



June 2018

# ***Making money work in the health and care system***



[www.pwc.co.uk/healthcare](http://www.pwc.co.uk/healthcare)





---

## Contents

1. Foreword	<b>1</b>
2. In short	<b>2</b>
3. Aligning policy objectives with the emerging place-based architecture	<b>10</b>
4. Rethinking financial flows	<b>13</b>
5. Aligning financial flows with the emerging place-based architecture	<b>20</b>
6. Giving local systems greater certainty through long term funding	<b>27</b>
7. Refocusing money to improve outcomes by incentivising services and individuals	<b>35</b>
8. Moving forward	<b>44</b>
Recap: Recommendations	<b>46</b>

---

## Our work

*Since publishing PwC's report **Redrawing the Health and Social Care Architecture**, which explored the role of national structures required to deliver localised and integrated care, we have turned our attention to how financial flows could be redesigned to find a better way to make money work in the health and care system.*

We have worked closely with the Healthcare Financial Management Association (HFMA), surveying its network to explore what those working in both policy and practice across the health sector think about the current mechanisms.

We have used our findings, and our own experience, to propose a number of recommendations which we believe would facilitate the move towards place based care and support the ambitions of the *Five Year Forward View*.

These recommendations are particularly timely as indications are that an announcement of a well needed, long term funding settlement for the NHS is imminent. The need for additional funds is widely recognised. The recommendations in our report would enable this funding to be put to best use for patients.

---

## Our approach

Our research took place over nine months. We have drawn on the views and expertise of a range of experts, from academics, to finance directors, to Non Executive Directors (NEDs), and taken into account previous research. In coming to the conclusions set out in the report, we:

- Conducted a desktop review of current research, academic thinking and evidence from the UK and internationally;
- Held one to one interviews with key stakeholders, decision makers and influencers who currently work in the NHS;
- Conducted a survey of HFMA members, with 203 respondents working in finance roles within the NHS; and
- Conducted round tables with a diverse range of individuals including NEDs and finance leaders from the NHS and local government.

Our Steering Group oversaw our research and were key to providing critical challenge to the thought process. Membership of the Steering Group comprises:

- Rt Hon Alan Milburn (Chair)
- Emma Knowles (Head of Policy and Research, HFMA)
- Ian Moston (Director of Finance and Information, Salford Royal NHS Foundation Trust, Chair of HFMA's Policy & Research Committee)
- Lee Outhwaite (Director of Finance and Contracting, Chesterfield Royal Hospital NHS Foundation Trust, Director of Finance, Joined Up Care Derbyshire, Derbyshire STP and HFMA Trustee)
- Richard Douglas (former Director-General of Finance, Department of Health and Social Care (DHSC) and NED, NHS Improvement (NHSI))
- Anita Charlesworth (Director of Research and Economics, the Health Foundation)
- Mike Farrar (Chair, Public Sector Health Board, PwC)

---

*We would particularly like to thank all the members of the Steering Group for their time, energy and advice throughout this process.*

*We would remind readers that the conclusions reached and views expressed, and of course any errors in the report, are those of the authors alone.*

---

# 1. Foreword

*As the NHS approaches its 70th birthday, it has much to be proud of. It is the world's fifth biggest employer, bringing together talent from across the globe to deliver cutting edge healthcare. Every 36 hours the service deals with one million patients and we can rightly be proud of the healthcare we and our families receive.*

The NHS is changing and needs change to survive for the future needs of our population. Increasing demand, alongside budgetary restraint, mean we need to find new answers to the challenges the NHS is facing. Part of this solution is, rightly, a move towards place based care and a focus on outcomes. As a result, new systems and structures are developing at pace at the local level. With the Government considering a more long term injection of resources into the NHS and, with a current net budget of over £120 billion, establishing a new set of financial flows is more important than ever. There needs to be a system in place that ensures that money is deployed efficiently and supports the purpose for which it is intended.

Following on from our report which examined the architecture of the NHS in England,<sup>1</sup> we have teamed up with the Healthcare Financial Management Association (HFMA) to analyse, research and develop ideas for how to make this happen. We have had extensive dialogue with key national and local stakeholders and conducted polling with NHS finance practitioners to ensure our ideas are relevant and practicable. We have considered very carefully, with the sector, the issue of how to make money work in the wider health and social care system so that benefits to patients are maximised and resources are put to their most effective use.

Together we have concluded that the current financial system needs to be overhauled if it is to support and enhance the journey that the NHS is on. Funding is currently too short term. It does not support the integration of health and care locally, nor does it drive a sharp focus on outcomes. There are limited incentives for providers to change their behaviour. There is an overwhelming consensus that the financial flows need to be redesigned if the aim of integrated care is to be achieved – and there is a strong appetite to make it happen.

Taking that challenge head on, we have developed a series of significant recommendations for a changed system. We believe these bold proposals will help to deliver a system that is much better suited to the new way health economies are being organised. We hope this work can start a national conversation about the best way forward.

I'd like to thank my PwC research team and the HFMA, plus all of those who took part in the study, whether through being a member of our Steering Group, attending our roundtables, taking part in an interview or in our survey with the HFMA.



---

**David Morris**  
Partner, Healthcare

---

<sup>1</sup> PwC, 'Redrawing the health and social care architecture: Exploring the role of national bodies in enabling and supporting the delivery of local health and care services', (2016)





## 2. In short

### Context

*The health and social care system is complex and changing. The current position of health and social care in England – rising demand in the face of increasing fiscal constraint – is well documented. NHS England's (NHSE's) response to this, the Five Year Forward View,<sup>2</sup> has provided local systems with a national vision for the business models intended to achieve the broadly defined strategic aims – increased prevention, more integration, a drive towards place based care, improved outcomes and reduced costs.*

The *Five Year Forward View* is a welcome policy framework but what it provided in terms of aspiration, clarity of business models and the final destination, it lacked in terms of a structured path to achieve its aims. In the years that have passed since its publication in 2014, it is clear that more needs to be done if the NHS is to evolve to meet the needs of populations in the future.

But change is happening; since PwC's *Redrawing the Health and Social Care Architecture* report was published, the direction of travel towards more place based care systems has continued. At a local level, the 44 Sustainability and Transformation Plans (STPs) have all published plans that include some elements of integrated care and have transitioned into increasingly influential implementation bodies which have the early hallmarks of the Regional Care Groups (RCGs) outlined in *Redrawing the Health and Social Care Architecture*.

The devolution of health and social care budgets and accountabilities is in progress (e.g. Greater Manchester, Surrey Heartlands), as is the introduction of Integrated Care Systems (e.g. Frimley Health and Care, Buckinghamshire). All of these system structures aim to promote the increasing integration of services, a drive to deliver care outside of the hospital setting and shared accountability for patient care and outcomes. The CQC has begun a series of system reviews, going beyond the quality of service within individual organisations looking at how organisations work in combination to deliver end-to-end patient services.

These changes are a definite step in the right direction for patients, those accessing social care services and those providing care.

More recently there have been increasing numbers of joint posts created between NHSE and NHSI. As well as the creation of joint regional directors for the South East and South West, NHSI and E have announced a single chief finance officer, nursing officer and medical director at a national level, as well as seven joint national director roles. Plans have been announced to create seven joint regional teams, although at the time of writing much of the detail around this had yet to be communicated. Again, this closer integration is necessary and should, in our view, continue.

It's clear that the appetite for change is growing, and at a pace which means this report will likely be quickly out of date. In March, calls were made for a cross-party commission on health and social care in order to "call on the Government to act with urgency and to take a whole system approach to the funding of the NHS, social care and public health."<sup>3</sup>

The Secretary of State, Jeremy Hunt, while acknowledging it is not currently government policy, has alluded towards a ten year financial settlement, with a view to breaking the cycle of short term efficiency savings conflicting with long term sustainability plans. Perhaps most importantly for frontline staff, after seven years of wage rise caps significantly below inflation, a new package looks to be on the cusp of agreement for those on Agenda for Change (AfC).

Our research explores our view of the changes we believe are necessary, explores the case for change and proposes a number of radical reforms we believe are necessary to enable the NHS staff to deliver the outstanding care to which they aspire.

---

*The Five Year Forward View is a welcome policy framework but what it provided in terms of aspiration, clarity of business models and the final destination, it lacked in terms of a structured path to achieve its aims. In the years that have passed since its publication in 2014, it is clear that more needs to be done if the NHS is to evolve to meet the needs of populations in the future.*

---

<sup>2</sup> At the time of writing, two judicial reviews of NHS England's Accountable Care Model contract are about to commence. The result of these reviews could serve either to accelerate the progress towards greater system integration, or to restrict the NHS's manoeuvrability to innovate in its payment methods.

<sup>3</sup> Stewart, H 'May must consider tax rises to fund NHS and social care, say MPs', *The Guardian* (2018)

### **Our assumptions**

In order to shape our thinking about how future financial flows might be designed, we have had to make certain assumptions about the future of our health and social care system. These are as follows:

1. The NHS will remain national. There must be a level of consistency in drivers and mechanisms across the country to:
  - limit variation in quality;
  - allow some level of national control over incentives and drivers; and
  - maximise opportunities to extract benefits of scale.
2. There will, however, be a continued shift towards place based care, and localities will become increasingly autonomous in, and accountable for, decision making.
3. Taxation will remain the primary source of funding for healthcare, with greater degree of mixed funding for social care likely in future.
4. National finances will remain challenged.
5. Demand will continue to rise, as the population demographic becomes older and prevalence of chronic conditions increases.
6. Health and social care policy and finances will continue to come closer together.

### **The case for change**

Current funding flows do not support the move towards place based care and worse still are acting as a significant blocker to system change. This is not at all surprising given their design some 15 years ago was linked to policy objectives aimed at: bringing down waiting lists by incentivising greater throughput from providers; bringing new capacity into the market from private providers and encouraging competition.

The funding mechanisms enabling these policy objectives have yet to be restructured to match the more recent emerging preference for place based integrated care and cooperation among organisations within systems. In many parts of the country, commissioners are attempting to move away from national payment mechanisms towards various forms of ‘aligned incentive’ or block contracting in an attempt to share risks and foreshadow place based work. But this brings its own risks, not all of which are yet understood, and makes the current position even more confusing and potentially misaligned. Without realigning the way money flows through the system, there is a high risk that the new objectives will not be successfully implemented and the system transformation will be unable to achieve its goals.

It is a welcome development that new models of care focused on delivering more outcome and value based care are now starting to emerge. Other countries – often with very different health systems – are following a similar pattern. So, strategically, England’s system seems to be moving in the right direction. But the way the NHS financial system currently works is simply not aligned with place – and outcome based care. Today the care system and the way that money moves around it is in a messy no-man’s land with a chaotic and bewildering array of financial mechanisms in place.

---

*Today, the care system and the way that money moves around it is in a messy no-man’s land with a chaotic and bewildering array of financial mechanisms in place.*



Specific examples in which this confusion is evident include:

- Commissioners individually contract with providers, each of which are separately regulated with their own financial performance targets to be met;
- The NHS tariff incentivises increased elective activity in an acute setting, while block contracts – typically held by community providers – incentivise costs outside of a hospital setting to remain as low as possible;
- Clinical Commissioning Groups (CCGs) currently bear most of the risks of meeting increasing demand (with the exception of emergency care) without possessing the full levers to control it;
- Acute providers bear the financial risk of increasing costs of delivery without the opportunity to incentivise delivery of care in more cost effective settings or the power to refuse to deliver increasing activity;
- A number of ‘add on’ financial mechanisms to incentivise the achievement of emerging priorities, such as the Provider Sustainability Fund (PSF), the Commissioner Sustainability Fund (CSF), Commissioning for Quality and Innovation (CQUIN), Marginal Rate Emergency Tariff (MRET) and cap and collar mechanisms, have been introduced in recent years. These have added complexity on top of the financial structures and mechanisms of the NHS which haven’t changed in over a decade; and
- The Better Care Fund has been introduced (and improved through the iBCF) in order to try and facilitate closer working of health and care services but has not actually integrated their governance and delivery.

Money talks. The way it is deployed and the objectives it is designed to realise have a huge influence on what individuals and institutions within the care system do. The implementation of integrated place based care is being constrained by an NHS financial system which, at best, no longer facilitates the implementation of current policy initiatives and, at worst, places barriers in its way. These incentives have yet to be reconstructed to match the emerging preference for place based accountable care and cooperation – rather than competition – among organisations within local care systems.

It now seems that the Government is considering the injection of more long term resources into the NHS and the wider care system. Such investment is welcome, but without changes to the way the financial system works the Government will not get the biggest bang for its buck. To maximise the value of extra resources there need to be major reforms.



**76%** of  
*respondents do not feel that  
the current financial systems  
are fit for purpose.*

### ***What we heard through our review***

Over the course of six months we have worked extensively with the sector in collaboration with the HFMA to hear the views of those working on the frontline of healthcare today.

The need for change in the arrangement of financial flows in the health and care sector was clear in our survey of 200 people working in NHS finance. This survey suggested that:

We supplemented our survey through discussions with over 100 key decision makers in the health and care system, through a series of in-depth interviews and roundtable events including finance leaders across the health and local government sectors. These conversations echoed the results of our survey and provided valuable additional insight.

---

**76%**

*believe the current approach to funding NHS organisations is not fit for purpose*

---

**78%**

*believe there should be a single budget for each local health, social care and public health economy*

---

**70%**

*and over believe that an integrated system will produce better value for money for patients*

---

**83%**

*believe that there is a conflict between long term financial sustainability and short term efficiency savings*

---

**56%**

*believe that local leaders should be held democratically accountable for the financial performance of health and social care systems*



Through our survey, interviews and roundtable discussions, we have identified three objectives for policy that, if pursued, would aid the development of new funding flows and associated mechanisms. These are as follows:

### **1. Financial flows should be aligned with the emerging place based architecture**

The current financial mechanisms for incentivising behaviour, activity and outcomes have not kept pace with the changes in the national system architecture and the move to place based care. There needs to be a balance between national levers and local accountability and responsibility, and an urgent shift towards system wide capitated budgets, combined with appropriate governance, to help break barriers to integrated working.

