South West London

Merton Clinical Commissioning Group

Report to the Merton Clinical Commissioning Group Governing Body

Date of Meeting: Thursday 24th January 2013

Agenda No: 7.1 **ATTACHMENT 06**

Title of Document: Draft Medium Term Financial Strategy (MTFS)	**Purpose of Report:** For Note
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Executive Summary:

The 2013-14 Draft MTFS report presents the 2013/14 PCT high level revenue budget for note.

The budget reflects the PCT's current understanding of its financial position, existing commitments and identifies prioritised investment. It also reflects the impact of the financial requirements placed on it by the Operating Framework.

Key sections for particular note (paragraph/page), areas of concern etc:

Key issues of concern have been reflected in the document.

Recommendation(s):
The Clinical Commissioning Group Governing Body is requested to:

1. Note the detailed revenue budget outlined in this paper
2. Acknowledge the risks identified in the budget

Committees which have previously discussed/agreed the report: Merton Executive January 2013 Merton Finance Committee January 2013
PEC Comments where appropriate: N/A
Financial Implications: Financial Balance
Implications for the Sutton and Merton Board or Joint PCT Boards: **Financial Balance**
Implications for transition to future commissioning structures. **N/A**
Other Implications: N/A
Equality Impact Assessment: N/A
Information Privacy Issues: N/A
Communication Plan: N/A

Draft
Medium Term
Financial Strategy

MERTON CLINICAL COMMISSIONING GROUP

CONTENTS

1. Introduction Aims/Purpose of Strategy

1. Merton Clinical Commissioning Group's (MCCG) Financial Strategy is concerned with using the CCGs resources wisely to meet the health needs of Merton and to ensure value for money and fair and effective use of resources to improve the health and well being of the community and secure the provision of safe high quality services.

2. The Financial Strategy is focused on:

   - communication of the CCG's financial position and context
   - the financing of the strategy of the CCG to deliver health gain objectives, within the constraints of its resource allocation and responsibilities and
   - ensuring that the CCG can trust its financial systems to support informed decision making.

3. The overriding objective of the Financial Strategy is to maintain, through prudent control, sustainable financial viability in order to enable the CCG to achieve its purpose and goals and achieve the CCG's statutory and financial duties.

4. The purpose of the financial strategy is to:

   - monitor and ensure the ongoing financial viability of the CCG
   - ensure the resource needs of the CCG and potential financial risks are correctly identified
   - enable the CCG to make informed decisions on new initiatives, future developments and opportunities
   - support the CCG's service strategies through effective and prioritised use of resources and enable service review and redesign
   - enable the movement of financial resources to support changing health needs and changes to the delivery of health.

5. The CCG has a number of statutory and financial duties that it is required to achieve. These duties are:

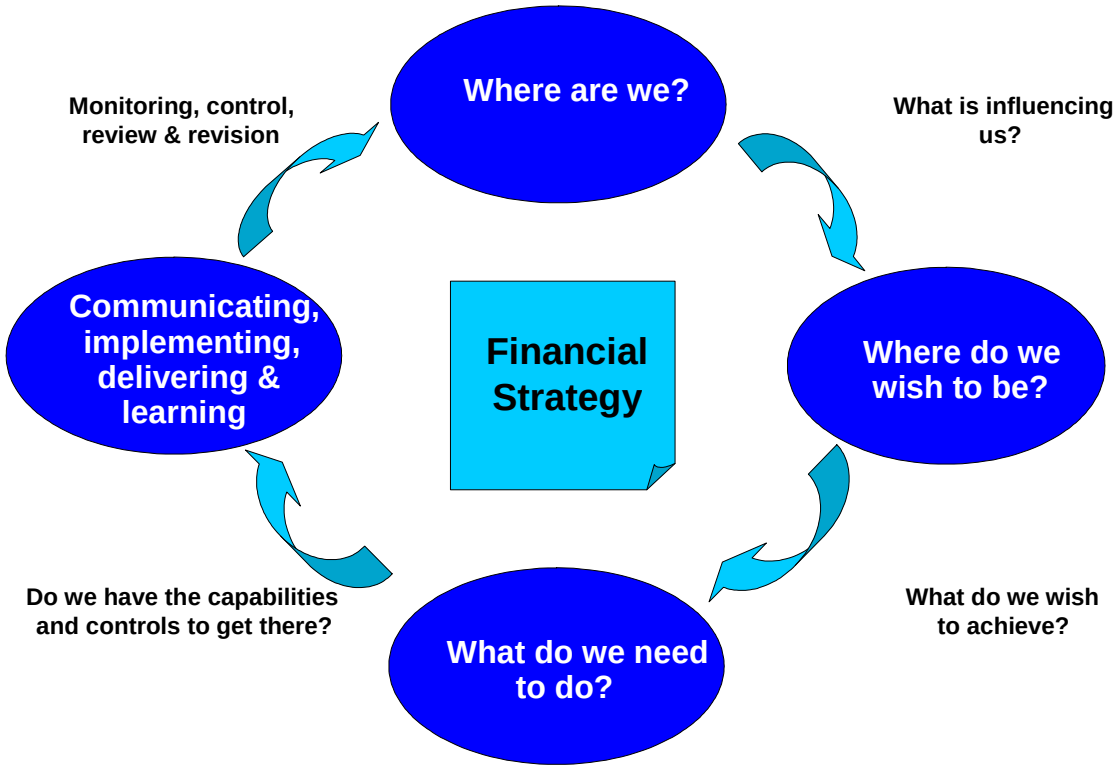
   - not to exceed its revenue, and cash limits in any one year
   - to pay all valid invoices by the due date or within 30 days of a valid invoice.

