Meeting: Strategic Commissioning Board			
Meeting Date	06 December 2021	**Action**	Receive
Item No.	10b	**Confidential**	No
Title	2021-22 H2 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 GM commissioners and providers into a single GM system-wide plan.

In 2021-22, the planning process has been split into two parts, the first covering the period April to September 2021 (H1) as reported to this Board during June, and the second covering the period October 2021 to March 2022 (H2). This report relates to the H2 plan.

On this occasion, providers submitted draft plans during October 2021 with final plans being submitted to GMHSCP on 5th November in advance of the national deadline of 16th November. This gap allowed 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 H2 2021-22, the CCG liaised closely with the Northern Care Alliance (NCA), other North East Sector (NES) CCG colleagues and Bury's own Clinical Leads to ensure plans were as aligned and realistic as possible.

In addition to taking note of the plan content and methodology applied, the SCB is asked to grant retrospective authority to the Executive Director of Strategic Commissioning to approve Bury's H2 plan.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Receives the updates relating to 2021-22 planning contained within this report; and
- Grant retrospective authority to the Executive Director of Strategic Commissioning to approve the H2 plan.

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 period October 2021 to March 2022 (H2).

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 split into two periods: April to September 2021 (H1) and October 2021 to March 2022 (H2). The priorities of the H2 guidance remain as per H1:

- 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 Plan submissions for H2 were at an Integrated Care System (ICS) level with input from both providers and CCGs. Providers submitted data for both point of delivery (POD) activity levels, eg outpatient attendance totals, and performance metrics whilst CCGs were required only to submit plans for a subset of mandatory metrics on this occasion.

2.4 Where necessary, the CCG sought advice and further guidance from GMHSCP to ensure maximum clarity of requirements. Liaison with the NCA, Bury's main acute provider, also took place to ensure alignment, where possible, in plans.

2.5 The CCG plan was submitted to GMHSPC on 5th November in advance of the national deadline of 16th November which was subsequently extended to 17th November. Following submission of the plan, the CCG did not receive any follow-up queries from the GM team.

2.1. The following section of this report summarises the key requirements set out within the H2 planning guidance for each POD. This is followed by a summary of the plan submitted for Bury with further detail included at Appendix A.

3. Key Requirements for H2

3.1 For the elements within this section of the report, acute providers submitted a plan though this was not a requirement for CCGs.

- **Outpatients**

3.2 There is an expectation that 25% of all outpatient attendances will take place remotely, for example via telephone or video.

3.3 For every 100 first outpatient attendances there should be 12 specialist advice requests. This includes pre-referral requests, eg advice and guidance, and post-referral requests such as via a Referral Assessment Service (RAS).

3.4 Patient Initiated Follow-up (PIFU) is to be rolled out across five specialties and 1.5% of outpatient attendances are expected to become PIFU by December 2021, followed by 2% by March 2022.

- **Elective and Cancer Care**

3.5 Providers were asked to focus on several elective specialties that have shown poor levels of recovery in the pandemic period to date. These are neurosurgery, cardiology, cardiac surgery, vascular surgery, neurology and solid organ transplant.

3.6 The overall waiting list size and number of 52+ week waits are expected to be stabilised at the September 2021 position whilst 104+ week waits are expected to be eliminated by March 2022, except where a patient chooses to defer treatment. The NCA plan shows 104+ week waits remaining at the end of the year. The impact of this for Bury patients is currently under review.

3.7 For cancer, there remains a focus in H2 on restoring outpatient and first treatment activity following a suspected cancer referral alongside a requirement to return the number of people waiting more than 62 days for treatment to pre-pandemic levels. There is also an expectation that the 28-day Faster Diagnosis Standard (FDS) is achieved from Quarter 3 onwards.

- **Urgent Care**

3.8 The overarching requirement is to transform community and urgent and emergency care to prevent inappropriate A&E attendances, improve timely admission and reduce length of stay. To support this, the first four weeks of post-discharge recovery funding will continue until 31st March at which point the scheme will end.

3.9 During the H2 period there are requirements for 12-hour A&E waits to be eliminated, for 2-hour community crisis response teams to operate from 8am until 8pm, seven days a week by April 2022, and for the volume and duration of ambulance handover delays to be reduced.