### **2. Systems should be provided with more clarity through longer term funding**

There is too little clarity over long term funding, causing confusion and preventing the sustainable planning required to responsibly invest in transformation of services. In addition, the financial mechanisms in the acute sector have become excessively complex, with a combination of debt to the DHSC, Provider Sustainability Fund (PSF), Commissioner Sustainability Fund (CTF) and confusion over the approach to capital funding generating opacity. There is also a growing gulf between financially strong and weak trusts.

### **3. Money should be focused towards achieving better outcomes**

In order to drive value, money should be focused on achieving better outcomes. There should be a combination of contracting for outcomes and better joint accountability across the system, and consideration given to incentivising the behaviours of individuals, including clinicians and citizens.

Potential funding mechanisms which could be considered by systems include a single, incentivised shared outcomes framework across all providers and the introduction of gain/risk share arrangements.

Moving towards a meaningful gain/risk share arrangements is not an easy task, and unless done thoughtfully has the potential to reduce integration (e.g. in a scenario where poorly designed agreements led to combative relationships between organisations). Agreed and robust activity baselines would need to be in place in order to understand where activity was due to scenarios within the control of the system (e.g. increased A&E activity due to underutilisation of primary care) and where it was outside of the system's control (e.g. increased activity due to an epidemic).

For this to be the case, current performance metrics, which are focused around access targets, will need to be supplemented with appropriate outcome measures. In the course of the discussions undertaken during our research there was a general agreement that these should cover length and quality of life for the population, and that the list of key measures shouldn't be too long. But work is needed to define a list of measures that better covers long term health and wellbeing, while still being timely and measurable enough to hold system leaders accountable for the impacts of their actions.

The solution to this is likely to be an adaptation and combination of the NHS Outcomes Framework, Public Health Outcomes Framework and Adult Social Care Outcomes Framework.



## Our recommendations

Working with these policy principles, we have made a number of recommendations we believe are required to drive the necessary change. These build on PwC's previous thinking in *Redrawing the Health and Social Care Architecture*. Similar to that report, we have split these by short and longer term recommendations. The split between long and short term reflects the challenges of implementing change at pace in the context of the existing legislative architecture, a finely balanced parliament and competing political priorities.

### Short term simplification

**1. The capital funding system needs to be redesigned** to enable a longer term investment in out of hospital infrastructure and reduction in maintenance backlog. We make two main suggestions for achieving this:

- prohibition of capital to revenue transfers; and
- a National Restructuring Fund should be created, with clear access rules and prioritisation criteria, aimed towards development of the out of hospital assets and infrastructure (including technology adoption) needed to deal with the challenges of future care needs. This fund could also be used to deliver the resources needed to deal with structural issues causing significant deficits in some providers.

**2. Internal debt should be restructured.** A significant – and growing – proportion of internal lending has built up through funding historical deficits. This places additional pressure on the financial performance of NHS trusts that are already in difficulty and have little to no prospect of repaying the debt. This debt should be converted to equity Public Dividend Capital (PDC) and the future approach to providing working capital funding for providers in deficit approached in a similar way.

**3. Current thinking to replace organisation based control totals with system wide targets must be developed further.** The alignment of NHSE and NHSI should facilitate this, with commissioners able to speak with one voice in holding systems to account rather than just the individual organisations within them.

**4. The National Expansion Plan for personal health budgets must be accelerated** if the target of 100,000 patients holding their own budget is to be reached by 2020 (7,646 had personal budgets in 2015/16, an increase of 74% on the previous year). This will require investment in out of hospital infrastructure and skills to ensure care is effectively coordinated and people are appropriately supported to make effective, safe and informed decisions. A further stretch target should be set to see 1m of the 15m people living with long term conditions holding personalised budgets by 2025.

**2. Local health, social care and public health budgets should be brought together** using either new powers or the existing statutory mechanism in s75 of the National Health Services Act 2006, a small number of which are already in place, and through increasing the numbers of joint appointments between the NHS and local government, as has been seen in Greater Manchester.

**3. If and when a long term financial settlement is reached for the NHS, this should be replicated within the system** to give local health economies the ability to plan and invest for the long term (c.5 years).

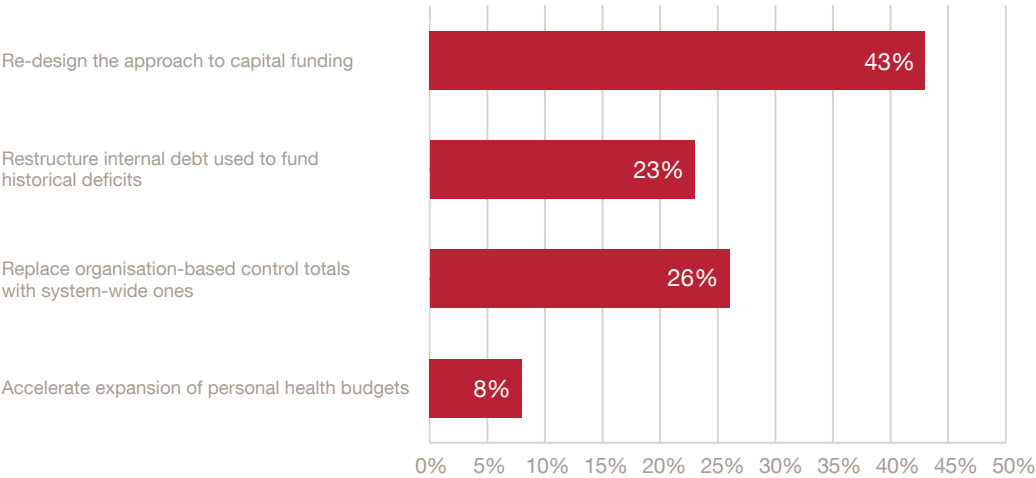
**4. A detailed assessment should be undertaken of how financial incentives for frontline and management staff can be used to improve cross-organisation working** along patient pathways. In particular this needs to reflect the sharing of risks and benefits between sectors and organisations to encourage and enable integrated service delivery. Finding ways of engaging and incentivising primary care to enter in to arrangements with Integrated Care Systems (ICSs) is key.

### Longer term restructuring

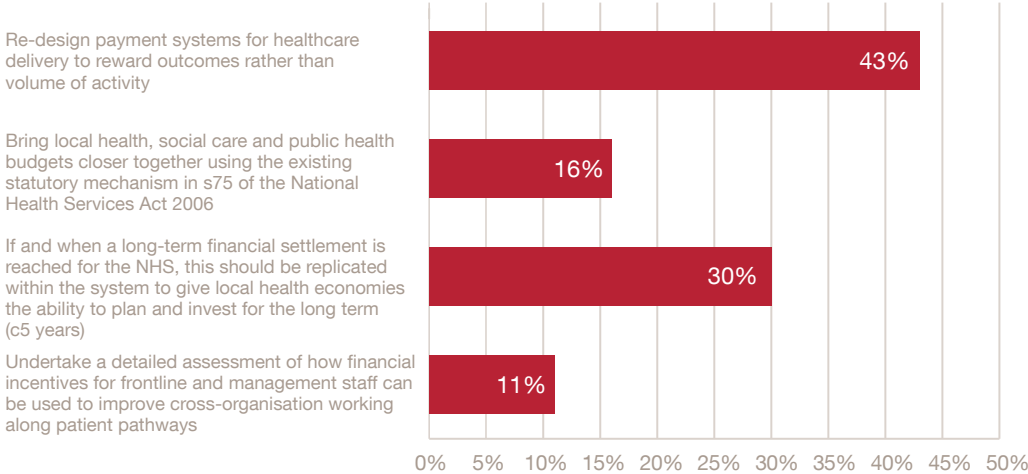
**1. Payment systems for healthcare delivery should be re-designed to reward outcomes rather than volume of activity.** Local systems should be given the power to determine their own internal contractual mechanisms, with guidance from the centre on the pros, cons, risks and mitigations associated with different contractual arrangements in different scenarios.

At a presentation of our report findings on 16 May, we asked members of the HFMA Provider Finance Faculty to prioritise our recommendations:

**Prioritisation of our short term recommendations at the HFMA Provider Finance Faculty**



**Prioritisation of our long term recommendations at the HFMA Provider Finance Faculty**



**Conclusions**

In the course of our work, we have been struck by the overwhelming consensus that the structure of financial flows in the NHS needs to change. Along with re-setting the architecture of national bodies, financial flows need to be re-designed if the move towards place based, integrated care is to achieve its full potential.

This is not a panacea. Coordinated work is needed in several strategic areas if we are to achieve the value we want from our health and care service, including:

- Redefining the measures we use to assess performance of the system – moving away from access times and taking a broader view of the long term health of the population;

- Building a plan for workforce, aligned with other arms of government including the Department for Education and Health Education England, to ensure that the future workforce has the scale and skills necessary to deliver the services needed in the future; and
- Ensuring the system remains open and agile to technological disruption that has the potential to change how we monitor and deliver care in the future (e.g. artificial intelligence, robotics, blockchain, predictive analytics, genomics and other advances not yet on the horizon).

We hope this report makes some contribution to what we believe is a key part of this debate.



---

### 3. Aligning policy objectives with the emerging place based architecture

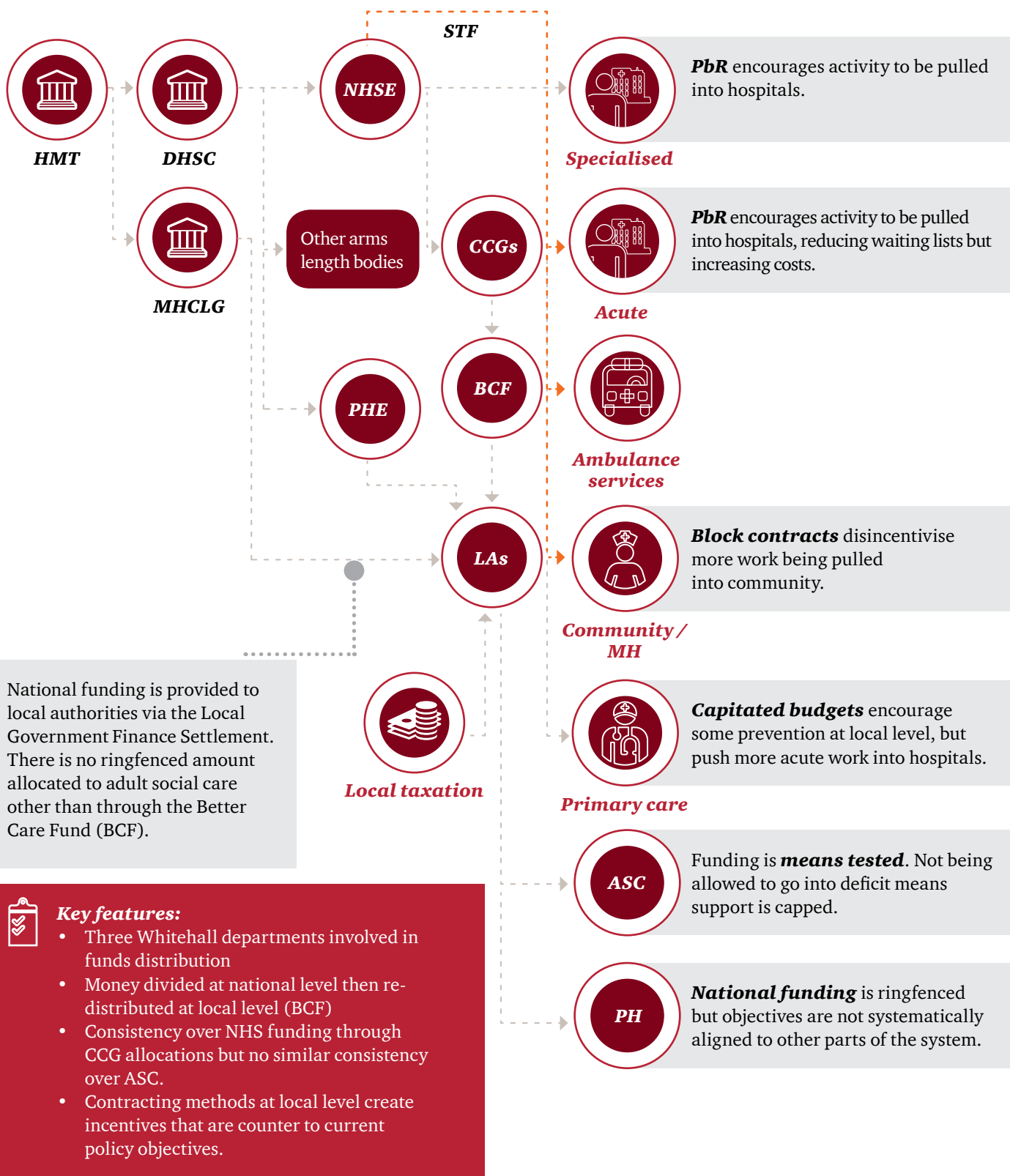
*The Five Year Forward View sets out the policy imperatives for the NHS in the context of serious fiscal constraint and increasing demand. In design is a place based system with aspirations to be coordinated, proactive and efficient, focusing on achieving population outcomes within a restrained budget.*

There is, however, a tension between these longer term aims and the current institutional focus on short term performance and access targets (such as A&E), reduction in cancer waiting times and the battle to tackle in year financial performance. In addition, split regulation of providers and commissioners, separation of financial targets by institution, organisational accountability for statutory obligations,

and access to 'transformation' funding based on achievement of short term operational and financial targets all contribute to a system which will struggle to transform in a meaningful sense. Figure 1 illustrates some of the complexity in how money reaches frontline services.