6. In addition, the NHS Commissioning Board will be setting control totals for each NHS organisation including CCG's. Due to the limited range of the control total, organisations have had to significantly improve their financial planning and the implementation of Quality, Innovation, Productivity and Prevention (QIPP) plans, as any slippage compromises the CCG's ability to deliver the control total.

2. Principles & Strategic Approach

7. The financial strategy has been developed on the following principles:

- an understanding of the current and prevailing financial position and current use of resource and the recognition that we need to better understand 'what we get for our healthcare spending' through benchmarking, care pathway and disease spend analysis
- consideration of the context in which the CCG operates in terms of health care policy and strategy and the impact of influences
- resources prioritised to deliver the CCG's strategic objectives in line with our Commissioning Intentions as detailed in our Commissioning Strategic Plan.
- that GP practices, local clinicians and managers work together to develop financial awareness, understanding and ownership of financial issues in the delivery and commissioning of services to deliver immediate and long term change and that the finance function will support them in making the right choices and commitments
- the need to develop public engagement programmes which will facilitate ownership of the use of resources
- new investment and disinvestment reviews are focused on the change in health improvements delivered
- that the underpinning financial processes need to be sufficiently developed to provide robust and complete financial information to assist in the delivery of the strategy



3. Financial Strategy

High Level Financial Summary

8. Planning at this stage is challenging as the CCG contract portfolio is still to be completely disaggregated from NHS Sutton & Merton. Work is ongoing to identify the required levels of funding via the contract negotiation round. An indicative analysis of the PCTs existing 2012/13 allocation is tabled in Appendix 1.

9. The CCG for 2013/14 has received growth funding of 2.30% on its resource limit, and this is anticipated to increase to 2.84% in 2014/15. A summary of the assumptions of price increases from 2012/13 to 2017/18 is attached in Appendix 2.

10. Delivering the financial plan from 2013/14 onwards, in the context of reduced and uncertain growth and in a period of significant transformation, will be challenging. .

11. A summarized Income and Expenditure plan is attached at Appendix 4 reflecting the overall Merton CCG position from 2013/14 to 2017/18.

Revenue Outlook

12. During 2013/14 and 2014/15 the CCG will experience considerable pressures primarily in acute but also in non acute areas of spend. This will be mitigated by the implementation of Better Services Better Value (BSBV) and Better Healthcare Closer to Home (BHCH) as this is rolled out from 2013/14 onwards.

13. Quality, Innovation, Productivity and Prevention (QIPP) are the key to unlocking this level of efficiency required. Achievement is dependent upon local clinicians, GP practices and managers and partners working together to deliver both immediate and long term change.

14. This, in an increasingly challenging financial environment means central to achieving financial balance is the continued requirement to maintain the CCG's focus on contingency and surplus planning, careful financial planning and investment prioritisation and through the delivery of significant, sustainable efficiency savings.

15. Continued investment will only be achievable if efficiency savings are created through service review and redesign over and above that required to deliver financial balance.

