MEETING DATE:	13 September 2012
AGENDA ITEM NUMBER:	**7.7**
AUTHOR: **JOB TITLE:** **DEPARTMENT:**	Therese Paskell Chief Financial Officer Finance & Contracting

North Lincolnshire Clinical Commissioning Group

REPORT TO THE CLINICAL COMMISSIONING GROUP COMMITTEE

CCG FINANCE PLAN / FINANCIAL STRATEGY DEVELOPMENT

PURPOSE/ACTION REQUIRED:	Decisions for Approval*
CONSULTATION AND/OR INVOLVEMENT PROCESS:	*This paper if approved will be followed up with a presentation and discussion at Council of Members on 27 September*
FREEDOM OF INFORMATION:	Public*

1. PURPOSE OF THE REPORT:

The purpose of this report is to encapsulate thinking and progress so far on the development of the CCGs finance plan and finance strategy development and process for its further progression. This report will be used for further discussion with the Council of Members (COM) on 27 September 2012.

The paper covers key financial areas including governance framework, medium term financial plans (including capital), reporting to the Committee and Council of Members and its development, financial risk identification and sharing, guiding principles, Finance and Business Support, CSU support, Financial Training and Development.

2. STRATEGIC OBJECTIVES SUPPORTED BY THIS REPORT: *(will be populated following agreement with Council of Members)*

3. IMPACT ON RISK ASSURANCE FRAMEWORK:	**Yes**	**x**	**No**	
Points to risks identified at Financial Plan stage and as part of monthly reporting, CCG risk sharing arrangements and possible options for risk sharing between Practices.				
4. IMPACT ON THE ENVIRONMENT – SUSTAINABILITY:	**Yes**		**No**	**X**
Minor issue - Covered in capital expenditure plans				
5. LEGAL IMPLICATIONS:	**Yes**		**No**	**X**
6. RESOURCE IMPLICATIONS:	**Yes**	**x**	**No**	
Outlines how the financial plan, strategy and Practice budgets might be developed in discussion with CCG and COM.				
7. EQUALITY IMPACT ASSESSMENT:	**Yes**		**No**	**X**
This is not a policy/procedure or guidance. The Commissioning Plan as a whole will need to have this assessed.				
8. PROPOSED PUBLIC & PATIENT INVOLVEMENT AND COMMUNICATIONS:	**Yes**	**x**	**No**	
This paper if approved will be discussed further with Council of Members re practice budgets and risk sharing.				

9. RECOMMENDATIONS:

The CCG is asked to:

- Approve this paper as accurately representing the progress so far and support the principles and plans for future development; and
- Approve the MTFP split for the CCG as summarised in Appendix 1
- Approve the Capital Plan and Primary Care capital grant for 12/13 outlined in Appendix 2
- Approve the integrated reporting project specification as outlined in Appendix 3
- Support the proposed discussions around budgets, risk sharing and reporting at the Council of Members in September (ready to start new reporting in October).

NHS NL CCG COMMITTEE - 13 SEPTEMBER 2012

CCG Financial Plan and Financial Strategy Development

1. PURPOSE

The purpose of this report is to encapsulate thinking and progress so far on the development of the CCGs finance plan and finance strategy development and process for its further progression. This report will be used for further discussion with the Council of Members (COM) on 27 September 2012.

2. GOVERNANCE FRAMEWORK

The governance framework, subcommittee structure and terms of reference (including Audit Group, Quality Group and Engine Room) are included with the Constitution as well as forming part of the interim draft Standing Financial Instructions/Standing Orders/Scheme of Delegation (SFI/SO/SDs) approved at the Audit Group on 30 August 2012. Both documents were provided as evidence for authorisation as well as the process for development, through a working group and approval by members before 1 April 2013.

Financial policies and procedures that back up the SFI/SO/SDs of the PCT will be adopted initially where appropriate, and upon review, further developed in discussion with the Humber CSU, and approved via the Audit Group.

In terms of the Board Assurance Framework (BAF) the Council of Members (COM) have agreed some strategic objectives and completed a risk survey enabling the CCGC to develop a BAF on its behalf.

Finance, Performance and QIPP issues are overseen through the CCG Engine Room which meets fortnightly. Independent assurance is provided via the Audit Group and a summary of its work is provided in action notes that go to the Council of Members. A new lay member Paul Evans has now been recruited to lead on audit and governance. Internal Audit is provided by East Coast Audit Consortium and External Audit via KPMG (to take over shortly).

