Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

2018/19 Commissioning and Financial Plans

Governing Body meeting

E

2 November 2017

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Purpose of Paper

The CCG's Governing Body has previously approved a two year operational plan and two year financial plan covering 2017/18 and 2018/19 as required by NHS England's planning guidance issued last September. These plans were approved in the context of the agreement of a five year Sheffield Place Based Plan and the South Yorkshire and Bassetlaw system wide work.

This paper is designed to set out the proposed approach to refresh and update both the operational and financial plan for 2018/19 to reflect any changes required to the CCG's commissioning plans, in the context of changes in national policy and guidance, the increased financial challenges the CCG faces and work which has started to be progressed through the Sheffield Accountable Care Partnership (ACP) and South Yorkshire and Bassetlaw Accountable Care System (ACS) arrangements.

Key Issues

Through the ACP work streams with our key partners we are reviewing the Sheffield Placed Based Plan and whether it remains "fit for purpose" and in particular confirming the key priorities for action in 2018/19. We need to ascertain whether /how these impact on the existing financial plan for 2018/19. A short presentation will be made to the meeting providing the latest information on proposed 2018/19 priorities following the review agreed at the ACP board on 25 October 2017.

The level of financial challenge for 2018/19 is significant if the CCG is to deliver its previously agreed share of the South Yorkshire and Bassetlaw CCG control total- that is an in year surplus of £2.5m. This is because of underlying pressures carried forward, anticipated new demand and price pressures and essential investment set against a very modest c£13m cash uplift per previously announced allocations. The latest modelling with a substantial number of caveats/assumptions made is that at least £20.5m of QIPP (cash releasing efficiency savings) will be required in 2018/19.

Whilst two year contracts were agreed with all key providers by 23 December 2016 as required by NHSE, it was acknowledged as part of this process that contract variations would need to be issued for the start of 2018/19 to take on board agreed changes to activity profiles, national policy requirements and efficiency requirements. The CCG is commencing this process and needs to complete in the context of the refreshed plans.

Is your report for Approval / Consideration / Noting

Consideration and Approval

Recommendations / Action Required by Governing Body

The Governing Body is asked to:

- Consider and endorse the approach being taken to refresh the 2018/19 plans and the key priorities identified in the presentation
- Consider and approve the initial assumptions being used for the financial plan refresh including the proposed QIPP target of £20.5m

Governing Body Assurance Framework

Which of the CCG's objectives does this paper support?
ALL five of the key objectives set out in the GBAF

Are there any Resource Implications (including Financial, Staffing etc)?

We will need to ensure we have appropriate clinical and managerial resources to implement the plans.

Have you carried out an Equality Impact Assessment and is it attached?

Please attach if completed. Please explain if not, why not
Not applicable re the overall plan. EIAs will be carried out for individual transformation projects as required.

Have you involved patients, carers and the public in the preparation of the report?

Public and patients were involved in the preparation of the Sheffield Place Based Plan and will be consulted on key service transformation proposals as appropriate during 2018/19.

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1. Background

NHS England and NHS Improvement published NHS planning guidance on 22 September 2016. This confirmed a two-year approach to planning and contracting services, underpinned by a two-year tariff and two-year NHS Standard Contract. It provides an update on the national priorities for 2017/18 and 2018/19 – distilled into nine 'must dos' – and details the longer term financial challenges for local health and care systems. CCG allocations for 2017/18 and 2018/19 were previously notified in January 2016. NHS England have confirmed that there will be no new overarching planning guidance issued for 2018/19 but NHSE have issued letters setting out particular policy requirements for example in relation to Integrated Urgent Care and Ambulance Response standards which we need to take into account in the plan refreshes for 2018/19.

The CCG's Governing Body approved in February 2017 the two year operational plan for 2017-19 and approved the detailed initial budgets for 2017/18 having previously approved the two year financial plan covering 2017/18 and 2018/19 in January 2017. These plans were approved in the context of the agreement of a five year Sheffield Place Based Plan and the South Yorkshire and Bassetlaw system wide work.

Governing Body received at its development session in October 2017 a presentation which firstly reminded members of the key ambitions by each major service area such as elective care and mental health and what work has already commenced to deliver these ambitions. The presentation secondly looked at the level of QIPP financial savings that might be required for 2018/19 based on current information on financial pressures and provided a first view on how those savings might be achieved linked to progress against the Sheffield Placed Based plan ambitions. This paper now asks Governing Body to endorse the initial QIPP target as part of progressing the detailed refresh of the financial plan and contracts.

This paper is also designed to set out the proposed approach to refresh and update both the operational and financial plan for 2018/19 to reflect any changes required to the CCG's commissioning plans in the context of changes in national policy and guidance, the increased financial challenges the CCG faces and work which has started to be progressed through the Sheffield Accountable Care Partnership (ACP) and South Yorkshire and Bassetlaw Accountable Care System (ACS) arrangements.

