Meeting: Strategic Commissioning Board			
Meeting Date	07 June 2021	**Action**	Receive
Item No.	8	**Confidential**	No
Title	2021-22 Activity and Primary Care Workforce Plan Update		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning		
Author	Susan Sawbridge, Head of Performance		
Clinical Lead	-		
Council Lead	-		

Executive Summary

As part of the NHS planning process, the CCG formulates an activity and performance plan. This is submitted to the Greater Manchester Health and Social Care Partnership (GMHSCP) which combines submissions from all Greater Manchester (GM) CCGs and providers into a single GM system-wide plan. At the same time workforce plans are also submitted with a return relating to primary care workforce required from CCGs.

Development of the plans is an iterative process and draft plans were submitted to GM on 4th May 2021. The deadline for final plans to be submitted to GM was 25th May in advance of the national deadline of 3rd June. This gap allows time for GM to analyse plans and request further refinement if this is required.

National guidance requires specific activity and performance levels to be achieved during the year and it is also essential that plans are aligned across GM between providers and CCGs and that each organisation's plan also aligns to the locality finance plan.

In formulating the plan for 2021-22, the CCG liaised closely with both Northern Care Alliance (NCA) and other North East Sector (NES) CCG colleagues. Following submission of the draft plan, the CCG undertook further work to reconcile baseline data incorporating revised or new assumptions from key providers. All required changes were included within the final plan and the Governing Body in May granted retrospective authority to the Executive Director of Strategic Commissioning to sign-off Bury's plan.

This paper sets out the high-level requirements of the 2021-22 plan along with the assumptions applied in the final version. A summary of the primary care workforce return is also included. The Strategic Commissioning Board is asked to receive this information.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Receives the updates relating to 2021-22 planning contained within this report.

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☒	No	☐	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☒	N/A	☒
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☒	No	☐	N/A	☐
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

1. Introduction

1.1. The purpose of this report is to provide an overview of the content of NHS Bury CCG's activity and performance plan for the 2021-22 financial year along with a summary of the intended growth in primary care workforce.

2. Background

2.1 Each year, NHS organisations are asked to submit operational plans for the next financial year, hereon in referred to as the 'planning round'.

2.2 For 2021-22, planning guidance was published during March 2021 to cover the period April to September 2021 and focuses on the following six priorities:

- Support staff health and wellbeing, taking action on recruitment and retention;
- Deliver the COVID vaccination programme and continue to meet the needs of patients with COVID-19;
- Build on what has been learned to transform the delivery of services, accelerate the restoration of elective and cancer care, and manage the increasing demand on mental health services;
- Expand primary care capacity to improve access, local health outcomes and address health inequalities;
- Transform community, 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; and
- Work collaboratively across systems to deliver on these priorities.

2.3 To support the planning round, system-level templates are completed for activity, mental health, finance and workforce with an overarching narrative submission too. The focus of this report is the activity template (referred to as "the plan") and the primary care workforce plan. CCG and provider versions of activity and workforce plans are submitted to GMHSCP who collate into a single system-wide plan.

2.4 Across GM, it is essential that activity plans are aligned between CCGs and providers and also with finance plans too. To achieve this in Bury, assumptions have been agreed with the main acute provider, Northern Care Alliance, and with wider GM intelligence sought too. The main forums for this have been:

- NCA / NES CCG Technical Group and GM Technical group;
- GM Elective Recovery and Reform Operational Leads group;
- NCA / NES CCG Acute Recovery and Restoration group (ARRG);
- NCA / Bury CCG Locality group; and
- GM Assurance team via email queries.

2.5 Draft plans were submitted to GMHSCP on 4th May in advance of the national deadline of 6th May. The national deadline for final plans was 3rd June with submission to the GMHSCP having taken place on 25th May.

2.1. The following section of this report will summarise the requirements set out within the planning guidance along with the main assumptions applied to each of the main sections of the activity template. A tabular summary is also included at Appendix A. A further section then outlines the primary care workforce plan, the output of which is shared at Appendix B.

3. NHS Bury CCG Operational Plan for 2021-22

3.1 Due to the uncertainty about future COVID-19 transmission, most elements of the plan for 2021-22 relate to the first half of the year only, ie April to September 2021. It is expected that a second planning round will be instigated at a later date.

3.2 The plan is projected from a baseline position that uses 2019-20 data. However, due to the pandemic having commenced during March 2020, a calculation is applied to 'normalise' data for that month. Bury's approach was to calculate the growth from February to March 2019 and apply this to the February 2020 figures.