3. MEDIUM TERM FINANCIAL PLANS (MTFP)

The MTFP is an integral part of the CCGs strategic planning process which will take place September through to February leading to sign off of 13/14 operational plans including finance, activity, QIPP, signed contracts and updated Single Integrated Plan (SIP).

For 2012/13, CCG Committee members were involved in signing off both financial and QIPP plans as part of agreeing the SIP which is the CCGs Commissioning Plan. COM had an opportunity to review and get up to speed in June of the financial objectives and project structure for the local health economy's Sustainable Services Review (SSR).

This includes finance input via the SSR Engine Room a multi-professional group at Deputy Director level and the DoFs group which provides direction and assurance. There are terms of reference for both these groups. These groups in particular review and use finance and other information from a variety of sources internally and externally to aid good evidence based decision making.

In July, Committee members were also involved in signing off the principles behind the baseline exercise which was to set the CCG baselines going forward. The resource split of the MTFP for 12/13 was submitted to the Strategic Health Authority (SHA) and is in line with the first column attached in Appendix 1.

The proposed Capital Plan for 12/13 is being updated ready for the Cluster Capital Committee. It includes approximately, 100k for IM&T, £100k for estates mainly relating to Scawby House and a £100k Primary Care capital grant (subject to approval by SHA) attached at Appendix 2. Although not yet confirmed the CCG is unlikely to be given capital resources in future years.

Using exactly the same principles and assumptions agreed and used for the baseline exercise, the MTFP approved as part of the SIP was split for the outer years and is summarised in Appendix 1. This was submitted as a draft as part of the evidence for authorisation and requires formal adoption by the CCG for CCG elements only.

The Finance Plan key financial assumptions and risks are outlined in section 2.4 of the Commissioning plan. In essence the Finance Plan incorporates the required control total, 2% recurrent surplus, QIPP plans, Investments and 2% non-recurrent expenditure from recurrent income. For 12/13 growth of 3% is offset by 1.8% inflation net of efficiency and 1% increase in CQUINs for providers. The Plan includes £4.7m QIPP plans and a contingency of £4m (1.5% of the Revenue Resource Limit). Running costs were planned broadly in line with guidance at £25 per head for the emerging CCG. The conclusion was that the Financial Plan in 12/13 was challenging but deliverable with a key focus on SSR, QIPP and partnership working.

It is expected that the baseline exercise and Financial Plan from 12/13 onwards will be updated for revised specialised services definitions and other more up to date information shortly.

Draft CCG commissioning intentions were agreed for 12/13 and 13/14. These will be updated as part of the development of the CCGs Commissioning Plan around November and will inform further financial plan development.

Discussions on financial assumptions for outer years will start to take place in advance of the publication of the Operating Framework which will determine the financial framework. Where assumptions are left for individual CCGs to decide this will be discussed with CCG Engine Room and COM as part of the process for agreeing plans for 13/14 onwards.

Allocations will not be released nationally until after this CCGs authorisation site visit and therefore Financial Plans updated for 13/14 onwards will need to be reviewed again later in 2012. Assuming guidance and allocations are issued in time, a first draft of the new CCG Finance Plan for 13/14 onwards will be completed by the end of November. The timeline for the whole Commissioning Plan is a separate paper to the CCG Engine Room on 20th September 2012.

Financial and other incentives for sustained changes in behaviour and transformational change will be explored as part of the CCGs financial strategy. Specific themes for this year will be discussed at a CCG Engine Room meeting as part of the wider discussion around contracting for 13/14. The SSR Management Board has approved the establishment of a Northern Lincolnshire community wide transformation fund for 13/14. The governance framework around this will be drafted for the SSR DOFs group.

4. REPORTING TO THE CCGC

Performance against the Financial Plan, financial risks and mitigations are shown in the monthly finance report. The month 4 finance report is a separate paper to the Committee.

Currently the CCGC has adopted the PCTs monthly performance and finance reports, until a new style of reports is developed. An integrated reporting working group has been established with Committee membership to ensure finance, performance, QIPP and quality reports fit together and can be reported at both practice and CCG levels (traffic lighted dashboard) providing true business 'intelligence' on which to take action. A project plan is provided at Appendix 3. Meetings are held in public bi-monthly but all the papers are available to the public. Updates are also provided at fortnightly engine room meetings.

