NHS
North East Lincolnshire
Clinical Commissioning Group

Agenda Item:

Report to: Governing Body
Date of meeting: 12 May 2022
Date paper distributed: Click or tap to enter a date.
Subject: Planning for 2022/23
Presented by: Laura Whitton, Chief Finance Officer
Previously distributed to: N/A

STATUS OF THE REPORT ***(auto check relevant box)***	
Decision required	☒
For Discussion to give Assurance	☒ *(Only if requested by Committee member prior to meeting)*
For Information	☐
Report Exempt from Public Disclosure	☒ No ☐ Yes

PURPOSE OF REPORT:	This paper provides an update on the CCG/ICB 2022/23 plan which was submitted on the 28th April, particularly in relation to:- 1. The Finance Plan 2. Elective activity recovery
Recommendations:	To note the update
Clinical Engagement	N/A
Patient/Public Engagement	N/A
Committee Process and Assurance:	CCG Senior Leadership Team, NHS Humber CCGs Executive Team Meeting, Regular updates to the Risk Committee & HCP Leadership

Link to CCG's Priorities	• Sustainable services • Empowering people	☒ ☐	• Supporting communities • Fit for purpose organisation	☒ ☒
Are there any specific and/or overt risks relating to one or more of the following areas?	• Legal • Finance • Quality • Equality analysis (and Due Regard Duty)	☐ ☒ ☐ ☐	• Data protection • Performance • Other	☐ ☒ ☐

Provide a summary of the identified risk

Finance: Mitigating actions required to bring the financial plan back into balance may have an impact on the ICBs recovery plans. A prioirtisation process is currently being undertaken as to which investments will be taken forward.
Elective Recovery: Risk that wont be able to deliver the trajectories as set out in the plan.

Executive Summary

FINANCE

The final plan agreed through the ICB transitional executive, through delegated authority from the ICB shadow board, is a deficit of **£56.2m** (Draft plan £139.9m deficit). It should be noted that this position is a **work in progress** and that there remains an ambition to achieve a balanced financial position for the system in 2022/23

Key Assumptions

The ICS has agreed a common set of principles across the 6 CCGs to ensure fairness and transparency of planning within the commissioning sector and recognising the transition to a single Integrated Care Board. Across the ICS the 11 organisations have agreed to the following principles and assumptions

- Tariff uplift of 1.7% plus 2.3% activity growth (or MHIS expectations for mental health) has been applied to all contracts.
- The plans assume achievement of the minimum investment in the Better Care Fund and the Mental Health Investment Standard.
- Hospital Discharge Funding is deemed to cease at the end of March.
- Across the ICS a general principle of "no new investments" has been taken to reduce the deficit down. Whilst some remain (critical and unavoidable) this approach has been key to reducing the deficit between draft and final plan. A further stage of ranking and prioritising will take place after submission to capture any further movements that can be achieved.
- Stretched efficiency in excess of 4% has been set as a target for providers and CCG influenceable spend.
- £0.5m of dual running costs are included within the plan. Funding is expected to offset this cost.
- Of the £6.5m health inequalities, £3.2m remains uncommitted and ring fenced
- The ICS is developing plans around rapid and extended virtual wards transformation to enable flow and aid delivery of the elective activity needed to secure the £58m elective recovery funding (£55m HNY + £3.2m inter ICS.) £8.7m (incl virtual wards SDF funding with a £10m FYE if successful and therefore continued) has been ring fenced to aid discharge and flow.
- The plan has significant non recurrent efficiencies which is mitigating the size of the deficit in 22/23 £35.9m. This adds significantly to the recurrent challenge as we exit towards 23/24.

Extraordinary Inflationary Pressures (£41.3m)

Extraordinary inflationary pressures above planning guidance assumptions are being witnessed within our system. driven mainly through increased energy costs but this is having a consequential impact on the supply of goods and services to our system

Approach to Elective Recovery

The ICB has been one of the most successful in 21/22 delivery elective activity compared to 19/20 baselines, however the scale of our waiting lists demanded this. The step change to deliver 104% of value-based/110% actual activity (including advice and guidance) is extremely challenging.

Efficiency with the Plans

All providers have a minimum of 4% efficiency within their plans, this being a mixture of: -

- Cost improvement plans
- Reduction in COVID spend
- Productivity
- "Technical" efficiencies

All CCGs have a minimum of 4% efficiency within their plans on their influenceable budgets (e.g., Prescribing, Continuing Health Care)

Risks and Mitigations

In terms of 22/23 our main risks are

- Delivery of elective recovery in order to secure the funding.
- Risk we deliver increased IS activity and pay for it at 100% but fall below 104% in total and so have the impact of losing funds when we need to pay 100% of tariff
- Hospital discharge programme ceasing results in the system unable to flow patients through and thus impacts on elective recovery.
- The scale of the stretched efficiency ask of 4% will be challenging for all organisations
- The level of extraordinary inflation is continuing to move. The position reflects known risks, but this will continue to rise during the year with suppliers passing on their increased cost through increased prices.
- Continuing healthcare and prescribing efficiencies have been set stretched efficiency targets and will require tight grip to deliver

