



Financial Strategy

Working in partnership to tackle inequalities
and improve the health and well being of local people

BEN PCT FINANCIAL STRATEGY

Contents

	Page
1 Aims and Objectives of the Financial Strategy	3
2 Context and Background	3
2.1 Historic and current Performance	
2.2 Policy Context	
2.2.1 Operating Framework 2008/9	
2.2.2 Investing for Health	
2.2.3 Changes to Financial Framework	
2.2.4 Economic Outlook	
2.2.5 PCT Strategic Plan	
3 Revenue Financial Plan	7
4 Capital Plan	8
5 Cash Management Strategy	9
5.1 Introduction	
5.2 Operation of cash funding arrangements	
6 Managing Financial Risks	10
6.1 Approach to Risk Management	
6.1.1 Financial Control System	
6.1.2 Financial Performance Management	
6.1.3 Managing between budgets	
6.1.4 Overall materiality	
6.1.5 Slowing or increasing the pace of investments	
7 Delivering Value for Money	12
7.1 Efficiency and Benchmarking	
7.2 Gateway Review	
7.3 Procurement	
Appendix I Financial Planning Assumptions	

1. AIMS AND OBJECTIVES OF THE FINANCIAL STRATEGY

The financial strategy sets out how the PCT will manage its finances, looking forward over a five year period with a focus on ensuring alignment with and delivery of the Strategic Plan. We seek to demonstrate good business planning, sound financial management and the wise stewardship of public money.

The Strategy has been developed in the first year of another generous Comprehensive Spending Review for the NHS, however the longer term resource outlook is one of significantly lower levels of growth in funding. In this context the aims of the financial strategy are to:

- Ensure that the PCT meets its statutory financial duties through strong financial management.
- Support the Strategic Plan by providing a consistent level of additional investment that allows services to be commissioned with certainty.
- Secure value for money in the form of improved health status and higher quality services from the investments that the PCT makes.
- Recognise that future funding growth may be significantly constrained by economic pressures.
- Recognise the contribution made to maximising resources through internal process improvement and system redesign.

2 CONTEXT AND BACKGROUND

2.1 Historic and Current Performance

Since the formation of BEN PCT in October 2006, the emphasis on resources has been on returning to robust financial health. In our first year we faced significant challenges as a result of changes to the national financial framework, and the West Midlands Strategic Health Authority's (WMSHA) response, which resulted in the PCT being given a £25.8m savings target in order to support the delivery of a balanced budget for the region for the year.

Whilst some £8m was identified through application of national policy (eg changes to tariff), we delivered the other £17m through a real reduction in activity of £5m and £12m from our cost base. Throughout this period, we continued to make investments where these were needed to deliver our strategic goals. This commitment to ensure we pursued investments which would deliver medium term gain meant that we did record a small deficit for the year 2006/7 which affected our performance ratings with the PCT receiving an overall ALE score of 2 (one of only 2 re-configured PCTs to achieve this level). However, our investment strategy meant that we were able to sustain development and innovation during this period, delivering significant cost control through demand management and further improvements in service

quality and responsiveness (increasing our HCC rating to 'excellent' for services) and in a position where we continue to invest the majority of the resources available to us in improving the health of our population.

Throughout 2007/8 we built on the strong base created in 2006/7 and returned to financial balance for the year recording a surplus of £3.2m which is being reinvested in patient care in the current financial year. This improved financial performance has contributed to the PCT receiving an overall ALE score of 3, achieving a rating of 4 for Value for Money (one of only 3 PCTs in the country to achieve this rating) and 3 for each of Financial Standing, Internal Control, Financial Reporting and Financial Management.

For the current financial year we are investing £631m and are forecasting a surplus of £1.9m, a level of surplus that provides the PCT with a small buffer against its statutory breakeven duty and at only 0.3% of our allocation ensures that we continue to invest the substantial majority of our resources on healthcare, the purpose for which it was voted by Parliament. The PCT continues to be slightly under target allocation given our demographic profile, but this may be addressed in the current review, as our demography includes the extremes of significant deprivation and diversity and a high proportion of the very elderly.

