NHS Financial Regime for 2020/21

1. Context

1.1. As the Covid-19 emergency period took effect in mid-March, the NHS saw major changes to how services and financial flows work. In their letter dated 17 March 2020, Sir Simon Stevens and Amanda Pritchard made a number of clear statements for the NHS, in relation to finances including the statement below:

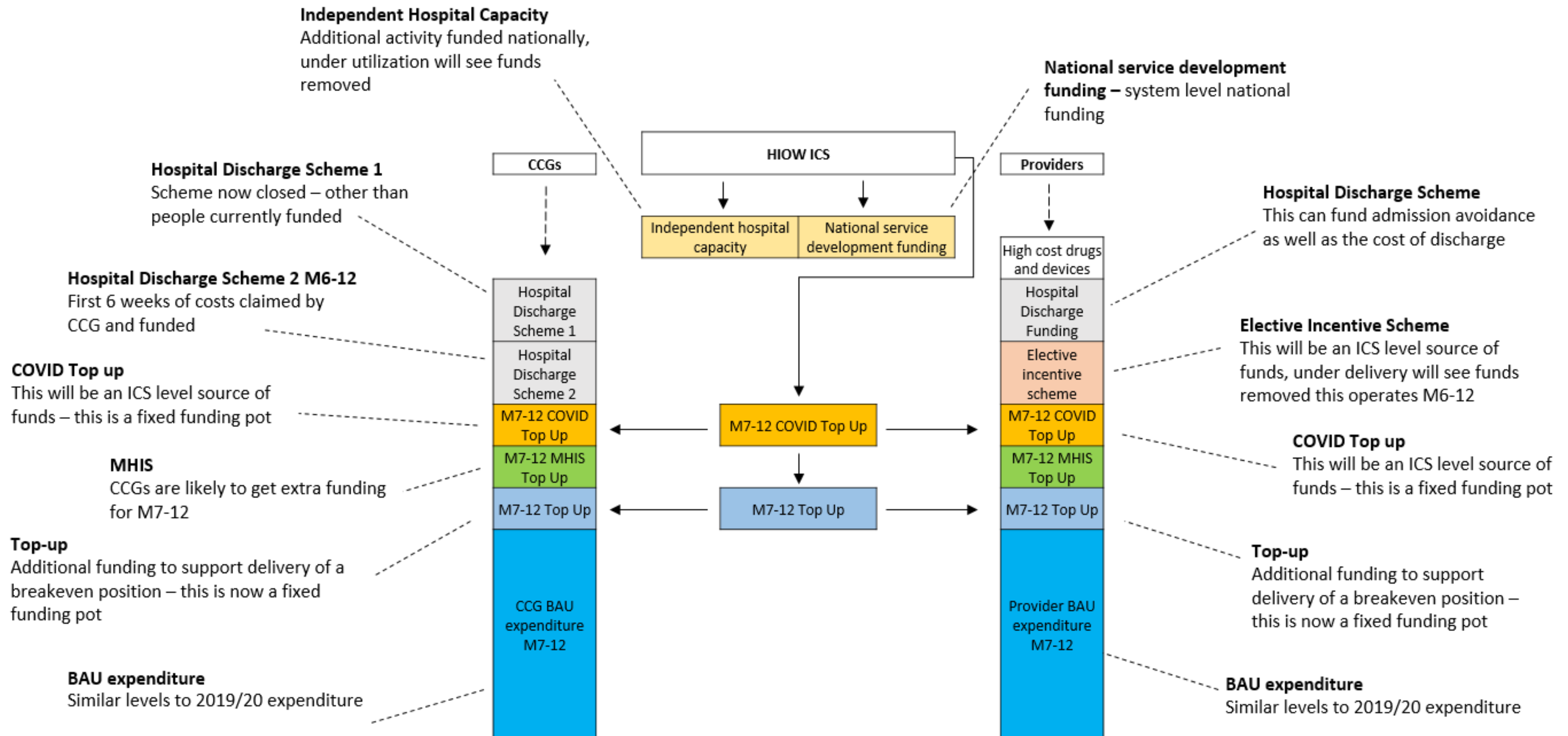
1.2. The Chancellor of the Exchequer committed in Parliament that "Whatever extra resources our NHS needs to cope with coronavirus – it will get." Therefore financial constraints must not and will not stand in the way of taking immediate and necessary action - whether in terms of staffing, facilities adaptation, equipment, patient discharge packages, staff training, elective care, or any other relevant category.