The level of financial challenge for 2018/19 is significant if the CCG is to deliver its previously agreed share of the South Yorkshire and Bassetlaw CCG control total- that is an in year surplus of £2.5m. This is because of the level of underlying pressures we expect to carry forward from 2017/18, the anticipated new demand and price pressures and essential investment set against a very modest c£13m cash uplift per previously announced allocations.

Whilst two year contracts were agreed with all key providers by 23 December 2016 as required by NHSE, it was acknowledged as part of this process that contract variations would need to be issued for the start of 2018/19 to take on board agreed changes to activity profiles, national policy requirements and efficiency requirements. The CCG is commencing this process and needs to complete in the context of the refreshed plans.

2. Process to Refresh of 2018/19 Commissioning Intentions and Operational Plan

The Sheffield Place Based Plan, which was signed off in December 2016 by the CCG's Governing Body builds on the successes that Sheffield already has across the city, strengthens our collaborative single system approach to working and builds on the strategic case for change set out by the South Yorkshire and Bassetlaw ACS. It sets out the ambition of what we would like to achieve by 20/21, outcomes and goals for Sheffield.

As we approach the second year of implementation against this plan, work is being undertaken across the Sheffield system to reaffirm commitment to this ambition, and to identify and quantify priorities for delivery for year 2. Each of the work streams within the ACP is finalising these shared priorities, based on the update provided at the last Governing Body development session in September. It is expected that these priorities will form the basis for our work across the system in the coming year, and that following discussions at the ACP Board on 25 October 2017, they will be agreed in the first week of November. At the time of writing this report it is anticipated that it will be possible to share these proposals by way of a short presentation to Governing Body to allow agreement of the priorities for 2018/19 which will then be used to inform negotiations for the contract variations for 2018/19.

The priorities have to align to efficiency requirements, with the aim of ensuring a financially sustainable health and social care system and that CCG QIPP efficiencies, City Council efficiencies to meet social care pressures and Provider CIP plans are aligned to achieve joint objectives.

Sheffield partners are committed to working together to design an infrastructure which can evolve to support the new ways of working. To achieve sustainable transformation, the strategy will need to allow money to be spent where Sheffield people will get the greatest value (quality and benefit). To do this, there is recognition that over time:

- new contractual and payment mechanisms will need to support models that work across and beyond the current organisational boundaries,
- we will manage our resources as a single account for the city and

Contract form should support the national direction of travel towards a more integrated system. We have a responsibility to ensure that the contract does not get in the way of progression and, given the strong established networks both in South Yorkshire & Bassetlaw and Sheffield, we have an opportunity to jointly explore ways in which the contract can enable change. However we also need to be mindful that there are potential risks associated with moving away from Tariff which need to be considered carefully to avoid unintended negative consequences.

We aim to have any variation to existing contracts agreed and signed off before the end of December 2017. Mechanisms to achieve this are in place, which will require significant effort required over the coming months to deliver.

The detail of format and content for Operational Plans for 2018/19 is not expected to be published until Quarter 4 (January to March 2018), and will be completed as required.

3. Financial Plan for 2018/19

The CCG's existing financial plan for 2018/19 was established based on confirmed allocations and national business rules as follows:.

CCG allocations were published on 8 January 2016. These confirmed the following cash uplifts (a note of the national average uplift is included for information):

Cash Uplifts		2017 18	2018 19
Sheffield CCG Programme	£k	11,904	12,911
Sheffield CCG Programme	%	1.6%	1.7%
National CCG Programme	%	2.1%	2.0%
Sheffield Primary Medical	£k	1,375	1,469
Sheffield Primary Medical	%	1.8%	1.9%
National Primary Medical	%	3.1%	2.5%
Running Cost Allocation	£k	-20	-22
Running Cost Allocation	%	-0.2%	-0.2%

In October 2016 NHSE revised the opening baseline allocations for two specific issues – change in responsibilities between CCGs and specialised commissioning (IR rule change) and an estimated impact of the new tariff currency – HRG4+.

The impact of the two adjustments is as follows:

£'000s	2017 18	2018 19
IR adjustment	-1,232	-1,252
Tariff adjustment	-2,190	-2,225
	-3,422	**-3,477**

The national planning guidance issued last year set out a set of business rules which we need to comply with as set out in the table below.

