Our Healthier South East London
Improving health and care together

NHS

South East London STP

Briefing Note on Financial Submission

21st October Submission

1. Introduction and status

This briefing note has been prepared to supplement the third financial template submission (21st October) and is intended to summarise the key changes from the submissions made in June and September.

This submission represents the first shift away from the plans each party agreed with their regulator (the basis of financial templates submitted 30th June and 16th September) and in particular provides updates for the following:

- Activity assumptions – this relates to both forecast out-turn and growth for future years.
- Forecast financial and activity performance out-turn for 16/17 – based on month 5; but with any material movements expected in month 6 noted.
- Other cost pressures and CIP / QIPP assumptions included in revised LTFMs for 2017 – 21
- Control totals for Trusts and CCGs

Since this analysis covers the out-turn position for 2016 – 17 the affordability gap and impact analysis of quality and productivity improvements moves to cover a four-year period to 2021. In addition, there is a key focus on the two-year period 2017 – 19 where control totals have been set for returning the sector into surplus.

1.1. Status

This submission describes a 'provisional' position for the sector. The contracting and planning process and timetable for 2017 – 19 has been clarified in a number of pieces of recent guidance. Since this submission is required at the start of this process a range of new risks and potential mitigation is set out, including:

- Any unresolved adverse Trust / CCG financial forecast for 16/17.
- Trusts decision on revised STF and Control Totals pending Trust Plan returns on 24th November.
- Discussion and resolution of changes to CCG's control totals and 2-year trajectory; and any modification required to the current risk share arrangements.
- Any income and contract value totals for Trusts and CCGs pending issue of the tariff in December.
- Any income and contract value totals for Trusts and CCGs pending final triangulation of activity assumptions and agreement to QIPP scheme delivery.

2. Summary

The revenue affordability gap for the sector has increased with this submission. Alongside this the underlying financial risk, and volatility, associated with the new measures proposed for delivering financial recovery for all organisations has increased significantly. The substantial shortfall for specialist commissioning requires much further work and, additionally, new capital constraints will require much more analysis and scrutiny.

2.1) Revenue affordability

The table below shows how the STP affordability gap in the 21st October submission builds on the two plan submissions in June and September.

	30th June		16th September		21st October	
EFFICIENCY CHALLENGE	**£m**	**% over 5 years**	**£m**	**% over 4 years**	**£m**	**% over 4 years**
20/21 do nothing surplus / (deficit)	(1,036)		(854)		(934)	
Do nothing (relative changes between submission)						
Impact of achievement of 16/17 CIPs in 20/21			132			
Impact of achievement of 16/17 QIPPs in 20/21			61			
Other revisions to plan			1			
Inclusion of LAS			(12)			
Changes to 20/21 provider position in plans					(64)	
Changes to 20/21 CCG position in plans					(16)	
Total change to surplus / (deficit)			182		(80)	
Memorandum: Changes to 16/17 FOT					(49)	
Memorandum: Control Totals - Providers (not yet applied)					(71)	
Do something (scale of efficiencies)						
BAU CIPS[1)]	339	1.6%	188	1.1%	188	1.1%
BAU QIPPS	0	0.0%	0	0.0%	73	0.4%
Collaborative Productivity	232	1.1%	232	1.4%	225	1.3%
Clinical Transformation	119	0.6%	115	0.7%	116	0.7%
NHSE / LAS	190	0.9%	203	1.2%	203	1.2%
Sub-total 20/21 impact of solutions (before STF)	880	4.1%	738	4.3%	805	4.7%
STF	134		134		134	
Total 20/21 'do something' impact	1,014		872		939	
Residual surplus / (deficit)	(22)		18		5	
Memorandum: Total CIP requirement (shared between Do Nothing and Do Something)	339		321		321	
Memorandum: CCG QIPP requirement in order to achieve Control Total	-		-		c. 120	

1) Total CIP requirement is shared between the £188m shown in the Do Something efficiencies section and the £132m contained in the Do Nothing scenario. The overall requirement would be £321m, which is comparable with the £339m in the 30 Jun submission.

The first line in the table shows that the 'do nothing' FY21 affordability gap has increased by £80m to £934m (note this is now over 4-years) once the latest analysis is incorporated. However, it is important to note that this comprises significant movements both up and down, and separately, the additional CIP required to recover Kings current forecast deficit for 2016/17. This volatility at organisation level gives rise to a much higher level of financial risk than is implied in the net change reported for the sector as a whole.

