Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

NHS Sheffield CCG Activity and Financial Plan Submission April to September 2021 (H1)

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Governing Body meeting

6 May 2021

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Purpose of Paper

The purpose of this paper is to present a summary of the CCG's Activity and Financial Plan 2021/22 submission to NHS England and Improvement (NHSE/I) for the six month period April - September, prepared in the context of the recently issued planning guidance. The paper outlines the key issues and risks for consideration.

Key Issues

- Governing Body approved the initial full-year financial plan for 2021/22 at its meeting on 4 March 2021 and considered some of the initial financial challenges.
- Subsequent to approval of the financial plan, NHSE/I issued planning guidance for the first six months of 2020/21, referred to as 'H1' in the paper ie the first half of the financial year, April to September 2021. The arrangements are similar to those in place for the latter six months of 2020/21.
- As part of the revised national planning guidance, updated System and CCG allocations were issued in March 2021 relating to the period H1 only. The allocations are based on a fixed envelope calculated nationally plus an agreed share of system resources.
- The CCG has submitted draft activity trajectories that are in line with the targets set out in the planning guidance in regards to elective activity recovery. The draft plan is also in line with the SY&B ICS ambitions for the same.
- The CCG has submitted a balanced financial plan which remains predicated on the delivery of a QIPP programme of £3.0m, alongside other mitigations to deliver a balanced position.
- The CCG has identified a range of risks, which for the purpose of the planning return, we have assumed have equal levels of mitigation to deliver a balanced, risk adjusted financial position. However these risks will need to be carefully monitored and where appropriate actions agreed to manage these risks.

Is your report for Approval / Consideration / Noting
Consideration and **noting**
Recommendations / Action Required by Governing Body
The Governing Body is asked to: • Note the submission of activity trajectories that are in line with targets set out in the planning guidance • Note the submission of a balanced financial plan for H1 2021/22 • Consider the key risks and issues to the delivery of the financial plan for H1
What assurance does this report provide to the Governing Body in relation to Governing Body Assurance Framework (GBAF) objectives?
Which of the CCG's Objectives does this paper support? Strategic Objective - 4. Improve health care sustainability and affordability. It supports management of the CCG's principal risks 4.1 and 4.7 in the Assurance Framework.
Are there any Resource Implications (including Financial, Staffing etc)?
None in respect of the plan submission, but there are significant staff resource implications for the CCG to be able to effectively deliver the service transformation requirements within the QIPP plan.
Have you carried out an Equality Impact Assessment and is it attached?
Not Applicable
Have you involved patients, carers and the public in the preparation of the report?
Not applicable

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1. Introduction

1.1. National planning guidance was published on 25th March 2021 and detailed the national priorities for the NHS for 2021/22, alongside confirmation of financial allocations for systems for the first six months (referred to as 'H1 21/22'). As previously confirmed to Governing Body, the normal timescales for the issuing of guidance and the production of plans was delayed by the national response to the latest wave of the pandemic.

1.2. The guidance recognised the current challenges that the NHS faces due to the COVID pandemic and the need to now restore services. The priority areas are listed below:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention.
- Delivering the COVID vaccination programme and continuing to meet the needs of patients with COVID-19.
- 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.
- Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments, improve timely admission to hospital for ED patients and reduce length of stay.
- Working collaboratively across systems to deliver on these priorities.

1.3. This year, plan returns are required to be submitted at an ICS system level which is in line with the Integrating Care white paper. Although submissions will be accumulated at a system level, each organisation and place is required to provide the granular level of detail on the various areas, to ensure a system position is created and informed from each place's priorities.

1.4. The purpose of this paper is to update Governing Body members on the assumptions made in the draft submissions (which will have been submitted ahead of the Governing Body meeting) as well as key issues and risks.

