NHS
Gloucestershire
Clinical Commissioning Group

Agenda Item 11

Gloucestershire Clinical Commissioning Group
Governing Body

Meeting Date	**31st March 2016**
Title	**2016-17 CCG Annual Budget**
Executive Summary	This paper outlines the 2016/17 budget for the CCG that supports the organisation's operational plan. The new financial year presents many challenges that have been shared with the Governing Body in previous reports and is, also, predicated on a significant, recurrent savings programme of £18.0m. Careful financial control and monitoring will need to be maintained during the year in order to deliver the planned system changes, to ensure that the planned surplus of £7.5m is achieved and also that the CCG has a recurrently balanced financial position.
Key Issues	Contracts with the CCG's main providers were not yet signed at the point of the report, however, the estimated impact of final contracts has been included in the CCG's budgets. The CCG's savings requirement totals £18m; plans having currently been developed for schemes and risk rated. The CCG budget includes an allocation of £78.523m for Primary Care co commissioning.
Risk Issues:	The key risk within the plan is the non-achievement of the planned surplus through: • Contracts with providers exceeding the envelope provided within the budget • In-year contract over-performance

Original Risk	within acute contracts • Under delivery of savings plans • Prescribing costs being higher than that planned either due to the introduction of new drugs or increased growth • The potential for increasing continuing health care cases from the relatively low base experienced in 2015/16 • Primary care expenditure exceeding the budget set 4 x 4 = 16
Financial Impact	The CCG has a statutory duty to achieve financial balance. The CCG is planning for a surplus of £7.5m.
Legal Issues (including NHS Constitution)	Not Applicable
Impact on Equality and Diversity	Not Applicable
Impact on Health Inequalities	There are no direct health and equality implications contained within this report. The assessed impact on health inequalities is contained within individual programmes for the year.
Impact on Sustainable Development	The are no direct sustainability implications contained within this report.
Patient and Public Involvement	Not applicable
Recommendation	The Governing Body is asked to: • Approve the 2016/17 budgets and note the risks inherent within the plan and; • Approve the Financial Management Framework

Author & Designation	Andrew Beard, Deputy Chief Finance Officer
Sponsoring Director (if not author)	Cath Leech, Chief Finance Officer

Agenda Item 11

Gloucestershire CCG - 2016/17 Budget

1.0	**Introduction**
	This paper presents the 2016/17 budget proposals to the Governing Body for approval. The financial planning reflects the CCG's strategic objectives as an established commissioning organisation that has progressed beyond transition and that is now developing a Sustainability and Transformation Plan (STP) with its partners in Gloucestershire.
2.0	**2016/17 Budgets**
	The budgets for the CCG are presented in Appendix 1. These budgets show a planned surplus of £7.511m for the year and are presented after removal of planned QIPP savings (as shown in Appendix 2). These budgets include those for health care contracts where agreements have been reached with providers or estimates where negotiations are ongoing at the point of writing. Budget changes will need to be made during the first month's operating period to reflect contract agreements and final prioritisation of investment decisions, which will be derived from available funding post the contracting round. Post opening budget changes and amendments will be reflected in the budgets, and future finance reports to the Governing Body. The proposals are fully inclusive of recurrent plans for the use of the 30% non-elective threshold monies, readmission credits and resilience funds. They also include investment to support the CCG's commitment to parity of esteem in mental health related services.
	Savings plans and risk sharing against delivery of savings plans have been allocated across headings within the plan

<table>
<tr><td></td><td>and these are currently the subject of discussions with providers. There remains some further outstanding work to finalise some of the detail around schemes.</td></tr>
<tr><td></td><td>The CCG's budgets include the financial planning parameters required by NHS England. These are as follows:

• a surplus equivalent to 1% of allocations (excluding primary care)
• a minimum contingency reserve of 0.5%
• non recurrent (headroom) reserve of 1.0%
These parameters are applied to the primary care allocation as well we the programme allocation with the exception of the surplus requirement

In addition the CCG has applied inflation uplifts of 3.1% and cash releasing efficiency savings (CRES) of -2% to its contracts. This is in addition to uplifts relating to the Clinical Negligence Scheme for Trusts (CNST) within specific published national tariffs. Monitor consulted on a national tariff for 2016/17 which has now closed. However, the number of objections received did not trigger the threshold criteria required for it not to be adopted in 2016/17.</td></tr>
<tr><td>3.0</td><td>Resources</td></tr>
<tr><td></td><td>The CCG's allocations have been published for the period 2016/17 to 2020/21; the first three years representing firm allocations with the subsequent ones being indicative only. The allocation for 2016/17 is as follows:
<table>
<tr><td></td><td>£m</td></tr>
<tr><td>Programme allocation (Used to commission health care services) [1]</td><td>730.2</td></tr>
<tr><td>Primary care services allocation</td><td>78.5</td></tr>
<tr><td>Running Cost Allocation</td><td>13.6</td></tr>
<tr><td>Return of the previous year's surplus [2]</td><td>7.3</td></tr>
<tr><td>Total Anticipated Allocation</td><td>829.6</td></tr>
</table></td></tr>
</table>

