Bexley Clinical Commissioning Group

ENCLOSURE:	E(ii)
Agenda Item:	**07/13**

Governing Body (Public) Meeting

DATE: 28th February 2013

Title	**Financial Planning 2013/14 and Budget Update**
Recommended action for the Governing Body	That the Governing Body: **Note** the CCG's submission of a balanced financial plan for 2013/14 as laid out in appendix 1of the attached report, reporting a 1% surplus; **Note** the risks identified around the transfer of specialist commissioning and the assumption being used that this will be cost neutral; **Note** the other risks identified to the financial plan; **Note** the progress made to date on the budget setting timetable – see appendix 2 of the attached report. **Note** the work being carried out on the 3-5 year financial plan to ascertain the CCG's financial position following changes to the 2012/13 position and planning assumptions.
Executive Summary	This paper sets out the process undertaken to submit a balanced financial plan for the CCG for 2013/14 – see appendix 1. There are a number of risks associated with the plan which are documented in detail in the report together with the actions being taken to mitigate them. The largest risks are around the assumption that the transfer of specialist commissioning will be cost neutral and the ability of the acute contracts to be negotiated within the resource envelopes available. There are additional risks to the 3-5 year plan following changes to the 2012/13 position and planning assumptions. Appendix 2 updates the Governing Body on the progress of the budget setting process. Generally speaking, it is on schedule. There has been some delay in re-issuing the budgets to the budget holders after the submission of the balanced plan. This has now been rectified and the finance team are in discussions with budget holders to ascertain if there are any further amendments to be made. The budgets will continue to be updated as contracts are agreed and signed. A further update will be brought to the Governing Body in March.

Which objective does this paper support?	**Patients:**	Improve the health and wellbeing of people in Bexley in partnership with our key stakeholders	
	People:	Empower our staff to make BCCG the	

		most successful CCG in (south) London	
	Pounds:	Delivering on all of our statutory duties and become an effective, efficient and economical organisation	✓
	Process:	Commission safe, sustainable and equitable services in line with the operating framework and which improves outcomes and patient experience	

Organisational implications	Key Risks (corporate and/or clinical)	There are a number of risks to the delivery of the financial plan as submitted. The main risks are around the transfer of specialist commissioning and the assumption that this remains cost neutral; and that the acute contracts will not be negotiated within the resource envelope available.
	Equality and Diversity	Not applicable
	Patient impact	Not applicable
	Financial	This paper demonstrates that the CCG has submitted a balanced plan, and followed the required national planning assumptions, to the Department of Health and National Commissioning Board ,for consideration.
	Legal Issues	Not applicable
	NHS constitution	Not applicable

Consultation (Public, member or other)	Not required	
Audit (Considered / Approved by Other Committees / Groups)	Not applicable	
Communications Plan	Not applicable	
Author	Julie Witherall Head of Finance and Business – CSU	
	Clinical Lead Dr S Deshmukh	Executive Sponsor Theresa Osborne Chief Financial Officer
Date	4th February 2013	

Financial Planning 2013/14 and Budget Update

Background

The CCG has a Medium Term Financial Strategy in place which will be updated following finalisation of 2013/14 financial plans. The Care Trust had a developed 3-5 year financial plan based upon the Trust Special Administrator (TSA) assumptions plus the national planning assumptions issued in December 2012. This is in the process of being updated following changes to the 2012/13 position, changes in the assumptions and following receipt of the CCG allocations. The plan will aim to return the organisation to recurrent financial balance, and meet the required 1% surplus. However, the increased acute outturn for 2012/13 and the reduction in growth for 2013/14 will be challenging for the CCG. Since 2011/12, Bexley Care Trust has relied on non-recurrent support, including use of the 2% non-recurrent resource, to meet its required financial duties. Part of the plan is for the CCG to undertake significant transformational QIPP schemes, often in conjunction with other local CCGs rather than transactional, as in 2012/13, to ensure delivery of the Operating Framework requirements.

The CCG has now received its 2013/14 allocation, announced in December 2012, and has developed draft 2013/14 budgets and QIPP schemes based upon these. However, there are a number of national concerns with the allocations which are being discussed with the Department of Health which may need to be addressed, and result in changes to the allocations, prior to plans being finalised. The main concern surrounds the value to be transferred to the National Commissioning Board in respect of additional specialist services. Assurance has been received that this adjustment should be cost neutral and this assumption has been used in planning, as advised. Other concerns are around the allocations for Primary care property, Primary care IT costs and Public Health costs.

The Care Trust is expecting to report in line with its control total of £3.5m surplus for 2012/13 and a pro-rated proportion of this has been included in 2013/14 financial planning. However, significant over-performance, above agreed acute contracts, has again been seen in this financial year. This is being covered in-year from non-recurrent resources plus the existence of a cap & collar agreement with South London Healthcare NHS Trust, which has resulted in a benefit to Bexley in this financial year. The over-performance, non-recurrent financial support and increase in SLHT activity after removal of the cap & collar are first call on growth for 2013/14 and are included within the submitted financial plans. This will also affect future year plans.

2013/14 Planning Process & assumptions

Bexley Care Trust had an agreed 3-year plan (2012/13-2014/15) that ensured achievement of statutory duties and the 1% required surplus over the 3-year planning period 2012/13-2014/15. This is in the process of being updated for 2013/14 onwards for the revised allocations and planning assumptions advised in the latest national planning assumptions. However, the increased acute outturn for 2012/13 and the reduction in growth for 2013/14 will be challenging for the CCG. Achievement assumes that the plan will be delivered in each of the financial years.

In the summer the Government appointed a Trust Special Administrator (TSA) to South London Healthcare NHS Trust to look at the viability of services across the Trust and South East London. This work looked at the financial gap across the health economy, but assumed that 2012/13 activity would be in line with budgets. A new set of planning assumptions were discussed and agreed with Chief Financial Officers across the CCGs and these resulted in a larger gap than the original 3-year plans submitted and agreed by each PCT. These assumptions have subsequently been adjusted across London and these have been included in financial planning for 2013/14, together with the national assumptions issued in December 2012.

The main changes from original assumptions are as follows:

- Decrease in recurrent resource limit
- Increase in non-demographic growth
- Increase in tariff / inflation uplift
- Decrease in expected prescribing inflation

In addition, during 2012/13, significant over-performance has once again been seen within the acute sector, which is being covered in-year from non-recurrent means, including financial support of £4.8m. The existence of a cap & collar agreement with South London Healthcare NHS Trust has also resulted in a benefit to Bexley in this financial year. These resources will be unavailable in 2013/14 and planning has included significant QIPP assumptions to cover this shortfall.

CCG allocations have now been received and these have been used in financial planning. The CCG will need to deliver net QIPP of £11.3m (£13.1m pre risk assessment), of which £0.4m relates to existing schemes carried forward from 2012/13 and £10.9m relates to newly developed schemes. The CCG has identified QIPP plans and has spent considerable time working these up. Numbers are available by provider and are currently being discussed in contract negotiations. Some will likely result in a significant shift in activity between providers. The CCG has moved from transactional QIPP in 2012/13 to transformational to secure the level of QIPP required to ensure financial sustainability. Significant resource has been expended in 2012/13 developing the plans and it is intended that business cases will be submitted to the National Commissioning Board, against the 2% non-recurrent resource for 2013/14 and 2014/15, as a source of investment for pump priming QIPP, and double running costs, to ensure its delivery. The plans for use of the 2% non-recurrent resource, across South East London, were recently presented to the National Commissioning Board, who looked on them favourably. Work is ongoing to identify further pipeline schemes in case of slippage on the initial schemes. However, primary resource will be on ensuring delivery of those already identified.

There is an agreed framework for collaboration agreement across South East London which includes risk sharing arrangements. This was approved at a previous Governing Body meeting and is attached at Appendix 1 for information. No specific funding has been included for risk sharing. However, it has been proposed that any agreed arrangements will be funded from the 0.5% contingency. The Key planning commitments as presented to the National Commissioning Board are as in table 1.

Table1: Key Planning commitments as part of the South East London collaboration agreement.

Source	Application
CCG allocations	SEL CCGs to set aside 0.5% of RRL in 13/14 as a general contingency to support risk management across SEL CCGs.
2% non recurrent headroom in CCG allocations	SEL CCGs to commit approx 1% non recurrent investment in 2013/14 to implement the SEL community based care strategy.
2% non recurrent headroom in CCG allocations	SEL CCGs to commit approx 0.5% non recurrent investment in 2013/14 to implement local CCG transformational QIPP (in addition to the SEL community based care strategy.
2% non recurrent headroom in CCG allocations	SEL CCGs to commit set aside 0.5% non recurrently in 2013/14 to mitigate in year expenditure pressures
Return of fair share of 2012/13 PCT surpluses	SEL CCGs to plan to deliver a 1% surplus in 2013/14

The initial financial plan submission for 2013/14 has been compiled using the planning assumptions shown in Table 2, which are a combination of the TSA assumptions and the national assumptions issued in December 2012.