CCG Financial Business Rules 2017/18 and 2018/19
CCGs should have a minimum 1% cumulative surplus at the end of each financial year
CCGs should set aside 1% of their allocation for non-recurrent use. 0.5% to be uncommitted and held as risk reserve to support the STP position; and 0.5% immediately available for CCGs to spend non recurrently, to support transformation and change implied by STPs;
CCGs should hold a 0.5% uncommitted general contingency at the start of the year to manage their in-year pressures and risks;
CCGs have to plan for in-year breakeven adjusted for draw up/ (draw down)

Key Assumptions

The finance team have reviewed the key assumptions used for the original 2018/19 plan and consider most of these remain valid at this time, although a number of the subsequent pressures have changed with updated baseline data for 2017/18. The high level assumptions are summarised on attached **Annex A.**

Impact of the Assumptions and Compliance with Business Rules

The table 1 below summarises the incremental increase in cash resources expected to be available to the CCG (excluding those for delegated primary care commissioning which will be separately considered by the CCG's Primary Care Commissioning Committee), together with a first assessment of likely pressures and investment requirements. These will need to be kept under review and refined as we work through the commissioning intentions refresh mentioned above and depending on how things progress with for example the delivery of 2017/18 QIPP programme and any further national policy requirements. A potentially particularly important issue is whether there will be any change to allocations, national tariffs and/or efficiency requirements if there is a change to the 1% pay increase assumptions on which the original 2018/19 plan was put together.

Table 1:

	£m	**£m**
Cash Uplift		(12.9)
a) Pressures from this year		
- Potential shortfall against QIPP plan	8.1	
- Other Pressures	8.6	
- Recurrent release of reserves	(7.0)	
		9.7
b) New Recurrent Pressures		
- Price	3.9	
- Acute Demand incl High Cost Drugs	5.7	
- CHC including Transforming Care	2.5	
- Prescribing volume & price	3.4	
- Mental Health	3.1	
- Recreate General Contingency	3.8	
		22.4
c) Non Recurrent Pressure		
- Increase surplus	2.5	
- Less prescribing benefit returned in 17/18	(1.2)	
- Any under delivery of 2017/18 position	0.0	
		1.3
Potential QIPP Requirement		**20.5**

The table reflects our current projection on how we will end 2017/18. There are 3 key components to this: 1) We will deliver our forecast £1.6m in year surplus. 2) We are likely to deliver this in part by non recurrent measures. 3) We have recurrent pressures which we need to plan to assume will continue at the same level in 2018/19 before we take any new QIPP actions. In total these would result in a £9.7m pressure being taken forward

into next year. Clearly significant efforts continue to reduce this pressure to support an improved opening position for 2018/19 if possible.

Based on the assumptions outlined in Annex A, we could have new pressures of £22m. The assumptions behind these pressures are still being "stress tested" and could both increase or decrease as more information becomes available.

Finally we have a non recurrent pressure of either £2.5m or £1.3m depending on NHS England decisions on the treatment of the projected category M price benefit which they are retaining centrally in 2017/18 but have indicated will be returned to CCGs. We are assuming this will happen in 2018/19.

As can be seen from table 1, the level of pressures set against the cash uplift we expect to receive creates at £20.5m cash releasing efficiency (QIPP) requirement.

How might QIPP be delivered?

We discussed at the development session in October how we might achieve a £20.5m QIPP. It is important to highlight that this QIPP would need to increase if we require new recurrent investment to support delivery of the service transformation involved. In this regard we would seek to access any national funding eg through the ACS or Five Year Forward View processes in the first instance.

We looked at the potential opportunities for QIPP compared to progress against our ambitions as set out in the Sheffield Place Based plan. We considered for example the ambition to reduce outpatient attendances and follow ups by 20% from 2016/17 baselines by 2020/21 and the ambition to reduce urgent inpatient admissions by 30% to the same timescale. We considered current progress in areas such as the joint mental health transformation programme and for children's services. We reflected on the very good progress that continues to be made to achieve cost effective prescribing but recognised there remains potential for further improvements. We also recognised that there are some areas of spend where it will be very difficult or inappropriate to make cash releasing efficiency savings in 2018/19 for example in our contract for ambulance services. Thus we recognised that where we target QIPP savings needs to reflect where we have the greatest opportunities and reflect that we have investigated opportunities against the full £839m of our expected allocation.

The summary in table 2 below reflects these discussions and Governing Body is being asked to endorse this as an outline plan as we move into the phase over the next few months of establishing whether we can put proposals and schemes in place with our key partners in the city. This work is already in progress through out clinically led CCG portfolio teams, through the ACP workstreams each sponsored by a Chief Executive from across the partner organisations in the city and through the contract refresh discussions.