	[1] The Programme Allocation received in 2016/17 includes items received as separate funding streams in previous years (e.g. Capital Grants, GP IT costs, Better Care Fund baseline, Public Health baseline changes etc). [2] Although the CCG had increased it's 2015/16 surplus to £9.6m (from a planned level of £7.3m), NHS England have advised that this will not be available in 2016/17 due to national financial pressures. The CCG received a 3.05% uplift in its programme allocation, which means that the CCG is -1.5% away from its distance from target allocation. The CCG is therefore deemed to be at its target allocation as this is not a significant difference and therefore, attracted an uplift equal to the national minimum.
	The CCG anticipates that there will be several planned recurrent transfer of resources during 2016/17 which, in the absence of further information, have been assumed to be neutral in the current budget proposals. These include • transfer of adult morbid obesity surgery from specialist commissioning (more transfers are expected in 2017/18); • the CCG taking the commissioning responsibility for English patients registered with Welsh GP practices; • other local specialist commissioning transfers in line with operational strategy.
5.0	**Expenditure**
	The CCG is planning to spend, prior to QIPP, £826.5m on commissioning health care services in 2016/17 including primary care. This accounts for over 98% of our expenditure as a clinical commissioning group, the remaining amount is spent on running costs. The services that we commission include: • Non specialist acute care in hospitals; • Services in the community;

	• Medicines prescribed in general practice; • Primary care services; and • Continuing healthcare for patients with longer term needs • Placements for individuals with complex needs Services are provided by both NHS organisations and providers from other sectors, such as private companies and voluntary organisations.
5.1	**Investments**
	Investments include the full year effect of 2015/16 investments, activity and demand driven investments from the previous year and those prioritised as part of the strategic plan through the CCG's Prioritisation Committee. Where an investment relates to a proposal which is still in development, the funding will be held in reserves and released against an approved business case. Investments include those required within the operating framework for operational resilience; these are shown in Appendix 4. The operational resilience investments are subject to final sign off by the Gloucestershire Strategic Resilience Group in April. Other investments include: • funding for forecast elective and non-elective demand, including demographic growth, within contracts in line with population growth trends by specialty; • investments to fund new NICE technology appraisals (TAs) and the full year impact of 2015/16 TAs; • Full year effect of the investment in rapid response, high intensity and integrated community teams; • investment in mental health services in line with parity of esteem, including the full year impact of crisis services and services for children's and young peoples' services • Self-care and self-management investments

- The full year impact of wound care services culminating in the creation of a consistent service across the county
- Personal health budgets
- The extension of the Choice+ pilot project which was initially funded as an integral part of the Prime Ministers Challenge Fund in Gloucestershire.
- Continuation of the Social Prescribing project which was funded through the Prime Ministers Challenge Fund in 2015/16.
- Increased investment in the ongoing costs of GP practice buildings following the completion of approved premises developments.
- Increased access to pulmonary rehabilitation services
- Improvements in the diagnosis and treatment of continence related issues.
- Implementation of agreed changes to the learning disabilities provision within the county, particularly relating to assessment and treatment beds.

5.2 Better Care Fund

There is more detailed information on the arrangements and function of the Better Care Fund (BCF) in the relevant section of the CCG's strategic plan. For the financial plans, the CCG has worked with Gloucestershire County Council to develop the current programme which builds on the initial schemes included within the fund in 2015/16.