The CCG intends to follow the principles outlined in Accounting Standards Council (ASC) Conceptual Framework for Financial Reporting (2010), i.e. relevance, materiality, faithful representation, comparability, verifiability, timeliness and understandability; all achieved within a cost constraint and deployed with judgement. Support to monthly reporting will be provided by the North Yorkshire and Humber CSS.

It is intended to report more specifically on use of Ear Marked Provisions, Contingency budgets and reserves.

5. PRACTICE BUDGETS

The COM is already getting involved in prioritising resources through new procurements and pathways, QIPP plans, capital investments (Primary Care capital grant), etc.

As indicative Practice budgets have already been moved to fair shares, there is no requirement to have a fair shares policy for NL CCG to move practices closer to target.

Draft indicative Practice budgets are currently being produced for the CCG along the same principles as last year according to guidance previously issued per the toolkit. The budgets are also being revised to reflect the most up to date information e.g. Practice list size, new Practices (transfer from NELCTP), mergers etc. Budgets will not be adjusted for risk sharing between Practices at this stage, until a discussion at Septembers COM meeting and the revised specialised services definitions issued.

These budgets will reflect and reconcile to the overall CCG resources outlined in Appendix 1, then adjusted for any in year allocations.

Draft indicative budgets will be included as part of the Practice reporting for month 2 (contract) information onwards until national allocations are known. Practice budgets will be then further updated so that Practices will have finalised budgets for 1 April 2013 for which they will be responsible and accountable to each other at the COM. These budgets will at that point cease to be indicative and members will be fully accountable for them and any overspends, for example.

Further details will be provided at the 27 September COM meeting to enable understanding of the 'split' of PCT/CCG resources, and allow discussion re future development of Practice budgets and reporting.

6. PRACTICE REPORTING AND THE COUNCIL OF MEMBERS

Currently monthly reports are sent to Practices combining finance and activity information against indicative budgets so that they are aware of their overall and relative position. It is intended to underpin this with a drill down facility being developed.

It is intended that from the meeting of 25 October onwards, the COM will peer review Practices finance and performance information. The development of this critical friend/challenge role by members and sharing of best practice is part of the CCGs OD plan.

Relationship Managers have been appointed with a mixture of skills to assist Practices in identifying unwarranted variation, QIPP plans, service change opportunities individually or collectively with other Practices.

The COM meetings are supported by the CCG Relationship Managers in the Business Support Team who will be fully established from 1 October 2012. They are Deborah Pollard, Julie Killingbeck and Jason Coombs (covering for Bill Lovell until 31 March 2013). The Practices to be covered by each Relationship Manager is currently being discussed.

7. FINANCIAL RISK IDENTIFICATION AND RISK SHARING

Financial risk scenarios and areas are included within the MTFP and monthly finance report. QIPP schemes are also RAG rated for financial delivery and reported internally and externally. Each team currently has its own risk register which will cease when the CCGs risk register is fully developed.

The process for development of the risk management strategy is currently under review. Scores over 15 are included on the Board Assurance Framework (BAF). A new CCG BAF has been developed with COM input on both strategic objectives and risk rating of these. This was approved at Augusts Audit Group.

Collaborative commissioning arrangements for the CCG have been approved at CCGC and form part of the authorisation evidence submission. These are under review as part of future commissioning intentions.

Current financial risk sharing arrangements relating to CCG only budgets include Mental Health and LD 'Pooled' budgets with the Local Authority. Currently for Mental Health North Lincolnshire Council contributes about 16% to the pool and about 94% for LD. This agreement is underpinned by a section 75 partnership agreement.

The only planned risk sharing with other CCGs is NHS 111 (for 13/14 only initially, subject to review) across Yorkshire and Humber.

Budgets will not be adjusted for risk sharing between Practices until a discussion at Septembers COM meeting and the revised specialised services definitions issued, due shortly which will affect the number of high cost patients and therefore appropriate options for risk sharing between practices.

Regardless of whether the CCG shares financial risk with other CCGs, practices may want to risk share between each other e.g. on high cost low volume activity that remains following removal of Specialist Commissioning Group (SCG) budgets by the National Commissioning Board (NCB). Risk sharing is particularly useful for rare and one off items of expenditure that could not be controlled or foreseen.

