Paper ref:	TB (03/22) 011

Sandwell and West Birmingham NHS Trust

Report Title:	Draft 22/23 Finance Plan		
Sponsoring Executive:	Dinah McLannahan, Chief Finance Officer		
Report Author:	Dinah McLannahan, Chief Finance Officer		
Meeting:	Trust Board (Public)	**Date**	2nd March 2022

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

Following the publication of the 22/23 planning guidance we are progressing with a relatively "normal" planning process.

We will start 22/23 from where we are (H2 x 2) and be expected to deliver within a convergence "glidepath" defined by the 22-25 spending settlement for the NHS. We must prepare to recycle resources rather than commit to additional cost, as growth over and above "flat cash" may not be available. We have received an initial allocation offer from the Integrated Care System (ICS) which we are currently evaluating, particularly to understand key assumptions regarding inflation, growth, efficiency, elective recovery and strategic development funding.

We have now had the 1st round of detailed planning meetings with the clinical groups with a key focus being on managing our cost base. Our BVQC programme will be key to achieving this through controlling costs and restoring productivity – progress with this has been slower than we would like due to competing demands. The Group review process in March will focus on 2223 budgets, cost run rate reduction, and BVQC plans.

The focus is again, system wide performance. There is therefore an ICS planning process which asked for activity and workforce submissions by 18th Feb, the headlines of which are contained in this report. NHS England/Improvement expect draft plans submitted by 17th March, with final plans submitted on 29th April. This report sets out the proposed approval process for our plans. System capital envelopes will be calculated similarly to the 2122 methodology, now including a reference to Estates Return Information Collection (ERIC) and backlog maintenance liabilities.

Only 1 year envelopes will be published, but it is based on a 3 year model so systems should be able to estimate future years and improve their medium term planning for capital. The Trust has maintained a 5 year capital programme for a long time, refreshed annually. This will be fed in to the system planning process. It is likely that the system envelope will not be sufficient to fund all initial plans, particularly as the system is being asked to support cost pressures on developmental externally funded schemes, which reduces the operational capital budget available.

It is intended that the 2223 plan will form the baseline budgetary year for future Metropolitan University Hospital (MMUH) specific changes, and that this will be reflected in April reporting to Board.

2.	**Alignment to our Vision** *[indicate with an **'X'** which Strategic Objective this paper supports]*					
Our Patients		**Our People**		**Our Population**		
To be good or outstanding in everything that we do	**x**	To cultivate and sustain happy, productive and engaged staff		To work seamlessly with our partners to improve lives		

3.	**Previous consideration** *[where has this paper been previously discussed?]*
FIPC 25th Feb 2022	

4.	**Recommendation(s)**
The Trust Board is asked to:	
a.	**DISCUSS** the summary section of the paper
b.	**RECEIVE** assurance on progress in relation to developing a clear, triangulated plan
c.	**AGREE** delegated authority to the Executive Team to submit a draft plan to NHSEI on 17th March, with the intention to reflect a break even finance plan that meets planning guidance ambitions wherever possible
d.	**AGREE** to receive a final 2022/23 plan at the Board meeting in April prior to submission to NHSEI on the 29th April.

5.	**Impact** *[indicate with an **'X'** which governance initiatives this matter relates to and where shown elaborate]*							
Trust Risk Register	x	3688, 3689						
Board Assurance Framework	x	SBAF 9, SBAF 10						
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed		
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed		

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Public Trust Board: 2nd March 2022

Draft 22/23 Finance Plan

1. Summary of the Paper

1.1 This paper sets out in some detail the intended approach and initial submissions in relation to the 2022/23 financial, workforce, activity and performance plan. It has been the first opportunity to pull together the various elements in to one paper and therefore the headlines are summarised here for Board discussion.

1.2 Over the past two financial years, the pandemic and operational pressures have meant that expenditure has often not been in line with budgets. It is a key Trust priority for the 22/23 plan to reflect meaningful budgets which can be used to hold budget holders to account. All will be asked to accept their budgets and confirm that they can deliver it, and where they cannot, produce a specific action plan with a timescale within which budgetary compliance will be achieved. Triangulation between workforce, activity and performance, and the financial implications of such will be in place wherever possible.

