Appendix 1

2011/12 Budget Delegation

Delegation Phase / Date	Budget Area	Budget (£m)	QIPP Gross (£m)	Detail / Complexity* (column consider the complexity of the commissioning area to inform phase)	
One – Jul 2011	Emergency PbR	49	4.8	This phase includes the following areas:	
	A&E PbR	12	0.1		
	New Outpatients	19	2.4		
	F-up Outpatients	22	1.5	Outpatient (GP referrals)	Low
	Drugs and Devices	11	0.5	Prescribing	Low
	Pri Care Prescribing	33	1.0	Urgent care (A&E / UCCs)	Med
	Corporate	17	2.0	Urgent care (Admissions)	Med
				Non GP referred outpatients	Med
				Intermediate Care / Reablement	Med
				Non-PbR Drugs and Devices	Med
Total		163	12.3	(6.3 delivered prior to delegation)***	
Two – Oct 2011	Community Services	33	1.5	This phase includes the following areas:	
	Other Acute**	166	2.6		
				Community Health	Low
				Direct Access Diagnostics	Low
				Sexual Health	Med
				Elective Care	Med
				Maternity	Med
				End of Life Care	Med
				Critical Care	High
				Specialist Acute Commissioning	High
Total		199	4.1	(3.6 delivered prior to delegation)	
Three – Jan 2012	Client Groups	22	-	This phase includes the following areas:	
	Mental Health	67	2.6		
				Community Mental Health	Med
				Voluntary Sector	Med
				CAMHS	Med
				Inpatient Mental Health	Med
				Physical Disability	Med
				Specialist Mental Health	High
				Continuing Care (inc. LD)	High
Total		89	2.6	(4.6 delivered prior to delegation)	
Other	Non-recurrent 2%	10	-		
	Reserves / Surplus	11	-		
Total		21	-		
Non-Delegated	Primary Care	68	1.2		
Total		68	1.2	(0.8 delivered - no delegation)	
Budget Total		**540**	**20.2**		

Notes:

***** SHC has sought to take early delegation for those areas that fall in areas of low or medium complexity. Complexity refers to the commissioning activity itself and SHC are equally aware of the different levels of control that can be secured over performance in these areas.

** Includes £30m budget for Specialised Commissioning which will continue to be led through the LSCG.

*** Clearly delegation is being made in-year and the figures provided above also seek to reflect the level of QIPP delivery undertaken ahead of delegation in the context of the overall QIPP challenge.

Rationale

In addition SHC made clear the criteria we had applied in decision making upon which budget areas we wished to receive earliest delegation for in our original Pathfinder application. The following factors were considered:

- **Scale** – GP Commissioners recognise the size and immediacy of the challenges facing the health economy - these are areas of high spend and where system change will result in improved outcomes across the entire borough

- **Performance** – These areas are currently the main drivers of commissioning overspends in 2010/11 (circa £7m in 2010/11) and improvement in the performance of these areas will have a significant and lasting impact upon the quality of care received by our patients in terms of health outcomes and the patient experience

- **Opportunity** – GP commissioners have identified through benchmarking and their clinical assessment of current service delivery, significant opportunities to make improvements in both the quality and cost of care

- **Experience** – GP Commissioners have a high level of knowledge about the performance of these services locally and clearly defined plans for the service redesign and change they wish to see in these areas in 2011/12

- **Engagement** – Members of the consortium have engaged with stakeholders across primary and secondary care to agree new ways of working in areas that they believe they can have a major influence in from the outset. Specifically, GP leads have agreed changes in these areas as a priority for our joint work with Kings Health Partners

- **Strategic Alignment** – Change in these spend areas will require the collaboration of all local practices, an early priority for our Consortium. We aim to enhance the management of long term conditions locally and believe that improved outcomes will be reflected in these areas of spend and we wish to establish new ways of working through Polysystems with immediate impact in unscheduled care and outpatient activity. We have agreed that the enhanced management of unscheduled care specifically provides an early opportunity to maximise the potential of our partnership with social care. Finally we know that early control of corporate budgets will allow GP Commissioners to shape key enabling factors and prepare for future years.