Figure 1: Current money flow to the 'frontline'



HMT = Her Majesty's Treasury, DHSC = Department for Health and Social Care, MHCLG = Ministry of Housing, Communities and Local Government, NHSE = NHS England, PHE = Public Health England, PH = Public Health services, LAs = local authorities, ASC = Adult Social Care, MH = Mental Health, CCGs = Clinical Commissioning Groups, BCF = Better Care Fund, STF = Sustainability and Transformation Fund, PbR = Payment by Results

So, systems appear to be in something of a bind, oscillating between short term pressures and a desire to achieve longer term sustainability, with complexity a pervading trait. The findings of our work are clear: structures should match place based system objectives rather than those of individual providers or purchasers.

To reach this point, there are some areas that we believe need more focus in current thinking:

1. The alignment of financial flows with the emerging place based architecture.
2. Giving local systems better line of sight over long term funding.
3. Refocus money on achieving better health outcomes (not just activity) by incentivising both services and individuals.

An additional layer of conflict is added between the desire for central regulatory control and the local focus of the *Five Year Forward View*. As new models of care emerge, balance of power will move from national bodies towards local areas as they assume greater accountability for the financing and control of services. In *Redrawing the Health and Social Care Architecture* we identified the need to clarify and co-ordinate the role of Whitehall departments, and to shift accountability to a local level. For financial flows to support delegated control, budgeting must be driven by an understanding of local challenges. For instance, in a local economy where age and comorbidities are a bigger driver of spend than deprivation, local commissioners must be able to flex priorities to meet that need. To enable this there would need to be a restructuring of how, in the diagram on page 11, funding flows from the centre to localities. In particular it would make sense to remove Ministry of Housing, Communities and Local Government (MHCLG) from the allocation process for social care and allow DHSC and NHSE to influence allocation of budget to align with pressure points in the health and care system.



---

## 4. Rethinking financial flows

### *How are current financial mechanisms and structures influencing behaviour?*

*Before considering what future financial flows should look like, it is worth reflecting whether, and how, current financial structures influence behaviour within the system. This appraisal is helpful in informing thinking on what currently does and does not work, and gives some indication of potential pitfalls to consider when designing future models.*

We have analysed several of the financial mechanisms currently at play in the system overleaf. This list is long but not exhaustive. The appraisal tells us these mechanisms do have the potential to influence behaviours, but that this potential is limited when there are multiple, competing incentives at play. People are also motivated by the rhetoric of system leaders, the performance measures used in the

system and the media (A&E four hour wait being a notable example), and perhaps most significantly, a desire to 'do the right thing' for people in the care system. Where these competing influencers aren't aligned, behaviours will inevitably misalign, and the performance of the system will suffer.

---

*"The NHS is currently in flux. We are trying to move away from a purchaser / provider split in some areas without this being legally possible. This leads to complicated systems which are confusing for the general public and the people that work in the NHS. Either get rid of the split or keep it, but don't try to do both."*

**HFMA/PwC survey respondent**



## Payment by results (PbR)



PbR is the primary form of payment for acute trusts in the NHS, bringing in approximately 60% of trust income.<sup>4</sup> The payment is retrospective payment for activity, with trusts being paid a nationally defined price for the care that they provide.

The shift towards PbR was originally intended to incentivise elective activity in the acute setting at a time of long waiting lists; and broadly speaking it delivered on this. Median waiting times for hospital treatment fell from 13.2 weeks in March 1997 to 4.0 weeks in March 2009.<sup>5</sup>

*“Tariff works as designed to promote the flow of funding to the ‘frontline’ of acute and general hospital services at a time of increased availability of funds and a need to increase activity (i.e. 14 years ago).*

*This is not the current state of the health system, but whilst the provisions of and demands on the service have moved on, funding systems have not.”*

HFMA survey respondent

It is also designed to encourage efficiency. A national efficiency factor is incorporated into tariff which means that, over time, providers must continue to make efficiency savings as tariff rises more slowly than costs. This appears to have worked for a sustained period of time, with NHS trusts delivering aggregate surpluses (i.e. absorbing the efficiency factor baked in to tariff) until 2012/13.<sup>6</sup> There is little evidence that quality was impacted, and there is incentive for providers to compete on quality where they are unable to compete on price.

PbR has much to be said in its favour, but a major drawback in the move to place based care is that PbR does not incentivise care to be delivered outside of an acute hospital setting. The driving argument against it is that PbR encourages hospital admissions, where more effective and cheaper care might be provided in the community.

It could be argued that PbR actively works against integration and prevention by providing a financial incentive for trusts to seek out additional activity, rather than being the provider of last resort, partly due to the large fixed overheads incurred by acute trusts. Without sufficient activity to cover these costs, acute trusts will incur financial deficits unacceptable to their regulators (an effort has been made to control against this incentive to admit for non-elective activity in the form of the Marginal Rate Emergency Threshold (MRET), discussed in this chapter). The perverse nature of this incentive is increased as community based care providers are often paid on block contracts, and so are not incentivised to increase activity.

Additionally, a major argument against tariff is that it does not accurately reflect the costs of an organisation – both impacting the degree to which tariff can drive efficiencies and pushing trusts into deficit. Unit prices are based on average costs, with any providers who were delivering care at a higher than average cost incentivised to bring that spend down. But analysis of acute provider financial performance compared with reference cost indices (weighting of relative unit costs, where 100 is considered the average cost), suggests little correlation between cost efficiency and overall financial performance (see Figure 2). There are likely many reasons for this. Our diagnosis is that it is a symptom of the number of other payment mechanisms layered on top of the tariff system (some of which are discussed in this chapter), which are individually tailored to incentivise specific behaviours and outcomes, but collectively serve to create a highly complex payments system that disconnects financial reward from operating performance.

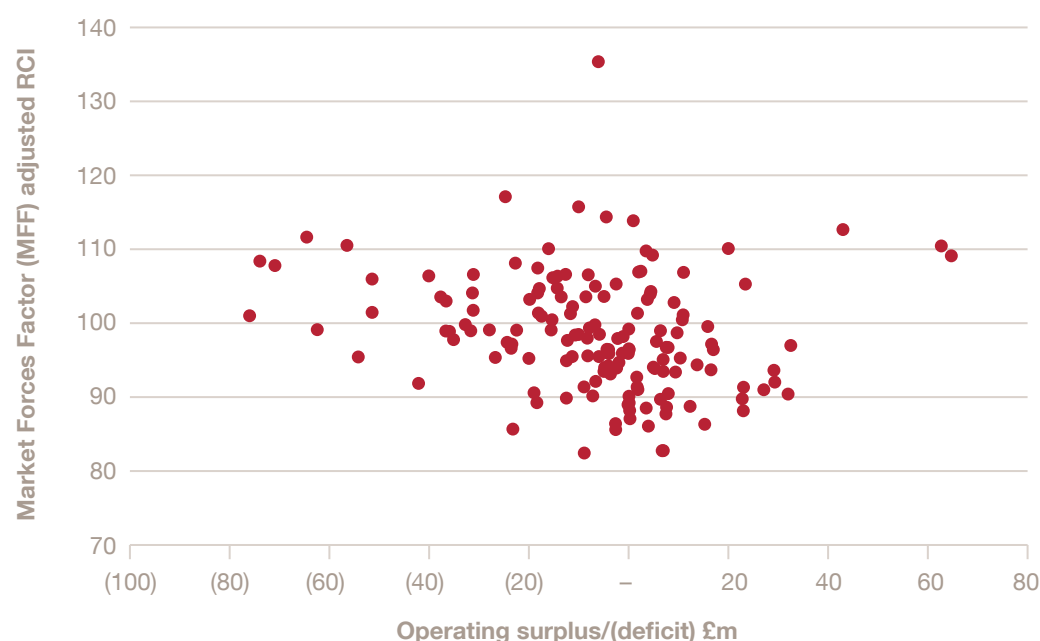
4 Gershlick, Ben, ‘Best Practice Tariffs’, OECD, (2016), p.3

5 Ham, Chris, ‘How much have waiting times reduced?’ (2010)

6 Morse, Amyas, ‘2012-13 update on indicators of financial sustainability in the NHS’, (2013)



**Figure 2: RCI as an indicator of financial performance in acute trusts**



Source: Analysis of 2016/17 Reference Cost Indices and Consolidation (FTC) files 2016/17 and NHS trusts accounts: 2016 to 2017

## Block payments



In a block contract, a provider receives a fixed payment for delivering specified services to a population, usually based on an anticipated volume of demand for that service. Community and mental health services are predominantly paid on block contracts.

For the commissioner, expenditure is predictable, and for the provider it is clear how much income will be coming in. There are fewer administrative costs associated with block contracts; although the counter to this is that there is reduced incentive to accurately capture data on patient activity, making it harder to track outcomes. In addition, block contract holders are generally not reimbursed if activity exceeds anticipated levels, further promoting reductions in activity delivered by providers. However, a fixed degree of income regardless of activity provides an incentive for block contract holders to minimise activity delivered, in order to minimise the incremental cost each patient would incur.

When combined with PbR, there is a lowered incentive to bring care into the community, as acute providers are not incentivised to reduce activity, while community providers are not incentivised to increase activity. The current incentives are a block against the reforms we want to achieve.

***“Defaulting to a block payment system does not help efficiency or a proper analysis of demand for services”***  
HFMA/PwC survey respondent

## GMS/PMS



GPs are currently paid on a (mostly) capitated basis, with risk adjusted payments made for each individual on a GP's list. This has some advantages – GPs are incentivised to act proactively on issues which might result in multiple visits to primary care if left untreated. However, as the capitated budget does not cover the individual's whole care, there is no financial incentive to minimise referrals and deal with issues within the GP setting.

GP capitated budgets are currently topped up by Quality Outcomes Framework (QOF) payments, incentivising a range of activity measures such as vaccinations, screening, and management of long term conditions. The evidence on QOF is mixed (there is, for example, some evidence that it has helped to reduce inequalities,<sup>7</sup> but not mortality rates in long term conditions<sup>8</sup>) and certain indicators are more meaningful than others due to the quality of available data.

## Other payment mechanisms



**Best Practice Tariffs and CQUIN** – providers can attract higher payments for demonstrating improved quality standards and practices. These have generally been successful in influencing changes in behaviour and practices within healthcare settings.

**Control Totals/PTF/CTF** – in 2016/17 national funding was set aside to reward providers for adherence to control totals and achievement of operational targets; those who reject or do not meet the control totals do not receive the money. It is hard to say whether this has influenced behaviours within the system. It is possible that those that have received funding would have achieved the same targets regardless. It is also possible that the quarterly review points at which receipt of funding is determined incentivise excessive caution in setting the phasing for annual plans, and more aggressive short term accounting for potential financial pressures. There are also a number of unintended consequences materialising with control totals, particularly in further entrenching challenges in trusts facing financial difficulty, while issuing payments to those with surpluses. A number of trusts have rejected their control totals this year due to the requirement to meet very aggressive Cost Improvement Programmes (in some cases 10-15% of annual spend) and so those arguably most in need of additional funding will miss out on PTF.

An extreme example of this is a trust that received a £27m STF boost triggered, in part, by insurance claims following a fire.<sup>9</sup>

**Marginal Rate Emergency Threshold (MRET)** – since 2010/11 a reduced tariff has been applied to emergency admissions above the baseline level set in 2008/09.<sup>10</sup> The intention behind this was to reduce the financial incentive for acute providers to admit emergency attendances. It could be argued that this has had some success, as admissions through A&E stabilised in the following years, (see figure 3). But its other consequence is to make hospital spells cheaper for commissioners, thereby reducing the financial incentive to create services outside of hospital that could be used to provide urgent care or reduce attendances.

There is a very long list of individual financial mechanisms at play within the healthcare system, including the Clinical Negligence Scheme for Trusts (CNST), Clinical Excellence Awards, Waiting List Initiative payments, Capped Expenditure Plans, Agency Controls and many others. Each of these adds a layer of complexity which, when combined with a budget constrained commissioning model, results in confusion and uncertainty about what behaviours will and won't be rewarded.

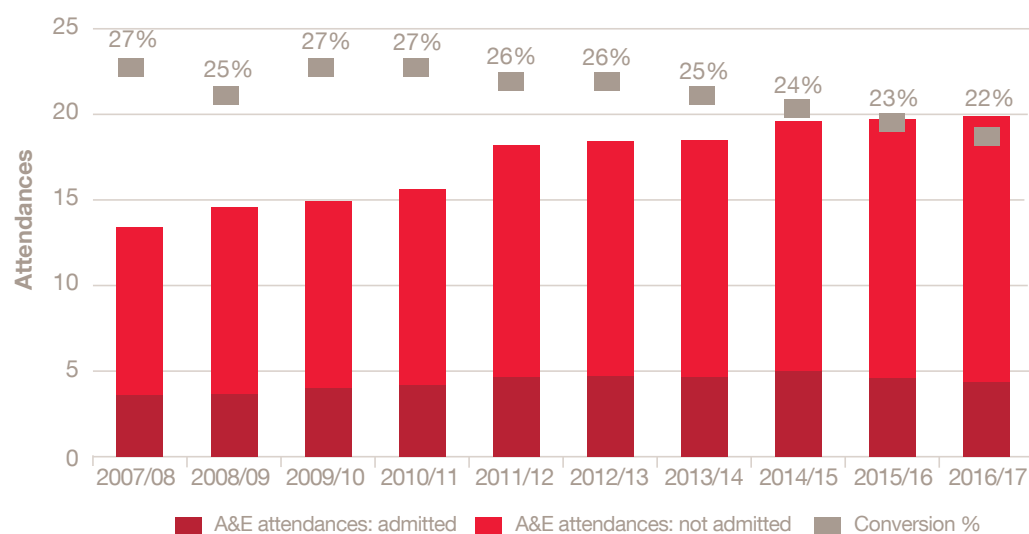
7 Doran, Tim, Fullwood Catherine, Kontopantelis Evangelos, and Reeves David, 'Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework', (2008)

8 Forbes, Lindsay JL, Marchand, Catherine, Doran, Tim, and Peckham, Stephen, 'The role of the Quality and Outcomes Framework in the care of long-term conditions: a systematic review', (2017)

9 Dunhill, Lawrence, 'Specialist trust set for £27m STF bonus in wake of insurance claim', (2018)

10 Rules have been adjusted since 2009 – the baseline year can now be adjusted, and this is happening more frequently. The marginal rate has also subsequently been changed from 30% to 70%.

