

[DRAFT]

*Getting better*

**NHS Brent**

**Medium Term Financial Strategy**

**2009 to 2014**



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# **SECTION 1: BACKGROUND, OBJECTIVES & CRITICAL SUCCESS FACTORS**

## **1.1 Background**

A Medium Term Financial Strategy (MTFS) was incorporated in the 2008 Commissioning Strategy Plan and the improvement in medium term financial planning in NHS Brent during 2008 was reflected in an improved Use of Resources assessment in 2008/09. The following key drivers have made the development of an updated MTFS for NHS Brent a priority.

- The requirement for a refreshed medium term financial strategy and projections to support the PCT's 2009 Commissioning Strategy Plan
- The strategic changes in service commissioning and provision as a consequence of the implementation of Healthcare for London need to be supported by robust and affordable PCT financial strategies
- The tighter economic climate now forecast

The development of a MTFS will also help facilitate sustainable relationships with other organisations within the local health economy including other PCTs and NHS providers through the NW London Sector's Integrated Strategic Plan (ISP).

The Brent PCT MTFS covers the 5 year period 2009/10 to 2013/14. It builds on the previous MTFS, the financial and service plans for 2009/10 as set out in the PCT Operating Plan and budgets in-year performance (to month 6) and the 09/10 forecast outturn. It has been developed as an integral part of Brent's overall strategic plan.

The MTFS also incorporates an assessment of the relative performance of the PCT drawing on a range of financial and efficiency benchmarking data. This has become more refined over 2009 as the quality and range of comparative data available for benchmarking purposes has improved and the analytical capacity and capability of the PCT has increased.

The MTFS is a commissioning based strategy and incorporates the PCT provider arm (Brent Community Services) as a commissioned service.

## **1.2 Objectives**

10 key objectives of the MTFS have been established and are set out below.

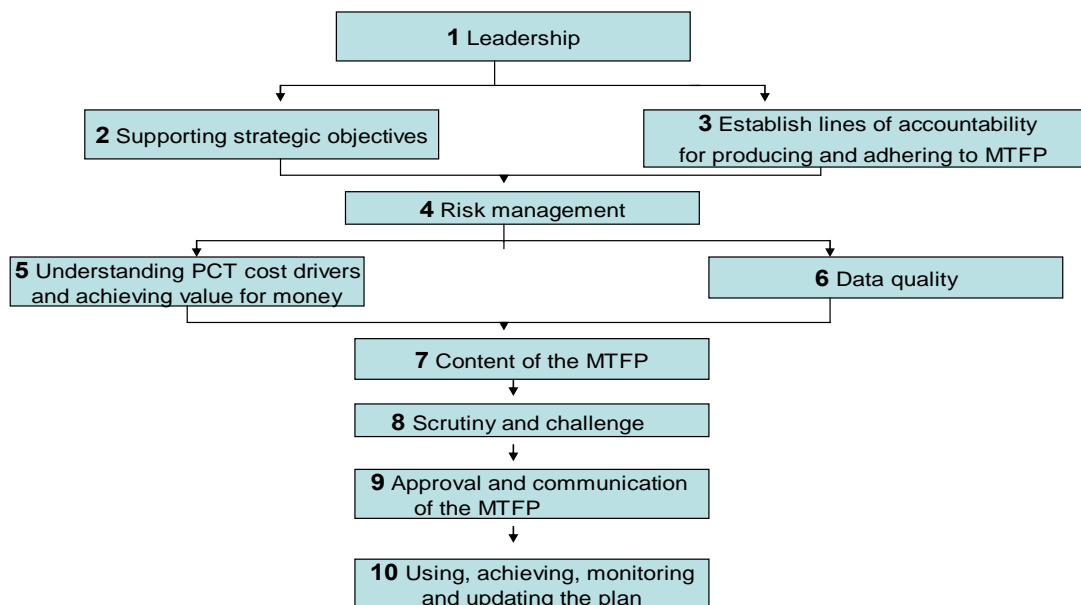
- Clearly linked to, and embedded in the PCT's overall strategy plan
- To ensure continued underlying financial stability in order that the improvement in financial standing achieved in recent years is maintained through a focus on the underlying recurrent position and the achievement of a minimum 1% surplus across all years and all scenarios
- To incorporate credible planning assumptions, including benchmarked savings plans and realistic timelines and delivery plans
- To incorporate a rigorous risk assessment with associated mitigation strategies
- To support the continued delivery of increased efficiency and effectiveness of spend
- To test the robustness of the projections through sensitivity testing and scenario planning, and to ensure flexibility in planning to respond to different scenarios

- To establish a clear process and key metrics to monitor progress and realign plans where necessary
- To incorporate revenue, capital, cash and balance sheet projections
- To ensure plans are underpinned by strong corporate financial management, governance and systems
- To ensure alignment between the MTFS and the annual Operating Plan and budget setting process

An assessment of the extent to which the MTFS achieves these objectives is set out in section 16.

### 1.3 Critical Success Factors in Development of MTFS

The following requirements and characteristics have been identified by the Audit Commission as critical success factors in the development of a meaningful and relevant MTFS.

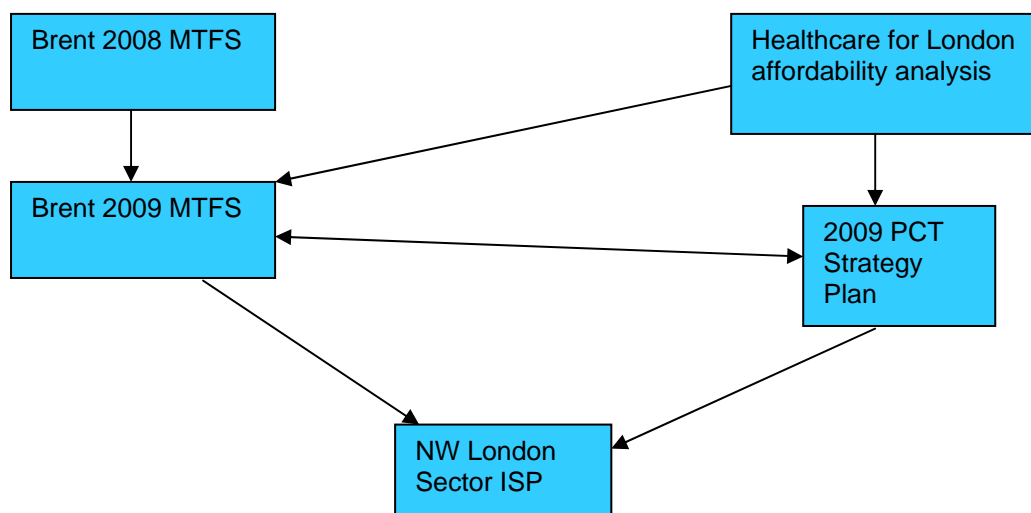


The Brent MTFS directly addresses the above requirements. An assessment is undertaken of the MTFS (in section 17) against the above criteria.

## SECTION 2: Approach to development of MTFS in Brent

### 2.1 Overall approach

The approach to the development of the 2009 MTFS including key timelines and linkages to the wider development of the PCT's strategy and the NW London Sector ISP is set out below.



### 2.2 Planning for the Downside –NHS Brent Approach

All PCT's have been asked to submit financial projections under three scenarios (best, base, downside) and NHS London have issued allocation uplift assumptions for each. The advice from the SHA is that Working through the implications of the base case, together with the downside case or 'flat cash' scenario (currently shown as the downside case in the planning assumptions and affordability model), should be the main focus for PCTs in their December WCC submissions.

**Having considered the assumptions, our weighted capitation position (currently £37m above target), and the difficulties and risks of developing and implementing significant efficiency and disinvestment plans without sufficient planning, the PCT's approach has been to explicitly assume the downside allocation scenario within our 'base case' and plan accordingly.**

Our approach has therefore been to:

- Assume the downside allocation scenario and plan accordingly (i.e., the downside allocation scenario of 'flat cash' is NHS Brent's base case)
- Develop a credible efficiency and disinvestment plan to meet the above.
- Undertake a rigorous risk assessment of our plan
- Demonstrate that the above produces a sustainable financial position across all of the years of the plan
- Consider how we would respond to other funding scenarios

This approach is felt to be both the most prudent and also in the best interests of the local health economy, as it is preferable to develop plans now for the downside, with headroom for further investment should the downside not happen, rather than respond to the downside at a later date.

This approach has been endorsed by both the Executive Management Team, the Finance and Investment Strategy Group (FISG), and the Board as a whole.

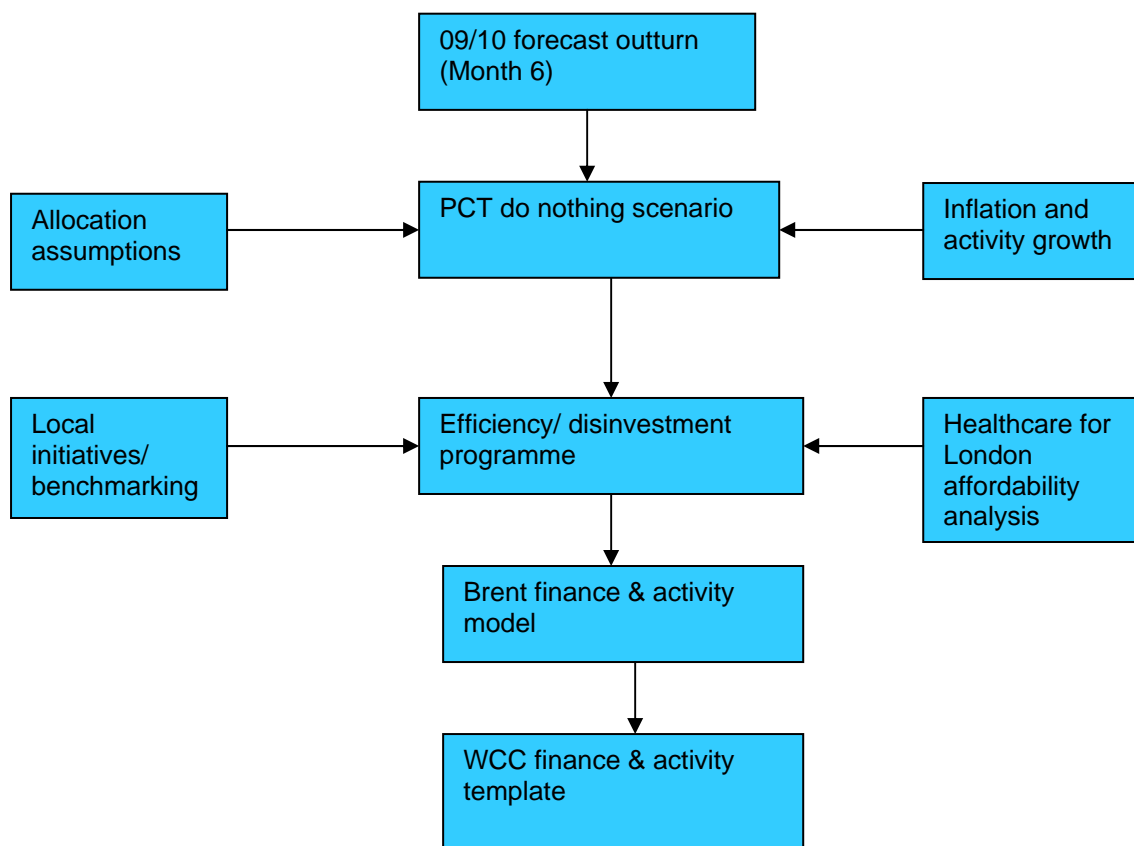
Also, we have been honest with stakeholders about the challenge of making significant savings by finding innovative ways to boost the quality, efficiency and productivity of services and of the need for transformational change. Having recently emerged from financial turnaround there has been strong agreement from all stakeholders that NHS Brent needs to remain financially strong; that to achieve this strength will require fundamental change to the ways that services are commissioned and delivered and that doing less of the same is not an option and that this change can only be achieved through working in partnership.

### 2.3 Modelling Approach

The modelling approach adopted has been designed to facilitate the completion of the national Finance & Activity template, whilst also:

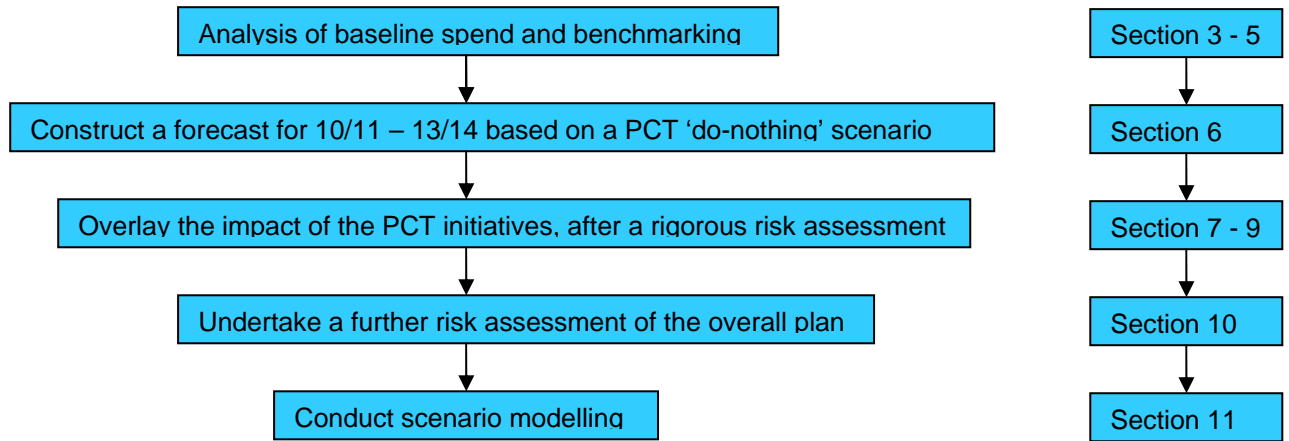
- Providing the level of detail at specialty or setting level to enable plans to be developed to implement Healthcare for London (HfL) including modelling the shift of provision of care for a range of services from acute to out-of-hospital settings
- Further developing our understanding of commissioning spend and activity in order to be in the position to make informed and transparent investment and disinvestment decisions and maximise value for money

In order to achieve the above a local finance & activity model has been built and the model architecture is summarised below.



## 2.4 Modelling Phases

The financial and activity modelling has involved five distinct phases as set out below:



## **SECTION 3: BASELINE FINANCIAL POSITION**

### **3.1 Historical Context and Financial Performance**

In 2006/7 the PCT ended the year with a £25m financial deficit. The origins of the significant financial and governance failures in Brent were documented in an independent report (the Taylor enquiry). As a result the PCT implemented a turnaround plan in 2007/08, and at the same time a new Board was assembled. In both 2007/08 and 2008/09 the PCT achieved all of its Statutory Financial duties as follows.

