Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Primary Care Commissioning Committee

Approval of 2016/17 Budgets

E

1 April 2016

Author(s)	Diane Mason, Senior Finance Manager
Sponsor	Julia Newton, Director of Finance

Is your report for Approval / Consideration / Noting

For Information: This report provides information on the delegated Primary Care budgets and the CCG Local Commissioned Service budgets for 2016/17, together with a discussion on key opportunities/risks along with the proposed governance structure.

For Approval:
Approve the detailed Primary Care and Local Commissioned Service budgets for 2016/17

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 3.1, 4.1, 4.2 and 4.3 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.

(the template can be found at http://www.intranet.sheffieldccg.nhs.uk/equality-impact-assessments.htm
(or contact Elaine Barnes elaine.barnes3@nhs.net / 0114 305 1581)

PPE Activity

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

Recommendations

The Primary Care Commissioning Committee is asked to:

- Note the resource allocation made to the CCG in respect of the delegated primary care budget of £74.7m for 2016/17.
- Approve the initial primary care budgets and Local Commissioned Service budgets for 2016/17 set out in Appendix A and Appendix B noting the assumptions used to

calculate the budgets.

- Consider the issues and financial risks for the delegated Primary Care budget set out in section 5 above.

- Note the proposed governance arrangements for the delegated Primary Care budget set out in Section 6 above.

Primary Care Commissioning Committee

Approval of 2016/17 Budgets

1 April 2016

1. Purpose of Paper and Introduction

Following approval for NHS Sheffield CCG to take on delegated responsibility from NHS England (NHSE) to co-commission GP led Primary Care, an allocation of funding has been made to the CCG for 2016/17 which will form part of the CCG's overall resource limit and need to be accounted for within the CCG's formal statutory accounts for 2016/17.

The purpose of this paper is to:

A) <u>For Delegated Budgets</u>

- Provide information on the allocation made from NHS England.
- Request approval for the initial detailed Primary Care budgets to be co-commissioned with NHS England for 2016/17.
- Set out a summary of the main assumptions used to develop the budgets.
- Set out the key issues and risks which require further work and consideration.
- To note the governance arrangements which are being considered by the Audit and Integrated Governance Committee

B) <u>For other budgets /contracts with Primary Care Providers</u>

The intention is that we will bring together information on all CCG contractual spend with primary care providers as part of financial reporting to the Primary Care Committee during 2016/17 and not just spend associated with core GMS/PMS services from the delegated budgets from NHS England. The CCG's Governing Body have previously agreed that as part of managing conflict of interest issues, it would be appropriate to delegate responsibility to the Primary Care Committee matters such as approval of Local Commissioned Services contracts. As a result, this paper also seeks approval of the initial deployment of the Local Commissioned Service budget for 2016/17.

2. Allocation made from NHS England for Primary Care Budgets and compliance with NHSE financial business rules.

An allocation of £74,747k has been made to Sheffield CCG for the delegated primary care functions. This is made up as follows;

- £72,174k 2015/16 budget brought forward
- £2,573k growth funding – 3.5% uplift

The 3.5% uplift is higher than the 2.2% uplift which the CCG received on its main allocation because nationally a separate allocation formula exists for primary care and because NHSE's Board at its meeting on 17 December 2015, agreed a higher average % uplift for primary care budgets.

NHS England has, however, stated that the allocation is not ring-fenced against primary care expenditure.

Two of the three finance business rules for CCG main allocations also apply to the allocation, i.e.

- establish a 0.5% contingency reserve – set at £374k for 2016/17.
- set aside a 1% uncommitted reserve which must be held as part of wider health system contingency arrangements and which can only be released or utilised with formal approval from NHSE - set at £747k for 2016/17.

However, there is no requirement in 2016/17 to deliver a 1% surplus against the primary care allocation. The requirement is "statutory breakeven". However, it is possible that we will be required to hold the 1% uncommitted reserve all year and then release to increase the CCG's overall surplus at March 2017.

Considerable work has been undertaken, along with the other South Yorkshire CCGs, over the past year to ensure that the budget to be allocated for the delegated services is a fair allocation for all 5 CCGs. Taking into account the original funding that was passed to NHS England from the PCTs in April 2013 and the current commitments against the allocation, it would appear that overall Sheffield CCG has received a fair and reasonable settlement.

3. Proposed Primary Care budgets for 2016/17

The proposed opening budgets for 2016/17 are detailed in **Appendix A.** Joint work has taken place with NHS England over the last few weeks to understand the current commitments against the budget, the financial risks at individual budget area level and the level of any uncommitted reserve. This work is still ongoing and the budgets are set at a level that best reflects our current understanding of commitments.

