Advisory

NHS Cambridgeshire & Peterborough CCG

Capability, capacity and independent review of financial position – FINAL

FINAL

26 March 2018

pwc

At a glance

PwC view

Our view on the likely FY17/18 outturn is in line with the CCG's most recent forecast of £48.2m.

Our risk assessment indicates a potential deficit of between £45m and £55.2m for FY17/18.

There has been a significant decline in the CCG's underlying performance year on year since FY14/15.

QIPP programmes have not had a material effect on demand and the issues with the CHC backlog are indicative of a culture of poor control and ineffective governance.

1 The CCG has asked us to provide an independent view of its financial position, capacity and capability.

Given the substantial deterioration in the CCG's financial performance in-year, the CCG has asked us to undertake an independent review of its financial position and the organisation's capability and capacity to deliver its plan.

We have conducted our review over a three week period through interview, document review and financial analysis. CCG management has supported our review.

2 The underlying deficit has increased year on year since FY14/15, with non-recurrent year end deals and reserve releases being used to achieve planned outturn positions.

There has been a continued deterioration in the CCG's underlying financial position:

- FY14/15 £8.0m deficit
- FY15/16 £15.7m deficit
- FY16/17 £32.3m deficit
- FY17/18 £49.2m forecast exit underlying deficit.

The main drivers of this have been acute and community expenditure. The exit underlying position for FY16/17, which was used for FY17/18 planning, was understated by £7.1m because it did not factor in non-recurrent actions taken after the plan submission: The CCG did not adapt its plan to reflect the need for an additional £7.1m QIPP.

3 The CCG's FY17/18 financial position has worsened from a planned £15.5m deficit control total to a forecast outturn position of £48.2m. The main drivers for the deterioration are acute over performance, QIPP under-delivery and a backlog of cases for Continuing Healthcare.

The CCG's financial deterioration has been driven mainly by over performance at CUHFT (£14.6m), QIPP under delivery, particularly in relation to demand management schemes (£8.8m), NCSO prescribing pressure (£6m) and a CHC backlog (£10m). These amounts have been offset by a number of underspends including primary care and delegated commissioning, plus central budget slippages and release of reserves.

All CCGs have been impacted by the NCSO prescribing issues. The issues with CHC resulted from poor governance and control, which allowed a large backlog of cases to build up.

Whilst there are issues with governance and control in the CCG, we note that the quality of working papers to support the financial analysis are of a better standard than at other CCGs we have worked with.

4 Our risk assessment of the FY17/18 forecast outturn indicates a potential range between £45m and £55.2m. Our view on the likely outturn is £48.2m which is in line with the CCG's recent reforecast.

The CCG's FOT for FY17/18 was updated from £44.7m to £48.2m for the Month 10 return to NHSE, primarily reflecting an increase in the financial risks arising from the year end deal with CUHFT.

At a glance

PwC view

The CCG has not taken sufficient action to address its declining underlying financial position. A lack of grip and control has continued this year.

The FY18/19 'do nothing' position of £83m deficit compared to a control total of £15m deficit gives rise to a gap of £68m (5.8%). Historically the CCG has not delivered significant recurrent QIPP of this magnitude. The CCG is continuing to work on bridging the gap.

The 'do nothing' plan does not include difficult decisions on pre-committed expenditure (c.£10m) and reserves (c.£10m). Action is being taken against these in CCG's plan to close the gap to the control total.

Our assessment indicates a FOT potential range of £45m to £55.2m, with a most likely view of £48.2m.

The main risks and potential upsides to the position are:

- Year end deal with CUHFT – the settlement is based on Associate activity levels. The value of this settlement has been impacted, in part, by the impact of national guidance to cancel elective care in January. We estimate an lower and upper range of +£2.3m and -£2.2m.
- CHC Backlog – the assumptions used to determine the risk are reasonable based on the information currently available; the precision of the estimate will increase as progress is made to clear the backlog. We estimate a risk range of +£1.4m to -£3.4m based on potential changes in CHC conversion rates.
- Balance sheet releases – we estimate an upper and lower range of -£0.4m and -£1.2m.

The CCG has not received permission from NHSE to release the 0.5% uncommitted reserve. If this permission is granted, there is £5.7m of mitigation available.

5 The CCG has a 'do nothing' forecast deficit of £83m for FY18/19 prior to QIPP.

The assumptions included in the plan are primarily based on actual growth percentages together with local STP assumptions, not all of which proved valid in FY17/18. The key area where underlying assumptions may change is in relation to the CHC backlog which has been included as recurrent in the underlying position.