- Underspend against Revenue Resource Limit in 2007/8 of £1.7m (against a plan of breakeven). This outturn position included the repayment of approx £15m of the PCT's 06/07 deficit.
- Underspend against Revenue Resource limit in 2008/09 of £12.6m (against a plan of £12.4m). This outturn position included the repayment of the balance of approx £10m of the PCT's 06/07 deficit
- Underspend against Capital Resource Limit of £8.9m in 2007/08 and £0.3m in 2008/09
- Underspend against cash limit of £16.8m in 2007/08 (after the repayment of the cash advance of £10.8m provided by DH in 2006/7), and £28.4m in 2008/09

Michael Taylor returned to the PCT during 2008/09 to conduct a follow up review and his report was a positive affirmation of the action taken to improve financial management as well as wider governance issues.

### **3.2 ALE/Use of Resources Assessment**

The PCT's historic weakness in financial management was reflected in the lowest possible ALE score (weak) in both 2006/07 and 2007/08. The PCT's Use of Resources rating in 2008/09 reflected the significant improvements made. In particular, in respect of 'quality of financial management', the PCT has moved from 'weak' in 07/08 to 'good' in 08/09.

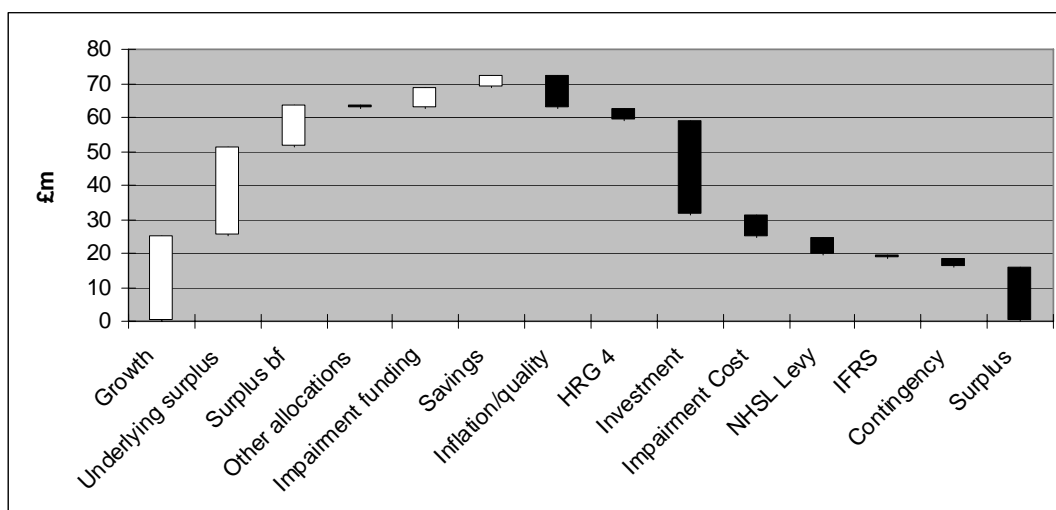
Sections 13 & 14 describe in more detail both the improvements made to date in financial management, together with the ongoing plans for further development.

### **3.3 Financial Plan 2009/10**

The PCT's financial plan for 2009/10 is set out in detail in the Operating Plan and detailed budgets which were agreed at 2 April 2009 PCT Board. The Operating Plan for 09/10 was also agreed by the SHA in March 2009.

The plan was for a forecast surplus on the revenue resource limit of £15.9m.

The chart below shows the summary sources and applications of funds in the 2009/10 plan.



The plan included a significant investment programme, which it was agreed would be re-profiled if acute contracts significantly over-performed.

### 3.4 Month 6 and Forecast outturn 2009/10

The year to date and forecast outturn surplus at month 6 is summarised below.

	Plan £'000	Actual £'000	Variance £'000
Year to Date (month 6)	11,786	8,821	(2,965)
Forecast outturn	15,954	15,959	5

The major areas of variance (adverse and favourable) against plan are set out in the bridge analysis below.

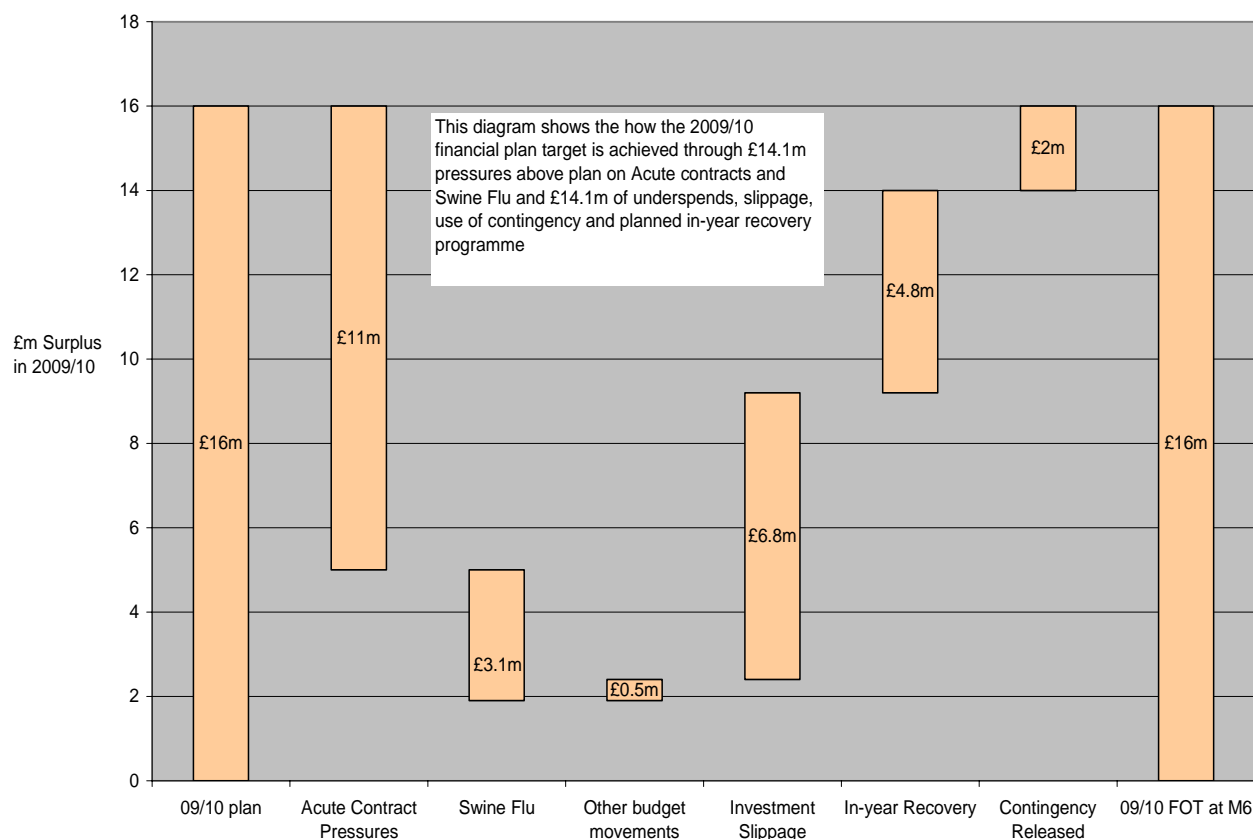
The major adverse variance has been in respect of acute commissioning. The PCT identified this variance at an early stage and promptly responded by re-ordering its activities and establishing an Acute Recovery taskforce, the terms of reference of which include:

- Ensuring resources for acute commissioning are in place until the NWL ACV is operational
- Ensuring the right information is received by PBC and the management team to address the acute spend
- Reviewing demand management activity and PBC engagement in it
- Ensuring PBC is set appropriate objectives and resources are aligned to enable them to undertake their role, including freeing up senior clinical time if appropriate
- Ensuring the appropriate contract challenge is presented to providers are the right representation is achieved at contract review meetings
- Reviewing whether external support should be accessed
- Ensuring links are made, and concerted action is taken, with other local commissioners e.g. Harrow PCT

As a result of these actions, together with a full review of other budget areas, the PCT at month 6 was able to forecast achievement of its 09/10 plan surplus of £16m.

For the remainder of the year, the PCT will be actively seeking opportunities to maximise the recurrent surplus at 31/3/10 to mitigate the risk of future plans.

### Achievement of the 2009/10 planned surplus forecasted at M6



### 3.5 Underlying Recurrent Financial Position

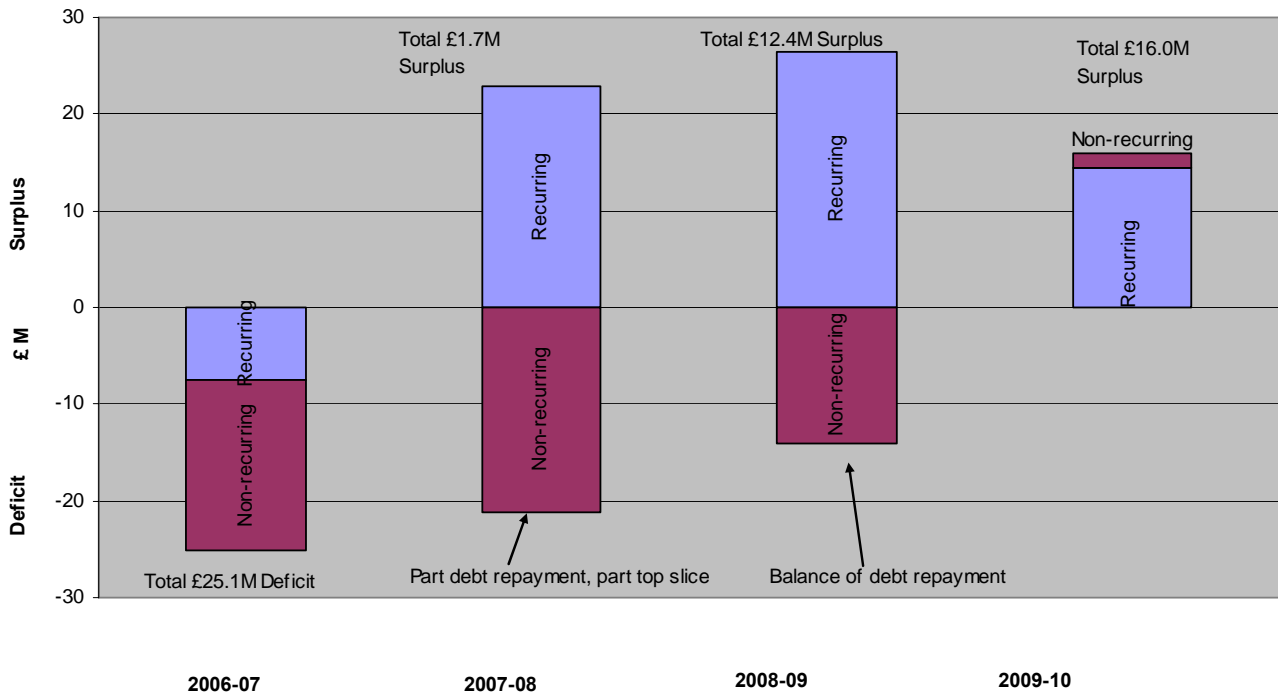
In order to understand and monitor the PCT's financial position, and to ensure ongoing financial sustainability, it is essential to distinguish between recurrent and non-recurrent income and expenditure.

A summary of the PCT's underlying financial position over the 4 years 06/07 – 09/10 is summarised below.

Year	06/07 £m	07/08 £m	08/09 £m	09/10 FOT £m
Recurring	(7.5)	22.8	21.6	10.0
Non-recurring	(17.6)	(21.1)	(9.0)	6.0
Total	(25.1)	1.7	12.6	16.0

The table illustrates the movement from the £25m bottom-line deficit in 2006/07 to the surplus forecast for 2009/10 of £16m. The recurrent position has been similarly transformed, with the forecast closing position for 2009/10 being an underlying surplus of £10m.

The 08/09-09/10 recurrent movement is due to a combination of the PCT's planned investment programme plus the unplanned increased spend on acute contracts during 09/10. It should also be noted that there is a balance to full year effect impact of 09/10 investments and in-year recovery measures which is factored into the 10/11 forecasts in section 6.



## SECTION 4: BASELINE ACTIVITY POSITION

### 4.1 Activity Summary

The table below summarises the 09/10 forecast outturn activity and the key points

Care setting		Currency	09/10 FOT
PRIMARY & COMMUNITY	GPs	Attendances	1,215,719
	Prescribing	No. of prescript.	3,951,296
	Dentistry	UDAs	527,402
	Community	Spells	356
		Outpatients att.	30,056
		Contacts	350,299
	GP Led HC	Attendances	22,092
MH & LD	Mental Health	IP bed days	66,529
		Other contacts	78,145
	LD	Contacts	1,582
CC	Continuing care	No of patients	593
SECONDARY/ TERTIARY ACUTE CARE	NHS/FT	Elective spells	8,216
		PSD procedures	25,814
		Non-elec. spells	34,711
		OP attendances	339,523
		A & E att.	137,066
	Ambulance	No. of calls	53,104
		No of journeys	52,188

### 4.2 Information Management (including Data Quality)

The PCT has focussed on developing Information Management as a key part of its 2008 OD plan and an overarching Commissioning Intelligence Information Strategy (CIIS) was agreed by the Board in July 2009 and is being implemented.

The purpose of the CIIS is to define the actions required for NHS Brent to achieve top World Class Competency and Use of Resources ratings in its use of information to improve health in Brent.

The strategy is supported by a project implementation plan covering the period to March 2010 at which point progress will be reviewed and a 2010/11 implementation plan produced in line with 2010/11 NHS Brent Corporate Objectives.

The strategy and implementation plan covers the actions needed to:-

- Ensure the provision and use of information required to develop and deliver our initiatives as set out in the CSP
- Support delivery of our performance improvement plans
- Enable effective commissioning and contract management including data for Practice Based Commissioners.
- Improve data quality
- Improve information governance and specifically the Information Governance toolkit requirements
- Improve the knowledge, skills and tools across the PCT including working with North West London Commissioning Partnership and Commissioning Support for London.

Implementation of the plan is well underway. Progress is monitored through an Implementation Board, Chaired by the Chief Executive who are accountable for delivering the

benefits. Sponsorship for the Programme is held at Director level and regular updates are provided to the Board.

Specific improvements during 2009 have included the following (which includes some of the specific feedback in the WCC 2008 panel report).