The indicative level of uncommitted reserve has currently been estimated by NHS England as £3.36m based on existing information on expected spend associated with core services including QOF and premises; and after allowing for transfer of the additional £1.1m which becomes available as part of PMS transition arrangements to the Locally Commissioned Services budget to partly fund the "over and above" LCS (see section 5 below) . It is split down as follows;

	£000
• 0.5% contingency reserve	374
• 1% uncommitted non-recurrent reserve	747
• Remaining uncommitted reserve	2,247
Total	**3,368**

The remaining uncommitted reserve is significant and results from several sources:

- funding reduction resulting from the APMS re-tender of core service contracts for The Clover Group practices and Broad Lane Medical Centre, currently estimated at around £1m. However, this is prior to any decision to contract for Locally Commissioned Services over and above core contract services from these APMS practices – a separate paper is being presented to private session of this Committee with proposals.
- review of rates resulting in rebates estimated at savings in expenditure of £456k and
- growth funding, a proportion of which remains uncommitted.

QIPP expectations

CCGs are expected to develop QIPP (efficiency) plans and NHSE have set a marker range of 2 to 3% of total allocation including any delegated Primary Care budgets. 2% of the primary care allocation would be £1.5m. Whilst on paper we appear to have uncommitted reserves in excess of this amount given the risks/issues discussed in sections 4 and 5 below and the CCG's strategic ambition to invest further in out of hospital care including primary care, it would appear difficult to plan on a full 2%. However, as members of this committee are aware, the CCG is facing a very financially challenged position for 2016/17 including whether we can put in place a financial plan which will deliver our statutory breakeven duty. As a result, Governing Body approved a draft QIPP plan of £19.5m at its meeting in March 2016 which included a £500k contribution from the uncommitted delegated primary care budget reserves. Primary Care Commissioning Committee is therefore asked to endorse this contribution.

Section 5 on financial risks discusses the current potential calls on the remaining uncommitted reserve.

4. Main Assumptions used to develop the Primary Care budgets

NHS England recently announced the outcome of the contract negotiations regarding the changes to the GMS contract for 2016/17.

- 1% pay uplift for core GMS contracts
- Increase in the value of a QOF point
- The dementia enhanced service to cease and the funding to be re-cycled into core contract at 73p per patient
- Additional funding to cover expenses relating to CQC costs and other business expenses.

Whilst the changes announced are specifically applicable to the GMS contracts, the same principles have historically been applied to PMS contracts and this is the basis of the assumptions used to calculate the 2016/17 budgets. The proposed budgets therefore currently include;

- NHSE best estimate of the recurrent commitments as the 2015/16 brought forward position. For QOF this is based on 2014/15 achievement as further work is still required on the likely 2015/16 position.
- 1% pay uplift for core GMS and PMS contracts.

- 1% inflation increase on premises reimbursements and QoF and 3% inflation on other premises budgets (mainly revaluations).
- An increase of 0.7% for expected demographic changes on the core contract, enhanced services and QoF.
- The dementia enhanced service to cease and the funding to be re-cycled into core contract at 73p per patient.

The specific financial impact of the increase in the QOF point is unknown at this point and hence a 1% uplift has been built into the budget to allow for this. Any additional funding for CQC and other business expenses has not yet been calculated.

5. Financial Risks and Key Issues of Primary Care budget

The detailed knowledge of the primary care budgets and associated risks currently sits within NHSE, but there is an on-going process to transfer this knowledge to the CCG budget holder (Katrina Cleary, Programme Director) and CCG finance staff.

At this stage in the process the level of financial risk of an overspend against the total budget appears to be small. The majority of the expenditure is driven by contracts for which values are known at the beginning of the financial year.

The budgets where expenditure can change in-year are;

- Premises - rent reviews, rate increases that occur mid-year
- Enhanced services – dependent on activity undertaken
- Other GP services – locum services required randomly throughout the year.
- List size adjustments – noting that 0.7% budget increase has been built in.
- QOF – dependent on the level of achievement by practices

We need to do further scenario planning to determine whether the 0.5% contingency reserve is sufficient to cover the above and hence whether a further contingency should be held.

<u>Other likely/potential calls on the currently uncommitted reserves</u>:

A separate paper to the private session of this PCCC details proposals on Locally Commissioned Services for APMS practices for the non- core services that do not form part of the recently tendered service for the core contract.

The revenue consequences of any capital developments need to be considered and a reserve should be set aside to accommodate this. As we currently understand there are 2 capital schemes that are already pre-committed by NHSE with associated revenue consequences of £160k. There is also a process underway for practices to bid for capital funds under the Primary Care Transformation Fund, we are working through the revenue consequences of these bids and just for illustration the potential high priority bids could have revenue impact of up to £300k and the potential medium priority bids revenue impact could be up to a further £300k. The revenue impact of these schemes is unlikely to start until 2017/18 but must nevertheless be budgeted for at a reasonable level.

Responsibility for GP IT support rests with CCGs and from 2016/17 part of the CCG's growth allocation is intended to support these costs. The current assessment is that it will not be possible to meet all the costs associated with the new regional contract

arrangements from the indicative figure within our main allocation and hence we are likely to need to deploy some of the primary care reserves.

