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|---|---|---|
| **MEETING DATE:** | 13 February 2014 | NHS North Lincolnshire Clinical Commissioning Group<br><br>**REPORT TO THE CLINICAL COMMISSIONING GROUP GOVERNING BODY** |
| **AGENDA ITEM NUMBER:** | Item 6.1.2 | |
| **AUTHOR:**<br><br>**JOB TITLE:**<br><br>**DEPARTMENT:** | Therese Paskell<br><br>CFO<br><br>Finance and Business Support | |

# DRAFT FINANCIAL PLAN 2014/15-2015/16

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|---|---|
| **PURPOSE/ACTION REQUIRED:** | Decisions for Approval |
| **CONSULTATION AND/OR INVOLVEMENT PROCESS:** | *The draft financial plan 14/15 AND 15/16 was approved at the CCG engine room on 6th February* |
| **FREEDOM OF INFORMATION:** | *Is this document releasable under FOI at this time? If not why not? (decision making guide being developed)*<br><br>**Public** |

**1. PURPOSE OF THE REPORT:**

To seek approval for the draft financial plan, which will be incorporated into a submission to the Area Team on 14th February.

**2. STRATEGIC OBJECTIVES SUPPORTED BY THIS REPORT:**

| | |
|---|---|
| **Continue to improve the quality of services** | **x** |
| **Reduce unwarranted variations in services** | **x** |
| **Deliver the best outcomes for every patient** | **x** |
| **Improve patient experience** | **x** |
| **Reduce the inequalities gap in North Lincolnshire** | **x** |

**3. IMPACT ON RISK ASSURANCE FRAMEWORK:**

| | | | |
|---|---|---|---|
| **Yes** | **x** | **No** | |

Narrative highlights financial risks and mitigation strategies

**4. IMPACT ON THE ENVIRONMENT – SUSTAINABILITY:**

| | | | |
|---|---|---|---|
| **Yes** | | **No** | **x** |

The CCG does not have any capital resource.

**5. LEGAL IMPLICATIONS:**

| Yes | | No | x |
|---|---|---|---|

Not that we are aware of

**6. RESOURCE IMPLICATIONS:**

| Yes | x | No | |
|---|---|---|---|

This draft financial plan outlines the resources and savings required to deliver a balanced plan, achieve our statutory financial duties in accordance with NHS England guidelines.
Any changes as a result of signed contracts will be advised at future meeting and a master budget will be drafted for approval before the end of March 2014.

**7. EQUALITY IMPACT ASSESSMENT:**

| Yes | | No | X |
|---|---|---|---|

This is not a policy or procedure. The commissioning plan overall needs to have an equality impact assessment.

**8. PROPOSED PUBLIC & PATIENT INVOLVEMENT AND COMMUNICATIONS:**

| Yes | x | No | |
|---|---|---|---|

This will form part of the CCGs overall commissioning plan for which there will be a communication process for.

**9. RECOMMENDATIONS:**

The CCG Governing Body is asked to: -

- Approve the draft financial plan for 14/15 and 15/16

# NHS NL CCG FINANCIAL PLAN ASSURANCE AND COMMENTARY - 2014/15 and 2015/16

## Introduction

For 2014/15 the CCG has a commissioning / programme budget allocation of £205,754m (£212,741m 2015/16) and a Running Cost Allowance (RCA) of £4.212m (£3.785m 2015/16) as per the Planning framework and NHS England announcements and letter of 31 January 2014.

The plan assumes a carry forward of the CCG 2013/14 surplus of £4m which is still expected to be achieved and will all be drawn down in 2014/15 to support transformation/ integration (i.e. transition to HLHF), new models of care and the development of the Better Care Fund (BCF).

A financial summary of the plan is shown in Appendix 1. The figures are based on estimated contract values and best indicative values of activity including values for service growth in community and continuing care services in particular, proposed adjustment to Specialist Commissioning for HEYT, and latest QIPP proposals. For reference, the forecast outturn for 2013/14 (as at month 9) has also been included on the financial plan submission to Area Team.

## Overall financial duties

The CCG has planned for the required 1% surplus overall in both years, on a recurrent basis subject to delivery of the QIPP programme and management of other risks for 2015/16 as well).

As required, the CCG has a plan to invest 1.5% (£3.086m) of its recurrent allocation, non-recurrently in 2014/15, as well as 1% (£2.085m) to fund the Call to Action Fund. This means that the CCG has 2.5% non-recurrent "headroom" in total for 2014/15, which then falls back down to 2% for 2015/16 (£4.255m). These are held in reserve as earmarked.

