NHS
Eastern Cheshire
Clinical Commissioning Group

GOVERNING BODY MEETING held in public

27 April 2016 **Agenda Item 1.5**

Paper Title	Chief Officer Report

APPENDIX B

NHS England : Frequently Asked Questions on the requirement for 1% Non-recurrent expenditure in CCG budgets to be set aside

Gateway Ref 05105

1% Non-recurrent Expenditure

Frequently Asked Questions

1. **Why do we have to set the 1% non-recurrent monies aside?**

The NHS faces a significant challenge in 2016/17 as it seeks to bring the system back into financial balance. In this context it is important that each health economy has sufficient reserves set aside to cover any unmitigated risks it faces. Alongside standard contingencies in each organisation, the DH has provided an additional system resilience buffer in the past which will not be in place in 2016/17.

2. **Isn't this just a top slice from CCG allocations to prop up the provider sector?**

It is still our intention that the 1% be used by CCGs for non-recurrent health economy priorities, not to bail out providers. Clearly, our ability to deploy it will be dependent on managing the total health economy risk profile, including providers, but we haven't changed its primary purpose.

The money will not be top sliced from commissioners – at worst, commissioners will be required to underspend in part or in full against the 1% non-recurrent and flow the resulting benefit through to the bottom line to create an in year underspend. This will be carried forward to be available as drawdown in future years.

3. **I already have transformation-related investment commitments for 2016/17 – how do I fund these if I am not authorised to spend my 1% non-recurrent?**

Commissioners will have to decide whether to prioritise transformation over other investments (funded out with the 1%) where this is the case, or whether transformation investments will need to be paused until confirmation of release of the 1% non-recurrent is provided.

4. **What are the conditions that have to be met for the non-recurrent monies to be released?**

Firstly NHSE working with system partners nationally, will need to be assured that the overall health system has a balanced set of robust plans for 2016/17 and that plans include appropriate risk mitigation. Secondly regular financial reporting,

including forecasts and risk/mitigation analysis, will need to show that we are on track to deliver these plans. We will then need to look to individual health economies to assess the level of risk within each economy, and to make a judgement as to whether the 1% non-recurrent should begin to be released.

We hope to be able to release the first tranches for investment by the end of quarter 1, subject to the conditions above. If necessary we will consider a framework for prioritising investment, by reference to the priorities set down in the five year forward view and the 2016/17 planning guidance.

5. **What if I don't get approval to commit the spend until half way through the year? What if I only get approval to spend part of the money?**

Commissioners are encouraged to phase their investment plans appropriately and to consider a range of scenarios from full release of the 1% non-recurrent monies at an early point in the year, to partial release at a later point in the year and decide how in each scenario the money will be deployed to best effect.

6. **Why is the money being pooled across the whole of the STP area? Is there any flexibility for the risk management mechanism to operate across a smaller footprint?**

The STP footprint is the prime operating unit for the development of strategic plans, so it is an obvious choice to link to the operation of risk pooling arrangements, and for encouraging a dialogue across the whole of the strategic planning footprint. Optimally the risk pool footprint should be big enough to manage risk but not too big for participants to be unable to influence the decision-making and outcomes of financial risk management.

Where commissioners are concerned that the operation of risk pooling arrangements across the STP footprints would be sub-optimal, they are invited to put forward alternative pooling arrangements explaining the following:

- Why the commissioners consider that the operation of pooling across the STP footprint would be sub-optimal
- A summary of the sub units over which it is proposed the risk management will operate showing the commissioners, providers and population size
- Confirmation that the choice of sub units fully reflects the commissioning linkages with each provider and also does not lead to sub units which are too small for risk management purposes
- An explanation of the main patient flows across the STP footprint and how these relate to the sub-units
- A summary of the financial position of each of the sub units across providers and commissioners together, compared with the financial position across the whole of the STP to provide assurance that the financial sustainability of each sub unit is no less than that of the STP as a whole

- An explanation as to how the operation of the risk pooling across a smaller footprint than the STP will not undermine the overall principles behind the risk management process based on the STP.

Submissions will be considered, and approval given in cases where there is a strong rationale for operating at a sub unit level rather than the STP level, and where arrangements at a sub unit level will not reduce the effectiveness of the risk mitigation arrangements across the STP.

A letter from the proposed sub unit supporting the request and evidencing the points above should be sent to local offices by 18th April 2016.

7. **Does each commissioner within a risk pool footprint need to meet the 1% non-recurrent requirement individually or is it sufficient for the footprint to achieve this in aggregate?**

Commissioners can meet the 1% non-recurrent requirement in aggregate as part of an STP or smaller sub unit as along as all commissioners in that footprint are in agreement on their respective shares.