NHS
Brent
Clinical Commissioning Group

Report to: Brent Health Partnerships Overview and Scrutiny Committee (OSC)

Report from: NHS Brent CCG

Date of meeting: 16 January 2014

Re: **CCG Financial Briefing Paper**

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1. Purpose of the Paper

1.1 The purpose of this briefing paper is to set out:

- The national financial framework for CCGs and the NHS Financial regime.
- Brent CCG's financial allocations and planning framework for 2014/15 and 2015/16 and the financial context that the CCG is operating within.
- The CCG's QIPP & Investment plans in this context.

2. National Financial Framework

2.1 Under the Health and Social Care Act 2012 funds flow through the NHS in the following way:

- Treasury allocates Department Expenditure Limit to Department of Health, who allocate NHS commissioning funding to NHS England
- NHS England are responsible for allocating funding to Clinical Commissioning Groups
- NHS England commission directly services such as specialist services and primary medical services

2.2 The CCG must utilise its allocation to fulfil its statutory functions which are comprised of:

a) Commissioning community and secondary healthcare services (including mental health services) for:

- All patients registered with its Members; and
- All individuals who are resident within the London Borough of Brent who are not registered with a member GP practice of any Clinical Commissioning Group (e.g. unregistered);

b) Commissioning emergency care for anyone present in the London Borough of Brent

2.3 The CCG is required to frame its commissioning plans and priorities in line with the national Operating Framework published by the NHSE, and to contract with its providers using national business rules including PbR (Payment By Results) whereby CCGs pay NHS acute providers according to a National Tariff for outpatient and inpatient activity.

2.4 Hospital providers receive income from CCGs, NHS England and Local Authorities. The vast majority of clinical income is received through application of the National Tariff and the business rules for Payment by Results. Providers may receive other income from private patients and other sources such as for catering, car parking etc. Education and Training funding comes from NHS Health Education England and Research and

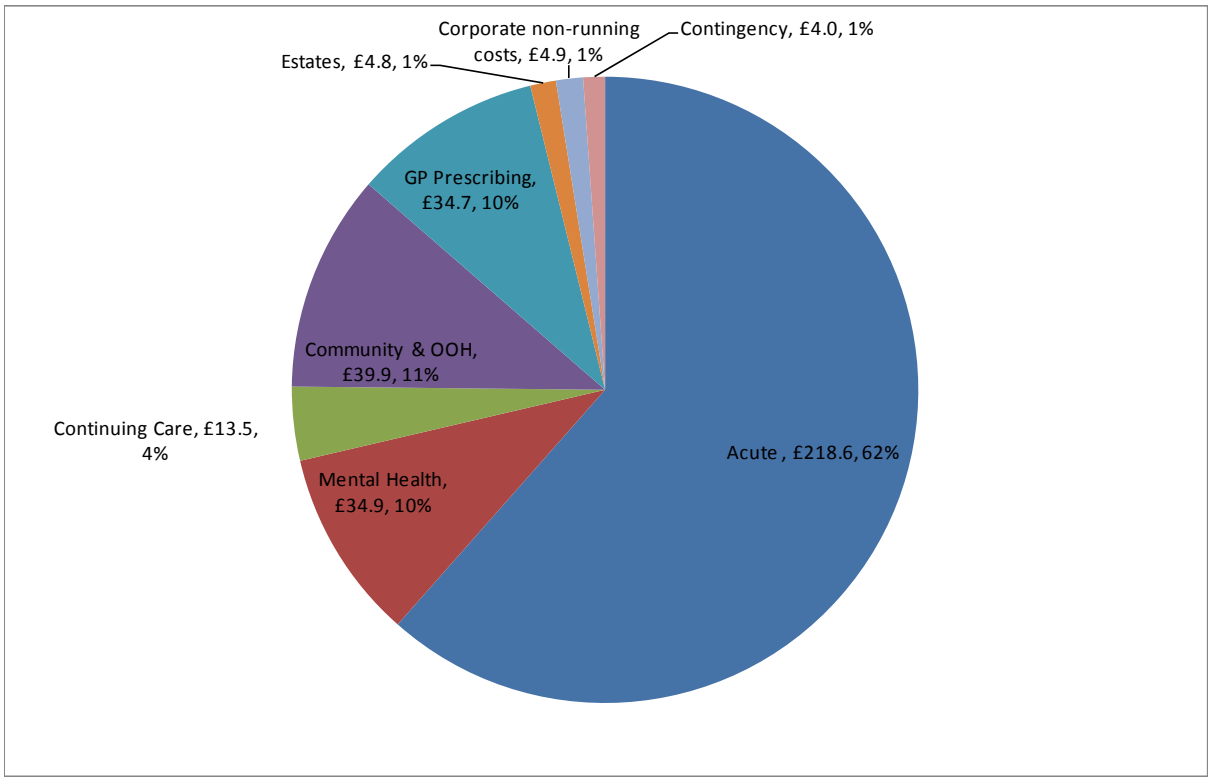
Development funding comes from the NHS National Institute for Health Research and others. Capital funding is subject to a separate Business Case process managed by the NHS Trust Development Authority.