4. NHS Bury CCG's H2 Plan

4.1 For CCGs, the H2 plan consisted of performance and activity trajectories for the remainder of 2021-22 against the measures outlined in the following paragraphs.

- **NHS 111 Referrals to Same Day Emergency Care (SDEC):**

4.2 The aim is to increase the number of referrals from NHS 111 or the GM Clinical Assessment Service (CAS) to SDEC as an alternative to attending an Emergency Department (ED).

4.3 National data is yet to be published for this metric. However, at a GM level there is an expectation in H2 that there will be 55 such referrals per day. The Bury plan was based on a population share (6.5%) of the GM aspiration and this equated to 3.6 referrals per day (107 per month) across the H2 period.

- **Learning Disability Metrics:**

4.4 The target in 2021-22 is for an annual health check (AHC) to be completed for 70% of patients on the GP Learning Disability Register thus creating a target of 782 health checks for Bury based on a register size of 1112.

4.5 In keeping with previous years, the plan has been back-loaded, ie significantly more AHC to be completed in Quarters 3 and 4. This sets a requirement for 198 AHC in Quarter 3 and 470 in Quarter 4. To support this, the CCG's Clinical Lead for Learning Disability services has carried out training events for primary care colleagues around AHC completion and is also engaged with colleagues via learning disability network meetings.

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

4.7 During the pandemic, increased demand resulted in the number of both CCG and NHSE-commissioned inpatients exceeding the planned level set under the Long Term Plan (LTP). For CCG-commissioned patients, there had been an increase to five such inpatients by the end of Quarter 2. Discharge planning arrangements are progressing for three of these patients with at least one expected to be discharged early in 2022, thus resulting in a plan of four such admissions in Quarter 4.

4.8 Similarly, for NHS England commissioned patients there had been an increase in admissions during the COVID-19 period. At the start of Quarter 3, there were four such inpatients and this is expected to remain the case for the remainder of the financial year. All four admissions are complex cases for which discharge planning has commenced.

4.9 It is possible that the CCG may receive challenge to the submitted plan for these inpatient numbers though it is noted that they are based on robust local knowledge from within the Continuing Healthcare team which provides case management to such complex cases.

- **Appointments in General Practice:**

4.10 The 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 H2 plan reflects the requirement though there is a caveat in that Ask My GP data is not currently included within published data meaning that 'actual' activity will remain below the planned position until this national issue is resolved. Work is underway in Bury to understand the volume of contacts via Ask My GP so that local monitoring of this can occur.

- **Cancer Activity:**

4.11 There are two elements in 2021-22 H2 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 addressing the shortfall of activity seen during 2020-21.

4.12 As CCG performance is heavily dependent upon trust performance, the NCA methodology of applying a 2% increase to the H1 outturn was adopted by the CCG. For EB30, this results in an increase of 16.4% in H2 compared to the same period of 2019-20 and +1.5% for EB31 when comparing the same periods.

5. Conclusion

5.1 The CCG submitted its final H2 2021-22 plan by the GM deadline of 5th November 2021. Where appropriate, the activity plan was aligned as closely as possible with that of the NCA and other North East Sector (NES) CCGs and also received input from CCG Clinical Leads, as appropriate.

5.2 The CCG's plan is largely in keeping with the spirit of the planning guidance. However, as provider plans cover a wider remit, for example POD activity levels and waiting lists, the impact for Bury patients may deviate from the guidance where provider plans

5.3 There was an opportunity for GM to provide feedback to CCGs and providers between the GM deadline of 5th November and the national deadline of 16th November. The CCG plan was not challenged between these dates.

5.4 Ordinarily, planning guidance for the following financial year would be received around December and it is therefore expected that guidance for 2022-23 will be issued soon.

6 Actions Required

6.1 The audience of this report is asked to:

- Receive this report; and
- Provide retrospective authority to Executive Director of Strategic Commissioning to approve the H2 plan.

