Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Update on 2015/16 Financial Plan and Approval of 2015/16 Initial Budgets

Governing Body meeting

C

2 April 2015

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Is your report for Approval / Consideration / Noting

This report is in two sections. Section A provides an update on the financial planning process for 2015/16 and asks Governing Body to approve the CCG's initial 2015/16 budgets as set out in Appendix A to allow Budget Holders to start to authorise expenditure. Section B sets out the proposals in relation to providing financial information at GP Practice level for 2015/16 for approval.

Are there any Resource Implications (including Financial, Staffing etc)?

None.

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?
Strategic Objective - To ensure there is a sustainable, affordable healthcare system in Sheffield. It supports management of the CCG's principal risks 3.2, 4.3 and 4.4 in the Assurance Framework.

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached? No.

If not, why not? There are no specific issues associated with this report.

PPE Activity

How does your paper support involving patients, carers and the public?
Not Applicable.

Recommendations

The Governing Body is asked to:

A) Approve the CCG's initial 2015/16 budgets as set out in Appendix A.

B) Approve the proposals in respect of providing financial information at GP practice level as set out in section B to the report.

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Section A: Setting Initial CCG Level Budgets for 2015/16

1. Background

CCG Governing Body has previously approved the key principles and assumptions to underpin the construction of the 2015/16 financial plan. A summary of these is set out at Annex A for ease of reference.

Work has continued since the last Governing Body meeting to refine the expenditure plans, taking into account specific issues relating to the impact of changes to the forecast out-turn position for 2014/15. As reported in the M11 finance report, we have increased our forecast surplus for 2014/15 by £1.8m. NHS England has confirmed that in releasing this funding at M11, we will be able to draw down the surplus in 2015/16 so that we can utilise this funding to support the financial plan. One of the main reasons for the additional surplus is slippage in delivery of the extra acute elective activity to ensure achievement of the Referral to Treatment (18 weeks) NHS Constitution pledge. This activity will now need to happen in 2015/16 and hence the funding will be deployed for this purpose.

As verbally reported to Governing Body in March, the financial plan was submitted to NHS England on 27 February. We expect general feedback in advance of the final financial plan submission, the deadline for which is currently 7 April 2015.

2. Key Issues and Risks

As expected at the start of a new financial year, there are a wide range of risks and uncertainties which will need to be managed. CCG Governing Body will receive an update each month on risks and the management of these and will be asked to consider and approve recovery actions if delivery of the financial plan goes “off track” in year. The key issues for noting are:

a) The opening budgets assume delivery of a 1.0% surplus, £7.4m (£6.4m against the programme allocation and £1m from running costs) in line with the minimum requirement from NHS England. Thus all the surplus above 1% confirmed at M11 in 2014/15 has been “drawn down” for use in 2015/16.

b) The financial plan has to be considered as draft at this stage and hence the initial budgets set out for approval at appendix A seen in this context. The main reason for this is that at the time of writing the report we have not yet agreed contracts with any of our main providers. Whilst activity plans are largely agreed there are a number of other issues including development requests, and a range of

technical/pricing issues which at the moment result in a substantial financial gap between provider expectations and CCG offers. The revised national target date for agreement is 31 March 2015. A verbal update on progress will be provided at the meeting. The primary cause of the delay in agreeing contracts is the rejection nationally by trusts of the original national tariff proposals and then the subsequent process for revised options offered by NHS England and Monitor. CCGs at the time of writing are still waiting to be advised of their share of the £150m additional funding being made available non recurrently to help manage the implications of the revised tariff options.

c) A key priority of the 2015/16 planning/contracting round has to been to ensure with our main acute hospital providers that we jointly plan for a level of elective activity which will sustainably allow the delivery of referral to treatment and other NHS Constitution requirements. This represents a significant cost pressure to the CCG – non recurrently and recurrently, leaving very limited capacity for other investments. A key risk to delivery of the financial position in 2015/16 is whether actual activity reflects these plans, both in volume and case mix terms and delivery will be monitored closely each month.

d) The pooling of £270m funds with Sheffield City Council – of which £165m is from the CCG's recurrent allocation supported by our Better Care Fund (BCF) section 75 agreement is a major initiative. There are various critical work streams within these arrangements which need to start to deliver significant changes during 2015/16. The BCF budgets for 2015/16 have been jointly agreed with financial risk share arrangements. However, the service areas involved include such as Continuing Health Care (CHC) and non elective admissions, as well as adult social care, and these can all be areas of overspend, keeping spend within the £270m will be a significant joint challenge.

e) The financial plan incorporates a Gross Quality, Innovation, Productivity and Prevention (QIPP) saving of £6.0m. Delivery of the QIPP Programme requires substantial and positive clinical engagement in supporting the service changes required. Our current risk assessment is around 50% may not deliver which is why through the clinical portfolios other schemes are currently being developed to provide much greater resilience to the delivery of the £6m.

f) All CCGs had a 10% reduction in their running costs allowance – so £1.5m reduction for Sheffield in 2015/16. This has reduced the level of funding we can transfer to support commissioned spend in 2015/16 and left us with a very small (c£0.1m) contingency reserve for in year pressures.