2.2 Policy Context

There are a number of national policy drivers that have a significant impact on the formation of our financial strategy.

2.2.1 Operating Framework 2008/9

In December 2007, the Department of Health (DH) issued its third 'operating framework', which provided a set of priorities and guidance for the NHS for 2008/9. As in previous operating frameworks, guidance was offered on financial management. For the first time in three years, achieving financial health was no longer identified as a national priority: this was a reflection of the growing financial stability as the NHS has moved from overall deficit to surplus during the period. The operating framework set out a number of assumptions with regards to financial management for the current and future years:

- Organisations are expected to plan for surpluses.
- The NHS is expected to deliver efficiency savings worth 3%.
- Allocations to PCTs were specified for 2008/9 equivalent to a 5.5% increase.
- Allocations for future years were not specified.
- NHS Organisations were encouraged to develop robust plans to spend the capital allocation increase of 10% made in the CSR.

2.2.2 Investing for Health

Investing for Health was published by the WMSHA in May 2007. This framework signalled the WMSHA's core priorities to all of its partners and specifically signalled to PCTs who commission services the SHA's expectations for judging their strategic plans.

The framework requires that PCTs ensure that all investment decisions are undertaken with the specific aims of:

- Targeting resources to ensure high quality, integrated, equitable and efficient primary and community care services.
- Improving Health and Service outcomes rather than reactive transactions.
- Investing in services across all sectors that are demonstrably viable in the medium term.
- Ensuring annual investment delivers a proportionate return in health and reduced inequality, and which significantly improves public confidence and patient satisfaction.
- Providing education and support to the population, to enable them to make informed lifestyle changes to improve their own health and wellbeing.
- Developing improved levels of service responsiveness in terms of no waits, increased choice and more services closer to home.

2.2.3 Changes to Financial Framework

The PCT operates in a politicised and volatile financial environment. Over the last 5 years we have seen changes to the funding policy for PCTs that have had a significant impact on the level of funding available for investment in healthcare in any given year.

On 26th January 2006 the DH issued the Operating Framework for 2006/7 which set out the business and financial arrangements for the NHS. It contained two key changes to the funding arrangements for PCTs: the removal of the Transitional Funding Arrangements for PCTs and the application of "Top Slices" by SHAs. The result of these two key changes was a £25.8m reduction in the level of resources available to the PCT, in February 2006, giving 8 weeks in which to redraw the financial plans for the following year.

There are a number of anticipated changes to PCT allocations that may impact the PCT in the next couple of years including the introduction of HRGv4¹ and the review of the allocation formula (expected to be announced in late Autumn 2008).

¹ This has recently been deferred to 2010 given the emerging difficulties in estimating its impact at a local level.

These examples illustrate that the PCT operates in an environment where the level of resources available over a 5 year period is uncertain and likely to vary significantly from our current assumptions. The PCT therefore needs to have a financial strategy that that can respond to changes in funding levels and to ensure that it focuses on its entire portfolio to release resources for reinvestment in other areas.

2.2.4 Economic Outlook

Over the last 10 years, the NHS has received record levels of growth with the total investment rising from £36billion in 1997/98 to £110billion by the end of this Comprehensive Spending Review (CSR) in 2010/11.

The UK economy, like the global economy, is now entering a turbulent period with latest forecasts by the Organisation for Economic Cooperation and Development (OECD) predicting that the UK economy will shrink during the second half of 2008 and the Chancellor warning that the economy is facing the worst crisis in sixty years. We will not be seeing investment increasing at the levels seen over the last 10 years with expected increases likely to be limited to 4% per annum over the next CSR. In this context we have to focus on the totality of our investment ensuring that we obtain Value for Money across our portfolio and using service redesign to release resources for investment in other areas. We continue to develop annual efficiency plans to maximise available resources, with up to £8m full year effect identified within this year, and a potential additional £1.7m per annum arising from targeted interventions in ambulatory care sensitive conditions (ACSC).