**Figure 3: Admissions through A&E have stabilised while attendances have continued to rise**



Source: Analysis of Reference Cost Data 2007/08 – 2016/17

### **Principles for designing financial flows**

If the evidence suggests that financial systems do have an influence on how the system works, but that these need to be aligned with other influencing factors, how should we go about designing new ones?

In order to carry out this exercise, we adopted some outline principles. The intention here is to set some ground rules that can be used as a basis for the complex task at hand. We have arrived at these principles based on our various discussions with experts across the NHS, and particularly those ‘at the coal face’ in finance roles. We have also tested them with our project Steering Group. They are intended to be uncontroversial, logical principles that can be used to assess how well financial flows are constructed. These are the principles we have adopted:

**1. Form should follow function.** Financial flows should be designed in a way that supports desired outcomes, rather than being a barrier that must be worked around.

**2. Money should be aligned to population needs.** Money should be directed towards the point where it has the biggest impact on the health outcomes for the population it is intended to serve. Doing so ensures that taxpayers get the best value from the money invested, and that service users get access to effective services.

**3. Operating costs and capital both need to be managed.** A balance needs to be achieved between funding ongoing operations and investment in assets and infrastructure.

**4. The people who control spend should be those who are held accountable for how it is spent.** It is wrong to hold someone responsible for something over which they have no control.

**5. Subject to the principles above, simplicity is preferable to complexity.** Transparency is a precondition for incentives to work, and people need to understand financial flows if they are to be influenced by them. Clarity and simplicity also act as a guard against inefficiency; navigating a complex system of payments, penalties and bonuses among a convoluted structure of organisations will inevitably create an unproductive drain on management time.

# What do finance leaders think?

*To get a sense of how the current system is viewed and appetite for change, we conducted a survey of over 200 individuals working in finance roles in the NHS.*



**76%** felt that current funding structures in the NHS were not fit for purpose while only **10%** felt they were (*the remaining were unsure*).



**27%** thought linking how NHS employees are financially incentivised to desired system outcomes would be an effective way of driving better value.



**78%** of people felt that there should be a single budget for each local health, social care and public health economy.



**81%** The majority of respondents thought they would be working in some kind of integrated care system or organisation within 5 years.

*“We can clearly articulate the policy goals of the ‘PbR-era’. I’m not sure we can be as clear about the policy goals of today and, therefore, judge where and in what circumstances particular payment mechanisms are or aren’t working.”*

*There was a strong sense from our survey that change was necessary – but that this needs to be done with care.*



**77%** felt outcomes would be improved through greater certainty of funding levels over a longer timeframe.



**83%** feel there is conflict between long term financial sustainability and short term efficiency savings.



**91%** said unpredictable annual cycles of funding need to be reformed if systems are to be able to engage in sustainable financial planning.

*“We should be very wary of thinking that handing the budget to a provider or group of providers without ensuring there is capability to handle it within the local system is the answer.”*





---

## 5. Aligning financial flows with the emerging place based architecture

*The system architecture that has developed over the last twenty years has promoted specific behaviours. Organisations within the same health economy have been encouraged to work in competition with one another, while payment mechanisms have been developed with the explicit intention of driving activity in the acute sector.*

For a long time, this seemed like the right thing to do in order to drive down waiting times for treatment. Caution must be used not to return to a system which neglects its obligation to perform elective care.

However, national priorities have changed and the current mechanisms for incentivising behaviour, activities and outcomes have not kept pace with the changes in the national architecture, and the behaviours that are needed for the move to place based care. Emerging from our review is a consensus that there needs to be a balance between national levers and local accountability and responsibility, and an urgent shift towards system wide budgets, combined with appropriate governance, to break barriers to integrated working.

The crucial first step is to clearly define the policy objectives of the system. We have the blueprint in the form of the *Five Year Forward View* and we have made the assumption that, through implementing that blueprint through place based care, policy makers are focused on three things: reducing the incidence of unplanned episodes of ill health (A&E performance being a symptom of challenges elsewhere); improving lifestyle-influenced ill health and financial balance.



In order to achieve these objectives – or something like them – and so to achieve the benefits of moving towards place based care, we have heard through this review that it is necessary to make three explicit changes:

1. **Move systems (STP footprints) towards a single budget for the whole population.**
2. **Bring together local NHS, adult social care and public health budgets.**
3. **Pay for outcomes rather than activity.**

We take each of these three recommendations in turn below.

### **5.1 Systems (STP footprints) should move towards a single budget for the whole population**

In line with the steps currently being taken by NHSI and NHSE, we would advocate regulation for financial performance sitting at the local health economy system (STP) level, rather than separate regulation for different bodies within the system. This would ultimately include the introduction of a combined system wide budget in each locality – for which there is clear local accountability – for health, social care and public health, as opposed to nationally mandated individual commissioner and provider control totals.\*

Supporting this, financial incentives should be aligned across organisations in order to encourage cooperation and reduce the risks associated with implementing a collective approach. Financial accountability is currently split several ways, with provider leadership currently accountable to NHSI for financial performance, and CCGs financially accountable to NHSE. Without tackling separate accountabilities head on, the move to a place based approach will only serve to sow further confusion.

Our suggestion would be as follows.

- **A single entity (referred to here as the ICS) should hold the budget for the local health system** (either for the STP or sub-regions within an STP). This entity should bring together NHS commissioners and providers, with their respective allocations and other income pooled. A single provider might not always be the most appropriate option, particularly in areas where the acute trust is in significant

deficit (as the provider of last resort and the biggest user of resources on the patch, the acute trust is a likely candidate for taking the budget in most areas). We found strong support from those surveyed for a single budget for health and social care, but, as a minimum, there should be an integrated alliance of the main public healthcare providers within a patch.

- **This alliance should have a single governance structure, giving it accountability, influence and control over the allocation of funding for services.** The ICS would also control funding to private providers that may be subcontracted to provide services, as well as payments to out of area providers in the same way as currently funded through CCGs. This alliance should be contractually bound: systems should not rely on memoranda of understanding or goodwill to have the same level of impact.
- **Payment to the ICS should be made, via the STP, on a whole system capitation basis.** The temptations to capitate by individual pathways, cohorts, or other splits of the population present risks of fragmenting care and reducing accountability for the ICS leadership for designing and commissioning services within its geographical boundaries. The details of how the budget should be calculated may require further consideration, but the existing CCG allocation formula provides a logical starting point.
- **In the purest form of an ICS, a single organisation should hold the budget for the local health and care system.** This organisation would have accountability for the provision of all care, including primary care (subject to notes below on things that should be paid for at a system level). This could be either done through direct provision (e.g. Ribera Salud's model, where the acute trust holds the budget for the population as the provider of last resort, and commissions community services where they can achieve better outcomes for less money<sup>11</sup>) or by subcontracting some of the services to other organisations, which could be NHS or private organisations.

*Financial accountability is currently split several ways, with provider leadership currently accountable to NHSI for financial performance, and CCGs financially accountable to NHSE.*

\* There is a risk that sudden removal of control totals could inspire a collective 'sigh of relief' in response to an impression of reduced focus on control. In any case, without legislative change, regulation on an organisational basis will need to continue. Until a change in legislation occurs system totals will need to be an aggregation of organisational totals, and it will be incumbent on regulators to move emphasis to this aggregated total.

11 De Rosa Turner, Alberto, 'Lessons from Spain: The Alzira Model', *The King's Fund International Integrated Care Summit*, (2012)

It is important that the creation of integrated budgets isn't seen as a panacea. It comes with dangers as well as benefits. The previous incarnation of regional/district health authorities are seldom referenced as a golden age of efficiency and effectiveness, and devolved nations that do not have the same purchaser/provider split as England do not stand out in terms of performance, despite higher spending per capita.<sup>12</sup> There would be a need to avoid monopoly and monopsony behaviours, which risk financial balance being maintained through rationing of access, rather than ongoing improvement of services and productivity. Safeguards would be needed, such as financial penalties to the system for not meeting nationally set benchmarks for access.<sup>13</sup>

In the event of an ICS failing to deliver within the terms of its contract over a sustained period, STPs and national bodies would need to retain interventional powers, ranging from making leadership appointments to taking control and varying internal contracts.<sup>14</sup> In order for this to work, outcome measures will need to be revisited and the rules and processes for intervention will need to be made very clear at a national level. As outlined in *Redrawing the Health and Social Care Architecture*, we also believe there is a place, in the long run, for enhancing and streamlining the approach to local democratic accountability within integrated systems.

### **Services of a specialised nature should be paid for above the level of the local system**

Although we advocate consolidation of budgets to a single accountable local body, it is neither practical nor desirable to try to delegate everything to the local system. There are several services and functions that are more effectively commissioned and paid for across a bigger footprint. Accordingly, some national control should be maintained over:

- Ambulance services. These are generally managed and provided over a much bigger geographical area than hospital or community based care services. In order to maintain incentives to control demand for the use of services, systems should retain responsibility for contracting with

ambulance providers rather than losing the benefits of scale by trying to break services up into smaller system-sized organisations.

- Specialised services for rare and highly complex conditions. There are many services that require highly specialised teams in a small number of specialised centres. It makes sense for such services to be planned and commissioned on a national basis to ensure development of highly specialised expertise and economies of scale. It also reduces the potential for systems to be thrown out of financial balance by a small number of very high cost health needs.
- Education and training – retaining national funding for workforce planning and development enables two benefits: 1. it enables the NHS to take advantage of its size and market position when recruiting staff, and 2. it removes the potential for local systems to make short term economies on workforce development in the hope that fully trained staff could be recruited from neighbouring geographies.
- Research and development – the current approach of funding research through the National Institute for Health Research (NIHR) has multiple benefits: it allows the NHS to prioritise funding where it is deemed to show the best potential return; acts as a clear point of reference for how to access funding from various sources and allows scale of support and standard practice that would be difficult to achieve if the budget were delegated. A similar approach could be taken towards capital, as referred to on page 30.

In addition, there is little rationale to fragment funding for national bodies and functions, such as the funding to Public Health England for dealing with national public health hazards, research and national campaigns aimed at improving health across the country. These types of functions should remain centrally funded and administered. Figure 4 represents a potential model for future funding flows.

---

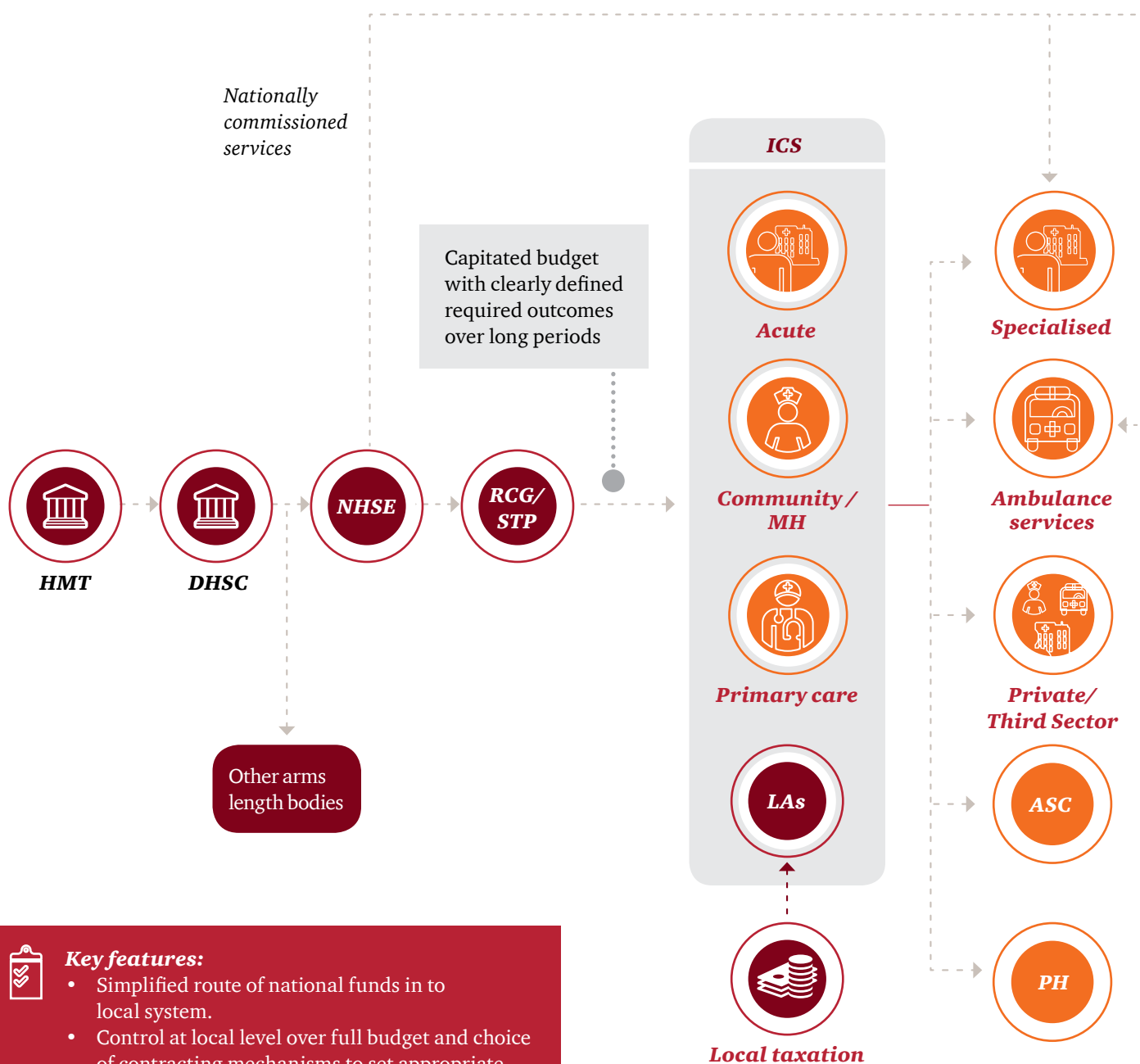
*There are several services and functions that are more effectively commissioned and paid for across a bigger footprint.*

<sup>12</sup> Bevan, Gwyn, Karanikolos, Marina, Exley, Josephine, Nolte, Ellen, Connolly, Sheelah and Mays, Nicholas, 'The four health systems of the UK: How do they compare?', (2014)

<sup>13</sup> An alternative would be creating an obligation for ICSs to fund alternative patient access to treatment, either inside (through private provision) or outside of the local geography, if access to appropriate services is not provided within the desired timeframe.