Essentially, the headroom will be used first to support any funding gap needed to maintain existing services and then to fund QIPP investment as well as non-recurrent spend relating to transformational change. In particular, this means funding support for developing new models of care across a number of providers, but especially NLAG (e.g. re HLHF). In addition, the CCG will also draw on the re-admissions penalty (held in reserve) and the Marginal Rates funds to support measures to reduce non elective and avoidable hospital admissions.

Business cases are required to utilise all of these earmarked funds and are being developed in agreement with our Providers to take to the HLHF Management Board for approval for onward submission to the Area Team of NHS England. The speed with which these are approved by the Area Team may affect the ability to deliver the full year effect of savings planned and the cost of financing them externally.

The £1.8m Better Care Fund for 2014/15 held in reserves has been created from old s.256 re-ablement and carers support funding, and the new 0.3%, £600k mandated nationally. This fund increases to £11m in 2015/16.

£0.845m has also been set aside for the Elderly Care Named GP Fund based on £5 per head of registered GP population as per the guidance in 2014/15, as well as an estimated £4.40 per head for a proposed levy for former PCT provisions nationally equating to £0.68m as requested by the Area Team.

The contingency budget for both 2014/15 and 2015/16 is currently planned to be maintained at £2m, (0.94% in 2014/15 falling to 0.92% in 2015/16). The £2m figure has been recurrently created but will be shown as applied non-recurrently each year in the external plan returns in line with the guidance received. Governance arrangements for the release of contingency will be agreed at the CCG Engine Room.

Pressures exceeded the contingency in 2013/14 mainly due to budgets in the wrong place/rebasing and growth in acute and continuing care spend etc. Therefore a further risk reserve (of £2.7m in 2014/15) is held for these pressures as well as for the potential removal of previous contract ceilings, in year cost pressures, and investment in HLHF and QIPP slippage, for example.

In addition, the CCGs Running Cost budget is within the RCA supplied. The allowance is £4.212m for a population of 169,395 and is effectively a reduction to only £24.73 per head. Per the letter of 31st January 2014 the revised RCAs for 2015/16 is 10% lower at £3.785m, only £22.07 per head. This means that the impact of incremental drift and any other 2014/15 inflationary increases will have to be absorbed by CCG and CSU and both organisations will have to contribute to meet a significant 10% RCA efficiency target reduction in 2015/16.

The existing RCA is split three ways: £1.814m (53%) for the CCG, £2.254m (43%) for the CSU and £162k (4%) for NHS Property Services (NHSPS) in 2014/15. However, it is assumed that external income for spare accommodation in Health Place should be obtained by NHSPS to marginally reduce the share of the CCG's RCA which is used by them. At this stage, an element of the CCG's RCA is being used non-recurrently to ensure that the organisation has some flexibility to respond to this RCA challenge, e.g. via funding set up costs as well as skill mix changes made in year.

The further reductions in RCA to 2018/19 down to £3.771m (£21.53 per head) need to be worked through over the next few months.

## Demographic assumptions

Based on ONS population projections, 0.72% population growth has been used for 2014/15 and 0.71% for 2015/16 for the NLAG contract –but it is proposed to be targeted for use in Community Services. In addition the activity modelling to support planned contract expenditure reflects the current activity case-mix down to specialty level, and latest Payment By Results (PBR) guidance.

## Financial uplift assumptions

In accordance with the Planning framework the CCG has based its financial uplifts on the following table:

| | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|---|---|
| **CCG Allocation Growth** | 2.14% | 1.70% | 1.80% | 1.70% | 1.70% |
| **Inflation** | | | | | |
| • Secondary Care & General | 2.8 - 2.2% | 2.7%-2.2% | 3.00% | 3.40% | 3.40% |
| • Prescribing | 7.00% | 7.00% | 7.00% | 7.00% | 7 .00% |
| • Continuing Healthcare | 4.0% | 4.0% | 4.0% | 4.0% | 4.0% |
| **Provider Sector Efficiency** | -4.0% | -4.0% | -4.0% | -4.0% | -4.0% |
| **Tariff Deflators** | | | | | |
| • Acute Services (Non CSNT Provider) | -1.50% | -1.50% | -1.50% | -1.50% | -1.50% |
| • Acute Services (CSNT provider) | -1.20% | -1.30% | -1.20% | -1.20% | -1.20% |
| • Non Acute Services | -1.80% | -1.80% | -1.80% | -1.80% | -1.80% |
| **CQUINs change** | 0% | 0% | 0% | 0% | 0% |



It is important to note that:

- The CCG has used 7% for Prescribing and 4% for Continuing Healthcare, taking into account all relevant factors and in agreement with the budget holders, before QIPP.

- The nominal increase in the net efficiency factor for non-acute services is slightly larger than for acute services. This is because an allowance has been made to allow acute providers to comply with the recent recommendations of the Francis & Keogh reports.