Sources of Funds

16. Sutton and Merton PCT receives a weighted allocation recurrent resource for 2012/13 of £615m for its weighted population of 366,547. Merton CCG currently has an indicative budget for 2012/13 of £213m and a weighted population of 182,464. The PCT's allocation is based on a weighted capitation formula, which takes into account the need for health care but also the PCT's population size, age, structure and any variations.

17. The PCT's allocation compared with its weighted capitation target is 3.5% higher than target for 2011/12. The PCT's financial plans assume that, as in previous years, any movement to weighted capitation target will be gradual and will be applied through a modified growth allocation.

18. No information has yet been published on how the allocation of growth and pace of change will operate for CCG's. However, given that the existing PCT's allocation is over target it is reasonable to assume that this will be a critical issue for the CCG in the future, the PCT is currently above target by 3.5%.

Efficiency Plans and Best Value Reviews

19. The operating framework for 2013/14 details a gross national tariff/uplift of 2.7% less efficiency of 4% resulting in a -1.3% tariff. The efficiency requirement is expected to remain static over the next two years. The tariff assumes that all providers will achieve internal efficiencies through changing the way services are delivered, reducing variations in activity and improving procurement practices.

20. Efficiency strategies as a result of lower growth and increasing demand will be required to be developed further by the CCG to deliver sustainable savings outside of, and in addition, to the tariff. These plans will be under pinned by 'best value' principles, which recognise service delivery and quality improvement as well as cost reduction.

21. The DH refers to this agenda as the QIPP (Quality, Innovation, Productivity and Prevention) programme. The objectives of the QIPP programme are to drive efficiencies in providers, optimise spend and deliver quality and shift care into the most cost effective settings.

22. An important focus of ongoing efficiency will be the development of a programme of service review based on the commissioning intentions. This will focus on all commissioned services, particularly recently implemented business cases, which will be conducted under the 'best value' principles of: challenge, consultation, competition and comparison and the economic concept of value added or health gain achieved

Financial Improvement Plans – Facing the Challenge

23. Delivering the financial plan from 2013/14 onwards will be challenging, with the total savings requirement for Merton CCG of approx 4% of the overall resource limit.

24. This savings requirement clearly increases if the CCG wishes to generate an 'investment fund' over and above that reflected in the existing plan or if the plans delivered are non recurrent.

25. In order to meet the financial challenge, the CCG, has embarked on a number of pieces of work to develop and deliver sustainable savings from greater efficiency and through managing demand for reinvestment.

26. The following levers will form the CCG's demand management and efficiency plan:

- **Redesign and Lower Cost Settings.** Finding ways of achieving the same (or better) outcomes for patients for less cost by completely redesigning and reorganising the way in which services are delivered and/or delivering services in a lower cost setting. This includes improving access to urgent care services in the community.

- **Long Term Conditions & Case Management.** Through improving the management of long term conditions through better use of community specialist and existing services including partners.

- **Prevention**. Focusing on prevention and screening - additional examples of projects and investments over and above those within the choosing health programme.

- **Management of Acute Contract Activity.** Monitoring and challenging of activity and finance monitoring returns to ensure adherence with PbR contracting rules, performance targets and effective commissioning guidance.

- **Utilisation of Demand Management Activities.** Reducing GP referrals by managing referral thresholds and managing care in the community.

- **Decommissioning**. Decommission evidence based low valued added interventions - for example cosmetic procedures, grommets, tonsillectomy, and minor skin lesions.

The priorities for the MCCG are built on the Integrated Strategic Operating Plan (ISOP) developed with stakeholders

In response to the key health issues, as identified in the Joint Strategic Needs Assessment (JSNA), the CCG has approved a number of key strategic initiatives (commissioning priorities) for the health and healthcare of the local population, below. These initiatives will be supported by the Quality, Innovation, Prevention and Productivity (QIPP) transformational programme include:

- Prevention, screening, early diagnosis and awareness initiatives
- Long Term Conditions
- Urgent Care/Older People
- Mental Health
- Children's Services
- Sexual Health
- Substance Misuse (drugs and alcohol)
- Supporting initiative: QIPP

Inflationary & generic pressures

27. The first call on growth or efficiency generated funds is to fund the recurrent cost of prior year outturn, inflationary tariffs and generic pressures and to recurrently fund known existing and future uncontrollable activity increases. Inflation is set by the DH and reflected in the national tariff.

