

reality check

Next steps in developing sustainability
and transformation plans



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\ introduction

The NHS planning guidance set out the notion of Sustainability and Transformation Plans (STPs) in 2015. The plans aimed to bring together local leaders in health, local government and patient representation to plan how services would become sustainable between 2016 and 2021.

The STPs would facilitate health service providers and local authorities working together to ensure that services are delivered across the whole of the local health and care economy and not lead by any particular organisation's priorities. Forty four local areas were established and initial plans were to be submitted in February 2017.

The 44 STPs which form the basis for NHS planning in the coming years, and explicitly link it to social care, are all now public in their draft forms. Commentators – including CIPFA in its briefing *Sorting the Plans*¹ and the King's Fund in *Delivering sustainability and transformation plans*² – appear to agree that:

- STPs represent a positive way forward – a move to place-based work across the full range of local players makes sense
- whilst the detailed financial modelling behind the plans is not yet publicly available, it is clear that financial pressures on the NHS have necessitated highly ambitious savings targets. It is less clear that the plans put forward can be expected to deliver on them, even taking account of the changes heralded in March 2017 by *Next Steps on the NHS Five Year Forward View*.³
- the planning timescales involved and speed of savings required have encouraged either low-profile 'business as usual' savings propositions or general statements of intent – rather than the development of concrete, transformational changes needed to deliver financial sustainability in the longer run.

As local leadership teams move on to develop the STPs further and consult with the public, it is likely that their realism will improve, though local objections to changing services may well reduce the savings assessed as deliverable.

1 *Sorting the Plans*, CIPFA, November 2016, www.cipfa.org/cipfa-thinks/briefings

2 *Delivering Sustainability and Transformation Plans*, The Kings Fund, February 2017, www.kingsfund.org.uk/publications/delivering-sustainability-and-transformation-plans

3 *Next Steps on the NHS Forward View* www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view, NHS England, published 31.3.17, henceforward *Next Steps*

Assuming that it does prove possible to arrive at a realistic and deliverable way of meeting the 'three gaps' identified in the Five Year Forward View⁴, so balancing service quality and financial pressures, there will still remain the problem of actually delivering to this highly challenging agenda. KPMG have suggested⁵ that there are 'only four things driving sub-optimal performance', but they are not easy matters to address. The four drivers are:

1. inefficient organisations
2. too much care being provided in hospitals
3. duplication and variation of acute care
4. high infrastructure fixed costs.

⁴ See the *Five Year Forward View*, at www.england.nhs.uk/wp-content/uploads/2015/06/5yfv-time-to-deliver-25-06.pdf That sets out the gaps as *The health and wellbeing gap*: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness. *The care and quality gap*: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist. The funding and efficiency gap: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

⁵ *KPMG: STP Plan – the what*, KPMG, February 2017 (not available to view).

the basics

The most obvious requirements for success are realistic plans which propose appropriate actions and a culture of genuinely sharing and working together. The latter is not something which can be readily deduced from a planning document, but it is encouraging that in its wide-ranging assessment of progress with integration, the National Audit Office identified as a rare bright point that ‘more than 90% of local areas agreed or strongly agreed that delivery of their Better Care Fund plan had improved joint working’.⁶ A helpful analysis by The Institute of Healthcare Management sets out the requirements of a collaborative culture:⁷

- building trust
- organisational development
- authentic leadership
- uniting the science of care with the art of politics
- engaging the staff
- engaging patients and public.

Other analyses have laid out the nature of the changes proposed and the potential for those to trigger public concerns (for example the Nuffield Trust⁸ and King’s Fund⁹ reports and that by Johnston Press Investigations for *The Independent*).¹⁰ Various prominent individuals have expressed serious doubts about deliverability, for example Sir Robert Francis¹¹ and Kinsley Manning¹², while Chief Inspector of Hospitals Professor Sir Mike Richards has opined that ‘the need for change is clear but finding the resources and energy to deliver that change while simultaneously providing safe patient care can seem almost impossible’.¹³ Although it is not compulsory for STPs to assess the pressures on social care about half of them have done so, and the Health Foundation’s analysis of those concluded that the social care shortfall could increase from about £2bn in 2017/18 to more than £4bn in 2020/21. That indicates both the necessity for the subsequent budget’s £2bn addition in support for adult social care and the logic for looking longer term through a Green Paper at the strategic issues around social care funding.