The Better Care Fund for 2016/17 has been increased by inflation and is made up as follows:

	£m
CCG Contribution	36.631
Disability Facilities Grant	4.682
BCF minimum contribution	**41.313**
GCC Additional contribution	2.519
Total 2016/17	**43.832**

	The minimum financial contribution that the CCG will make to the fund is mandated nationally, this is £36.631 million (an increase from £35.989 million in 2015/16). Of this amount, the CCG will receive £11.596 million of funding that has been re-allocated from NHS England as part of its baseline programme allocation. The remaining £24.835 million is funded from the CCG's existing allocation. The planned partnership budgets with Gloucestershire County Council for 2016/17, including the BCF, are shown in Appendix 5.
5.3	**Primary Care Budgets**
	The allocation for Gloucestershire's primary care budgets is £78.5m. The allocation is based on the agreed expenditure baseline calculated in 2015/16 as part of the CCG's delegated co-commissioning budget; this has been uplifted by 3.6%. The CCG is 0.1% above its fair shares target allocation. As 2016/17 represents the second year of the CCG holding delegated primary care co-commissioning responsibilities, a separate, bottom up budgeting exercise has been undertaken for this element and the assumptions behind the proposals have been reported to the Primary Care Co-Commissioning Committee (PCCC). However, there remains an element of risk in these budget proposals which, primarily, relate to increased charges from NHS Property Services and the impact of the changes to the 2016/17 GP contract.
5.4	**Running Costs**
	The CCG's running cost envelope is £13.6m; this represents a minimal increase of £28k on the 2015/16 running costs. The running cost budgets are fully committed and it is important to note that any recurrent changes will need to be carefully managed to ensure that the running cost allocation is not exceeded.

	The plan assumes that running costs expenditure will be maintained at 2015/16 recurrent levels and that the CCG will not expend more than the allocation received for this purpose.
6.0	**Savings Requirements**
	The CCG's budget assumes delivery of a savings programme of £18m. A breakdown of schemes across the main headings is shown at Appendix 3. Savings associated with each scheme have been profiled in year based on their expected implementation date and risk profiling has also taken place to mitigate against slippage in implementation or the realisation of expected benefits. The projects represented within the programme are a mixture of transformational and transactional schemes. Investments shown against each scheme represent the 2016/17 investment in each scheme.
	Savings plans are being discussed as an implicit part of the contract negotiation process. However, some schemes are more developed than others at this point and this represents a risk to the CCG's overall financial position. As in previous years, the largest proportion of savings relate to urgent care initiatives that are being progressed by the Strategic Resilience Group including the full year impact of existing schemes together with new projects. These schemes focus on treating patients in the most appropriate setting for their condition and with the most appropriate member of staff and include the full impact of the rollout of the Integrated Community Team model that focusses on the case management of those patients in high risk categories. Other schemes to develop more effective pathways for specific areas are being progressed through the Clinical Programme Groups and represent the continuation of schemes started in 2015/16. These schemes include the implementation of changed pathways and models of delivery in in ophthalmology and orthopaedics and the respiratory

	outpatients work programme.
	Prescribing savings of £3.5m include a focus on improved prescribing with better outcomes and more cost effective prescribing, including procurement savings, combined with a reduction in waste.
7.0	**Reserves**
	The CCG has set aside the following specific reserves: - Headroom reserve equivalent to 1% of all allocations - A contingency reserve for expenditure which will also cover the risk around primary care co-commissioning - Specific investments, where an approved business case or contract variation has yet to be signed off, are held in reserves until approval.
7.1	Headroom
	In line with national requirements, the CCG has to set aside 1.0% of its resources, which equates to £8.3m for Gloucestershire CCG. Unlike previous years, national guidance states that this reserve should be held as uncommitted at the start of the financial year and release will be through a process managed by NHS England. This strategy has led to a cost pressure for the CCG as some unavoidable commitments (e.g. the CCG's contribution to the national CHC risk share arrangement) have historically been funded from this source. Guidance is emerging regarding access to these funds, but it should be noted that they will be applied at a health economy level; their application being agreed between the partners to the Sustainability and Transformation Plan.
8.0	**Risk Management**
	Minimal contingency funds have been built into the CCG's budgets. Key risks and mitigating actions are shown in Appendix 6. In

	addition to this, the CCG Financial Management Framework has been reviewed and is attached for approval at Appendix 7.
9.0	**Capital**
	The CCG has bid for capital funding of £1.5m which has been reviewed and approved by NHS England. These funds cover: • Technical IT infrastructure refresh for GP practices (£622k) • GP practice network changes (£451k) • GP practice minor improvement grants (£242k) • CCG network capacity (£190k) Other capital bids will be completed in the forthcoming months against the Primary Care Transformation Fund (including for completion of existing practice build schemes) and Transforming Care Partnerships (relating to Learning Disabilities).
10.0	**Recommendation**
	The Governing Body is asked to: • Approve the Budgets and note the risks inherent within the plan and; • Approve the 2016/17 Financial Management Framework
	Appendices • Appendix 1 – 2016/17 Budget proposals • Appendix 2 – 2016/17 Allocation of QIPP • Appendix 3 – 2016/17 Savings Plans • Appendix 4 – Resilience Scheme Budgets • Appendix 5 – Partnership Budgets • Appendix 6 – Risk Management • Appendix 7 – Financial Management Framework