28. In addition to growth, the negative tariff means a net increase in available resources to CCG's, it is expected that this will be reinvested in services and meet activity growth.

Contingency Reserve

29. It is assumed that the National Commissioning Board will expect all CCGs to continue to include a level of contingencies in their financial plans. The contingency is held in reserve and assessed in year to determine its availability for investment.

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Target Surplus & Non Recurrent Headroom

30. Similarly it is assumed that CCGs will continue to plan for surpluses of 1% and maintain a 2% non-recurrent commitment to create in year flexibility.

Maintenance of Reserves & Provisions

31. There are a number of risks which may impact on the delivery of the CCG's Revenue Plan. Going forward the management of reserves is going to be a key factor in ensuring plans are managed effectively and more importantly risks are mitigated. Current draft plans assume a level of reserves that allows for the surplus target of 1% to be achieved and some investments made. This will be under constant review.

Investments

32. Due to the overall financial position there will be no funding available in 2013/14 for new investments, with the exception of limited funding to support the QIPP plan and bids against the non recurrent 2% reserve.

QIPP

33. The programme of QIPP is managed by regular governance monthly meetings of the QIPP Steering Group ensures that

- There are regular reviews of the progress and finance reports.
- Risks to delivery are identified at an early stage and ensure effective corrective action is taken and project leads supported in this process.
- Other QIPP initiatives are identified as required to ensure efficiency targets are delivered.
- Senior leadership inputs to achieving QIPP.
- Senior leadership of Merton Borough and SWL is informed of progress against QIPP and appropriately escalates risks and concerns.
- QIPP is also a regular agenda item at the Executive Team. Details of the QIPP programme are contained within Appendix 3

Treasury Management Strategy

34. The CCG has a financial duty not to exceed its cash limit in any one year. The CCG receives a cash resource, which is based on its revenue and capital resource less capital charges. The CCG draws its cash resource from the treasury on a monthly basis; it is unable to invest this resource.

35. The CCG's cash management strategy is based on:

- continued delivery of income and expenditure balance
- production of accurate detailed cash flow forecasts
- achievement of creditor payment targets
- income collection and debtors management

36. Key to the delivery of the CCG's cash management strategy is the robust and regular forecasting of the CCG's cash flow to ensure that it achieves its year end balance and that it utilises appropriately the cash it draws on a monthly basis.

Achievement of Creditors Payment Policy & Targets

37. One of the CCG's financial duties is to pay all valid invoices by the due date or within 30 days of a valid invoice. The achievement of this Better Payment Practice Code (BPPC) for all of the CCG's creditors is an important part of the CCG's cash management strategy.

38. The CCG aims to pay its smaller suppliers as quickly as possible within the 30 days Better Payment Practice code.

39. The CCG is working with budget holders to ensure:

- invoices are promptly coded and electronically approved by authorised signatories
- immediate action is taken where necessary to resolve invoice disputes

Capital

40. It is the current assumption that the estates portfolio of Sutton and Merton PCT will be transferred to PropCo. MCCG will not have capital funding or a capital programme, but will incur the revenue implications of any agreed capital schemes provided by PropCo.

Robust Financial Processes

41. Financial management is central to the CCG's decision making process to provide information that is used to direct and control the CCG's activities, report and discharge accountability and utilise resources efficiently and effectively.

42. Central to the CCG's ability to provide good financial planning, budget setting and budget reporting and monitoring is the delivery of accurate, timely and efficient treasury management functions, including adherence to better payment practice codes.

43. Significant focus will continue to be placed on improving financial processes.

Risk Assessment & Management

44. The CCG has made adequate provision to manage many of the risks identified above through ensuring appropriate levels of investment in recent years and through maintaining a contingency reserve and planned surplus. MCCG is working with neighbouring CCGs to develop a risk sharing strategy which will further mitigate against future financial pressures.

45. Main risks:

- Transition
- Acute activity performance
- Delivering QIPP

4. Key Points in Delivering & Managing Our Strategy

Robust Financial Systems

46. The strategy will be delivered through the continued development of robust financial systems to enable informed decision-making. Focus will be on improving:

- developing and communicating financial policies, controls & processes
- the timeliness and efficiency of treasury management functions including creditor payments and debt recovery
- the implementation of sound, modern financial systems, procedures and policies
- clear & timely financial reporting & preparation
- accurate and improved forecasting and modelling techniques
- the support and training given to service managers
- transparency & governance within the CCG
- devolved decision making to encourage greater accountability

Investment/Disinvestment Prioritisation

47. MCCG will develop a prioritisation process to assess the relative importance or value of health service interventions and programmes against agreed principles and criteria. Prioritisation decisions include; introducing new or increasing resources or services, reducing existing resources or services and replacing existing resources or services.