<sup>14</sup> If they retain a role as regional oversight bodies – for further discussion of the role of the intermediate tier, see our recommendations regarding creation of RCGs in *Redrawing the Health and Social Care Architecture*

**Figure 4: Future option: Simplified long term system-based settlement**



**Key features:**

- Simplified route of national funds in to local system.
- Control at local level over full budget and choice of contracting mechanisms to set appropriate objectives for each point of care.
- Services run across local boundaries (specialised services, ambulance, blood and transplant) are commissioned by NHSE at scale, but large proportion of funding comes from RCGs on episodic basis to ensure incentive to manage demand.



## 5.2 Local NHS, Social Care and Public Health budgets should be brought together

Through this review there has been wide acceptance that the integration of health services with social care services is essential to improve outcomes, better manage demand and reduce the overall cost of health and social care in the UK. In our survey, we found that the majority (78%) felt there should be a single budget covering health, social care and public health for each health economy. However, the current dislocation between the funding of health and social care services provides a significant barrier to integration.

In contrast to healthcare funding, there is no such thing as 'social care funding'. Instead, local authorities fund their social care provision through a combination of a Local Government Finance Settlement, local taxation (the 'Social Care Precept'), NHS contributions through the Better Care Fund and individual client funding. The value of these funding sources varies annually, resulting in great uncertainty for local authorities each year.

Public health funding is currently provided through ring-fenced grants which, despite being essential for the longer term health of the population, have been reducing in value in recent years. Consequently, the International Association of National Public Health (IANPHI) recommends that public health grant funding should be examined to make sure it is equitable across regions.<sup>15</sup>

It is proposed in our recommendations that in order to overcome these difficulties, healthcare, public health and social care funding should be fully integrated into a single budget within a health economy/ICS. To achieve this in full would require significant legislative change with implications across a broad range of public services, as well as the current taxation system. However there is an existing mechanism to pool large areas of spend under section 75 of the National Health Services Act 2006 which has been used in some parts of the country.<sup>16</sup>

Coupled with moves towards greater use of joint appointments across the NHS and local government, this should create entities with improved ability to influence wider determinants of population health.

Any change in the division of health and social care, including integrated budgets, will inevitably raise challenges between free at the point of use services (i.e. health care) and partly means tested services such as social care. This tension already exists, but is partly obscured through the complexity of the system. There is an ongoing challenge in ascertaining where continuing healthcare ends and self-funded social care begins. This requires work across NHS commissioners and local authorities. Bringing these budgets under common leadership will reduce the difficulties in dealing with this tension but will not eradicate them.

## 5.3 Pay for outcomes, rather than activity

The NHS is, and should in our view remain, a national system. There are three major advantages to defining the majority of outcomes at a national level. First, it reduces the risk of variable outcomes by region: as a national system any structures which drive a 'postcode lottery' should be avoided. Secondly, it removes the risk of significant money being spent to define broadly the same outcomes 44 times across STPs. Thirdly, it allows local accountability to be meaningful, as systems are not in a position where they must hold themselves to account for outcomes they themselves have set. The majority of system outcomes should be defined at the national level (and would likely align with the developing ACO outcomes framework), but local systems should be able to and be expected to supplement contracts with local priorities. While there should be nationally adhered to standards and guidelines, the process and inputs that systems use to reach these outcomes should be locally decided and managed.

Currently, for the most part, providers are not held accountable for delivering a good value service to the patient (i.e. the best possible outcomes for the tax contributed payments that they put in), nor are they particularly rewarded for doing so.

---

*"[Capitated budgets] should allow partners to share risk and have accountability for delivery linking financial outcomes to operational outcomes with transparency within the system. It should drive best return for the 'health pound'. The disadvantage is that the current system discourages this and behaviours and relationships are so embedded that implementing this will require a sea change in the attitude, approach and work of many health finance professionals that will be difficult."*

**HFMA/PwC survey respondent**

---

<sup>15</sup> Public Health Institutes of the World, *Public Health England evaluation and recommendations*, (2017)

<sup>16</sup> Section 75 of the National Health Services Act 2006 has been used to create joint commissioning arrangements in Lincolnshire, Sheffield, Devon and Greater Manchester. Creation of joint appointments and management functions are also underway in several of these geographies.



Accountability for provision of services should move from institutionally driven targets to a more holistic approach centred around system outcomes.

While there will always be a need for nationally adhered to standards and guidelines, there needs to be a better awareness in the system that multiple agencies will have an impact on patient outcomes and therefore there must be shared decision making and accountability for outcomes across a system.

#### **Example of aligned outcome payment approach:**

- A national priority outcome is determined as an annual reduction in the number of avoidable unplanned hospital admissions per head of population.
- Leaders within an STP determine that they are a particular outlier in hospital admissions for respiratory conditions and set specific targets for an ICS.
- The ICS puts in place financial rewards for providers meeting specific target outcome measures for different parts of the pathway: e.g. % reductions in prevalence of smoking for public health, increased identification of at-risk patients for primary care, proactive outreach and annual review of condition management packages for acute.
- Contract values vary based on achievement of individual targets at each point along the pathway as well as overall achievement of the ICS target for respiratory admission reduction.

Key to this, paradoxically, is that the NHS's efficiency works in its favour. Healthcare in the UK is already relatively efficient and there is mostly little fat in tariff prices – and as such there is potential to put a relatively small amount at risk in order to make a relatively large impact. There is some evidence<sup>18</sup> that existing outcomes based payments such as the Commissioning for Quality and Innovation frameworks (CQUIN) and Best Practice Tariff have a positive impact.<sup>17</sup> However, the focus is narrow and not always directed towards outcomes (as in the case of CQUINs for removing unhealthy food from hospital sites).

However, there is still a place for activity based payments within a place based model. There are three main reasons for keeping an element of tariff within any payment mechanism in a future state:

- 1. There needs to be a mechanism for reimbursement of cost between systems.** Patients are mobile, and will inevitably, at times, require treatment away from their registered address.
- 2. A mechanism needs to exist to empower patients to seek treatment from alternative providers,** in order to guard against monopolistic behaviour by ICSs, when access requirements are not met by the ICS. Maintaining a price list – ideally an outcomes based one – would be necessary to ensure that there is a currency to make this possible.
- 3. Tariff should be seen as an important vehicle for collecting the data to make capitation a reality.** Data is improved where there is a link between activity and reimbursement. Maintaining an average pricing model (as long as it is regularly updated to ensure it genuinely reflects average cost of delivery) allows systems to benchmark the financial efficiency of their services, even if this is not the primary means of reimbursement.

*“Whilst unpopular with some, the link between the cost of care to a patient and an individual level can drive delivery efficiency (at the risk of destabilising some providers) but has the real benefit of providing a bottom up approach to understanding the true cost of the service.”*

**HFMA/PwC survey respondent**

<sup>17</sup> Marshall, Louise, Charlesworth Anita & Hurst Jeremy, *The NHS payment system: evolving policy and emerging evidence* (2014)

### **Norrtälje, Sweden**

In response to an increasingly elderly population in Norrtälje, Sweden, Stockholm County Council and Norrtälje Local Authority brought together their respective responsibilities for health services and social care, to form a joint Governing Committee with responsibility for health and social care for the whole population. The Governing Committee has ultimate responsibility for commissioning and delivery of health and social care through the public company that it controls.

The new model of care allowed for better care coordination than elsewhere in Sweden, where health and social care remained funded and organised separately. Among the changes was a district nurse led home care service, which tackled admission rates in the elderly. Home care staff are able to identify those whose needs

are increasing, and quickly escalate this to the district nurse who can provide extra care. Each elderly person was assigned a care coordinator (an established role in Sweden – the biståndshandläggare), who is able to support people to navigate the system as a whole, from home care and primary care to admission and reablement.

There are lessons to be learned from the experiment in Norrtälje. There was, in particular, a challenge in creating cultural change within the system which took some time to embed. However, after implementing the new model, home care costs were half that of other areas in Sweden. The Norrtälje region improved in some key performance measures when compared to other regions in Sweden. And to achieve transformation no additional funds were required – all change took place within the existing budget.<sup>18</sup>

### **Summary of key recommendations**

- 1. Systems (STP footprints) should move towards a single, whole population budget.** A single organisation (ICS) should hold the budget for the local health and care system (either for the STP or sub-regions within an STP). There needs to be clarity around the organisation that is responsible for determining the model of care within a geography.
- 2. Local NHS, Social Care and Public Health budgets should be brought together.** Use of the existing mechanism under s75 of the National Health Services Act 2006 should be encouraged by national bodies. Joint appointments between the NHS and local government, as has been seen in Greater Manchester, should also be encouraged.
- 3. Pay for outcomes, rather than activity.** Payment systems for healthcare delivery should be redesigned to reward outcomes rather than volume of activity. Local systems should be given the power to determine their own internal contractual mechanisms, with guidance from the centre on the pros, cons, risks and mitigations associated with different contractual arrangements in different scenarios.

---

<sup>18</sup> Calltorp J., MA Bäck, 'The Norrtälje model: a unique model for integrated health and social care in Sweden. *International Journal of Integrated Care*' (2015)

## 6. Giving local systems greater certainty through long term funding

*In a national health service which is delivered at a place based level, there is a need for national clarity and consistency, combined with local flexibility. The **Five Year Forward View** has paved the way for systems to forge their own path to meet the needs of the population, and this is valuable to patients and providers.*

However, there is a public need for greater transparency on the rules surrounding distribution of funding and payments for health services. We believe greater clarity over these rules would create an environment allowing commissioners and providers

to execute long terms plans and investments, with clear accountability within the system for success or failure. Greater clarity can be delivered through a number of approaches.



**83%** believe that there is a conflict between long term financial sustainability and short term efficiency savings<sup>19</sup>



19 Survey of 203 staff working in finance roles in the NHS

### 6.1 Long term funding allocations and contracts should be introduced across the NHS

In the context of a move to ‘place based’ systems that are regulated as systems rather than individual organisations, financial levers (additional funding, financial sanctions) will need to be reconsidered in a way in which national policy makers retain some financial power to influence delivery on the ground.

Currently, funding is allocated at a system level to CCGs through a national allocation formula, whereby NHS England utilises a statistical ‘weighted capitation’ formula to forecast healthcare demand in a system. This allows areas estimated to have higher health needs or greater health inequalities to receive more funding. The weighted capitation formula is based on a range of underlying drivers of need, including:

- Population age
- Morbidity (underlying physical and mental health need in the region)
- Disability rates
- Excess deaths
- Deprivation
- Associated factors such as unemployment

There are a number of health economies which at any one time appear to be under – or over-funded compared with the recommended allocation suggested by the funding formula, indicated as their ‘distance from target’.<sup>20</sup>

Policy suggests that CCG allocations should be gradually moved towards their target allocation through a ‘pace of change’ adjustment and larger variances are corrected at a higher pace than smaller ones. Overall, in our view, the funding allocation formula is largely a fair approach to the distribution of central funding across the country.

However, a theme that has been discussed as causing organisations pain more frequently than the inner workings of allocation formulas during our research is the length of allocation settlements. The annual cycle of funding allocations, and annual contracting between commissioners and providers, results in difficulty in planning for the longer term. Uncertainty as to whether funding may be reduced in subsequent years can also be an issue (where commissioners and providers may focus on retaining surpluses and contingency balances rather than investing in services, to mitigate reductions in funding in the coming year). This is often compounded by autumn allocations of ‘winter funding’, which allow so little time for operational planning that they can only serve to either fund existing, unfunded, winter plans or to create a rush to put in place measures that are hastily thought through and implemented.<sup>21</sup> This has been partially offset at times in recent years through indicative five year allocations and the current ‘1+1’ planning approach, but periods of committed funding have consistently remained at a single year.

---

*“Changing to a system such as capitation may still drive funds towards the acute part of the system unless a longer term approach is taken. Any funding system selected and the governance around it needs to encourage long term planning and decision making, the NHS is currently working in crisis mode, and there needs to be systems and processes in place that allow medium term recovery.”*  
**PwC/HFMA survey respondent**

---

20 NHS England, Analytical Services (Finance), ‘Technical Guide to Allocation Formulae and Pace of Change For 2016-17 to 2020-21 revenue allocations to Clinical Commissioning Groups and commissioning areas’, (2016)

21 The King’s Fund, *Preventing a recurrence of this winter’s crisis* (2018),



In our view, single year performance is not an appropriate measure of time for health outcomes, nor an appropriate length of time for an organisation to have guarantees about funding. Annual planning locks in a state of dealing with the status quo, rather than rethinking for the long term. Consequently, in line with longer term contracts, longer term investment in the prevention of illness should be incentivised. This should be undertaken at a STP/ICS/Regional Care Group level, with gain and risk sharing arrangements introduced to maximise the longer term return on investment. This would see prevention prioritised within health economies, rather than a short term focus on individual financial performance. Importantly, risks and benefits would then be distributed across the organisations best placed to deliver these benefits.