6 Health and Social Care Integration, NAO, 2017, www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf

7 ‘Swimming together or sinking alone’ by Richard Vize, from interviews with senior figures in health and local government, <https://ihm.org.uk/wp-content/uploads/2017/01/FULL-REPORT.pdf>

8 *Shifting the balance of care*, Nuffield Trust, March 2017, www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf argues that ‘NHS bodies frequently overstate the economic benefits of initiatives intended to shift the balance of care’, and hold that many STPs are set to continue that trend.

9 February 2017 at www.kingsfund.org.uk/publications/delivering-sustainability-and-transformation-plans

10 The Independent: ‘NHS Special Report’, 14 February 2017

11 ‘STP and forward view plans ‘unrealistic’, Sir Robert Francis QC, Health Service Journal 9 February 2017 www.hsj.co.uk/topics/finance-and-efficiency/stp-and-forward-view-plans-unrealistic-francis-warns/7015541.article

12 *Productivity, Technology and the NHS*, Newchurch, February 2017, www.newchurch.online

13 See www.theguardian.com/society/2017/mar/02/nhs-outdated-acute-care-model-cqc-government-cuts

By 2017, it was apparent that the *Five Year Forward View* had become undeliverable in its original form by aiming to improve all services while making historically unprecedented levels of savings. A dose of financial pragmatism was needed, and the *Next Steps* document aimed to administer it by explicitly prioritising the care to be given to reduce budget pressures and by accelerating service redesign. The logic being that by improving governance, leadership and the clarity of efficiency programmes the realisation of savings would be faster. Such actions make a lot of sense, but raise the question of whether they would be enough to close what CIPFA estimates¹⁴ is likely to be £10bn gap by 2020/21?

Ideally, *Next Steps* would have quantified the impacts anticipated so that the effect on the financial gap could be assessed. However it fell short of this level of detail – instead, for example, stating that elective surgery volumes are expected to increase, albeit too slowly to meet the waiting time targets which the plan’s headline admits will be missed. A marginal impact on the finances can therefore be expected at best, and CIPFA believes it unlikely that – simply by factoring in the actions set out in *Next Steps* – STPs will now deliver the scale of savings required. If so, it remains the case that additional funding will be needed in the medium term, and more still in the longer term because *Next Steps* does nothing to rectify the under-investment in the preventative actions needed to stabilise the long term financial position of the NHS.

This may be simply a more public and extreme version of a common enough pattern relating to setting of public sector targets and budgets. Richard Douglas (formerly the Director-General of Finance at the Department of Health) has described the spending review process as follows: ‘It starts well with a high degree of evidence being used and healthy risk adjusted scepticism about achievability. However, when the figures fail to reach the required total, a series of discussions and tweaking of the assumptions moves the resulting budget from one which is likely to be achieved to something which would require more than a fair wind and a bit of fairy dust to deliver... At this stage, all contingencies are wiped out and although the spreadsheet adds up, the end position is one which ‘might’ work rather than one which is likely to work’.¹⁵

However, rather than crawl over savings plans which are at a transitional, pre-consultative, stage, and already subject to high profile challenge, it seems more constructive to ask: what other conditions are likely to be critical to success, and do the STPs suggest that those conditions are in place? And if a realistic plan allied to a genuine commitment are the first requirements, CIPFA believes that three additional conditions are critical:

- Adequate up-front investment.
- Robust and appropriate governance arrangements.
- Sensible contingency planning in the context of horizon scanning and an assessment of alternative scenarios.

CIPFA looked at the 44 draft submitted plans to see whether there was evidence that these factors had been identified and were being taken into account.

¹⁴ In *More Medicine Needed*, CIPFA May 2016

¹⁵ Richard Douglas on performance tracking in the CIPFA Health and Integration newsletter, April 2017 at www.cipfa.org/cipfa-thinks/health

up-front investment

A successful transformation programme requires adequate up-front investment:

- Capital, to ensure that the systems and infrastructure are in place.
- Revenue, to take the preventative action to stabilise the budget in the longer term.
- Revenue, to ensure there is sufficient change management capacity.