The impact locally of new PbR rules on the CCGs contracts (in conjunction with the Specialist Commissioning defund) is still being worked through. However, this risk to the CCGs will need to be addressed via the Contingency Fund and Risk Reserve which has been set based on 2013/14 experience.

## Capital assumptions

The CCG would like to support a bid by co-commissioners at the Area Team for a Primary Care capital grant to obtain premises and IT systems in particular in a number of localities, to support the outcomes of HLHF and new models of care. The CCG will therefore work with the Area Team to develop a business case.

## Commissioning Intentions

The JSNA, which itself reflects on population changes, has been used to identify needs and priorities for the population of NHS NL CCG which GP members were consulted on. In addition, benchmarking information, using ONS, Atlas of Variation, Commissioning for Value and monitor guidance re, transformation of services etc., was used to ensure both investments and QIPP opportunities were maximised within the CCGs financial framework. It has also aided the development of proposals for future models of care to support HLHF.

**Expenditure Assumptions**

| Assumption | Approach in plan |
|---|---|
| 30% marginal tariff for non-elective activity & use of the 70% top slice | The top-slice has been incorporated into the finance plan in line with guidance, using 13/14 month 9 contract monitoring information. There will be opportunities to access this resource for investments for jointly agreed demand management schemes via business case to the Area Team. This funding would be used to support demand management in the delivery of future models of care especially further developing the effectiveness of the new urgent care model. Some non-recurrent resources will be needed to balance the plan in 2014/15 in particular which may come from this or other sources below. |
| Financial impact of non-payment for readmissions | Non-payment for 30 day re-admissions is not modelled back into the contract baseline non-recurrently in contrast to previous years and in line with the issued guidance, although overall contract cash envelopes are to be finally agreed and use of penalties will be agreed with partners. Funding for post discharge support and re-ablement services has been separately earmarked from recurrent resources. |
| Contract sums | The contract envelopes are based on: the case mix from the last 12 months (i.e. activity which spans two financial years, so this is not technically out-turn).<br>• The latest PBR Tariffs<br>• The last PBR rule changes.<br>• Demographic growth based on ONS information<br>• 2.5% CQUINs |

| | |
|---|---|
| CQUINS payments | Tariff guidance has been adopted at 2.5% |
| Better Care Fund including Social Care and Re-ablement funding | The Section 256 Agreements for Social Care and Re-ablement funding will be incorporated into the s.75 pooled budget called BCF, along with carers support funding. This agreement will be subject to review with the CCG and the LA and a governance process has been developed for decision making around the fund via a joint Board. H&WB will monitor to ensure benefits and outcomes are achieved. The BCF template will be submitted separately following sign off at H&WB 15th February, which includes broad plans stretching the level of ambition, timescales governance and risk management arrangements. |

## QIPP and Investment Plan

The Table below provides a summary of the CCG's QIPP and Investment plan for 2014/15 (and 2015/16).

| QIPP CATEGORY | 2014/15 GROSS VALUE £000s | 2014/15 INVESTMENT £000s | 2014/15 NET VALUE £000s | 2015/16 GROSS VALUE £000s | 2015/16 INVESTMENT £000s | 2015/16 NET VALUE £000s |
|---|---|---|---|---|---|---|
| **Focused on Acute Care** | 3,790 | 220 | **3,570** | 630 | 0 | **630** |
| | | | | | | |
| **Focused on Non Acute Care** | 3,071 | 196 | **2,875** | 2,316 | 196 | **2,120** |
| | | | | | | |
| **BCF commissioning** | - | - | 0 | 6,346 | 6,346 | **0** |
| | | | | | | |
| **Total QIPP Schemes** | **6,861** | **416** | **6,445** | **9,292** | **6,542** | **2,750** |

The QIPP schemes planned for 2014/15 and 2015/16 reflect the net savings that the CCG feels is realistic but stretching, within the context of HLHF and BCF.

CCG investments are mainly centred on delivering the identified QIPP schemes for 2014/15 and 2015/16 and those required in the guidance to establish in 2014/15 a Call to Action Fund of 1% (£2.058m) and circa 0.3% (£0.634m) additional increase in the BCF in advance of the 2015/16 mandated BCF of £11m (a circa £6m increase in resource to be funded via decommissioning from contracts). The CCG is also working towards going beyond the mandated levels for 2016/17 onwards to maximise economies of scale for BCF to have the biggest impact possible,

and has mapped for example, resources spent collectively on frail and elderly persons which will be monitored as a shadow budget in 2014/15 by the Joint Board.

The FYE of additional staffing to facilitate faster and improved pathways in Continuing Care, will not only improve the quality and responsiveness of services for patients, but also produce efficiency savings on the cost of inappropriate care packages for the CCG. The remaining investment is targeted on implementing an 'advice only' process across NLAG for Respiratory / COPD services, risk profiling as an enabler, and to facilitate community diabetes services for people with long term conditions.