4. Approval of opening 2015/16 revenue budgets

It is recommended good practice for approval of budgets before or at the very start of a new financial year. **Appendix A** sets out the initial budgets covering our total anticipated resources of £724m (programme) and £12m (running costs).

The budgets have been assigned to individual directors where possible, and the Governing Body is asked to approve these opening budgets and the distribution to individual directors to enable expenditure to be committed and payments to be made as necessary at the start of 2015/16.

Section B. GP Practice level financial reporting

5. Background

The CCG has set indicative practice level budgets for the last two years based on the view that it was appropriate to demonstrate how the total allocation for the CCG could be notionally split at individual member practice level. This has been a time consuming task for the finance directorate, requiring a range of estimates and calculations. The other primary purpose has been to incentivise practices to support the delivery of the organisation's strategic objectives. The setting of practice level budgets, and the provision of in year financial monitoring information via the electronic Practice Reporting System, alongside activity data allows Localities and practices to access a range of information.

Since 2013/14 there has been no new guidance issued by NHS England on the approaches CCGs should take to set practice level budgets. In the absence of any new guidance the actual practice level activity from the previous year has been used as a basis for the following year. Some estimates of 'capitation shares' were required to allocate certain budgets and the old fair shares formula from the DH toolkit, was updated with the latest available practice list size information. The whole process of developing and producing the practice budgets can take several weeks and is time consuming not only for the finance team but also other CCG Directorates and Health and Social Care Information Centre (HSCIC) support.

For 2013/14 NHS England devised a new "fair shares" formula for allocations to CCGs. The basis is age/sex weighted population with little weighting given for deprivation factors. No information was provided to devise a similar fair share calculation at practice level and we understand that there will be no guidance issued for 2015/16.

The NHS Act 2012 makes no reference to the requirement for CCGs to set practice level budgets. The level the budget devolved is at CCG level where it gives groups of GP practices and other professionals – clinical commissioning groups (CCGs) – 'real' budgets to buy care on behalf of their local communities. Thus there is no legal requirement for the CCG to set practice level budgets. There is no requirement within our Constitution to allocate CCG budgets to the level of GP practice or Locality.

We have tested out with other local CCGs in Yorkshire and Humber and with Core Cities. Very few CCGs are choosing to set budgets at practice level.

As a membership organisation, the only time a CCG needs to split its allocation by constituent practices is if any practice were to opt to move to a different CCG, as the level of resources that would need to transfer would need to be confirmed. The likelihood of this occurring is thought to be small. This would be a one off exercise and the methodology would need to be agreed with both the 'giving' and 'receiving' CCG at that time.

6. Proposal for 2015/16

The proposal is to cease setting practice level budgets but to continue to provide in year financial monitoring information via the Practice Reporting System alongside related activity information, at practice level. The exception would be if budgets are required for example as part of any incentive scheme established at practice level. The Finance directorate would continue to support the Localities by providing benchmarking information which would highlight practices that are outliers or trends in performance.

Discussions are taking place within the CCG regarding new ways of working with GP practices and localities. The CCG has also just appointed the five new Clinical Directors for each of the Portfolios. We expect this will accelerate the service redesign work of the CCG including the preparation of business cases, and there is much to be done currently to develop and implement QIPP schemes. Some of these cases will require detailed financial modelling and potentially information to be shared at practice level. The finance team believe we would be best deployed using our expertise and experience to support these specific initiatives.

This proposal reflects the discussions at Commissioning Executive Team (CET).

It is important to note that this proposal does not change the process whereby the CCG has contracts with individual practices for locally commissioned services.

7. Recommendations

The Governing Body is asked to:

A) Approve the CCG's initial 2015/16 budgets as set out in Appendix A.

B) Approve the proposals in respect of providing financial information at GP practice level as set out in section B to the report.