Table 2 – 2013/14 Planning assumptions

	demographic Growth	Non-demographic growth	Total population & incidence growth	Prescribing growth	Tariff/ Inflation Uplift	Tariff efficiency assumption/ Price Efficiency applied	Net Tariff/ Inflation Uplift
Acute	0.43%	2.00%	2.43%	0	2.90%	(4.00%)	(1.10%)
Client Groups and Community	0.43%	2.00%	2.43%	0	2.70%	(4.00%)	(1.30%)
Primary Care	0.43%	1.00%	1.43%		1.00%	0	1.00%
Primary Care Prescribing				4%			
Corporate	0	0	0.00%	0	2.50%	0	2.50%
Other Budgets and Reserves	0	0	0.00%	0	0.00%	0	0.00%

These assumptions will be refined as planning progresses to take account of:

- Any notified changes to planning assumptions;
- Any changes in Payments by Results for 2013/14;
- Any changes in the market forces factor following any change in hospital configuration or patient flow as a result of TSA recommendations;
- Any adjustments necessary in respect of the reductions for Specialist Commissioning or other CCG allocations;
- Any adjustments necessary in respect of changes to allocations.

2013/14 Financial Plan

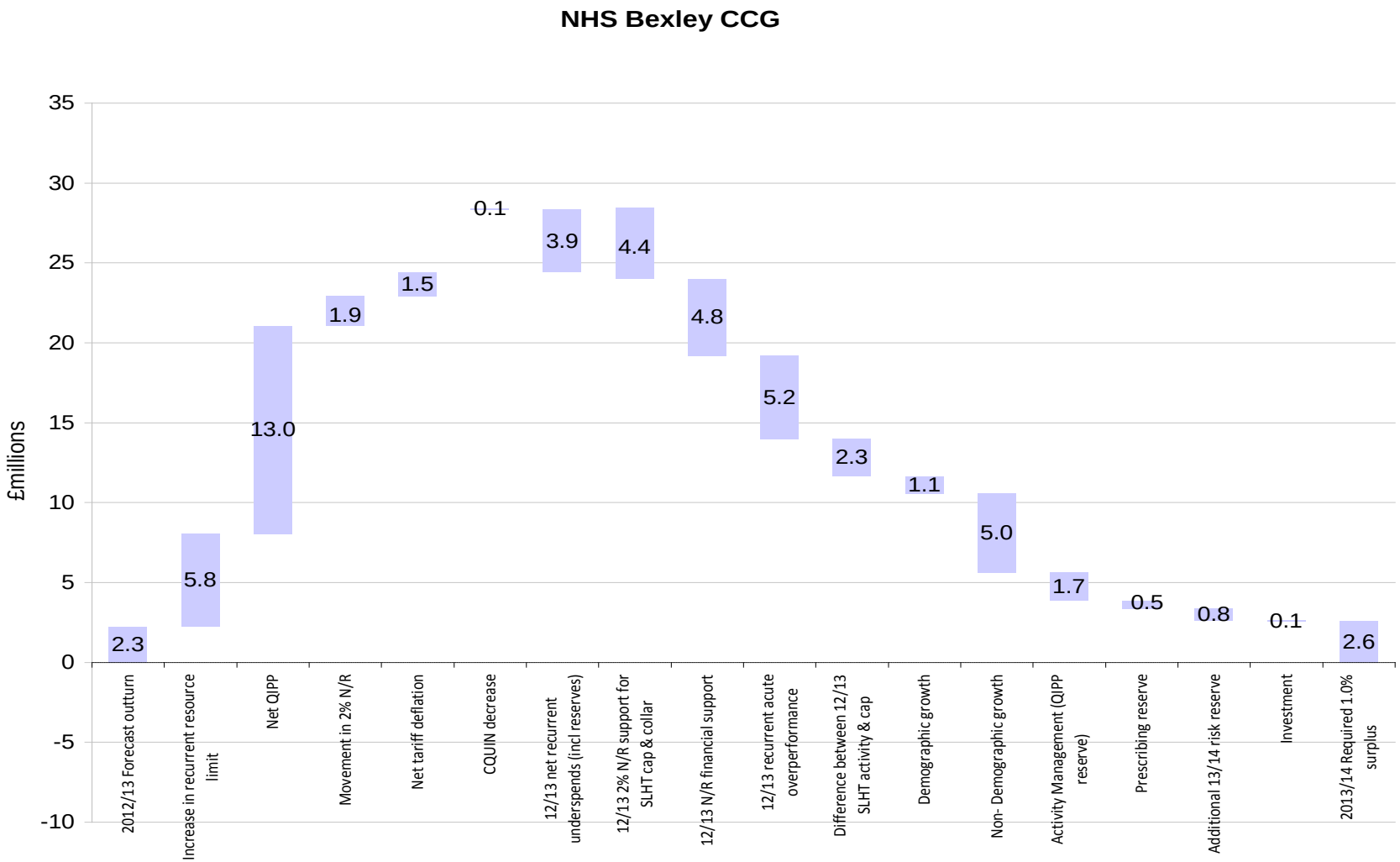
The CCG has submitted a balanced financial plan, including achievement of 1% surplus and setting aside of 0.5% contingency and 2% non-recurrent resource, albeit with a number of risks associated with it. These risks are articulated in the next sections. Appendix 2 is the full plan submitted. Table 3 is a summary of that financial plan:

Table 3: Summary of Financial Plan

Total CCG Resources	**(265,211)**
Acute services	150,524
Mental Health services	27,029
Community services	24,075
Continuing Care services	8,217
Primary Care services(incl Prescribing)	33,967
Other Programme services(incl reablement)	2,015
Total - Commissioning services	**245,827**
Corporate costs(not Running costs)	1,128
Contingency (Minimum 0.5%)	1,285
2% Headroom (Subject to BC Approval)	5,138
CCG Activity Management reserve	1,723
Other CCG Risk reserves	1,910
Total Planning Application	**257,011**
Total Running costs Application	**5,631**
Total 2013/14 Applications	**262,642**
1% Planned surplus	**2,569**

Movements by type of application	**£'000**
2013/14 net opening applications	**268,171**
CQUIN	-103
Inflation	8,418
Efficiency	-9,911
Demographic growth	1,070
Non Demographic growth	4,967
Cost pressures	82
QIPP	-13,029
Investments	2,977
2013/14 Closing applications	**262,642**

The major factors behind the movement from the 2012/13 CCG outturn (i.e. the proportion of the 1% surplus allocated to the CCG) and 2013/14 is shown in the bridge analysis below:



Running Costs

The CCG's proposals for the use of resources for running costs are drawn up within a resource envelope of £25/head of the CCG's capped ONS population, of 226,505, including both pay and non-pay, CCG and South London Commissioning Support Unit (CSU) costs. At all times the CCG's proposals have been presented within the required £25 per head running costs limit, which for Bexley is £5,663k. The national ready reckoner was also used. The CCG's structure has been approved and recruitment is near to completion.

The budgeted running costs, submitted within financial plans, are £5,631k, £24.86 per head. This includes £7.40 for the cost of services purchased through the CSU. There is little headroom within these costs, which could be severely tested where interim resource is necessary to cover vacant posts, sickness, maternity leave etc.

Contingency and Reserves

The CCG has planned for 0.5% contingency, 1% surplus and the 2% non-recurrent resource in line with planning requirements. The latter has been assumed will be available for business case bids for double running costs, pump priming and the implementation of transformational schemes (QIPP), aswell as to deliver Community Based Care. A £0.5m prescribing reserve is in place to mitigate the large prescribing QIPP planned for in this financial year and a further £1.4m is available as a risk reserve (this will be first call on any increases to budgets required or reduction to allocations). £1.7m activity management reserve is also available to offset the RAG rating of QIPP schemes (with the exception of prescribing which has a separate reserve). This is in addition to the agreed framework for collaboration agreement across South East London which includes risk sharing arrangements (Appendix 1).

Risk and Opportunities

Bexley CCG has identified the following risks in 2013/14:

- New 2013/14 QIPP of £10.9m is required to achieve a 1% surplus in 2013/14, based on financial planning. This is a challenging target when considering the substantial QIPP delivered by Bexley over the previous five years.
- The final allocation for the CCG is now known, however, there are a number of issues which remain outstanding in terms of the split of the specialist commissioning transfer by provider to ensure that it is cost

neutral and also confirmation of any adjustments in respect of property services, public health, primary care and GP IT services. A number of assumptions have been made to achieve a 1% surplus plan. If any of the assumptions are found to be incorrect, then there is a possibility that it may increase the 2013/14 QIPP savings requirement.

- A major risk for the CCG is the management of the acute contracts within the planned 2013/14 envelope allowing for the QIPP requirement, the TSA recommendations and assumptions and delivery of the transformation programme. This is heightened by the continued unavailability of changes as a result of tariff updates.
- Changes in the market forces factor following any change in hospital configuration / patient flow as a result of TSA recommendations.
- The CCG has received a large number of potential continuing healthcare unassessed periods of care claims. The most likely assessed costs have been included in 2012/13, but these are difficult to assess accurately and a risk remains that further costs may transpire in 2013/14, considering the time to assess each claim, outstanding judicial review and appeal timescales. The Care Trust has employed the services of a specialist consultancy firm to increase the speed of assessment which will improve the reliability of these costs.
- The implementation and shadow running of Payments by results (PbR) in Mental Health services may introduce further costs pressures. However, in mitigation, costs in line with 2012/13 baselines have been agreed for 2013/14.
- The wider prescribing of anti-coagulation drugs in 2013/14, based on NICE guidance, may introduce an additional costs pressure.
- There is a risk that the introduction of the audiology any willing provider (AWP) scheme may increase expenditure in this area.
- There is a risk that no funding will be returned to CCGs for the NHS Direct 0845 service to cover the new 111 provision, despite earlier assurances. No expenditure has been included in the financial plans in this respect.
- There is an emerging cost pressure for 2013 and beyond caused by the transfer back to the Local Authority of responsibility for post-18 education for young people with learning difficulties previously funded by the YPLA. Bexley (both the London Borough and Care Trust) is one of only three areas nationally which have not contributed to the social and health elements of the funding of such places (in Independent Specialist Provision) in the past.