Specifically:

- Both GSTT and LGT have made adjustments to their LTFMs (relative to 16 / 17 plan); the combined effect of which is a deterioration of £71m for the sector.
- For GSTT a revised LTFM takes into account non-recurrent items in 2016 / 17, costs of capital for completed schemes and the cost of additional activity growth over the period; resulting in a deterioration of £80m by FY21.
- For LGT their revised LTFM improves the FY21 position by £9m. This represents a small reduction in the income position and a reduction in operating costs.
- There are significant changes to cost assumptions made by KCH (£49m) where the 16 / 17 forecast out-turn position is resolved by FY21. Although Kings has a forecast out-turn deficit the revised LTFM deals with this entirely over the period to FY21 through increasing efficiency, by expenditure reduction.
- This revised affordability challenge excludes a requirement to deliver new control totals (£71m improvement) for providers; pending Board decisions.
- CCG control totals are now incorporated into the financial template; but the QIPP required to close the commissioner affordability gap is approximately £70m. The impact of this has not been mapped to provider LTFMs pending contract discussions. This does not increase the affordability gap but represents a QIPP challenge of approximately 3%.
- Elsewhere the two-year activity forecasts have been updated and triangulated and show that before adjusting for QIPP as noted above (but excluding NHSE Specialist Commissioning) this is likely to be affordable. But, delivering the QIPP schemes required is critical to signing contracts on this basis.

2.2) Capital availability

NHS England has advised that capital is highly constrained; especially in 2017/18 and 2018/19. In response they have issued new instructions for completing the financial template as follows:

In the 'do nothing' plans, capital requests should not be higher than can be funded from locally agreed resources (i.e. the lower of the average of the last three years' spend and the level of projected depreciation, approved FBCs and successful primary care capital bids). Solutions should not in general depend on additional capital being made available in 2017/18 and 2018/19 except where business cases are at an advanced stage of development. For all future years we will be running a prioritisation process with the aim of supporting those schemes that demonstrate a robust business case and a very strong return on investment. This process will be based on the 21st October returns and will take into account the credibility of service plans and their overall revenue and capital affordability within available resources.

In response the STP has produced a version of the template that complies with this instruction based on returns received from each Trust. In particular, this affects GSTT capacity schemes (£100m) and LGT endoscopy, IT and ED redesign schemes (£53m). These schemes will continue to be described in the template – but with no value against them pending agreement of the relevant funding authority.

3. Risk

The revenue productivity requirement described in 2.1) above represents increased financial risk across the sector when compared to the plans set out in June and September. Forecast financial performance in 2016 – 17 is broadly on plan overall; with the exception of KCH and separately with some schemes still due to start in collaborative productivity. In some cases, performance on 2016 / 17 is supported by non-recurrent funds and the underlying position is weaker than is reported in the accounts.

Taken together at sector level this means that the 'do something' activities equate to a requirement to deliver annualised productivity improvement of 4.7% over the 4-years to FY21 at the sector average level. However, crucially, the embedded assumptions for Kings deficit (£50m 0.2%) and control total acceptance (£71m 0.6% over 2 years) mean that the total requirement is much greater at 5.5%. This significantly exceeds the historical level of delivery.

Note that this challenge includes NHSE Specialist commissioning and London Ambulance Service financial gaps that will be dealt with from changes to those services and not from subsidy elsewhere in the sector.

The impact of control totals for providers is significant over the next two years and is set out in more detail elsewhere in this briefing. Since the net effect of the offers is to substitute surplus for STF funding over the next two years this increased financial challenge is shown separately because Trusts will be considering their plans in detail before responding to NHS Improvement.

The CCG control totals issued now introduce an adverse variation from NHS Business rules previously deployed in SEL. Although the sector has risk sharing arrangements in place some further consideration is required on the impact of this by CCG and for the sector.

4. Mitigation

Other than for increasing efficiency and modification to control totals risk mitigation at STP level is being approached through:

4.1) Contracting approach to support STP delivery

SEL CCG leads are working on principles that would underpin block contract offers for 17-19. Activity forecasts and assumptions would inform or be used as the basis for any block contract offer - but each CCG/Associate CCG would need to determine the level of activity they wish to commission, recognising that their response will drive whether a block type or cost and volume contract is agreed.