3.3 For some points of delivery (PODs), the CCG-generated baseline figures differ to those provided by NHS England (NHSE). This is not unusual and further work was undertaken to ensure the CCG had correctly interpreted the guidance. In all cases, the 2021-22 plan is based on the CCG generated baseline figures.

3.4 The NCA has commissioned KPMG to undertake some demand and capacity modelling and had expected the output of this to be reflected in the trust's final plan. The NCA did, however, advise that although the KPMG modelling will be used for internal purposes, it was not used to inform the plan.

3.5 Provider planning assumptions are crucial to CCG plans and detail was received from NCA and Manchester University Foundation Trust (MFT) and these were reflected in Bury CCG's plan. NCA assumptions were then applied to all other providers.

Elective POD Plans

- **Outpatients**:

3.6 For outpatient attendances, elective admissions and diagnostics, the planning guidance sets a requirement for systems to reach 70% of the 2019-20 baseline in April, 75% in May, 80% in June and 85% in July to September.

3.7 For outpatients, the Bury CCG plan reflects the 70% - 85% requirement. The guidance also sets a minimum level of outpatient attendances to be delivered as non-face to face. This minimum level is reflected in Bury's plan where the non-face to face level (41%) has been based on the proportion that NCA has included in its plan. MFT had indicated a lower proportion though linked this to recording and reporting issues rather than delivery, therefore once these issues are resolved the MFT percentage should increase too.

3.8 There is a requirement for outpatient transformation to take place and this ultimately will realise a growth in Advice and Guidance (A&G) requests and Patient Initiated Follow-up (PIFU) attendances. In advance of larger scale transformation taking place, the growth seen in A&G in recent months is shown to remain static in Bury's plan. Similarly, although PIFU has been initiated at NCA, this is currently on a small scale and therefore activity is very low. The CCG has therefore reflected the NCA plan of zero PIFU for the first six months. It is expected that growth would be seen in the latter half of the year once transformation schemes are progressed and this would then be reflected in both the CCG and NCA future plans. This approach also ensures alignment across NES CCGs.

- **Elective Admissions**:

3.9 For both elective PODs (day case and ordinary admissions), Bury's plan shows achievement of the 70% - 85% requirement.

- **Diagnostics**:

3.10 Activity plans are required for a specific subset of seven diagnostic test types and recognising that diagnostic capacity is critical to support elective recovery, guidance is for "recovery of the highest possible diagnostic activity volumes" in 2021-22. The methodology applied by the NCA has been reflected in the CCG plan. This includes capping activity at 100% of 2019-20 levels and also increasing activity for any tests that might fall below the specified percentage level.

3.11 Against the 2019-20 baseline, the result of the applied assumptions is that activity levels between April and September 2021 will range from 80% of the baseline for echocardiography to 97% for computerised tomography (CT) scans. Additional activity was included in the plan for echocardiography to ensure the required activity level could be reached.

3.12 The increase predicted in diagnostic activity reflects the increased capacity generated locally through out-sourcing, recruitment and, in some cases, additional scanners (eg a new CT scanner at NCA).

3.13 Diagnostics transformation will also be achieved through implementation of the Community Diagnostic Hub (CDH) model for which local planning has commenced.

Non-Elective POD Plans

- **A&E Attendances:**

3.14 The requirement is for activity to reach 100% of the 2019-20 baseline from April 2021 onwards and this has been reflected within both the CCG and NCA plans. Although attendances during 2020-21 reduced significantly during the pandemic, a month on month increase was seen with attendances during March 2021 being just a little below the baseline position.

3.15 In-year, the biggest change in A&E attendances is likely to be the split between the various attendance types which are coded as Type 1 through to Type 4, with the highest acuity being Type 1. Currently, the Fairfield General Hospital (FGH) Urgent Treatment Centre (UTC) attendances are coded as Type 1 though these will become Type 3 once the new UTC becomes operational and this will therefore impact on the split, most likely once plans for the second half of the year are required.

- **Non-Elective Admissions:**

3.16 The requirement is for activity to reach 100% of the 2019-20 baseline from April 2021 onwards and this has been reflected within both the CCG and NCA plans for both zero day and one+ day length of stay admissions.