The CCG has also identified the following opportunities in 2013/14:

- The evolution of the new commissioning organisation with renewed vision and goals for the commissioning and delivery of healthcare for the residents of Bexley.
- The development of Community services on the Queen Mary's Sidcup (QMS) site and the joint working with other partners to ensure the success of the project provides an opportunity to improve healthcare for Bexley residents.
- The new integrated commissioning team across the CCG and Bexley Local Authority provides an opportunity to share expertise and commissioning experience and benefits from economies from increased purchasing power.
- To work collaboratively with other CCGs in South East London and also with our partners in the CSU to share best practice and benefit from economies of scale.
- To work towards a community based care model to increase healthcare closer to home and decrease reliance on acute hospital based care for the residents of Bexley.

Mitigation of Risks

Bexley CCG has a number of plans in place to manage the financial risks identified for 2013/14 which are as follows:

- 0.5% contingency funding including in the financial planning model.
- £0.5m Prescribing reserve.
- £1.4m risk reserve
- £1.7m activity management reserve to offset the RAG rating of QIPP schemes.
- Further pipeline schemes for QIPP are being developed.
- Additional resources have been invested in 2012/13 in the planning and delivery of QIPP schemes to ensure delivery of the schemes.
- Transformational QIPP schemes are being developed to ensure sustainable change.
- The CCG has its own Programme Management Office (PMO) which is integral to the organisation and the processes are fully embedded in the organisation. The PMO has robust monitoring and reporting systems in place to support delivery of the QIPP schemes.
- There is a South East London PMO, across the six CCGs, which will also support the development and delivery of QIPP.
- Bexley CCG is part of the South East London risk share collaboration agreement, which may be called upon in certain circumstances to assist

with short term financial support as well as assisting with joint working around commissioning etc.

- Bexley CCG is currently screening and assessing the claims received in respect of continuing healthcare unassessed periods of care and has invested in additional support in order to undertake this work. It is hoped that a realistic provision has been included in 2012/13.
- For 2013/14, the CCG has agreed with its main Mental Health provider that the contract will remain on a block basis whilst the initial clustering and PbR data is reviewed and assessed for accuracy before being used as a basis for the following year's contract.
- The CCG will also be ensuring that community based care, linking with 111, is considered where possible to reduce hospital admissions and treat patients in the community or their own homes when possible.
- The CCG will be working closely with the South London Commissioning Support Unit to robustly performance manage contracts with all acute providers. In-house teams will provide the same level of robust support with community and mental health contracts.

2013/14 budget setting & sign off

The Governing Body approved a budget setting timetable earlier in the year, which is running concurrently with the planning process. Appendix 3 gives an update on progress Generally the timetable is on schedule. There has been some delay in re-issuing the budgets to the budget holders after the submission of the balanced plan. This has now been rectified and the finance team are in discussions with budget holders to ascertain if there are any further amendments to be made. The budgets will continue to be updated as contracts are agreed and signed. A further update will be brought to the Governing Body in March. All budgets are expected to be signed by budget holders before the start of 2013/14.

Next Steps

A further iteration of financial plans, including details of acute envelopes is due by 15th February. Some changes are envisaged in this return from those presented here and these will be reported at a future meeting. Final plans cannot be agreed until after agreement of acute envelopes for 2013/14.

Conclusion & Recommendations

The Governing Body are asked to:

Note the CCG's submission of a balanced financial plan for 2013/14 as laid out in appendix 1of the attached report, reporting a 1% surplus;

Note the risks identified around the transfer of specialist commissioning and the assumption being used that this will be cost neutral;

Note the other risks identified to the financial plan;

Note the progress made to date on the budget setting timetable – see appendix 2 of the attached report.

South East London Clinical Commissioning Groups

Draft framework for collaboration

August 2012

Rev. December 2012

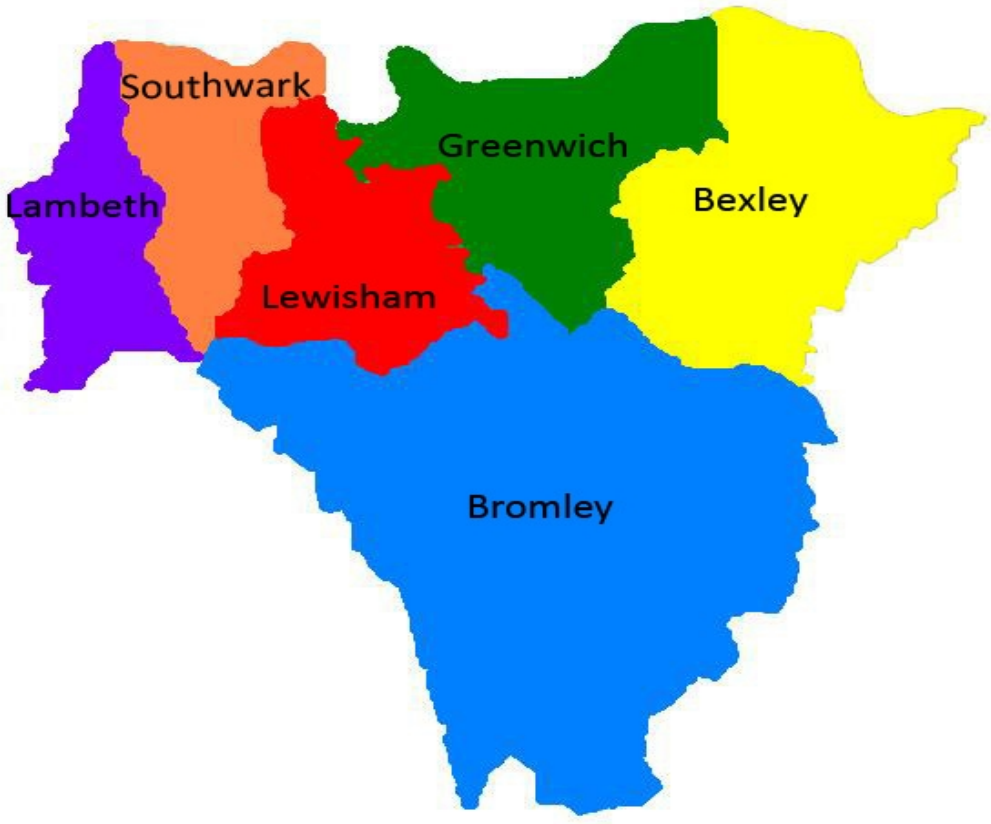
Contents

This document describes a framework for Clinical Commissioning Groups (CCGs) in South East London to collaborate to support effective clinical commissioning. It includes the following specific sections:

Section 1: Introduction and context

South East London comprises the following six CCGs:

- Bexley CCG
- Bromley CCG
- Greenwich CCG
- Lambeth CCG
- Lewisham CCG
- Southwark CCG



Over the past year CCG Chairs, clinical leaders, Chief Officer (Designates) and senior managers have been working together, through a series of collaborative workshops, to design the collaborative approaches to clinical commissioning that will be required in order to operate effectively as authorised CCGs from April 2013.

Many of the mechanisms for CCG collaboration in south east London have been established for some time and in particular the South East London Clinical Strategy Group (CSG), a joint Governing Body committee for each CCG under future arrangements has brought together the CCG Chairs and Chief Officers (Designates) on a regular basis to design and agree the arrangements outlined by this framework.

Collaboration at scale

Our design principles are outlined below. They recognise and reflect the optimum scale at which collaboration will be exercised taking in to account patient flows, the scope of strategic initiatives and the provider landscape from which south east London's CCGs will commission. As a result collaboration is and will continue to be secured:

- At borough level, with each CCG working with local partners and in particular the Local Authority

- Between boroughs, recognising that commissioning challenges and priorities will require the direct collaboration of a group of CCGs to achieve specific strategic goals. To this end our framework establishes specific arrangements for the collaboration of Bexley, Bromley and Greenwich and for Lambeth, Southwark and Lewisham for example.

- South east London wide collaboration where commissioning imperatives demand and are best addressed by a collaboration of all six boroughs.

In addition the south east London CCGs will play an active part in London wide CCG collaboration attending the London Clinical Commissioning Council (LCCC) and developing the appropriate relationships and interaction with the London Senate.

Effective commissioning support

In defining clinical commissioning support arrangements, CCGs have considered what they want to build (within local CCGs) buy (purchase from a Commissioning Support Organisation or elsewhere) and share (share roles or functions between CCGs) across the spectrum of commissioning support functions.

South east London CCGs have already used our collaborative arrangements to consider our shared approach to commissioning support capability, in particular through establishment of the South London Commissioning Support Unit (SLCSS) to provide support at scale and provide value for money in support functions.

Commissioning support at scale has been designed alongside local borough commissioning structures to ensure the optimum capacity and capability to deliver at, the appropriate scale, our individual and collective commissioning intentions. Our collaborative arrangements will also be supported by a south east London Programme Management Office (PMO) accountable to, and funded by the CCGs via our South East London CSG.

Design principles

In appraising the options, all CCGs have held a common goal to ensure that where possible, commissioning support is 'local' to CCGs and where needed south east London CCGs will collaborate to improve outcomes, quality and value for money in the services that they commission.

