NHS
Blackpool
Clinical Commissioning Group

Financial Recovery Plan

Introduction

1. This Recovery Plan describes the deteriorating financial position of the CCG, the reasons for this and the measures that have and will be taken to bring finances back into line with our overall financial aims.

2. The CCG has been developing its QIPP and savings plans to ensure we achieve our financial duties this financial year. However, we have through our QIPP governance process established that there is still a high risk that we will not be able to achieve the 1% surplus requirement. Therefore there is a need to escalate to a Recovery Plan and the extra action it proposes. The Recovery Plan must be shared with NHS England and be incorporated into the overall NHSE/CCG assurance process.

3. The Governing Body is asked to approve this plan.

Context - why does the CCG have a financial problem?

Specialised commissioning

4. Since its inception in April 2013 the CCG has experienced budgetary pressures that have impeded our ability to plan for and achieve our service and financial aims. An allocation error by NHS England's Northwest Specialised Commissioning Team caused a £7.4m shortfall in the CCG's budget at the start of 2013/14. For the first two years of our existence we have had to curtail our investment plans and seek non-recurring financial support from other NHS organisations while we resolved the shortfall in funding.

5. Most of the big developments that were required to achieve our service and financial aims were postponed. For example, the CCG had to substantially downscale the amounts originally planned for developing Primary Care and Community services in 2013/14 and Extensive Care services at BTH and Primary Care in 2014/15. We were grateful for the non-recurring funding support received from the Lancashire CCGs and NHS England (Lancashire) that enabled us to manage the position over the first two years of our existence.

6. By April 2015 the CCG still had an unresolved recurring shortfall of nearly £2m, but the non-recurring support had ended. Although the CCG received a 3% uplift to its allocation in 2015/16 (including 0.5% already committed for resilience schemes) the impact was closer to 1.6% because we finally took the view that resolution of the residual specialised commissioning error was unlikely and therefore accepted that some of the growth (0.8%) was needed to offset the recurring shortfall. However, this reduced the flexibility to be able to accommodate recurring pressures and fund longer-term developments.

2014/15 activity levels

7. Increases in activity levels in this year went well beyond the levels that could have been anticipated or afforded. The diagram at the top of the next page shows the longer-term non-elective activity trends at Blackpool Teaching hospitals FT and in particular highlights the unusual pattern for 2014/15.

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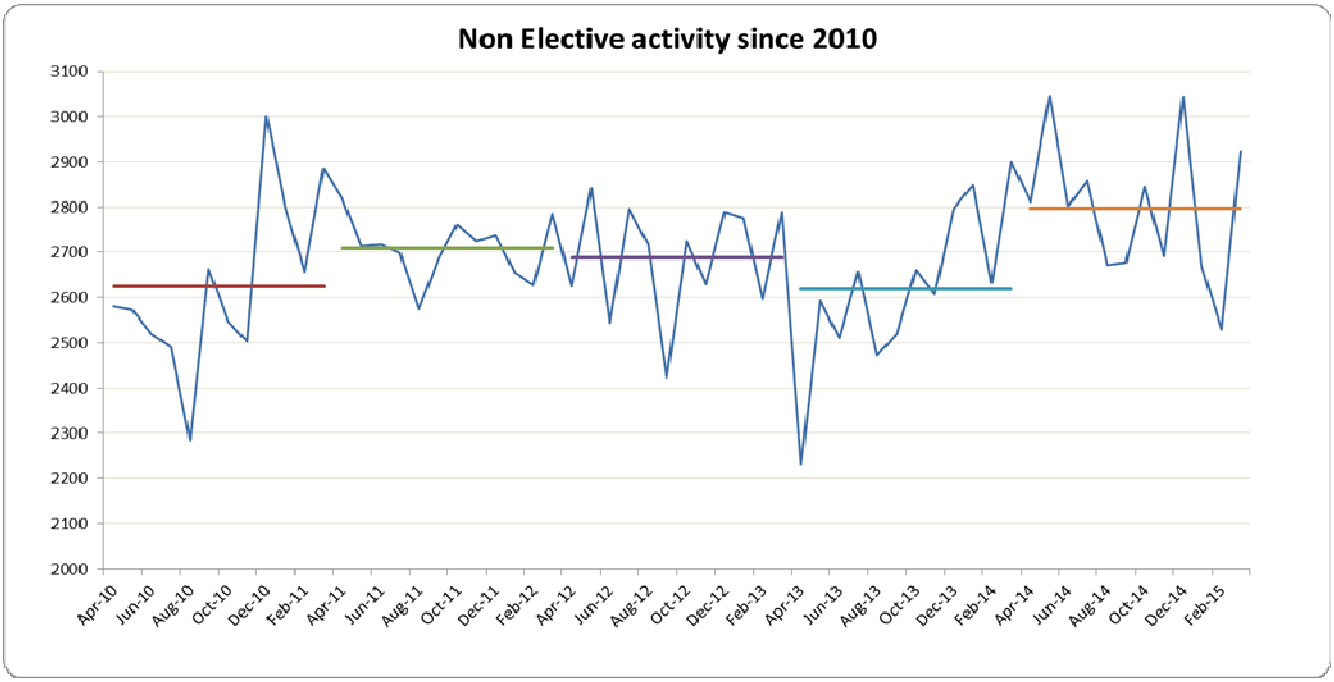