- Development of a Data Quality Strategy and monthly monitoring of progress through a Data Quality Dashboard
- Mental Health – development and reporting of service line reporting and improvements in data quality
- Community Services - development and Implementation of a Data Quality Improvement Plan
- Primary Care – Implementation of a data cleansing project to improve the quality of our Child Immunisation records with over 4,000 records cleansed.
- Acute – the continued development of claims management prior to the handover to NW London Acute Commissioning Vehicle (ACV).

Continued improvement is planned for 2010/11 onwards, as outlined in our OD plan, focussed on:

- Continuing to improve the quality of data
- Embedding a culture of advanced analysis and modelling
- Continued development of investment and disinvestment processes
- Ensuring the information flows and analysis to enable the monitoring and delivery of our key CSP initiatives

## **SECTION 5: FINANCIAL AND EFFICIENCY BENCHMARKS**

### **5.1 Scope for benchmarking**

As part of developing the MTFs and the Strategic Plan the PCT has assessed its performance as a commissioner of services on behalf of the Brent population on a comparative basis with other PCTs, using a wide range of measures, including those available from the NHS Institute for Innovation and Improvement, Dr Foster, the WCC data pack together with analysis undertaken by the PCT itself.

### **5.2 Summary**

The benchmarking analysis undertaken is summarised in appendix 1 (a more detailed pack of information has been produced internally). [Appx. 1 to follow]

## SECTION 6: PROJECTIONS (PRE-INITIATIVES) 10/11 – 13/14

### 6.1 Introduction

This section focuses on the identification and measurement of the key income assumptions and cost drivers for the financial model under a PCT 'do nothing' scenario.

### 6.2 Downside Allocation Assumptions

The following allocation cash uplifts have been assumed:

YEAR	2010/11	2011/12	2012/13	2013/14
%	4.1	0.0	0.0	0.0

Whilst the allocation uplift for 2010/11 has previously been announced (at 5.1% for NHS Brent) it was felt prudent to plan on a lower figure of 4.1%. The zero growth for 11/12 – 13/14 reflects the NHS London downside assumption.

In accordance with NHS London guidance, we have assumed that carry forward of surpluses continue to apply. For 2010/11 we have included the second (and final) non-recurrent contribution to the London Challenged Trust process.

### 6.3 Identification of Cost Drivers

The factors influencing the future financial position of the PCT have been categorised into **external** (i.e. those driven by factors external to the PCT) and **internal** (i.e. those within the PCT's decision making).

In identifying external factors, the standard PESTEL (Political, Economic, Sociological, Technological, Environmental, Legal & Regulatory) approach has been adapted into two categories:-

- Economic, legal, regulatory and policy
- Demographic, technological and environmental

The economic, legal, regulatory and policy drivers identified include:

- 1) **Tariff Uplift** – the annual uplift to provider contracts to reflect the impact of inflation, service quality enhancements and provider efficiency gain
- 2) **Legal changes** – the forecast impact on PCT finances of legislation in relation to health and social care (e.g. continuing care)
- 3) **National policy changes / national Operating Framework** - the impact on the PCT of national/London policy initiatives in relation to health targets and priorities

The demographic, technological and environmental policy drivers identified consist of:

- 4) **Population growth and mix** – estimated changes in total population numbers, as well as the impact of changes within the overall population, including age, gender, ethnicity
- 5) **Other activity increases** – including the impact of changes in deprivation, the effect of key changes in lifestyle factors including smoking, drinking, obesity and diet, the financial impact of increasing patient expectations in relation to access to and quality of healthcare, and the effect of technological change within the NHS (including new drugs)

## 6.4 Cost Driver Assessment of Impact

An assessment of the specific impact of individual cost drivers on the PCT expenditure position has been made as follows:

- 1) Tariff uplift – the following tariff uplifts assumptions have been provided by NHS London:

YEAR	2010/11	2011/12	2012/13	2013/14
Tariff (incl. CQUIN)	4.7	3.5	3.5	3.5
Efficiency	(3.5)	(4.0)	(4.0)	(4.0)
Tariff (net)	1.2	(0.5)	(0.5)	(0.5)

For services not subject to tariff, the following has been assumed:

- non-PbR services provided by NHS Trusts/FTs (including community services, mental health, etc) – as above
- primary care – 1.5% inflation uplift per annum
- non – NHS (ISTC, continuing care, etc) – 1.5% inflation uplift per annum
- prescribing – 4% per annum (NB, national price reductions are included in the efficiency/disinvestment programme)

The overall weighted impact of the above tariff/price changes per annum is shown in the table below.

YEAR	10/11	11/12	12/13	13/14
% weighted increase	1.5	0.3	0.3	0.3

- 2) Population drivers

The assessments of both total and age mix population changes have been derived from the latest GLA estimates. The total Brent population is estimated to grow from 277,000 in 2009/10 to 291,000 in 2013/14, an overall increase of 5% across the next four years.

Within the overall growth position, higher than average increases in relation to the under 14 and over 75 age groups, both high consumers of health care resources are forecast. Brent is the most ethnically heterogeneous borough in the country and Brent's diverse communities have specific health needs associated with them. For example our Asian groups tend to have higher rates of diabetes and heart disease and develop these diseases about 10 years earlier than white groups, whilst black groups have higher rates of diabetes, hypertension and stroke and also develop these diseases earlier.

Prevalence estimates for key conditions highlight that many issues with which Brent is currently grappling are set to increase in scale in the coming years. For example:

- The prevalence of diabetes is expected to increase to around 8.5% of the adult population by 2014;
- Numbers of people with HIV or AIDS will increase by over 25% by 2014;
- Prevalence of key diseases such as hypertension, CHD and COPD will increase over the next 5 years;
- Health needs for Brent's ageing population will increase. The number of people over 75 with dementia is expected to increase from 2,027 to 2,226 between 2009 and 2014. Likewise the number of people with visual impairment in this age group is expected to increase from 2,760 to 3,140 over the same period.

## Other activity drivers

Much of the historic increases in activity have been driven by factors over and above demographic changes such as:

- Legal changes
- Policy changes
- National operating framework targets
- Impact of deprivation/lifestyle trends
- Impact of patient choice/expectations
- Increase in survival rates
- Technological developments

As it has not been possible to assess the individual impacts of each of the above, from a combination of NHS Brent historical trends and London/national data sources, activity and cost growth rates (over and above population changes) have been calculated for each major expenditure heading.

The results of above analysis is summarised below, with the % changes in cost and activity shown separately. In some areas, increases in activity do not translate into proportionate cost increases due to a combination of marginal cost rates applying and/or productivity in service provision.

Expenditure Category	Cost %	Activity %
Primary Care	1.0	3.0
Prescribing	3.0	3.0
Dental	1.0	3.0
Community	1.0	3.0
Mental Health	1.0	3.0
Continuing Care	3.0	3.0
Acute	4.5	4.5
<b>TOTAL (WEIGHTED INCREASE)</b>	3.0	

Clearly there is no 'correct' answer to the issue of assessing the future impact of individual activity and cost drivers. It is important therefore to attempt to validate the estimates within the MTFS with other external credible sources of data.

As an initial approach to validation, the % uplifts derived from the internal PCT modelling have been compared with the projected increases for the period 2008/9 to 2012/13 identified within the Wanless report of 2002. We have also reviewed the Healthcare for London modelling undertaken by NHS London.

The compound annual growth rate in cost is set out in the table below and compared with the Healthcare for London affordability assumptions.

	Brent	Healthcare for London		
	Base	Lower	Base	Upper
Overall spend weighted %	3.0	1.1	2.6	3.9

Overall, our assessment of the underlying growth rate is approx 15% above the 'base' rate assessed by Healthcare for London. We have modelled variations in our projections in our risk/opportunity assessment. (see section 10 below).

## 6.5 Summary of Financial position (pre-initiatives)

The forecast financial position for 10/11, as well as taking account of the above, also needs to include the balance to full year effect of 09/10 (both investments and non-recurrent in-year recovery measures), which is expected to have a net expenditure impact of 1.2%.

The expenditure impact of the cost, volume and 09/10 full year effect drivers are summarised below.

YEAR	10/11 %	11/12 %	12/13 %	13/14 %
Cost/tariff	1.5	0.3	0.3	0.3
Activity/volume	3.0	3.0	3.0	3.0
FYE of 09/10	1.2	-	-	-
<b>Total</b>	<b>5.7</b>	<b>3.3</b>	<b>3.3</b>	<b>3.3</b>

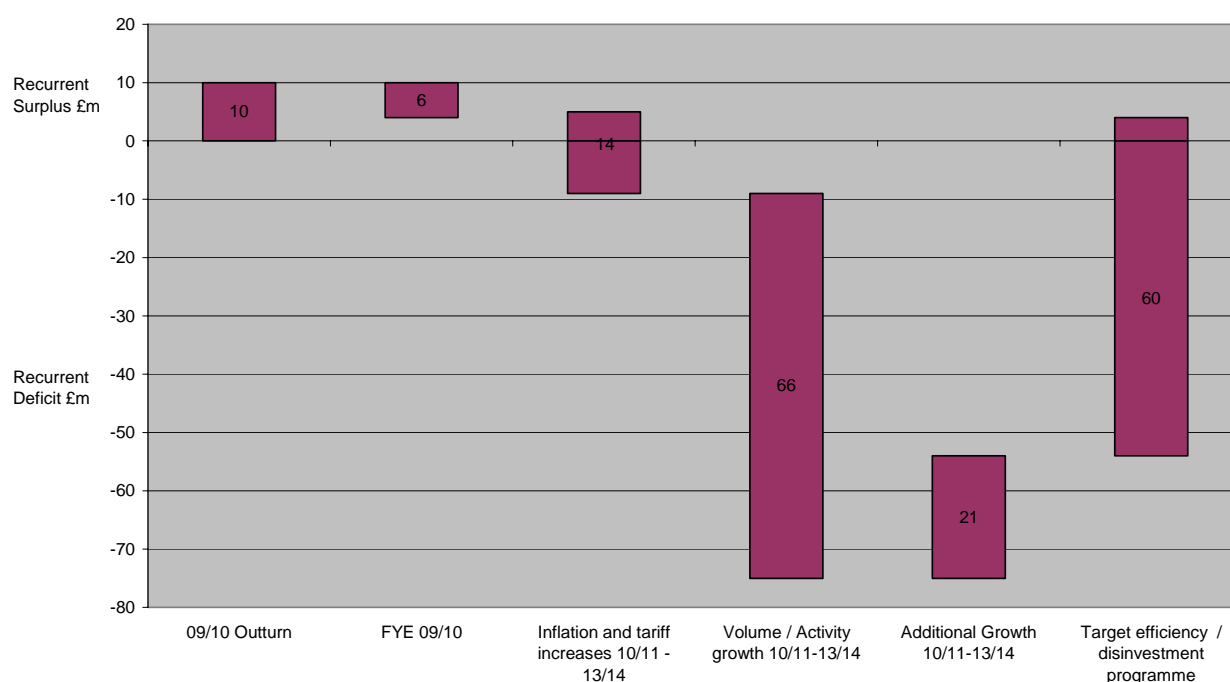
The financial modelling (pre-initiatives) summarised below indicates that the underlying recurrent position would progressively worsen as expenditure growth outstrips allocation growth. Whilst the PCT has a significantly strong underlying position to withstand this deterioration in 10/11, by 11/12 the PCT would move into recurrent deficit.

	09/10 £m	10/11 £m	11/12 £m	12/13 £m	13/14 £m
Income - recurrent	524.2	545.4	545.4	545.4	545.4
Expenditure - recurrent	514.2	544.0	561.7	580.2	599.5
Surplus / (Deficit) - recurrent	10.0	1.4	(16.3)	(34.8)	(54.1)

The above excludes the non-recurrent carry forward and other non-recurrent income/expenditure items. Under the surplus/deficit carry forward rules, the PCT would enter a cycle of increasing deficits once a sustainable recurrent position is lost as income would be reduced to reflect the previous year's deficit. It is therefore critical that the recurrent surplus position is maintained. In order to maintain a 1% surplus (approx £5.5m) the PCT will therefore need to deliver a recurrent efficiency/disinvestment programme of approx. £60m, as illustrated below.

This graph below illustrates the movement in the recurrent surplus. The recurrent surplus starts at £10m at 2009/10 Outturn and is reduced by £86m for Full Year Effects, price increases and volume growth and improved by £21m for additional growth. The target efficiency and disinvestment programme therefore needs to be £60m, resulting in a £5m recurrent surplus by the end of 2013/14.

Our assessment of the scale of the gap at £60m is less than that implied in the Healthcare for London downside (£520m for NW London, £80m for Brent) due to a) Brent's strong starting position, b) our inclusion of productivity gain in the activity/cost uplifts for non-acute services and c) the Healthcare for London analysis extending to 2016/17.



Based on the 'do-nothing profile of income and expenditure above, the PCT could aim to deliver the £60m in years 2011/12 – 2013/14. However, a more prudent and realistic approach would be to engage in a four year programme and a target profile has therefore been established as below.

Year	10/11	11/12	12/13	13/14
In-year (£m)	9	17	17	17
Cumulative (£m)	9	26	43	60

## 6.6 Summary of Activity (Pre-initiatives)

The activity growth under a PCT 'do nothing' scenario reflects the growth rates in section 6.4. The ongoing increase in acute care would lead to the levels set out in the table below.

Acute Care	09/10	13/14
Elective spells	8,216	9,835
Planned same-day	25,814	30,902
Non-elective spells	34,711	41,346
Out-patient attendances	339,523	406,437
A&E attendances	137,066	164,079

## **SECTION 7: DEVELOPMENT OF PCT EFFICIENCY AND DISINVESTMENT PROGRAMME**

### **7.1 Approach**

The PCT's efficiency and disinvestment programme has been developed through drawing on the following:

- Healthcare for London affordability modelling, applied locally to Brent
- our comprehensive benchmarking analysis
- our 2008 CSP and subsequent Business Cases
- a review of ideas from other PCTs/SHAs
- the experience and local knowledge of our commissioning teams and clinicians
- a zero based review of all areas of expenditure
- the application of WCC competencies

We have aimed to identify plans in excess of the minimum level required to allow for the risks of non-delivery or slippage, whilst maintaining realism in our projections. We have therefore ensured that the items/values included are, as far as possible, supported by robust analysis and benchmarking of Brent's current performance or can be validated through other external sources/evidence. All savings plans (except those relating to the PCT's internal cost base) are aligned with our Strategic Plan initiatives, to ensure consistency with the PCT's goals and outcomes.

