NHS
North Staffordshire
Clinical Commissioning Group

Financial Plan
2013/14-2014/15

Final May 2013

1.0 Synopsis and Recommendations

This Plan provides detail of NHS North Staffordshire Clinical Commissioning Group financial planning intentions for 2013/14. As a new statutory body, the CCG will be expected to comply with the requirements to ensure that it keeps expenditure within the resources available to it and to deliver the system requirements contained in the 2013/14 Planning Guidance, *Everyone counts : Planning for Patients 2013/14.* The Plan also builds on the detail contained in the CCG's Integrated Strategy and Operating Pan (ISOP).

This requires the CCG to be able to demonstrate delivery of a 1% surplus, for it to spend 2% of its resources in a non-recurrent manner, and to hold a minimum level of uncommitted contingency reserve.

Maintaining financial balance and sustaining financial health in the first year of operations for the new CCG will be crucial in terms of its position in the Local Health Economy.

In summary this paper sets out:

- The background context in which the budgets have been set
- The Health Economy Context and scale of the QIPP challenge locally
- The CCG Finance and Activity Model and its impact on the Local Health Economy
- The financial plan in relation to Prescribing, Continuing Healthcare and other significant components of the CCG baseline.
- The CCG position in relation to running costs (inc. commissioning support)
- Running Costs
- Cash Management
- The financial risks and associated mitigation

Progress against the plan will be reported throughout the year to the CCG Board and the Commissioning, Finance & Performance Committee.

2.0 Background and Context

CCG baselines for 2013/14 were announced on 18th December 2012. For NHS North Staffordshire CCG this amounted to £242.8m. As part of this announcement all CCGs have also received 2.3% growth which equates to £5.6m bringing the 2013/14 opening recurrent baseline to £248.4m for the CCG. In summary, this equates to £1,179 per head of population (registered with a North Staffordshire GP).

The weighted capitation formula and pace of change policy (potentially moving CCGs towards fair share funding) have been frozen in 2013/14 and all CCGs have received the same level of growth.

The Planning Guidance for 2013/14 included a number of system requirements that have been applied to the Financial Plan for the CCG. These are:

- An expectation that CCGs set aside 2% of their recurrent funding for non-recurrent expenditure purposes only (referred to as Strategic Change Reserve (SCR) in this document).
- An expectation that CCGs will hold a minimum 0.5% uncommitted contingency reserve
- An expectation that CCGs will plan to achieve a 1% surplus
- The application of the national efficiency requirement for 2013/14 of 4%, offset by pay and price inflation of 2.7% (i.e. a net deflator of 1.3%). A price inflation adjustment of 0.2% is also allowed for acute providers linked to CNST premiums.
- The application of 2.5% CQUIN that providers can earn based on their ability to achieve certain quality markers.

PCT Surplus from 2012/13

North Staffordshire PCT planned to achieve a control total surplus of £1m in 2012/13 and the draft accounts submitted on 22 April posted an outturn surplus of £1.152m (subject to audit). Achievement of the control total will be carried forward to the NHS Commissioning Board in 2013/14, with an expectation that PCT originated surpluses will be made available to the relevant local health systems in future years. Proportionately, for the CCG this equates to approximately £0.750m and has been included as a non recurrent allocation in 2013/14.

CCG Approach to budget setting

The CCG approach to budget setting has been to establish recurrent baselines based on the most likely forecast outturn levels predicted for 2012/13, adjusted for local circumstances or known changes in activity / demographics. This provides the CCG with a robust starting point for 2013/14 contracts before the application of efficiency requirements and inflationary adjustments.

Contingencies

The CCG will hold an uncommitted contingency reserve of around 1% (equivalent to £2.5m) of its recurrent resource. This is double the national recommended % but is felt prudent given risks in relation to Acute activity and given the current financial climate in the Local Health(and Social Care) Economy. The contingency will be used to mitigate in-year cost pressures and is an integral part of the CCG approach in managing financial risk (described in more detail below).

Contracts

At the time of the production of this Financial Plan main contracts with local NHS providers are still in the process of being finalised. Updates to the Financial Plan will be reported via CFO finance reports during the year.