An updated process for review and identification of QIPP schemes has been agreed with the CSU re horizon scanning and governance processes using all available information and linking into the Relationship Managers with Practices in the CCG.

A non-recurrent QiPP investment reserve of £0.25m has been planned for, of which the majority will support new models of care, held in general reserves.

## Financial Risks and mitigation strategies

Specific outstanding risks to be finalised / confirmed include:

- Resolution of outstanding issues with NHS England e.g. HVs/HEYT specialist/walk in services costs re. Market Hill.
- Local impact of PbR/contract modelling
- Local impact of new Specialist Commissioning rules on providers (and confirmation of no revisiting of baselines)
- Potential contributions to a national risk pool for Trusts in difficulty in 2015/16
- Allocations - Distance from Target/Pace of change in future years

In addition, general risks remain as in previous years around QIPP delivery/ implementation of HLHF/ New models of care, plus:

- Engagement of the wider GPs in: clinical commissioning, changing primary and secondary clinical behaviour
- Underlying cost/activity growth above those modelled in the plan
- Investments not delivering the required improvements/savings
- Resource reduction reduced financial freedoms, non-recurrent flexibility and management resource/capacity etc.

- Transition costs e.g. HLHF/ decommissioning for BCF

- Continuing Care claims/ packages for vulnerable people.

These risks will be mitigated through a track record of internal review, tight financial control, risk and contingency reserves, increased partnership working and transformation, use of contract levers and incentives and OD work with CCG and GPs. It will be this ownership that ensures the changes to healthcare are delivered within the Commissioning Plan.
Specific risk mitigation strategies include:

- The retention of a contingency fund of circa 1% in each year, which is in excess of the 0.5% minimum contingency level set out in the guidance..

- The creation of a risk reserve for general risks of £1.570m, in addition to earmarked reserves for re-admissions, general headroom, the Call to Action Fund, Marginal Rates, and the Elderly Care Named GP Fund. However, some (£1.364m) of non- recurrent resources have had to be used to balance the plan.

- Wherever possible QIPP will be incorporated within contracts.

- Risk sharing with other CCGs in 2014/15 (e.g. main acute contracts with Humber, as well as NHS111 across Yorkshire & Humber- tbc).

- Risk sharing within contracts – e.g. a contract ceiling on the main acute contract (tbc) and other informal arrangements with providers. If this is not achieved the risk serve will need to cover the potential additional activity.

- 2 Relationship Managers working with Practices to support budget and performance management, identify opportunities including around pathways and reducing unwarranted variation.

## Conclusion

Overall the CCGs Financial plan is as challenging as previous years. North Lincolnshire has a track record of tight budget and reserve management, which coupled with the engagement of GPs as Clinical Commissioners, support from Relationship Managers and the developing CSU. The challenge is to make monies and contract arrangements for transformation and integration in 2014/15 count, to enable the CCGs ambitions to be achieved in the more challenging years to come.

APPENDIX 1

# NORTH LINCOLNSHIRE CCG DRAFT FINANCE PLAN 2014/15 & 2015/16

| | | FOT | DRAFT PLAN | |
|---|---|---|---|---|
| | | YEAR 0 2013/14 £000s | YEAR 1 2014/15 £000s | YEAR 2 2015/16 £000s |
| | **INCOME** | | | |
| 1 | Recurrent Programme Allocation - After Headroom Transfers | 196,565 | 200,610 | 208,486 |
| 2 | Recurrent Running Cost Allocation (RCA) | 4,230 | 4,212 | 3,785 |
| 3 | Non Recurrent Programme Allocations | 7,924 | 9,593 | 6,848 |
| | **TOTAL** | **208,719** | **214,415** | **219,119** |
| | **GROSS EXPENDITURE** | | | |
| 1 | **Acute Services** | 113,015 | 113,049 | 104,639 |
| 2 | **Mental Health Services** | 13,788 | 12,928 | 12,714 |
| 3 | **Community Health services** | 13,887 | 13,541 | 13,979 |
| 4 | **Continuing Care Services** | 21,869 | 20,857 | 20,661 |
| 5 | **Primary Care Services** | 31,682 | 30,587 | 31,304 |
| 6 | **Other Programme Services** - Pay: | 54 | 54 | 54 |
| 7 | **Other Programme Services** - Non Pay: | 6,194 | 17,043 | 29,792 |
| | **Total Programme Expenditure** | **200,489** | **208,059** | **213,143** |
| 8 | **Running Costs** | **4,230** | **4,212** | **3,785** |
| | **TOTAL DIRECT EXPENDITURE** | **204,719** | **212,271** | **216,928** |
| | **SURPLUS** | **4,000** | **2,144** | **2,191** |