Our key design principles:

Individual CCGs remain accountable whilst recognising that if we are to address transformation at scale we will need to work in collaboration

That CCGs need to operate with local capability and seek the advantages of sharing commissioning support where it is responsive, supports our ambitions, improves our effectiveness and secures value for money

In designing our framework for collaboration and designing our model of commissioning support south east London CCGs are clear that:

- Arrangements should be responsive, flexible, resilient and sustainable
- Where possible commissioning support should remain local to each CCG whilst ensuring a consistent and coherent voice is offered to providers and stakeholders
- Proposed arrangements are affordable within the current operating framework costs of £25 per head of population
- Provides continuity and stability throughout transition

- The model is flexible, enabling CCGs to:

  - tailor commissioning support to meet local requirements
  - meet requirements for 2012/13 and is able to adapt as requirements change in future years
  - meet the requirements placed upon CCGs for primary care improvement
  - supports and enables joint working with local authorities

Model for collaboration and commissioning support arrangements

Our model for collaboration:
The south east London model for collaboration is based upon: Local accountability and delivery, shared programmes, common standards and ensuring that expertise and purchasing power is brought together where it makes sense to do so

In determining our collaborative arrangements and commissioning support, clinical leaders from our CCGs have designed a model that:

- Identified the right set of areas where CCGs wish to collaborate, i.e. bring together, co-ordinate and align existing resources to ensure genuine collaboration in clinical commissioning.

- A common set of commissioning support functions purchased from South London Commissioning Support Unit (SLCSU)

- Ensures commissioning resources are predominantly locally based, for example each CCG will retain local lead commissioners for both acute and non-acute commissioning as well as support to develop local CCG strategy, QIPP and service re-design work

The table below provides, at high-level, the areas where CCGs wish to collaborate and how this relates to local and SLCSU activities. The model outlines initial priority areas for CCG collaboration, other areas where CCGs may wish to collaborate may be added as new clinical commissioning arrangements develop.

Accountable CCG Governing Bodies			
Area	**CCG Collaboration**	**CCG Local**	**SLCSU**
Acute	Lead Commissioner (acting as host)	Lead Contracting team	Multi-disciplinary contract team
Non Acute	'Common Standards, Local Delivery' – shared programmes and common approach to contracting	Local Commissioning and redesign	None
Strategy	Strategic development - (Six Borough / LSL and BBG)	Local leadership of: Integrated Plan, Commissioning Intentions and QIPP	Health intelligence to support decision making
Risk	South east London Risk Sharing agreement	Local CCG arrangements within contracts and with local authority	Support to derive risk assessment / decision-making
Other areas	Common Assurance Committees	CCG Governance Structures	Delivery of common policies and reporting (e.g. IFRs and Integrated Performance reporting)
Key:	Within CCGs	Within SLCSU	

CCGs also recognise that it will be necessary to collaborate to manage relationships with both the National Commissioning Board (NCB) and the SLCSU. Our CSG, supported by the South East London Chief Officers Group (COG), provides an effective forum to provide coherent and consistent involvement in the LCCC where each CCG will also be represented. The CCGs have elected a lead CCG Chair (NHS Lambeth CCG) for this area.

The remainder of this document seeks to describe in more detail what collaboration will mean in practice for south east London CCGs, beginning with the over-arching principles for collaboration. Subsequent sections describe how the model will work in practice, the mechanisms for collaboration and how CCGs will hold each other to account for each of the following areas:

- Acute commissioning
- Non-acute commissioning
- Strategy
- Risk Sharing

Section 2: Agreed principles of collaboration

In defining this framework for collaboration, south east London CCGs have identified a number of principles to frame and guide the detailed design of how collaboration will work in practice. These include:

- Focus on building relationships and trust so CCGs have confidence in each other's ability to deliver on their behalf and do not always feel they have to be in the room to have a voice.

- Have a clear transparent framework by which we hold each other to account.

- Create space for CCGs early in the annual commissioning cycle to come together to build understanding of each other's clinical commissioning and service re-design priorities and where possible align and agree collective strategies to support the achievement of better outcomes, improved quality and value for money.

- Co-ordinate dialogue with provider Trusts to maximise impact by ensuring that they speak with a single voice.

- Ensure regular opportunities for dialogue between clinical and executive leaders and local provider Trusts.

- Engagement with the public and stakeholders to ensure confidence in the local NHS is sustained

- Ensure the involvement of our communities and of patients in the redesign of services and scale

- Seek to co-ordinate and combine efforts to manage relationships and influence the NCB, the LCCC and London Senate and our SLCSU.

- Deploy clinical capacity where it is most needed, in a timely way and ensure that critical meetings are held at times when clinicians can attend.

- Learn from existing experience and make time to reflect on and build ‘what good looks like’ as CCGs progress through transition, authorisation and beyond.

Section 3: Mechanisms for collaboration

In order to support the collaborative activities set out in this document, south east London CCGs have identified the need to come together to establish a structure that will allow them to:

- Share and align strategic priorities and to share best practice on issues that are of common interest to more than one CCG
- Create formal and shared committees of the relevant CCG Governing Bodies to allow decision making at scale
- Gain collective assurance on the quality and performance of the commissioned services of shared providers
- Plan, co-ordinate and deliver collective work programmes

In 2011/12 the emergent CCGs established a governance structure to set strategic direction, review progress, make joint strategic decisions and hold each other to account. This has allowed our CCGs to collaborate effectively, at the right scale, whilst acting with 100% delegated responsibility from PCT Boards.

These well established arrangements will be continued by CCGs post authorisation. At present they are supported by a shared management office and from October 2012 they will be supported by a PMO hosted by NHS Southwark CCG on behalf of south east London CCGs and led by a PMO Director.

Accountability and responsibility for decision making sits with each CCG as outlined in their respective constitutions and discussions that take place at a collaborative level will often support that decision making at Governing Body level within each individual CCG.

In south east London the committees listed below will be formal (joint) committees of each relevant Governing Body and their members will be mandated by their Governing Body to take decisions on the CCG's behalf.

- The South East London Clinical Strategy Committee[1]
- The Lambeth, Southwark and Lewisham Collaborative Commissioning Committee[2]

Bexley, Bromley and Greenwich have also established a Clinical Strategy Group for the co-ordination of joint work and agree mechanisms for shared decision making.

[1] *Current South East London Clinical Strategy Group*
[2] *The Lambeth, Southwark and Lewisham Committees is currently established within CCG Shadow governance structures and report to respective Governing Bodies and the CSG.*

These committees will be supported and co-ordinated by the South East London CCG Chief Officers Group (COG), that is also responsible for overseeing the full range of collaborative arrangements outlined by the framework.

CCG constitutions allow for the establishment of further joint committees of their governing bodies that will allow them to discharge their functions effectively. The Lambeth, Southwark and Lewisham CCGs will, for example, continue their existing Integrated Governance and Performance PCT Board committees as joint committees of their Governing Bodies post authorisation. This committee will monitor the quality, performance and financial position by provider and CCG in order to assess and ensure collective action is taken to address areas of variance to agreed levels of performance or address quality concerns.

The south east London CCGs will also be members of the London Clinical Commissioning Council. The Draft terms of reference are provided at **Appendix A** and our CCGs anticipate this forum becoming a formal joint committee to allow shared decision making on a pan London basis.

Over the transition period many of these committees and groups have been run in tandem alongside and with the Cluster. This will allow for a smooth transition and has allowed these forums to act in shadow form, with full CCG leadership, to support the annual commissioning cycle in advance of authorisation.

The following table outlines the major joint committees that will allow the full delivery of this framework:

Committee	Membership	Role	Frequency
South East London Clinical Strategy Committee	Chair: Dr Zeineldine (Southwark CCG) CCG Chairs CCG Chief Officers PMO	• To develop, agree and oversee commissioning strategy at the SEL level • To align CCG wide priorities e.g. commissioning intentions and service re-design priorities • To address strategic issues in the provider market – mergers and acquisitions, reconfiguration and service change, foundation trust applications, receivership – affecting the whole of South East London, where acting as scale is necessary to ensure the CCGs' interests are promoted effectively • To liaise on behalf of SEL CCGs with the NHSCBA London specialist commissioning hub • To share LSL and BBG CCG strategies for clinical engagement and patient and public engagement in order to promote synergies and avoid any unnecessary inconsistencies • To develop a shared approach to	Bi-monthly

		London-wide issues and co-ordination, preparation for, and participation in, the LCCC • To co-ordinate strategies and plans with SEL clinical networks • To determine, oversee and review any pan-SEL management arrangements • To determine, oversee and review any pan-SEL CCG contingency funding and risk management arrangements • To act as an escalation point • To hold each other to account	
LSL CCG Collaborative Committee	Chair: Dr Tattersfield (Lewisham CCG) CCG Chairs CCG Chief Officers Governing Body representatives PMO	Common roles applied to LSL and BBG geography alongside leadership of strategic priorities spanning three borough work • To share thinking and learning on themes of shared interest in relation to clinical commissioning and professional development in LSL / BBG • To share CCG strategies for clinical engagement and patient and public engagement in order to promote synergies and avoid any unnecessary inconsistencies • To share CCG commissioning strategies and plans in order to promote synergies and avoid any unnecessary inconsistencies • To identify, and oversee the development and implementation of, joint commissioning programmes, including QIPP programmes • To develop and agree joint strategies for procurement and contractual negotiation with major providers to maximise commissioning leverage • To address strategic issues for LSL / BBG in the provider market – mergers and acquisitions, reconfiguration and service change, foundation trust applications, receivership – where acting as scale is necessary to ensure the CCGs' interests are promoted effectively • To develop and agree joint strategies and plans, and making investments in, infrastructural projects – workforce, information management and technology (IM&T) and estates – particularly in relation to primary care • To determine, oversee and review any joint CCG management arrangements • To recommend, oversee and review any joint CCG financial risk management arrangements	Bi-monthly (those months falling between SEL CSG meetings)
BBG CCG Clinical Strategy Group	Chair: Dr Andrew Parson (Bromley CCG) CCG Chairs CCG Chief Officers Governing Body representatives PMO		Bi-monthly (those months falling between SEL CSG meetings)

South East London Chief Officers Group	Chair: By rotation of Chief Officers CCG Chief Officers PMO Director	▪ To lead all areas of collaborative working ▪ To support clinical leaders to develop strategic direction and align priorities ▪ Provide oversight on performance and quality ▪ Ensure leadership accountabilities are in place to deliver and hold each other to account ▪ Act as the first point of escalation for issues arising from relating to collaborative activities	Fortnightly

These formal meetings will be supplemented by informal and ad hoc interactions, and we recognise that there may be a need to convene special meetings of the committees and their groups at different points in the annual commissioning cycle to transact more urgent business.