2.2.5 PCT Strategic Plan

The PCT's Strategic Plan sets out how we move from assessing the needs of our population to delivering services that will drive improvements in health and reductions in health inequalities. It reflects our local priorities over a 5 year period and identifies a number of strategic initiatives. The financial strategy underpins the delivery of these initiatives and recognises we shall need to make non recurrent investment available to support the transition from existing patterns of services before the full financial benefits are realised from the new. However the initiatives will need to deliver the planned savings in line with their profile if the PCT is to achieve operational financial balance and deliver its target surplus of 0.5% of its allocation in each of the five years of our plan.

3 Revenue Financial Plan

The PCT's Financial Plan for the next five years fulfils the following criteria:

- It delivers a surplus of 0.5% of PCT Core Allocation to provide a buffer against the Statutory Financial duty to achieve breakeven.
- It provides a consistent level of recurrent investment to support the delivery of the PCT's strategic initiatives.
- It makes non recurrent resources available for years 2-4 of the plan to support any transition costs associated with the strategic initiatives and for investment in new initiatives that are self financing by 2012/13.
- It is based on a set of assumptions that provide an overall budget that has a balanced set of financial risks.

The high level financial plan is shown below; Appendix 1 contains the assumptions that support the plan

	2008/9 £m	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m
Recurrent Resources	637.3	637.3	678.1	724.5	753.3
Non Recurrent Resources	(4.4)	(6.3)	(3.0)	(6.6)	(6.8)
Recurrent Growth		40.2	42.8	28.8	30.1
Total Resources	632.9	671.2	717.9	746.7	776.6
Baseline Expenditure		630.5	682.1	720.0	755.8
Inflation		17.9	18.6	19.4	20.3
Joint Commissioning		6.0	6.3	4.9	3.7
Population Growth		0.5	0.5	0.5	0.5
Strategic Initiatives		21.0	6.9	4.2	6.2
NR Initiatives Fund			3.0	6.0	
PCT Infrastructure		2.5	3.5	3.5	3.5
Contingency		3.4	3.8	4.0	4.4
Income Risk Contingency			7.2		
Total Expenditure	631.0	681.8	731.9	762.5	794.4
Surplus/(deficit) before savings	1.9	(10.6)	(14.0)	(15.8)	(17.8)
Savings from Strategic Initiatives		13.9	17.6	19.5	21.7
Surplus	1.9	3.3	3.6	3.7	3.9

Population	389,682	390,066	390,450	390,834	391,219
Health Spend 1,000 population	£1.62m	£1.72m	£1.84m	£1.91m	£1.99m

4 Capital Plan

The PCT has limited Capital expenditure with investments in Primary Care infrastructure being delivered through LIFT; these premises are leased by the PCT and costs charged as revenue over the life of the lease.

The PCT has realised capital receipts of £10m from land and building sales over the last couple of years and is exploring the options of how to use this to support our investment programme over the next 5 years. We are currently assuming that all investments in our primary care infrastructure are funded through LIFT, whilst we explore the best value impact of investing over £10m of capital. The Capital Plan includes the PCT's contribution towards the sub debt associated with our LIFT programme.

The PCT's capital programme covers areas such as maintaining existing assets and purchase of equipment and is set out in the table below. The PCT is currently exploring the right balance of asset ownership for market leverage and intervention versus the minimising of capital charges and the asset being passed to provider organisations. The Swedish model looks interesting, where commissioners retain significant assets, supporting rapid market entry and opportunities for shifts of provider. It is noteworthy that the Kaiser Healthplan owns the hospitals from which the Permanente Medical Group operates.

The planned spend excludes investments in IT which have been provided for within the PCTs Revenue budgets, the PCT will review its accounting treatment for this expenditure and if necessary transfer funding from Revenue into Capital.

	2008/9 £m	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m
Capital Investment	2.1	0.7	0.8	0.8	0.8
LIFT Schemes	0.5	0.2	0.4	0.4	0.4
Total	2.6	0.9	1.2	1.2	1.2

5 Cash Management Strategy

5.1 Introduction

As Exchequer bodies, the funding for NHS Bodies must take account of both local cash requirements and the cost to the Public Sector Borrowing Requirement overall. Cash funding and banking arrangements for NHS bodies must therefore be cost effective, efficient and involved the minimum costs for the Exchequer overall.