Susan Sawbridge
Head of Performance
November 2021

Appendix A: Methodology for NHS Bury CCG H2 Plan Calculations

<table>
<tr>
<td>Urgent and emergency care</td>
<td>
E.M.28: NHS 111 referrals to SDEC (as an alternative to ED)

Aim: To increase the number of calls to NHS111 that result in a referral to Same Day Emergency Care (SDEC) as an option to attendance at an Emergency Department (ED).

This was a new plan metric in H1 and as data to support this was not available, plan figures were generated by GM for each locality. For Bury, this resulted in an H1 plan of 306 referrals (51 per month).

Data remains unavailable for H2 planning though an update from GM states that 55 SDEC referrals from NHS111 per day are expected across the ICS. As Bury's population is approximately 6.5% of the total GM population, this equates to 3.6 such referrals per day (107 per month). This has been shared with NCA colleagues who confirm that this H2 plan appears realistic. This is based on the fact that the Fairfield General Hospital (FGH) site sees between 15 and 25 SDEC patients per day (approx. 9-15 per day from Bury) and that a proportion of these will be via NHS111 referrals.

NB: Some Bury patients would be referred to SDEC at the North Manchester General Hospital (NMGH) and the 3.6 per day therefore refers to Bury patients across all sites.
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<tr>
<td rowspan="2">Learning disabilities and autism</td>
<td>
E.K.1a: Reliance on inpatient care for people with a learning disability and/or autism - Care commissioned by CCGs

Aim: To reduce the number of CCG-commissioned adults who have a learning disability and/or autism and who are in inpatient care for a mental disorder.

Under the Long Term Plan (LTP), Bury had a maximum number of 2 CCG commissioned inpatients by the end of each year. However, demand increased during the COVID period and the plan was therefore increased to 3 during 2020-21.

Increased demand has continued and at the start of Q3 2021-22 there are 5 CCG-commissioned inpatients. Plans are progressing for three of these patients with at least one expected to be discharged early in 2022. Individual person specifications are currently being formulated for the remaining two to support discharge planning.

<table>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>CCG Commissioned</td><td>3</td><td>3</td><td>5</td><td>4</td></tr>
</table>

The H2 plan figures above are subject to no further admissions occurring and have been proposed and agreed by Catherine Jackson, Director of Nursing and Quality Improvement, and Dawn Parker, Lead Nurse for Mental Health and Complex Cases.
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<tr>
<td>
E.K.1b: Reliance on inpatient care for people with a learning disability and/or autism - Care commissioned by NHS England

Aim: To reduce the number of NHSE-commissioned adults who have a learning disability
</td>
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</table>

and/or autism and who are in inpatient care for a mental disorder.

Under the LTP, the number of NHSE Commissioned inpatients was expected to reduce to 2 during 2021-22 though increased to 4 due to increased demand during the COVID period. In line with the H1 plan, there remain 4 NHSE-commissioned inpatients at the mid-year point and feedback from Catherine Jackson, Director of Nursing and Quality Improvement, predicts this will be the case for the remainder of the financial year. All four are complex cases for which discharge planning has commenced.

	Q1	Q2	Q3	Q4
NHSE Commissioned	4	4	4	4

The H2 plan figures above are subject to no further admissions occurring and have been proposed and agreed by Catherine Jackson, Director of Nursing and Quality Improvement, and Dawn Parker, Lead Nurse for Mental Health and Complex Cases.

E.K.3: Learning disability registers and annual health checks delivered by GPs

Aim: To improve uptake of the annual health checks (AHC) in primary care for people with a learning disability in order to help to tackle the causes of morbidity and preventable deaths in people with a learning disability and/or autism.

For 2021-22, the target is for 70% of patients on the GP LD register to receive an AHC. The H1 plan showed 227 patients receiving their AHC, however, actual data shows just under half of this number actually receiving their AHC.

Completion of the AHC tends to be heavily weighted to the latter half of the year, and in particular to Q4, and this was certainly the case in both 2019-20 and 2020-21 (row A below). AHC completion in H1 has been below the planned level and this variance has then been applied to quarters 3 and 4 of H2 to show the annual target being achieved.