The SEL STP has discussed and considered options for the 2017-19 contracting round, with a focus on:

- Supporting the delivery of STP commitments through the 2017-19 contracts.
- Ensuring a pragmatic approach to contract negotiations, to ensure that we roll forward existing schedules, specifications and documentation where appropriate, to enable us to focus on securing timely agreements and specifically agreed approaches to funding, activity, QIPP and key STP/local CCG commissioning and provider priorities by 5 December.
- Ensuring a collaborative approach to the contract round, recognising the very real challenges that each organisation and the local health economy is facing and the need to work together to find mutually acceptable solutions to managing these issues across the SEL STP.

To support these outcomes and the primary need for financial certainty for both providers and commissioners, whilst freeing up capacity to focus on our transformational and developmental change programmes over the next two years, we are seeking to agree the following approach across the STP:

- Traditional cost and volume approach – this provides the opportunity for CCGs to determine their proposed start contract baselines whilst ensuring that providers are funded for the actual activity undertaken. This is likely to be the preferred option for many CCGs that fall outside of the STP footprint for GSTT and KCH, given the volatility of activity and cost associated with the smaller value contracts for these CCGs.
- Exploring the scope for a block type contract option – this provides financial certainty and increases overall financial and system stability. The setting of mutually acceptable start contract baselines would be crucial – to include a realistic assessment of expected demand plus the impact of agreed STP commitments. The ideal would be to secure this block type contract option for STP footprint CCG commissioners. This might ideally also include specialised commissioning although there has previously been little evidence for how this might apply.

Further consideration is required to determine any block type contract offer, including:

- Geography – the extent to which a mixed economy of block type and cost and volume contracts will be feasible. In the past block type contract offers were applied in 2015/16 for GSTT and KCH on a Sector/STP footprint basis (either cost and volume or block), with the exception of SEL for which a mixed economy across key local and non-local CCGs was agreed.
- Scope – the extent to which a block type offer would cover the whole contract or part of the contract. If a differentiated approach is taken the obvious split is across elective and non-elective pathways, with elective commissioned on a cost and volume basis and non-elective on a block. Current referral flows and volatility combined with the need to reduce incomplete backlogs over 2017-19 may mean that a cost and volume arrangement for elective care would be optimal, noting it would also allow commissioners to utilise any funding associated with underperformance to seek alternative activity/capacity elsewhere.
- Terms and conditions – including potential reopener reviews, year 2 review and refresh commitments.

Developmental contracting - Within either of the above two options there would also be flexibility to develop, test and implement new contracting models (e.g. MCP/PACS type approaches) to support the implementation of new integrated models of care. Within the STP we are assuming this developmental agenda will be taken forward on a Local Care Network/local CCG commissioner to Trust basis.

4.2) Collaborative approaches across CCGs

It is assumed that current London CCG collaborative arrangements will continue in relation to the planning and contracting round for 2017-19. This will mean that:

- Coordinating or host commissioner arrangements will continue, with a lead CCG for each acute provider.
- London CCG interfaces continue to be articulated through Trust specific Collaborative Commissioner Agreements, working to a consistent set of principles, roles and responsibilities across London in line with the existing Collaborative Agreement framework, with decision making and voting rights set out and agreed on an individual Trust basis recognising that commissioner flows and therefore decision making will differ by Trust. Agreements to be signed off by end October.

Whilst the above process will make clear lead and associate commissioner responsibilities and decision making processes, the following issues need to be recognised:

- Many London provider contracts will span STP footprints. Further consideration needs to be given as to how STP specific priorities and issues will be applied across footprints. It is suggested that host CCG STP requirements should be applied at a Trust wide level e.g. timelines for implementation of London Quality Standards, but with the ability for other STPs/CCGs to decommission services from Providers subject to contractual notice requirements being met.

The Collaborative Agreement makes explicit that the determination of start contract value and activity is the responsibility of individual CCGs. The host commissioner can sign off the methodology for Trust costed proposals and make recommendations to associate CCGs but cannot make decisions in relation to funding and activity on behalf of other CCGs. Given the need for CCGs to meet their own business rules and control totals we think this approach needs to be continued for 2017/19, with any issues or concerns in relation to the level of commissioned activity addressed through CCG operating plan assurance processes.

