • Draft narrative plan submission	Thursday 6 May 2021
Non-mandated provider organisation finance plan submission	w/b 24 May 2021
Final plan submission deadline • Final activity, workforce and mental health workforce numerical submission • Final narrative plan submission	Thursday 3 June 2021

NHS Providers view

After an incredibly turbulent year, the planning guidance sets out a framework for trusts – and their system partners – to plan for the months ahead with confidence.

Overall, the guidance strikes a balance between ambition and pragmatism. It is absolutely right that supporting staff health and wellbeing is a top priority, and that a realistic approach is being taken to elective recovery, with a clear focus on prioritising the most clinically urgent patients. Trusts will welcome the continued emphasis on collaborative working across primary and secondary care. The extension of COVID-19 finance and contracting arrangements until at least the end of September provides stability, and will give trusts breathing space to focus on the task at hand.

We also welcome acknowledgement of the unique challenges facing different parts of the provider sector. For example, the accelerated roll out of the two-hour crisis community health response standard will help measure progress and provide consistency of care across the country, and the continuation of discharge funding for the first half of the year is vital to reducing length of stay in hospital. The guidance recognises the increasing and new demands on mental health services, stresses the importance of this being adequately prioritised by systems and helpfully emphasises that meeting the Mental Health Investment Standard (MHIS) is a minimum requirement – not a cap. It is, however, disappointing not to see greater recognition of the role that ambulance services have played throughout the pandemic. Patient transport needs to be factored into the overall recovery strategy and ongoing pressure on the acute sector could impact on ambulance handover times. We will continue working with NHSE/I to understand and shape the implications of system working for specialised services.

However, with 17 sub-priorities sitting beneath the six headline priorities, the scale of the task facing trusts and their system partners should not be underestimated. On top of managing pressing operational demands, there is a renewed emphasis on service transformation, in line with the ambitions of the LTP. ICSs are asked to continue strengthening their approach to system finances, confirm delivery and governance arrangements to drive forward the 2021/22 priorities by the end of Q1, and take additional steps to prepare for the possibility of becoming statutory bodies from April 2022 – this has the potential to take up considerable leadership time, particularly for systems still in their infancy. Making meaningful progress on health inequalities is going to require action far above and beyond the next steps set out in the guidance, which focus on data collection and pre-existing prevention programmes.

There are also areas where it is difficult to see how significant progress can be made without additional support and investment. It looks increasingly likely that there will be a COVID-19 re-vaccination programme from the autumn, which needs to be resourced and staffed on a sustainable basis. We are still waiting for a fully costed and funded national workforce plan. The £1.5bn allocated for elective recovery, mental health and workforce development is welcome, but it is only an initial down payment and it will not be effective if it does not reach the frontline quickly. While out of the scope of the guidance, it is impossible to ignore the detrimental impact of prolonged government inaction on public health and social care, which directly affects the NHS.

We support the flexible and iterative approach to planning that NHSE/I is taking this year. This is entirely appropriate given that the full financial settlement for months 7-12 will not be confirmed until

there is greater certainty around the challenges and opportunities going into the second half of 2021/22. What we must avoid is a repeat of the situation seen earlier this month, when the NHS budget was only confirmed 13 days in advance of the new financial year. This kind of uncertainty risks compromising patient care, puts unnecessary pressure on staff and is entirely avoidable.

NHSE/I has maintained an ongoing dialogue with trusts throughout the pandemic. It is imperative that this continues across acute, community, mental health and ambulance services: no one knows exactly what COVID-19 will bring over the next 12 months and additional preparation will be needed heading into winter. There is a real opportunity for NHS to emerge from the pandemic stronger than it was before, if services are restored in a sustainable way.

NHS Providers press release

Planning guidance provides much needed clarity for the year ahead

Responding to the publication of the planning guidance, the deputy chief executive of NHS Providers, Saffron Cordery said:

"The planning guidance provides welcome and much needed clarity for the year ahead. It rightly acknowledges the extraordinary efforts made by trusts and frontline staff in dealing with the pandemic, adapting and innovating to confront COVID-19 while continuing to deliver other essential services.

"It is good to see the approach will place staff wellbeing at the centre of service recovery and transformation. Trusts and their partners are already looking at how they can help staff recover from an unprecedented period of sustained pressure, and will welcome the roll out of 40 mental health hubs.

"Ensuring that we have enough staff not only to cover existing workforce gaps, but to build flexibility into the system, is vital to ensure more realistic workloads and better work life balance. The calls for systems to develop local workforce supply plans will not be effective without national funding for recruitment and retention initiatives, underpinned by a fully costed and funded national workforce plan.

"Trust leaders agree on the need for further progress on equality, diversity and inclusion. However the planning guidance has not listed clear actions or next steps which are fundamental if we are serious about tackling health inequalities nationally and locally.

"We have also welcomed additional funding for elective activity to address the backlog of care created during the pandemic and will work closely with NHS England and NHS Improvement to ensure the funding flows effectively for trusts and patients. We also welcome the additional £95m made available for maternity services.

"We welcome the focus on clinical prioritisation in the guidance to ensure those patients most in need receive timely care, and recognise the need for sustained focus on cancer care and other services. The thresholds set do, to some extent, reflect the difficulties involved in scaling up this work as the threat from COVID-19 persists.

"The guidance highlights the importance of the vaccination programme. It is sensible to plan now for a possible booster campaign and extension of vaccines to children. However the extraordinary success of the programme so far should not disguise the fact that this is a huge logistical commitment which will need to be resourced and staffed on a sustainable basis.

"Similarly it is right to acknowledge the growing impact of long-COVID. The true impact of this is not yet clear, but it is already evident that it will be a major concern for years to come.

"We support the work to avoid unnecessary hospital admissions, which is an important element in steps to ensure a sustainable service. We welcome continued funding for discharges, but would like to see this made permanent to improve capacity for long term planning and to reduce uncertainty.

"We welcome plans to move forward with the roll out of two-hour crisis community health response standards, but it is crucial that funding reaches these services to help with the roll out.

"The additional £500m for mental health services secured last year is of course very welcome, but there is a risk that it is spread too thinly to make the difference people in need of mental health care and support really need, and deserve, to see. While a welcome £79m was allocated to children and young people's mental health services last month, we still do not have complete clarity on exactly where the rest is going to be targeted.

"The planning guidance provides much needed clarity for trusts and their partners for the year ahead. However it is important to remember that funding has only been allocated for the additional costs of COVID-19 for the first half of the year. This will need to be kept under close review as the true costs of the pandemic become clear.

"The operational burden that trusts and local systems are still bearing is huge. The planning guidance rightly seeks to establish priorities, but given the immediate pressures and the big task of recovery, the health and care sector will continue to face considerable challenges for the year to come."