Financial Risk profile for the CCG

At the time of the production of this Plan, there are a number of 'live' issues that when finalised, could result in further financial risk for the CCG. These include:

1. Local Health Economy contracts are still in the process of being agreed.
2. The CCG has received little or no information from other lead commissioners, where the CCG is an associate commissioner on other contracts (outside of the Local Health Economy).
3. The CCG is pursuing outstanding information in support of Specialised Services allocation adjustments that could present the CCG with a further cost pressure.
4. Closure of outstanding allocation issues with the NHS Commissioning Board.

In order to mitigate against this potential financial risk, it is recommended that a Task & Finish Group be established to address this issue and target additional an additional efficiency (QIPP) requirement to the value of £3m.

Consideration should be given to the constitution of the Group. The initial proposal is that the Group should be led by the Clinical Accountable Officer, include the Chief Operating Officer, the Chief Finance Officer and the Head of Quality & Governance. For overview and scrutiny purposes, the Group would also benefit from Lay Member input.

Regular reporting and progress updates are required on this issue. As such, reporting is proposed via the Commissioning, Finance & Performance Committee and the Chief Finance Officer Reports to the CCG Board would include regular updates.

3.0 Health Economy Context and scale of QIPP Challenge

Health Economy Context

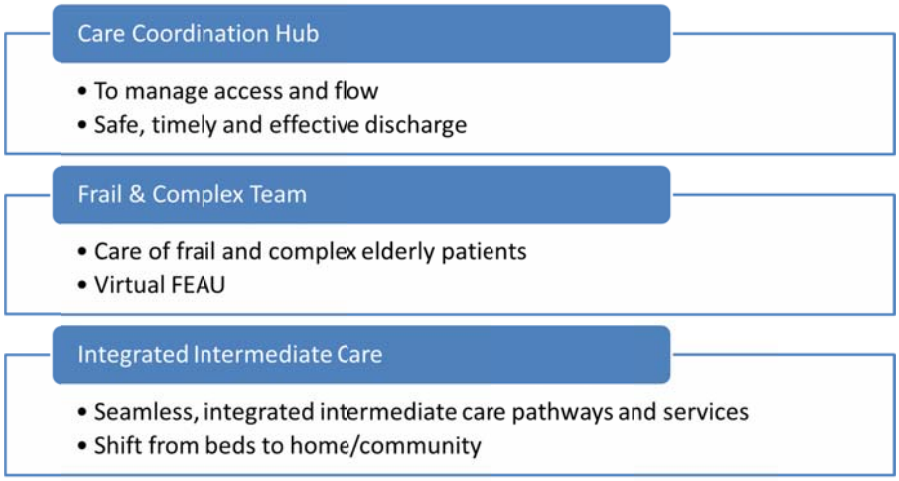
The initial phase of the local health economy strategy, the Fit for the Future strategy, has now come to an end. The strategy was successful in bringing acute services together onto a single site, supported by investment in community infrastructure. The aims were to improve efficiencies by reducing lengths of stay, reduce the acute bed base by c300 acute beds, transfer 120,000 outpatient appointments to tier 3 and/or primary care settings. Furthermore, the strategy supported investment into community services strengthened by a new model of care and included integrated teams working with primary care clinicians. Much has been achieved, including:

- Reductions in patient lengths of stay (on average, 23% since 2010/11)
- Reductions in acute beds of approximately 220, before counting escalation beds because of winter pressures
- Multi £million investment in community services and infrastructure
- In excess of 100,000 outpatient appointments transferred into community/primary care

However, it is recognised that even more needs to be done and the CCG has been working closely with its health and social care partners to build on Fit for the Future's legacy developing further the model of care that in turn will deliver the next stage of transformation

of the local health and social care system for the next 5 years.

In support of this, the CCG held a whole Health & Social Care Economy Away Day on 20 December 2012 to discuss and agree the next stage strategy going forward. In summary there was sign up to the 3 significant strategies being put forward, summarised as follows:



In constructing the Financial Plan, the CCG is mindful of the UHNS financial position. The CCG is aware of the significant deficit reported during 2012/13 and the need for it to play a part in providing a sustainable solution for the Trust underpinned by a formal financial recovery process.