5) Control Totals

The proposed control total for the sector combines the CCG and Trust surplus position, as follows:

- 16 / 17 – Provider (-£16.7) and Commissioner (£27.8m) equals (£11.1m)
- 17 / 18 – Provider (£32.6) and Commissioner (£26.3) equals (£58.9m)
- 18 / 19 – Provider (£54.5) and Commissioner (£29.5m) equals (£84m)

5.1) Commissioners

Commissioner control totals have been sent to the footprint by NHS England. These values, which are under discussion with local CCGs, and an indicative (unconfirmed) split by CCG are provided on pages 9-10.

Control totals issued at a sector level (only) by NHSE have been broken down by the STP to show the values by CCG and the draw down available for any amount above 1% that must be retained under business rules. The position for each year is as follows:

- 16 / 17 – Carry forward above 1% - £3,855k (1.16%)
- 17 / 18 – Carry forward above 1% - £1,798k (1.07%)
- 18 / 19 – Carry forward above 1% - £4,748k (1.18%)

This means that although there is a small movement towards 1% for the sector in 17 / 18 this is subsequently pushed out further (to 1.18%) in 18/19. This represents a £3,221k pressure on the system in 18 / 19.

5.2) Providers

The efficiency challenge shows a requirement across the sector associated with delivering control totals. Trusts have until 24th November to accept these. The table below shows a requirement to generate a surplus of £32.6m in FY18 and £54.5m in FY19.

The agreed plan position for 2016/17 is set out in the table below:

Providers (all figures in £m)	2016 - 17		
	Deficit - Surplus + b/f STF	STF	Control Total
Guys and St.Thomas'	-12.7	19.2	6.5
Kings	-31.6	30.0	-1.6
Lewisham and Greenwich	-36.8	16.6	-20.2
SLAM	-6.3	2.3	-4.0
Oxleas	1.0	1.6	2.6
Total Providers	-86.4	69.7	-16.7

This is updated with the following offers for 2017/19:

Providers (all figures in £m)	2017 - 18 Deficit - Surplus + b/f STF	STF	Control Total	Change in CT	2018 - 19 Deficit - Surplus + b/f STF	STF	Control Total	Change in CT Cumulative
Guys and St.Thomas'	0.0	22.1	22.1	15.6	7.1	22.1	29.2	22.7
Kings	-4.4	30.6	26.2	27.8	10.9	30.6	41.5	43.1
Lewisham and Greenwich	-37.7	16.6	-21.1	-0.9	-40.9	16.6	-24.3	-4.1
SLAM	0.0	2.3	2.3	6.3	2.0	2.3	4.3	8.3
Oxleas	1.6	1.5	3.1	0.5	2.3	1.5	3.8	1.2
Total Providers	-40.5	73.1	32.6	49.3	-18.6	73.1	54.5	71.2

The tables show that the SEL-wide control total moves to surplus by a cumulative £71.2m over the period - improving from a deficit of £16.7m to a surplus go £54.5m. This means, in effect, that STF provided today is converted into a surplus over the next two years (with £49.5m in FY18). This means that although non-recurrent revenue and one-off cash has gone out into the service, for three years, the recurrent revenue allocation has been returned to the centre.

The SEL 5-year financial recovery plan uses STF funding to close the affordability gap in FY21 (£134m). NHSE has confirmed that this treatment (of STF) is acceptable.

6) Workforce

The workforce template has been completed by calibrating the workforce requirement to the overall changes in the financial template. At this stage there are no other detailed assumptions available from the transformation and collaborative productivity programmes.

The headlines are as follows:

- Under the 'do nothing' scenario the current workforce across primary (GP) care and secondary care would increase from 46,639 to 52,430 in FY21; an increase of 5,791 (12%) to meet increased demand. This is the equivalent of a new hospital of approximately the size of Lewisham and Greenwich Trust and would cost approximately £350m.
- Under the STP programme this increase is largely avoided for acute providers with the FY21 workforce being reduced by 930 (2%). Substantial investment in local care networks would be required however this is not sufficiently developed to include for the moment.

7) Conclusion

The revenue affordability gap for the sector has increased with this submission. Alongside this the underlying financial risk, and volatility, associated with the new measures proposed for delivering financial recovery for all organisations has increased significantly. Finance Directors considered the finance template and the accompanying narrative at their meeting on 21st October. They agreed that:

- The completed template, at sector level, presents a position that they believe understates the degree of underlying financial risk for its constituent organisations. They agreed that the financial risk for the sector is better expressed by reference to the increased efficiency requirement set out in the narrative.