Additional forums may need to be developed as the new clinical commissioning arrangements bed in, for example, on specific strategic or commissioning issues.

Operational groups and programme boards

There are a number of areas for which CCGs in south east London have established joint programme boards across CCG areas for the delivery of the commissioning intentions outlined by their integrated plans or operational groups for collaboration or joint working at an operational level. The nature, scope and role of each of these areas is described within the relevant sections of this Framework for Collaboration.

Decision-making and process for holding each other to account

The joint committees outlined above are governed by agreed terms of reference and the provisions of their respective members' CCG Constitutions. In general terms CCGs aim is to always achieve collective decision-making in a collaborative manner through consensus. The six CCGs will have a collective responsibility to resolve and minimise any local challenges or disproportionate impact of CCG wide decisions on any one CCG.

Section 4: Collaborating in acute commissioning

As with all areas of commissioning, acute commissioning will be owned, provided and led by the Clinical Commissioning Groups. In their development of commissioning intentions CCGs in south east London will use our collaboration arrangements to ensure alignment of intentions and consistent, coherent interaction with major providers.

In acute commissioning and contracting our collaboration will be underpinned by the use of multi-disciplinary contracting teams and host arrangements for providers.

Multidisciplinary contracting teams draw together the clinical leadership of each CCG, leads from SLCSU (e.g. contracting, performance management, information), the CCG commissioning teams (including medicines management) and local Public Health resource.

In this way each acute contract will be managed by a team comprising:

- Clinical leads from each of the major CCG commissioners (by spend) including one acting as host
- Senior management leads from CCG commissioning teams (reflecting Host arrangements)
- Multi-disciplinary team from SLCSU
- Public Health support

A summary of key roles and responsibilities is set out below.

Local CCG led

- Each CCG has a senior manager who is responsible for co-ordinating the monitoring and management of the CCG's total acute portfolio and providing robust and expert professional advice and guidance to the CCG on the commissioning of acute services. The 'Head of Acute Contracting' will be employed by the SLCSU but will be predominantly based in the local CCG and will draw support from the acute multi-disciplinary team in SLCSU to ensure the provision of timely, comprehensive and systematic support to manage the annual cycle of commissioning and contracting activity.

- Each CCG provides clinical leadership, chairing contract management & quality meetings and leading the annual acute negotiating process. Local clinicians provide expertise, for example in the completion of clinical audits, review of care pathways and medicines management.

Services delivered by SLCSU

South east London CCGs have agreed to purchase acute contract management support from the SLCSU as part of their core package of commissioning support. As a result, CCGs will have a dedicated multi-disciplinary acute contracting team, comprising dedicated leads for acute contracting, finance and information. This team will be directly employed by the SLCSU, and will support the overall delivery of the commissioning cycle by:

- Supporting annual and on-going contract negotiations;
- Co-ordinating contract management including challenging over performance, performance targets, quality standards, KPIs and acute QIPP and Demand Management schemes
- Delivery of robust claims management
- Supporting and the host/lead commissioners role
- Advising on impact of service redesign, CQUIN or QIPP proposals on acute contracts
- Translating service design, CQUIN & QIPP plans into acute contracts

CCG collaborative activity

- The south east London CCGs have agreed to act as "host commissioner" for all London CCGs, for one or more Trusts which are geographically located within the CCG, liaising closely with the other CCGs' acute contract management teams to ensure that all CCGs achieve maximum leverage across all Trusts in south east London.

- In order to deliver the major benefits of inter-CCG collaboration to maximise scale and leverage with the large acute Trusts CCGs recognise that they will need to work together to

    - Share CCG commissioning intentions and service re-design priorities to identify areas of common interest and difference
    - Align priorities and agree collective negotiation strategies with provider Trusts to support the achievement of better outcomes, improved quality and value for money
    - Co-ordinate dialogue with provider Trusts to maximise impact by ensuring that they speak with a single voice
    - Improve efficiency by avoiding multiple conversations with providers where possible

Host commissioner arrangements

From 1 April 2013, the Host Commissioner will be charged with leading the delivery and performance management of a hospital contract, on behalf of a host CCG and its associate CCGs. This host 'leadership' role will be performed with the full support of the multi-disciplinary team described above for each contract. The geographical spread of south east London provider Trusts and the proportion of spend between CCGs has led to an agreement that clinical commissioners and their CCG leads will participate, alongside the host, in contract negotiation, quality and performance meetings (see table below).

These arrangements will require the Host Commissioner to coordinate and empower a number of different relationships including with clinicians, the Chief Officer and commissioning support staff of the Host CCG, and also those of its key associate CCGs.

The table below sets out the current host commissioning responsibilities and the south east London CCGs represented on the contracting teams.

Provider	Host CCG	SEL CCG in contract teams
Guy's and St Thomas' NHS Foundation Trust	NHS Lambeth CCG	NHS Southwark CCG NHS Lewisham CCG
Kings College Hospitals NHS Foundation Trust	NHS Southwark CCG	NHS Lambeth CCG NHS Lewisham CCG
Lewisham Hospital NHS Trust	NHS Lewisham CCG	
South London Hospitals NHS Trust	NHS Bromley CCG	NHS Greenwich CCG NHS Bexley CCG

Roles and responsibilities

The table below summarises the broad roles and responsibilities for the host commissioner (working with other major commissioning CCG by contract spend) and the SLCSU. It is recognised that Host CCGs will also need to work with a range of associate CCGs will need to sign a consortium agreement in advance of annual negotiations which

define their responsibilities to each other. This agreement will set out arrangements for quoracy and decision making between CCGs as well as a process for dispute resolution.

Host CCG	Associate CCG	CSU
Set individual and trust wide commissioning intentions while being mindful of the intentions of Associate CCGs	Share individual commissioning intentions and play an equal and active part in dialogue between CCGs	Co-ordinate dialogue between host CCG and associate CCGs to align priorities, set direction and agree negotiating lines. Provide robust and professional advice on the commissioning of acute services
Lead on contract negotiations, agreeing final terms and conditions after due consultation with associate CCG.	Support contract negotiation meetings and provide information on a timely basis.	Support CCGs to translate commissioning intentions and priorities into signed acute contracts, while ensuring Host CCG is appropriately facilitated to lead negotiations and agree terms & conditions acceptable to all parties.
Manage the performance against contract reporting back to associate CCGs on a regular basis. Consult with associate CCGs to agree pro-active management action to rectify performance or variances to plan.	Support performance management process.	Ensuring Host CCG is appropriately facilitated to manage performance and ensure management action both Trust wide and on behalf of all CCGs. Monthly monitoring reports against contractual targets and validates price and activity (claims management), underpinned by analysis and interpretation of issues and trends.
Co-ordinate clinical dialogue and decision making on investment and disinvestment in services. Sign-off decisions and monitor and review outcomes, reporting back to CCGs	Share views on a timely basis on individual investment and disinvestments, based on local circumstances.	Provide advice and recommendations to support decision-making on suitability, feasibility and affordability of proposed service changes.
Share QIPP and CQUIN schemes to a timetable to enable input from Associate CCGs	Input into QIPP and CQUIN schemes discussions in a timely manner.	Facilitate process for Host and associate CCGs to submit QIPP schemes and ideas for CQUINs

		Report on QIPP and CQUIN schemes to support contact negotiations
Lead negotiation with the Trust on in year financial settlement , taking into account individual associate CCGs concerns	Respond on a timely basis to information prepared by CSU to enable Host to negotiate an in-year financial settlement	Provide robust financial reports and analysis Co-ordinate in-year financial settlement, preparing settlement proposals for discussion with associate CCGs and leading negotiation with the Trust, taking into account individual associate CCGs concerns
Chair the monthly Clinical Quality Review Group (CQRG). Oversee Serious Incident (SI) reviews and ensure sign-off with National Commissioning Board (NCB)	Play a part in CQRG proportionate to overall share & stake in contract. Provide clinical expertise to support SI reviews and clinical audits	Co-ordinate SI review process, with input from clinical leads from relevant CCG and disseminate learning. Ongoing reporting against quality, safety indicators and co-ordinate clinical audits

Mechanisms for collaboration

The south east London CCGs strategy group will be the main forum for clinical chairs and Chief Officers to come together to share and align commissioning intentions and service re-design priorities and where possible agree a south east London wide strategy for negotiating across the portfolio of providers serving residents and patients in south east London. The Chief Officers group will support the strategy group in developing the strategic direction and will act as the first point of escalation for collaborative activity.