### **7.2 Impact assessment**

The impact of each of the PCT initiatives has been assessed in terms of both activity and financial implications, with analysis being undertaken at HRG/specialty level as appropriate. Both investment and disinvestment implications have been considered and a clear distinction has been drawn between recurrent and non recurrent impacts (all non-recurrent enabling costs have been drawn together in our OD Plan – see section 7.7 below).

The details of each of the individual initiatives are their forecast impacts are detailed within both the Strategic plan and also within the Finance and activity template and are not repeated here. The aggregated recurrent financial and activity impacts of the initiatives by 2013/14 (pre-risk assessment) are summarised in the tables below.

**Finance impact (all figures as at 13/14)**

**Pre-risk assessment**

<b>Initiative</b>	<b>Savings £000</b>	<b>Investment £000</b>	<b>Net £000</b>
1 Maternity	(873)		(873)
2 Children & Young People	(2,184)	761	(1,423)
3 Acute Care: Intermediate and urgent care reprovision	(7,427)	3,083	(4,345)
Acute Commissioning Vehicle benefits realisation and other commissioning efficiencies	(14,068)		(14,068)
4 Planned Care:			
Acute shifts/decommissioning Primary and Community Services Efficiencies	(36,117)	20,576	(15,541)
	(17,195)		(17,195)
5 Mental Health	(9,940)		(9,940)
6 Staying Healthy	(1,117)	2,634	1,517
7 Long Term Conditions	(8,270)	3,228	(5,042)
8 End of Life Care	(1,390)	176	(1,214)
9 Other	(2,100)		(2,100)
<b>TOTAL</b>	<b>(100,682)</b>	<b>30,457</b>	<b>(70,224)</b>

**Activity impact (all figures as at 13/14)**

**Pre-risk assessment**

<b>Acute Care</b>	<b>Pre-initiatives</b>		<b>Post-initiatives</b>					
	<b>No</b>	<b>%</b>	<b>Tfr to Polysystem</b>		<b>Decomm</b>		<b>Remain in acute</b>	
			<b>No</b>	<b>%</b>	<b>No</b>	<b>%</b>	<b>No</b>	<b>%</b>
<b>Elective Spells/Planned Same Day</b>	40,737	100%	3,266	8%	1,270	3%	36,201	89%
<b>Non-elective Spells</b>	41,346	100%	281	1%	4,860	12%	36,205	88%
<b>Outpatient attendances</b>	406,437	100%	241,739	59%	30,034	7%	134,664	33%
<b>A&amp;E Attendances</b>	164,079	100%	24,290	15%	13,000	8%	126,789	77%

Total Activity Changes split by initiatives (Pre risk assessment)

Initiatives

	Total all Initiatives		Children & Young People		Acute: Intermediate and urgent care reprovion		Planned: Acute shifts/ decommissioning		Staying Healthy		Long Term Conditions		End of Life Care	
	Transfer	Decomm	Tfr	Decomm	Tfr	Decomm	Tfr	Decomm	Tfr	Decomm	Tfr	Decomm	Tfr	Decomm
Elective spells	(3,266)	(1,270)					(3,266)	(1,270)						
Non-elective spells	(281)	(4,860)	(281)			(2,265)		(1,875)		(254)				(466)
Outpatients	(241,739)	(30,034)	(4,420)	(2,652)			(188,229)	(27,382)			(49,090)			
A&E	(24,290)	(13,000)			(24,290)	(13,000)								

### 7.3 Comparison with Healthcare for London

The table below provides an analysis of our initiatives (pre-risk assessment), plus the productivity gain assumed in section 6.4, against the Healthcare for London 'aggressive scenario', as applied to Brent. The comparison provides a useful benchmark of our plans and the notes below the table provide an explanation of key variances.

Comparison Of Savings Analysis under HFL Aggressive Scenario and NHS Brent CSP						
Savings Initiatives	HFL Aggressive Scenario	Brent PCT (before risk assessment)	Productivity in uplifts		Total Brent PCT incl. productivity	Brent % of HFL
	Net Reduction £m	Net Reduction £m	%	£m	£m	%
<b>Shift to Lower Cost Settings/ LTC management:-</b>						
Out patients	8.4	7.9			7.9	94.0
Admitted patients - elective and day cases	5.0	5.0			5.0	100.0
Admitted patients - non-elective	10.7	5.7			5.7	53.3
A&E	1.3	1.3			1.3	100.0
Community	8.9	1.6			1.6	18.0
<b>Sub total Shifts to Lower Cost Settings/LTC</b>	<b>34.3</b>	<b>21.5</b>			<b>21.5</b>	<b>62.7</b>
<b>Prevention</b>	<b>2.3</b>	<b>-1.5</b>			<b>-1.5</b>	
<b>Decommissioning:-</b>						
Out patients	3.4	3.4			3.4	100.0
Admitted patients - elective and day cases	2.3	2.3			2.3	100.0
<b>Sub total Decommissioning</b>	<b>5.7</b>	<b>5.7</b>			<b>5.7</b>	<b>100.0</b>
<b>Reduced Unit Costs in Non Acute Sector:-</b>						
Mental Health/ Learning Difficulties	0.0	9.9	8	2.8	12.7	
Primary Care Services:-						
Staff Productivity	39.0	7.3	8	4.2	11.5	29.6
Drug Expenditure	8.0	7.2		0.0	7.2	90.0
Primary Care Services sub total	47.0	14.5		4.2	18.7	39.9
Community Services:-						
Staff Productivity	27.3	2.7	8	3.3	6.0	21.9
Space Utilisation	2.0	1.0		0.0	1.0	50.0
Community Services sub total	29.3	3.7		3.3	7.0	23.8
<b>Sub total Reduced Unit Costs in Non Acute Sector</b>	<b>76.3</b>	<b>28.1</b>		<b>10.3</b>	<b>38.4</b>	<b>50.4</b>
<b>Other Savings Initiatives:-</b>						
ACV Benefits Realisation	0.0	9.2			9.2	
LAS Utilisation	0.0	0.9			0.9	
Specialist Commissioning	0.0	4.0			4.0	
Management Costs	0.0	2.3			2.3	
<b>Sub total Other Savings Initiatives</b>	<b>0.0</b>	<b>16.4</b>			<b>16.4</b>	
<b>Grand Total</b>	<b>118.6</b>	<b>70.2</b>		<b>10.3</b>	<b>80.5</b>	<b>67.9</b>

- Shifts to Lower Cost Settings - Non-elective. The Brent savings represent the planned savings associated with the Intermediate Care and Enhanced Reablement programmes which reflect 53% of the HFL level.

- Shifts to Lower Cost Settings – Community services. The Brent savings represent identified schemes, primarily relating to long term condition community services clinical pathway redesign. We have not forecast the HfL level since there was no available methodology within the analysis to facilitate this and no further local proposals.
- Primary care and community services –staff productivity

## 7.4 Risk Assessment

We have recognised that:

- Our plans to deliver a total net efficiency and disinvestment programme are of a scale and complexity that they inherently have a high degree of risk, and
- Whilst the PCT has a recent track record both of delivering savings (turnaround) and strong financial management, it does not have demonstrable evidence of achieving clinical and service transformation on the scale now being proposed

We have therefore undertaken a rigorous financial risk assessment of our initiatives (both the savings and the associated investments). This was undertaken by the finance team in conjunction with the SROs and risk factors were applied across all initiatives in each year. The financial risk assessment also takes into account the overall Strategic Plan risk assessment.

Overall, the risk assessment results in a reduced net recurrent savings projection by 2013/14 of £42m (60%) as shown in the table below. This reflects the fact that a number of the initiatives (particularly for the later years) need more work before we can have the required level of confidence in delivery, and with the measures we have in place to develop our plans and monitor delivery (see below), we expect the projected delivery % to increase.

The plans with the highest risk rating (i.e. lowest estimated achievement) are:

- Planned care – acute shifts/decommissioning – we have modelled a 30% shortfall on the levels of activity to be transferred, coupled with a 30% increase in the unit cost of reprovision, reducing the projected savings from £15.5m to £3.5m
- Acute care – Acute commissioning vehicle benefits realisation and other commissioning efficiencies (specialist commissioning) – we have assumed 50% delivery
- Long term conditions, where the same risk factors have been applied as to planned care above.
- Children and Young People, where we have risk assessed the likelihood of redesigned care pathways delivering the forecast savings.

The above four items account for £22m of the total reduction of £28m (i.e. £70m to £42m)

**Finance impact (all figures as at 13/14)**
**Post-risk assessment**

Initiative	Savings £000	Investment £000	Net £000	% estimated achievement
1 Maternity	(655)		(655)	75%
2 Children & Young People	(1,604)	761	(843)	59%
3 Acute Care: Intermediate and urgent care reprovision (ACV) benefits realisation and other commissioning efficiencies	(6,685)	3,170	(3,515)	81%
4 Planned Care				
Acute shifts/decommissioning Primary and Community Services (inc. prescribing and estates)	(24,145)	20,601	(3,544)	23%
	(14,480)		(14,480)	84%
5 Mental Health	(8,201)		(8,201)	83%
6 Staying Healthy	(1,005)	2,634	1,628	n/a
7 Long Term Conditions	(5,789)	3,228	(2,561)	51%
8 End of Life Care	(973)	185	(788)	65%
9 Other	(1,890)		(1,890)	90%
<b>TOTAL</b>	<b>(72,460)</b>	<b>30,578</b>	<b>(41,883)</b>	<b>60%</b>

**Activity impact (all figures as at 13/14)**
**Post-risk assessment**

Acute Care	Pre-initiatives		Post-initiatives					
	No	%	Tfr to Polysystem		Decomm		Remain in acute	
	No	%	No	%	No	%	No	%
<b>Elective Spells/Planned Same Day</b>	40,737	100%	1,633	4%	635	2%	38,469	94%
<b>Non-elective Spells</b>	41,346	100%	197	0%	4,281	10%	36,869	89%
<b>Outpatient attendances</b>	406,437	100%	169,217	42%	21,024	5%	216,196	53%
<b>A&amp;E Attendances</b>	164,079	100%	21,861	13%	11,700	7%	130,518	80%

Total Activity Changes split by initiatives (Post risk assessment)

Initiatives

	Total all Initiatives		Children & Young People		Acute: Intermediate and urgent care reprovision		Planned: Acute shifts/ decommissioning		Staying Healthy		Long Term Conditions		End of Life Care	
	Transfer	Decomm	Tfr	Decomm	Tfr	Decomm	Tfr	Decomm	Tfr	Decomm	Tfr	Decomm	Tfr	Decomm
Elective spells/PSD	(1,633)	(635)					(1,633)	(635)						
Non-elective spells	(197)	(4,281)	(197)			(2,039)		(1,688)		(229)				(327)
Outpatients	(169,217)	(21,024)	(3,094)	(1,856)			(131,760)	(19,167)				(34,363)		
A&E	(21,861)	(11,700)			(21,861)	(11,700)								

## 7.5 Achieving the target level

As explained, we have set ourselves the target of delivering approx. £60m over the period. A comparison of the phasing of the £42m with the target level shows that, whilst 2010/11 meets our target, we will need to increase the delivery in years 2011/12-13/14 as set out in the table below.

	10/11 £m	11/12 £m	12/13 £m	13/14 £m	Total £m
Risk assessed level	8.4	13.1	10.9	9.5	41.9
Additional	0.4	3.9	6.0	8.3	18.6
PCT Target	8.8	17.0	16.9	17.8	60.5

This is a level we believe we can achieve, through a combination of:

- increasing delivery of our current initiatives from 60% to 75% - through the measures we are putting in place (see below)
- the maximisation of Sector-wide and pan-London collaboration – for example we have included a conservative estimate of the impact of the NW London Acute Commissioning Vehicle.
- developing the elements of the Healthcare for London affordability analysis that we have not yet included in our plan (see above)
- continuing to explore other opportunities identified locally, including the maximisation of the recurrent surplus at the end of 09/10 and reduction in FYE in 2010/11.

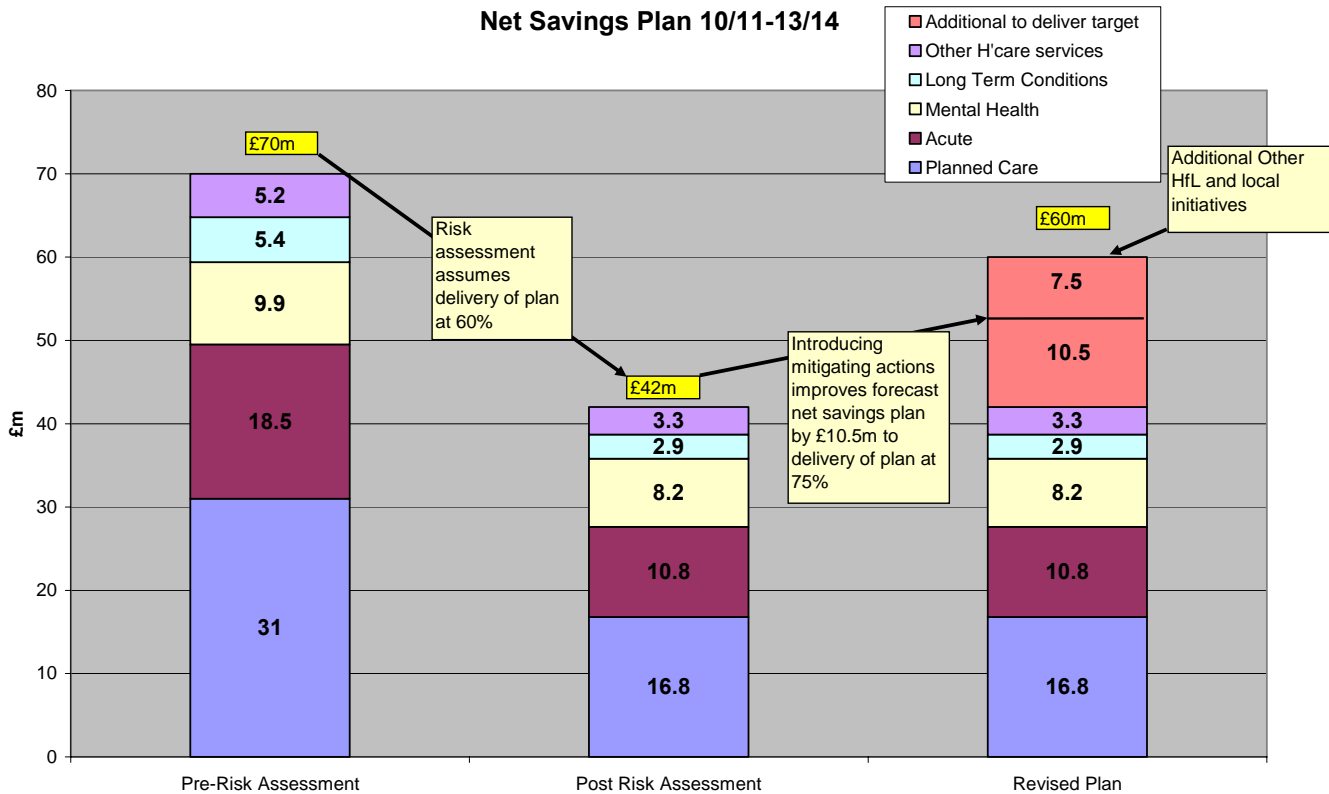
**The following 12 point action plan is being implemented to ensure delivery of our financial plan:**

- subject our plans to an external assurance review and strengthen our plans accordingly (by 28 February 2010)
- ensure that all investments/disinvestments are subject to robust Business Cases that meet WCC competency 11 levels (ongoing)
- ensure that our plans are implemented through commissioning arrangements that underpin and incentivise delivery (ref. market management strategy) (ongoing)
- complete our 10/11 budget – setting processes and ensure alignment with MTFs (by 31 March 2010)
- maximise the 09/10 recurrent surplus (by 31 March 2010)
- minimise the 2010/11 full year effect of 09/10 (by 31 March 2010)
- ensure 'best practice' programme and project management arrangements (supported by the use of the Performance accelerator software) (by 31 March 2010)
- ensure that a fully identified plan to meet the required level of efficiency/disinvestments for years 2-4 is in place (by 30 June 2010)

- target our non-recurrent investment plans to support key enabling and transition measures, including those set out in the OD plan (see section 7.6 below)
- continue to strengthen our monitoring and forecasting processes (see section 13 below)
- continue to strengthen our financial management and governance arrangements (see section 14 below)
- align PBC arrangements to incentivise delivery of the CSP (see section 15 below)

We have therefore reflected in our plans our target level of £60m. (In order to maintain transparency, we have identified the £18m separately in the F & A template).