3. 13/14 Brent CCG Financial Position

3.1 Each year CCGs are required to deliver agreed financial plans with the NHSE. Brent CCG inherited a healthy financial position from the PCT and agreed a surplus budget of £26m in 13/14.

3.2 Surpluses are normally carried forward and for 13/14 NHSE have confirmed that surpluses forecast at month 6 will be able to be carried forward into future years. At Month 6 Brent forecast a surplus of £29.2m and therefore this funding will be carried forward and be available for the CCG.

3.3 Total CCG spend at Month 8 c£350m is shown in the table below.



3.4 Community services includes the community contract with Ealing ICO, HIV, Children and Families, community investment schemes, carers, intermediate care and palliative/hospice services. Out of Hospital services are the local enhanced schemes payable to GP Practices. Further detail is included in Section 10.

3.5 Mental Health services include contracts with NHS providers such as CNWL, investment in Dementia services and SLAs with the voluntary sector. Corporate non-running costs include staff costs on clinical services such as prescribing advice and expenditure on GP IT. Estates costs relate to the cost of void space not recharged to providers.

4. Pan-CCG Financial Arrangements

4.1. In 2013/14 Brent CCG has agreed to take part in two Pan-CCG financial arrangements. The first is to use 2% non-recurrent headroom (a national financial planning requirement)

to support Shaping a Healthier Future implementation across NW London, covering the following:

- The programme management costs for Shaping a Healthier Future during implementation
- Pump priming CCGs' Out-of-Hospital investments and delivery teams on the ground in each CCG
- Providing resources to providers to support the transition of services and the provision of transitional funding

4.2 Secondly, it has agreed to take part in a pan-Brent, Harrow and Hillingdon CCG in-year risk share arrangement. The objective is to establish a mechanism for CCGs to share in-year risk on external issues (as opposed to those that are within the CCG's internal ability to control). Recommendations on the application of the risk share are due to be made to all CCG Finance Committees and Governing Bodies in January / February.

5. 13/14 QIPP and Investment plans

5.1 The CCG's forecast net QIPP savings is £8.1m including £3.9m in the acute sector, £1.8m on mental health continuing care closer to Brent (repatriation) and £1m on GP Prescribing.

2013/14 QIPP SCHEMES		FOT Actuals
	Local Scheme Name	£'000
Acute	Referral Standardisation/ Referral management	-536
Acute	Outpatients at lower cost - Ophthalmology	-54
Acute	End of Life	-575
Acute	Outer North West London -Cluster Integrated Care	-567
Acute	Acute contract metrics	-1,302
Acute	STARRS Stretch	-500
Acute	Primary Care Divert / Clinical SPA	-408
Community	Productive Community Health Services	-567
Continuing Care	Continuing Care	-100
Continuing Care	Mental Health savings on budget FYE 12/13 repatriation	-829
Continuing Care	Mental Health savings on budget 13/14 repatriation	-1,000
Mental Health	Mental Health savings on budget CNWL	-235
Mental Health	Mental Health savings on budget small contracts	-96
Mental Health	Mental Health savings on budget BEH	-300
Prescribing	Reduction in Prescribing costs	-1,023
BRENT Total		**-8,092**

5.2 The CCG's investment plan forecast for 2013/14 is £16.3m. The forecast spend on non-acute investments is £8.9m, the vast majority on community and out of hospital schemes. There is also forecast spend of £5.2m on Winter planning schemes and £2.2m on improving the 18 Weeks performance at NWLHT.