1.3. NHS organisations have just submitted draft financial plans on a system basis to NHS England, which align to the submissions made late September around the restoration and recovery of services. Final submissions are due end October 2020.

1.4. As yet we do not know what the financial regime will be for 2021/22. This is likely to become clear at the publication of the spending review.

2. What can HIOW spend before allocations for the rest of the year are finalised?

The following sections look at the known funding for the remainder of the year for the NHS. Please note the size of boxes are not to the scale of funding.



3. Months 1-6 Financial Regime

3.1. The Covid emergency financial framework put in place by the government and NHSE/I at the beginning of the financial year continues until the end of September (M6). For the first half of the financial year, the financial regime is based upon block payments centrally calculated for all NHS providers, with an ability to claim top ups to ensure a breakeven position. Providers and commissioners can claim retrospectively for the additional Covid 19 costs on a monthly basis.

3.2. The CCG is currently forecasting an overspend to the end of September of £4,088k, £3,595k of which relates to Covid expenditure and £494k to underlying services. This will be covered by a retrospective allocation adjustment to achieve a break-even position. Retrospective allocations have already been received for April to July.

3.3. This is a very different regime to normal operating, which is driven by payment for activity.

3.4. The CCG’s funding is based upon last year’s funding.

3.5. Sources of Revenue funding for first half of 2020/21:

- CCG and provider baseline funding based upon last year
- Hospital Discharge Service Tranche 1 (those people funded between April and September through this scheme)
- Independent hospital capacity
- Retrospective non-recurrent Covid allocation
- Retrospective top ups – to break even

4. Months 7-12 Financial Regime

4.1. The financial framework for October to the end of the financial year has now been confirmed. As expected, this sees us move to prospective allocations. This funding is now more contained, with funding given to the Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP) centrally for a fair share of Covid funding and some additional monies to support recovery and restoration. The requirement for months 7-12 is not to solve all of the long-term health issues related to Covid; that is likely to form the basis of the NHS’ request for future years additional funding in line with the current spending review that is being undertaken by Government.

4.2. The starting point for financial plans for the second half of the year should be a similar funding envelope to the first half of the year, the chart in this document helps outline all of the funding types.

4.3. In July 2020 Simon Stevens, NHS Chief Executive, and Amanda Pritchard, NHS Chief Operating Officer, issued the Third Phase of NHS Response to Covid-19 guidance, which is available on NHS England's website, setting out the following three priorities for the rest of 2020/21 which the month 7-12 funding will be expected to cover:

A. **Accelerating the return to near-normal levels of non-Covid health services**, making full use of the capacity available in the 'window of opportunity' between now and winter:
- Restore full operation of all cancer services
- Recover the maximum elective activity possible between now and winter
- Restore service delivery in primary care and community services
- Expand and improve mental health services and services for people with learning disabilities and/or autism.

B. **Preparation for winter demand pressures**, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally:
- Continue to follow good Covid-related practice to enable patients to access services safely and protect staff

C. Prepare for winter.
Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

4.4. Our progress to date on meeting each of the three priorities includes:

3.4.1. Accelerating the return to near-normal levels of non-Covid health services

Restore full operation of all cancer services
- Two-week wait cancer referrals and treatment activity returning to pre-Covid-19 levels
- Cancer screening capacity being rapidly increased whilst taking into account Covid-19 infection control requirements with routine

invitation letters being sent for bowel, breast and cervical screening.

Recover the maximum elective activity possible between now and winter

We have worked with the Trusts across HIOW to develop opportunities to restore inpatient/day case activity to 87% by October, improving month on month to 93% by January. We have also made progress in reducing the number of people waiting over 52 weeks to be no more than 6,325 in March 2021. We are doing this by:

- Continuing to clinically validate waiting lists
- Contacting all patients whose care has been disrupted
- Reopening wards to support restoring theatre capacity
- Recruiting additional theatre staff and supporting shielding staff to return
- Reviewing session times, reducing on-the-day cancellations and late starts, and improving scheduling and pre-assessments
- Commissioning additional theatre capacity
- Increasing Advice and Guidance Services to support GPs when considering making a referral
- Restoring use of NHS commissioned capacity within the independent sector and exploring potential additional capacity.