The graphs below shows the analysis of the net savings plans based on the above.



## 7.6 Resilience of programme

We believe our plans are resilient and deliverable due to:

- Our 12 point action plan set out above
- The mix of service changes, stronger commissioning (WCC) and other plans

Whilst the Polysystem changes are an important component of our programme the table below, which illustrates the modelling under each scenario, demonstrates that our programme is not unduly reliant on activity shifts.

**Summary of Activity Shift to Polysystem (all figures at 13/14)**

Point of Delivery	Activity	Pre-risk assessment					Post-risk assessment					
		Acute		Polysystem			Acute		Polysystem			
		Unit cost £	Savings £000	Unit cost £	Reinvestment £000	Net Savings £000	Unit cost £	Savings £000	Unit cost £	Reinvestment £000	Net Savings £000	
Elective/PSD	3,266	1,660	(5,423)	115	377	(5,046)	1,633	1,660	(2,712)	231	377	(2,335)
Non-elective	281	705	(198)	114	32	(166)	197	706	(139)	162	32	(107)
Out-patients	241,739	126	(30,554)	90	21,833	(8,721)	169,217	126	(21,388)	129	21,833	445
A&E	24,290	71	(1,731)	56	1,350	(381)	21,861	71	(1,558)	62	1,350	(208)
<b>Total</b>			<b>(37,906)</b>		<b>23,592</b>	<b>(14,314)</b>			<b>(25,796)</b>		<b>23,592</b>	<b>(2,204)</b>

**Note: above excludes activity decommissioned, other acute changes e.g. non-PBR and other efficiency/savings programmes**

Finally, in order to provide further resilience to our plans, we have also provided for an increased level of contingency compared to the minimum 0.5% recommended by NHS London. (see section 7.8 below).

## 7.7 Non-recurrent Costs

The enabling measures we need to take to support the changes set out in the Strategic Plan are set out fully in our Organisational Development (OD) plan and non-recurrent expenditure is included in the template as a separate initiative.

Explicit allowance has been made for non-recurrent enabling and transition costs in implementing the initiatives. The areas highlighted in the Healthcare for London affordability analysis were:

- Increase in costs of polysystem – in first year
- Residual activity in acute setting due to wrong referral pathways etc in first year
- Set up costs of polysystem

We have reviewed the above and also made allowance for the estimated project and procurement costs of the initiatives, as well as other OD costs and critical enablers, such as IT and Information management. The table below summarises the proposed investment.

	10/11 £m	11/12 £m	12/13 £m	13/14 £m	Total £m
New ways of working	0.2	0.1	0.1		0.4
Information and analytics	0.2	0.2	0.1		0.5
Polysystems:					
- governance	0.1	0.1			0.2
- capacity and capability	0.4	0.4	0.2		1.0
- care pathways	0.2	0.2	0.1		0.5
- PPI	0.2	0.1	0.1		0.4
- IT	0.2	0.5	0.3		1.0
- market management	0.5	0.5	0.4		1.4
Polysystem transition		0.5	0.5	1.0	2.0
List validation	0.3	-	-	-	0.3
Programme management	0.5	0.4	0.2		1.1
Balance to be identified	0.7	0.5			1.2
<b>Total</b>	<b>3.5</b>	<b>3.5</b>	<b>2.0</b>	<b>1.0</b>	<b>10.0</b>

As with all other investments/disinvestments, all non-recurrent investments will be subject to a robust Business Case process. Also in-year investment will be phased to allow for spend levels to be reviewed if our downside scenario (see section 11.3) arises.

## 7.8 Contingency

Given the inherent risks in delivering the £60m programme, the level of contingency has been increased beyond the minimum 0.5% advised in the planning guidance. The contingency has been set at 0.75% in 10/11, 1.2% in 11/12 and 1.4% in 12/13-13/14 as indicated in the table below.

Year	10/11	11/12	12/13	13/14
%	0.75	1.2	1.4	1.4
£m	4.0	6.5	7.5	7.5

This is the level we feel is required to cover both the initiative risks identified above, together with other risks. The level will be kept under review (both in-year and across years).

## SECTION 8: FINANCE & ACTIVITY PROJECTIONS (POST-INITIATIVES)

### 8.1 Financial sustainability

The aggregate recurrent expenditure for each year of the financial plan is set out below:

	10/11 £m	11/12 £m	12/13 £m	13/14 £m
Pre-initiatives (1)	544.0	561.7	580.2	599.5
Net Initiatives impact (2)	(8.8)	(25.3)	(42.0)	(59.5)
Total	535.2	536.4	538.2	540.0

(1) From section 6.5

(2) From section 7.5 – above figures differ slightly due to roundings

The overall recurrent surplus for each year is projected as follows:

	10/11 £m	11/12 £m	12/13 £m	13/14 £m
Recurrent				
- Income	545.4	545.4	545.4	545.4
- Expenditure	535.2	536.4	538.2	540.0
- Surplus	10.2	9.0	7.2	5.4

The PCT's underlying financial position is maintained throughout the planning period at a surplus level of a minimum of 1%.

### 8.2 Non recurrent analysis

Whilst the PCT needs to identify recurrent savings, the non-recurrent position means that the PCT has the capacity to invest its surplus carry-forward on a non-recurrent basis.

The areas of non-recurrent investment to support the delivery of the PCT plans, including polysystem transition costs, were outlined in section 7.7. In addition the in-year contingency (at the increased level set out in section 7.8 is included).

	10/11	11/12	12/13	13/14
Transition Costs	3.5	3.5	2.0	1.0
Contingency	4.0	6.5	7.5	7.5
Total	7.5	10.0	9.5	8.5

To the extent that the contingency is not fully required, further non-recurrent investment could be possible.

### 8.3 Overall Financial Position

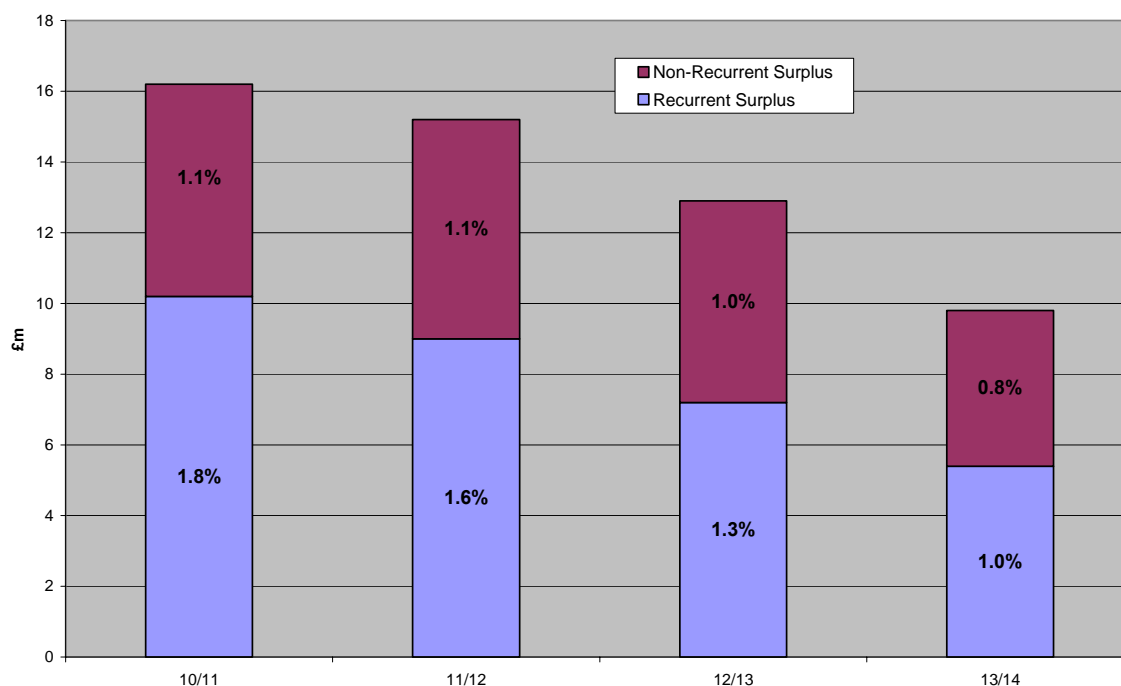
The summary financial position (recurrent plus non-recurrent) for the plan is as follows:

	10/11 £m	11/12 £m	12/13 £m	13/14 £m
Recurrent				
- Income	545.4	545.4	545.4	545.4
- Expenditure	535.2	536.4	538.2	540.0
Total surplus (Rec)	10.2	9.0	7.2	5.4
Non Recurrent				
- Income	13.5 (1)	16.2	15.2	12.9
- Expenditure (2)	7.5	10.0	9.5	8.5
Total Surplus (Non Rec)	6.0	6.2	5.7	4.4
Total	16.2	15.2	12.9	9.8

- (1) £2.5m of 09/10 carry forward of £16m will be provided in 2010/11 to NHS London as second and final contribution to the Challenged Trust process. This will be actioned as an allocation reduction, reducing the non-recurrent carry forward to £13.5m.
- (2) Including contingency (see above).

The above projections are shown below, including as a % of total income.

Recurrent and Non-Recurrent Surplus showing % Surplus of Total Income



The projections assume that the contingency covers the in-year risk to delivery and that the recurrent efficiency/disinvestment programme of £60m is achieved by 2013/14. A lower level of achievement is modelled in our downside scenario (see section 11.3).

The table below shows the I & E projections for 2008/09 through to 2013/14 as reflected in the output section of the Finance & activity template. Explanatory notes are set out below.

**Sustainable Financial Position: Actual and 5-year forecast**

	(£000s)	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	CAGR*
Resource	New recurrent baseline	476,654	501,538	522,101	522,101	522,101	522,101	1.8%
	Non-recurrent allocation received every year	(25,832)	11,407	11,875	11,875	11,875	11,875	-185.6%
	Non-recurrent allocation	(10,725)	3,161	-	-	-	-	100.0%
	Other Miscellaneous allocation	12,099	11,255	11,390	11,390	11,390	11,390	-1.2%
	Prior year lodgements	-	-	-	-	-	-	0.0%
	New lodgements	-	(5,512)	(2,456)	-	-	-	0.0%
	Return of previous year surplus/deficit	1,704	12,583	15,968	16,162	15,237	12,890	49.9%
<b>Total</b>		<b>453,900</b>	<b>534,432</b>	<b>558,878</b>	<b>561,527</b>	<b>560,603</b>	<b>558,256</b>	<b>4.2%</b>
Expenditure	Primary and community	140,565	149,633	155,332	155,995	158,625	171,462	4.1%
	MH and LD commissioning	44,356	47,186	46,401	44,461	42,916	42,212	-1.0%
	Continuing care	24,456	24,661	25,396	26,175	27,012	27,903	2.7%
	Secondary or tertiary acute care	195,224	248,111	260,013	262,598	262,994	251,751	5.2%
	Specialised Commissioning	22,417	24,783	25,545	25,354	25,195	25,068	2.3%
	Other PCT Commissioning Spends	943	5,598	9,995	10,387	9,205	8,668	55.8%
	Other PCT Spend	13,356	15,476	16,033	14,820	14,266	13,941	0.9%
	Contingencies	-	3,016	4,000	6,500	7,500	7,500	0.0%
<b>Total Expenditure</b>		<b>441,317</b>	<b>518,464</b>	<b>542,716</b>	<b>546,290</b>	<b>547,712</b>	<b>548,505</b>	<b>4.4%</b>
<b>PCT Surplus/ (Deficit) Reported</b>		<b>12,583</b>	<b>15,968</b>	<b>16,162</b>	<b>15,237</b>	<b>12,890</b>	<b>9,751</b>	<b>-5.0%</b>