The STPs narratives are patchy both in terms of whether those factors are separately identified and evaluated, and whether the resources said to be needed are actually in place. It isn't unusual to come across such statements as 'This change will require investment. We are exploring options for identifying transformation funding to support this work'. This may be a perfectly sensible position in the circumstances, for example Norfolk and Waveney state that 'Due to the rapid development of solutions... the implications for capital expenditure are not yet clear... A robust assessment of capital across the system is required'. Nonetheless, this does indicate that capital planning is at an early stage. Consistent with that, many plans assess the capital required to modernise and rationalise the hospital estate, but acknowledge that there are risks attached, particularly in relation to available financing. Leicestershire, for example, identify a £250m capital requirement whilst stating that 'increased demand and a lack of availability of capital are the key risks to the acute reconfiguration'.

Next Steps recognises but does not itself address the need for more capital, reporting that in the March 2017 Budget the Chancellor said 'At Autumn Budget I will announce a multi-year capital programme to support implementation of approved high quality STPs'. An initial down-payment of £325m divided evenly over the next three years has been announced for well-developed STPs 'where there is the strongest case to deliver real improvements for patients'. The Naylor Review¹⁶ (an independent report written for the Department of Health, April 2017) suggests that the down-payment is a modest start. It warned that 'the current NHS capital investment is insufficient to fund transformation and maintain the current estate. We estimate that STP capital requirements might total around £10bn, with a conservative estimate of backlog maintenance at £5bn and a similar sum likely to be required to deliver the *Five Year Forward View*'.

Meanwhile, many plans assume a level of successful bidding for a share of the national Sustainability and Transformation Fund (which reaches £3.4m by 2020/21). Results of the bidding process were due by the end of March 2017, and so one concrete update required shortly for STPs will be to integrate the results into plans. One point frequently noted in this context is that local government has more capital flexibility than the NHS, suggesting that there are opportunities to advance the joint working agenda by taking forward capital projects of joint benefit through a local government route. CIPFA is working with HFMA to develop guidance based on recent and current projects and proposals in the pipeline on how best to exploit current flexibilities to do this. It appears to be a matter requiring awareness and collaboration rather than new powers.

¹⁶ See www.gov.uk/government/publications/nhs-property-and-estates-naylor-review

\ governance

Every STP sets out a view on governance, though not all give full details of their current or planned system (eg that might be as yet unspecified or be in an as-yet-unpublished appendix).¹⁷ It would make sense to compare proposed arrangements with the best practice requirements applicable to any governance set-up, but that is a matter which might be more appropriately assessed once the mature arrangements are in place.¹⁸ Initially it is subsidiary to the particular constitutional issue of how best to structure integrated arrangements. The positioning of those STPs which tackle this issue might be categorised against the following options:

1. Informal collaboration: Joint working and discussions set up to inform working across separate organisations.
2. Formal collaboration: Formalised collaborative structures to take collective decisions but with each organisation retaining full statutory powers so that those decisions are enforceable only by collective pressure.
3. Joint decision making: Statutory powers of separate authorities ceded to formal joint decision making process.
4. Merger: Delivery of STP plans by merged organisations/a separately constituted statutory body.

Our review of the plans revealed the following picture on current and planned STP governance arrangements:

- Current position – mostly (1)
- Declared intention in 2017/18 – entirely (1) or (2)
- Declared long term intention – mostly (2)

Evidently moving towards the more integrated structures as described by (3) and (4) requires radical approaches. Those approaches may well be developed in the context of moving to an accountable care system (for population based integrated health with no purchaser-provider split) and on to an accountable care organisation (contracted to deliver population health for an area), as set out in *Next Steps*.

¹⁷ For example Merseyside, Cheshire, Warrington and Wirral, with one of the most complex set-ups, stated in last year's plan that governance and stakeholder mapping would take place in 2017

¹⁸ See *The International Framework: Good Governance in the Public Sector*, CIPFA/IFAC 2014, at www.cipfa.org/policy-and-guidance/standards/international-framework-good-governance-in-the-public-sector

Although there are other stakeholders involved, STPs are primarily a partnership between the NHS and local government. As such, there has been a concern among many in local government that arrangements have not yet made the most of their involvement. For example:

- The role of social care is recognised, but often left to one side as a matter to be dealt with separately (as is consistent with the STP guidance).
- STP footprints are, often, a poor geographical fit for the local government systems of accountability.
- There has been neither the financial nor political buy-in required from local government which might have come from requiring more political input.