1.5. The submission timeframe is detailed below:

- SY&B ICS first draft submission 6 May 2021 (this is the only submission for the CCG's financial plan)

- SY&B ICS final submission 3 June 2021

1.6. The templates that are required to submitted include:
- Financial plans for the first six months 2021/22
- Activity trajectories for the first six months of 2021/22
- Workforce trajectories for the first six months of 2021/22
- SY&B ICS system plan detailing priorities, risks and actions

2. Draft Activity trajectories

2.1. It is widely acknowledged that the pandemic has had a significant impact on the delivery of elective care and this is recognised within the planning guidance for 2021/22, which details an ambitious plan to recover to previous levels (2019/20) of activity and beyond where possible.

2.2. The national targets recognise the ongoing challenges in re-establishing affected services and workforce recovery. The targets as a percentage of the value of the 2019/20 activity are:

- 70% for April 2021
- 75% for May 2021
- 80% for June 2021
- Then 85% from July to September 2021

2.3. A draft plan has been submitted for Sheffield that assumes we will meet these targets in regards to elective activity recovery. The draft plan is also in line with the SY&B ICS ambitions of:

- 85% of elective activity to be included within core funded baselines
- Date and treat all P2 capacity in 28 days by end of Qtr1
- Clear 52 ww by end of March 22
- Average waiting times in 18 weeks rather than 92% RTT

2.4. Whilst these ambitions are very challenging, Sheffield will be working towards achieving these throughout the year, with the biggest challenge being those patients who have exceeded the 52-week period. The longest waiters will be addressed on the basis of clinical need and urgency, as well ensuring health inequalities are tackled throughout the plan, with a particular focus on analysis of waiting times by ethnicity and deprivation as detailed within the planning guidance. Therefore, incorporating clinically led, patient focused reviews and validation of the waiting list on an ongoing basis to ensure effective prioritisation and managing clinical risk. Effective communication with patients will be embedded throughout the process including proactively reaching out to those who are clinically vulnerable.

3. Financial Plan submission

3.1. Governing Body approved an initial full-year financial plan for 2021/22 at its meeting on 4 March 2021, in line with the requirements of our Prime Financial Policies, and considered some of the initial financial challenges. It was acknowledged at that NHS England and Improvement had confirmed that national planning guidance was delayed due to the focus of national resources on the response to the COVID pandemic. At that point it had been confirmed that, for at

least the 1st quarter of 2021/22, the financial regime that had operated in the second half of 2020/21 would be rolled forward.

3.2. The planning guidance issued on 25 March confirmed the details of the finance and contracting arrangements for the six-month period from 1 April 2021 to 30 September 2021 (referred to as 'H1' i.e. the 1st half of 2021/22).

3.3. Considerable work has taken place across SY&B ICS to agree the distribution of system resources, understand the CCG allocations and therefore support the development of a financial plan and budgets for H1, building on the work undertaken for the initial financial plan but updated for the latest guidance.

4. System and CCG Allocation Envelope

4.1. As in 2020/21, funding has been allocated on a system basis, i.e. individual CCG allocations plus additional system funding plus funding for providers received from outside the system envelope as summarised in table 1 below.

Table 1: SYB System Envelope Month 1 - 6	**SYB ICS**
	£000
CCG Allocations	1,291,618
Total Growth Funding	10,356
System Top-up funding	74,372
COVID Funding	72,040
Support for NHS provider other income loss	3,580
Funding for free car parking for patient and staff groups	519
System top-up adjustments due to SpecComm corrections	43
Transfer of specialised high cost drugs and devices fundin	(2,612)
CNST inflation	1,757
H1 System envelope funding	**1,451,674**

4.2. The national process for calculating system allocations is summarised as follows:

- Programme allocations have been calculated based on the same methodology as for 20/21 M7-M12 i.e. based on envelopes for 2020/21 M7-M12 adjusted for known pressures and policy priorities
- Allocations for primary care have been re-calculated resulting in additional funding for the GP contract settlement
- Allocations for running costs remain as the original allocation
- Further adjustments were made for programme spend, linked to independent sector spend and also for the Mental Health Investment Standard
- The growth, top-up and COVID system funding has been distributed following internal discussions within SY&B ICS.