PRIORITIES & OPERATIONAL PLANNING

A narrative submission, totaling 170 pages, was completed for the ICB, which focused on: -

- Delivery
- Key Themes
- Combined Risks
- Any additional support requirement

Whilst the document covers the whole of the HNY, the key points to draw to the Governing Bodies attention from an NEL perspective particularly in relation to "elective recovery" are: -

Introduction. Health Inequalities (HI) - Maintain focus on preventing ill-health and tackling health inequalities.

Priority 1 - Restore NHS services inclusively

- Analysis of the Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) has shown more patients on their waiting lists in lower quintiles, meaning there is a greater health need for those patients. This will be picked up as an HI prevention action to address in 2022/23.

- NLAG to work with the ICS develop plans by June 2022 to put in place the systems, skills and data safeguards that will make effective use of patient data to reduce HI. They plan to utilise longitudinal linked data when available to enable population segmentation and risk stratification. This will form the basis of care pathways redesign and measure outcomes with a focus on improving access and health equity for underserved communities.

- They are working in collaboration with CCGs at PLACE level in the HNY ICS to agree a common approach to the measurement of HIs for waiting lists in relation to ethnicity and deprivation. NLAG elective waiting lists continue to be analysed regularly, and current average waits of patients who are BAME show no variation of wait against those that are non-BAME. The split of ethnicity in the population against the waiting list is similar, however data sources for ethnicity are less reliable due to old census data. Therefore, further work is required regarding improving quality of data collected in 2022/23.

The Waiting Well Programme alongside the HNY Elective Programme will support the identification of cohorts for target work to reduce risk whilst awaiting surgery.

To support this work, two tools have been developed:

- A risk stratification model (developed by Northern Lincolnshire and Goole NHS Foundation Trust (NLAG)) which is a predictive model producing a risk score for those on the waiting list based on data held in secondary care. This considers a range of risks including age, ethnicity, IOD of home postcode, comorbidities, outpatient DNA, A&E attendances, non-elective admissions and on more than one waiting list.
- A waiting well RAIDR dashboard commissioned from NECS which was launched 1/3/22, which brings waiting list and primary care data together and supports analysis by a range of risk factors including age, ethnicity, and data decile as well as learning disability, SMI, smoking, BMI etc.

Priority 2 - Mitigate against digital exclusion

- Within the Connected Health Network, a digital literacy assessment of every patient is undertaken to understand level of digital skills and obtain their consent for how they would like to be contacted e.g. text, email, telephone, letter. This programme has minimised 'in person' clinical attendances by supporting patients to make use of digital communications.

- In primary care the Roxton practice assess the 'Digital Readiness' and identify tech ready patients to optimise the efficacy of a digital self-care platform. Where patients are less ready there is focus on human resources to support people and encourage take up of digital tools. They have also been able to code all their patients using SNOMED coding in their GP system so when they are dealing with a patient, they can see their digital readiness and what level of support they might need.

Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.

C1. Maximise elective activity and reduce long waits, taking full advantage of opportunities to transform the delivery of services

- **Activity -** Activity plans must deliver in excess of 104% of pre-pandemic value weighted elective activity levels and systems need to agree their (and their constituent providers') levels of contribution to this ambition, including going further for those that are able to.

  The final plans submitted increased our position to 102.3% but with the impact of changes in case-mix of activity potentially getting us closer or even over the 104% target

- **Eliminate waits of over 104 weeks** as a priority by July 2022 and maintain this position through 2022/23 (except where patients choose to wait longer)

  No patients at NLAG are expected to wait more than 104 weeks in 2022/23, this excludes any patients who may present as a result of data quality/validation errors.

  There is a risk that, ICS 'levelling up' plans may affect NLAG's RTT (Referral to Treatment) position and result in patients being IPT-ed (Transferred) across affecting the zero '104 weeks plus' position. NLAG will

see some 104 week waiters during Q1 as a result of mutual aid support to Hull University Teaching Hospitals NHS Trust.

- **Eliminate waits of over 78 weeks by April 2023**

  The plan is to fully achieve this target

  As with the 104 week wait target, there is a risk that ICS levels plans for 'levelling up' may affect NLAG's zero '78 weeks plus' waits position.

C2: Complete recovery, improve performance against cancer waiting times standards

Return the number of people waiting for longer than 62 days to the level of February 2020

NLAG are planning to achieve this target.

- Backlog baseline position at Feb 2020 was >62 days 132, >104 days 24, total 156.

- Backlog Feb 2022 position (as at 27/2) is >62 days 119, >104 days 25, total 144.