Cash requirements for NHS bodies form part of Her Majesty's Treasury (HMT) overall borrowing. To borrow cost effectively HMT require all Exchequer bodies (including NHS bodies) to manage cash effectively throughout each month. They require advance notice of cash needs.

Cash funding requisitions for each month therefore plan for the entire cash needed for the month, taking account of both anticipated month end balances carried forward and payments and receipts for the month. Efficient cash management and cash requisitioning should result in minimal month end balances and no supplementary cash advances in month. Supplementary cash advances and significant month end balances are a reflection of poor cash management and are kept to a minimum by the PCT.

There is a real cost to the NHS as a result of poor cash management and forecasting. Failure to properly estimate cash requirements for the month and to forecast cash needed for the following month means that DH forecasts to HMT will be poor. HMT impose a financial penalty on DH where the actual cash used in any month varies by more than 5% from the forecast made at the start of the month. Except in exceptional circumstances the PCT has not breached this 5% limit in any month.

5.2 Operation of cash funding arrangements

All NHS Bodies are required to have Office of HM Paymaster General (OPG) accounts for the receipt of funds from DH, other health bodies and for the settlement of transactions with other OPG users i.e. NHS trusts and Foundation Trusts. For the PCT, cash should not leave the OPG earlier than needed to settle transactions with individuals and private companies.

All cash advances are made to OPG accounts in round thousands so requisitions are made in round thousands by the PCT. Cash requirements for the month are transferred to OPG accounts on the first working day of the month. This simplifies the cash funding process for NHS bodies and minimises costs to the Exchequer as HMT gets the benefit of the balances until they leave the OPG system.

The PCT does not include contingency sums in the main funding request. If additional funds are required during the month, because initial funding requests failed to accurately forecast payments and receipts, one supplementary request will be made per month, in accordance with the DH rules on weekly funding. Such requests will only be made in exceptional circumstances as HMT will already have planned their borrowing on the basis of PCT requisitions.

As the main requisition for the month should have covered all cash needs for the month, it is unlikely that the PCT will need to request more than one supplementary advance in the month. If the PCT needs to submit more than one request per month a business case will be prepared and submitted to DH to justify the reason for the request.

Good cash forecasting and management applies to requisitions for both discretionary and non discretionary funding. It is important that all requisitions record the most realistic assessment of cash needs for the funding month with a realistic forecast of cash needed for the next month.

The PCT will ensure that the cash limit for the financial year, as notified by the DH, is not exceeded and that bank balances are kept to a minimum. As part of regular reporting to the PCT Board, current cash requisitioning status and forecast cash requirements will be included in the Finance report.

6 Managing Financial Risks

The PCT's high level financial plan supports investment of £631m in 2008/9 rising to £777m by 2012/13; this plan is based on a set of assumptions that provide an overall budget that has a balanced set of financial risks. It would be naïve to expect all individual budgets to breakeven and the PCT therefore needs to manage variances against individual budgets across its entire portfolio to ensure that it meets its statutory duty to achieve financial balance and deliver its planned surplus targets in each year of the financial plan.

6.1 Approach to Risk Management

There are a number of processes that the PCT uses to manage its financial risks as discussed below. The key risks faced by the PCT are contained within the financial plan.

6.1.1 Financial Control System

A strong financial control system assists the PCT in managing its finances within agreed budgets and therefore reduces the PCT's exposure to financial risk. The PCT Board has adopted standing orders, standard financial instructions and a scheme of delegation; these are regularly reviewed to ensure that they reflect the needs of the PCT and all members of staff with authority to commit expenditure are provided with training on their use.

6.1.2 Financial Performance Management

The PCT has a strong Financial Performance Management System that assists in managing financial risk by controlling expenditure within the overall resources available, it consists of the following key elements, a robust financial plan, regular performance review meetings with budget holders and performance monitoring meetings with providers and robust reporting both internally and externally.