8. The key activity issues for the CCG were:
    - Non-elective admissions increased by 5% in activity and money terms compared to the previous year. Comparison to recurring plans was substantially higher as originally it was planned to reduce non-electives by 3% at BTH.
    - Prescribing expenditure increased by 3% above the budget.
    - Elective activity increased by 10% in activity and money terms compared to the previous year, which included additional amounts for RTT improvement.
    - After a period of no growth, CHC expenditure increased by 18% compared to 2013/14.

9. The full impact of the growth in non-elective admissions in 2014/15 was mitigated by the assured value contract for those services agreed with BTH and the 30% tariff for such activity. The benefit was circa £0.5m. However, the move in 2015/16 to a full PbR contract at ETO rates for non-electives has increased costs. A substantial increase in activity in month 12 at BTH, the timing of which precluded the CCG from being able to mitigate the impact using any remaining internal funds, led to the CCG seeking £0.7m NR support from another CCG. Part of this sum was repayable in 2015/16.

10. In summary there were £2.7m NR funds available to the CCG in 2014/15 to enable it to achieve its surplus of £2.3m, which was not available in 2015/16.

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Financial background

11. The CCG Governing Body agreed the following budgets at its meeting on 31st March 2015. The 'Source and Application of Funds' statement was as follows:

Source of new funds	**£k**
• Uplift of 3.03% including 0.5% resilience money	6,898
• Release of recurrent resources from 2014/15	4,253
• NHS E money for ETO tariffs	2,776
Total new sources	**13,927**
Applications	
• Funding the recurrent shortfall on 2014/15 savings	2,454
• Funding budgets at outturn levels in providers	4,733
• Funding CHC and prescribing budgets at outturn	2,300
• Supporting the BTH contract (includes the spec comm. pressure)	3,500
• Funding for Developments	2,598
• Funding for pressures	311
• Resilience schemes	1,240
Total Applications	**17,136**
Savings target	**3,209**

12. The CCG Governing Body had to delay £4.7m worth of service developments planned for 2015/16 within the 2014/15 Strategic Plan on the grounds that they were no longer affordable. An explicit decision not to stop all longer-term developments was taken, as there was concern that not making any progress on out of hospital services would damage the ability of the CCG to contain spending on acute services in the longer term. Therefore there was support for funding £2.6m of developments despite the need for recurring savings of £3.2m to meet the financial duty to return a 1% surplus. The percentage savings target was 1.3% of the CCG's total allocation and this was considered to be achievable.