It is also worth noting that because of changes in commissioning responsibilities, the CCG along with Stoke on Trent CCG will be directly responsible for about 55% of all services commissioned from UHNS. This means that both local CCGs along with UHNS will need to ensure a significant level of engagement with the NHS Commissioning Board (Local Area Team) and other commissioners in ensuring financial recovery is recognised by all commissioning bodies.

Scale of the QIPP (Quality, Innovation, Productivity and Prevention) Challenge

If demand, activity, costs and therefore spend were to increase in line with trends from recent years, a gap will open up between available resources and that level of spend. It is this gap between existing levels of funding and what may occur in terms of financial demand that represents the QIPP challenge. Nationally, for the NHS this gap has been sized at around £20 billion by 2014/15 and we can also expect government austerity measures to go well beyond 2014/15. By way of background, the QIPP Challenge for North Staffordshire was calculated by the former PCT at £84m, £63m of which was intended to be secured from provider efficiencies. Of the residual £21m, £15m is planned to be secured through transformational (service redesign) measures with the remaining £6m to be secured from transactional means.

The CCG took full devolved responsibility for the management of QIPP from April 2011, and has demonstrated a track record of delivery both in 2011/12 (£11.4m) and in 2012/13 (£3.4m). Whilst the CCG (under the auspices of the former PCT) has overseen a reduction in acute beds (consistent with the Fit for the Future strategy locally) and at the same time invested in community services, the CCG is mindful of a growing demand for urgent care services in the health economy and more still needs to be done to sustain the recent improvements seen.

Therefore, the QIPP agenda remains at the forefront of the CCG priorities. Delivering further efficiency savings to invest in meeting growing demand whilst at the same time improving quality has been embedded in the contract and financial planning process for 2013/14. The table below summarises the CCG's QIPP targets through to 2017/18.

The QIPP Plan for 2013/14 is set at £17.5m. This includes £9.7m of provider (baseline) efficiencies generated by the application of the 4% national efficiency requirement and £7.8m of Commissioner QIPP transformational schemes. The requirement to deliver an additional £3m of QIPP is now included in the Plan.

In order to succeed in delivering QIPP / organisational cost improvement programmes (CIPs) going forward means local health systems have to deliver genuine system wide QIPP. Whilst there will always be internal efficiencies that providers must secure on their own, we can no longer afford for individual organisations to deliver large scale efficiencies in a silo manner, they must be connected to whole system, pathway re-design proposals. The financial challenge will be daunting in itself and failure to connect QIPPs and CIPs could result in significant financial failure in one part of the system. This in itself will then become a barrier to delivering genuine transformational change.

Provider	Scheme		2013/14 £'m	2014/15 £'m	2015/16 £'m	2016/17 £'m	2017/18 £'m	TOTAL £'m
Acute	Planned Care		0.3	0.3				0.6
	Emergency Care		2.6	1.0	0.5	0.5	0.5	5.1
	Outpatients		0.6	0.1				0.7
	Other Incl 4% Efficiency		4.5	4.7	4.7	4.8	4.8	23.5
Community	Other Incl 4% Efficiency		1.5	1.8	1.8	1.8	1.8	8.7
Mental Health	Other Incl 4% Efficiency		0.9	1.1	1.1	1.1	1.1	5.3
Corporate	Other Incl 4% Efficiency		0.4	0.3	0.3	0.3	0.3	1.6
Other	Other Incl 4% Efficiency		6.7	3.1	2.8	2.7	2.7	18.0
Total			17.5	12.4	11.2	11.2	11.2	63.5

By way of assurance, the CCG will be reporting in-year performance of QIPP to the CCG Board / Commissioning, Finance and Performance Committee. Additionally, the Local Health Economy QIPP Board will also receive regular reports during the year. This established forum is already providing useful in terms of holding each other to account for delivery of system wide QIPP's.