\*Compounded annual growth rate

**Notes**

**Resource:**

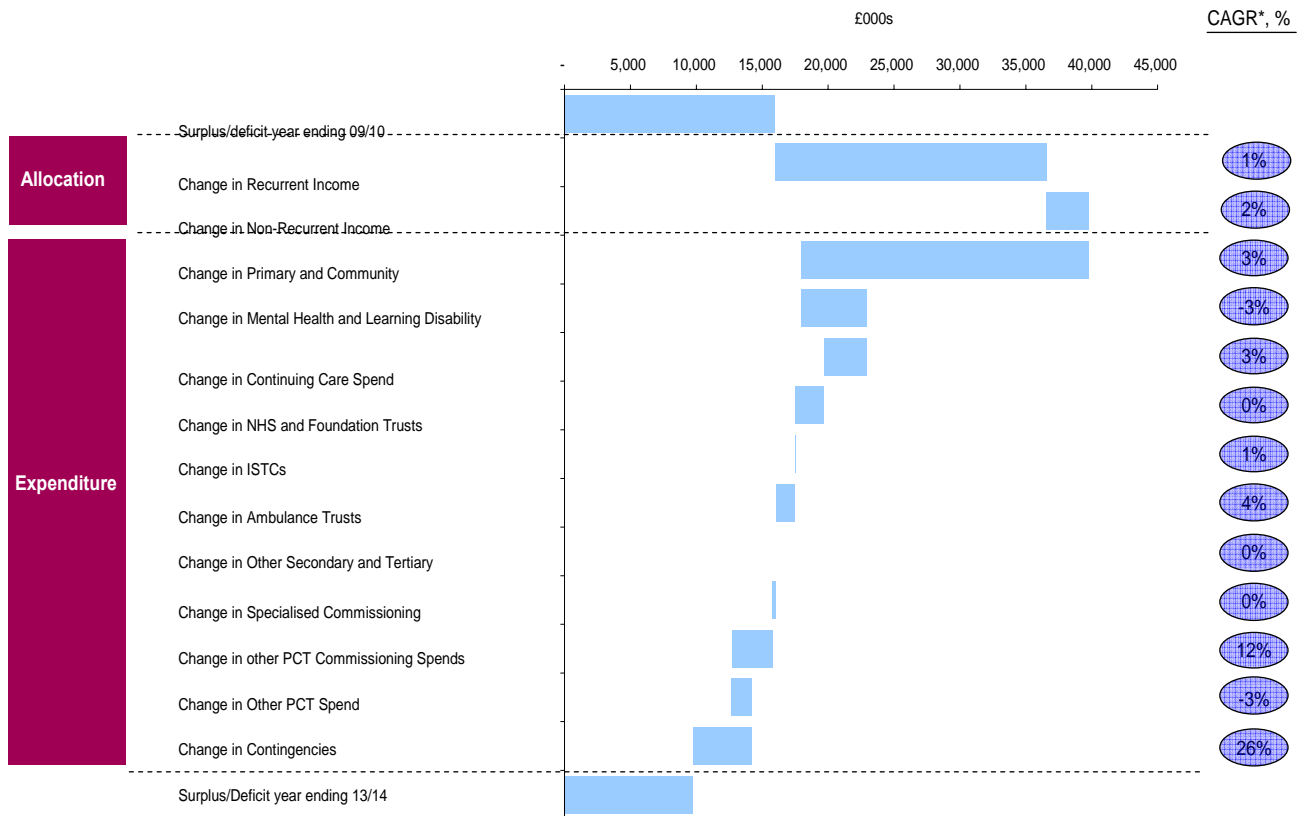
- Recurrent income comprises recurrent baseline, non-recurrent allocation received every year (e.g. Dental) and other misc allocation (mainly income) shown separately to ensure consistency with annual accounts.
- Movement in non-recurrent allocation received every year between 08/09-09/10 largely due to treatment of Market Forces Factor (MFF).
- Non-recurrent allocation deduction in 08/09 includes final tranche of repayment of 06/07 deficit of approx £10m.

**Expenditure:**

- Primary and Community includes polyclinic activity re-provision costs
- Increase in secondary/tertiary between 08/09-09/10 includes Market Forces Factor.
- Mental Health includes impact of CNWL 'rebasin' from which Brent is forecast to benefit, as well as service changes /efficiencies
- Other PCT commissioning includes non-recurrent costs 10/11 – 13/14
- Other PCT spend is PCT management costs plus Estates
- Contingency in 09/10 reflects projected swine flu costs (as at M6)

The table below shows the changes in Income and Expenditure from 2009/10 to 2013/14 as reflected in the output section of the finance and activity template. Explanatory notes are set out below.

## Sustainable Financial Position - Changes in I&E



### Notes

#### Allocation:

a) The change in recurrent and non-recurrent income reflects the 10/11 increases

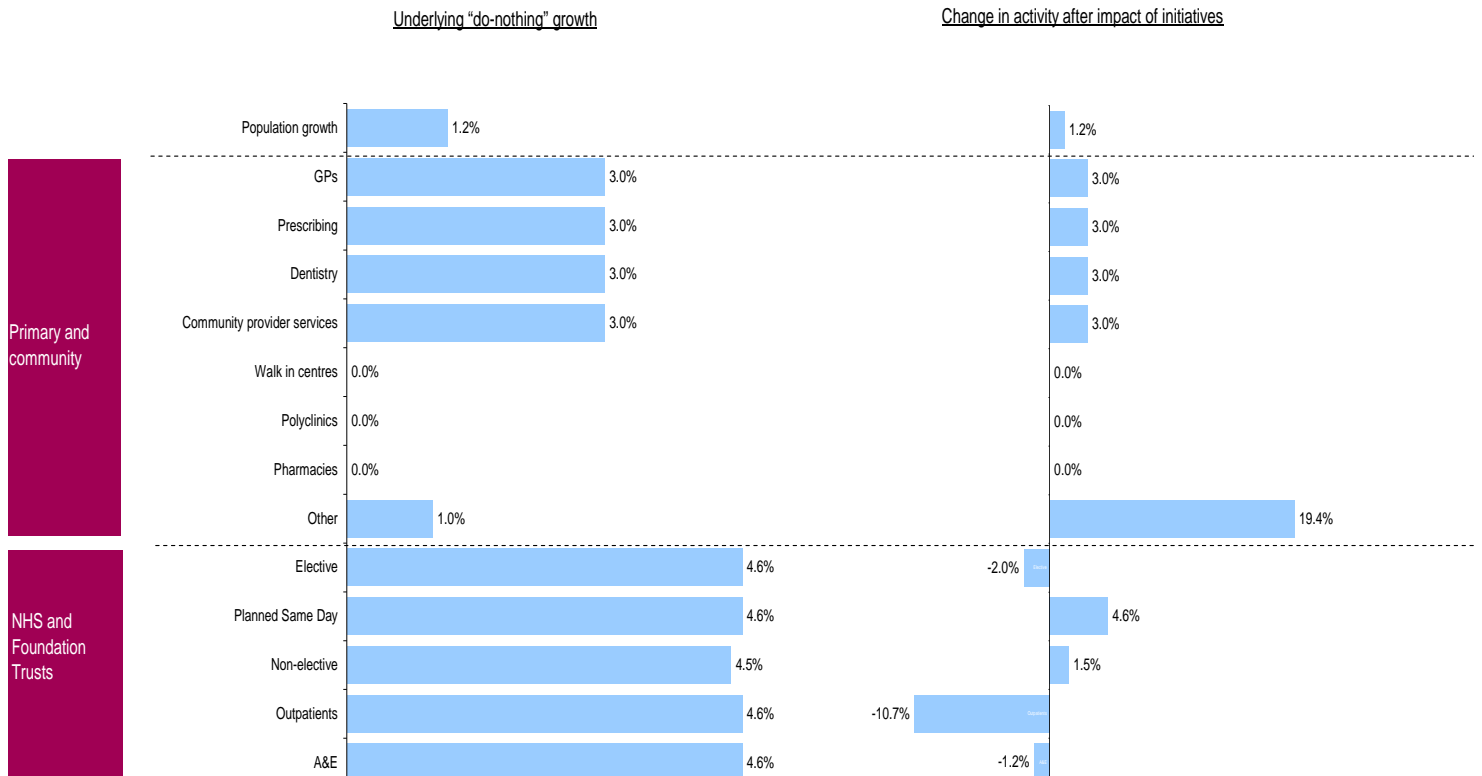
#### Expenditure:

b) The changes in expenditure reflect the figures in the previous tables.

## 8.4 Activity projections

The table below compares the projected activity growth under the 'do-nothing' scenario with the changes after the impact of initiatives. The 'do-nothing' levels reflect the assumptions set out in section 6.4.

4 year CAGR\* in activity growth, %



The main changes following the impact of initiatives are:

- Transfer of activity to polyclinic setting – this is classified within the template as 'Primary and Community – Other'
- Impact on acute activity of the transfer to the polysystem plus decommissioning, as shown in section 7.4. For example, for outpatients, the figures are as follows:

	Attendances	CAGR %
09/10 baseline	339,523	-
Do nothing growth	406,437	4.5
Post-initiatives	216,196	(10.7)

## SECTION 9: SOURCES AND APPLICATIONS AND SHIFTS IN PROVISION OF CARE

### 9.1 Introduction

This section sets out a summary sources and applications of funds (bridge analysis) together with changes in the provision of care.

### 9.2 Summary Sources and Applications of funds

The tables below set out a summary sources and applications of funds statement for each of the next two years (the following two years show similar patterns so are not included).

	10/11 (All figs. £m)		
Sources	Recurrent	Non-Recurrent	Total
Growth in income	21.1		21.1
Carry forward of prior year surplus		16.0	16.0
Underlying surplus b/f	10.0		10.0
<b>Total</b>	<b>31.1</b>	<b>16.0</b>	<b>47.1</b>
Applications			
SHA top slice		2.5	2.5
Inflation (net tariff etc)	7.6		7.6
FYE of 09/10	6.0		6.0
Underlying activity growth	16.1		16.1
Initiatives			
- Investment (Rec)	3.5		3.5
- Investment (Non/Rec)		3.5	3.5
- Savings (Rec)	(12.3)		(12.3)
Contingency		4.0	4.0
<b>Total</b>	<b>20.9</b>	<b>10.0</b>	<b>30.9</b>
<b>Outturn (sources less applications)</b>	<b>10.2</b>	<b>6.0</b>	<b>16.2</b>

	11/12 (All figs. £m)		
SOURCES	Recurrent	Non-recurrent	Total
Growth in income	-	-	-
Carry forward of prior yr surplus		16.2	16.2
Underlying surplus	10.2	-	10.2
<b>Total</b>	<b>10.2</b>	<b>16.2</b>	<b>26.4</b>
Applications			
Inflation (net tariff etc.)	1.7	-	1.7
Underlying activity growth	16.0	-	16.0
Initiatives			
- Investment (Rec)	5.5	-	5.5
- Investment (Non-Rec)		3.5	3.5
- Savings (Rec)	(22.0)	-	(22.0)
Contingency		6.5	6.5
<b>Total</b>	<b>1.2</b>	<b>10.0</b>	<b>11.2</b>
<b>Outturn (sources less application)</b>	<b>9.0</b>	<b>6.2</b>	<b>15.2</b>

### 9.3 Shifts in provision of care

The table below shows expenditure by Care setting, with the CAGR from 2009/10 to 2013/14. Explanatory notes are set out below.

Expenditure by care setting, £000s

		2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	CAGR*, %
Primary and community	GPs	39,421	40,934	41,348	40,643	40,329	41,386	0.3%
	Prescribing	38,350	40,662	42,415	42,701	42,242	42,010	0.8%
	Dentistry	16,492	16,828	16,901	16,974	16,874	17,138	0.5%
	Community Provider Services	41,228	45,677	46,349	45,522	45,088	44,000	-0.9%
	Pharmacies	2,652	3,181	3,261	3,343	3,426	3,512	2.5%
	Other							
	Walk-in centres	-	-	-	-	-	-	0.0%
	Polyclinics	-	-	250	2,956	7,312	20,059	0.0%
	GP Led Health Centres	-	759	778	797	817	830	2.2%
	Other	2,421	1,591	4,031	3,060	2,536	2,528	12.3%
Mental Health and Learning Disabilities	Mental Health	39,739	42,377	41,657	39,741	38,220	37,541	-3.0%
	Learning Disabilities	4,617	4,809	4,744	4,720	4,695	4,671	-0.7%
Continuing Care	Continuing Care	24,456	24,661	25,396	26,175	27,012	27,903	3.1%
Secondary and Tertiary	NHS Foundation and Acute Care	186,540	236,921	248,254	250,392	250,815	239,070	0.2%
	ISTC and private sector	-	2,155	2,286	2,423	2,069	2,223	0.8%
	Ambulance Trusts	8,684	9,035	9,474	9,783	10,111	10,459	3.7%
	Other	-	-	-	-	-	-	0.0%
Specialised Commissioning	Specialised Commissioning	22,417	24,783	25,545	25,354	25,195	25,068	0.3%

\* Compound Annual Growth Rate from 2009/10 to 2013/14

#### Notes

- Polyclinic re-provision costs shown separately
- Urgent care centre included in Primary and Community – other
- Mental Health reflects impact of CNWL 're-basing' plus service change / efficiencies

In terms of activity shifts, sections 7.3 and 7.4 summarised the shift of activity from acute to polysystem, including the levels of activity forecast to be decommissioned.

The financial impact on acute providers to 2013/14 has been assessed and is set out below.

	NW London £m	Imperial £m	Royal Free £m	Other £m	Total £m
09/10 FOT	111.4	83.9	15.0	26.6	236.9
Do-nothing – activity / tariff Initiatives	21.6 (24.7)	16.2 (18.6)	2.9 (3.2)	8.0 -	48.7 (46.5)
Total 2013/14	108.3	81.5	14.7	34.6	239.1

## SECTION 10: RISKS AND OPPORTUNITIES

### 10.1 Overall Approach

The overall approach taken to the assessment of risks and opportunities is set out below:



### 10.2 Identification and assessment of risks/opportunities

The risk assessment undertaken of the efficiency/disinvestment programme was described above. The risk of non-delivery, together with other risks and opportunities is covered here.

Variable	Impact Tested		Likelihood		Adjusted	
	Risk	Opportunity	Risk	Opportunity	Risk	Opportunity
1. 09/10 outturn	0.5% lower surplus (£2.5m)	0.5% higher surplus (£2.5m)	20%	20%	£500k (per annum)	£500k (per annum)
2. Impact of population growth/mix and other activity drivers (per annum)	0.9% higher i.e. Healthcare for London downside (£5m)	0.5% lower	50%	20%	£2.5m (per annum)	£500k (per annum)
3. Impact of PCT initiatives	£18m not delivered	Additional £10m delivered	50%	10%	£9.2m (total)	£1m (total)
4. Impact of tariff changes	0.5% higher (£2.5m)	0.5% lower (£2.5m)	20%	20%	£500k (per annum)	£500k (per annum)
				<b>TOTAL (£m)</b>	23.2	7.0

### 10.3 Calculation of Risk Adjusted Impact

The table below summarises the impact of the totality of adjusted risks and opportunities from the above, by year, and compares this with the contingency. Our modelling is based on the contingency covering the in-year risks of delivering the £60m programme (plus other risks), with the recurrent programme of £60m achieved by 13/14.