In outpatients, we are on track to deliver 101% of baseline activity, including Advice and Guidance by October. We are doing this by:

- Restoring outpatient clinic space that was used by other services during the Covid-19 response
- Reducing the number of patients who do not attend (DNA) outpatient appointments
- Increasing productivity through the continued use of virtual and telephone appointments
- Restoring endoscopy to full capacity by reopening all units and extending working hours
- Restoring CT and MRI to full capacity by improving DNA rates, extending working hours and increasing productivity
- All provider Trusts using the e-Referral service with all being fully open to primary care referrals.

Restore service delivery in primary care and community services

- Primary care restoring services to pre-Covid-19 levels
- Community services returning to pre-Covid-19 levels
- Developing a community care model with enhanced services to support people at home as clinically appropriate to reduce

avoidable hospital admissions and increase supported hospital discharges.

Expand and improve mental health services and services for people with learning disabilities and/or autism

- 24/7 crisis lines continuing to be maintained
- Increasing access to Child and Adolescent Mental Health Services (CAMHS) and Improving Access to Psychological Therapies (IAPT) to pre-Covid-19 levels and now focussing on tackling waiting lists and responding to Covid-19 demand
- Increasing perinatal mental health access
- Increasing the number of annual physical heath checks undertaken for those with serious mental illness
- Increasing the number of annual health checks undertaken for those with learning disabilities
- Planning the replacement of our remaining mental health dormitory wards
- Restarting work to support GP practices to achieve Learning Disability friendly status.

3.4.2. Preparation for winter demand pressures

- Starting the annual flu vaccination programme with the expanded priority groups
- Developing local escalation plans with common thresholds for the implementation of pre-agreed actions
- Agreeing mutual aid plans and protocols
- Establishing virtual wards with remote monitoring to support avoidable hospital admissions and enable step down care
- Implementing 111 First across HIOW, building on the learning from Portsmouth and South East Hampshire
- Operationalising Community Urgent Response Teams across HIOW
- Community, primary care and social care providers continuing to work together to provide out of hospital services
- Implementing an approach to pro-actively target groups who are at risk of poor Covid-19 outcomes
- Each HIOW Trust developing and implementing plans to improve Emergency Department performance in preparation for winter
- Supporting primary care winter resilience by establishing dedicated ‘hot sites’ across HIOW where patients with suspected Covid-19 will be seen if clinically required.

3.4.3. Support for our staff and action on inequalities and prevention

- Mapping the workforce capacity required to enable our acute recovery
- Trusts across HIOW regularly collaborate regarding their recruitment and incentive plans
- We continue to provide support to our staff in a number of ways with mental health and wellbeing programmes and bespoke support is in place for all staff groups.

4. **Sources of Revenue funding for second half of 2020/21** (all of which are described in more detail in the next section)
   - Hospital Discharge Service Tranche 1 & 2 (DH&SC specifically funded)
   - Elective incentive scheme (marginal rate for over delivery and under delivery)
   - Independent hospital capacity
   - Mental Health Investment Standard Monies
   - Prospective Covid funding
   - Prospective Top up funding
   - Month 7-12 baseline
   - Covid-19 related services such as testing and centrally purchased PPE
   - National service development funding (SDF)

5. Hospital Discharge Service

4.5. The guidance was published on 21 August 2020. The Government has agreed to fund, via the NHS:

- The cost of post-discharge recovery and support services, such as rehabilitation and reablement (in addition to what was provided prior to admission) for up to a maximum of six weeks to help people return to the quality of life they had prior to their most recent admission.
- To support urgent community response services for people who would otherwise be admitted into hospital. These will typically provide urgent support within two hours and for a limited time (typically 48 hours) and, if required, transition into other ongoing care and support pathways.

4.6. Under the provisions of this scheme, additional costs of post-discharge recovery and support services will be funded until the person’s long-term care needs are assessed, or for up to the first six weeks if the assessment is not completed by that time. It is expected that an assessment for ongoing health and care needs takes place within six weeks of discharge and that a decision is made about how this care will be funded by this date. CCGs will not be able to draw down funding from the discharge

support arrangements after the end of the sixth week to fund any care package beyond this date.