Julia Newton
Director of Finance
March 2015

Annex A

Key Assumptions for 2015/16 Financial Plan and Initial Budgets

1. Delivery of 1% reported surplus: The CCG has a statutory duty of financial breakeven but NHS England requires each CCG to plan for a 1% surplus which it will carry forward to future years. With the increase in allocation our figure increases from £7.2m to £7.4m.

2. Retain 1% of baseline resources for NON recurrent expenditure National guidance is that for 2015/16 CCGs have to plan on at least 1%. In simple terms the plan for 2015/16 assumes two main areas of spend: a) £3m will be needed to contribute to the national risk pool on clearing CHC retrospective claims. This could be an underestimate; b) £3m will be used as the contingency reserve as part of the Better Care Fund risk share arrangements which can include using for QIPP pump priming/double running. The remaining c£1m is allocated to other specific initiatives.

3. Maintain a 0.5% (£3.7m) general contingency reserve This is the third national financial planning requirement. It is financial "good practice" to start the year with a reserve for unexpected in year pressures. Should such pressures not materialise the funding can be used for local priority investments in year.

4. Recurrent baseline opening budgets: For each contract or service area the finance & contracting team have made an assessment of the recurrent baseline requirements using the latest intelligence on 2014/15 spend. This is before taking into account any full year effect of existing QIPP programmes as these will be built into the following year's QIPP programme to allow for transparent monitoring of these savings and allow for stronger in year risk management.

5. Inflation, Tariff and PbR changes: We have used the national planning assumptions and most recently have amended to reflect the options made by trusts in response to NHE England revised proposals - ie the Enhanced Tariff Offer (ETO) or the default 2014/15 tariff roll over less the right to earn 2.5% CQUIN.

   However, Governing Body has agreed that there are a few areas of community and primary care spend where the CCG may find it appropriate to not impose a cash releasing efficiency requirement. In such circumstances the CCG will be looking for improvements in outcomes.

   GP prescribing is a major budget (£96m) where we have applied no price reduction as prices are set nationally through national negotiations or by individual suppliers and the CCG has no control over price setting. A provision for growth in activity/price fluctuations is made within cost pressures equating to 4% of budget before QIPP.

6. Underlying/Specific Activity Demand: A critical element of the financial planning process is to understand the underlying demand due to population changes, new technologies and other factors influencing demand for health services. Modelling has been undertaken jointly with service providers where appropriate and internally with information and contracting colleagues to identify possible cost pressures. For

example the acute contracts build in agreed activity projects to deliver the Referral to Treatment Target.

7. Investment Priorities: The current Commissioning Intentions document sets out the priorities identified by portfolio leads in some detail. The financial plan has a £1m fund for discretionary investment of which part is pre-committed eg for the full year impact of Mental Health transition services. It also incorporates a £0.5m budget to continue with the innovation fund to support testing out pilot proposals.

   We believe that the 2014/15 initiative which required CCGs to demonstrate £5 per head of new investment was being spent on initiatives to support the care of patients over 75 years (c£2.7m for Sheffield) does not apply in 2015/16.

8. Better Care Fund: The CCG is entering into a section 75 agreement with Sheffield City Council to undertake integrated commissioning in a number of areas as set out in our Commissioning Intentions. As part of these arrangements the two organisations have agreed to an initial pooled fund of £270m for 2015/16, of which £165m is from the CCG, as approved by the CCG's Governing Body at its March 2015 meeting. The spend against the £270m will be reported separately within the monthly monitoring arrangements to Governing Body. The section 75 agreement contains the financial risk share arrangements for the pooled funds as agreed by Governing Body.

9. Quality Premium: At this stage the plan does not include an allocation for the Quality Premium based on funding likely to be earned against 14/15 targets. We estimate the value might be c£700k and this would be allocated primarily to support a continuation of the Quality Incentive Scheme with GP Practices.

10. QIPP: The key driver for QIPP is to improve services to patients. We are looking to achieve a major shift in the setting in which patients receive services and reduce the need for acute interventions where appropriate. From a financial perspective the CCG needs to undertake QIPP for 2 reasons:

    - To deliver the planned financial position where we need savings from QIPP to meet cost pressures as the cash uplift will be insufficient to meet assessed pressures

    - To allow the CCG to invest in new quality developments.