	10/11 £m	11/12 £m	12/13 £m	13/14 £m	Total £m
Risks					
- initiatives	-	2.6	3.0	3.6	9.2
- other	3.5	3.5	3.5	3.5	14.0
Total risk	3.5	6.1	6.5	7.1	23.2
Contingency	4.0	6.5	7.5	7.5	25.5
Risk as % of contingency	87%	94%	87%	95%	91%
Opportunities	1.5	1.5	2.0	2.0	7.0
Risk minus opps	2.0	4.6	4.5	5.1	16.2
Risk minus opps as % of contingency	50%	71%	60%	68%	64%

#### 10.4 Mitigation strategies and actions

The actions to both mitigate the risks and maximise the opportunities are those in the 12 point action plan set out in section 7.5. We believe the risk/contingency ratio is reasonable and this will be kept under regular review as part of the financial monitoring and updating process set out in section 13.

## SECTION 11: OTHER SCENARIOS

### 11.1 Introduction

As explained above, the PCT's 'base case' plans have been developed to respond to the downside allocation assumptions for 2011/12 – 2013/14. This section explains a) the impact on our plans of the base case allocation assumptions which we have reflected in our best case, and b) a downside scenario in which our full plans are not delivered.

### 11.2 Best Case

The table below illustrates the differences between our base and best case projections, with the major difference being the improved allocation modelled.

	BASE CASE	BEST CASE
Allocation uplift	4.1% 10/11 0% 11/12-13/14	5.1% 10/11 2.5% 11/12-13/14
Inflation & activity uplifts (pre-initiatives)	As per section 6	No change
Initiatives (net efficiency/disinvestment) included in plan	As per section 7	No change
Increased investment headroom (recurrent)	N/A	1% 10/11 2.5% 11/12-13/14
Increased non-recurrent headroom	N/A	£2.5m 11/12 £3.5m 12/13-13/14
Level of contingency	As per section 7.9	0.75% per annum
Level of surplus	As per section 8	See below

Under our best case, the PCT would continue with its efficiency and disinvestment initiatives with the aim of delivering the levels set out in section 7. This would allow further investment opportunities in areas such as those set out below.

The additional investments would be subject to Business case approval and would be prioritised in terms of greatest health benefit (including addressing inequalities).

Also the further investments would not proceed until the delivery of the efficiency/disinvestment initiatives had been assured. As a result, the level of risk to the initiatives would be offset and the level of contingency required reduced, resulting in increased non-recurrent investment headroom, also shown below.

	£K
<b>2010/11</b> [table to be updated]	
Primary care premises (if not cost neutral)	1,250
Obesity strategy	250
IAPT	500
Children services	350
Capacity in primary care	450
Vascular ILI	450
Other	1,850
	<hr/>
	5,100

### **2011/12 Onwards**

Priorities to be identified during 2010/11, should it appear likely that resources will be available, with the potential maximum sums outlined in the table below.

	<b>Recurrent £m</b>	<b>Non-recurrent £m</b>
11/12	13.8	2.5
12/13	14.1	3.0
13/14	14.5	3.0

The revised projections taking into account the additional investment are summarised below:

	<b>10/11 £m</b>	<b>11/12 £m</b>	<b>12/13 £m</b>	<b>13/14 £m</b>
<u>Recurrent</u>				
Income	550.5	564.3	578.4	592.9
Expenditure	540.3	555.3	571.2	587.5
<b>Surplus</b>	10.2	9.0	7.2	5.4
<u>Non-recurrent</u>				
Income	13.5	16.2	15.2	12.9
Expenditure	7.5	10.0	9.5	8.5
<b>Surplus</b>	6.0	6.2	5.7	4.4
<b>TOTAL SURPLUS</b>	16.2	15.2	12.9	9.8

The analysis of risks, opportunities and contingency under this scenario are as follows:

	<b>10/11 £m</b>	<b>11/12 £m</b>	<b>12/13 £m</b>	<b>13/14 £m</b>	<b>TOTAL £m</b>
Risks					
- initiatives (1)	-	-	-	-	-
- other (2)	3.5	3.5	3.5	3.5	14.0
Total risk	3.5	3.5	3.5	3.5	14.0
Contingency (3)	4.0	4.0	4.0	4.0	16.0
Risk as % of contingency	87%	87%	87%	87%	87%
Opportunities (4)	1.5	1.5	2.0	2.0	7.0
Risk minus opps	2.0	2.0	1.5	1.5	7.0
Risk minus opps as % of contingency	50%	50%	38%	37%	44%

- (1) Risk of initiatives in base case offset by additional discretionary investment headroom
- (2) As base case
- (3) Reduced from base case to £4.0m per annum
- (4) As base case

### 11.3 Downside Case

Having already taken on board the potential downside allocation uplifts in our base case, for our downside case we have used the same allocation and underlying activity assumptions but assumed a lower level of achievement (recurrently) of the efficiency/disinvestment programme.

We have assumed in this scenario that of the £18m of initiatives at highest risk, 50% is not achieved (i.e., the £9m in the base case risk assessment is moved from risk into I&E as not achieved). This leads to with a resultant reduction in the level of surplus (before remedying actions) as outlined in the table below.

	10/11 £m	11/12 £m	12/13 £m	13/14 £m
Recurrent				
- Income	545.4	545.4	545.4	545.4
- Expenditure (1)	535.2	539.4	544.2	549.0
Surplus	10.2	6.0	1.2	(3.6)
Non-recurrent				
- Income	13.5	16.2	12.2	3.9
- Expenditure (2)	7.5	10.0	9.5	8.5
Surplus	6.0	6.2	2.7	(4.6)
<b>TOTAL</b>	<b>16.2</b>	<b>12.2</b>	<b>3.9</b>	<b>(8.2)</b>

(1) As per base case plus £9m, spread over 11/12-13/14

(2) Level of non-recurrent expenditure unchanged, including contingency which is kept at base case levels to cover the risk of delivering the remaining 50% of the £18m.

The reduced level of recurrent savings has the impact of:

- reducing the recurrent surplus in 13/14 from £5.4m in the base case by £9m to a £3.6m deficit and
- the knock-on impact on the non-recurrent position due to the reduced surplus carry forward.

Given the timeline we have established to confirm our plans for 11/12-13/14 (i.e. 30 June 2010 – see section 7.5) we will be able to respond promptly to the downside.

Faced with this position the PCT would:

- reduce the level of recurrent expenditure by £4m (from £30m in the base case to £26m)
- reduce the level of non-recurrent expenditure from £10m in the base case (section 7.7) to £6m (excluding contingencies)

The summary position after these actions is summarised below:

	10/11 £m	11/12 £m	12/13 £m	13/14 £m
Recurrent				
- income	545.4	545.4	545.4	545.4
- expenditure (1)	534.2	537.4	541.2	545.0
Surplus	11.2	8.0	4.2	0.4
Non-recurrent				
- income	13.5	17.7	17.2	12.9
- Expenditure (2)	7.0	8.5	8.5	7.5
Surplus	6.5	9.2	8.7	5.4
Total	17.7	17.2	12.9	5.8

(1) £4m reduction is recurrent expenditure - £1m per annum

- (2) £4m reduction in non-recurrent expenditure - £0.5m 10/11, £1.5m 11/12, £1m 12/13, £1m 13/14 - contingency unchanged from base case.

The revised risk assessment for the downside scenario is set out in the table below.

	10/11 £m	11/12 £m	12/13 £m	13/14 £m	TOTAL £m
Investment risk (additional) (1)	0.5	0.5	0.5	0.5	2.0
Base case risk (2)	3.5	6.1	6.5	7.1	23.2
Total adjusted risk	4.0	6.6	7.0	7.6	25.2
Contingency (3)	4.0	6.5	7.5	7.5	25.5
As % of contingency	100%	101%	93%	101%	99%
Opp from base case (3)	1.5	1.5	2.0	2.0	7.0
Adjusted risk less opportunities	2.5	5.1	5.0	5.6	18.2
As % of contingency	62%	78%	67%	75%	71%

- 1) 50% of the proposed recurrent expenditure reduction above
- 2) As base case, i.e., efficiency/disinvestment risk of £9m, other risks of £14m
- 3) As base case

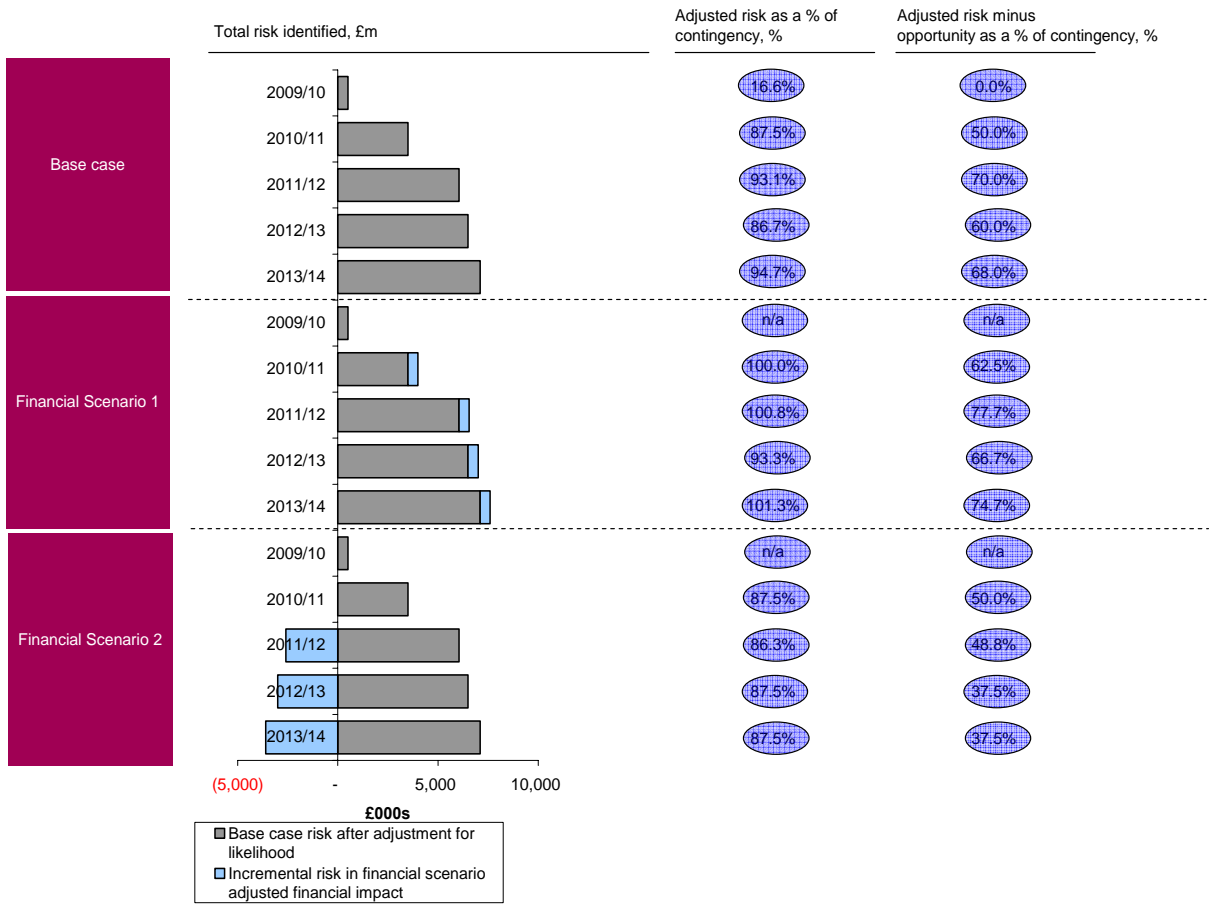
The level of contingency is sufficient to cover the total risk (i.e. incremental risk plus base case risks), with headroom available if the opportunities are able to be realised.

## 11.4 Summary of scenarios

The table below summarises the surplus and the risk ratios under each of the scenarios.

	10/11	11/12	12/13	13/14	TOTAL
<b>BASE</b>					
Recurrent surplus	10.2	9.0	7.2	5.4	
Non-recurrent surplus	6.0	6.2	5.7	4.4	
Total Surplus	16.2	15.2	12.9	9.8	
Surplus as %	3%	3%	2%	2%	
Risk as % of cont.	87%	94%	87%	95%	91%
Risk less opportunity as % of cont.	50%	71%	60%	68%	64%
<b>BEST</b>					
Recurrent surplus	10.2	9.0	7.2	5.4	
Non-recurrent surplus	6.0	6.2	5.7	4.4	
Total surplus	16.2	15.2	12.9	9.8	
Surplus as %	3%	3%	2%	2%	
Risk as % of cont.	87%	87%	87%	87%	87%
Risk less opportunity as % of cont.	50%	50%	38%	37%	44%
<b>DOWNSIDE</b>					
Recurrent surplus	11.2	8.0	4.2	0.4	
Non-recurrent surplus	6.5	9.2	8.7	5.4	
Total surplus	17.7	17.2	12.9	5.8	
Surplus as %	3%	3%	2%	1%	
Risk as % of cont.	100%	101%	93%	101%	99%
Risk less opportunity as % of cont.	62%	78%	67%	75%	71%

**How risk to contingency ratio changes under financial scenarios**



## 11.5 Managing uncertainty

Given the inherent risks and uncertainties involved in planning both income and expenditure over the coming years, the PCT has focussed on ensuring that it is able to respond to changes in base case assumptions and projections in a flexible and optimum manner. This is enabled by

- our base case assumption of the downside allocation
- our financial monitoring and updating process (see section 13)
- the strength of our underpinning financial management systems (see section 14)
- the strength of our planning process including our understanding of risks and opportunities
- the levels of contingency and non-recurrent investment

**We believe that we have sufficient grip and flexibility in our plans to ensure that under all scenarios we will be able to maintain a sustainable financial position.**

## SECTION 12: CAPITAL, CASH AND BALANCE SHEET

### 12.1 Capital

The capital required to create polysystems in Brent is at a level that can reasonably be expected to be funded. The capital requirement is limited as there exists significant spare capacity in existing facilities as outlined in the Strategic Plan. We have included preliminary estimates of the capital required in our plans, as set out below.

	Capital Projections			
	10/11 £m	11/12 £m	12/13 £m	13/14 £m
Operational capital	1.0	1.0	1.0	1.0
Polysystem (refurb.)	1.5	1.0	-	-
ICT		0.5	0.5	0.5
Total	2.5	2.5	1.5	1.5

### 12.2 Cash and PSPP

As a consequence of the deficit incurred in 2006/07, the PCT needed to secure a cash advance (loan) from the Department of Health. The whole of the cash advance was repaid in 2007/08 and in 2008/09 the PCT under spent by £22.6m as follows:

	£m
Revenue resource under spend	12.4
Deficit repayment (non-cash)	<u>10.2</u>
	22.6

For 2009/10, the PCT is forecasting to achieve its cash plan. For 2010/11 onwards, the cash position is expected to mirror the financial position set out in section 8.3. The PCT has an extant Cash Management Strategy (agreed by the Board in July 2008).