As at the time of our review, the FY18/19 'do nothing' plan includes some figures which are estimates. The CCG is working to refine these estimates further.

The 'do nothing' plan includes items of budgeted pre-committed expenditure (c£10m) and reserves or contingencies (c.£10m) such as an acute growth and winter pressures reserve that the CCG recognises it will need to robustly assess and address. Actions to address these items are included in the gap to the control total while the CCG develops plans to minimise the impact of taking difficult decisions against pre-committed expenditure.

The level of QIPP required to achieve the control total in FY18/19 (5.8%) is significantly higher than the CCG's previous recurrent QIPP delivery levels. Releasing reserves and contingency of c.£10m would reduce QIPP delivery target to 4.9%, however this is still higher than historically achieved levels.

Although the CCG has historically reported QIPP delivery in line with targets (FY16/17: 4.5%), a significant proportion of this has been achieved through year end deals with providers and non recurrent schemes (FY17/18: 3.6% delivery FOT).

At a glance

PwC view

At the time of our fieldwork, which commenced on 25 January 2018, the CCG only had a partially complete list of QIPP ideas for FY18/19. This is significantly behind where we would expect it to be so close to the start of FY18/19.

The opportunity for improvement has been tested through benchmarking and is between £36m and £45m. Delivery of the whole opportunity would require an improvement in performance to upper quartile in every area and leaves a residual gap to the control total of £25m - £34m.

6 QIPP planning for FY18/19 started late, and is at least two months behind where it should be. The pace of development of FY18/19 QIPP has increased to support the financial recovery of the CCG.

Financial planning for FY18/19 started later than we would have expected, and is two months behind where we would expect it to have been when we commenced our fieldwork. Whilst work had been conducted across the health system looking for system savings, the first CCG QIPP long list was produced on 29 January 2018.

As at 15 February, the CCG has a summary view of the FY18/19 programme, with a total value of £21m (including the full year effect value of schemes from FY17/18) with 99 QIPP schemes. However, only 37 PIDs exist with a total value of £10m, and these PIDs lack detail which will reduce the likelihood of successful delivery.

In addition to the urgent action being taken to address this, the planning cycle for future financial years must be brought forward to avoid this position recurring.

7 Benchmarking data indicates that the size of the opportunity to improve is substantial, between £36m and £45m, but this will require a move to upper quartile performance in every benchmarked area.

The opportunity for improvement has been tested through benchmarking and is between £36m and £45m. This would require an improvement in performance to upper quartile in every area which will require robust plans, rigorous programme management and the highest levels of clinical engagement.

The total level of opportunity identified by benchmarking is insufficient to bridge the gap between the forecast deficit and the control total by £25m-£34m.

8 The CCG's control total for FY18/19 of a £15m deficit represents a significant challenge due to both the size of the financial gap and the capacity and capability of the CCG to deliver at pace.

The 'do nothing' forecast deficit of £83m is £68m from the £15m control total. There are three main areas that must be addressed to reduce the £68m gap: a) QIPP: The CCG is planning to deliver £45.6m of QIPP net of any implementation costs; b) Mitigation of pre-committed expenditure and cost pressures; and c) Consideration of releasing reserves and contingencies.

This is a very ambitious target and will require the delivery without fail of all plans, specifically: Support from providers in relation to guaranteed income contracts (GICs), rapid PID development and resolution of significant internal capacity and capability issues.

The CCG's delivery plan does not include, in some cases, difficult decisions in relation to pre-committed expenditure (c.£10m). However , in our view, these are not sufficient to offset risks in relation to the planned QIPP delivery and bridge the gap to the control total.

Our sensitivity analysis indicates a FY18/19 outturn range of between £35.8m deficit in a better case and £68.9m deficit in a worse case. There would need to be significant support put into the CCG to lower this range.

In order to return to financial stability, a multi year recovery plan is required to address the extensive issues we have identified and which are the root cause of the current organisational crisis.

At a glance

PwC view

The instability in the leadership team has not been conducive to effective planning and delivery. The CCG urgently needs a stable leadership team to move forwards effectively.

The CCG lacks experienced leadership capacity and capability. The overall structure and posts within the leadership team should be revised to meet the current challenge.

The CCG has become very reactive and the culture is not focussed on sustainable improvement. A medium term improvement plan encompassing both financial recovery and OD is required.

9 A significant level of instability in the CCG's leadership team over the last two years has impacted on the ability of the organisation to plan effectively and has caused a high degree of uncertainty for staff.