4.0 finance and Activity model

Finance

The impact of the strategies outlined in Section 3 above reflects the need to curtail expenditure in the acute sector whilst at the same time invest further in community services, primary care and social care. Significantly the strategies aim to deliver:

- upto 10% reduction in NEL short stay admissions
- improved flow through the whole health and social care system
- reduced attendances at A&E
- further improvement in lengths of stay in both acute and community settings

In support of the this our investment plans feature the following:

- investment in a care co-ordination hub to manage access to services and secure safe, timely and effective discharge
- investment to secure a greater level of expertise in the management of frail and complex patients via the input of a 'Care of Frail & Complex Specialist Team'
- investment in community nursing services
- investment in a fully integrated intermediate care service exploiting alliance commissioning models as appropriate

Addressing the 4 hour wait in A&E and in particular patient 'flow' issues across the health and social care economy are recognised as key priorities. Therefore, in addition to the strategies outlined above the CCG will utilise the standard NHS contract levers as appropriate and apply contract clauses in the way they are intended, to ensure there remains a continuous drive to improve performance standards across our providers. In support of this and to recognise delivery of the 4hour A&E target is increasingly seen as a system wide issue, additionally, the CCGs locally have developed a local performance fund (£5m) for all parties to access contingent on delivery of the A&E 4 hour target. This will bind the whole Health & Social Care Economy in a way not done so previously.

Our plans also feature additional investment in Continuing Healthcare (detailed in Section 5 below) and investment in primary care prescribing.

We have constructed 3 financial scenarios, our base case scenario is set out below.

Summary Financial Model	2013/14 £m	2014/15 £m
Resources		
Recurrent baseline allocation	242.8	248.4
CCG Growth	5.6	5.8
Running Costs	5.3	5.3
Quality Premium		0.5
Surplus from prior year	0.7	2.5
Total Resources	**254.4**	**262.5**
Expenditure		
Baseline expenditure	238.9	245.8
2% Strategic Change Monies (SCR)	5.0	5.2
Inflation	7.8	7.9
Investments	15.2	10.8
Contingency	2.5	2.6
Total Expenditure	**269.4**	**272.3**
QIPP Challenge		
Provider Efficiency (4%)	9.7	9.7
Transformational Change	7.8	2.7
Prescribing		
Total QIPP	17.5	12.4
CCG SURPLUS	**2.5**	**2.6**

The CCG intends holding a 1% contingency

Investments include UHNS activity, community investment, demand growth, continuing healthcare, 111 service

QIPP includes provider 4% efficiency

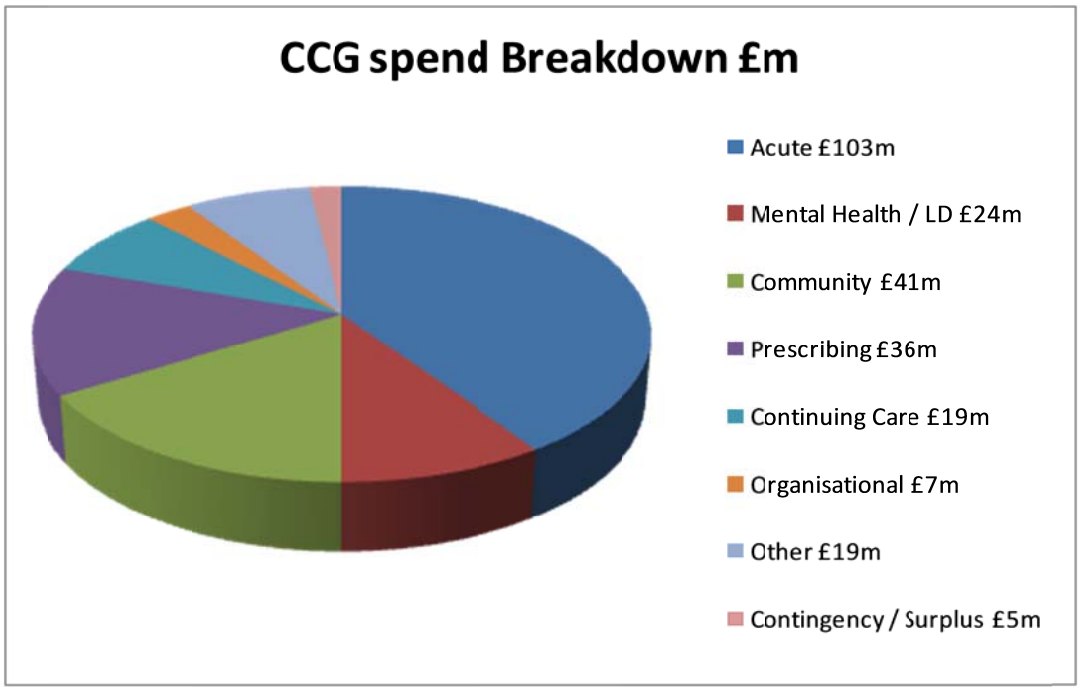
QIPP will be subject of Health Economy challenge via the QIPP Board locally