48. The prioritisation process is essential as it:

- aligns investment to pre agreed strategies, priorities and policies
- facilitates making fair decisions which balance competing need
- supports understanding of funding options, outcomes, consequences and opportunity costs
- supports the delivery of 'clinical commissioning'
- provides better value for money.

Value for Money

49. Commissioning and provision decisions will become increasingly informed by value for money or 'best value' considerations.

Health Outcomes

50. Success will be measured through using improvements in health outcomes. This can be achieved by routine before and after measurements of health to monitor and manage the performance of providers, but to also to ensure the CCG's resources are focused on securing demonstrable health gain.

Action, Monitoring, Control, Review & Revision

51. The financial strategy has been developed after an assessment of MCCG's financial background, current position and consideration of the impact of policy, priorities and influences of the context in which it operates.

52. The financial strategy by its nature will require continuous review and update and will be formally reviewed on a six monthly basis by the Executive Team and Finance Committee

London Context

Better Services Better Value

53. CCGs have recognised, as a critical component of a sustainable health economy, the necessary acceleration in scale and pace of their locally owned and developed out-of-hospital (Long Term Conditions) models along with the required transformation of primary care. This imperative is also a key enabler for the *Better Services Better Value* programme, expected to deliver significant change to the acute service configuration in South West London.

54. MCCG has reflected the priority pathways in our Integrated Strategic Operating Plan (ISOP) in line with agreed set of priorities across NHS SW London.

55. Merton Clinical leaders have identified the key priorities for delivering a clinically sustainable and financially affordable healthcare economy for our population which reflects key priorities, identifying appropriate actions as they respond to local needs and circumstances

56. In order to achieve this step change, MCCG has, with other local CCGs, acute trusts, community providers and social care representatives, formed a South West London Long Term Conditions Programme Delivery Board.

57. The stated aims of the Long Term Conditions Programme Delivery Board are to:

- Ensure that shifts in settings of care are consistent with the assumptions in the models of care agreed for acute reconfiguration
- Identify those work streams where integration may secure faster implementation including end of life care and the frail elderly
- Support the successful delivery of local and national QIPP schemes
- Share learning and spread best practice, new ways of working
- Identify key enablers such as IT and workforce and incentives to drive change
- Provide peer support and challenge for delivery of key service model components

Local Context

London Borough of Merton

58. MCCG has worked very closely with the local Council in developing its Integrated Strategic Operating Plan and also in planning, commissioning and delivering services.

62. During 2012/13, NHS Sutton and Merton and the London Boroughs of Sutton and Merton completed a Joint Strategic Needs Assessment (JSNA) in line with the recommendations of the Commissioning Framework for Health & Wellbeing. The JSNA is now split so Merton CCG has its own JSNA which highlights a range of strategic priorities to improve the health and wellbeing of local people which are reflected in these commissioning intentions.

63. The CCG has a number of existing LAAs (Local Area Agreements) with the borough. LAAs are local public service agreements negotiated between local partnerships to deliver a range of aims and outcomes to improve services to local people based on local needs and priorities.

Karen McKinley
Chief Finance Officer
January 2013

5. Background Data

Appendix 1.