At an operational level it is expected that each host CCG will establish mechanisms to co-ordinate dialogue between associate CCGs and the provider Trust, with support and input from SLCSU. One size will not fit all, and arrangements will need to be tailored to deal with individual Trust circumstances and the available time of local clinicians. However each multi-disciplinary contract team will lead contract negotiation, performance and quality meetings across any given contract year.

Section 5: Collaborating in Non Acute Commissioning

Non-acute commissioning will be owned, provided and led by the Clinical Commissioning Groups. In their development of commissioning intentions CCGs in south east London will use our collaboration arrangements to ensure alignment of intentions and consistent and coherent interaction with major providers.

Each CCG has established leadership and capacity for the commissioning and contracting of mental health and community services and for the redesign of out of hospital care. Each CCG will work with their respective local authority and be responsible for commissioning services, contract management and pathway redesign. As such, in all circumstances, commissioning responsibility for out of hospital care remains with each CCG and there is a limited level of commissioning support provided directly by the SLCSU.

Community services and Mental Health

Arrangements for the commissioning and contracting of community services reflect the current provider landscape and has required the collaboration of CCGs, particularly where current and major providers of care are shared (much of the provision of community services is now secured through integrated service provision).

To this end south east London's CCGs work in collaboration to commission and contract these services, outlined in the table below, aligning commissioning intentions and establishing a consistent approach to contracting, undertaken collectively.

Community Services Provider	Borough	Commissioning Arrangements
Guy's and St Thomas' NHS Foundation Trust	NHS Lambeth CCG NHS Southwark CCG	Lambeth and Southwark CCG Commissioning teams and clinical leads (working in partnership)
Lewisham Hospital NHS Trust	NHS Lewisham CCG	Lewisham CCG Commissioning team and clinical leads working with access to SLCSU Acute contracting team (integrated contracting across acute and community)
Oxleas NHS Foundation Trust	NHS Greenwich CCG NHS Bexley CCG	Greenwich and Bexley CCG Commissioning teams and clinical leaders (working in partnership)
Bromley Healthcare	NHS Bromley CCG	Bromley CCG Commissioning team and

		clinical lead
Mental Health Provider	**Borough**	**Commissioning Arrangements**
South London and the Maudsley NHS Foundation Trust	NHS Lambeth CCG NHS Southwark CCG NHS Lewisham CCG	Lambeth, Southwark and Lewisham CCG Commissioning teams and clinical leads (working in partnership plus link to NHS Croydon CCG)
Oxleas NHS Foundation Trust	NHS Greenwich CCG NHS Bexley CCG NHS Bromley CCG	Greenwich and Bexley CCG Commissioning teams and clinical leaders (working in partnership)

CCG collaborative activity

In recognition of the common goals and specifically the aspirations of CCGs to redesign and enhance the quality of out of hospital care in response to our agreed strategies and commissioning intentions CCGs from across south east London have come together to establish strategic and operational delivery groups reflecting the size, scale and scope of those areas. Lambeth and Southwark CCGs have, for example, established shared programme boards for Planned and Unplanned care delivery across the two boroughs. Likewise, Bexley, Bromley and Greenwich have established transformation groups to address their collective redesign priorities and initiatives.

In response to the Unsustainable Provide Regime that is currently applied to South London Healthcare NHS Trust (see section 6) CCGs in south east London are all engaged in the 'Out of Hospital Care' work stream of the Trust Special Administrator programme. Each of the six CCGs will collaborate in this work to establish a common vision for this area of care and to ensure the appropriate implementation of that vision in each borough – 'Shared Standards, Local Delivery' is a principle that all six CCGs share and champion passionately.

As detailed above the collaborative models outlined by this framework provide Lambeth, Southwark and Lewisham CCGs and Bexley, Bromley and Greenwich CCGs with committee structures that provide the leadership and governance arrangement for managing that work and to ensure clear lines of accountability back to CCG Governing Bodies and within and between south east London's CCGs as they hold each other to account for these shared arrangements.

Section 6: Strategy and collaboration for delivery

The South East London CSG and the strategic committees outlined in this framework will provide key forums for strategic development, implementation and shared decision making across the six CCGs for those areas of commissioning that extend beyond a single CCG borough boundary, whilst accepting that ultimate accountability rests with each Governing Body.

In addition to the ongoing production of strategy across this group of CCGs, it is anticipated that the CSG and related committees will work with clinical networks across south east London to establish collective commissioning responses to service change in areas such as Cardiac and Stroke or Cancer. The CSG will also provide opportunity for shared decision making in response to the commissioning of tertiary services across the patch and to anticipated changes to the provider landscape and context for health care commissioning.

Our arrangements also reflect the current work being undertaken under by the Trust Special Administrator for South London Healthcare NHS Trust, an organisation that is currently subject to the Unsustainable Provider Regime, securing the appropriate and collaborative response of CCGs.

Trust Special Administrator – South London Healthcare NHS Trust

At the time of production of this document, South London Healthcare Trust is subject to the Unsustainable Provider Regime. The Secretary of State (SoS) has appointed a Trust Special Administrator (TSA) who is required to produce a report with recommendations to the SoS by 29 October 2012. After a brief period of consultation, a final plan for recovery will be decided upon by the SoS at the beginning of February 2013.

The remit of the TSA is twofold; firstly to ensure that SLHT continues to function and provide good quality acute services in as efficient a way as possible, and secondly, to create a set of recommendations for a financially sustainable health economy in south east London. To enable this second function to happen, the TSA has established a programme that engages all six CCGs and all acute, community and mental health providers in South East London. The whole health economy is supporting the TSA an advisory role, both managerially and clinically, and also in developing options for sustainability.

The current arrangements and partnerships of CCGs may be subject to change, depending on the outcome of the TSA recommendations to the Secretary of State

Model for strategy, business planning and organisational performance

Each CCG will maintain local resources for strategy, business planning and organisational performance, to lead the development of statutory planning requirements such as Integrated Plans, Operating Plans, QIPP plans and JSNA (in partnership with Local Authority and working with the Health and Wellbeing Boards).

CCG collaborative activity - PMO

All CCGs party to this agreement have agreed to fund a Programme Management Office for the collaborative work of the CCGs in south east London. At the present time the collaborative groups outlined in this framework are supported by a small, jointly funded management office. By 1 October 2012, that resource will be expanded in size and scope to support all collaborative work outlined by this framework and will be led by a PMO Director. The PMO will be hosted by NHS Southwark CCG and will be funded by each CCG.

Section 7: Risk Sharing

South east London CCGs are collaborating to mitigate and effectively manage financial risks, working together and with other health partners and public sector organisations. Agreed risk sharing approaches have been used effectively over 2011/12 and will be kept under continuous review to ensure that they incentivise good performance, avoid untoward incentives and can demonstrate best practice stewardship in the use of resources.

It is recognised that risk is best managed by those best able to address the specific risk. As such there is no single place that financial risk management will best be delivered. A range of risk management approaches are encompassed within our overall risk sharing framework including actions through;

- Individual CCG financial controls and governance through budgetary and other risk and contingency management frameworks
- Risk sharing with local commissioning partners, including local government, such as through joint commissioning arrangements
- Risk sharing with providers through contractual agreements to incentivise service change and QIPP delivery
- Risk sharing and pooling across CCGs to reflect approaches to sharing risk in specific commissioned services and to support the delivery of shared programmes
- Mutual Financial Aid to support delivery of individual CCG financial targets in the short term, assist recovery and sustain ongoing strategic direction without destabilising the health economy.

Proposed arrangements are found in full at Appendix B

Section 8: Agreement

The arrangements for collaboration set out in this framework have been designed and established by the six CCGs that comprise south east London.

Chief Officer (Designates) have approved this draft framework that reflects the current and established collaboration work between south east London CCGs and the future collaboration that will exist between these statutory bodies post authoristaion.

Work to finalise and agree this draft framework will be undertaken by the CCG Chief Officers Group and will be overseen and agreed by south east London Clinical Strategy Group at its September 2012 meeting.

In the interim period the signatories, for an on behalf of their CCG, have agreed the Draft Framework.

Signatories

CCG	Chief Officer Designate	Date
Bexley	Name:	
	Signature:	
Bromley	Name:	
	Signature:	
Greenwich	Name:	
	Signature:	
Lambeth	Name:	
	Signature:	
Lewisham	Name:	
	Signature:	
Southwark	Name:	

	Signature:	

Appendix A

Office of London PCT Chief Executives

Draft – London Clinical Commissioning Council – Draft

Clinical Leads

Terms of Reference

1. Introduction

From April 2013 Clinical Commissioning Groups will be statutory organisations charged with commissioning a range of care for their population. They will concentrate on issues local to them, but will also need to collaborate with other CCGs (and the NHS CB) to manage care pathways, and areas of common interest, where joint decision making is needed.

This council is not a requirement of the new arrangements but builds on the experience of collaborative working with the 31 London PCTs. For the council to be of value it must be wholly owned by CCGs, help deliver the CCGs' agenda, be focused, and low cost.