APPENDIX 1

Gloucestershire CCG

2016/17 Budget

			Admin/Prog (net of QIPP) £'000	Primary Care Co-Commissioning £'000	TOTAL CCG £'000
Resources					
Programme Allocation			730,181		730,181
Primary Care Co-Commissioning				78,523	78,523
Running Costs Allocation			13,563		13,563
2014/15 Surplus returned			7,300		7,300
			751,044	**78,523**	**829,567**
Expenditure					
Programme					
	Acute		364,309		364,309
	Community		84,893		84,893
	Mental Health		81,799		81,799
	Primary Care		113,675	77,345	191,020
	CHC		31,175		31,175
	Other		22,884		22,884
	Reserves	Headroom	7,533	785	8,319
		Contingency	3,767	393	4,159
		Other, specific reserves	19,935		19,935
Corporate (Running Costs)			13,563		13,563
Total Expenditure			**743,533**	**78,523**	**822,056**
SURPLUS			**7,511**		**7,511**

APPENDIX 2

Gloucestershire CCG

2016/17 Application of QIPP (Programme Budgets only)

		Gross Budget Excl QIPP £000	QIPP Applied to Budgets £000	Net Expenditure £000
Programme				
Acute		377,366	(13,057)	364,309
Community		84,943	(50)	84,893
Mental Health		81,799		81,799
Primary Care including prescribing		117,610	(3,935)	113,675
CHC		32,175	(1,000)	31,175
Other		22,884		22,884
Reserves	Headroom	7,533		7,533
	Contingency	3,767		3,767
	QIPP	(18,042)	18,042	
	Other, specific reserves	19,935		19,935
Corporate		13,563		13,563
Total Expenditure		**743,533**	**0**	**743,533**

APPENDIX 3

Gloucestershire CCG

2016/17 Savings Plans

			2016/17 SAVINGS PROGRAMME				INVESTMENT
			£'000				£'000
Scheme Description		**Category**	2016/17 In the baseline / BAU £'000	2016/17 Remaining opp re 15/16 £'000	2016/17 New Savings £'000	**2016/17 Total £'000**	£'000
ICT - Rapid Response	Existing Scheme	Urgent Care	1,538	1,407		**1,407**	2,594
ICT - HIS / Case management - step up functionality	2nd Stage of ICT	Urgent Care			1,320	**1,320**	1,306
OPAL	Existing Scheme	Urgent Care	1,200				500
IDT (Discharge Team)	Existing Scheme	Urgent Care		500		**500**	2,374
AEC	Existing Scheme	Urgent Care		783	717	**1,500**	1,500
Respiratory Pathways	New Scheme	Urgent Care			300	**300**	
Choice + - Primary Care (prime ministers challenge) - ED Attendance	Pilot	Urgent Care		168		**168**	2,146
Social prescribing	Pilot	Urgent Care			75	**75**	600
PC in ED (PAU element)	2nd Stage	Urgent Care	22	94		**94**	
PC in ED (PAU element) -NON Paediatric	Existing Scheme	Urgent Care	88	270		**270**	263
MH - Liaison	Existing Scheme	Urgent Care	5	135		**135**	160
Highly Sensitive Troponin Testing	New Scheme	Urgent Care			136	**136**	
Falls and Bone Health	New Scheme	Urgent Care			232	**232**	209
Elective demand management (Enhanced Pathway compliance)	New Scheme	Planned Care			512	**512**	
Follow ups - Other areas	New Scheme	Planned Care		250	3,547	**3,797**	
Diabetes ES	Existing Scheme	Planned Care		263		**263**	240
Respiratory Pathways	New Scheme	Planned Care			100	**100**	
Ophthalmology - Commissioning Policy for Eyes	New Scheme	Planned Care			400	**400**	
Ophthalmology Pathway	New Scheme	Planned Care			134	**134**	30
MSK New Pathway - Outpatients	New Scheme	Planned Care			92	**92**	