6.1.3 Managing between budgets

BEN PCT has an established history of strong financial performance and has a record of managing within overall resources. This includes reprioritising money between directorates and initiatives and managing over and underspends across budgets within the year.

6.1.4 Overall materiality

The PCT is investing from £631 million in 2008/9 to £777m in 2012/13. In terms of materiality a 1% financial variance would be equates to over £6m. Whilst this seems like a large number in isolation the structure of the PCT's portfolio is such that variances up to this level can be managed without having a detrimental effect on the overall PCT's financial position. We are seeking to find the right balance between financial forecasting which can drive robust budget setting and management and the reality check of operating in a context where both income and expenditure may come under pressure for significant variances in year. As a relatively large organisation we have significant flexibility in managing within this total resource.

6.1.5 Slowing or increasing the pace of investments

Economic horizon scanning suggests that we may be entering a yet more volatile period within considerably constrained allocations. In this context it may be more challenging to manage variances across the PCT's established portfolio. Our learning from 2006/7 has given us the experience to be able to vary the pace of investment whether this be to slow down or restrain developmental activity or increase the pace of demand management infrastructure in order to meet our statutory financial duty.

7 Delivering Value for Money

The PCT prides itself on its strong track record of sound stewardship of the public funds allocated to it for the health needs of its population. This was recognised in the 2007/2008 External Auditors Local Evaluation, where the PCT was awarded the top score of four in respect of Value For Money, putting it in the top performing 2% of PCTs in the country. The Audit Commission identified two areas of significant good practice, the use of Neighbourhood Development Officers and the Gateway Process, both of these have been shared nationally.

7.1 Efficiency and Benchmarking

The PCT has a well developed governance and control framework, designed to ensure the appropriate scrutiny by both comprehensive Internal and External Audit Plans and a committee structure that ensures adequate review at all levels.

The PCT is a member of the Core Cities Benchmarking programme and regularly uses the information provided by this programme to review its costs in a number of areas.

We have also been a champion of the Commissioning Business Support Agency (CBSA) and this provides rich information for activity and cost comparisons. Early review of the Institute/Doctor Foster ACSC benchmarking identified a range of areas for assertive action in 2006, and 2008's review has again identified opportunities for cost reduction through coding challenges and service redesign.

In addition, the PCT has a thorough service review programme in the Provider arm, designed to ensure that all services provided by the PCT are subject to an efficiency review over a three year cycle.

7.2 Gateway Review

The PCT implemented a Gateway Review Process during 2007 to ensure that all investment decisions were subject to full scrutiny, developed through comprehensive business cases and represent an appropriate return on investment. This review process was refined during 2008 and has been highlighted by the Audit Commission as representing best practice.

7.3 Procurement

The procurement strategy for the PCT, being developed alongside World Class Commissioning competencies, enables the PCT to demonstrate that it has robust processes designed to ensure value for money, safety and quality in all that it procures. Increasingly, the PCT is utilising the services of procurement specialists both at Healthcare Purchasing Consortium and Birmingham Primary Care Shared Services Agency to enable it to deliver quality and value for money in procurement.

Two recent OJEU (Official Journal of the European Union) procurements secured new partners in each of “intelligence” and “OD” within the 107 day minimum delivery timescale and received very positive feedback from commercial participants.

The PCT has well developed arrangements for delivering efficient back office functions through a shared services approach to a range of ICT, Facilities and Financial functions across the City of Birmingham. In addition, the PCT, along with colleagues in two neighbouring organisations, took part during 2008 in the procurement process to re-tender the Payroll contract, resulting in the delivery of financial savings to the PCT.