The PCT has historically had poor performance on PSPP due to inefficient systems. The PCT moved to NHS Shared Business Services on 1<sup>st</sup> September 2009 and as a result the PSPP performance will improve.

08/09 Performance before the move was	
Non NHS	75.9%
NHS	91.0%

The PCT aim by March 2010 to be at the target level of 95%.

### 12.3 Balance Sheet

The forecast balance sheet over the planning period is included in the financial template. The following assumptions have been made:

- Creditors – a reduction over the period in order to improve PSPP rates
- Debtors – a reduction over the period as a result of improved processes
- Capital – see above for additions.
- IFRS – the opening 2009/10 balance sheet has been restated for the impact of IFRS.

## **SECTION 13: FINANCIAL MONITORING AND UPDATING PROCESS**

### **13.1 Introduction**

This section of the MTFS should be read alongside section 5 (delivery) of the Strategic Plan as monitoring of financial delivery will be an integral part of the overall mechanisms of reviewing delivery of the Strategic Plan.

### **13.2 Current financial monitoring and forecasting processes**

We already have strong processes in this area, including:

- Budget setting processes
- In-year budget monitoring
- Monthly forecasting processes, including three scenarios (best, mid, worst) and recurrent/non-recurrent expenditure analysis
- Quarterly 'hard close' process, including agreements of balances and analysis of spend in accounts format
- Quarterly update of rolling 18 month forecasts
- Finance and Investment Group (FISG), a Board sub-committee reviews issues and risks on a monthly basis.

In the above we specifically aim to follow best practice (e.g. as identified by CIPFA and the Audit Commission) and our approach has been documented in an internal procedure note. We have received substantial assurance from internal audit in respect of their reviews of budgetary control and forecasting for both 2008/09 and 2009/10. We achieved a level 3 in the 09/10 Use of Resources assessment for Key Lines of Enquiry 1.1 and 1.3.

### **13.3 Further developments**

We are continually looking at areas to develop our monitoring and forecasting arrangements and this is included as a specific objective within our financial forecasting document as well as our Use of Resources Plan for 09/10 (see section 14).

### **13.4 Integration with overall Strategic Plan monitoring**

Best practice project management methodology will be applied across all of our strategic initiatives. Individual project level risks will be managed and escalated through standardised processes through the SRO, to the Executive Management Team and the Board (including the sub-committees).

**Add overall Strategic Plan delivery & governance arrangements.**

### **13.5 Integration with NW London ISP**

**To follow**

## SECTION 14: UNDERPINNING FINANCIAL MANAGEMENT SYSTEMS

### 14.1 Achievements to date

The PCT has made major steps forward in its financial management arrangements over the last 12-18 months, as evidenced by:

- Use of resources improved scores in 08/09
- Quality of financial management' assessment improved from 'weak' to 'good' in 2008/09
- the Taylor follow-up review, 2008/09
- significant improvement in internal audit opinions on core systems 2008/09-2009/10
- improved external audit annual governance report 2008/09
- shortlisted for HFMA Accounts Team of the Year award, autumn 2009
- promoting Good Practice in Finance staff Development (silver) award awarded July 2009
- Substantial strengthening of the finance team, including numbers qualified and training
- improvement in SHA financial risk rating in 2008/09, maintained in 2009/10

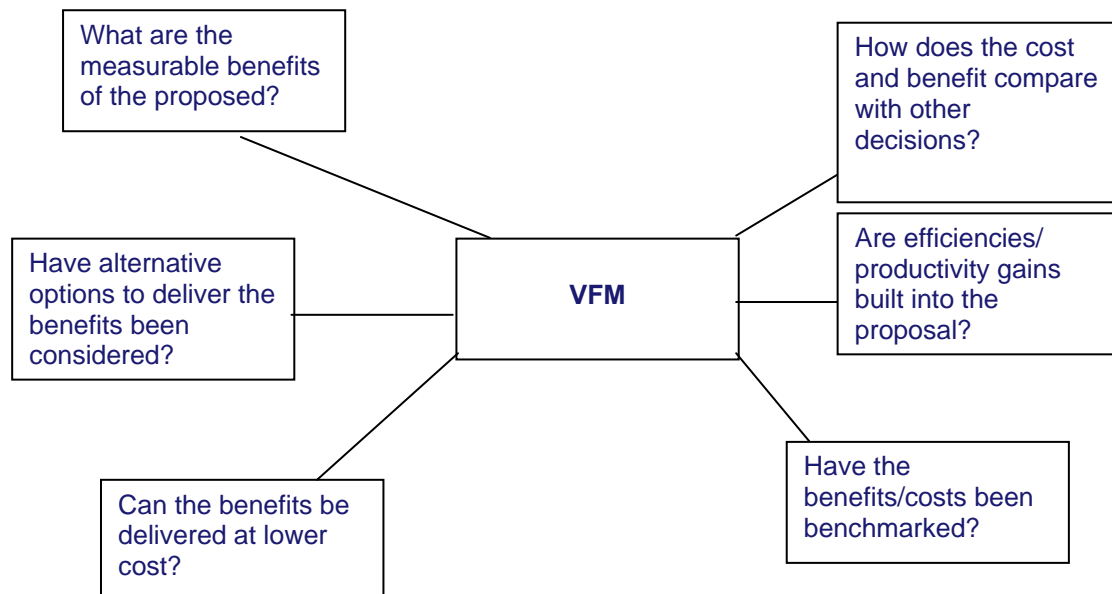
### 14.2 Further development

Our plans for development in 09/10 and beyond are encapsulated in our Use of Resources improvement plan, the main components of which are:

- SBS implementation, successfully achieved go-live from 1/9/09
- Continued improvement in the financial planning and financial reporting key lines of enquiry to reach level 4.
- Developing the PCT's investment /disinvestment processes to WCC competency 11 standards (see below)
- Further development of Board sub-committees (Finance & Investment Strategy Group and Audit Committee) in line with best practice.

### 14.3 Investment/disinvestment processes

We have reviewed our Business Case process to ensure alignment with WCC competency 11. In particular we have adopted the approach outlined below to ensuring Value for money is fully considered.



Given the importance of ensuring that our efficiency/disinvestment programme is robust, we have adopted the following 10 point checklist for the initiative projections.

Initiative checklist:

- Is the SRO/project lead identified?
- Are the activity and financial projections aligned?
- Has the activity/financial analysis been undertaken at HRG/specialty level (where applicable)?
- Have costs of delivery/re-prioritisation been considered and identified (where applicable)?
- Have the projections been informed by relevant benchmarks/external evidence?
- Are the timelines realistic?
- Does the financial profile match the delivery timeline?
- Have the metrics to monitor delivery been identified?
- Have the working papers been made available?
- Have the projections been reviewed/validated with the finance team?

## **SECTION 15: PRACTICE BASED COMMISSIONING DEVELOPMENT**

(To be updated)

The arrangements for the re-establishment of PBC in Brent for 2008/09 were agreed at the March 2008 PCT Board, alongside the 2008/09 Operating Plan and opening budgets.

The 2008/09 arrangements were developed in 2009/10. Arrangements for 2010/11 onwards are being developed in conjunction with the delivery of the Strategic Plan.

## SECTION 16: ASSESSMENT AGAINST OBJECTIVES AND CRITICAL SUCCESS FACTORS

### 16.1 Assessment against objectives

The table below reviews the 10 objectives agreed for the MTFS set out in section 1.2 and assesses the extent to which they have been achieved.

OBJECTIVE	ASSESSMENT
1. Clearly linked to, and embedded in, the PCT's overall strategy plan.	The MTFS has been developed hand-in-hand with the strategy plan and is entirely consistent with it.
2. To ensure continued underlying financial stability in order that the improvement in financial standing achieved in recent years is maintained through a focus on the underlying recurrent position and the achievement of a min. 1% surplus across all years and all scenarios.	A recurrent/non-recurrent split is rigorously maintained throughout the projections in the MTFS. The achievement of min. 1% surplus across all years and all scenarios is demonstrated. (see section 11.4)
3. To incorporate credible planning assumptions, including benchmarked savings plans and realistic timelines and delivery plans.	We have assumed downside allocation assumptions and inflation uplifts as per NHS London. Activity growth assumptions are credible in the light of Brent's recent experience and Healthcare for London modelling. (see section 6.4) Savings plans are benchmarked where appropriate and have realistic timelines and delivery plans.
4. To incorporate a rigorous risk assessment with associated mitigation strategies.	Plans have been subject to rigorous risk assessment (see sections 7.4 and 10). Mitigation strategies have been identified. (section 7.5)
5. To support the continued delivery of increased efficiency and effectiveness of spend.	The baseline benchmarking analysis undertaken together with the benchmarking underpinning savings plans and the PCT's approach to investment/disinvestment appraisal should ensure this.
6. To test the robustness of the projections through sensitivity testing and scenario planning, and to ensure flexibility in planning to respond to different scenarios.	Three scenarios have been modelled. Using the downside allocation assumptions within the PCT's base case will increase flexibility to respond to different scenarios.
7. To establish a clear process and key metrics to monitor progress and realign plans where necessary.	Key metrics for each initiative are in place. Overall monitoring and realignment process in place. (see section 13).
8. To incorporate revenue, capital, cash and balance sheet projections.	All incorporated.
9. To ensure plans are underpinned by strong corporate financial management, governance and systems	Outlined in section 14
10. To ensure alignment between the MTFS and the annual Operating Plan and budget-setting process.	MTFS based on 09/10 forecast outturn at month 6 and 10/11 budget setting process explicitly linked to MTFS.

## 16.2 Assessment against critical success factors

Section 1.3 set out the key requirements which every PCT needs to address and incorporate within its MTFS (as recommended by the Audit Commission) and these are considered below with a view to assessing the extent to which this MTFS incorporates these requirements:-

- **Strong leadership at both EMT and Board level** – The development of the MTFS has been overseen by the Executive Team and the Finance and Investment Strategy Group. (Board Sub-Committee). The Board received a draft in July and agreed the final version in December 2009.
- **Support the achievement of strategic objectives** – The MTFS reflects a financial assessment including modelling the impact of service priorities emerging from the strategic planning process. The MTFS will continue to be developed alongside the implementation and annual refresh of the Strategy Plan.
- **Establishing accountability for producing and adhering to MTFS** – The project plan for the production of the Strategic Plan identified the processes, timetable and responsibility for the development of the MTFS as a key element of the Plan. The implementation of the Strategic Plan will be tracked alongside the updates of the MTFS.
- **Identifies and manages the financial implications of risk** – The MTFS incorporates an assessment of financial risk throughout, including and scenario planning. Mitigation strategies and actions have been identified.
- **Understands the PCT's cost drivers** – The MTFS incorporates an assessment of the impact of key cost drivers over the planning period. This assessment will continue to be refined as the plan is implemented.
- **Recognises the importance of good quality data** – The need to underpin the PCT's Strategy and MTFS by ensuring the quality of planning data has been recognised. A Data Quality Strategy was agreed by the PCT at its July 2008 Board, a Commissioning Intelligence Information Strategy at the July 2009 Board and both the 2008 and 2009 OD plans include plans to strengthen this area further.
- **Producing an MTFS that is comprehensive, accurate and relevant** – The PCT is of the view that the MTFS is a comprehensive accurate and relevant as possible at this point in time. The MTFS has been comprehensively reviewed and updated from the 2008 version and this process will continue into the future.
- **Providing the opportunity for internal and external stakeholder scrutiny** – This requirement has been addressed both as part of the wider Strategic Plan stakeholder engagement programme as well as specific sessions with key stakeholders focussed on the MTFS.
- **Ensuring Board approval and appropriate communication** – the PCT Board approved the initial MTFS at its July 2008 meeting as the 2008 Strategic Plan at the November 2008 Board meeting. The 2009 MTFS was discussed in draft in July 2009 and will be signed off alongside the Strategic Plan in December 2009.
- **Using the MTFS as the key financial document and implementing systems for achievement, monitoring and refreshing MTFS** – Annual revenue budgets for 2009/10 are consistent with the MTFS and the 10/11 Operating Plan will similarly be directly linked to the MTFS. Delivery of the MTFS will be supported by systems for monitoring and refreshing the plan.

## SECTION 17: WCC GOVERNANCE (FINANCE) SELF-ASSESSMENT

### 17.1 Introduction

Within the WCC Governance assessment, the 2008 panel assessment on Finance was 'Amber'. This section reviews the 2008 Panel recommendations and summarises the PCT's 2009 self-assessment.

### 17.2 WCC panel recommendations 2008

The panel made four recommendations and these, together with the actions taken, are set out in the table below.

Panel Recommendation	Action
1. Revisit the financial plan to ensure underlying assumptions are clearly understood by PCT staff and that explanation of assumptions is included in future submissions.	The MTFS includes explanations of assumptions used throughout the document. Specific finance presentations have been given to the Executive Team, FISG, Board, PBC Executive, all GPs and an all staff event. In addition the Strategic Plan stakeholder events have included a high level summary of the financial position.
2. Clarify a strategy for reinvestment of surpluses	The MTFS clearly distinguishes between recurrent and non-recurrent sources and applications, enabling a clear demonstration of how the surplus carry forward is being applied each year.
3. Monitor progress towards expected improvement on the ALE score	Our quality of financial management assessment improved from 'weak' to 'good'. The PCT has in place action plans to improve its Use of Resources assessment in 09/10.
4. Revisit elective elderly care growth trajectory	All specialty specific growth rates have been revisited as part of the 2009 MTFS

### 17.3 Self-assessment 2009

The PCT has undertaken a self-assessment against each of the five components of the finance assessment and submitted this (with supporting evidence) as part of the wider WCC submission. Our assessment is summarised in the table below.

## **GOVERNANCE – FINANCE COMPONENTS**

### **SELF-ASSESSMENT**

	<b>Last Year</b>	<b>This year</b>
<b>Historical financial management</b>	<b>Amber</b>	<b>Green</b>
<b>Robust financial management</b>	<b>Amber</b>	<b>Green</b>
<b>Robustness of planning assumptions</b>	<b>Amber</b>	<b>Green</b>
<b>Sustainable financial position as ‘base case’</b>	<b>Amber</b>	<b>Green</b>
<b>Sustainable financial position under different scenarios</b>	<b>Amber</b>	<b>Green</b>

**We believe that our overall improvement in financial management over the last two years, which is supported by externally validated measures/ratings, provides a solid foundation for our plans and that this, coupled with the robustness of our planning and ongoing financial monitoring arrangements set out in this plan, supported by the organisation’s strengths set out in our OD plan, are sufficient to support a ‘green’ assessment in 2009.**

### **References**

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**December 2009**