BRENT CCG - 13/14 INVESTMENTS

Budget heading	Budget area	FOT Spend £'000
Gynae Pathway - Harness/Willesden	Community	100
Outer ICP	Community	1,066
Additional 2 beds Pembridge Unit	Community	57
Re-ablement Funding	Community	1,795
Self care projects	Community	50
STARRS Stretch	Community	516
Community Investment Reserve	Community	164
Breastfeeding Team	Community	210
MSK enhanced Pathway	Community	82
Paediatric OT	Community	113
IAPT	MH	148
Dementia	MH	220
LD Self - assessment action plan	MH	78
LAC Audit	MH	8
GP IT Pressure	Out Of hospital	171
EMIS Web extension	Out Of hospital	706
LAC Nursing Team	Out Of hospital	30
Primary Care Network Development	Out Of hospital	1,134
Diabetes (Insulin) LES	Out Of hospital	70
Cardiology Diagnostics LES	Out Of hospital	75
Better GP Performance Outcome	Out Of hospital	576
Phlebotomy LES - extend to all practices	Out Of hospital	200
Phlebotomy LES - top up existing	Out Of hospital	40
Primary Care Single point access	Out Of hospital	254
Primary Care Hub/Access	Out Of hospital	813
Organisational Development	Out Of hospital	100
Scriptswitch	Prescribing	154
Non-acute investment		8,930
Winter / Emergency planning	Winter	5,160
18 Weeks investment	18 Weeks	2,197
Acute investment		7,357
Total		16,287

6. 14/15 & 15/16 CCG Allocations

6.1 NHS England has responsibility for determining funding allocations to commissioners within the NHS system. At their Board meeting on 17 December 2013 they considered a paper that sets out the proposed funding allocations for 2014/15 and 2015/16. The paper outlined:

- The proposed formula to be used to determine the target allocation for CCGs
- The proposed distribution of funding between different elements of commissioning (CCGs, primary care, specialist commissioning, public health, and other commissioned services). This includes funding arrangements for Integrated Transformation Fund (now called the Better Care Fund (BCF)) and the running cost allowance
- The proposed distribution of funding within the CCG element of commissioning, including the pace of change of movement away from historical allocations to the target allocations (which are based on a national formula for how funding should be distributed between CCGs).

6.2 NHS Brent CCG's financial allocations for 2014/15 and 15/16 are set out in the table below.

14/15	14/15	14/15	15/16	15/16	15/16
Uplift	Uplift	Distance from target	Uplift	Uplift	Distance from target
£'000	%	%	£'000	%	%
7,841	2.14%	7.67% over	6,362	1.70%	6.28% over

6.3 Brent received the minimum level of growth awarded to CCGs in 14/15 (2.14%) and 15/16 (1.7%) due to being over the capitated target allocation level (i.e. assessed as 7.67% (£28m) over funded in 14/15).

6.4 The uplift of 2.14% in the 14/15 allocation and 1.7% in the 15/16 allocation will not keep pace with the estimated 3-4% per annum cost pressures that Brent CCG is expected to face due to local demand and cost growth. The impact of a reducing allocation (relative to demand) over the next few years needs to be mitigated through delivery of Out of Hospital strategies and the CCG's savings and investment strategies.

6.5 As in previous years, the allocations guidance from NHS England confirms that commissioning organisations are required to set aside some of their funding for non-recurrent expenditure. NHS England has increased this requirement in 2014/15 to 2.5%, and it is envisaged that the Pan NWL-wide financial strategy will continue to support SaHF. In addition BHH collaborative financial arrangements are expected to continue.

7. Better Care Fund

7.1 The Better Care Fund plan requires local areas to formulate a joint plan for integrated health and social care and to set out how their single pooled Better Care Fund budget will be implemented to facilitate closer working between health and social care services. Joint plans should be approved through the relevant local Health and Wellbeing Board and be agreed between all local CCGs and the Upper Tier Local Authority. Health and social care providers should also be closely involved in plan development.

7.2 In 2014/15, a total of £1,100 million (increased from £859 million) will transfer to Local Authorities for social care to benefit health, using the same formula as 2013/14. This will become transacted through a central Section 256 transfer. In 2015/16, this funding will be part of the pooled Better Care Fund; while it will continue to be allocated to areas on the same basis as in previous years, the funding will be added to CCG allocations. CCGs will be required to pass this funding to the Better Care Fund pooled budget along with the funding from core CCG allocations.