- The financial improvements mapped onto the template for QIPP, NHSE Specialist Commissioning and changes to Trust and CCG LTFMs are not yet sufficiently supported by worked up plans for action. They acknowledge that this submission is provisional pending the outcome of contract and planning processes due to start but have highlighted the scale of improvement required - in particular for 2017/19.
- They remain committed to delivering on the provisional plans for clinical transformation and for collaborative productivity and see these as critical. Individual plans will be updated when investment supported business cases and implementation plans have been approved by Boards locally.

The system approach is seen as the only way the sector can sustainably address the challenges it faces. They believe that over time the service transformation and collaborative opportunities should be expected to deliver an increasing proportion of the requirements for financial sustainability and that localised 'BAU' savings become the top-up rather than the other way round.

- They believe there is more to do in developing a collective understanding of the sector position and response. Although the financial template contains the consolidated position for each organisation the means for reaching collective STP outcomes are not yet fully developed.

Most of the key planning variables remain under negotiation / discussion (contracts, control totals and capital) or are unknown at this time (tariff) and therefore this submission is considered provisional pending the outcome of that work.

Alan Goldsman

21st October 2016

Appendix 1: Indicative (unconfirmed) allocation of CCG control totals

2016/17

	2016/17						
CCG	**Programme budget**	**Running cost allocation**	**Brought forward surplus**	**Overall allocation**	**1% of allocation**	**Planned in year movement**	**Planned carry forward**
Bexley	293,260	5,109	151	298,520	2,985	18	169
Bromley	421,490	7,257	5,911	434,658	4,347	0	5,911
Greenwich	359,356	6,067	3,249	368,672	3,687	-4,544	-1,295
Lambeth	451,428	7,627	7,752	466,807	4,668	0	7,752
Lewisham	405,174	6,608	7,645	419,427	4,194	-45	7,600
Southwark	393,667	6,457	7,677	407,801	4,078	0	7,677
Total	**2,324,375**	**39,125**	**32,385**	**2,395,885**	**23,959**	**-4,571**	**27,814**
Figure in STP CT							**27,810**
Variance							-4
Available to draw down							3,855
Carried forward surplus %							1.16%

2017/18

	2017/18						
CCG	**Programme budget**	**Running cost allocation**	**Brought forward surplus**	**Overall allocation**	**1% of allocation**	**In year movement to business rule**	**Carry forward**
Bexley	301,097	5,123	169	306,389	3,064	965	1,134
Bromley	430,892	7,286	5,911	444,089	4,441	-490	5,421
Greenwich	367,702	6,093	-1,295	372,500	3,725	1,242	-53
Lambeth	461,374	7,656	7,752	476,782	4,768	-995	6,757
Lewisham	415,400	6,651	7,600	429,651	4,297	-1,101	6,499
Southwark	403,327	6,496	7,677	417,500	4,175	-1,167	6,510
Total	**2,379,792**	**39,305**	**27,814**	**2,446,911**	**24,469**	**-1,547**	**26,268**
Figure in STP CT						**-1,546**	**26,264**
Variance						1	-4
Available to draw down							1,798
Carried forward surplus %							1.07%

2018/19

	2018/19						
CCG	Programme budget	Running cost allocation	Brought forward surplus	Overall allocation	1% of allocation	In year movement to business rule	Carry forward
Bexley	309,127	5,136	1,134	315,397	3,154	2,020	3,154
Bromley	441,612	7,315	5,421	454,348	4,543	-292	5,128
Greenwich	376,804	6,119	-53	382,870	3,829	3,882	3,829
Lambeth	471,871	7,684	6,757	486,312	4,863	-631	6,126
Lewisham	426,168	6,694	6,499	439,361	4,394	-702	5,797
Southwark	413,452	6,533	6,510	426,495	4,265	-748	5,761
Total	**2,439,034**	**39,481**	**26,268**	**2,504,783**	**25,048**	**3,528**	**29,796**
Figure in STP control total paper						**3,221**	**29,485**
Variance						-307	-311
Available to draw down							4,748
Carried forward surplus %							1.18%