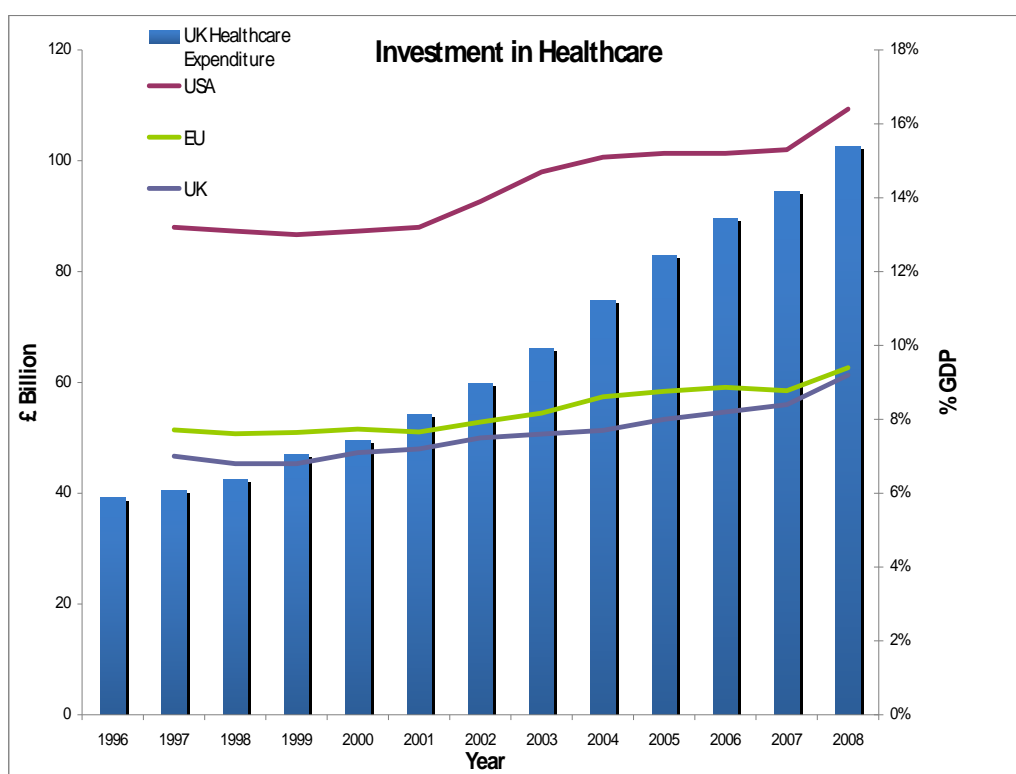
The significant programme of service change proposed for the next 5 years will require investment in procurement processes and infrastructure, and an enhanced understanding of legal requirements and best practice performance by middle managers and executives throughout the PCT. A first phase of training has recently been initiated.

Financial Planning Assumptions

1. Resource Availability

1.1 Background

The NHS has seen record levels of growth in recent years as part of a national commitment to increase levels of funding to match the best of our European counterparts. The chart below shows how investment has increased over the last 10 years, rising from £36billion (6.7% of GDP) in 1997/98 to £90billion (8% of GDP) in 2007/08.



1.2 Outlook

The 2007 CSR will increase spending on the NHS by a further 4% per year in real terms over the next three years, taking the budget from £90b in 2007/08 to £110b by 2010/11. After that future settlements are not considered to be as generous due to recession and inflationary pressures in the UK and global uncertainty in the world's financial markets. On the basis of previous notifications, we have been planning on increases of 6.3% and 6.4% over the remaining two years of the current CSR with increases limited to 4% for future years.

1.3 Increases to PCT Allocations

The DH has announced PCT allocation growth rates for Year 1 (2008/9) only of the 3 year period covered by the CSR. Growth rates for the second two years of the CSR are expected to be announced in Autumn 2008 following a review of the Resource allocation formula. The table below shows the PCT's assumptions for increases to our allocation over the following 5 years.

	2008/9 %	2009/10 %	2010/11 %	2011/12 %	2012/13 %
Growth Rate	5.5	6.3	6.4	4.0	4.0

1.4 Other Changes to Resources

The PCT is also making a number of other assumptions with regards to the level of resources available over the next 5 years.

1.4.1 Equitable Access to Primary Care

The PCT is procuring 3 new GP Practices as part of the Equitable Access to Primary Care Medical Services Programme. These new practices will open from 1st April 2009 and attract additional funding from the DH that will be added to the PCT's allocation in line with increase in practice list sizes up to a maximum of £1.15m per practice.