In addition to the system allocation, NHSE/I has confirmed additional non recurrent Service Development Funding (SDF) to support transformation projects £14.3m (of which £10m relates to ICS funding for which Sheffield CCG acts as the host).

4.3. A proposal on the distribution of the system resource, which recommended a similar approach to the distribution of resource in H2 20/21 to support stability, was approved by the ICS Health Executive Group.

4.4. Of the £1.4bn, Sheffield CCG is planning to receive £483m in our own right, £15m as host to the ICS and a further £62m of additional funding for our Sheffield Providers, as summarised in Table 2 below. It is worth noting that the share of the system wide resources (Growth funding + top ups + Covid funding + Provider income loss) allocated to Sheffield organisations (CCG + providers) accounts for 38% of the total funding available.

Table 2: Sheffield CCG Resources	**Sheffield CCG**	**SY&B ICS**	**Sheffield Providers**	**Total**
	£000	**£000**	**£000**	**£000**
Programme	425,682	-	-	425,682
Primary care delegated	44,410	-	-	44,410
Running Costs	5,577	-	-	5,577
National surplus allocation adjustment	(9,026)	-	-	- 9,026
Baseline Allocation	**466,643**	**-**	**-**	**466,643**
				-
System Funding				-
Growth Funding	1,873	-	2,961	4,834
COVID Funding - make good national surplus allocation adjustment	9,026	-	-	9,026
COVID Funding	766	5,000	23,108	28,874
System Top up	-	-	33,713	33,713
Provider income loss	-	-	2,243	2,243
SDF Allocations	4,213	10,360	-	14,573
				-
Total allocation	**482,521**	**15,360**	**62,025**	**559,906**

4.5. This represents a total increase in resources for the CCG, compared to the H2 20/21 funding, of £7.4m or 1.5% (of which £4.7m (1%) relates to programme and £2.4m (5.7%) relates to delegated primary care).

5. Key issues

5.1. Governing Body received, in its session on 4 March 2021, a paper setting out the key issues, assumptions and annual budgets for approval; noting that the financial guidance for 2021/22 had not been published at that time. The assumptions utilised for the initial budgets have been refreshed to take account of the final 20/21 outturn as well as the national planning guidance. As with the allocations received for the last 6 months of 20/21 (H2 20/21) we have identified issues within the national financial framework which result in additional pressures that will need to be managed. The key issues are as follows:

- Prescribing growth – the national model uses the 20/21 H2 envelope (which we had previously confirmed was insufficient to meet our actual spend) and allows for 0.68% cost growth. Historic increases in CCG prescribing spend, which would take into account delivery of significant QIPP (efficiency) savings, are always significantly above 0.68%. In 2020/21, Sheffield CCG the year on year growth in spend was circa 6% (mainly due to cost per item increases, rather than volume).

- CHC growth – as with prescribing, the H2 funding was insufficient to meet the recurrent costs already in the system. The national model allows for a 1.56% increase in costs for CHC and 3.4% for FNC. Nursing Home fee rate increases for CHC, agreed alongside Sheffield City Council rates, are around 4.12%, reflecting

the projected increase cost of delivery (including the increases to the national living wage), support the need for skilled and effective staff, retention and recruitment and recognising that rates in Sheffield have historically benchmarked relatively low (for a variety of reasons).

- Primary care delegated – the budget has been uplifted by the expected growth alongside some additional new allocations to reflect national priorities. The budgets have been calculated to reflect the requirements of the GP contract settlement uplift. It also assumes the Additional Roles Reimbursement Scheme allocation is utilised in full, excluding the element confirmed as being retained centrally. There is a significant shortfall on this budget compared to the allocation which is due to cost pressures within the GP locum budget, the recurrent shortfall carried forward from 20/21 and the requirement to set aside a 0.5% contingency.

- NHS Block Contracts – the blocks values have been uplifted by 0.5% in line with the national guidance (0.7% inflation (which excludes Agenda for Change pay awards which are still to be confirmed) less 0.28% efficiency).