IFR	Existing Scheme	Planned Care	980		500	**500**	
IBS	Existing Scheme	Planned Care		220	47	**267**	119
Cancer New model (including Living with and beyond cancer)	New Scheme	Planned Care	56		200	**200**	
Dermatology tariff change	Existing Scheme	Planned Care	30	42		**42**	
Dermatology pathway	New Scheme	Planned Care			125	**125**	
CHC	New Scheme	Community	500		1,000	**1,000**	
Leg Ulcers	New Scheme	Community			50	**50**	851
Primary Care Prescribing	New Scheme	Prescribing	3,500		3,500	**3,500**	
Home Oxygen	Existing Scheme	Prescribing	12				129
Centralised Continence Supplies	New Scheme	Prescribing			69	**69**	340
Care Homes pharmacist medication reviews	Existing Scheme	Prescribing	24	366		**366**	87
Secondary Care Partnership - Biosimilars - CCG 50%	New Scheme	Prescribing			318	**318**	
Secondary Care Partnership (specials / homecare)	Existing Scheme	Prescribing	52	170		**170**	
Total			**10,209**	**4,668**	**13,374**	**18,042**	**13,448**

APPENDIX 4

Gloucestershire CCG

2015/16 Resilience Funding - Draft, subject to final sign off by the Gloucestershire Strategic Resilience Group

Breakdown of resilience funding by priority

	Priority	2016/17 Funding Proposal		
		R	NR	TOTAL
		£000	£000	£000
1	ED Staffing and Rotas	682.0	-	682.0
2	Acute Capacity	1,244.0	-	1,244.0
3	Community Capacity	143.0	-	143.0
4	Weekend Discharges	953.0	-	953.0
5	Admission Avoidance	1,343.0	17.0	1,360.0
6	System Support	90.0	-	90.0
7	Escalation Reserve	932.0	60.0	992.0
	Total	**5,387.0**	**77.0**	**5,464.0**

Breakdown of resilience funding by sector

Priority	2016/17 Funding Proposal		
	R	NR	TOTAL
	£000	£000	£000
Primary Care	650.0	-	650.0
Acute	2,208.4	-	2,208.4
Community	2,273.6	77.0	2,350.6
CCG	255.0	-	255.0
Total	**5,387.0**	**77.0**	**5,464.0**

APPENDIX 5

Gloucestershire CCG

2016/17 Partnershire Budgets with Gloucestershire County Council

	2016/17 Budget		Total Budget
	GCC £'000	CCG £'000	£'000
Child & Adolescent Mental Health Services	1,073	5,635	6,708
Adult Mental Health Servoces	5,103	49,806	54,909
Occupational Therapy	2,983		2,983
Community Equipment Services (CCG proportion now in BCF)	1,553	3,050	4,603
Continuing Health Care and Funded Nursing Care		20,000	20,000
Better Care Fund Programme (BCF)	7,201	36,631	43,832
Other s256 joint commissioning primarily placements)	5,506	14,087	19,593
Public Health Commissioning	11,261	112	11,373
Total	**34,680**	**129,321**	**164,001**

APPENDIX 6

Gloucestershire CCG

2016/17 Risk Management

Risk	Mitigating Action
Further changes to the CCG's allocation as a result of transfers between commissioning organisations may not be cost neutral	Work with the Area Team and local providers to ensure that adjustments are cost neutral and transacted on the correct basis.
Assumed allocations may not materialise	Ongoing liaison with NHSE and other relevant parties to ensure that all issues are known together with a phased approach to the release of expenditure commitments to mitigate the risk of a reduced allocation.
Expenditure on Primary Care Co-commissioning may not be contained within the budget due to pressures within primary care and also external pressures such as NHS PS charging	Close monitoring and forecasting to enable early warning of financial issues arising. Regular contact with NHSE and other relevant parties.
Non achievement of the required level of savings through slippage in implementation or benefits not being realised as anticipated:	Close review of resources allocated to each project to ensure sufficient to ensure robust implementation and delivery, enhanced monitoring of the project to ensure timely warning of slippage or benefit realisation differing to the forecast project. Development of robust exit strategies for projects to ensure that these can be stopped at short notice if they do not deliver against agreed objectives
Overperformance on acute contracts	Strengthening the contract management & monitoring processes. Plans to improve practice engagement to ensure that pathways followed are the most appropriate for the presenting condition.
Potential loss of control over service priorities or cost changes where the CCG is an associate commissioner to a contract	Establish stronger working relationships with other commissioners to ensure early warning of pressures within other contracts
Increased growth in prescribing	Monthly enhanced monitoring in place. Prescribing working group set up to implement savings plans.
Increases in continuing health care and placements	Monthly monitoring of trends. Joint plan to manage process improvement in year.
Costs of nationally approved NICE developments in excess of that provided for (both in cost and take-up)	Increased profile of NICE horizon scanning and close liaison with contract management.
Population growth above planning assumptions	Continuing work to benchmark services to identify areas to review to ensure value for money from all services

Mitigating Actions Covering all risks:

Non release of development funds unless key to delivering service change or contactually committed, until planned financial targets are forecast to be delivered with a reasonable degree of confidence.