MERTON CCG
2012/13 RESOURCE ALLOCATION SUMMARY

NHS SUTTON AND MERTON
REVENUE RESOURCE LIMITS 2012/2013

Description	Annual Budget £ NHSSM	Annual Budget £ Merton CCG	Annual Budget £ Sutton CCG	Annual Budget £ PH	Annual Budget £ NCB	Annual Budget £ Prop Co
PCT REVENUE EXPENDITURE						
COMMISSIONING EXPENDITURE						
Acute Healthcare Services - *Annex 1*	346,067,471	158,836,896	157,109,368	3,511,015	26,610,192	0
Mental Health Healthcare Services - *Annex 2*	52,681,301	21,742,681	21,506,204	4,009,872	5,422,544	0
Learning Disabilities Healthcare Services - *Annex 3*	4,018,028	2,019,999	1,998,029	0	0	0
EOLC, Long Term Conditions, Urgent Care And Intermediate Care - *Annex 4*	8,966,879	4,507,954	4,458,925	0	0	0
Community, Children and Young People and Continuing Care - *Annex 5*	47,979,801	20,211,705	19,991,880	3,038,574	4,737,642	0
TOTAL COMMISSIONING EXPENDITURE	**459,713,480**	**207,319,235**	**205,064,406**	**10,559,461**	**36,770,378**	**0**
OTHER EXPENDITURE						
Primary Care - *Annex 6*	82,080,268	2,212,111	2,188,051	1,548,305	76,131,801	0
Public Health - *Annex 7*	2,496,086	0	0	2,496,086	0	0
Prescribing - *Annex 8*	46,075,813	23,164,431	22,911,382	0	0	0
Other PCT Expenditure & Reserves - *Annex 9*	11,619,193	3,525,763	3,487,417	0	0	4,606,013
Headquarters - *Annex 10*	13,371,160	5,033,675	4,978,928	1,392,148	1,486,629	479,780
TOTAL OTHER EXPENDITURE	**155,642,520**	**33,935,980**	**33,565,778**	**5,436,539**	**77,618,430**	**5,085,793**
PCT REVENUE EXPENDITURE	**615,356,000**	**241,255,214**	**238,630,184**	**15,996,000**	**114,388,808**	**5,085,793**

Appendix 2 – Assumptions

Merton CCG		12/13	13/14	14/15	15/16	16/17	17/18
Funding levels		2.80%	2.30%	2.84%	2.84%	2.84%	2.84%
Inflation							
	Pay	2.00%	2.90%	2.90%	2.90%	2.90%	2.90%
	Non pay	3.90%	3.70%	3.70%	4.00%	4.00%	4.00%
Tariff inflator/deflator (Acute)		(1.50)%	(1.30)%	(1.30)%	(0.20)%	(0.20)%	(0.20)%
Tariff inflator/deflator (Non Acute)		(1.80)%	(1.30)%	(1.30)%	(0.20)%	(0.20)%	(0.20)%
Contingency		0.50%	0.50%	0.50%	0.50%	0.50%	0.50%
Surplus		1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Non recurrent investment reserve		2.00%	2.00%	2.00%	2.00%	2.00%	2.00%

Merton CCG	12/13	13/14	14/15	15/16	16/17	17/18
Prescribing inflation	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%
Continuing Care growth	1.86%	2.69%	2.79%	2.79%	2.79%	2.79%
Demographic growth	0.61%	0.59%	0.59%	0.58%	0.29%	0.29%
Acute - non demographic growth	2.39%	1.79%	1.79%	1.79%	1.79%	1.79%
Non acute non demographic growth	1.25%	1.50%	1.50%	1.50%	1.50%	1.50%

Appendix 3 – Draft QIPP

Merton 5 year QIPP Plan

QIPP Level 2 Categories	2012/13 GROSS	2013/14 GROSS	2014/15 GROSS	2015/16 GROSS	2016/17 GROSS
Mental Health	£251,350	£725,000	£250,000	£50,000	£50,000
Acute Sector	£1,682,312	£745,000	£400,000	£250,000	£100,000
Community Support Services	£502,700	£500,000	£500,000	£500,000	£500,000
Long Term Conditions	£1,228,520	£362,000	£362,000	£362,000	£362,000
Urgent Care	£2,665,366	£618,000	£618,000	£400,000	£200,000
Planned Care	£1,334,465	£1,976,000	£1,000,000	£1,000,000	£1,000,000
End of Life Care	£313,685	£0	£0	£0	£0
Prescribing	£502,700	£500,000	£500,000	£500,000	£500,000
Unidentified	£0	£3,052,000	£2,370,000	£0	£350,000
Other	£1,765,351	£0	£0	£0	£0
	£10,246,449	**£8,478,000**	**£6,000,000**	**£3,062,000**	**£3,062,000**