Indeed, there often seems to have been an expectation that local politicians will support the changes proposed by STPs but without their direct involvement through the political process which is the primary local expression of the democratic will. This fails to recognise the realities: local politicians cannot be expected to support controversial measures such as hospital closures if nationally and regionally there isn't the same political backing. MPs, for example, are likely to oppose such measures in their constituencies. The Local Government Association has set out its view on the importance of engaging elected members, stating that 'the level of involvement and engagement of elected members and other key stakeholders in the development of STPs has so far been as variable as STPs themselves' and calling for:¹⁹

- elected members and Health and Wellbeing Boards to be engaged in an open and transparent process.
- lead members to be given an important role in explaining the purpose of and proposals in STPs to local communities, advising on the early and effective public engagement needed to support their development and implementation.
- lead members to advocate that the STP fully analyses and addresses the totality of the funding pressures and quality gap across the health and social care system, recognising that these pressures cannot be solved in isolation.

CIPFA, in conjunction with iMPower, is conducting surveys of public sector finance leaders on the practicalities of integration. The initial findings are consistent with that perception:

- Most local authorities say they have only a limited involvement in the decisions made by STPs.
- Working together on STPs has not, generally, improved relationships between the NHS and local government.
- Only 12% of respondents considered the STP was well placed to progress joint projects between health and social care.

This is the case even though 84% of respondents believed the opportunity to better manage patient flows and levels of demand through joint work was moderate (42%) or significant (42%).

¹⁹ In *Sustainability and transformation plans (STPs): How do you know if STPs are making a positive impact?*, LGA, Feb 2017, www.local.gov.uk/documents/10180/8150261/1.50+STP_must_know+_06.pdf/bf034d12-3d9d-4cb0-8c42-da5de19b3dcf

Moreover, the service integration role of STPs isn't just a matter of health and local government bodies working effectively together, but also the various different health bodies in each STP area doing so. That expectation is emphasised by the introduction of system wide financial control totals for the NHS organisations in an STP area. The extent to which NHS bodies work effectively together differs significantly across the country, due to the legacy of historical relationships, competitive commissioner/provider structure and the degree to which the STP reflects natural patient flows. Many factors interact to complicate such integration, which is by no means as simple as it can sound.²⁰ We suggest there are two key requirements among those which might minimise inter-body disputes in those circumstances – open communication backed up by and agreed, clear framework of financial responsibilities.

Good communication

Working closely during the year to share – openly and honestly, in regular meetings – each organisation's projections, ensuring that the reasons for difficulties are flagged early, and can be widely understood and owned. That increases the ability and inclination of other organisations to offset such pressures by mutually taking agreed action across other organisations.

A clear framework

A framework, agreed in advance, which sets out how the finances will be dealt with. That means the principles involved can be tackled in a relatively objective manner. Once a practical reality is reached – say, one body massively overspends and three underspend in order to improve their future flexibility – the differential practical impacts of the various options for sharing surpluses and deficits within the whole system become more fraught.

Ideally, both a culture supportive of partnership working and an effective governance structure will be in place, including those specific features of communicative working and a clear framework. If only one or other, culture or governance is present, the chances of problems developing increase. If neither is present, the risk of a breakdown, should any difficulties arise, is severe; or else there is a danger that though discussions remain amicable, the STP proves to be little more than a talking shop.

These measures deal with the primarily reactive business of preventing problems from derailing relationships. An indication of a more mature partnership working (in line with an accountable care system) will be to go beyond this to pool budgets, align resources and measure the results of spending across the whole system. This might mean, for example, being open to proactively transferring resources around the system in order to maximise the 'whole system' rate of return.