13. Following an assessment of the level of investment required in elective activity to achieve the RTT, the CCG also took the view that the level of growth in acute activity was unlikely to increase at the same rate or indeed at all compared to 2014/15 and agreed contracts with the main local provider on that basis. If any growth did occur, it would have to be accommodated from within the CCG's 0.5% contingency reserve. The same approach was taken in respect of prescribing and CHC as the CCG could not afford to fund budgets above the previous year's outturn levels.

14. Overall, the financial position of the CCG has been deteriorating against the background of funding problems caused by another organisation, an inability to fund developments that we have known are required to stem the unaffordable growth in acute activity and a simultaneous large increase in those activity levels above longer term historic trends. The stark choice for the CCG when planning for 2015/16 was to continue funding for acute services, or seek to develop its longer term plans for out of hospital services. A level of financial risk was associated with the latter option requiring the development of a QIPP to generate £3.2m savings, which is described in the next section.

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Plans to ensure the CCG meets its financial duties

15. The Blackpool CCG QIPP must be seen in the context of a number of strategic developments, much of which has been designed to address and resolve emerging financial pressures as part of the move to implement the five-year forward view.

16. **The Fylde Coast Value Proposition for our out of hospital strategy** is scoped to save around £14m in acute services by 2017/18 with investment in Extensive Care, Enhanced Primary, Community and Social Care services of circa £10m and support for residual acute services of up to £4m. Extensive Care services started at Moor Park Health and Leisure Centre in June 2015 (about 35% of the Blackpool population is now covered by Extensive Care services). Community nursing services have been reorganised and assigned to specific practices within neighbourhoods to support the primary care teams from July 2015 across Blackpool. The Fylde Coast partners received notification during October that their 2015/16 Vanguard bid for funding (£4.3m) had been approved.

17. The Blackpool CCG **Primary medical services strategy** has begun with the agreement by all practices to a new specification for primary medical services and local enhanced services (GMS+). This is aimed at achieving consistently high standards across the CCG and addressing many of the acute pressures being experienced. The specification ensures that the right primary care services are available in core hours, for example, same day access for all children under 12 years requiring a consultation, to relieve the pressure on the child assessment unit and reduce acute activity levels. The principle underpinning GMS+ in Blackpool is equal funding for equal services. The financial aspects of the strategy will be implemented from April 2016, but the service changes are starting in September 2015.

18. The planning for the **QIPP** started in good time during 2014, but the agreement of schemes that are feasible in 2015/16 has happened later than originally anticipated. The original programme management arrangements have recently been totally refreshed in the light of the experience gained so far in scoping and implementing the savings schemes. The new savings matrix/master list is shown in appendix 1. So far £2.7m savings have been identified, which is still £0.5m short of the figure agreed during budget setting, but further high impact prescribing schemes were approved by the Clinical Leadership team on 20th October.

19. Based on the current assessment of schemes, it is estimated that £2.7m savings will be achieved out of a total requirement of £3.2m in 2015/16.

Current contract and expenditure trends

20. At month 4 the CCG reported that it was £1.4m above its budget profile for the period. Most of this overspending is within elective care and prescribing. Cancer related activity is a particular concern coming on the back of a number of national campaigns and reduction in thresholds as recommended by NICE.

21. The CCG has met with all its acute providers to emphasise that we do not expect to spend more than necessary to maintain RTT standards. We will not fund improvements in RTT beyond the levels achieved in 2014/15, with the exception of T&O. CCG managers have some confidence that the early increases in elective activity can be curtailed by the end of the year and in particular the increases experienced in dermatology (skin lesions) and joint injections, neither of which we wish to commission, can be drastically reduced. We have ascertained that some of our providers have changed coding practice. Procedures previously treated as outpatients are now

coded as day cases without our agreement and with substantial financial consequences. This is currently being investigated by the CSU and has been raised for discussion and agreement for action with executives within provider organisations.