Examples of this might include haemophiliacs, critical care patients or unusual IFRs/exclusions in an acute hospital, or a long term continuing care patient with a particularly expensive individual care package. This is an area for development which will be considered in more detail at Septembers COM meeting. Consideration will be given to options for when, where and how financial risk sharing between practices might be undertaken. This will include a discussion about methodologies.

As a matter of principle and good practice it is intended to include expenditure where it falls to ensure accurate reporting, provide the right incentives, identify variation and support best practice etc.

However whilst expenditure overall may not vary much, it is hard to predict where (which Practice) this will fall against in year.

Using the example of high cost low volume patients, risk sharing between practices might utilise a central budget or reserve, specifically held back for this purpose as follows;

- Central budget used to offset the overall impact at the end of the year (but need to be able to identify separately and agree arrangements for using any difference before 31 March 2013).

- Central budget allocated in year to match expenditure (as in 11/12) until the reserve runs out (the analogy of an insurance policy is useful here i.e. Practices 'pay' equally but 'claim' on an actual basis).

The level of the central budget or reserve would need to be set in agreement with COM using historic information and ideally, taking into account likely growth for elderly/technology changes etc. and change in SCG definitions. This would be outside the separate requirement for budgets held at CCG level including Contingency, Ear Marked Provisions and 2% non-recurrent budgets per national and SHA guidance.

One of the questions to be answered is the agreements and consequences of Practice underspends or overspends at the end of the year. There is a commitment that subject to active budget management (and appropriate measures) the CCG will ensure budgets are regularly updated in year to match contract values less agreed QIPP schemes to ensure true budget positions against core budgets.

8. SOME GUIDING PRINCIPLES FOR CCG FINANCIAL REPORTING AND DECISION MAKING

The CCG are considering as part of its financial strategy development how GPs will know things are different from the old PCT.

Finance is an identified key enabler. It is intended to support clinical commissioning in transforming care locally (e.g. through SSR) by aligning the financial strategy with the key objectives. If the CCG is to be successful in achieving its objectives, this will require a more facilitative, developmental, supportive and innovative approach as well as being more rigorous and transparent in providing evidence base on which to base good decisions.
The CCG intends to adopt a more systematic approach to reviewing and acting upon bench marking information to ensure excellence in financial management and that evidence base.

It will also require re- aligning of financial processes and incentives to make transformational change, service redesign and innovation easier to support and implement quickly to get required results.

Decision making will under the new governance model require more collaboration and discussion and development of criteria and a more sophisticated approach for prioritisation of investment for example, in the coming year.

The values of the CCG under development with the CCGC and Council of Members will also be applied to further develop these guiding principles to ensure finance and business support does just that and facilitates the organisations culture, development and achievement of objectives.

9. CCG FINANCE AND CSU SUPPORT

The overall vision for the CCG is a small responsive team focussing on supporting clinical commissioning and transformation. NHS NL CCG has invested around £14 per head in the CSU in order to buy in expert support. As the previous PCT was a small one it was felt this ensured sustainable arrangements for the long term. This allows further access to expert support, cover and capacity at peak times and opportunities for economies of scale and adopting best practice across North Yorkshire and the Humber. Finance support being bought in includes contract finance (analysis, monitoring, reporting etc.) acute, mental health, continuing care, as well as introducing management of ledger and monthly reporting process, new SBS ledger or 'spine' etc. annual accounts co-ordination, budget reporting and setting, 'buy in' of internal audit, payroll and procurement services etc.

In addition, the CCG has adopted an integrated approach so that the Chief Financial Officer (CFO) is responsible for 'Business Support' as a whole, with specific investment in relationship managers, which the PCT has previously never had the capacity for to support clinical commissioning.

The process maps, specifications and product/function lists (including finance) have been developed with involvement of staff from the CCG, Cluster and CSU and are to be incorporated within the CSU SLA which will be in place by 31 March 2013. The current Memorandum of Understanding is under process of development until the full SLA is available. KPI's will be developed in conjunction with the CSU and monitored and reviewed by the CSU with a Director lead. Third party assurance for all CSU services will also need to be provided as part of year end and audit processes.

9. FINANCIAL TRAINING AND DEVELOPMENT

A learning needs assessment was undertaken in October 2011 to help inform financial awareness and training for Committee members. An action learning approach has been taken in this forum and a number of workshops delivered including financial reporting, annual plan including financial and QIPP plans, governance, audit and annual accounts, assurance and risk management to name a few.

The same principles and approach will be applied to the COM with OD support.