There has been recent significant turnover in the Executive team: The Interim Accountable Officer joined the CCG in October 2017 on a fixed term contract to 31 March 2018.

The Interim Chief Financial Officer commenced in post three weeks before our review started. We note that there have been four different individuals in the AO role and four individuals in the CFO role in FY17/18.

The Chief Nurse post is being filled by the Deputy Director of Nursing on an interim basis. The Director of Transformation for Urgent and Emergency Care is due to leave the CCG at the end of the month.

The CCG's former Turnaround Director left the organisation in November 2017.

We have also been told that there has also been a significant amount of churn at all levels in the organisation.

The instability in the leadership team, with a number of recent appointments and individuals acting into posts, also means that there is a relative lack of corporate memory and experience at Executive level.

The Executive team needs to be stabilised with experienced permanent appointments made wherever possible, and long term interim appointments where substantive appointments are not viable.

10 The CCG has lacked experienced leadership capacity and capability. This has resulted in insufficient grip, control and energy in relation to driving improvement.

We have found some silo working and a lack of a corporate approach: With the significant churn in leadership roles, in our view, people have focussed on what they can control within their own portfolios and have not been held to account for delivery of performance overall. A Chief Operating Officer is needed to take responsibility for all commissioning activity and to address the silo working.

Clinical leadership is lacking within the Executive team: This should come from the appointment of a substantive Director of Nursing and the creation of a Clinical Director role.

Significant and substantial OD experience and capacity is needed within the Executive team, reporting to the Interim AO, to develop and deliver an OD plan to enable a sustained recovery. This role might have an associated system OD requirement.

The impact of the lack of experienced operational leadership has been a lack of grip and control. The issues in relation to CHC and the lack of a robust QIPP programme are a manifestation of this. There is insufficient leadership capacity and capability in relation to driving financial turnaround. A Financial Improvement Director, supported by dedicated resource, is required to drive financial recovery at pace.

Given the scale of the challenge at the CCG we believe the Interim AO should consider whether she has the capacity to deliver both the AO role and the STP leadership role in the short term.

At a glance

PwC view

Engagement and communication will be important in allaying stakeholder concerns and communicating that there is a clear plan to address the financial gap. The CCG should prioritise continuing to develop its communication with staff and health economy partners.

The System Delivery Unit (SDU) lacks direction, is not focussed on supporting the CCG's recovery and accountability is unclear.

Whilst there are several individuals with relevant skills and experience, as well as willingness within the SDU, the value of these individuals is not being realised to the benefit of the health system under the current operating model.

11 Continuous engagement and communication with CCG staff and health economy partners should be prioritised, to emphasise the scale of the financial challenge, the solutions being developed and the role of all stakeholders in developing a sustainable health economy.

The development and implementation of a clear communication and engagement plan should form part of the OD programme.

Investment in communication skills/experience will be needed to support this. We note that staff morale has been impacted by the level of management and leadership change at the CCG over the past two years. Engagement and communication will be important in allaying concerns and communicating that there is a very clear plan to address the financial gap.

12 The accountability and expectations of the SDU have not been clearly defined. The CCG should facilitate a review of the role of the SDU, to maximise its value for the health system.

The SDU accounts for a significant amount of resources, with in excess of 30 posts (albeit it there are a number of vacancies currently). A theme from our interviews is that the contribution of the SDU in relation to tangible outcomes that have provided significant value to the system has been limited. The SDU has drawn in resources from the CCG and partners, for example from the PMO at the CCG.

We note that the PMO led meetings to drive QIPP have happened less frequently and/or inconsistently at the CCG since September 2017. Therefore, the focus of CCG resources on the SDU may have had a short term negative effect on the pace and drive in relation to the CCG's own statutory responsibilities to develop robust financial plans.

The CCG should facilitate a review of the role and remit of the SDU for the STP partners' organisations. As an outcome from this review, accountability and clear objectives and outcomes for the SDU should be defined. Taking into account the level of resources available within the SDU, the CCG should ensure that the SDU role is defined to have maximum impact on recovering the overall financial position of the health system.

13 There has been a breakdown in governance and control in relation to finance, of which CHC is a clear example.

The CCG invited a peer reviewer to appraise its CHC processes and governance in November/December 2017. The peer reviewer identified weaknesses and a significant financial impact of a backlog of cases, which had not been processed and therefore were not factored into the historical financial position or forecasts.