22. Despite the work that has been undertaken on making savings in prescribing, the CCG is concerned that this budget could still overspend by around £1.6m this year and we are currently reviewing further measures that could be taken to reduce spending levels. Managers are not confident that prescribing can be contained within the current budget, but discussions with GP colleagues on further measures are continuing and new plans to control repeat prescriptions (many of which are determined by pharmacies) are being scoped.

23. CHC budgets are on track and are currently in line with budgets.

Recovery Plans

Latest assessment of the QIPP

24. As mentioned in paragraphs 4 to 6 above, it has become clearer that there is a high risk that the CCG will not be able to achieve the full savings requirement this financial year. This is partly due to the complexities of the schemes themselves, but also because current activity and expenditure trends suggest that the position has become more challenging since budgets were set in March. Therefore further action is required, which is discussed in the following paragraphs.

New programme management arrangements

25. The CCG is aware that there is still more work to do to establish and embed the new mechanisms that are required to give effect to our plans and has already revised its original arrangements to improve the chances of delivery. A permanent programme administrator started with the CCG on 7th September to supplement commissioning managers' time in delivering the savings programme.

26. CCG managers are confident that the programme management arrangements are robust enough to support their delivery of the savings schemes identified.

Reporting developments

27. A number of reporting developments have been implemented to assist the CCG with providing assurance on QIPP schemes. The reports have been developed using the existing Business Intelligence platform – Aristotle. Practices and individual GPs can access these reports via the web and engagement and training sessions have been held with Practices to encourage and enable them to use the information that is now available, as follows:
    - **£5 per head monitoring (£860k)** - this money was made recurring by the CCG in 2015/16 to ensure that GPs were incentivised to continue their schemes to reduce non-elective admissions to hospital. All practices submitted business cases (for approval by the CCG executive team) to describe the schemes they would implement. The schemes target different areas in each practice such as NEL admissions for patients with Long Term Conditions (LTC), Paediatric admissions, coding in providers, etc. The Business Intelligence team developed a reporting tool for non-elective admissions this year compared to the same period last year. Practices have been set indicative activity and financial targets, the latter calculated using the average cost of a non-elective spell for CCG activity. This tool is now a regular item at practice manager and GP link meetings. Interactive sessions at these meetings have enabled peer review and further learning from schemes that are showing early signs of success.

- **QIPP monitoring** - Alongside the monitoring of the QIPP project plans and milestones the Business Intelligence team has developed targets and trajectories for all activity based QIPP schemes – acute activity, referrals, medicines management. Once finalised these reports will be available on the Aristotle portal and will be used as part of the assurance process by the Executive Team and at the relevant CCG committees.
- **Contract validation challenge** - The Central CSU Business Intelligence team has produced a monthly working document that highlights anomalies reported in SLAM data that can then be raised within the Finance and Technical group, which oversees contract monitoring. To date the report has facilitated discussions on coding anomalies at BTH and Spire – in particular the coding of patient classifications and the charging of the drug Lucentis when treating patients with AMD.

28. Appendix 2 shows some of the information and summary reports now available to GPs and the CCG. This information is shared at our Finance and Performance Committee.

Enhancements to CSU contracting services

29. Having determined late in 2014 that local NHS and private acute providers had begun a process to up-code the activity statistics underpinning PbR, the CSU enhanced its offer from the Contracts and Business Intelligence team to provide a more robust validation service to challenge SLAM submissions from providers. This has enabled GP scrutiny of detailed charges at patient level using pseudonomised data and, if necessary, uses of patient identifiable data at a practice level. GPs are now involved in validating charges and other coding issues for areas that are highlighted by the Business Intelligence team and this has led to substantial challenges to charges for Dermatology services, Lucentis drugs and admissions to the Children's Assessment Unit.