Other Metrics / Activity Levels

- **Appointments in General Practice:**

3.17 The Long Term Plan (LTP) set a target for there to be 50 million more appointments in general practice by 2024 and the requirement for 2021-22 is for systems to demonstrate restoration to the 2019-20 baseline. The CCG's plan reflects the requirement though this is caveated by Ask My GP data not currently being included within the published data. It has been confirmed that this issue, which will impact all users of the Ask My GP software, has been escalated to NHS Digital.

- **Cancer Activity:**

3.18 There are two elements in 2021-22 for which CCG plans were required. The first, EB30, relates to outpatient appointments following a suspected cancer referral whilst the second, EB31, relates to the number of first treatments required following such a referral. In both cases, the requirement is for activity to be restored to the 2019-20 baseline level in addition to making up the shortfall of activity seen during 2020-21.

3.19 For EB30, the Bury plan requires 744 (+15.9%) more outpatient appointments between April and September 2021 than in the same period of 2019 whilst for EB31 the increase required is 84 more first treatments (+16%).

3.20 The methodology applied is aligned to that of the NCA and has been sense checked by the CCG's clinical lead for cancer. Data has shown that in each month since June 2020, suspected cancer referrals have been higher than in the equivalent month of the previous year and recent performance data has started to show an improvement in the number of patients seen within two weeks of their referral.

3.21 Oversight of cancer plans and performance is provided by the GM Cancer Alliance.

- **Learning Disability Metrics:**

3.22 The target in 2021-22 is for an annual health check to be completed for 70% of patients on the GP Learning Disability Register thus creating a target of 796 health checks for Bury based on a register size of 1112.

3.23 The plan requires a quarterly breakdown of projected health checks to be submitted. In previous years, the completion of health checks has tended to back-loaded, ie more completed in the second half of the year. For this reason, the proportion split seen in 2019-20 has been applied to 2021-22, resulting in a spread of 13.1% in Quarter 1, 15.3% in Quarter 2, 36.5% in Quarter 3 and 35.1% in Quarter 4.

3.24 The above plan has been shared and approved in principle by the CCG's Clinical Lead for Learning Disability services though the challenge this presents is acknowledged.

3.25 Plans are also required for the number of CCG-commissioned and NHSE-commissioned learning disability patients occupying inpatient beds.

3.26 During the pandemic, increased demand resulted in the number of both CCG and NHSE-commissioned inpatients exceeding the planned level set under the LTP. Discharge plans are underway for some patients and a realistic plan has been set that

shows a higher level of inpatients in the first half of the year with an expectation that this plan could reduce by year-end as discharge plans progress. This plan has been approved by the CCG's Director of Nursing and Quality Improvement.

- **2-hour Care Contacts:**

3.27 A plan is required that shows an increase in the number of referrals to the Rapid Response Team that are responded to with a care contact within two hours. Discussion has taken place with the Locality Care Organisation (LCO) and Rapid Response Team to arrive at a realistic increase. An average of the previous two quarters was used to provide a plan figure for Quarter 1 of 2021-22 with 10% added to each quarter thereafter.

4. Primary Care Workforce Plan

4.1 Workforce plans are required for a number of staffing groups that include: acute, community and ambulance; primary care; urgent community response; and mental health. CCGs are required to collate and submit the primary care element of this.

4.2 Roles within the plan are split between GPs, nurses, direct patient care roles (whether they be funded via the Additional Roles Reimbursement Scheme (ARRS) or not) and 'other' roles, eg administration or other non-clinical roles.

4.3 Across all groups, the data showed a workforce establishment of 477.22 whole time equivalent (wte) in 2020-21. Planned growth in 2021-22 shows this establishment increasing to 513.86 wte. This equates to a 7.7% increase with most growth expected in the ARRS funded direct patient care roles. In terms of a comparison against the actual number of staff in post at 31st March 2021, the plan represents an 18% increase. A breakdown of the plan by role type is included at Appendix B.

5. Conclusion

5.1 The CCG submitted its final activity and primary care workforce plans for 2021-22 in line with the timescale set by GM. As described earlier in this report, the activity plan was aligned as closely as possible with that of the NCA and other NES CCGs and has received input from CCG Clinical Leads, as appropriate.

5.2 There is opportunity for GM to provide feedback to CCGs and providers between the 25th May and the national submission date of 3rd June. At the time of this report, the CCG has not received feedback indicating amendment to the plan is required.

5.3 In time, further planning guidance is also expected to be published for the second half of 2021-22 and it is at this point that the impact of local transformation schemes, particularly in elective care and urgent care would be reflected in the CCG plan.

6 Actions Required

6.1 The audience of this report is asked to:

- Receive this report.