There are numerous examples of evidence based interventions in building resilient communities and improving the social determinants of health at a local level. These interventions are often multi agency such as the fire service in delivering smoking cessation or working with those living in squats or other low quality and often temporary housing, or the education system in promoting positive mental and physical health in school age children and adolescents. There is a requirement to think beyond the health and care system and take a region wide approach to prevention. This requires the pooling of budgets at a local level and an ability to invest for long term returns.

NHSE have in recent years attempted to reduce this uncertainty by publishing notional five year allocations, confirming actual allocations for the next two years and ‘indicative’ allocations for the subsequent three years. This has been supported by a two year contract between commissioners and providers between 2017-2019.<sup>23</sup> To promote a longer term planning horizon, long term funding allocations and contracts should be introduced across the NHS. This is beginning to gain political traction. The Prime Minister has promised a ‘multi-year’ funding plan for the NHS in England to address its long terms financial needs.<sup>24</sup> Our suggestion is that whatever the length of this national plan, it should be quickly replicated across the system (e.g. a five year plan for the NHS should translate to a five year allocation plans for local systems).

Seattle provides a good example of success in prevention. Their “Communities that Care” project has supported the building of resilient communities through a suite of evidence based interventions aimed at families with school age children. Their multi agency approach has demonstrated significant success in bringing down drug and alcohol use, smoking, and violence in those who went through the programme. Importantly, however, the evidence was assessed after eight years – this is not, and should not be seen as, a quick fix. However, interventions such as these work, and where the evidence supports it there must be consistent funding to allow the change to bed in.<sup>22</sup>

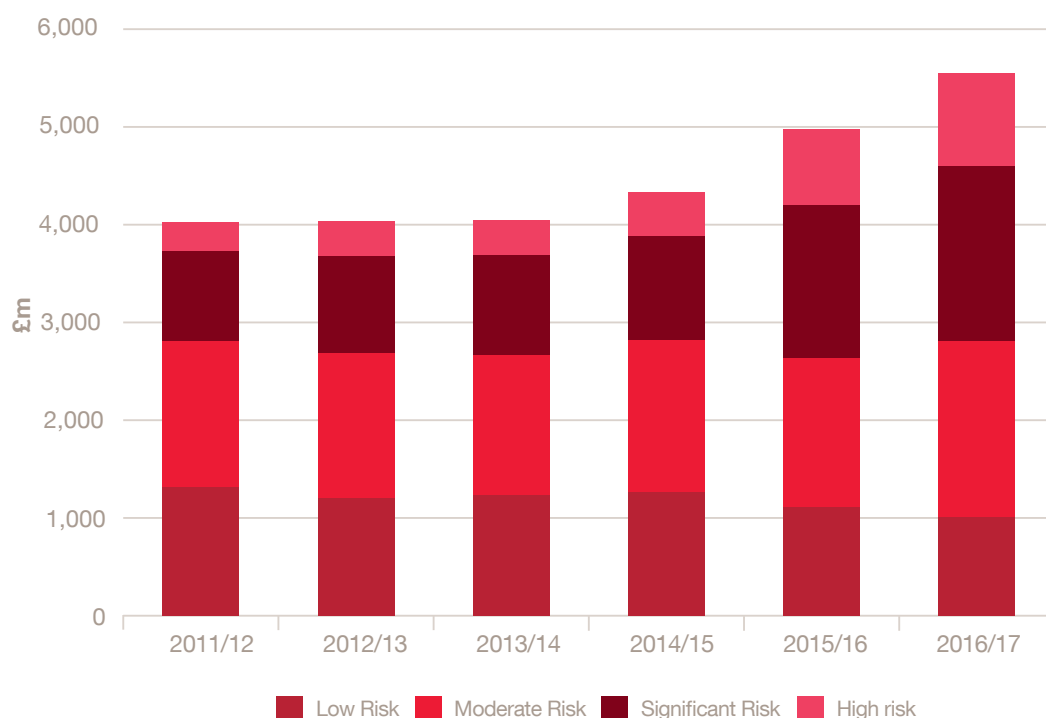
22 Van Horn, Lee M. and others, ‘Effects of the Communities That Care System on Cross-Sectional Profiles of Adolescent Substance Use and Delinquency’, (2014)

23 NHS England and NHS Improvement, ‘NHS Operational Planning and Contracting Guidance 2017-2019’, (2016)

24 BBC News, ‘NHS: PM to look at ‘multi-year’ funding plan for health service’ (2018)



**Figure 5: Capital – estimated cost to eradicate maintenance backlog**



Source: Estates and Returns Information Collection

## 6.2 The capital funding system needs to be redesigned

Capital investment in health and social care is essential for the ongoing delivery of safe services in facilities which are future-proofed to meet increases in demand and acuity of care. Investment in estates should be a priority within STPs and provider organisations. However, short term pressures, both clinical and financial, often require a short term financial focus for trusts and, in recent times, a reallocation of capital budgets into revenue budgets.

Through the course of our research, issues have been raised relating to the quantum and distribution of capital.

Regarding quantum: significant capital investment (around £10bn<sup>25</sup>) will be needed in order to realise STP plans, and therefore the *Five Year Forward View*, a reality. But over recent years there has been a growth in the maintenance backlog as trusts have responded to short term I&E pressures through reductions in capital expenditure. Between 2015/16 and 2016/17 maintenance backlog across all NHS trusts grew by 11.5% to £5.5 billion.<sup>26</sup>

Regarding distribution: the process by which DHSC chooses between business cases for capital funding through Public Dividend Capital (PDC) has been unclear, although recent publications of evaluation criteria should assist with system clarity.

*“...current NHS capital investment is insufficient to fund transformation and maintain the current estate”<sup>27</sup>*

<sup>25</sup> Naylor, ‘NHS property and estates: Naylor review’, (2017)

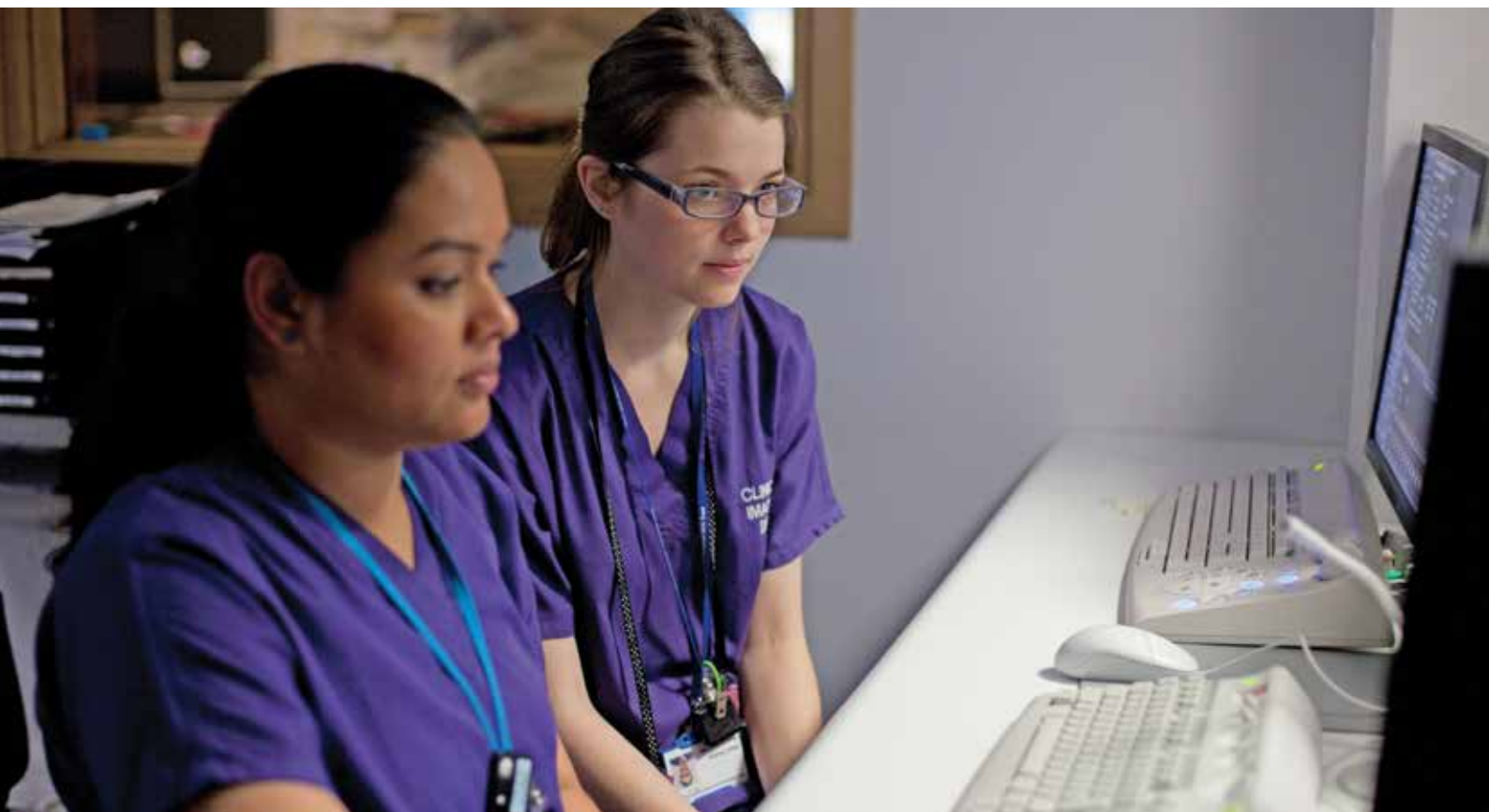
<sup>26</sup> NHS Digital, ‘Estates Return Information Collection 2016/17’ (2017)

<sup>27</sup> Naylor, *ibid*

**Figure 6: Total capital investment has declined in recent years**



Source: Estates and Returns Information Collection



### Quantum: existing alternative sources of capital funding are unlikely to be sufficient

With a limited headroom on DHSC's Capital Department Expenditure Limit (CDEL) the availability of PDC will remain constrained with only £256m likely to be available in 2018/19.<sup>28</sup> Therefore, the use of DHSC approved alternative routes to accessing capital finance that do not score against CDEL, such as local improvement finance trust (LIFT) and Private Finance 2 (PF2), along with emerging public private partnership programmes such as the expected Regional Health Infrastructure Companies (RHIC), will become more prominent. The affordability of such alternative financing sources, and the timelines required to access these various sources of funds, will continue to be critical to an NHS organisation's ability to use them.

Additionally, disposals of land and estate have recently been proposed in the Naylor review<sup>29</sup> as a further means through which providers can access capital funding. We support this proposal but believe that trusts need to remain realistic regarding the space which can be released for disposal, and therefore the quantum of funding available via this route. Trusts should be able to retain the capital received through disposals, however, in the interests of fairness, disposal receipts should be balanced nationally through the allocation of public capital to those trusts unable to raise funding through this route.

The system finds itself in a catch-22 position: it requires increased capital in order to deliver system plans to make services more financially sustainable, but it is unable to find this cash because of increasing pressure on operating budgets.

### Distribution: routes to capital funding

In order to support the move towards place based care, especially since many individual providers report recurrent financial deficits, some degree of national strategy is required to ensure that routes to capital are understood and well deployed so that the maximal benefits to the health sector are achieved.

Traditionally, capital decisions can be thought of as having been made at a 'national' level (e.g. investments too expensive to be made at a local level and national priorities delivered across a wide number of organisations) and at an 'institutional' level (e.g. local investments through retained depreciation and development loans). However, we recognise that there is now a 'regional' level in between within which cross-institutional service change across STPs should be delivered.

There is therefore a need to determine the quantum of capital funding required at each of these three levels (through an evidence based approach). Subsequently, the methods best suited to the allocation of funding at each level should be determined. It is important that these allocation methods are made clear, and also avoid disempowerment of local institutions and systems in determining their own investment priorities.

In response to these problems, we suggest two key actions, in addition to the recommendations that were laid out within the Naylor Review:

1. There should be a prohibition on future capital to revenue transfers; and
2. A National Restructuring Fund should be created, with clear access rules and prioritisation criteria, aimed towards the development of the out of hospital assets and infrastructure (including technology adoption) needed to deal with the challenges of future care needs. This fund could also be used to deliver the resources needed to deal with structural issues causing significant deficits in some providers.