Utilisation of contingency and activity reserves

Increased financial management awareness throughout the organisation and member practices

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Appendix 7

Gloucestershire CCG

Financial Management Framework

1. Purpose

The Clinical Commissioning Group is accountable for the effective, efficient and economical use of public funds allocated to the organisation and the safeguarding of public resources. There is an expectation that reporting on how funds are being spent will be reliable and transparent. The policy framework sets out key principles, especially around the management of financial risk including the management of cash.

2. Principles

Effective financial management is guided by the following fundamental principles:

Value for money

Public funds are managed with prudence and probity, resources are safeguarded and are used effectively, efficiently and economically to achieve the organisation's objectives.

Accountability:

There are clear accountabilities for financial management, which provide assurance regarding the effective use of public funds and the results achieved.

Transparency:

The Governing Body and NHS England are provided with pertinent, reliable and timely financial and related non-financial information and reports so they can be well informed of the use and management of the CCG's financial resources. Governing Body financial reports are published on the CCG's website.

Risk management:

Effective and efficient systems of internal control are in place, and controls are proportionate to the risks they aim to mitigate, yet support innovation and results for the CCG.

Appendix 7.1 clarifies the guidance for:

- Compliance with clearly defined systems for controlling spend
- The responsibilities of budget managers
- Provision of financial advice and support
- Processes and systems

Financial Risk Management Policy

- The organisation will set a balanced annual financial plan based on national guidance on resource availability. The level of surplus within the plan will be within guidance issued by NHS England.
- The organisation will create a contingency reserve of at least 1% of its recurrent resource limit.
- In line with national requirements, the organisation will created a 1.0% reserve from recurrent resources. This reserve will be applied in line with the guidance from NHS England; the current guidance states that this reserve will not have been committed at the start of the financial year and will be released following sign off by NHS England. This reserve will primarily be used to fund non recurrent pump priming initiatives, double running costs associated with change programme or to offset financial risk for commissioners. Approval to spend against this reserve can only be made by the Accountable Officer or Chief Finance Officer.
- All financial plans will include an assessment of financial risk and actions for managing and responding to the risk.
- Developments funded within the Annual Operating Plan which are not unavoidably committed will be retained centrally and only released by the

Accountable Officer and / or Chief Finance Officer once achievement of the organisation's control total is forecast to be delivered with confidence. Release of developments will be subject to a business case sign off, through the QIPP Development and Monitoring Group process. The holding of these amounts centrally is to provide flexibility in order to protect the control total, and ultimately the CCG's statutory breakeven duty.

- All project plans include outcomes with robust, measurable KPIs, timely monitoring mechanisms and exit plans to ensure that projects which are not delivering agreed outcomes can be stopped at short notice.

- Options for risk sharing arrangements within the Health Economy or with other agencies must be considered and evaluated as appropriate. Approval for risk sharing will be by the Chief Finance Officer.

- Recurring commitments will be funded from recurring resources and there will be no avoidable over commitment of recurring funds. Business cases must clearly indicate the recurrent/non-recurrent elements of each proposal and must be developed with the assistance of the Finance and Information Department.

- When making a non-recurring commitment in areas with potential recurring expenditure, consideration will be given to the implications of the cessation of funding either by clear exit strategies or how commitment may be funded. Authorisation from the Chief Finance Officer must be obtained.

- The use of reserves will be minimised consistent with prudent financial management. The need for and level of contingency reserves will be reviewed annually. Access to and release of general and earmarked reserves will be authorised by the Accountable Officer and the Chief Finance Officer.

- Robust monitoring and control mechanisms will be maintained. Where potential overspends are identified, corrective action plans to address the issue will be required.

- Any organisational recovery plans will be subject to rigorous review by the Audit Committee and clearly identified on the risk register which will be scrutinised by the Integrated Governance and Quality Committee.

- Both the recurring and non-recurring development programmes will be proactively managed to secure maximum flexibility. This may mean phasing planned developments throughout the year and exercising the option not to proceed or to defer schemes if unavoidable expenditure is incurred.

- Underspends will be removed from budgets periodically throughout the year on a non-recurrent basis in year following discussion with the relevant Director. A review of the recurrent level of budget requirement will take place during the annual budget setting period.

- Budget holder skills will be reviewed and appropriate development and training agreed and arranged.

- Identified recurrent deficits will be funded from growth or savings in future years.