The CCG has appointed a new lead for CHC and is currently reviewing the function. The CCG should process the backlog of CHC claims in a robust way to minimise appeals. The CCG should re-run its model with updated assumptions prior to submission of the final plan in April 2018 to ensure the estimate included for FY18/19 reflects the most up to date information.

At a glance

PwC view

Urgent action is required to regain control over CHC expenditure to address the extensive backlog and put in place appropriate management for the future. Contract management must also be reinstated to regain control over other significant areas of CCG spend.

The Governing Body has not complied with its statutory financial duty.

The CCG has largely completed the action plan from its previous Capacity and Capability review but the changes have not been embedded. There has been a tick box approach to governance rather than the required cultural change.

We have been told that contract management activity has not taken place in FY17/18 due to the system wide approach taken to population health management agreed through an MOU. We understand that the intention was to move away from enforcing contract penalties but that in practice this has resulted in an absence of contract management overall. Contract management must be reinstated as a priority in FY18/19 to ensure robust financial control is in place.

14 The Governing Body has not complied with its statutory duty in relation to the stewardship of public money. A Governing Body effectiveness review is required to define the detailed actions needed to make it fit for purpose.

The CCG has had an underlying deficit for a number of years and action has not been taken to address this in a sustainable, recurrent way. Based on our interviews, we identified that there is a perception that whilst the Governing Body asks questions, the level and type of scrutiny is less effective than it should be and information sources are not triangulated.

An updated independent review should be undertaken of the effectiveness of the Governing Body and its processes for seeking and receiving assurance over the robustness of plans and ongoing monitoring of implementation.

The effectiveness of Lay Members and Clinical Leaders should be considered on the Governing Body and its sub-committees, including clinical leadership at Clinical Executive Committee. Action should be taken to strengthen the financial capability of Governing Body members through additional training and the recruitment of one or more Lay Members with NHS finance experience.

There is also a need for a review of the governance failings in relation to CHC to identify the lessons learnt.

15 The finance function and other support functions need to be reviewed and vacancies filled.

The CCG should review the finance, contracts and BI functions to ensure that accountability is clearly defined and that the structure and roles within these functions is right, taking into account the role of the SDU and resources within it. Duplication of effort between the SDU and CCG functions is currently evident and must cease. Vacancies within the finance function and contracting team should be filled urgently in order for there to be sufficient capacity and capability within this function to support the CGG's financial information and contract management needs.

At a glance

PwC view

The PMO is not fit for purpose in its current form. A sponsoring Executive needs to be identified to re-define accountability and clarify structures and purpose.

Support functions including finance should be reviewed in the context of the SDU.

We are deeply concerned with the breadth and depth of capacity and capability issues of the CCG coupled with the scale of the financial challenge in FY18/19. There is a need for the development of an organisational improvement plan including a detailed short and long term recovery plan.

16 The PMO lacks clear leadership, clarity of purpose and a mandate to drive and objectively assess delivery of the QIPP programme. The CCG also lacks a robust Business Intelligence function

There has been a lack of clear leadership and direction of the CCG's since Q3 17/18, a situation which remains.

This has been caused in part by confusion over the intention to integrate the CCG's and SDU's PMO functions.

The CCG should redefine the CCG PMO's remit, and identify a sponsoring Executive to lead this function. A CCG Head of PMO should be appointed to provide day to day leadership.

The CCG should implement Director led weekly financial recovery meetings across the programme, with PMO support. Detailed discussions of QIPP progress and implementation should be held at these meetings and action taken to address emerging risks and issues.

The current Business Intelligence (BI) function is the result of integration of the SDU's and PMO's BI functions. It is currently not operating at the pace and extent required to drive improvement forward and to support the CCG's recovery.

17 Concluding comments: We are deeply concerned with the breadth and depth of capacity and capability issues of the CCG coupled with the scale of the financial challenge in FY18/19.

Based on our experience of working with a large number of CCGs nationally, the issues facing the CCG in relation to capacity, capability and financial recovery, combined with the financial challenge facing the local health system, are among the broadest and deepest set of issues facing any CCG we have worked with.

The Governing Body must take responsibility for the leadership and governance issues identified and urgently put in place plans to address them.

It will take the CCG and the system a number of years to achieve financial sustainability, however, with additional support and capacity the CCG should be able to make significant progress in addressing its underlying deficit in FY18/19. This will require difficult decisions to be made by the CCG and a constant focus on financial recovery at the same time as working with its system partners to ensure the deficit is not just moved around the system.

18 Next steps.

We set out on the following pages a detailed set of recommendations that should be developed into a full action plan to be owned by the Governing Body and agreed with NHSE.

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