    QIPP Plan for 2015/16

Programme Area	Note	GROSS QIPP Savings	Investment Provision	NET QIPP Savings
		£'m	£'m	£'m
Elective care	1	0.7	-	1.0
Urgent care	2	4.3	-	4.0
Mental Health	3	-	-	-
CHC	4	0.5	-	0.5
Prescribing	5	0.5	-	0.5
Community Care	6	-	-	-
TOTAL		**6.0**	**0**	**6.0**

Note 1: **Elective Care** – the portfolio team are working on a number of proposals around the redesign of outpatients, reduction of follow ups and changes to clinical pathways. This is for both adult and children. If we are discussing simply a transfer of care with no financial savings then this is best presented outside of QIPP.

Note 2: **Urgent Care -** The savings to the CCG broadly come in 3 areas: Reduced admissions, reduced A&E attendances and reduced excess bed days. Each of the key themes within the integrated commissioning arrangements with Sheffield City Council which form part of the Better Care Fund arrangements support reducing the number of people requiring urgent hospital care

Note 3: **Mental Health**. Where we identify savings on particular services we would expect to re-invest in other mental health services as part of maintaining /increasing spend on mental health linked to the parity of esteem initiative.

Note 4: **CHC** Sheffield spend on CHC now benchmarks around the national average. However, there remain opportunities for reducing demand and for increased efficiency and these will be explored primarily as part of the Better Care Fund joint working.

Note 5: **Prescribing** Historically the Medicines Management team has been very successful in working with GP practices to deliver substantial year on year savings. Clearly as a result of this, the opportunity to deliver further savings in future years is diminishing, so a modest target has been set for 15/16.

Note 6: **Community services** – the working assumption is that there will be no QIPP requirement against community services other than where we agree it is appropriate to levy the negative tariff deflator or there are specific community services which we could/should disinvest in.

11. Running Costs: The national planning guidance makes it clear that CCGs will receive a Running Cost Allowance (RCA) separately from their commissioning allocation. CCGs are not allowed to overspend against this allocation but can plan to underspend against the allocation and can use any in year underspend to support commissioned activities.

    The financial plan assumes we will deploy £1m to support commissioned spend in 2015/16. This is less than that achieved in 2014/15 because of the 10% or circa £1.5m cut in RCA funding for 2015/16.