- COVID budget – a budget of £766k has been allocated to the CCG as part of the system envelope, which is in line with expected commitments. The plan assumes no additional or on-going costs associated with the Hospital Discharge Programme and that if they arise they will be funded separately as they have been in 20/21 i.e. in addition to the allocations shown in Section 2.

6. Summary Financial Position

6.1. Having updated the financial plan for the above assumptions and issues, we are forecasting a deficit of £6.5m, before mitigations. Appendix 1 provides a breakdown of this position which is summarised as follows:

Table 3: Financial Plan Overview H1 2021/22

	£m
Uplift to resources	(7.4)
Recurrent deficit from H2 20/21	2.7
2021/22 New Cost Pressures	7.6
2021/22 New Investments/pre-commitments	3.6
Net Pressure H1	**6.5**

6.2. The £6.5m deficit above takes no account of the any forecast QIPP savings, above the NHS provider efficiency inherent in the block uplift. If the CCG were to deliver the same ask of providers ie 0.28% on its own budgets excluding the NHS blocks, this would deliver £0.5m savings. However, in the initial plan approved by Governing Body in March we outlined an identified QIPP plan of £5.2m full year. Whilst it would increase the ask on teams, I have built into the submitted plan an expectation that in H1 we will be able to deliver a QIPP programme of £3m, broken down as follows:

Table 4: QIPP	**£m**
Continuing Healthcare	1.25
Prescribing (including Stoma)	1.50
Running Costs	0.25
Total	**3.00**

6.3. The CCG has historically been required to start the year with a 0.5% contingency on all its budgets which would require a budget of £2.1m for the six months (which is built into the pressure noted in 6.1 above). I believe that there is some flexibility in this requirement for H1 and have proposed to reduce the contingency to equate to 0.5% on budgets excluding provider blocks which are assumed to be fixed. This reduces the financial deficit by £1.5m.

6.4. The 2 measures outlined in section 6.2 and 6.3 would reduce the financial deficit by £4.5m to £2m. I have forecast that this remaining pressure could be met through the following assumptions:

- Utilisation of the remaining contingency reserve (£0.6m) but this would leave no contingency to manage any additional in year pressures
- Assumed slippage on forecast spend (£1m)
- Additional income/allocations that could be utilised to support the bottom line (£0.4m) which was mainly how we balanced in H2 20/21.

6.5. None of the assumptions outlined above can be built into the financial plan submission and so for the moment these are shown in the plan submission as additional unidentified QIPP.

6.6. A summary of the position noted in this report was discussed with the senior management team on 28 April, and a briefing prepared for the CCG Chair and the AIGC Chair. The discussions supported my proposal to submit a balanced financial plan, noting a level of risk inherent in this position. As a result, the finance team have submitted a balanced financial position to the ICS finance team. This will be consolidated alongside the plans from the other CCGs and NHS providers in South Yorkshire and Bassetlaw in order that the system financial plan can be submitted to the regional NHS England and Improvement team on 6 May. At the time of writing my understanding is that the other CCGs and NHS providers are also planning to submit balanced plans.

7. Risks

7.1. As part of the financial plan submission, we are required to assess the level of potential risks which we have not included in the budgets and what actions /options we have available to mitigate those risks.

7.2. Key risks to delivery of the financial position are summarised below:

- Prescribing – the level of growth forecast for 2021/22 is below that experienced in recent years and does not build in any assumption regarding nationally changes to Cat M or any horizon scanning regarding new drugs that could place additional pressures on the prescribing budget. HIGH RISK
- Independent Sector activity – the plan is based on the baseline level of activity within the funding envelope. Any activity above baseline is assumed to be funded from the Elective Recovery Fund, but this will be dependent on performance at a system level on a month and month basis. There is potential if funding is received in full at 120% of tariff, we will receive additional resource above plan but there is also a risk that we incur costs but receive no/insufficient additional funding. LOW RISK