It's not a simple matter for individual institutions with statutory purposes to work as part of system, as from a governance point of view decisions may have to trade off what is a 'statutory duty' (eg for the organisation to hit financial targets) with a non-statutory encouragement of good practice (eg that value for money is achieved as assessed on a whole system basis). There can only be one winner if those goals come into conflict, so the importance of the whole system point of view needs to be built into the set-up of cross-organisational governance.

²⁰ These are two out of many potential obstacles. CIPFA provides integration training for health and social care which is designed to take forward the shared agenda by enhancing mutual knowledge and understanding of each other's systems and approaches. While running this in Essex, a consideration of potential obstacles included individual organisations' pressures and workload, lack of baseline information to measure benefits, lack of trust, silo working/mentality, mismatched footprints/complex geography, not understanding the root causes of system problems, professional protectionism, different finance policies and reporting, incompatible systems, short-term pressures vs long-term rewards, differing locations, ability/inability to charge and political influences.

Simply introducing a system-wide control total will not in itself suffice, especially when the assessments of NHS regulators are made on a single organisation basis: even if an STP footprint agreed that organisation A would accept going into deficit on the basis that organisations B, C and D would aim at a compensating surplus, the relevant regulator would be likely to criticise organisation A for not planning to break even. Rather, STPs need support, capacity and space from regulators to develop medium-term resource plans for the health and care economy.

There are several potentially more substantive ways of achieving the right kind of joint working.

Adopt the values

Greater Manchester's model doesn't change the formal powers and decision making processes, but adopts the clear principle that 'Decisions will be focused on the interests and outcomes of patients and people in GM and organisations will collaborate to prioritise those interests'.²¹ The key is then to see that the agenda taken forward, and the spirit in which it is tackled, follow through on the stated vision.

Resource the process

Devon is unusual in having a chief executive level role dedicated to the STP rather than its constituent authorities.²² That's a strong statement of intent, and recognises that the change and stakeholder management required is unlikely to be of the sort for which 'part time resources' will be best placed. In Scotland, similarly, the somewhat different structure includes 14 Integrated Joint Boards (IJBs) which act as single, unified commissioners of health and social care, allowing the IJB Director of Finance to play a role analogous to having an STP lead outside of the constituent bodies' structures. *Next Steps* does go some way towards recognising this, stating that 'NHS England will provide funding to cover the costs of the STP leader covering at least two days a week pro rata'. We believe local match funding to enable something closer to a fulltime role would make sense.

Set up the governance structure

STPs have typically set up arrangements which separate out a direction, decision making and assurance layer (key leaders from around the whole system) from a delivery layer (implementation working groups).²³ Those arrangements generally look well suited to consensual working. They don't interfere with existing powers. For example the One Herefordshire alliance has been established in shadow form between the council, CCG, voluntary sector bodies and the NHS Trust on the basis of a non-legally binding adherence to a set of common principles, which could form the basis for further work to develop a legal agreement in due course. Oxfordshire and Buckinghamshire have an oversight board, which brings together leaders of all organisations involved to ensure that the STP is connected with their organisations. A delivery board meets monthly, bringing together the leaders of the three local health economies, with the STP chair and executive lead, the leader of the finance group and representatives from NHS England and NHS improvement, while an operational group oversees delivery of the plan's projects.

21 *Governing for Transformation: STPs and governance* at www.nhsproviders.org/media/2463/hempsons-governing-for-transformation.pdf provides a useful template and commentary on setting up a Memorandum of Understanding.

22 Funded in the first instance by the Department for Health under its 'success regime', the alternative being for the STP footprint's organisations to joint fund. Given what's at stake that makes sense.

23 Terminology as used by Northamptonshire STP.

Alter the powers

STPs have been planned by consensus. The question is will that work for implementation, once difficulties arise? Or will it be necessary to vest some formal power with a cross-organisational decision making body, such as an executive Health and Wellbeing Board? This is not simple to achieve. As NHS Providers stated: 'directors of provider organisations, individually and collectively as boards, have specific legal duties to patients, the public and their own organisations'. Exhortation from elsewhere, no matter where or how forceful does not alter this²⁴ and so 'Boards are not able to agree to 'pool sovereignty' because legal responsibility and liability lies with the board and cannot be assigned elsewhere'. It may be that clarity of roles aligned to working together is a better enabler than formally integrated structures or joint control totals.