30. The CCG is moving from identification of exceptions, to holding Practices to account for the totality of their spending. The aim is to change referral patterns and other behaviours that drive up acute activity and/or enable Practices to challenge Trust behaviour with respect to their patients.

The Fylde Coast Vanguard

31. The CCG has jointly led the development of proposals on the Fylde Coast for a MCP Vanguard. As mentioned above, we have already commenced implementation of Extensive Care and Enhanced Primary Care services. The Vanguard bid will secure the funds that enable services to be rolled out quickly during the latter half of 2015/16 and throughout 2016/17 across the whole Fylde Coast. This will deliver the health, service and financial benefits outlined in the Value Proposition document. The first tranche of funding for 2015/16 within the Value Proposition (£4.3m) was approved by NHS England on 16th October, giving the Fylde Coast health and social care economy the ability to move quickly to implement its plans.

Further planned developments

32. CCG managers are still concerned that the schemes developed so far may not impact on the CCG's bottom line position. There is confidence that the current roll-out of systems like Map of Medicine will assist GPs in improving referral practice and meeting the early aim for procedures of limited clinical value, but this may merely free up capacity at providers to undertake other procedures. Therefore proposals are being developed in the following areas to improve the robustness of systems and processes:

- The Commissioning Intentions for the CCG have identified a number of solutions for the emerging key problem areas related to the non-payment of invoices where commissioning policies are not followed by providers.
- Extend current ad hoc training in contracting and business intelligence processes to all practice managers as part of the development of neighbourhood teams.

Review of budgets

33. The final aspect of the CCG's Recovery Plan in 2015/16 is to conclude the review of all budget lines and stop spending in all areas that are considered to be non-essential. To date £300k has been identified which can be released by April 2016 at the latest and further proposals are under consideration.

2016/17 Financial year

34. The financial position in 2016/17 is likely to be more challenging than 2015/16 because if the CCG does not achieve its surplus in 2015/16 savings against the allocation will have to be made, as opposed to bringing forward the previous year's surplus to become this year's surplus.

35. A base case assessment of the 2016/17 financial position has been made based on a number of assumptions, the most significant of which are:
    - An allocation uplift of 2% or £5.2m
    - A 1% surplus requirement or £2.6m
    - Holding a contingency reserve of 0.5% or £1.3m
    - The CCG achieving break even in 2015/16 with nothing to bring forward into 2016/17
    - The full year recurring savings requirement of £3.2m in 2015/16 being available from 1st April 2016
    - Funding all expenditure budgets at 2015/16 outturn levels, which amounts to £3m
    - Funding underlying 2% growth in acute and prescribing budgets at £3.1m
    - The CCG finding the recurring effect of the NR ETO top up in 2015/16 of £0.5m

36. All the above assumptions plus a few minor issues give the CCG a £4m savings requirement in 2016/17 or about 1.5% of its allocation. The above estimate does not make any assumptions about the following risks, which at this stage cannot be accurately assessed (the risk level is shown in brackets):
    - Any cost or benefit arising from changes to Identification Rules for specialised services and/or the implementation of HRG4+ (medium)
    - Any significant increase in activity levels above a 2% increase (low)
    - The costs associated with paying a living wage (high)
    - Any additional costs associated with a new framework agreement for Continuing Healthcare (high)
    - Any impact of ending the risk sharing agreement across Lancashire for acute mental health expenditure (high)
    - Not achieving a break even position in 2015/16 – going into deficit (medium)

37. A possible downside of all the above risks occurring would be a savings requirement of up to £10m.

38. Perhaps the biggest risk is that the main local provider, BTH, is in deficit in 2015/16 and without a whole local health economy recovery plan the prospects for 2016/17 are very poor. The role the CCG should play in this whole system plan and any funding requirements for providers are not included in this Recovery Plan.