---

*"In 2016-17, the Department decided at the start of the year to transfer £1.2 billion of its £5.8 billion capital budget to revenue budgets to fund day-to-day services. This followed transfers of £950 million in 2015-16 and £640 million in 2014-15."* **Sustainability and transformation in the NHS, National Audit Office, January 2018**

---

<sup>28</sup> Department of Health and Social Care, 'The Government's mandate to NHS England for 2018-19', (2018)

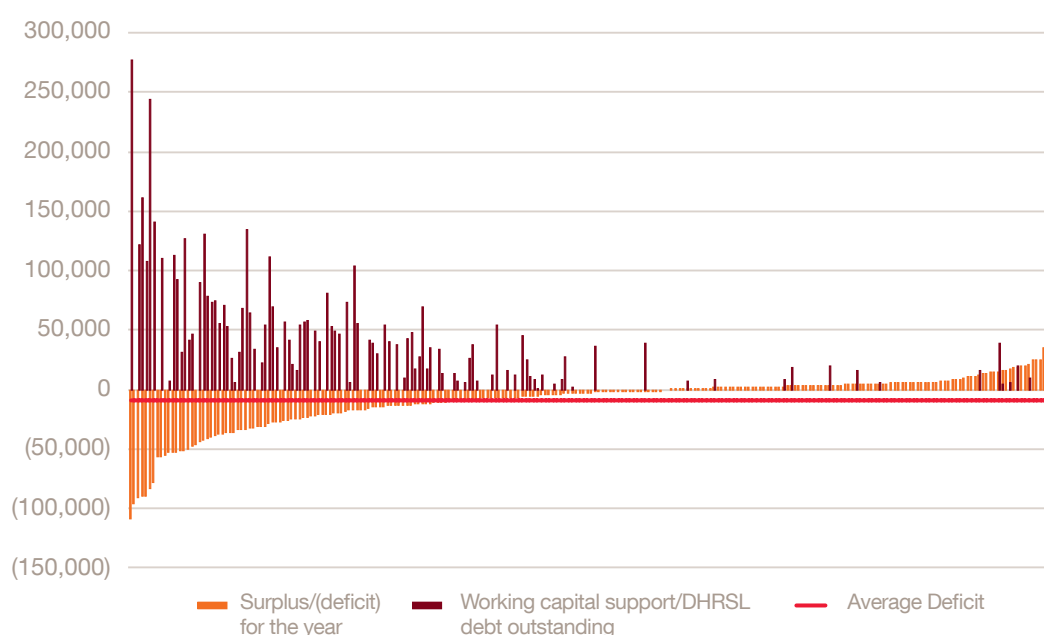
<sup>29</sup> Naylor, 'NHS property and estates: Naylor review', (2017)

### 6.3 Internal restructuring of debt between NHS organisations should be considered

Over recent years, interest bearing loans from the centre have funded cash shortfalls driven by financial deficits. At the end of 2016/17 the total debt accumulated across NHS trusts and Foundation trusts was £4.9bn with an associated interest cost of £169m. Around 42% of providers had debt associated with working capital or revenue support loans from DHSC (30% of Foundation trusts and 64% of NHS trusts) with over half in deficit.<sup>30</sup> Up to Q3 of 2017/18, 139 trusts reported a year to date deficit, with 11 in Financial Special Measures.

As providers get into more distress, the interest rates applied to these loans increases, rising to 6% for trusts placed in Financial Special Measures. This means trusts experiencing significant financial challenges are further financially penalised and for some trusts this debt burden is likely to grow and become unsustainable, with little to no prospect of it ever being repaid. (e.g. at Q3 2017/18 five trusts had year to date deficits in excess of £50m, with one already past £100m for the year<sup>31</sup>).

Figure 7: Distribution of provider deficits and internal debt 2016/17



Source: Analysis of NHS foundation trust accounts: consolidation (FTC) files 2016/17 and NHS trusts accounts: 2016 to 2017

30 Analysis of NHS foundation trust accounts: consolidation (FTC) files 2016/17 and NHS trusts accounts: 2016 to 2017  
31 NHS Improvement, 'Quarterly performance of the NHS provider sector: quarter 3 2017/18' (2018)

This mirrors approaches in the private sector, where increased risk comes hand in hand with increased cost of capital. However, the key difference in the private sector is that there is a realistic possibility of borrowing organisations being allowed to fail, in which case either the debt will be restructured to bring it down to a more manageable level, and the business saved, or the borrower enters an insolvency process and is eventually wound down. In both scenarios, the lender is required to write off its lending.

For obvious reasons, equivalent mechanisms are not in place in the NHS. Instead, organisations continue to accrue debt that they are unable to service and attempts to turn around the financial performance of the organisation are often hampered, while the money owed to the DHSC is unlikely to be repaid.

Serious consideration should be given to resetting internal debt within the NHS. At a consolidated level, these internal debt arrangements do not have a direct impact on NHS costs: the interest costs to NHS providers is counterbalanced by the interest income in DHSC. But they do absorb management time in negotiating lending arrangements and serve to amplify the difference between financially healthy organisations and those in difficulty. Any aspiration to develop financially sustainable ICSs in the future will inevitably be hampered if organisations inherit the financing costs of their predecessors. And so consolidating debt at a consistent cost of finance across the service will be necessary to begin with a level playing field.

This links with the approach to capital allocation. There is clearly a place for diversity of options including term loans and PDC to fund different capital investment requirements. However, funding of structural deficits with high interest loans that eventually make it impossible for NHS trusts to return to financial surplus increases inequality between localities as well as obscuring genuine comparison of financial performance relative to peers (i.e. at an operating surplus/deficit level).

It is important to note that because this 'lending' is within the 'DHSC group', changing the accounting treatment wouldn't require any 'new' money to be put in to the NHS. It would only mean an adjustment between asset categories on the DH's balance sheet. But it could have a big impact on the financial health of organisations delivering services on the frontline.

### Summary of key recommendations

1. **Long term funding allocations and contracts should be introduced across the NHS.** If and when a long term financial settlement is reached for the NHS, this should be replicated within the system to give local health economies the ability to plan and invest for the long term (c5 years).
2. **The capital funding system needs to be redesigned.** We suggest two actions in addition to the recommendations in last year's Naylor review:<sup>32</sup>
  - a. There should be a prohibition on future capital to revenue transfers; and
  - b. A National Restructuring Fund should be created, with clear access rules and prioritisation criteria, aimed towards development of the out of hospital assets and infrastructure (including technology adoption) needed to deal with the challenges of future care needs. This fund could also be used to deliver the resources needed to deal with structural issues causing significant deficits in some providers.
3. **Internal restructuring of debt between NHS organisations should be considered.** A significant, and growing, proportion of internal lending has built up through funding historical deficits. This places additional pressure on the financial performance of NHS trusts that are already in difficulty and have little to no prospect of being repaid. This debt should be converted to equity (PDC) and the future approach to providing working capital funding for providers in deficit approached in a similar way.

32 Naylor, 'NHS property and estates: Naylor review', (2017)



## 7. Refocusing money to improve outcomes by incentivising services and individuals

*The current financial drivers within the NHS are an example of function following form – or, more accurately, of the function changing, but the form remaining static.*

It is clear that the national aspirations set out in the *Five Year Forward View* – to make serious progress on prevention; and to improve patient experience and outcomes while working within a sustainable financial envelope – are not born of the same challenges that the NHS faced in previous decades. What they fail to capture, however, is a single, defined challenge that the NHS is currently trying to tackle.

A consensus is needed on what the appropriate outcome measures are. In the course of the discussions undertaken during our research, there was a general agreement that these should cover length and quality of life for the population and that the list of key measures shouldn't be too long. But work is needed to define a list of measures that:

- a. moves beyond operational access targets, and
- b. better covers long term health and wellbeing, while still being timely and measurable enough to hold system leaders accountable for the impacts of their actions.

The solution to this is likely to be an adaptation and combination of the NHS Outcomes Framework, Public Health Outcomes Framework and Adult Social Care Outcomes Framework.

Through our Steering Group interactions and confirmed through our round table events, we have focused this discussion by distilling the aims of the contemporary NHS down to three broad statements:

1. to minimise the number of avoidable unplanned health and care episodes;
2. to improve on quality and safety measures; and
3. for the service to live within its means.

Minimising the number of avoidable unplanned episodes of care encapsulates a number of issues. First, there is a clear need for the system to work to reduce the number of times that people feel they need to access the system in crisis, both by more effectively driving prevention and so avoiding crises in the first place. Secondly, there is a need to provide services in the community which enable people to access urgent support in a low acuity setting when appropriate and to give individuals the confidence to access these services.

Once a system is aware of its financial envelope and the parameters it has to work within, there are three 'levels' of financial flow that need to be considered:

1. Organisation level
2. Pathway level
3. Individual level



### 7.1 Organisation level: contracting for provision

It is entirely possible that the accountable body (i.e. the ICS) within a system will directly deliver services. However, it is unlikely that it will deliver the entirety of services within that patch. Alternatively, it could deliver no services at all and act purely as a commissioner. In any case, it will need to commission services from other bodies within a system. We believe that system leaders should be given the powers to select the most appropriate contracting approach for the services they wish to commission and the outcome objectives they set for those services. In order to do this, systems will need to consider the levers at their disposal to commission/contract with providers for the provision of services.

We have tried below to categorise the different types of financial levers we see as being available and assessed their relative pros and cons. Each has its benefits and its problems. National bodies should develop guidance around the relative merits and shortcomings of different contracting methods in different circumstances, and the contractual safeguards that can be put in place, in order to support systems to implement best practice.

### Available financial levers

There are a multitude of different funding mechanisms that can be put in place. We have put these in three categories: episodic payments, block contracts and capitated budgets. Each needs to be used in the right combination, circumstances, and with the right safeguards and variations in place to ensure guarding against negative incentives.

#### Definition

#### Current common use

#### Pros

#### Cons

#### Potential mitigations

#### Best applied in...

33 There is some incentive to increase efficiency (i.e. the unit cost of treating each episode), but increased throughput is not incentivised

34 A capitated budget should have a loss/gain sharing mechanism wrapped around it which would mean everyone shares in improved productivity, and so somewhat mitigate against this at a system level, but not at an organisational level

<b>Episodic reimbursement</b>	<b>Block contracts</b>	<b>Capitated budgets</b>
The only form of episodic reimbursement likely to be considered for the NHS is a nationally set tariff, where providers are paid a fixed rate for each patient that they treat.	A fixed level of payment for a fixed, defined scope of services.	In a capitated budget, levels of funding are linked to population numbers, rather than actual amount of care delivered. Capitated budgets can cover whole populations from cradle to grave; segments of the population (e.g. a particular demographic or pathway); and can be weighted for demographic factors.
Acute services	Community and Mental Health	Primary Care
<ul style="list-style-type: none"> <li>• Can be used as an incentive to increase supply/encourage new market entrants</li> <li>• Very clear link between payment and activity undertaken</li> <li>• Creates incentive for accurate data capture</li> <li>• Can be used to drive efficiency and productivity by setting prices at average marginal cost</li> <li>• Allows providers to be paid for individual patients' care, and so facilitates choice and competition</li> </ul>	<ul style="list-style-type: none"> <li>• Simple to understand and manage</li> <li>• Gives certainty to commissioners</li> <li>• Encourages management of costs within a fixed envelope</li> </ul>	<ul style="list-style-type: none"> <li>• Long term, whole population budgets should drive more preventative care and encourage services to 'live within their means'</li> <li>• Encourages collaboration amongst organisations and disciplines to minimise cost</li> <li>• Encourages 'upstream' spending to prevent acute, high cost episodes by managing long term conditions</li> <li>• Easily understood and financial risk very clearly borne by primary service provider</li> </ul>
<ul style="list-style-type: none"> <li>• Risk of cherry picking by organisations (particularly where profit making enterprises are involved). Risks leaving 'stranded costs' in publicly funded parts of the system</li> <li>• Encourages providers to 'do more' – not all rises in activity will be clinically appropriate or achieve the best value – can result in oversupply</li> <li>• Less clear link between cost and funding in services with high proportion of fixed costs/low marginal costs</li> <li>• Fails to incentivise integrated working across different organisations who may be competing for activity</li> </ul>	<ul style="list-style-type: none"> <li>• Encourages 'rationing' of access to control cost</li> <li>• Encourages monopolistic behaviour – smaller providers, including private and voluntary sectors – driven out, lower competitive pressure leading to less incentive to innovate and drive efficiency over the long term</li> <li>• Removes financial reward for increases in productivity<sup>33</sup></li> <li>• Inequitable share of financial risk when there are unanticipated increases in demand</li> <li>• Does not allow for variation in population need over time</li> <li>• Providers have less certainty as to how they will be paid relative to activity</li> </ul>	<ul style="list-style-type: none"> <li>• Encourages 'rationing' of access to control cost</li> <li>• Encourages monopolistic behaviour – smaller providers, including private and voluntary sectors – driven out, lower competitive pressure leading to less incentive to innovate and drive efficiency over the long term</li> <li>• Removes financial reward for increases in productivity<sup>34</sup></li> <li>• Inequitable share of financial risk when there are unanticipated increases in demand</li> </ul>
<ul style="list-style-type: none"> <li>• Link price movements to system demand</li> <li>• Apply caps in areas where limiting access is desired/possible</li> </ul>	<ul style="list-style-type: none"> <li>• Risk share/bonuses for exceeding performance targets</li> <li>• Risk share/penalties for failure to meet targets</li> <li>• Mechanisms to allow patients to choose alternative providers (i.e. partial loss of funding to alternative provider)</li> </ul>	<ul style="list-style-type: none"> <li>• Risk share/bonuses for exceeding performance targets</li> <li>• Risk share/penalties for failure to meet targets</li> <li>• Mechanisms to allow patients to choose alternative providers (i.e. partial loss of funding to alternative provider)</li> </ul>
<ul style="list-style-type: none"> <li>• Services where the objective is to drive increased supply and productivity</li> </ul>	<ul style="list-style-type: none"> <li>• Services with fixed costs of delivery over a long term</li> </ul>	<ul style="list-style-type: none"> <li>• Contracts for discreet pathways/subsections of the population, where the objective is to incentivise providers to focus resources in the most cost effective areas</li> </ul>

In practice, systems are likely to use a combination of reimbursement mechanisms, even where under a capitated contract. The challenge is ensuring that they are used in the right circumstance to achieve the desired outcomes.

In order for funding to support more integrated ways of working, there are a number of payment mechanisms that will need to be considered in detail beyond how individual organisations are reimbursed by the entity that holds the capitated budget – be that a single or group of CCGs, or an ICO/ICS, STP, primary and acute care systems (PACS) or multispecialty community providers (MCP). For real value to come from these arrangements, considered risk and gain share agreements will also need to be in place and systems will need to make decisions as to how reimbursement can actively drive working across organisational boundaries.

A way to tackle the current perverse incentive to treat patients in the acute sector, regardless of whether this is in the best interests of the patient, would be to flip the current arrangement on its head: giving a capitated budget based on population size to the acute provider and considering paying for community services by activity.