4.7. For people discharged from hospital or assigned a package of short-term care to avoid admission into hospital from 1 September 2020, this funding arrangement will apply, replacing the previous arrangements introduced on 19 March 2020 as part of the COVID-19 Discharge Guidance.

4.8. Where a person was in receipt of a care package prior to admission to hospital and is discharged with a package of short-term reablement, this funding will pay for those additional costs (where these are over and above the activity that is ordinarily commissioned by CCGs and local authorities). This would apply regardless of whether or not the person was still being cared for by the same care provider.

4.9. Where the enhanced care services are most appropriately commissioned directly by NHS commissioners, these should be placed under existing contractual arrangements with providers but invoiced separately to ensure that enhanced discharge support funding is identifiable. This care should be paid for from the additional funding set out in this section.

4.10. The additional funding will not pay for:

- Long-term care needs following completion of a Care Act and/or NHS Continuing Healthcare (CHC) assessment.
- Social care or NHS CHC packages that are restarted following discharge from hospital at the same level as that already delivered prior to admission to hospital.
- Pre-existing (planned) local authority or CCG expenditure on discharge services.

4.11. People funded though the COVID-19 Discharge Guidance funding arrangements, which commenced on 19 March 2020, who enter a care package between 19 March and 31 August 2020, will continue to be funded through those arrangements. Relevant assessments should be completed for these individuals as soon as is practical to ensure transition to normal funding arrangements.

4.12. For the purposes of definition, the arrangements prior to 1 September 2020 (detailed in the 19 March 2020 hospital discharge guidance) will be termed ‘scheme 1’ and the arrangements from 1 September 2020 will be defined as ‘scheme 2’. The scheme funding arrangements will apply up until 31 March 2021.

5. Elective incentive scheme

5.1. In August 2020 more detail was given about how block payments will flex to reflect expected elective activity levels.

5.2. The following financial arrangements will apply from 1 September 2020:

- A notional baseline of month 6 to month 12 2019/20 activity for ordinary electives and day cases, outpatient procedures and outpatient first and follow-up attendances undertaken by NHS providers will be calculated for each system.
- Where aggregate in-scope activity delivered in the period M6-M12 is below the expected value, 25% (for elective and outpatient procedure activity) and 20% (for outpatient attendance activity) of the shortfall will be deducted from the nationally determined funding envelopes.
- Where in-scope activity delivered in this period exceeds the expected value, 75% (for elective and outpatient procedure activity) and 70% (for outpatient attendance activity) of the difference will be added to nationally determined funding envelopes.

5.3. The scheme will apply in September 2020, which is the final month of the retrospective top-up, during which NHS providers are supported to achieve a breakeven position against reasonable expenditure. As such, this scheme and the associated activity payments will support organisations to recover performance as soon as possible.

5.4. Funding for independent sector activity is being provided either via the national contracting arrangements, or through the nationally determined funding envelopes, which will include an allowance for local independent sector commissioning. In addition, where actual independent sector usage exceeds/falls below levels seen in the same period of the prior year, 10% of the difference in value will be added to / deducted from nationally determined funding envelopes.

6. Independent hospital capacity

6.1. In August 2020, NHS England and NHS Improvement (NHSE/I), in collaboration with the Independent Healthcare Providers Network (IHPN) and independent sector providers, have now agreed modifications to the contract terms to ensure access to independent hospital capacity until the longer-term arrangements for the additional capacity the NHS needs, outlined in the phase 3 letter, are procured by October/November. The national contract notice has a closing date of 27 August 2020 with a

contract start date of 30 November 2020 with an end date of 1 December 2020. These longer-term arrangements will be commissioned by call-off contracts at a local level under a national framework agreement.

6.2. The expectation of the revised contract is for the NHS to use a designated proportion of capacity in every independent sector site. For clarity, patients referred directly to the independent sector providers via the e-Referrals Service, transferred from waiting lists to be treated by the independent sector and those treated by NHS teams deployed into IS sites are all defined as NHS patients within this capacity allocation. This will release a defined amount of capacity for private patient activity and enable private patients who have been waiting to receive care and independent sector providers to offer the NHS a guaranteed minimum private patient cost offset.