Savings programme including assumptions from the Fylde Coast Vanguard

39. Most of the 2015/16 savings schemes have been implemented part way through the year and the full year impact for some of them cannot at this stage be accurately assessed. However, based on a conservative estimate of savings where benchmarking data (Right Care/CSU data packs) has been used as the basis for estimates, the full year savings of 2015/16 schemes is £7.7m, £4.5m more than the £3.2m required. This would be enough to cover the base case estimate of savings required. Appendix 1 shows the full estimate of savings for each scheme, not the amended version in the table below. The estimates are:

Scheme	**2015/16 PYE £k**	**2016/17 FYE £k**
GP £5/head (linked to delivery in practices, no delivery no future funding)	900	900
Enhanced Primary Care Services (PYE of approved Vanguard VP)	0	100
Extensive Care Services (BTH business case estimate) *	100	2,000
Falls services (Right Care)	0	480
Paediatric review (local estimate)	50	198
Respiratory, Asthma and COPD pathway compliance (Right Care)	125	400
Lucentis (Local estimate)	500	500
Increased income from Walk in Centre (Local estimate based on usage)	250	500
Regularisation of respite care provision (estimate based on cost)	113	157
Introduction of 'map of medicine' tool in all practices (Right Care)	100	160
Stop referring procedures of limited clinical value (CSU data pack)	100	160
Implement decision support tool at BTH (Right Care)	80	80
Medicine optimisation schemes (Local estimate)	348	1,079
Other (local estimates)	80	380
Total	**2,716**	**7,692**

* BTH full year estimate for 1/3rd of the service and CCG estimate for PYE for remaining 2/3rd.

40. In addition to the 2015/16 schemes the CCG has identified a further 21 schemes in an 'ideas bank' which are currently being developed for implementation in 2016/17 and which are not included in the above.

41. Furthermore, in the successful Vanguard bid the CCG has planned to make savings in acute services of £14m, £2m of which is already in the above savings plan and for which NR Vanguard funding is available to establish the new services. The remaining £12m saving is expected to be delivered from the back-end of the 2016/17 financial year from the implementation of Enhanced Primary Care services, which again are being pump-primed using NR Vanguard money. This pump-priming enables funding of the new services for the first year, giving a NR benefit but in the longer run the recurring savings are expected to fund the new services. In the longer run the reinvestment of recurring savings is expected to be less than the savings generated, but plans for the application of the £4m net savings have yet to be made.

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Conclusion

42. The CCG identified and addressed within its plans for 2015/16 the risks associated with its contracts for the financial year and the requirement to develop a robust QIPP with associated savings of £3.2m. The QIPP is the short-term response to a deteriorating financial position. The combination of historic allocation problems and an unforeseeable increase in activity during 2014/15 led to a situation requiring further action.

43. Since its inception the CCG has been developing longer term plans to address the strategic issues it can discern. Indeed, the CCG has been proactive in developing the sorts of plans that anticipated national policy and strategy. However, the CCG has been stymied in its ability to fund its plans for the reason mentioned in paragraphs 4 to 6 above. In short, the CCG has taken a robust, creative and strategic approach to developing plans to sustain local services within the resources available, but some recent circumstances have constrained our freedom to make faster progress.

44. The CCG is confident that its current financial problems will be resolved so long as we are able to continue with our out of hospital strategy supported by the national Vanguard team.

45. The CCG is less confident that it can achieve the 1% surplus in 2015/16, but it is seeking to ensure that it does not slip into deficit. Our QIPP schemes for 2016/17 (initial estimates shown in paragraph 39 above) show that they will allow us to achieve our financial duties and make up the balance of any required surplus not achieved in 2015/16.

Recommendation

46. That this Recovery Plan be **approved**.

Gary Raphael
Chief Finance Officer
22nd October 2015

Appendices

a) Revised QIPP schemes master list (unadjusted savings estimates for 2016/17)

See attached.

b) Screenshots of BI report

5 per head screen shots.msg

See attached.