1.4.2 Dehosting of GUM/A&E

From April 2009 the Commissioning arrangements for GUM and A&E Services will change from a host PCT basis to a responsible commissioner arrangement. As host to 2 A&E Departments routinely serving 6 PCTs the PCT gains from this new arrangement. A scheme has been agreed across the West Midlands to phase in the change over 2 years. The result of this is that the PCT gives up 50% of its gain in 2009/10 only to support those organisations that lose with the full gain being realised in 2010/11. We would wish to accelerate this transition to realise more quickly the benefits of our investment in demand management and diversion schemes.

1.4.3 Return of Previous Year's Surpluses

The PCT plans to generate a non recurrent surplus of at least 0.5% of its allocation each year; it is assumed that this surplus will be returned to the PCT in the following year. Given the deteriorating economic position we will be keeping this target under review, and if necessary revising it to increase our headroom in any given year.

1.4.4 Central Allocations

The PCT is assuming no change to the level of central allocations over the next 5 years.

1.4.5 Review of allocation formula

The national formula for resource distribution to PCTs has been under review for the past year with the outcome of this review expected to be published in the autumn of 2008. Refinements to the existing formula include:

- A rurality adjustment to recognise the additional resource burden of maintaining services across a wider geographical area.
- An amendment to the health needs factor to more appropriately reflect deprivation.

Until the outcome of the review it is difficult to make an assessment of the impact of the changes but at this stage we are assuming that any impact on the PCT's allocation will be minimal.

1.5 Overall Level of Resources Available

The table below summarises the planned level of resources available to the PCT over the next 5 years.

	2008/9 £m	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m
Recurrent Resource Limit	637.4	637.6	678.1	720.9	749.7
Non Recurrent Resource Limit	(7.8)	(9.2)	(9.8)	(10.2)	(10.5)
Recurrent Growth		39.9	42.8	28.8	30
Equitable Access in Primary Care	0.2	2.1	3.5	3.6	3.7
Dehosting of GUM/A&E		(1.1)			
Return of Previous Year's Surplus	3.2	1.9	3.3	3.6	3.7
Total	633.0	671.2	717.9	746.7	776.6

2 Expenditure

2.1 Inflation/Efficiency

We have assessed inflation across our portfolio as shown in the table below, these assumptions all fall within the planning range issued by the WMSHA.

	2009/10 %	2010/11 %	2011/12 %	2012/13 %
Commissioning Portfolio	2.3	2.3	2.3	2.3
Prescribing	7.0	7.0	7.0	7.0
GP	2.0	2.0	2.0	2.0
Dental	3.4	3.0	3.0	3.0
All other areas	2.3	2.3	2.3	2.3

All inflationary uplifts are assumed net of the nationally required efficiency savings of 3%. The figure for Prescribing is the expected increase in the total drugs bill and therefore includes both price and volume increases.

2.2 Subscriptions to Joint Commissioning Arrangements

The PCT invests over £160m through joint commissioning arrangements; additional investments in these areas are agreed through the appropriate governance arrangements and are a mix of the growth in the number of patients eligible for these services and specific investments. The table below shows our planning assumption for the increased investments in these areas.

	2009/10 %	2010/11 %	2011/12 %	2012/13 %
Mental Health	4.0	4.0	3.0	2.0
Learning Disabilities	5.0	5.0	3.0	2.0
Complex Care	17.6	15.0	13.0	11.5
Sexual Health	4.0	4.0	3.0	2.0

2.3 Population Changes

The PCT has been planning on an overall population growth of 0.5% by the March 2013; this has been phased into our plans evenly over the next 5 years. Our Joint Strategic Needs Assessment (JSNA) has identified that in fact our local population growth has been 1.8% over the last 7 years, however this has been concentrated into children and young people and has limited impact on our redesign and investment decisions which are largely driven by older adults. We have however planned for increased investment into both maternity and newborn services.

2.4 Underlying Growth in Acute Portfolio

The PCT has modelled activity trends in its Acute portfolio over the last couple of years and has not provided for any underlying growth in its Acute portfolio; this assumption has been agreed with its major Acute Provider the Heart of England Foundation Trust.