Table 2

2018/19 QIPP: How might we deliver?	£'m	As % of total Budget	Budget £'m
Elective Care	4.7	4.6%	103
Urgent (excl XBDs) - incl via MH programme	7.0	5.4%	130
MSK contract (QIPP built in)	0	0.0%	45
Excess Bed Days (XBDs)	0.8	13.3%	6
Maternity, Direct Access, Critical Care & Other	0.5	1.0%	50
Ambulances	0	0.0%	24
Community including voluntary sector - adults	1.5	2.1%	70
Local Authority including Pass through grants	0	0.0%	21
Children's' services incl CAMHs	0.5	1.4%	35
Primary care	0	0.0%	84
GP Prescribing & Acute High Cost Drugs	2.0	1.8%	112
Continuing Care (including high cost MH & LD)	2.0	3.4%	58
Mental health acute spend	1.0	1.3%	80
Running Costs	0.5	3.8%	13
Reserves required by NHSE	0	0.0%	8
	20.5		839

4. Recommendations

Governing Body is asked to:

- Consider and endorse the approach being taken to refresh the 2018/19 plans and the key priorities identified in the presentation
- Consider and approve the initial assumptions being used for the financial plan refresh including the proposed QIPP target of £20.5m

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Annex A

Key Assumptions

This section sets out the key assumptions being used in the draft financial plan.

1. Comply with NHSE Business Rules

   Return to cumulative reserve (surplus) of 1%: The CCG has a statutory duty of financial breakeven but NHS E planning guidance requires each CCG to plan for a cumulative reserve (surplus) of 1%. For 2018/19 we need to move to full compliance with this 1% as part of the overall SY&BL CCG control total – increase of £2.5m.

   Spend 1% of our allocation non recurrently. CCGs should plan for 1% non-recurrent spend. 0.5% has to be uncommitted at the beginning of the planning period and held as risk reserve as part of STP wide arrangements; and 0.5% is available immediately for CCGs to spend non recurrently.

   Maintain a 0.5% (£3.8m) general contingency reserve. This is the third national financial planning requirement. We have a number of risks which are not included in the plan but if/when they crystallise would need to be a call on this contingency reserve. Thus it is essential that we start the year with this contingency reserve un-committed and not used to offset any shortfalls in QIPP proposals.

2. Base opening budgets on an assessment of 2017/18 recurrent spend: For each contract or service area the finance team have made an assessment of the recurrent baseline requirements using the latest intelligence on 2017/18 spend. This needs further testing with contracting and portfolio colleagues.

3. Use national assumptions on Inflation & Tariff Efficiency with minimal exceptions:
   National tariff inflation will be 2.1% for 2018/19. In addition, the impact of increases to CNST premiums will be added to specific HRG chapters. The estimated impact of this is an additional 0.5% to national tariff prices for both years.

   Tariff efficiency has been confirmed at 2%. Hence the net tariff uplift is 0.1% (or 0.6% including CNST). This is before any change that might be made nationally if pay inflation is re-assessed.

   CQUIN. National arrangements for CQUIN have been amended for 2017/18 and 2018/19. Of the 2.5% CQUIN, the 1% previously associated with the local CQUIN indicators will be assigned to support providers locally. 0.5% will be available subject to full provider engagement and commitment to the STP process. In effect, this will be a cost free indicator for providers with clear scope for providers to earn the full amount. The remaining 0.5% will be held in a risk reserve. If a provider delivers its control total in 2017/18, the CQUIN will be paid to the provider, who will be required to hold it as a reserve until release is authorised (with CQUIN for 2018/19 linked to delivery in 2017/18). For providers that do not accept or deliver their control totals in the prior year the 0.5% CQUIN will be held by the CCG prior to potential release. In both instances this element of the risk reserve will be released for investment by the relevant providers when it is demonstrated that the system in question is delivering its control total.

1.5% of the 2.5% will be linked to delivery of nationally identified indicators. The indicator set has been streamlined, and with different indicator sets for different provider types. The financial plan assumes that 100% of CQUIN will be earned by providers, there is potential that providers will struggle to achieve some of national indicators which might give us some in year mitigation of other risks.

GP prescribing is the one budget line where we have applied NO separate price increase or reduction as prices are set nationally through national negotiations or by individual suppliers and the CCG has no control over price setting. Instead a provision for growth in activity/price fluctuations is made within cost pressures currently equating to 3.5% of budget before QIPP. Further work is required to fully model activity growth, expected price changes and the expected impact of new drugs/drugs coming off patent.

4. Demand led Activity Pressures: A critical element of the financial planning process is to identify any demand led pressures. This work is ongoing but table 1 includes the current assessment.

5. Running Costs: The national planning guidance makes it clear that CCGs will receive an RCA separately from their commissioning allocation. CCGs are not allowed to overspend against this allocation but can plan to underspend against the allocation and can use any in year underspend to support commissioned activities. The financial plan assumes we will need to fully utilise our allocation except for £0.15m which can contribute to our surplus requirement in 2018/19.