1.3 Priority areas from the guidance and how the Trust intends to address each area are set out in Annex 1 to this paper. Dealing with them in turn;

1.4 **People -** Investing in our workforce – we describe in our return the various ways (set out in Annex 1) in which we will reduce our reliance on temporary workforce, increase substantive staff, improve sickness levels, improve retention and a renewed focus on wellbeing. The results of these actions are expected to increase our total substantive workforce by 5% to current budgeted levels (budgeted establishment for 2022/23 to be confirmed through financial planning processes). Within that, scientific, therapeutic and technical staff numbers are expected to increase by 8% (includes AHPs), nursing staff 4%, support to clinical staff 12%, and no increase expected in medical staff. Alongside this we are expecting a 50% reduction in bank usage, and a reduction in agency to zero.

1.5 **Patients -** Tackling the elective backlog is a major focus for the NHS in 2022/23. Elective Recovery Funding is available at a similar level to that received in 2021/22, and clawback will be in place for under-delivery, or additional funding for over-delivery. Performance will be measured at a system level, and initial submissions on elective recovery suggest that although long waits are expected to reduce in line with the guidance, we have more work to do on RTT, absolute activity volumes, and ensuring a reduction in our waiting list size by the end of March 2023. There is significant capital funding available to create more elective capacity in our region, and high level bids have

been submitted for 5 schemes, details of which are in the annex to this report. We currently expect to plan for achievement on all cancer standards as an organisation, but this may not be the case across the system and we may be asked to do more if we can on this to improve system wide performance.

1.6 There is significant Diagnostics ambition in the planning guidance for which some modalities the Trust expects to achieve (MRI and NOUS) with achievement by the year end on CT and Colonoscopy, and further improvement required in Echo, Endoscopy, and Flexi Sigmoidoscopy. This ambition is supported by three-year capital allocations (£13.98m in 2022/23) and dedicated revenue funding to support the set up and running of community diagnostic centres (CDCs). Alongside the development of CDCs, £21 million programme funding is available to support pathology and imaging networks, where plans should include the use of artificial intelligence in diagnostics. The Trust expects to meet faster diagnostic standard targets (FDS).

1.7 Improvements in maternity care are supported by approximately £93 million funding into baselines from 2022/23 to invest in workforce and support the implementation of actions from the Ockendon Report. For our system this totals £2.1m. Allocation of this resource has not been finalised.

1.8 Urgent and emergency care activity volumes are expected to reduce on pre-pandemic levels in the planning ambition and this is not currently reflected in our expectations.

1.9 In relation to transforming and build community services capacity, significant funding will be available to support the development of virtual wards. The PCCT group have described how this will work for the Trust as part of the MMUH business case planning process, identifying £1.243m of funding required for virtual wards. The guidance also states that, by December 2022, systems need to develop a plan to provide proactive care in the community for multimorbid and frail individuals. A national operating model for anticipatory care is expected. The Trust has covered this again in D2A and Frailty plans in relation to MMUH, and the reinvestment of community bed funding in to pathway 1 and pathway 2 care provision, doubling current expenditure.

1.10 Delivery of the Mental Health Investment Standard (MHIS) remains a mandatory requirement. The guidance states that, where Service Development Funding (SDF) supports ongoing services, this will continue to be funded beyond 2023/24. The Trust intends to bid via the MHIS for service improvements specifically in relation to the MMUH Mental Health service model, implemented in 2022/23, helping to meet significant challenges in relation to MH issues in our hospitals.

1.11 **Population -** The guidance states that, by April 2023, every system should have the technical capability for population health management, supported by longitudinal linked data. There will be a clear set of national technical requirements and standards to support this, along with national data platforms for key programmes such as Covid vaccinations. Systems are encouraged to work together to develop their data and analytic capabilities. Our system has been allocated £5.3m specifically in relation to Health Inequalities as a recurrent increase to the core allocation.

1.12 **Enablers - Digital technologies -** The guidance states that, in line with the NHS long term plan, acute, community, mental health, and ambulance providers are expected to reach a core level of digitisation by March 2025. Systems should develop plans by March 2022 to set out the first year's priorities to meet this ambition. Capital will be available to systems for three years from 2022/23 to support these plans. In 2022/23, £250 million will be allocated and directed towards those services and settings which are the least digitally mature. For our system this funding is £6.3m and the process to prioritise and allocate this funding is being led by the system. Funding will be provided to establish dedicated teams to support the development and delivery of costed three-year digital investment plans, which should be finalised by June 2022.