2.5 Additional Investments

2.5.1 Strategic Plan Initiatives

The Strategic Plan outlines six strategic initiatives that will be the driver for the PCT's investment plan over the next 5 years. The table below summarises the investment in each area.

	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m
Birmingham Health and Well-being Partnership programme for improvement	1.5	1.5	1.5	1.5
Working together for Health Programme	3.9	4.0	4.2	4.2
Care Closer to Home	9.8	13.5	15.5	18.2
Specialised Services	3.1	6.4	10.0	13.9
PRIME	2.2	2.0	0.4	
Quality Safe Services	0.5	0.5	0.5	0.5
Total additional investment	21.0	27.9	32.1	38.3
In Year investment	21.0	6.9	4.2	6.2

2.5.2 PCT Infrastructure

2.5.2.1 Information Technology (IT)

The key messages articulated in the Operating Framework 2007/8 set out the need for PCTs to continue to drive forward IT as a major lever for modernisation and to ensure that this is reflected in increased capacity and more efficient ways of delivering technological innovation. In particular the IT infrastructure is essential to support robust information for commissioning and contract management. The PCT has prioritised investment in GP infrastructure, a provider Patient Administration System (PAS) and has developed a near time activity tracking system: Insight.

The PCT plans to exploit the use of digital technologies to both communicate with patients and the public and also to monitor patient's conditions remotely, supporting the PCT's strategy of offering alternatives to the traditional face to face contact. We are seeking to reinforce our core hardware availability and to roll-out technology to front line clinicians and provide mobile access to information and tools, as well as using the technology to bring about greater productivity, improve process operation, and manage risks within clinical practice.

We have assumed additional investment of £1m per year to support this programme of work. The detailed investment plans will be worked up over the next 6 months and will be a combination of Hardware, Software and additional capacity.

2.5.2.2 Estates

The PCT has entered into a 25 year Strategic Partnership with Birmingham and Solihull LIFTCo to deliver a new range of Primary and Community Facilities. The PCT has recently taken possession of the first two of these new buildings in Perry Common and Stockland Green with a similar facility under construction in Stechford. A number of other projects are at various stages in the planning process, the PCT plans to deliver 2 additional facilities each year for the next 5 years at a revenue cost of £1m per year for each facility.

The PCT has collaborated with Birmingham City Council (BCC) to develop purpose built integrated rehabilitation facilities on the patch. These buildings have been developed by BCC and the PCT has committed to a 15 year lease for 64 beds. A further facility is planned in Sutton Coldfield.

2.5.2.3 PCT Management Capacity

The PCT needs to ensure that it has the management capacity to respond to the range of additional initiatives that it is faced with whilst ensuring that management costs continue to be scrutinised. BEN PCT has a track record of knowing when to invest in internal capacity, when to collaborate with other organisations and when to buy in specific skills and we will continue to take this approach. In the last 2 years we have invested in significant knowledge and skills at Director level and in commissioning management. We have assumed further additional investment of £0.5m per year in increased PCT capacity.

3 Non Recurrent Investment Fund

The Financial Plan includes provision for all of the Strategic Initiatives contained within the Strategic Plan. In addition to this the PCT has created a non recurrent investment fund in 2010/11 and 2011/12 that will be used to fund additional schemes that are self financing by 2012/13.

4 Income Risk Contingency

As a result of the increased economic uncertainty the PCT has made a provision of 1% of its Resource Limit for 2010/11 to cover the impact of any negotiation between the Treasury and the DH over spending levels in the last year of the existing CSR.

5 Savings from Strategic Initiatives

The financial plan includes £21.7m of savings from strategic initiatives, as can be seen these are not only required for the PCT to deliver its planned surplus of 1% of its allocation each year but are also required for the PCT to meet its statutory duty to breakeven. Whilst the PCT has some non recurrent flexibility up until 2011/12 that could be used to offset any slippage on delivering the savings this is not available from 2012/13 on and it is therefore essential that the savings are achieved.