2. Issues where CCGs may need to work together?

- To coordinate commissioning plans and leverage, where more than one CCG uses the same provider.
- To redesign specific clinical services or types of service, e.g. emergency provision across different providers or a wider area.
- To share financial risk
- To coordinate arrangements for securing commissioning support especially where it makes sense to do this 'once for London' from a single supplier.
- To work together to ensure commissioning support services deliver that CCGs require

- To speak with a unified voice to the NHS Commissioning Board, the London Clinical Senate and the London arms of other national NHS bodies
- To have a coordinated approach and dialogue with key partners which operate at London level e.g. the Mayor and GLA, London Councils and the London Health Improvement Board.
- To provide peer support, networking and learning opportunities for CCG leaders and CCG staff.
- To coordinate other functions which are the responsibility of CCGs e.g. continuous improvements in the quality of services.

3. Aims of the London Clinical Commissioning Council

a. To be a forum for CCGs, run by CCGs to manage CCG shared business

b. To provide a vehicle for CCGs to make collective decisions where more than one CCG is needed to achieve an aim

c. To effectively manage any powers the constituent CCGs chose to invest in it

d. To be effectively run by a small versatile team who

- Can work on and help resolve joint issues

- Keep the agenda focussed and be decision orientated

- Communicate effectively with all parts of the system

4. Rules of engagement

- The Chair has been duly elected for a term of two years.
    - The Chair is Howard Freeman

- Governance arrangements
    - The Council will meet bi-monthly, from July 2012, and be organised by the Office of PCT CEs. Invitations for the meetings will be sent out at least one month in advance of the next meeting. Meetings will run from 6pm – 8pm preceded by a light supper from 5pm.
    - Deputising, when circumstances dictate clinical leads may nominate a deputy for the meeting, (remembering that it is impossible to maintain the clinical emphasis for the meeting).
    - Quoracy, the meeting shall be considered quorate if 12 clinical leads are in attendance.
    - Decision making, each CCG of the council has one vote. The Chair holds the casting vote.
    - When necessary representatives from other organisations may be asked to attend the meeting to present or engage in relevant discussion.

- This Council focuses on CCG clinical leads, but the full network of collaborative activities will need to include CCG officers.

- The Council would agree a work programme of issues where collaboration would be beneficial

- Other agencies and organisations have previously provided effective support to the Clinical Commissioning Council. Membership of the Council needs to be reappraised in the re-worked constitution.

5. Officers networks

- Much of the collaborative work for CCGs is likely to be carried out by the Chief Officers of the CCGs. A Chief Officers network has been established to run in parallel with this group.

6. Revisions to the Terms of Reference

- The ToR for the Clinical Leads will be revised annually.

Appendix B

Draft Proposals

Financial Risk Sharing across South East London CCGs

1. Introduction and Context

SE London CCGs are collaborating to mitigate and effectively manage financial risks, working together and with other health partners and public sector organisations. Agreed risk sharing approaches have been used effectively over 2011/12 and will be kept under continuous review to ensure that they incentivise good performance, avoid untoward incentives and can demonstrate best practice stewardship in the use of resources.

It is recognised that risk is best managed by those best able to address the specific risk. As such there is no single place that financial risk management will best be delivered. A range of risk management approaches are encompassed within our overall risk sharing framework including actions through;

- Individual CCG financial controls and governance through budgetary and other risk and contingency management frameworks
- Risk sharing with local commissioning partners, including local government, such as through joint commissioning arrangements
- Risk sharing with providers through contractual agreements to incentivise service change and QIPP delivery
- Risk sharing and pooling across CCGs to reflect approaches to sharing risk in specific commissioned services and to support the delivery of shared programmes
- Mutual Financial Aid to support delivery of individual CCG financial targets in the short term, assist recovery and sustain ongoing strategic direction without destabilising the health economy.

Agreed risk sharing approaches are embedded in agreements between organisations and where appropriate Memorandum of Understanding will be put in place setting out the joint agreements of CCG Boards. This builds upon the approaches developed during the period of shadow working across the six PCTs in the SE London Cluster, operating through six shadow Clinical Commissioning Groups with delegated financial responsibilities.

Each of the six SEL CCGs retain individual accountability for the management of the CCGs financial risk. All CCGs set aside a proportion of its recurrent budget for this purpose including a general 0.5% contingency reserve and through the use if other non recurrent resources. This is overseen and assured through CCG's own governance arrangements reporting to CCG Governing Bodies in order to ensure that CCG financial statutory duties are met and that the CCG's financial objectives in support of their health strategies are achieved. The SEL Clinical Strategy Committee, with membership of CCG Chairs and Chief Officers, will have the oversight of the development and operation of SE London-wide risk sharing approaches under delegated authority from CCG Governing Bodies. The LSL Integrated Governance Committee and BBG Integrated Governance Committees will support CCGs in the operational management of risk sharing approaches within secondary care contract management.

The six South East London CCGs will be implementing the Transforming Community Based Care (CBC) programme developed in support of the Trust Special Administrator (TSA) programme across South London Healthcare Trust and wider South East London. In addition to funding raised through driving efficiencies within providers, and possible transitional funding provided nationally, this will need a level of funding within CCGs to ensure community and primary care resource is delivered. This will include double running and implementation costs.
It is proposed that 0.5% to 1% of CCG 2% non recurring funding is used to further develop and implement the CBC transformation programme. A further 0.5% to 1% will be used for additional internal QIPP transformational initiatives, with 0.5% being used by each CCG as an internal reserve available to support the principles of this risk management arrangement.

2. Framework for Financial Risk Management across South East London CCGs

We have defined through our financial risk management approaches a clear and stratified approach, as follows:

- Risks managed by individual CCGs and through local shared arrangements joint commissioning arrangements

- Risks managed through collaborative CCG risk sharing commissioning arrangements

- Risks managed through Mutual Financial Aid arrangements to ensure all CCGs in SE London can support each other achieve their annual financial outturn targets in a way that supports the SEL health economy to support sustainable underlying financial balance. Arrangements to be incorporated into a Memorandum of Understanding setting out the conditions under which Mutual Financial Support is given or received and the obligations on the partners.

- Risks around the implementation and transition period of the Trust Special Administrator (TSA) programme across South East London, including

implementation of the community based care transformation programme and internal CCG QIPP programmes

Approaches to each if these elements of our Framework are Arrangements are set out below;

3. Risks managed through individual CCGs

Each CCG has financial reporting and risk management arrangements in place around key areas of expenditure. This is part of normal business to meet individual commissioning outcomes and targets. For these areas the CCGs will share information, and good practice, but will manage the financial risk individually often working with borough partners.

Examples include;

CCG Specific Provider risk shares

- Individual risks agreed within some Acute providers
- Existing pooled budgets and shared commissioning arrangements, e.g. mental health pool with a risk share with an NHS trust and the Council.
- Risk shares with Community services at Guys, Lewisham, or Oxleas around individual services or shared agreements to manage demand growth.
- Individual agreements around a key local service, or its redesign.
- Risk share on forensic/complex placements with SLAM

CCG Specific Local authority and other key partner risk shares

- Specific S.75 and S.256 risk sharing agreements for example on placements or additional investment in Social Care services.
- Agreed handling through local Partnership arrangements to manage shared resources such as substance misuse shared programmes to address in partnership changes in available resources across commissioners.

- Joint approaches with local government social care commissioners to commissioning from private sector providers, for example addressing voids in nursing home contracts

- The scale of these approaches vary depending on the nature of the commissioning budget and exposure to risk.

4. Risks managed through collaborative CCG risk sharing commissioning arrangements

CCGs already have in place a wide range of effective risk sharing arrangements in place to support the shared commissioning of specific services and programmes or to reflect shared contracting arrangements negotiated with providers. Some of these operate at a South East London wide level whilst others operate across groupings of CCGs, often reflecting shared contracting approaches with specific providers or shared programmes of work. CCGs will continue to evaluate the effectiveness of our approaches and consider further opportunities to better manage risk through common approaches with providers or to smooth impact where financial impact is unpredictable across CCGs. These will be reviewed through the development of our annual Integrated Plans and through contract negotiation strategies developed by our shared CCG led contracting teams with providers. In doing so the appropriate level of commissioner risk sharing will be reviewed, for example CCG contracting partners, LSL/BBG, SEL or beyond SEL.

Current and potential risk sharing areas;

A. Shared CCG contracting approaches with providers

- Acute contract pressures on tertiary services with hospital providers

- Acute pressures on elective and emergency activity with hospital providers

- Delivering key national performance and outcome standards and CQUINs

- Impact of SLHT solutions for 2013-14 onwards, which may embrace effects on all 6 CCGs.
- Management of the impact of Payment by Results implementation in mental health.

- Implementation with providers of service transformation initiatives, such as through integrated care approaches

- Supporting the introduction of new drugs on a trial or full basis

B. Shared approach to CCG risk sharing for commissioned services

- Implementation of shared CCG initiatives and programmes, including transformational QIPP and out of hospital care programmes such as 111, integrated care programmes etc.
- High cost low volume services with unpredictable demand
- Specialised services overspends
- Supporting the introduction of new drugs on a trial or full basis of new drugs
- London-wide or other network based implementation of new strategic improvement initiatives
- Continuing care
- Supporting organisational change and transition across the health system, including infrastructure improvement such as shared information systems
- Specific organisational risks such as the impact of mental health investigations

5. Mutual Financial Assistance across CCGs

CCGs have already recognised that it is in the interests of the whole SEL health economy to support all commissioning organisations to be in a position of underlying financial balance, with robust affordable plans in place to address health improvement and to manage growing demand services. Through our collaborative working we have developed shared approaches to strategic planning aimed at supporting the ambitions of SEL CCGs and addressing the challenges they face. This includes implementation of the challenging TSA recommendations, including the community based care transformational programme. The six CCGs recognise, however, that in the short to medium term individual CCGs may require mutual financial assistance to ensure they can all continue to deliver their annual financial statutory responsibilities and support the delivery of their underlying strategic direction.