- Primary Care – the plan includes a number of cost pressures, but there is potential for additional cost pressures that could materialise particularly in relation to locums which have seen a significant growth in the last 12 months. There is a level of contingency within primary care that could be utilised to offset identified pressures. LOW RISK
- CHC - the growth in the number of CHC cases is based on historic levels, although we have seen a growth in palliative cases over the last six months. The plan assumes that this growth will stabilise. There is a risk that we could experience a growth in expensive home care packages but this risk is being managed by active case management by the CHC team. MEDIUM RISK
- Phasing of expenditure – one of the main issues in compiling a plan for six months relates to the assumed phasing of expenditure, which in a number of cases assumes a smooth level of spend. The reality may be somewhat different which will have implications for how we balance the first six months and the level of financial pressure/benefit carried forward (if indeed the financial arrangements allow/require the position being carried forward into the second six months. MEDIUM RISK
- Service Development Funding (SDF) – the plan assumes that the level of spend equals the SDF funding received. There has been a significant level of movement in the SDF assumptions issued by the centre. We have currently raised queries about the level of funding assumed to be embedded within the brought forward allocation that could bring with it additional cost pressures. Balancing the plan is predicated on some slippage on new allocations, and, as funding is allocated for the first 6 months and we are already into the second of those 6 months, the potential for slippage is reasonable to assume, although this would then potentially lead to further pressures into the second half of the year. LOW RISK
- COVID budget – the plan assumes that spend is in line with the funding available. However there is a risk that further pressures are experienced over the first 6 months that required additional funding. LOW RISK
- QIPP – as noted above that whilst we have an outline plan for QIPP we still need to agree detailed delivery plans. Our Medicines Optimisation and CHC teams are working on these plans but we also know that a number of our key staff continue to support other areas of work related to the covid response (including vaccinations and hospital discharge). Again as we are in the second month of H2, the ability to deliver £3m in the remaining 5 months is challenging. HIGH RISK

7.3. For the plan submission we have assumed that the upside/downside risks will compensate to be able to deliver a balanced, risk adjusted plan. However, clearly this will continue to be carefully reviewed by the finance team, with updates provided to governing body members as part of the monthly financial report.

8. Recommendations

The Governing Body is asked to:

1. Note the submission of activity trajectories that are in line with
2. Note the submission of a balanced financial plan for H1 2021/22
3. Consider the key risks and issues to the delivery of the financial plan for H1

Paper prepared by:	Diane Mason, Senior Finance Manager Jackie Mills, Director of Finance Sandie Buchan, Director of Commissioning Development
On behalf of:	Jackie Mills, Director of Finance Sandie Buchan, Director of Commissioning Development

April 2021

Appendix 1

Financial Plan Overview 2021/22

	£m	£m
Uplift to resources		
CCG Programme Uplift	(4.7)	
CCG Primary Delegated Uplift	(2.7)	
		(7.4)
2020/21 Issues		
Underlying Recurrent Deficit		
Primary care delegated	1.0	
Prescribing	1.1	
CHC/FNC	0.9	
Other budgets	(0.3)	
		2.7
2021/22 New Pressures		
Inflation uplifts (excl prescribing)	3.1	
Efficiency NHS Blocks	(0.9)	
Recreate 0.5% contingency	2.1	
Prescribing growth	1.5	
CHC Growth	1.0	
Other cost pressures including community equipment	0.8	
		7.6
2021/22 New Investments from CCG Baseline		
Pre-committed expansion of Primary & Community MH	1.1	
Mental Health Investment Standard (excl MH uplifts)	2.2	
Other pre-commitments	0.2	
		3.6
Net Pressure		**6.5**
Mitigations to reduce gap		
QIPP		
NHS Efficiency requirement	(0.5)	
Additional CCG QIPP	(2.5)	
		(3.0)
Reduce contingency to 0.5% excluding NHS blocks	(1.5)	
Utilise balance of contingency to offset pressures	(0.6)	
		(2.1)
Assumed slippage		**(1.0)**
Assumed additional income		**(0.4)**
Mitigations		**(6.5)**