1.13 **Revenue -** One year revenue allocations have been published. The remaining two-year revenue allocations to 2024/25 are due to be published in the first half of 2022/23. The 2022/23 allocations have been set out in a draft envelope by provider and the finance team are working through the validation of that offer, and whether it covers our expected cost base. In addition, we must be very clear what unallocated budgets might be available (e.g. MHIS, SDF, other non-recurrent allocations that reasonably might be expected) as uncommitted at the beginning of the year, or are committed and increase the envelope. It is vital that we make decisions on resource commitment as early as possible to ensure we make the greatest difference, whilst balancing the books and wherever possible improving the underlying position. It is the Trust's aim to secure enough resource to cover expected costs, and plan for a cash backed break even position, supported by a risk share agreement as has been in place recently. The Black Country ICS will remain as the Trust's "host" ICS; i.e. the Trust's cost base will be part of the system control total for the Black Country ICS. When West Birmingham transfers on 1st July, this will mean that the Trust has a bigger contract than before with the BSol system. The resource envelope to transfer has been agreed between the two systems, and the Trust is validating its share of that as identified by the BC CCG. The BSol system is open to discussion on the nature of the agreement with SWBH – i.e. a similar approach to BSol ICS current members, or an alternative. The Trust is assessing options in relation to this.

1.14 **Capital –** An operational capital envelope of £84.794m has been allocated to the ICS, plus circa £10m of funding for digital and CDCs as outlined above. The Trust's initial

assessment of the capital budget required stood at £26.756m. Excluding some schemes for which alternative funding sources could be identified, this was reduced to £21.5m which was close to an expected envelope of £21m. The Trust is being asked to support the pre-commitment of several schemes already underway where cost pressures require funding which could reduce the Trust's envelope further by approximately £2m. Further work is required therefore on risk and prioritisation, and clarity on access to the CDC and Digital pots of funding.

2. Recommendations

2.1 The Trust Board is asked to:

a. **DISCUSS** the summary section of the paper
b. **RECEIVE** assurance on progress in relation to developing a clear, triangulated plan
c. **AGREE** delegated authority to the Executive Team to submit a draft plan to NHSEI on 17th March
d. **AGREE** to receive a final 2022/23 plan at the Board meeting in April prior to submission to NHSEI on the 29th April.

Dinah McLannahan
Chief Finance Officer

23rd February 2022

Annex 1 Priority Areas in the guidance and how the Trust intends to address them

Annex 1 - Priority Areas in the guidance and how the Trust intends to address them

2.2 **Invest in the workforce**

The guidance asks systems to accelerate work to transform and grow the workforce, building on existing people plans. It is expected that this will be achieved through improving retention; improving belonging and equality; working differently through the introduction of new roles and developing workforce to deliver care closer to home; and growing for the future through expanded international recruitment and supporting training programmes.

2.3 Our draft submission to the ICS describes the following headline areas in response to the above priority;

- A renewed focus on flexible working
- Improving the frequency and quality of early / mid and late career conversations and improving our onboarding process
- Continuing to help staff understand their pensions and options
- A renewed focus on health and well-being, including development of and access to Mental Health hubs
- To improve attendance by addressing the root causes of non-Covid absence and supporting staff to return to work
- To improve belonging in the NHS (whilst recognising that systems extend beyond the NHS), improving the Black, Asian and minority ethnic disparity ratio by delivering the six high impact actions to overhaul recruitment and promotion practices, and implement plans to promote equality across all protected characteristics
- Accelerating the introduction of new roles such as anaesthetic associates, first contact practitioners, and the expansion of Advanced Clinical Practitioners
- Development of the workforce to deliver multidisciplinary care closer to home, the rollout of virtual wards and discharge to assess models
- Optimising the capacity of the workforce through e-job planning and e-rostering
- Establishing or becoming part of NHS cadets and Reservists
- Expansion of international recruitment
- Creation of employment and training opportunities for local people, and expansion of apprenticeships as a route in to Health and Care
- Expanding collaborative bank arrangements, reducing reliance on high cost agency
- Ensure training of postgraduate doctors continues, with adequate time in the job plans of supervisors to maintain education and training pipelines, and ensure sufficient clinical placement capacity to enable students to qualify and register as close to their initial expected date as possible.

The results of the above actions are reflected in draft workforce submission wtes reflected in the table below, and the detailed budget setting process will align with the workforce plan by submission.