CCG will be targeting delivery of a 1% surplus each year

The CCG has assumed partial receipt of the quality premium in 2014/15 and thereafter. The CCG has also assumed this will be revenue neutral.

An 'upside' and a 'downside' financial scenario are also included at Appendix 1.

Our 2013/14 planned expenditure amounts to £254.4m and is spent as follows:



As can be seen from the above almost 40% of our expenditure is with the acute sector. Our investment strategy means that over the next 5 years we will be looking to invest additional sums of money into community services and primary care.

In total, if we were to include the planned future years' commitments, inclusive of the 2013/14 investment, cumulatively, we estimate this additional investment in community services to be £5.3m or equivalent to growth of plus 13% in these services of the next 5 years.

Activity

Our activity plans are predicated on what we believe to be a reasonable start point for 2013/14, largely based on 2012/13 outturn levels of activity and adjusted for future changes in demographics. Activity plans are then adjusted to reflect planned changes with regards to QIPP and other known service changes.

As outlined above, it is our intention to reduce the trajectory for unplanned care, both in terms of A&E attendances and non-elective activity. For planned care it is our intention to hold referrals at broadly the same levels as for 2012/13, once adjusted for activity that will be carried out as an outpatient procedure.

	Elective non ffce's	Non elective FFCE's	1st OP	A&E attendances
April	2281	1802	3566	
May	2189	1892	3662	
June	2484	1903	4079	
July	2379	1980	3834	
August	2300	1901	3788	
September	2386	1912	4086	
October	2454	1794	4010	
November	2557	1709	4200	
December	2237	1738	3558	
January	2259	1772	3939	
February	2316	1590	3817	
March	2648	1718	4250	
2013/14 total	28488	21713	46789	37224
2012/13 forecast outturn	30795	23182	48855	38547

What does this mean for our main NHS contracts in 2013/14?

The CCG is actively negotiating contracts with its providers and is looking to have all main contracts agreed by the end of April 2013.

University Hospital of North Staffordshire (UHNS)

Subject to ongoing contract negotiations with the provider, the opening SLA value will be set at £83.4m which includes Strategic Change Monies (SCR) of £1.2m and is net of QIPP schemes valued at £7.3m (inclusive of tariff efficiency). At this quantum the CCG represents approximately 22% of the Trust's total clinical income.

Activity levels for 2013/14 are based on the projected 2012/13 outturn, adjusted to reflect movements in waiting lists to secure delivery of the 18 week referral to treatment target, demand growth, reductions as a result of QIPP and to maintain delivery of the 18 week referral to treatment target. Consistent with national rules, the SLA will again include the setting of an emergency activity threshold.

A further £2m of CCG SCR monies (£5m as a LHE) has been protected in support of a risk share approach with UHNS directly linked with non elective activity in 2013/14. There is an intention to move towards a 'prime commissioning' model which in future years could see this investment routed directly via SSOTP.

Staffordshire and Stoke on Trent Partnership Trust (SSOTP)

Subject to ongoing contract negotiation with the provider, the opening SLA with the provider will be set at £40.8m which includes SCR monies of £1.0m and is net of QIPP Schemes to the value of £1.5m (tariff efficiency). Investment in Community Services has been recognised, supported by the following initiatives ;

- Investment in Integrated Community Teams
- Investment in Community Nursing Services
- Investment in Community Hospitals

North Staffordshire Combined Healthcare NHS Trust (CHT)

Again, subject to ongoing contract negotiations with the provider, the opening SLA with the provider will be set at £22.2m which includes SCR monies of £0.5m and is net of QIPP Schemes to the value of £0.9m (tariff efficiency).