In this context, *Next Steps* looks to move matters in the right direction. It:

- recognises that all STPs need a basic governance and implementation 'support chassis' to form part of a Sustainability and Transformation Partnership, which will 'form an STP board drawn from constituent organisations and including appropriate non-executive participation, partners from general practice, and in local government wherever appropriate'. The board will 'establish formal clinical commissioning group (CCG) committees in common or other appropriate decision making mechanisms where needed for strategic decisions between NHS organisations.
- requires that an STP chair/leader should be appointed (or re-appointed) in line with the national role specification
- emphasises that the STP must have necessary programme management support by pooling expertise and people from across local trusts, CCGs, commissioning support units and other partners
- allows STPs to propose an adjustment to their geographical boundaries where that is thought appropriate by local bodies in agreement with NHS England.

These suggestions lead to the conclusion that full commissioner integration – including local government – may be the aim, in terms of formal powers, unless a more radical model such as full merger through creation of an accountable care organisation is followed. Meanwhile, the whole system control total remains a mechanism with no obvious means of enforcement. A practical approach may be to set matters up on the basis of shared principles, shared planning and regular communication, accepting that a withdrawal from collaboration – eg by one organisation refusing to accept the amalgamation of outturn positions – remains possible. In practice that would be something that which could be used once only, meaning it would make sense to proceed on the basis of its not being used.

There is a strong case for applying an appropriate analytical framework to the governance and related management issues for an STP, just as is routinely applied to individual organisations. The frameworks provided by the Future Focused Finance programme in the NHS or by CIPFA's Financial Management (FM) Model would facilitate such an assessment.²⁵ That is not to argue with NHS England's conclusion that 'the corollary to not being prescriptive about STP structures is that the way to judge the success of STPs – and their constituent organisations – is by the results they are able to achieve'. Thinking through the local governance issues improves the chances of the right results.

²⁴ See *Governing for Transformation: STPs and governance*, see reference 21

²⁵ The CIPFA FM Model considers organisational issues relating to 'leadership', 'people', 'stakeholders' and 'getting it done' which can easily be adapted to the multi-organisational requirements of an STP, and CIPFA plans to work with the LGA to exemplify that fully. www.cipfa.org/fmmodel

contingency and scenario planning

The right planning system is a necessary part of identifying the key issues and assessing how to tackle them. It will not though, make it easy to sort inherently difficult conflicts. There remains the very real tension between short-term actions to balance the books and satisfy NHS regulators now and a longer-term set of strategies to create sustainable and transformed economies. Although the STPs often do acknowledge risk factors and seek to mitigate them, it is very rare to base analysis on alternative scenarios underpinned by quantified sensitivity analysis to assess the range of savings likely to be achievable by the various actions, though Kent is one example, setting out the position as shown in figure one.

Figure 1 Sensitivity analysis on STP financial submission

Health system impact, £ Millions

	Upside	Base case	Downside
20/21 challenge, 'do nothing'	(434)	(434)	(434)
CCG QIPP	50	50	25
NHSE QIPP	51	51	25
Secondary to out-of-hospital care	74	33	10
Primary Prevention	22	22	11
RightCare Savings	46	46	23
Total	141	102	44
Cross Organisational Savings	39	39	20
Delivery of Provider BAU CIP	151	151	75
Total	190	190	95
TBC			
Reconfiguration of Commissioners	6	6	3
Reconfiguration of Providers	6	6	3
Total	12	12	6
Service Developments cost more/less than £122m	70	0	(35)
Variance on 16/17 Position	0	0	(108)
Ebbsfleet Additional Growth	28	0	0
Total	126	0	(143)
Grand Total	110	(29)	(382)

Source: the Kent and Medway Sustainability and Transformation Plan

The result is that plans are likely to be optimistic, ie the savings projected are at the top end of the range, and assume smooth progress – which won't always be the case. That fits with a suspicion that plans are in large part worked backwards from the required result: not building up robustly evaluated options to reach an objectively assessed achievable end position, but distributing the required end position across the available components of savings whether or not the resulting