	2021/2022	Staff in post outturn	As at the end of Mar-23		
	Year End (31-Mar-22)	Year End (31-Mar-22)			
Workforce (WTE)	Total WTE	Total WTE	Total WTE	+/-	+/- F
Total Workforce (WTE)	7012.81	7757.25	7439.53	-4%	-317.72
Total Substantive	7012.81	6662.19	7006.52	5%	344.34
Total Bank		866.00	433.00	-50%	-433.00
Total Agency		229.06	0.00	-100%	-229.06
Substantive WTE	**7012.81**	**6662.19**	**7006.52**	5%	344.34
Registered nursing, midwifery and health visiting staff (substantive total)	**2336.71**	**2085.87**	**2178.74**	4%	92.86
Community Nursing staff	432.88	358.60	358.60	0%	0.00
Critical Care / ICU Nursing	205.71	177.69	177.69	0%	0.00
Registered scientific, therapeutic and technical staff (substantive total)	**789.87**	**763.18**	**823.17**	8%	59.99
of which registered allied health professionals	518.43	517.72	559.51	8%	41.79
of which registered health care scientists	135.67	127.89	127.89	0%	0.00
of which registered pharmacists	55.75	46.83	55.75	19%	8.92
of which registered pharmacy technicians	43.90	38.41	43.90	14%	5.49
of which registered other scientific, therapeutic and technical staff	36.12	32.33	36.12	12%	3.79
Registered ambulance service staff (substantive total)	**0.00**	**0.40**	**0.40**	0%	0.00
Support to clinical staff (substantive total)	**1825.25**	**1584.22**	**1775.70**	12%	191.48
of which support to nursing staff	1086.38	919.90	1086.38	18%	166.48
of which support to allied health professionals	102.71	94.65	119.65	26%	25.00
of which support to health care scientists and other ST&T	161.92	143.56	143.56	0%	0.00
of which support to ambulance	0.00	0.00	0.00	0%	0.00
of which other clinical support	474.24	426.11	426.11	0%	0.00
Total NHS infrastructure support (substantive total)	**1069.51**	**1268.57**	**1268.57**	0%	0.00
Medical and dental (substantive total)	**991.47**	**959.94**	**959.94**	0%	0.00
of which Consultants	386.36	347.88	347.88	0%	0.00
of which Career/staff grades	124.05	97.71	97.71	0%	0.00
of which Trainee grades/trust grade	481.06	514.35	514.35	0%	0.00
Any other staff (substantive total)	0.00	0.00	0.00	0%	0.00
Bank		**866.00**	**433.00**	-50%	-433.00
Agency		**229.06**	**0.00**	-100%	-229.06

2.4 **Respond to Covid-19 more effectively**

Some £90 million is being made available to support work to respond to Covid-19. This funding is expected to enable an increase in the number of patients referred to post-Covid services and seen within six weeks. It is also expected to decrease the number of patients waiting longer than 15 weeks to access appropriate post-Covid services. It is expected that the vaccination programme will remain a priority in 2022/23. The Trust received funding via the Service Development Funding for Long Covid clinics for 2122. It will seek to identify the full year effect of this funding for 2223.

2.5 **Tackle the elective backlog**

To be managed at a system level – therefore individual organisational plans need to combine to create one system plan that meets the planning guidance requirements, or be clear on the limiting factors where this is not possible. Maximise elective activity and reduce long waits. The guidance states that each system is required to develop an elective care recovery plan for 2022/23, to meet the ambition for systems to deliver over 10% more elective activity than before the pandemic. The draft position suggests the system does not meet that target in initial plans. From a Trust point of view, we do get there, but at the end of the year rather than for the year as a whole. There is also an expectation that long waits will be reduced, including an elimination of waits over 104 weeks; a reduction of waits of over 78 weeks; and extension of three-monthly reviews to all patients waiting over 52 weeks by 1 July 2022. In the draft submission the Trust and system expects to meet these long wait reduction targets.

2.6 It is also expected that outpatient follow-ups will continue to reduce by a minimum of 25% against 2019/20 activity levels by March 2023. The guidance sets out a number of ways that this might be achieved. The initial plan does not meet this requirement.

2.7 Some £2.3 billion of elective recovery funding has been allocated to support systems recover elective services in 2022/23. Four our system this is equivalent to circa £40m for 2022/23. In 2021/22, the Trust received £10.2m in ERF. We need to ensure we have a deliverable plan that earns the equivalent sum without risk of clawback in 2022/23, otherwise this creates a financial gap. A paper to the FIPC meeting in February reviewed the internal capacity against budgets for the Trust, plus insourcing and outsourcing opportunities. These will be aligned for final plan submission.