6.3. NHS England and NHS Improvement may trigger a return to ‘peak surge’, securing access to 100% of available IS capacity, staff and facilities to facilitate an expansion of the NHS Covid-19 capacity if required.

7. CCG Mental Health Investment Standard

7.1. To support the ambitions within the NHS Long Term Plan, the NHS made a renewed commitment that mental health services will grow faster than the overall NHS budget, creating a new ring-fenced local investment fund worth at least £2.3 billion a year by 2023/24.

7.2. In consecutive years the NHS in England has met its commitment that the increase in local funding for mental health (excluding learning disabilities and dementia) is at least in line with the overall increase in the money available to CCGs. This is called the mental health investment standard (MHIS). From 2019/20 onwards, as part of the NHS Long Term Plan, the MHIS also includes a further commitment that local funding for mental health will grow by an additional percentage increment to reflect additional mental health funding being made available to CCGs.

7.3. As per the guidance issued in August 2020, the NHS priority for Mental Health in 2020/21 is the rapid expansion of services. It is likely that the Covid-19 pandemic is likely to lead to a longer-term increase in mental health needs, in addition to the existing treatment gap. Ambitions previously stated in the NHS Long Term Plan for Mental Health still stand and are now even more critical to deliver as part of the response to Covid-19. All systems should thus strive to achieve 2020/21 LTP ambitions and drive recruitment, whilst locking-in beneficial changes and adapting plans in response to Covid-19.

7.4. ICSs/STPs will lead a review of the ICSs/STPs five year Long Term Plan planning submission for 2020/21. This review will support systems to integrate activity and financial planning and ensure that there is system understanding across ICSs/STPs, CCGs and providers, of delivery across all 2020/21 LTP deliverables.

7.5. ICSs/STPs will also have an opportunity to outline any additional pressures services are facing in 2020/21, that are currently unfunded. Whilst additional funding has not been confirmed, the information you provide will inform consideration at a national level of potential additional funding requirements.

7.6. The intention of the revised financial regime from month 7 (October) is that funding to meet the remaining MHIS requirement for the period will be included within system funding envelopes.

7.7. Systems will be able to determine the appropriate deployment to delivery partners, either through uplifts to NHS provider block payment arrangements for continuation of services funded through the retrospective top-up and to fund new commitments, or contracting with non-NHS providers

8. Non-recurrent Covid funding

8.1. Non-recurrent Covid funding was retrospectively funded to fund the additional cost of Covid as below. For months 7-12 a fixed funding pot has been given. If this is overspent, NHS bodies will not be funded for this.

8.2. For months 1-6 reasonable costs claimed included:

a) Evidenced increases in staffing costs compared to the baseline period associated with dealing with increased total activity.

b) Increases in temporary staffing to cover increased levels of sickness absence or to deal with other caring responsibilities (e.g. to look after other family members).

c) Payments for bank or sub-contractor staff to ensure all sickness absence is covered consistent with Government's announced policy and public health advice which are not otherwise covered under normal practice; and

d) Additional costs of dealing with COVID-19 activity. For example: the costs of running NHS111 assessment pods; increases in the volumes required or prices of equipment to deal with the response to the virus which aren't offset by reductions elsewhere; extra costs of decontamination and transport for the ambulance service; higher testing volumes in acute-based laboratories; and community-based swabbing services.

9. Top ups

9.1. A national top-up payment for months 1-6 was provided for providers and commissioners to reflect the difference between the actual costs and income.

9.2. This process has changed for months 7-12 with a fixed envelope given, if expenditure exceeds this then NHS bodies will overspend.

10. Temporary Covid-19 related services

10.1. Temporary Covid-19 related services which are funded by government on an actual cost basis (e.g. PPE acquired through the national system and Covid-19 testing services) – relevant organisations will be funded on an actual cost basis.

10.2. Costs will be monitored, and services will be subject to amendment based on costs incurred and the maximum budget available.

11. National service development funding (SDF)

11.1. System-level SDF allocations will be issued which consider revised priorities for 2020/21. Organisations should not include costs related to SDF-funded programmes in plans except where these programmes have been explicitly confirmed already.

11.2. At this point, this applies to all mental health SDF funding programmes and specific notified primary care programmes. Additional revenue allocations for 111 First are also expected but yet to be confirmed.