During 2011/12 and 2012/13 arrangements for Mutual Financial Aid have been put in place to support the agreement of balanced financial plans across the six boroughs. This will be reviewed further as part of developing our approach to service and financial planning going forward. This has enabled all six SEL PCTs and shadow CCGs to successfully deliver their financial control totals in 2011/12 and supports the delivery of our 2012/13 financial plans.

This approach has been supported by the use of 0.5% contingency reserves, alongside the availability of 2% non recurrent resources to support strategic change and fund transitional cost pressures. In future years it is envisaged that this 2% will be used to fund the implementation of CBC to support the success of the TSA recommendations, and provide more and better care closer to home; and other QIPP schemes, and internal reserves to ensure the financial sustainability and viability of the CCGs. In seeking to take forward this approach SEL CCGs are considering the application of an additional 0.5% recurrent contingency fund to be set aside by the six CCGs from 2013-14, to create an collaborative risk reserve, on top of existing CCG 0.5 % contingency reserves. This would give a fund of circa £14 million to give the range of cover for achieving overall financial balance in any one year across all 6 CCGs. Any CCG whose financial position allows for further in year flexibility and wishing to contribute more, to assist its peers will be supported to supplement this contingency fund. The uncertainty in relation to the allocation of resources to CCGs including the approach to management of distance from allocation targets will need to be considered as this could have a significant differential impact on individual CCGs.

Based on the principles of mutual financial support, any assistance with achieving target balance and surplus positions should be repayable over no more than 2-3 years. Any CCG receiving mutual financial aid will need to have a recovery plan in place agreed with the partners setting out assurance as to how this will be delivered. Those CCGs who are already in an agreed planned recovery position will contribute less in the short term to avoid short term deterioration and equity of contribution will be addressed through agreement of the duration of payback period, within a maximum of 3 years.

This approach has been agreed by all SE London CCGs, and will be considered alongside the development of CCG Commissioning Strategy Plans and annual Integrated Plans for submission to NHSCB. Oversight and collective decision making will be through the SEL Clinical Strategy Group, as a committee of the six CCGs. Annual approaches to risk sharing will be informed by proposals developed by Chief Officer and Chief Financial Officer Groups who will also address issues of operational management, reporting and assurance to the SEL CSG.

Annual arrangements will need to take into account the annual operating frameworks as set out in NHS Commissioning Board guidance. This will include, for example, clarity on the treatment of carry forward arrangements for PCT/CCGs surpluses and deficits which is not set out in the Health and Social Care Act 2012 and the requirement, and availability, of 2% funds currently within PCT baselines.

2013/14 Budget Setting Timetable

Start Date	Action Owner	Target Completion Date	Task	Date Completed
29 August 2012	Julie Witherall	**29 August 2012**	New Environment Created on Business Planning System	**29 August 2012**
14 September 2012	Julie Witherall	**23 September 2012**	New CCG Budget Hierarchy Agreed with CFO	**23 September 2012**
25 September 2012	Directors	**15 October 2012**	Future Investments / Cost Pressures and Savings Identified	**15 October 2012**
03 October 2012	Julie Witherall	**03 October 2012**	Budget Setting Methodology Agreed with CFO	**03 October 2012**
12 October 2012	Maria Daly	**12 October 2012**	2012/13 Initial Budgets Downloaded into Planning Template as at Month 6	**12 October 2012**
15 October 2012	Maria Daly	**17 October 2012**	2012/13 Budgets as at Month 6 Starting Point to be Updated for: Forecast Outturn; New Business Cases; Known QIPP; Non Recurrent Items; Part Year Effects; Increment Points; Planning Assumptions - Inflation; Efficiency; Demographic and Non Demographic Growth.	**17 October 2012**
18 October 2012	Maria Daly	**19 October 2012**	Copy Initial Planning Template to Second Planning Template which uses TSA Assumptions	**19 October 2012**
25 October 2012	Theresa Osborne	**26 October 2012**	Initial Budgets to be Reviewed by CFO (Initial and TSA Planning Assumptions)	**02 November 2012**
29 October 2012	Maria Daly	**30 October 2012**	Amendments to budgets based on CFO review	**24 November 2012**
31 October 2012	Maria Daly	**31 October 2012**	Initial 2013/14 Budgets to be Issued to Directors and Budget Holders (TSA Assumptions)	**24 November 2012**
01 November 2012	Maria Daly/Sandra Ackland/Martin Kayes	**16 November 2012**	1:1 Budget meetings held with Directors and Budget Holders to Discuss 2013/14 Budget Commitments / Requirements. Discussions and Assumptions Documented. Evidence of Expected Spend, Timing of Expenditure Obtained, Filed and Recorded on Business Planning (templates completed to be used to inform discussion)	**Being held between 24/11/2012 and 04/12/2012**
19 November 2012	Maria Daly	**23 November 2012**	Adjustments Made to 2013/14 Budgets and Revised Budgets Sent to Directors and Budget Holders for Confirmation and Sign Off of Interim 2013/14 Requirements and to Check Omissions / Duplication and Savings	**Request for comments back by 07/12/2012**
26 November 2012	Sandra Ackland	**07 December 2012**	Ensure all Interim Budget Sign off Forms are Received and Filed	**On target for delivery**
03 December 2012	Theresa Osborne	**07 December 2012**	Draft CSP/Budgets Report on progress to Governing Body for 20th December	**On target for delivery**
03 December 2012	Theresa Osborne/Julie Witherall / Maria Daly	**16 December 2012**	CSP Financial Template Submitted - CFO approved	**N/a**
14 December 2012	Maria Daly	**14 December 2012**	Agree/Reconcile CCG Budget to CCG Allocation	**21 December 2012**
17 December 2012	Theresa Osborne/Julie Witherall/Maria Daly	**21 December 2012**	Review budgets based on CCG allocation and make necessary adjustments prior to re-issue of budgets	**21 December 2012**
03 January 2013	Maria Daly/Sandra Ackland/Martin Kayes	**17 January 2013**	1:1 Budget meetings held with Directors and Budget Holders to discuss 2013/14 budgets based on revised allocations and to establish if adjustments are required	**To be issued early February**
14 January 2013	Theresa Osborne	**14 January 2013**	Operating Plan Submission	**14 January 2013**
14 January 2013	Maria Daly	**13 February 2013**	Adjustments made to 2013/14 Budgets based on the revised allocation and discussions with Directors etc	
14 February 2013	Julie Witherall	**14 February 2013**	Progress Paper on Final Budgets and Paper Sent to Finance Working Group & Executive Committee	**06 February 2013**
22 February 2013	Julie Witherall	**22 February 2013**	Progress Paper on Final Budgets Discussed at Finance Working Group Prior to Presentation at Integrated Audit Committee	
24 January 2013	Julie Witherall Maria Daly	**25 February 2013**	FIMs Plan Submission	
14 February 2013	Theresa Osborne/Julie Witherall	**28 February 2013**	Budget progress paper presented to Executive Committee	
01 February 2013	Theresa Osborne	**28 February 2013**	Agreement of 2013/14 SLAs with Providers	
01 March 2013	Julie Witherall	**01 March 2013**	Progress Paper on Final Budgets and Briefing Paper Sent to Integrated Audit Committee	
01 March 2013	Sandra Ackland	**04 March 2013**	Updated Authorised Signatory Forms Distributed to Budget Holders	
01 March 2013	Theresa Osborne	**07 March 2013**	Directors to discuss budget paper prior to being presented to Integrated Audit Committee etc	
08 March 2013	Theresa Osborne/Julie Witherall	**08 March 2013**	Budget Presented to Integrated Audit Committee for Approval	
11 March 2013	Julie Witherall	**11 March 2013**	Final Budgets and Briefing Paper Sent to Governing Body Members	
07 January 2013	Martin Kayes	**15 March 2013**	Budget Holder's Handbook and Procedure Manual Updates Distributed to all Budget holders	

Start Date	Action Owner	Target Completion Date	Task	Date Completed
07 March 2013	Directors and Budget Holders	**11 March 2013**	Receipt of Signed Authorised Signatory Forms from Budget Holders	
21 March 2013	Theresa Osborne	**21 March 2013**	Budget Presented to Governing Body for Approval	
21 March 2013	Sandra Ackland	**22 March 2013**	Final Signed 2013/14 Budgets Distributed to Directors and Budget Holders	
22 March 2013	Sandra Ackland	**31 March 2013**	Ensure all Final Budget Sign off Forms are Received and Filed	
22 March 2013	Martin Kayes	**31 March 2013**	Prepare Budget Journals for Upload to GL when Available	
01 April 2013	Sandra Ackland	**04 April 2013**	New Authorised Signatory Forms Sent to Commissioning Support Unit	
18 April 2013	Martin Kayes	**30 April 2013**	New Budgets Uploaded on to General Ledger	
Ongoing	Maria Daly Sandra Ackland Martin Kayes	**Ongoing**	Budget Holder's Training & Guidance Given to Budget holders as Necessary	

Issues/Decisions

dates unsure