Ref		Q1	Q2	Q3	Q4	Total	LD Register size (QOF)	% of LD register
A	2020/21 Actuals	28	65	180	452	**725**	1112	**65.2%**
B	2021/22 Actuals & H2 plan	55	59	198	470	**782**	1112	**70.3%**

The proposed plan has been shared with Nigget Saleem, Medicines Optimisation and Learning Disabilities Clinical Lead, who confirmed agreement to submit the above figures whilst acknowledging that they (particularly Q4) are very optimistic. Nigget is in the process of delivering training on health checks (two undertaken in October and more scheduled for November) and plans to join a couple of networks during their LD QOF meetings with the aim of helping to boost the number of health checks undertaken.

NB: Population figure of 1112 is taken from the non-functional template. Had previously taken 1146 from QOF files. Amended Q4 plan figure to reflect lower population estimate.

Primary Care

E.D.19: Appointments in general practice

Aim: Under the LTP, the national aim is to provide 50 million more appointments in general practice by 2024.

The CCG's plan for 2021-22 shows restoration to the 2019-20 level. However, as General Practice contacts generated through the AskMyGP software are not currently captured within the published appointment data, this will have an impact on the actual activity reported in 2021-22 in advance of this being resolved.

As expected, actual data for H1 shows activity below the planned level due to AskMyGP appointments not currently being included. The proposal therefore is to retain the original plan figures for H2 which shows restoration to the 2019-20 level.

E.D.19: Planned number of General Practice appointments			Apr 2019-Feb 2020	Apr 2021-Mar 2022	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
E.D.19 (H1)	Count	Planned number of General Practice appointments	1142785	1234548	97593	92713	107352	107352	102472	107352	102472	107352	102472	97593	97593	112232
E.D.19 (H2)	Count	Planned number of General Practice appointments	1142785	1067687	65217	67716	74989	68585	64814	107352	102472	107352	102472	97593	97593	112232

NB: Baseline figures are reached by following the calculation provided to account for those practices for which there is no reported data. There is a national programme of work underway to increase the quality and completeness of this data.

Cancer

E.B.30: Urgent cancer referrals
E.B.31: Cancer treatment volumes

Aim: to accelerate the restoration of cancer care by delivering sufficient outpatient and treatment capacity to return to 2019-20 levels with additional activity planned to meet the shortfall experienced during the pandemic.

In H1 planning, the Northern Care Alliance (NCA) shared its methodology and this was reflected in the CCG plan. The calculated shortfall was applied in equal 1/12 across the year. Actual activity during the H1 period was below the planned level for both metrics and the initial proposal was to retain the original plan figures and reapportion activity across the remaining months, with seasonal adjustment applied, as per feedback from Dr Liane Harris, CCG Clinical Lead for cancer.

However, NCA methodology for H2 has since been shared and in order to achieve alignment, the CCG proposed plan has been amended.

The NCA has confirmed that for each measure, it is applying a 2% increase to their H1 outturn. The impact of applying this methodology to the CCG's H1 data is:

- EB30: Urgent Cancer Referrals: this delivers activity above the 2019-20 baseline (+16.4% in H2 and +9.6% across the financial year) and ensures alignment with NCA methodology.
- EB31: Cancer Treatment Volumes: this delivers activity a little below the 2019-20 baseline for H2 (-2.5%) though +1.5% across the financial year and ensures alignment with NCA methodology.

Row 2 of each table below shows the proposed CCG plan based on alignment with the NCA methodology and with newly available 'actuals' for September taken into account.

E.B.30: Urgent Cancer Referrals (first outpatient appointments)			Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total
E.B.30 (H2 Plan NCA methodology applied)	Count	All patients urgently referred with suspected cancer by any source of referral excluding from a National Screening Programme who received a first outpatient appointment in the given month.	819	858	819	780	780	897	4953
E.B.30 (19/20 Actual)	Count	All patients urgently referred with suspected cancer by any source of referral excluding from a National Screening Programme who received a first outpatient appointment in the given month.	780	789	682	664	676	663	4254

E.B.31: Cancer Treatment Volumes			Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total
E.B.31 (H2 Plan NCA methodology applied)	Count	Total number of patients receiving first definitive treatment for cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).	93	98	93	89	89	102	564
E.B.31 (19/20 Actual)	Count	Total number of patients receiving first definitive treatment for cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).	112	102	84	91	74	113	576