The contract for Mental Health Services will continue to operate under a block contract arrangement with a shadow cost and volume arrangement in preparation for the introduction of PBR tariff for mental health services in 2014/15.

5.0 Prescribing, Continuing Healthcare and other significant issues

Prescribing

The Prescribing budget for 2013/14 has been rebased. This Plan proposes that the prescribing budget be increased by 4% over and above 2012/13 projected outturn levels to reflect expected growth and price inflation. However, there is a requirement that efficiencies be obtained in this area and a QIPP efficiency target of 6% (£2.2m) has been set, therefore resulting in a net reduction of 2%. This approach is supported by the Medicines Management Strategic Plan.

Continuing Healthcare and Funded Nursing Care

2012/13 has continued to see increased pressure on this budget and as part of the planning process for 2013/14 the budget has again been rebased. In anticipation of continued future growth in demand, an additional £1.0m (almost 8% growth over and above the 2012/13 baseline) investment has been built into this plan. The opening baseline for Continuing Healthcare and Funded Nursing Care will be £18.7m**.** The CCG will be working collaboratively with other CCGs in Staffordshire in the management of continuing healthcare, the lead CCG for which is Stafford & Surrounds CCG. In support of this a collaborative commissioning agreement is in place to clarify governance and operational matters.

Social Care and re-ablement

The allocations announced on 18 December 2012, ensured there would be further transfers of NHS funding for Social Care. For North Staffordshire this equates to £3.256m and whilst the money is to be transferred from the NHS Commissioning Board (via the local Area teams), the CCG must be a signature to the agreement as to how this resource is to be utilised.

Additionally, the CCG has £1.2m available in its baseline to support re-ablement initiatives. Collectively, these schemes include initiatives to support service users discharged from hospitals with the aim to speed up recovery.

Specialised Services

The CCG is not responsible for the commissioning of specialised services, typically high cost, low volume activity. As such, CCG allocations for 2013/14 have been adjusted to reflect the new 'minimum take' activity that will become the responsibility of the NHS CB (Birmingham Local Area Team, on behalf of the West Midlands). This has resulted in the transfer of a further £18.9m to the Commissioning Board, previously the responsibility of the PCT/CCG. The CCG is working with the Birmingham Area Team to understand the

detail supporting these resource transfers and how they affect local provider contracts.
A reserve of 2% (£5m) recurrent funding is to be utilised non-recurrently in-year to support system change and transformation within the Local Health Economy as mandated in the 2013/14 Planning Guidance. This is referred to as Strategic Change Reserve Monies (SCR).

Both local CCGs and providers are working together to agree the metrics in support of release of the 2%, and these will be specified in the contracts with providers once they are finalised.

As outlined earlier in this Plan a proportion of the SCR is proposed to be used as a risk reserve to fund non elective activity beyond planned levels linked to the health economy transformation programme described in this document. This amounts to £2m for the CCG (£5m as a LHE).

£1.2m of SCR has also been earmarked in support of tariff transitional issues with UHNS and is part of the contract offer with the provider.

Use of SCR also includes SSOTP (£1.0m), again linked to the health economy transformation programme and for CHT (£0.5m) with regards to RAID.

6.0 Running Costs

The CCG has been set a running costs allocation of £5.3m for 2013/14, equivalent to £25 per head of population allowable for CCG's. This can be broken down as follows:

- £3.1m CCG Executive, directly employed staff, regulatory costs (eg Audit Fees etc)
- £2.2m Commissioning support Unit (CSU) costs

CCG directly employed staff equates to approximately 38 whole time equivalents which highlights the need to ensure the CCG receives a full, comprehensive and value added support service offered by the Staffordshire Commissioning Support Unit (CSU). A number of business critical functions are supplied by the CSU including contract management, finance, business intelligence functions, communications etc.

The Staffordshire CSU is well placed to support the new CCG. The SLA for 2013/14 has already been agreed and a detailed product matrix is in place with key performance indicators being actively measured and monitored.

As a result of the generally good level of service received to date from the CSU, the CCG is looking to build a longer term relationship going forward. This, will however, be dependent upon continued high levels of performance at a cost that provides excellent value for money.

7.0 Cash Management

The CCG's expected Cash Limit for the year amounts to £253.6m.