COM and Practice Managers are also on circulation for finance awareness webcasts run by the HFMA and slides provided by the HFMA on finance and governance.

In the past GPs and Practice Managers have had an open invitation to budget holder training. This will now be further developed to reflect the new world, working with COM to meet practices needs and what they find most useful, e-learning workshops etc. The same action learning approach is intended to be adopted. The Finance and Business Support team also recognise that learning is a two way process with their clinical commissioning colleagues.

10. RECOMMENDATION

The CCG Committee is asked to:

- Approve this paper as accurately representing the progress so far and support the principles and plans for future development; and
- Approve the MTFP split for the CCG as summarised in Appendix 1
- Approve the Capital Plan and Primary Care capital grant for 12/13 outlined in Appendix 2
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- Support the proposed discussions around budgets, risk sharing and reporting at the Council of Members in September (ready to start new reporting in October).

Therese Paskell, Chief Financial Officer 4 September 2012

APPENDIX 1

NHS NORTH LINCOLNSHIRE: MEDIUM TERM FINANCIAL PLAN 2012/13 TO 2015/16
MTFP - ANALYSED INTO DoH BUDGET BASELINE FORMAT AS AT JULY 2012 : VERSION 1. :

	Year 0 2012/13 £000S	Year 1 2013/14 £000S	Year 2 2014/15 £000S	Year 3 2015/16 £000S
A) CLINICAL COMMISSIONING GROUP				
CCG List Based Responsibilities				
Secondary + Community Services	173,233	180,857	186,769	190,952
Prescribing - Including Recharge for Central Drugs	29,911	30,863	31,884	32,956
Primary Care - LES	241	242	243	244
Primary Care - Out of Hours	1,353	722	726	730
Running Costs - Excluding Premises Costs	3,364	3,022	3,022	3,022
TOTAL	**208,102**	**215,707**	**222,645**	**227,905**
CCG Geographical Responsibilities				
Unregistered Populations	20	21	21	21
Exempt Overseas Visitors	0	0	0	0
Non-rechargeable Services	0	0	0	0
Other - Services Hosted for Local Authority	0	0	0	0
TOTAL	**20**	**21**	**21**	**21**
TOTAL for CCG(s) - Excluding Premises Costs Below	**208,122**	**215,728**	**222,666**	**227,926**
B) NHS Commissioning Board				
Specialised Services	19,338	19,244	19,290	19,337
Armed Forces and Dependents	0	0	0	0
Offender Health - Outside Prison	0	0	0	0
Prison Healthcare	0	0	0	0
GP Services	18,543	19,950	20,071	20,164
General Dental Services	5,427	5,894	5,894	5,894
General Ophthalmic Services	1,615	1,615	1,615	1,615
Pharmaceutical Services	7,270	6,554	6,901	7,262
Primary Care Capital Grants	0	0	0	0
Secondary Dental Care	2,015	2,057	2,083	2,099
Public Health - NCB responsibilities	4,362	3,910	3,949	3,989
PCT Running Costs - Attributable to NCB functions	677	653	653	653
TOTAL for NHS Commissioning Board	**59,247**	**59,876**	**60,455**	**61,012**
C) Public Health - Local Authority Responsibilities				
Programme	7,071	7,090	7,141	7,189
Admin - Running Costs	361	361	363	365
TOTAL for PH Responsibilities Transferring to LA	**7,432**	**7,451**	**7,504**	**7,554**
D) Public Health England	547	550	553	556
E) Hosted Services	0	0	0	0
F) Clinical Networks	55	54	54	54
G) Other (Impairments & Cost of Capital)	0	0	0	0
H) Premises transferring to NHS Property Services				
- CCG: Commissioned Services.	728	728	731	733
- NHS CB: Commissioned Services.	1	1	1	1
- Local Authority: (Public Health Functions).	109	109	109	109
- Within CCG Running Costs.	158	158	158	158
- Within NHSCB Running Costs.	15	15	15	15
- Cost of Estate Management: NHSCB.	53	53	53	53
CHECK TOTALS	**276,467**	**284,723**	**292,298**	**298,171**
Reported Surplus or (Deficit) Has Been Redistributed Un-spent By Area	0	0	0	0
TOTAL PER REVENUE RESOURCE LIMIT (RRL)	**276,467**	**284,723**	**292,298**	**298,171**