Appendix 4 – Income & Expenditure

Merton Clinical Commissioning Group **5 YEAR PLAN ESTIMATE FOR MERTON CCG**		**2013/14 BUDGET**	**2014/15 BUDGET**	**2015/16 BUDGET**	**2016/17 BUDGET**	**2017/18 BUDGET**
Opening Resource Limit		208,304,000	212,981,000	219,030,000	225,250,000	231,647,000
Growth		4,677,000	6,049,000	6,220,000	6,397,000	6,579,000
Non-Elective Threshold		-1,985,000	-2,041,000	-2,092,000	-2,144,000	-2,198,000
Prior Year Surplus		1,594,000	2,130,000	2,190,000	2,253,000	2,317,000
Other Allocations		408,000	420,000	431,000	442,000	453,000
ANTICIPATED REVENUE RESOURCE LIMIT		212,998,000	219,539,000	225,779,000	232,198,000	238,798,000
CORPORATE BUDGETS						
ACUTE HEALTHCARE SERVICES						
Block Contracts		121,146,730	126,266,385	130,420,473	134,722,117	139,093,968
Non-Contracted Aactivity (Formerly OATS)		2,050,518	2,023,861	2,019,813	2,015,773	2,011,741
Non-NHS Providers		327,852	323,590	322,943	322,297	321,652
Healthcare Provisions		2,813,737	2,850,239	2,921,450	2,927,493	2,943,350
	SUB-TOTAL	126,338,837	131,464,075	135,684,679	139,987,680	144,370,711
MENTAL HEALTH HEALTHCARE SERVICES						
Block Contracts		14,535,140	14,096,184	14,017,991	13,939,955	13,862,074
Joint Agency/Section 28A Grants		574,653	603,385	633,554	665,232	698,495
Voluntary Sector/Section 64 Grants		906,839	952,182	999,792	1,049,782	1,102,272
Forensic Named Patients		3,524,716	3,700,952	3,886,000	4,080,301	4,284,316
Primary Care MH Services		1,190,796	1,175,316	1,172,965	1,170,619	1,168,278
Healthcare Provisions		282,015	296,116	310,922	326,467	342,790
	SUB-TOTAL	21,014,159	20,824,135	21,021,224	21,232,356	21,458,225
LEARNING DISABILITIES HEALTHCARE SERVICES						
Provider Services		142,259	149,372	156,840	164,682	172,916
Joint Agency/Section 28A Grants		738,969	775,917	814,713	855,449	898,221
Special Contractual Placements		1,239,627	1,301,609	1,366,690	1,435,025	1,506,777
	SUB-TOTAL	2,120,855	2,226,898	2,338,243	2,455,156	2,577,914
EOLC, LONG-TERM CONDITIONS URGENT AND INTERMEDIATE CARE						
End Of Life Care		1,028,526	1,079,952	1,133,951	1,190,648	1,250,180
Long-Term Conditions Management		271,259	284,822	299,063	314,016	329,717
Urgent and intermediate care		2,101,398	2,140,706	2,181,979	2,225,315	2,270,818
	SUB-TOTAL	3,401,183	3,505,480	3,614,993	3,729,979	3,850,715
COMMUNITY SERVICES, CHILDREN AND CONTINUING CARE						
Community Services		12,983,982	12,853,097	12,860,244	12,869,020	12,879,503
Children and Young People		1,353,156	1,420,813	1,491,852	1,566,447	1,644,769
Continuing Care		6,692,390	7,027,010	7,378,361	7,747,280	8,134,644
	SUB-TOTAL	21,029,528	21,300,920	21,730,457	22,182,747	22,658,916
TOTAL COMMISSIONING EXPENDITURE		173,904,562	179,321,508	184,389,596	189,587,918	194,916,481
PRIMARY CARE		2,075,921	2,134,877	2,195,507	2,257,861	2,321,983
PRESCRIBING		23,820,427	24,511,448	25,237,021	25,998,872	26,798,816
OTHER HEALTH AUTHORITY EXPENDITURE		95,309	98,018	100,804	103,669	106,616
PCT ADMINISTRATION		5,646,781	5,807,149	5,972,072	6,141,680	6,316,104
MANDATORY CONTINGENCY		1,065,000	1,095,000	1,126,000	1,158,000	1,191,000
2% HEADROOM		4,260,000	4,381,000	4,505,000	4,633,000	4,765,000
TOTAL PCT REVENUE EXPENDITURE		210,868,000	217,349,000	223,526,000	229,881,000	236,416,000
NET PCT POSITION (CUMMULATIVE)		2,130,000	2,190,000	2,253,000	2,317,000	2,382,000