Whilst the subject of further in depth analysis and cash flow forecasts which will be completed by the end of March, it is envisaged that the CCG will have sufficient flexibility to meet its cash payment requirements to satisfy Better Payment Practice Code requirements during 2013/14. Managing the in-year revenue Income and Expenditure position and delivery of the key statutory financial targets will again be crucial in

achieving the cash limit for 2013/14. The CCG will again be entering into dialogue with its host providers to support cash flow within the Trust's, especially in the early part of 2013/14.

8.0 Risks

Management of financial risk will be crucial to ensure successful delivery of corporate and financial objectives for the new CCG. A number of financial risks have been identified that are summarised below. The CCG will need to consider these risks and address them during the year.

Risk	Mitigating Action
Delivery of QIPP financial savings	• Regular monthly monitoring of QIPP Plans • Plan to deliver more than minimum QIPP requirement • Confirm & challenge process with portfolio leads • Secure additional in year QIPP to ensure headroom in financial position • Utilise available contingency funding, • Suspend investment programmes
Managing acute trust activity within agreed contract values	• Regular monitoring of contract performance including early Forecast Outturn projections • Apply contract terms in full • Contingency Reserve in place • Defer / delay investment programmes
CCG Baseline queries unresolved into 2013/14 presenting a level of financial risk	• Process underway to understand Specialised Services baseline adjustments. Must be resolved alongside main acute contract • Progress potential risk sharing approach with NHS CB colleagues • Target delivery of additional £3m QIPP from existing CCG baseline
In year increasing costs and volumes of activity relating to Continuing Care	• Regular reporting to CCG Governing Body • Ensure regular assessment of patients

Financial Scenarios

	Upside Model				Downside Model			
Summary Financial Model	2014/15 £'m	2015/16 £'m	2016/17 £'m	2017/18 £'m	2014/15 £'m	2015/16 £'m	2016/17 £'m	2017/18 £'m
Resources								
Recurrent Baseline Allocation	248.4	254.7	261.1	267.9	248.3	253.4	258.6	263.9
CCG Growth	6.3	6.5	6.7	6.8	5.1	5.2	5.3	5.4
Running costs	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3
Quality Premium	0.5	0.8	0.8	0.8	0.5	0.8	0.8	0.8
Suplus Prior Year	2.5	2.6	2.7	2.7	2.5	1.3	1.3	1.3
Total Resources	263.0	269.9	276.6	283.5	261.7	266.0	271.3	276.7
Expenditure								
Baseline Expenditure	243.2	249.3	255.6	261.9	247.1	252.1	257.2	262.3
2% Strategic Change Monies (SCR)	6.5	6.7	6.8	7.0	5.2	5.3	5.4	5.5
Inflation	6.8	6.8	6.8	6.8	10.2	10.5	10.7	11.0
Investments	12.9	11.9	12.0	12.2	9.9	7.7	6.6	6.5
Contingency	3.9	4.0	4.1	4.2	1.3	1.3	1.3	1.4
Total Expenditure	273.3	278.7	285.3	292.1	273.7	276.9	281.2	286.7
QiPP Challenge								
Provider Efficiency	10.1	10.2	10.1	10.1	7.6	7.7	7.7	7.8
Transformational Change	2.1	1.0	1.0	1.3	5.0	4.2	3.2	3.6
Prescribing	0.7	0.3	0.3		0.7	0.3	0.3	
Total QiPP	12.9	11.5	11.4	11.4	13.3	12.2	11.2	11.4
CCG Surplus	2.6	2.7	2.7	2.8	1.3	1.3	1.3	1.4

Salient Features
1) CCG resource growth at 2.5%
2) 1% Surplus
3) 1.5% unallocated Contingency held
4) 2.5% of recurrent resource allocated non recurrently
5) QiPP of £47.2m delivered over the planning cycle
6) Total investment of £49m available over the planning cycle

Salient Features
1) CCG resource growth at 2%
2) 0.5% Surplus
3) 0.5% unallocated Contingency held
4) 2% of recurrent resource allocated non recurrently
5) QiPP of £48.1m delivered over the planning cycle
6) Total investment of £30.7m available over the planning cycle