APPENDIX 2

NHS NORTH LINCOLNSHIRE PRACTICE TOTAL LIST SIZES & PRACTICE TARGET CAPITAL GRANT SHARES
LATEST LIST OF PROPOSALS WITH VALIDATION AND INITIAL COMMUNICATION BACK TO PRACTICES

	Practice	Practice List Size AS AT 31-03-2012	%	PRACTICE TARGET GRANT SHARE £	PRACTICE BID £	MAXIMUM PRACTICE CONTRIBUTION £	COMMENTS
1	Shambhu & Ugargol (Cauvery MC)	4,019	2.91%	2,910	5,191	2,281	**1)** Ear syringe cost below capital threshold so excluded.
2	Market Hill	2,402	1.74%	1,739	5,500	3,761	**2)** Two BP Machines £3,000 and a digital height, weight, BMI Scale £2,500).
3	Whitaker & Partners (Bridge Street)	6,524	4.72%	4,724	6,167	1,443	**3)** ECG Machine £3,672, and infection control £1,500. The spiro-USB at £995 is effectively the Practice's choice to self fund.
4	Jaggs-Fowler & Partners (Barton Central)	16,866	12.21%	12,212	15,294	3,082	**4)** New passenger lift for disabled patients to reach the first floor.
5	Hall & Partners (West Common Lane)	4,813	3.48%	3,485	5,000	1,515	**5)** Practice cannot afford to fund any car park top up, so require equipment including ECG, portable bladder scanner, and baby changing unit.
6	Melrose & Partners (Church Lane MC)	8,654	6.27%	6,266	6,000	-266	**6)** Either bladder scanner or 3 electronic patient displays (The Practice cannot afford to fund further capital top ups for all the other items on their original list).
7	Dwyer & Partners (Cedar Medical Centre)	5,711	4.14%	4,135	5,400	1,265	**7)** Doppler, dermatoscope, LED display & patient call board, and ambulatory blood pressure machine. A bicycle rack is excluded - but would have to be funded by the Practice anyway if they wish to proceed.
8	Newman & Partners (Cambridge Avenue)	15,314	11.09%	11,088	11,342	254	**8)** Ophthalmoscopes £5,000, ECG machine £2,142, emergency lighting upgrade £1,000, vaccine fridge £1,200, operator chairs £1,000, and digital screen £1,000. Other items (BPP cuffs and fencing excluded but would need to be funded by the Practice if they wish to proceed anyway).
9	Padley & Partners (Kirton in Lindsey)	5,637	4.08%	4,081	5,000	919	**9)** Extra air conditioning for 3 treatment rooms £4,482 - will need to be topped upto £5,000 by the Practice with a small item or items of equipment.
10	Webster & Partners (Winterton Surgery)	9,832	7.12%	7,119	7,610	491	**10)** New equipment list supplied totalling £ 7,610. This comprises: A Welch Allyn wall unit & diagnostic set £2,003, examination light £698, digital platform scales £740, multi dopplex II with probes £ 1,011, EEG machine £2,034, digital floor scale £ 862, and sphygmomanometer £ 262.
11	Kennedy & Partners	17,191	12.45%	12,447	12,500	53	**11)** Two ECG machines £3,000 and 2 Jayex boards £8,000, plus spirometer £1,500. A second spirometer requested by the practice for £1,500 would need to be self funded.
12	Fraser & Partners (Trent View MP)	12,343	8.94%	8,937	12,000	3,063	**12)** Infection control - circa £3,000 per room for 3 rooms Practice can self fund remaining 4th room if it wished.
13	Rajkumar & Kurien-George (Oswald Road)	4,105	2.97%	2,972	5,000	2,028	**13)** Cholesterol testing Instrument and home monitoring blood pressure monitors £6,000 or patient call system £7,000, but Practice should be to limit spend to £5,000 or will have to increase their funding top up..
14	Burscough & Partners (Riverside Surgery)	12,438	9.01%	9,006	10,836	1,830	**14)** The Practice have submitted a revised bid totalling £ 15,833. The cost of consulting room changes for Infection control, with new blinds and examination lights, totals £ 10,836, and is the nearest cost to the practice target grant share. Other items bid for are: 2 pro dermoscopes £654, a dermalite FOTO system £1,259, an external defibrillator £945, and a Microlab MK8 spirometer and software £1,540. The 6 pulse oximeters totalling £ 299 are below the capital threshold, and cannot be funded from a capital grant.
15	Lees & Partners (Ashby Turn)	12,263	8.88%	8,879	7,800	-1,079	**15)** Ultrasound machine with a cost upto £7,800
None	Muralee	2,505		0	0	0	
None	Balasanthiran	2,866		0	0	0	
None	Vora	2,880		0	0	0	
None	Birches Medical Centre	7,011		0	0	0	
None	Falk & Partners	14,501		0	0	0	
	Total	**167,875**	**100.00%**	**100,000**	**120,640**	**20,640**	

NOTES

1) More detailed quotes etc will be required for the StHA Bid application process, but the information above is based on conversations with practice staff..