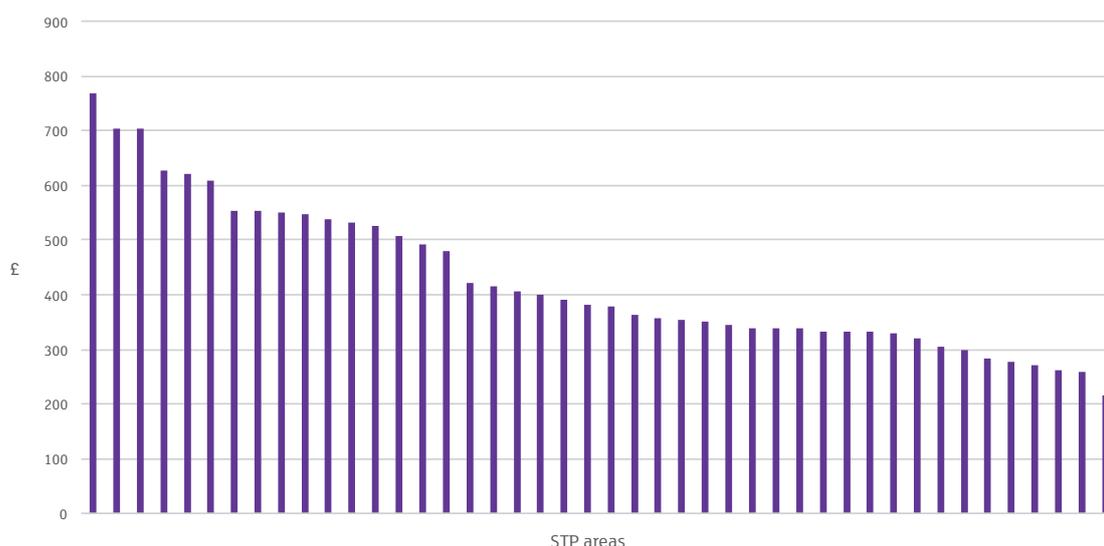
savings targets are realistic. Even the setting of a quantified contingency, however derived, is rare, yet that is a highly appropriate means of building realism into such wide ranging and largely untested system-wide savings plans.

Ideally, that should go alongside:

- horizon scanning, which assesses likely future developments, for example, rates of demand, the state of the economy, success in identifying capital resources, and the availability of sufficient workforce
- scenario planning, which looks at what possible situations might develop in the light of the information given by horizon scanning and the possibility of particular aspects of the plan moving more or less quickly or successfully. Alternative scenarios can then be used to ‘strength-testing’ the plans to check how well-suited they would be to respond to different scenarios, then seeking to build in mitigation as appropriate.

One crude indicator of likely risk is the extent of savings per head of population required by the STPs. This ranges widely, from £216 in Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby to £769 in Surrey Heartlands:²⁶

STP ‘do nothing’ savings per head of population



Source: The Independent, 14 Feb 2017

It might be salutary, perhaps when the STPs move from draft to finalised status, to investigate the reasons for the extent of variation shown above, likely to be a mixture of such factors as particular population issues, allocation decisions, historic performance backdrop, scale of previous investment, extent of past savings and thoroughness of analysis.

²⁶ ‘NHS Special Report’, The Independent, 14 February 2017

conclusion and recommendations

While it is good practice to plan for contingencies in all STPs, we would expect the degree of risk to correlate to some extent with the magnitude of the savings required. Looking at the 10 CCGs which plan to save most per head of population:

- none had included a sensitivity analysis
- there is some horizon scanning, but it is not carried through into full scenario planning
- only two had built a quantified contingency into their plans, both on a relatively crude basis²⁷
- most had failed to build the risk of falling short in savings plans explicitly into how the plans were formulated.²⁸ No doubt those writing the plans were aware of the risk factors, but the relative lack of quantification here adds weight to the suspicion that plans were constructed with the need to assume maximum savings in order to get to the financial position required, and that target was too arduous to leave scope to increase the savings planned in order to cover contingency assumptions. That is to say the level of savings required for each STP and the timescale for their production is likely to have restricted the robustness of the analysis.

CIPFA's view is that transparency and realism up front is to be preferred, even if it does expose the risks and difficulties involved in achieving the plans – those problems will anyway need to be dealt with at some point, so the sooner that is acknowledged, the better.