- The financial risk management policy will be reviewed annually by the Governing Body.

Cash Management Policy

- Cash plans, to ensure compliance with statutory duty to remain within the CCG's maximum cash drawdown, must form part of the budget proposals, monthly monitoring to the Governing Body and the medium term resource strategy.

- Working balances will be maintained at the minimum levels consistent with prudent financial management and within resource accounting guidelines.

- Budget Managers must ensure that invoices are processed promptly and always within 30 days. Those for non NHS suppliers should be processed within 10 days.

- All invoices in dispute should be placed “on hold” within the Oracle financial management system.

- Budget holders and managers must ensure that they have a nominated deputy set up as an authorised signatory for invoices to cover any absences and not delay payments.

- Monies due should be invoiced promptly.

- Budget managers must discuss cash requirements, if exceptional or out of the ordinary, with their management accountant.

- Any cash shortfall should be identified at the planning stage and discussed with Chief Finance Officer. Should a cash shortfall arise at year end, there will need to be a slowing down of payments. Detailed options will need to be discussed and agreed with the Chief Finance Officer.

- Options for managing excess cash are:

  - Reduction of Creditors
  - Delay income collections
  - Making Pre-payments. These are only permitted in exceptional circumstances and must be agreed by the Chief Finance Officer.
  - Reduced drawdown from NHSE (although the implications for future financial years must be considered).

- Cash management options must not impact adversely on the CCGs financial position or increase financial risk.

Appendix 7.1

1. Compliance with Clearly Defined Systems for Controlling Spend

Budgetary control is maintained by:

- clear definitions of budgetary responsibility both in terms of delegating budgets to specific managers and clearly setting out their responsibilities both in Prime Financial Policies, Standing Orders, the detailed scheme of delegation and in this document.

- Accountability of budget managers to the relevant Director where overspends arise

- compliance with specified control arrangement as in Prime Financial Policies, documented financial management arrangements and this document.

- auditing compliance via internal audit.

2. Responsibilities of Budget Managers

The nature of financial responsibility for budgets will vary depending on the budget. All managers who have delegated responsibility must have a good understanding of the budget and be able to monitor and forecast spend. The authority and ability to incur and control expenditure varies as follows:

- Responsibility for controlling the budget including authority to incur costs, authorise spend and exercise virements.

- Authority to approve spends and exercise virement

- Responsibility for monitoring and forecasting spend realistically and accurately.

- Responsibility to ensure that they have the skills to manage the budget effectively and to seek further training where required

If managers are in any doubt about the extent of their responsibilities they should seek guidance from their line manager or a member of the finance team.

Prime Financial Policies make explicit the requirement that budget holders, at every level, **must not** exceed the limits of the budget delegated to them i.e. must not overspend against their budget. Any overspending by the CCG as a whole constitutes a breach of its statutory duty to remain within its allocated resources.

Therefore, any individual overspending against a delegated budget contributes to the CCG failing to achieve its statutory duty.

2.1 Prime Financial Policies

The policies and procedures which govern the CCG's financial transactions are set out in its Prime Financial Policies and scheme of delegation and other policies and procedure. Budget managers must be familiar with and adhere to the policies contained within them. The authority to transfer or vire funds to another budget head is also delegated within prescribed limits (see Table 1).

The responsibilities of budget holders as set out in Prime Financial Policies are repeated below together with practical comments (in italics) on their implications.

a) Any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Governing Body*. (Budget managers must not incur expenditure without being clear that budgetary provision exists to meet the expenditure).*

b) The amount provided in the approved budget is not used in whole or any part for any purpose other than that specifically authorised subject to the rules of virement. *(Expenditure/invoices for items other than those expressly covered by the budget cannot be charged to a budget head. If in any doubt, advice should be obtained from a finance contact).*

c) No permanent employees are appointed without the approval of the Accountable Officer other than those provided for in the budgeted establishment as approved by the Board.

2.2 Authority and Transfer of Budgetary provision (Virement)

Budget managers are able to transfer between budget heads within the prescribed limits as approved by the Board replicated below in Table 1 with the exception that

- There shall be no virement between "Patient Services" and "Administration".

- There shall be no virement between capital and revenue without the agreement of the Chief Finance Officer. Opportunities for this are limited and governed by strict financial rules. Budget Holders wishing to incur capital expenditure shall contact the Chief Finance Officer.

- Virement under these arrangements only applies to established budget heads. Budget managers are not authorised to create new budgets. Proposals for spending in new areas should be submitted to Accountable Officer and Chief Finance Officer.