The budgets for existing Locally Commissioned Services have generally been maintained at 2015/16 levels (as discussed in section 7 below). If we decide in year it is appropriate to expand the scope /activity volumes within these services or we see new pressures these will be an appropriate call on the un-committed primary care reserves.

We can hopefully look to target part of the reserves at developments in primary care to support more care of patients outside of hospital. Thus for example, to support the development of the neighbourhood pilots as part of Active Support and Recovery proposals. We will need to consider priorities in conjunction with any further funding from the Prime Minister's Challenge Fund if this is made available.

We may need to increase the contribution from the primary care allocation to QIPP as part of meeting the CCG's duty of statutory financial breakeven

6. Governance Arrangements for delegated Primary Care budgets

There have been discussions over the last few months with NHS England to determine how best to execute the day to day tasks associated with delegated responsibility of the primary care budget and how, and who is best placed, to authorise payments.

In summary it has been decided that the best way forward initially is to give responsibility to NHS England staff to continue with responsibility for the day to day transactions associated with administering the budgets. This primarily means that NHS England staff will make all payments, deal with any associated queries, code payments to the General Ledger system and journal budgets/expenditure onto the system where needed. The CCG will retain responsibility for the management accounts function, which means carrying out the monthly monitoring and forecasting of budgets and also the cash management function. In order to enable these tasks to be executed this it is proposed that NHSE are given write-access to the General Ledger system.

In terms of authorisation of expenditure it is proposed that the CCG is the budget holder and that Katrina Cleary, Programme Director – Primary Care is set an authorisation limit of £30k which is the standard for Directors and the Director of Finance and Accountable Officer are set an unlimited authorisation level up to budget on primary care budgets. This is in line with how most CCG budgets operate. Proposed amendments to the CCG's Prime Financial Policies and the Operational Scheme of Delegation to reflect this proposal are due to be considered by the Audit and Integrated Governance Committee at its meeting on 24 March 2016 and verbal feedback on the decision of AIGC can be given.

As the delegation of duties for primary care is new to the CCG the proposed governance arrangements will be tested over the next few months and amended if necessary.

The Primary Care Commissioning Committee is asked to note this proposed arrangement.

7. Local Commissioned Service Budgets for 2016/17

The proposed budgets are set out in **Appendix B**. The assumptions used to calculate the budgets are;

- the current forecast of the recurrent commitment against each budget forms the 2015/16 brought forward position.
- No adjustment for inflation or efficiency savings has been made. Historically the CCG has not applied the nationally agreed net tariff (inflation less efficiency) % reduction to LCS budgets. In 2016/17 the national inflation/efficiency factor is an overall 1.1% increase to budgets for the first time. However, given that LCS budgets have not suffered a cumulative funding reduction, in line with other budgets where we have exceptionally applied cash stand still, rather than required an efficiency factor, the proposal is not to include a % increase in 2016/17.
- The one area of service we have specifically attributed a QIPP efficiency target is interpreting services as this has been subject to a review over the last year and is shortly due for a procurement exercise in readiness for a new service start date of 1 September 2016. Should this QIPP not be realised it will form a pressure against the primary care un-committed reserves.

As part of the PMS transition arrangements, members of Committee will be aware that the CCG has previously approved a Locally Commissioned Service which by 2017/18 will offer £5 per head of population to each practice. (For 2016/17 as previously agreed the offer is £4 per head.) At the same time we are offering a Local Commissioned Service as part of the Special Cases arrangements (as discussed in a separate paper to this meeting.). Some of these costs are being met by resources released as part of the PMS transition arrangements (cumulatively nearly £1.5m is expected in 2016/17) but the CCG is also needing to "top up" the funding. We were originally looking to fund from our 1% non recurrent reserve but for 2016/17, the new NHSE business rules require this reserve to be un-committed. As part of finalising our overall plan submission for 7 April 2016 to NHSE we are continuing to look to find this funding from within our main CCG allocation but depending on the position in terms of the other risks/calls on the uncommitted primary care reserves discussed above, we may need to look for a contribution from these reserves.

Separately the CCG is looking to fund from part of our systems resilience reserve a new LCS to GP practices to recognise primary care's role in our planned service transformation programme. The options/proposals are under discussion and will be brought to a future meeting.

8. Recommendations:

The Primary Care Commissioning Committee is asked to:

- Note the resource allocation made to the CCG in respect of the delegated primary care budget of £74.7m for 2016/17.

- Approve the initial primary care budgets and Local Commissioned Service budgets for 2016/17 set out in Appendix A and Appendix B noting the assumptions used to calculate the budgets.

- Consider the issues and financial risks for the delegated Primary Care budget set out in section 5 above.

- Note the proposed governance arrangements for the delegated Primary Care budget set out in Section 6 above.

Julia Newton
Director of Finance
March 2016