7.3 From 2015/16, the Better Care Fund will also include a £1.9 billion contribution from core CCG funding, over and above the existing £300 million re-ablement funding and £130 million carers' breaks which will also be pooled in the Better Care Fund. Core CCG funding going to the pooled Better Care Fund will be allocated based upon the CCG allocation formula. Additional contributions to the Better Care Fund from Local Authorities, in the form of social care capital grants and disabled facilities grants, will continue to be allocated to them by central government on the same basis as for 2014/15.

7.4 Locally £13.7m will transfer from CCG baseline into the Better Care Fund (BCF) in 2015/16 in addition to the £6.2m received in 14/15. Plans for this fund will be taken to the Health and Wellbeing Board.

8. 2014/15 QIPP and Investment Plans

8.1 QIPP and Investment planning for 2014/15 has been subject to a rigorous process to ensure early stakeholder engagement in proposed schemes.

8.2 Following clinical and stakeholder engagement, each scheme has been subject to scoping and refinement with a view to determining the feasibility and deliverability of schemes. This was done through developing Project Initiation Documents (PID) which scoped the:

- QIPP/Investment potential
- Assessment of deliverability/feasibility
- Procurement approach and delivery model
- Risk rating

PIDs which have demonstrated low value and/or impact have been rejected on eh basis of poor value for money in terms of return on investment/effort.

8.3 The QIPP Programme Management function has identified a Senior Responsible Officer (SRO) and Clinical Responsible Officer (CRO) for each QIPP and investment scheme which will ensure clinical and managerial ownership, delivery and PMO management of schemes as they progress through to approval and delivery phases.

8.4 Both QIPP and Investment plan schemes are contained within the CCG's commissioning intentions for 2014/15, as these schemes will be subject to provider and commissioner contract negotiations and/or service development plans.

9. Evaluation of QIPP & Investment Projects/Schemes

9.1 All CCG commissioned services are subject to regular contract and performance reviews. The delivery of QIPP and investment schemes is monitored through a Programme Management approach. Issues are escalated for intervention to the QIPP Sub Committee, a subcommittee of the CCG Executive Committee and/or through the QIPP, Finance and Performance Committee, which is a formal Committee of the Governing Body.

9.2 For new investment schemes in addition to the routine monthly contract and performance reviews, there are more comprehensive evaluation plans in place.

10. Out of Hospital services commissioned from GPs

10.1 The following local enhanced services are being delivered by Brent GP Member Practices:

- Childhood surveillance for children under 5 years where their registered practices does not undertake
- Prescribing and administration of hormone blockers for treatment of prostate cancer
- Phlebotomy for 12 years and over
- Insulin initiation
- Register and plan for patients requiring palliative care
- Register and plan for carers
- Undertake ECG monitoring and 24 hour ambulatory blood pressure monitoring.

The forecast outturn on spend for these services in 13/14 is £3.7 m. In addition £1.0 m is earmarked to spend with practices to reimburse them for time spent and outcomes achieved for commissioning such as cost effective prescribing.

10.2 Brent CCG is considering for 14/15 commissioning of all services currently commissioned through a local enhanced service agreement, in line with national requirements.

The options for the CCG are:

a) To cease commissioning the service

b) To consider whether:

- Only one provider is capable of providing the service
- Only one provider or provider type is most capable of providing services
- Benefits of competitive tendering outweigh the cost of running a competitive tender process

10.3 A procurement panel, including Lay Member and External GP representative, was held in December 2013 to consider the above. The panel is due to make a recommendation to the Governing Body on the 29th January 2014.

10.4 In 2014/15 Brent CCG intends to commission services from the four GP networks in Brent for the following services:

a) Subject to successful pilot for extended GP services, locality primary care access centres for 7 day GP services outside core contract hours.

b) A number of services currently commissioned through Local Enhanced Services.

c) Integrated care services from GP networks and other providers for:

- Adults vulnerable to hospital admission or residential care
- 24/7 urgent care

10.5 The intention is to commission services from the four GP networks through out of hospital contracts. Procurement would be subject to the same Procurement Panel process described in 10.3 above.