STPs represent a promising start towards taking forward the changes which are needed in the health and social care system, whether or not the actions which they identify to date are sufficient to solve the scale of problems faced. *Next Steps on the NHS Five Year Forward View* recognises the issue, and is helpful without making a sufficient immediate change to alter the likelihood that the financial challenge will not be met in the timescale required. The three gaps identified by the *Five Year Forward View* in 2014 make for a very challenging agenda.²⁹ It is apparent, for example in the uncertainty regarding many STPs' capital availability, that significant updating will be needed before taking the plans forward as implementable plans of action. Before moving from these initial plans to real, deliverable actions, it is important to test and develop the realism and scope of the activities set out.

In that context it is critical that finance staff feel empowered to take a robust, professional view when appropriate. To that end, the following statement sets out CIPFA's position.

27 Many STPs are relying on STF funds, whereas Greater Manchester states that that although it 'has been allocated STF of £170m ... given the level of risks and uncertainties this funding should be regarded as a contingency'. North Central London recognises the issue by discounting its saving plans by a £53m 'risk adjustment' to recognise that the 'cost savings which will be realised from each avoided day of acute hospital care will be significantly lower than the average tariff which is currently paid to providers'. However, it could be argued that is more a matter of setting the savings (over £800m planned) at a sensible level than of allowing for some not anticipatable non-delivery. Moreover, NCL's savings plans are £64m short of those required, pending further development, so the risk hasn't yet been mitigated.

28 Sussex and East Surrey recognise the issue but merely state that they will 'monitor plans fortnightly and accelerate plans if any additional risks come to light'.

29 *The NHS Five Year Forward View*, NHS England, 2015 www.england.nhs.uk/wp-content/uploads/2015/06/5yfv-time-to-deliver-25-06.pdf

The professional finance role in the context of STPs

There is an expectation that STPs will set out how the three gaps identified in the *Five Year Forward View* will be plugged, and a danger that the desire to present a positive plan which does so will lead to unrealistic judgements being made. Although chief finance officers (CFOs) working in the NHS don't have the same statutory duties as CFOs in local government (where there is a formal duty to set a balanced budget and to report publicly on any contrary plans) that doesn't dilute their professional responsibilities. CIPFA would expect and support finance staff involved in preparing STPs to ensure that they represent a realistic assessment of the financial position. That might require them to:

- assess the achievability of savings plans, calling for evidence as necessary to gain the appropriate assurance
- apply quantified sensitivity analysis to all material aspects of the plan
- build into budget projections appropriate contingencies in the light of that sensitivity analysis, so that there is a fall back if plans go awry
- ensure that a realistic assessment is made of the upfront investment needed to achieve change, and if the amount identified is too low, or its availability is in doubt, to flag this up and to adjust the sensitivity analysis accordingly.

The finance professional also needs to think outside of the established comforts of organisational control – making assessments on a whole system basis and, for example, working across current organisational boundaries to advise on and help develop payment systems that incentivise prevention more than the present tariff system does.

In carrying out sense-checking, consultation and development, CIPFA believes that the chances of successful delivery are higher if plans:

- are based on realistic assessment of the financial issues – as opposed to working backwards from an end point – and explicitly set out and assess the adequacy of the up-front investment proposed. Where the requirement for and/or the availability of such investment is not yet known, it should be a priority of STP updates to resolve both sides of the investment equation.
- make clear the immediate and subsequent governance arrangements envisaged. This should cover how each stage ensures that decisions are made for the benefit of the place, not just for its constituent organisations.
- consider a dedicated lead (preferably beyond the two days per week to be funded centrally) and plan to move organisational cultures forward to reinforce the agenda. The application of an analytical framework, such as CIPFA's FM Model, can be helpful here.
- incorporate horizon scanning as back up to assessing the possible scenarios, linking those to quantified sensitivity analysis which enables contingency planning. That should enable the financial risks involved to be assessed alongside the potential for mitigation.

Those may seem obvious recommendations. Yet not many of the current draft STPs examine those issues with the necessary clarity and thoroughness. CIPFA thinks it is important that the next iteration of plans does, so that the high profile headlines of savings targets and actions are backed up by adequate investment, clear governance and sensible contingency planning.



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