Susan Sawbridge
Head of Performance
May 2021

Appendix A: Summary of CCG Plan Assumptions for 2021-22

<table>
<tr><th>Indicator(s)</th><th>Basis of Plan</th><th>Concerns/Issues/Notes</th></tr>
<tr><td>All Indicators</td><td colspan="2">Following investigation of differences between NHSE and CCG baselines in first submission, these were revised in line with NES colleagues and known issues. Some differences remain but generally smaller percentage variance and with CCG value higher than NHSE which will allow some leeway for under-performance in targets.</td></tr>
<tr><td>Outpatients</td><td>Elective % targets</td><td>NF2F proportion based on NCA 41%. Smaller % seen in MFT assumptions but they are addressing known issues in recording NF2F.</td></tr>
<tr><td>Elective DC</td><td>Elective % targets</td><td></td></tr>
<tr><td>Elective IP</td><td>Elective % targets</td><td></td></tr>
<tr><td>A&E</td><td>100% of baseline</td><td>Possible change to Cat 3 in year at both NCA and MFT though this is likely to be in latter half of year.</td></tr>
<tr><td>NEL</td><td>100% of baseline</td><td>Covid levels estimated on last 6 mths 20/21</td></tr>
<tr><td>Diagnostics</td><td>Currently on run rate for Feb-21, as per NCA assumption. Except for Echos set at elective %s as would under-perform.</td><td>Due to the calculation of a run rate it is possible that monthly figures exceed 19/20 baseline levels. In this case we have capped at 100% of 19/20 as per NCA method.</td></tr>
<tr><td>A&G Requests</td><td>Run rate last 6 months, flatline projection, as per NCA assumption</td><td>May change as a result of outpatient transformation work but not before Q3/Q4.</td></tr>
<tr><td>PIFU</td><td>Set to zero as with NCA</td><td>May change as a result of outpatient transformation work but not before Q3/Q4.</td></tr>
<tr><td>GP Appts</td><td>Based on 100% of 19/20 baseline</td><td>Concern re recording of AskMyGp appts</td></tr>
<tr><td>LD Health Checks</td><td>796 (GM Target) for year, trajectory ramping to Q4 as per 19/20 model</td><td>Plan discussed and agreed with LD Clinical Lead</td></tr>
<tr><td>LD Inpatients</td><td>Trajectory set based on current position agreed by Director of Nursing & Quality</td><td></td></tr>
<tr><td>SDEC Referrals</td><td>Confirmed that GM to complete</td><td></td></tr>
<tr><td>2 hour care contacts</td><td>Q3/Q4 20/21 average taken as Q1 21/22 with 10% cumul inc by quarter</td><td></td></tr>
<tr><td>Cancer 2WW/ 31 Day</td><td>19/20 plus shortfall in prev year</td><td>
<table>
<tr><th></th><th>19/20 Activity</th><th>Est 20/21 Activity</th><th>21/22 Plan</th><th>% Var vs 19/20</th><th>% Var vs 20/21</th></tr>
<tr><td>Cancer 2WW</td><td>8952</td><td>7466</td><td>10430</td><td>16.51%</td><td>39.70%</td></tr>
<tr><td>Cancer 31 Day</td><td>1095</td><td>928</td><td>1274</td><td>16.35%</td><td>37.30%</td></tr>
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</td></tr>
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Appendix B: NHS Bury CCG's Primary Care Workforce Plan for 2021-22

	Establishment	Baseline	Plan	Plan	Plan	Plan	Establishment
	2020/2021	Staff in post outturn	As at the end of June 2021	As at the end of September 2021	As at the end of December 2021	As at the end of March 2022	2021/2022
NHS Bury CCG	Year End (31st March 2021)	Year End (31st March 2021)	Q1	Q2	Q3	Q4	Whole Year
Workforce (WTE)	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Total by staff group							
GPs excluding registrars	105.34	95.50	101.16	103.17	103.17	104.59	104.59
Nurses	62.19	56.09	57.59	59.40	59.40	62.40	62.40
Direct Patient Care roles (ARRS funded)	15.00	15.00	18.00	46.00	46.00	46.00	46.00
Direct Patient Care roles (not ARRS funded)	43.56	41.30	44.01	44.22	45.02	45.02	45.02
Other – admin and non-clinical	251.13	227.74	249.15	250.81	251.55	255.85	255.85
Total Provider Workforce (WTE)	**477.22**	**435.63**	**469.91**	**503.6**	**505.14**	**513.86**	**513.86**