2.8 £1.5 billion capital funding has been made available to the NHS over the next three years to develop new surgical hubs, increase bed capacity and equipment to help elective recovery. Systems are expected to demonstrate how their capital proposals will increase elective activity. In addition, systems are required to develop delivery plans across elective inpatient, outpatient, and diagnostic services for adults and children for 2022/23. These plans should include how they will meet the elective recovery ambitions and how services will be organised to maximise productivity. Recovery must be inclusive, addressing health inequalities. The system has submitted several high level bids in relation to the £133m of regional funding available in 2022/23. These are additional theatre capacity at Cannock Hospital, additional theatre capacity at Sandwell Hospital (that had previously been assumed to be de-commissioned as part of MMUH plans), a Black Country Skin Cancer Hospital in Walsall, and then local theatre refurbishment, Vanguard, and Robotic Surgery opportunities in all areas. It is expected that the available funding will be significantly over-subscribed and plans will need to be rationalised.

2.9 **Cancer services**

The post-pandemic cancer recovery objectives set out in the 2021/22 H2 planning guidance must be completed as a priority. Cancer alliances are asked to work with local systems to improve performance against all cancer standards, with a number of specific areas of focus. Initial submissions indicate that the Trust expects to meet these standards, with improvement required system wide.

2.10 **Diagnostics**

The guidance states that systems should increase diagnostic activity to 120% of pre-pandemic levels to support elective recovery and early cancer diagnosis. It is expected that capacity will expand further in 2023/24 and 2024/25. The Trust's initial view is that MRI and NOUS will be achieved, with achievement by the year end on CT and Colonoscopy, and improvement required in Echo, Endoscopy, and Flexi Sigmoidoscopy.

2.11 This ambition is supported by three-year capital allocations, planned investment through Health Education England to facilitate training and workforce, and dedicated revenue funding to support the set up and running of community diagnostic centres (CDCs). Diagnostic equipment over ten years old should continue to be replaced. Our system has been allocated £13.98m in relation to this and the Trust has a significant equipment replacement programme of £7m for 2022/23 (subject to securing CRL).

2.12 Alongside the development of CDCs, £21 million programme funding is available to support pathology and imaging networks, where plans should include the use of

artificial intelligence in diagnostics. The Trust expects to meet faster diagnostic standard targets (FDS).

2.13 **Improvements in maternity care**
Approximately £93 million funding will go into baselines from 2022/23 to invest in workforce and support the implementation of actions from the Ockendon Report. For our system this totals £2.1m. Allocation of this resource has not been finalised.

2.14 **Urgent and emergency care and community care**
Systems are expected to reduce 12-hour waits in emergency departments towards zero and no more than 2%. In addition, work is required to minimise handover delays between ambulance and hospital to support achievement of ambulance response standards. We have not been required to submit a return on this yet but in all areas of non-elective and urgent and emergency care, activity is too high.

2.15 **Transform and build community services capacity**
The guidance states that up to £200 million will be available in 2022/23 and up to £250 million in 2023/24 to support the development of virtual wards. Systems are asked to develop detailed plans to maximise the rollout of this approach to deliver care for patients who would otherwise have had to be treated in hospital. Plans should cover two years and should be developed across systems and provider collaboratives, rather than individual institutions. The PCCT group have described how this will work for the Trust as part of the MMUH business case planning process, identifying £1.243m of funding required for virtual wards.

2.16 The guidance states that, by December 2022, systems need to develop a plan with health and care providers to deliver anticipatory care from 2023/24, providing proactive care in the community for multimorbid and frail individuals. A national operating model for anticipatory care is expected. The Trust has covered this again in D2A and Frailty plans in relation to MMUH, and the reinvestment of community bed funding in to pathway 1 and pathway 2 care provision, doubling current expenditure.

2.17 The hospital discharge programme will end in March 2022 and funding for related costs will not continue into 2022/23. Ongoing work should be supported by the rollout of virtual wards and working with partners through the better care fund (BCF).

2.18 **Improve access to primary care**
Improving access to primary care continues to be a national priority and the guidance reinforces previous expectations on local systems. Work towards digital-first primary care by 2023/24, should continue. Currently our system plans indicate we will need to increase capacity in this area.

2.19 GP contract changes will take effect in 2022/23. In addition, from April 2022, there will be a phased introduction of two new services; anticipatory care and personalised care; for Primary Care Networks (PCN).

2.20 **Mental health services**

The guidance recognises the impact that the pandemic has had on demand for mental health services. £150 million targeted capital funding will be made available over the next three years to support improvements to mental health urgent and emergency care. Funding to eradicate dormitories will continue in 2022/23 and 2023/24.
The ambitions of the NHS mental health implementation plan 2019/20 – 2023/24 still stand.