2) For a capital bid individual items of equipment must be over £ 250 and individually or collectively grouped to £ 5,000 or more. This value must be the formal quote / order price - but at the moment most of the above figures

3) For many Practices the grouped equipment scheme will have to be defined as "Equipment to Improve Practice Based Patient Treatment & Experience" or something similar

4) Individual Practice Capital Costs must equal at least £5,000. Where the cost exceeds the Practice allocation, the Practice will need to confirm that it is prepared to fund the Practice Contribution shown.

5) Where Practices are unable to spend their full allocation, any "spare" allocation will be re-cycled once firm quotes have been obtained to reduce the contribution which any practice is needing to make to bring their expenditure upto the £ 5,000 threshold. therefore, the indicative practice Contributions shown above, should be viewed as "maximum figures"

6) All figures have been rounded to the nearest £, so the detailed equipment figures may not add back exactly to the overall total bid figure.

Project Plan

NHS North Lincolnshire Integrated Performance Report Publication

1 Purpose

The Project purpose is to create an Integrated Performance Report, which will inform a varied audience, of the current state and direction of travel on the statutory and agreed priorities, plans, aims and objectives of NHS North Lincolnshire Clinical Commissioning Group.

2 Plan Description

This plan covers the stages needed to create a fully integrated report from a starting point of a summary of existing priorities to be submitted to Council of Members in October 2012 to a fully integrated report commencing on 1st April 2013.

The integrated report will be electronic, with drill down to various levels, to satisfy different audiences from summary headings, based on the aims and objectives of NHS North Lincolnshire Clinical Commissioning Group to detailed indicator validated data. The drill down will be available to the lowest level of validated data which, in the case of some indicators, could be to Practice or GP level, however there will be no patient identifiable information contained within the report. It is anticipated that the report will be accessible on the Business Intelligence Suite and NHS North Lincolnshire Clinical Commissioning Group Internet site.

3 Prerequisites

The project requires the development of processes within the Commissioning Support Unit to supply the relevant data to NHS North Lincolnshire Clinical Commissioning Group in the format required. It also requires the continued investment and development of the Business Intelligence Suite by NHS North Lincolnshire Clinical Commissioning Group through the Clinical Support Unit.

4 Dependencies

A robust Performance Management Regime is dependent upon a variety of reports and information, including this Integrated Performance Report, to inform Performance Manangement decisions.

5 Assumptions

The Integrated Performance Report will form one of a suite of reports that will be available within the Business Intelligence Suite which will contribute to an agreed NHS North Lincolnshire Clinical Commissioning Group Performance Management Regime. This will integrate with a Local Area Team and National Commissioning Board Performance Regimes in 2012/13. Changes may have to be made to the project once these Performance Regimes are agreed and published.

6 Stages

i) Split current indicators into agreed Summary Headings and publish in pdf version by October 2012. This report to continue to be published and developed on a monthly basis throughout the project.

ii) Agree performance indicators available under headings and drill downs.

iii) Agree electronic processes required at both CSU level and within the Embedded Team including data transfer requirements.

iv) Agree publication Portal via Business Intelligence Suite within Internet or as standalone document.

v) Review, summarise and drill down 2013/14 Indicators following publication.

vi) Formation of an Integration sub group to integrate headings and ensure read across at all levels of reporting.

vii) Publication of Final Report.

viii) Review and evaluate effectiveness and impact as standalone document and its use within a Performance Management Regime.

6.1 Resource Requirements

Financial Resources will be dependent on the agreement and contract with the CSU for both data requirement and maintenance of current systems.

Project Management will be part of the role of the Relationship Manager (Performance). Further Personnel requirements will be needed to support the Project Management Group and any sub groups required.

6.2 Tolerance

The project will be completed by the 31st March 2012.