Sheffield CCG
Initial Revenue Budgets for 2015/16

Appendix A

	Proposed Budget Holder	2015/16 Recurrent Budget b/f £000	Virements* £'000	Growth £000	Rec RRL £000	Non-Rec RRL £000	Inflation £000	Efficiency £000	QIPP Rec £'000	Cost Pressures Rec £000	Cost Pressures NonRec £000	New Investment Rec £000	New Investment NonRec £000	Annual Budget Rec £000	Annual Budget NonRec £000	Annual Budget Total £000
PROGRAMME BUDGETS																
Allocation		**694,274**		**13,475**	**12,399**	**10,300**								**720,148**	**10,300**	**730,448**
Expenditure	**N.B. ALL BUDGETS ARE SHOWN NET OF INCOME**															
Secondary Care																
Sheffield Teaching Hospitals NHS FT	Director of Finance	308,236	(42,848)				7,968	(10,085)	(2,125)	4,947				266,093	0	266,093
Sheffield Children's NHS FT	Director of Finance	30,426					913	(1,156)	(250)	500				30,433	0	30,433
Ambulance Services	Director of Finance	21,417					413	(814)		500				21,516	0	21,516
System Resilience	Director of Finance			3,766										3,766	0	3,766
Other NHS Trusts	Director of Finance	9,975	(668)				279	(354)						9,233	0	9,233
ISTC & Extended Choice	Director of Finance	8,406	(6,773)				49	(62)						1,620	0	1,620
IFRs	Chief Nurse	646												646	0	646
NCAs	Director of Finance	3,493	(232)				98	(124)						3,235	0	3,235
Mental Health																
Sheffield Health and Social Care NHS FT	Director of Finance	73,465	(446)				1,409	(2,775)		422				72,076	0	72,076
IFRs MH	Chief Nurse	497					10	(19)						487	0	487
Other Mental Health	Director of Finance	1,259	(774)				9	(18)						475	0	475
Primary & Community Services																
Sheffield TH NHS FT	Director of Finance	55,388	(40,185)				293	(578)						14,918	0	14,918
Sheffield Children's NHS FT	Director of Finance	3,103					60	(118)						3,045	0	3,045
Primary Care Access Centre	Director of Finance	2,771					53	(105)						2,719	0	2,719
Other Community	Director of Finance	605	(268)				7	(13)						331	0	331
St Lukes Hospice	Director of Finance	2,528												2,528	0	2,528
Voluntary Organisations	Director of Finance	821												821	0	821
Locally Commissioned Services	Programme Director & Director of Finance	4,660	(1,455)						(101)	20				3,124	0	3,124
111	Director of Finance	1,147					24			100				1,271	0	1,271
Local Authority																
Section 256 - Grants	Director of Finance	3,146	(2,340)					(20)						786	0	786
Section 75 - LD Pooled Budget		2,664	(2,665)											(0)	0	(0)
Section 75 - Equipment Service Pooled Budget		1,736	(1,736)											0	0	0
Other Commissioning	Director of Finance	276								40				316	0	316
Premises - voids and other recharges	Director of Planning & Partnerships	1,461												1,461	0	1,461
Continuing Healthcare																
Continuing Care	Chief Nurse	45,852	(44,129)							175				1,898	0	1,898
Funded nursing care		5,749	(5,749)											(0)	0	(0)
Prescribing	Chief Nurse	92,572							(500)	3,623				95,695	0	95,695
Other Programme Expenditure																
Continuing Healthcare Assessments	Chief Nurse	2,019					20							2,039	0	2,039
Medicines Management Team	Chief Nurse	1,127					11							1,139	0	1,139
Development Nurses	Chief Nurse	459					5							463	0	463
Better Care Fund					12,399									12,399	0	12,399
Theme 1 - Keeping People Well	Programme Director & Director of Finance		1,608				0	0	0	360				1,968	0	1,968
Theme 2 - Active Support & Recovery	Director of Finance		38,261				622	(1,226)	0	4,396				42,053	0	42,053
Theme 3 - Equipment & Adaptations	Director of Finance		1,736				0	(60)	0	0				1,675	0	1,675
Theme 4 - Long Term High Support	Chief Nurse		53,317				701	(27)	(500)	1,000				54,492	0	54,492
Theme 5 - Urgent Care Inpatient admissions STH	Director of Finance		55,346				1,660	(2,103)	(2,524)	553				52,932	0	52,932
Reserves																
Commissioning Reserves	Director of Finance	131				(223)				1,802		1,000	2,887	2,933	2,664	5,597
General Contingency Reserve	Director of Finance											3,700		3,700	0	3,700
1% Non recurrent reserve	Director of Finance												7,077	0	7,077	7,077
CCG Expenditure		**686,034**	**0**	**3,766**	**12,399**	**(223)**	**14,605**	**(19,656)**	**(6,000)**	**18,439**	**0**	**4,700**	**9,964**	**714,286**	**9,741**	**724,028**
Net Surplus Programme		8,240	(0)	9,709	0	10,523	(14,605)	19,656	6,000	(18,439)	0	(4,700)	(9,964)	**5,861**	**559**	**6,420**

* virements relate to transfer of budgets to either the Better Care Fund or to the MSK Outcomes Contract shown within the Sheffield Teaching Hospitals Secondary Care Budget line

	Proposed Budget Holder	2015/16 Recurrent budget b/f £000	Virements £'000	Growth £000	Rec RRL £000	Non-Rec RRL £000	Inflation £000	Efficiency £000	QIPP Rec £'000	Cost Pressures/ Rec £000	Cost Pressures/ NonRec £000	New Investment Rec £000	New Investment NonRec £000	Annual Budget Rec £000	Annual Budget NonRec £000	Annual Budget Total £000
Running Cost Allocation		**14,057**		**(1,430)**										**12,627**	**0**	**12,627**
Expenditure																
Governing Body & Directors (incl Clinical Directors & Governance) and Locality Management	Accountable Officer	2,320					28							2,348	0	2,348
Clinical Engagement + PLI	Medical Director + 5 Clinical Directors	490												490	0	490
Finance & Contracting	Director of Finance	1,732					17							1,750	0	1,750
Operations Management	Chief Operating Officer	1,875					19							1,893	0	1,893
Clinical Quality & Clinical Services	Chief Nurse	1,743					17							1,761	0	1,761
Premises & Bought in Services	Chief Operating Officer	3,066					31							3,097	0	3,097
Collaborative commissioning arrangements	Director of Finance	138					1							139	0	139
Running Costs Reserve	Director of Finance	1,192		70			(114)						(1,000)	1,148	(1,000)	148
10% reduction in RCA in 15/16		1,500		(1,500)										0	0	0
Running Costs expenditure		**14,057**	**0**	**(1,430)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(1,000)**	**12,627**	**(1,000)**	**11,627**
Net Surplus														**0**	**1,000**	**1,000**
TOTAL CCG Planned Position														**5,862**	**1,559**	**7,420**