2.21 Delivery of the Mental Health Investment Standard (MHIS) remains a mandatory requirement. The guidance states that, where Service Development Funding (SDF) supports ongoing services, this will continue to be funded beyond 2023/24. The Trust intends to bid via the MHIS for service improvements specifically in relation to the MMUH MH service model, implemented in 2022/23, helping to meet significant challenges in relation to MH issues in our hospitals.

2.22 Local systems are asked to develop a mental health workforce plan to 2023/24 in collaboration with partners across NHS provider organisations; Health Education England; Voluntary, Community and Social Enterprise (VCSE) sector; and Education.

2.23 **Develop population health management, prevent ill-health, and address health inequalities**
The guidance states that, by April 2023, every system should have the technical capability for population health management, supported by longitudinal linked data. There will be a clear set of national technical requirements and standards to support this, along with national data platforms for key programmes such as Covid vaccinations. Systems are encouraged to work together to develop their data and analytic capabilities.

2.24 Local systems are required to develop plans for the prevention of ill-health covering a range of areas including smoking cessation (utilising £42 million of System Development Funding (SDF), lifestyle services, stroke and cardiac care, and reduction of antibiotic use. Our system has been allocated £5.3m specifically in relation to Health Inequalities as a recurrent increase to the core allocation.

2.25 **Digital technologies**
The guidance states that, in line with the NHS long term plan, acute, community, mental health, and ambulance providers are expected to reach a core level of digitisation by March 2025. Systems should develop plans by March 2022 to set out the first year's priorities to meet this ambition. Capital will be available to systems for three years from 2022/23 to support these plans. In 2022/23, £250 million will be allocated and directed towards those services and settings which are the least digitally mature. For our system this funding is £6.3m and the process to prioritise and allocate this funding is being led by the system.

2.26 Funding will be provided to establish dedicated teams to support the development and delivery of costed three-year digital investment plans, which should be finalised by June 2022.

2.27 **Effective use of resources**

The 2021 spending review provided a three-year settlement for both revenue and capital. This section provides a summary of the key points included within the overarching planning guidance.

2.28 **Revenue**

The government committed £8 billion in the spending review to support tackling the elective backlog from 2022/23 to 2024/25. Of this, £2.3 billion is committed in 2022/23 to support elective recovery, as long as planning guidance targets are met. As outlined above, this is equivalent to £40m for our system. In 2021/22 the Trust received £10.2m in ERF. We can expect clawback if we do not achieve (system wide), planning guidance ambition. This would represent a reduction in funding from this financial year which we would not normally plan to do. Equally, if we over-perform, more resource would be available.

2.29 One year revenue allocations have been published. The remaining two-year revenue allocations to 2024/25 are due to be published in the first half of 2022/23. The 2022/23 allocations have been set out in a draft envelope by provider and the finance team are working through the validation of that offer, and whether it covers our expected cost base. In addition, we must be very clear what unallocated budgets might be available (e.g. MHIS, SDF, other non-recurrent allocations that reasonably might be expected) as uncommitted at the beginning of the year, or are committed and increase the envelope. It is vital that we make decisions on resource commitment as early as possible to ensure we make the greatest difference, whilst balancing the books and wherever possible improving the underlying position. It is the Trust's aim to secure enough resource to cover expected costs, and plan for a cash backed break even position, supported by a risk share agreement as has been in place recently.

2.30 **Financial framework**

Allocations will be based on current system funding envelopes but will begin a glide path to fair share allocations. A convergence adjustment will be applied to bring systems towards their fair share of NHS resources over time. Funding previously included to support financial sustainability will be included in the allocation, and an efficiency requirement will be in place.

2.31 There will be a requirement to deliver a financially balanced system through collective local accountability across system partners.

2.32 2022/23 sees a return to local ownership for payment flows, with signed contracts between commissioners and providers. Local systems and organisations are expected to take a partnership approach to establishing payment terms.

2.33 Additional revenue and capital resources will be provided to systems to support elective recovery. Where systems exceed target levels, additional revenue will be available. Provider elective recovery plans will be funded in line with the aligned payment and incentive approach, with payment linked to the actual activity delivered.

2.34 At the time of writing the paper, the ICS has not had the chance to discuss the details as to regards the finer points such as contract form, elective recovery plans, and Covid allocations. The Trust Board and respective Board Committees will be kept updated as appropriate.