- Virement from general reserves should only be actioned following the agreement of the Accountable Officer and Chief Finance Officer, and from earmarked reserves following the agreement of the Chief Finance Officer.

- Where virement is proposed between budget heads under control of different managers it must be approved by both.

Table 1 – Virement Limits

	Budget Holder		**Chief Finance Officer**		**Accountable Officer**	
	Admin £'000	**Patient Services £'000**	**Admin £'000**	**Patient Services £'000**	**Admin £'000**	**Patient Services £'000**

Virement						
Non-recurring	10	50	50	100	>50	>100
Recurring			50	100	>50	>100

Additionally budget managers, with assistance from the finance staff are required to:

- Monitor the performance of the budget and have a good understanding of the reasons for variances at any point in time.
- Regularly forecast the year-end position on the budget.
- If budget begins to overspend take prompt corrective action.
- Where expenditure is outside the manager's direct control any overspending should be reported to the Chief Finance Officer.

3. Provision of Financial Advice and Support

Budget managers receive support and advice from the finance team. Finance staff should:

- be able to quickly investigate queries on expenditure raised by budget managers.
- provide regular monitoring information to budget managers
- be clear what financial systems are in place for accounting for and monitoring income/expenditure and advise budget managers on their development and use.
- make proposals on behalf of the budget manager for changes in budget structure to the Deputy Chief Finance Officer

- explain technical changes in budgets arising from NHS England.

- explain how budgets are financed and follow up on any outstanding cash and resource limit adjustments.

- seek guidance from other finance staff and Chief Finance Officer as necessary.

- ensure that the interaction between financial management teams, financial services teams and budget managers is understood and works to facilitate timely support and advice.

4. Processes and Systems

4.1 Reporting Systems

A comprehensive financial and reporting system is in place. Individual budget managers should:

- expect to receive monthly details of expenditure against budgets within 10 working days from the end of each month and identify problems or issues arising.

- ensure they meet regularly with their finance contact and follow up issues which arise. Actions must be agreed and recorded.

- Make a monthly assessment of outstanding commitments (accruals) and forecast outturn on their budget.

- be clear what financial information relating to budgets for which they are responsible is being included in financial reporting to line managers and onwards.

- identify any deficiencies in financial monitoring and reporting and draw these to the attention of the Chief Finance Officer who will work with finance staff to rectify any such deficiencies.

- Identify any issues which could impact on projected cash flows,

4.2 Budgets

4.2.1 Annual Budget Setting

Budgets are reviewed annually and approved by the Board.

All budget managers should review the adequacy of their budgets as part of the annual process and raise concerns with their Finance contact. Managers wishing to restructure budgets (i.e., differently or more details) should make requests by 30th November.

Any unused funds revert to the Accountable Officer. Any requests to carry forward deferred income budget should be addressed to the Chief Finance Officer by the end of December. The decision to carry forward unused budget is at the discretion of the Chief Finance Officer, taking account of the overall CCG financial position for the current and following financial year and within Resource Accounting guidelines.

Formal budgets should be issued to budget holders by the end of March or as soon as a balanced Annual Operating Plan has been signed off by the Governing Body and NHS England.

4.2.2 In-year Change

There are two routes for changes. As indicated previously budget managers can request/authorise virement. All virements are actioned by the Finance Department on receipt of a properly authorised virement request form.

Budget changes can also be imposed as a result of financial difficulties. All such changes will be notified to the budget manager by the Chief Finance Officer.

4.3 Expenditure

4.3.1 Incurring Expenditure

Arrangements for ordering and processing of invoices are set out in Prime Financial Policies. It is the responsibility of the budget manager to ensure invoices are properly and promptly authorised and coded to

enable payment within 30 days. This will enable accurate cash flow monitoring. Invoices for non NHS organisations should be processed to achieve payment within 10 working days.

4.3.2 Invoice Disputes

All disputes on invoices must be notified promptly to the Creditor payments provider and to the relevant Management Accountant.

4.3.3 Receipting of Goods

Delivery of goods should be confirmed in writing (by e-mail wherever possible) to the Procurement Team. It is the responsibility of budget managers to ensure that goods received are booked in promptly.

4.3.4 Classification of Expenditure

Expenditure should always be coded to the correct subjective (account) code for the type of expenditure incurred.

If budget managers wish more detailed or different expenditure reports they should discuss their requirements with the Finance Department.

4.4 Year End Financial Management

Detailed instructions for managing the closure of the year will be issued by the Finance Team and must be followed by all members of staff.

4.5 Income

4.5.1 Invoice requests must be raised promptly by budget managers and within the financial year to which they relate.