A purist model would be to delegate the entire budget for the population to the acute, who would then take on a commissioning function to buy or provide services from the community in line with the needs of the population that they see coming in the front door. In practice, the lead provider for a service or pathway would be given a capped budget from the acute provider and an agreed set of target outcomes. They would then have the freedom to choose the most appropriate contracting structure for the various services and interventions along that pathway (see example for aligned outcome payments on page 25).

One – not insignificant – challenge of this approach is the idea of giving significant financial control to a sector which is financially very challenged, especially in relation to acute care. Under these circumstances, the risk of taking on responsibility and accountability for a whole population budget should not be underestimated. In order to give this level of financial responsibility to the acute sector, investment will be needed in strong leaders who are able to influence decisions beyond the four walls of the hospital.

A further challenge is the way that primary care is currently commissioned. The underlying basis of the primary care contract is a nationally-defined capitation method, plus uplifts for delivering nationally-determined quality standards (QOF), with variation within CCGs for locally enhanced services. Introducing greater flexibility for systems to vary this to align incentives with shared success of other parts of the system will not be fast or easy.

A potential solution may be to identify the locally defined elements in the General Medical Services (GMS) contract, usually covered by Locally Enhanced Services, and orientate these towards outcomes for the locality population (i.e. aligned with community, acute, MH and social care budgets).

There are other pressing reasons to address the primary care contract. The pilot of 'GP at Hand' in London is an example of the potential for technology to enhance the service: increasing access and potentially bringing increased capacity into the market with the potential for greater flexible working for clinicians in terms of when and where they work. However, the current financial model means that patient registrations are held by the platform on the same basis as they would with a traditional GP practice. Given that the demography of uptake is assumed to be among lower risk, lower complexity patients,<sup>35</sup> this creates risks with regards to the equity of payments made for patients who do not select to move (both carry the same capitated payment). The current way that primary care is paid for therefore has the potential to either become unsustainable if the approach to technology continues or the potential to act as a blocker to the NHS being open to harnessing innovative technology to improve.

---

35 Wickware, Carolyn, 'BMA considering 'all legal options' to challenge GP at Hand rollout' (2018)



For the above to be effective, risk and gain share agreements will be needed between the ICS and the rest of the health economy. This arrangement should incentivise services which promote prevention and provide good value; that is, they reduce avoidable unplanned episodes of care episodes of care, particularly in high cost, acute settings.

Who would be part of the gain share agreement is worth considering. One option for GPs would be that individual practices or federations would ‘buy in’ to the ICS, and receive dividends based on the performance of the health economy. This could happen at federation, practice level or at the level of individual GPs.

### **Non-financial levers**

As noted in the introduction, financial flows and incentives are only one of a range of tools at the disposal of leaders, commissioners and policymakers. For example, ‘peer benchmarking’ can be used as a powerful incentive to encourage convergence to best practice operational performance or outcomes. Varying degrees of earned operational autonomy can be used as an incentive to encourage desired performance. Also, investment decisions (including the location of services, the technology available, staffing models and training) can be used to influence behaviours and, ultimately, outcomes in the system.

### **7.2 Pathway level: influencing providers working along a patient journey**

As noted previously, once an organisation has been made responsible for the health and care needs of a population, it faces a choice about how to meet those needs. It is possible that the organisation could provide a significant proportion of services itself and indeed there are arrangements emerging in various parts of the country where a single large scale provider takes responsibility for the majority of provision. But it is highly unlikely that a single organisation would be able to provide a holistic package of care from social care, to primary care, to mental health care as well as acute and other secondary and tertiary services. It would arguably also be undesirable to establish such a comprehensive monopoly, something raised consistently by those we spoke to.

It is far more likely that an organisation will be given primary responsibility for coordination of patients along particular care pathways. In these circumstances, their task will be to engage other providers involved with that treatment pathway in a way that encourages cooperation to ensure that patients’ needs are dealt with at the earliest opportunity, in the most efficient and cost-effective manner.

Payment mechanisms that are dependent on successfully dealing with patient needs and delivering good outcomes are likely to drive greater efficiency in these circumstances than episodic payments for the individual inputs along the way. Mixing this with top-ups for adherence to preferred best practice pathways and processes should allow systems to ensure providers’ incentives are aligned with the system objectives of dealing with care requirements in the most efficient manner possible. Shared targets and incentives should also help encourage working across organisational boundaries in the best interests of patients.

---

*Shared targets and incentives should also help encourage working across organisational boundaries in the best interests of patients.*



### 7.3 Individual level: influencing workforce behaviours

Health and social care is a people business. Around 2.8 million people work across the NHS and social care in England. In other words, one in ten working age adults are employed by the health and care sectors.<sup>36</sup> Staff costs make up as much as 74% of spend in the average mental health trust – and while this proportion is lower in the acute sector, it is still the majority of spend.

#### We need to incentivise workforce behaviours

The pay cap is on its way to being lifted a little, which should ease the financial pressure for a workforce that have seen a nearly 8% drop in real term pay since 2010.<sup>37</sup> If this is an indication of a willingness to see growth in overall pay rates in future years, there is an opportunity to look at how the workforce is incentivised more broadly. There are various issues that warrant consideration.

Our starting point is that people respond to incentives, and within the scope of this paper we are only considering financial incentives. This is, it should be noted, only part of the puzzle. Few social workers or clinical staff go into those professions because they are purely financially motivated. However, it should be made as easy as possible for an overstretched workforce to do the right thing for patients, and they should be rewarded when they do, rather than being expected to behave nobly in spite of the financial implications for themselves.

#### Staff should be paid for output rather than input

Staff within the service are currently paid almost entirely for their input in terms of time (i.e. a combination of base salary, plus additional hourly rates), instead of output and outcomes. In circumstances where payments are varied, this is often done in a way that creates incentives that are contrary to what is best for the system. For example, enhanced rates for teams who deliver extra sessions under waiting list initiatives (WLIs) create a scenario where teams are better rewarded when waiting times are high than when they are low.

This is, all things considered, quite perverse. In a scenario where waiting lists are high, there are two options for the surgeon and his or her team. One is to tackle the waiting list through putting on additional sessions – waiting list initiatives. The other is to work with and corral the whole team, looking carefully at areas where flow can be improved, where delays exist currently preventing theatres from starting on time and whether patients are prepped and moved to theatre in an efficient way to reduce delays. The second option is more sustainable, more cost effective, better value for the taxpayer – but more challenging, and offers no financial incentive for the team.

In the earlier example, where we discussed aligning outcome measures and financial incentives between the national, STP, ICS and other providers along a patient pathway (see page 25), there is potential to further align incentives towards maximising outcomes by incorporating creation of bonus pools when the combination of metrics are met or exceeded. This would create a personal and shared incentive across organisational boundaries within the pathway in order to achieve the particular objective for a particular part of the pathway, as well as the overarching objective of reducing hospital admissions associated with respiratory conditions.

---

*The pay cap is on its way to being lifted a little, which should ease the financial pressure for a workforce that have seen a nearly 8% drop in real term pay since 2010<sup>38</sup>.*

---

<sup>36</sup> The entire social care workforce as of 2017 was 1.6m, while the health workforce was 1.2m. Skills for care, 'The state of the adult social care sector and workforce in England', (2017), NHS Digital, 'NHS Workforce Statistics – August 2017, Provisional statistics' (2017)

<sup>37</sup> Chu, Ben, *Public sector pay cap: 'NHS staff real income cut by almost £2,000 over seven years of wage squeeze'* (2017)

**Recap: example of aligned outcome payment approach:**

- A national priority outcome is determined as an annual reduction in the number of avoidable unplanned hospital admissions per head of population.
  - Leaders within an STP determine that they are a particular outlier in hospital admissions for respiratory conditions and set specific targets for an ICS.
  - The ICS puts in place financial rewards for providers meeting specific target
- outcome measures for different parts of the pathway: e.g. % reductions in prevalence of smoking for public health, increased identification of at-risk patients for primary care, proactive outreach and annual review of condition management packages for acute.
- Contract values vary based on achievement of individual targets at each point along the pathway as well as overall achievement of the ICS target for respiratory admission reduction.

It is important that the full breadth of staff who influence outcomes be included in these arrangements. Take the example of maximising throughput in a theatre session (the antidote to WLIs referred previously). Aside from the surgeon performing the operation, there is a huge range of activity required inside and outside the theatre to increase throughput. Patients must be prepped, kits must be checked, and anaesthetics must be administered. Starting theatre on time requires everyone to be punctual. Teams need to be prepping for the next case while the surgeon is operating. Porters need to be available to move patients at the right time. Ward staff must know if patients are 'nil by mouth'; investigations must have been done in advance and equipment must be ready.

The size of these staff bonus pools, relative to overall reward, does not need to be significant. And their universal use would not necessarily be desirable. But greater flexibility within pay structures currently at play in the NHS would allow arrangements such as these to be considered in instances, such as WLIs, where without them, financial incentives are set up in a way which has the potential to penalise, rather than reward, behaviour in line with the objectives of the system. A detailed assessment should be undertaken of how financial incentives for frontline and management staff can be used to improve cross-organisation working along patient pathways. In particular to reflect the sharing of risks and benefits between sectors and organisations to encourage and enable integrated service delivery.

#### **7.4 Individual level: influencing patients and those receiving care**

As stated in our assumptions, we expect the NHS to remain free at the point of use, with means testing funding for social care remaining as the status quo. This places limitations on the financial incentives that can be brought to bear on the individuals who access services. We watch with interest as to how public health initiatives such as the sugar tax will have an impact on diseases impacted by lifestyle; however, we restrict discussion in this paper to how money can be a driver at the point of delivery.

In the current system there is a disconnect between the actions of individuals and the payment system. The vast majority of those using services have no understanding (and probably no more than a passing interest) in how NHS bodies are paid. Their demands on the system, which are the main driver of activity and cost, are not affected by the financial mechanisms which exists.

The exception to this is personal budgets. Personal budgets are beginning to look like a success story in terms of being an effective way to empower individuals to engage in their own health and care in a way which improves outcomes and value. Early evidence from pilot schemes suggests that they increase patient wellbeing and reduce unplanned care episodes at the same or lower cost.<sup>38</sup> While more robust evidence is being and should be gathered, independent evaluation of the use of personal health budgets for those receiving Continuing Health Care was associated with a significant improvement in the care related quality of life (although these did not improve absolute clinical measures relating to their condition).<sup>39</sup>

However, the government is at risk of missing its own target – which has been substantially watered down – when it comes to personal budgets, and there is more to be done to realise their potential. In 2014, Simon Stevens announced a plan to give 5 million people personal health budgets by 2018.<sup>40</sup> That was later revised to 50,000-100,000,<sup>41</sup> with a consultation announced to expand this. By the time 2018 came around, a new target was announced to give 350,000 people personal budgets,<sup>42</sup> with a consultation launched to expand this to a number of additional groups, including those leaving the armed services and wheelchair users.<sup>43</sup> In the first nine months of 2017/18 nearly 23,000 people received a personal budget.<sup>44</sup>

Personal budgets must form an integrated part of person centred care to avoid further fragmentation within the system. There is opportunity in those systems which are developing strong models of care coordination to adopt personal budgets into a way of working that privileges a joined up approach to both health and social care needs. Ideally, the individual would have a single care coordinator who would be able to offer support in managing their whole package of care, whether it is purchased through a personal budget or through traditional commissioning routes. It seems counterintuitive in a person-centred system to have multiple care coordinators, when the focus should be on the individual rather than on myriad needs.

---

*Personal budgets must form an integrated part of person centred care to avoid further fragmentation within the system.*

---

38 Forder, Julien, and others, 'Evaluation of the personal health budget pilot programme', (2012)

39 Forder, *ibid*

40 West, Dave 'Stevens unveils 'radical' personal budgets plan for health and social care', (2014)

41 NHS England, 'Personal health budgets and Integrated Personal Commissioning' (2017)

42 Greenfield, Patrick 'Thousands of patients to get personalised NHS budgets', (2018)

43 Department of Health and Social Care, 'A consultation on extending legal rights to have for personal health budgets and integrated personal budgets, (2018)

44 Department of Health and Social Care, (2018), *ibid*

There is also more that could be done to provide transparency of budgeting (in a pilot for personal budgets in maternity care, women were unaware as to how their budget had been calculated) and those who took part in the national pilot valued transparency over what budget they had, how it was calculated, and what it could be spent on. In an increasingly technology-enabled world it doesn't seem unrealistic to expect a portal or app which supports individuals to have sight of their budget and to find and purchase services which could help them.

In a future of place based budgets to support population management, there is a logic to enabling those with long term complex needs to access personal budgets. The evidence currently suggests that higher value personal budgets are more impactful, so there should be consideration as to who would gain most value from intervention. However, by limiting the scope to those eligible to Continuing Health Care there is a risk that those with complex needs, but with an opportunity for some secondary prevention, could miss out.

Given that the number of people living with long term conditions in England has been estimated at 15m, with an increasing number living with multiple long term conditions, there is potential to cast the net wider. Investment will be needed to maximise the proportion of the 350,000 eligible people who take up personalised budgets. We believe that further stretch targets could be set to see 1m of the 15m people living with long term conditions holding personalised budgets by 2025.

### **Summary of key recommendations**

**1. National bodies should develop guidance around the relative merits and shortfalls of different contracting methods in different circumstances, and the contractual safeguards that can be put in place, in order to support systems to implement best practice.**

**2. A detailed assessment should be undertaken of how financial incentives for frontline and management staff can be used to improve cross-organisation working along patient pathways.**

In particular to reflect the sharing of risks and benefits between sectors and organisations to encourage and enable integrated service delivery.

**3. The National Expansion Plan for personal health budgets must be accelerated if the target of 100,000 patients holding their own budget is to be reached by 2020 (7,646 had personal budgets in 2015/16, an increase of 74% on the previous year).** This will require investment in out of hospital infrastructure and skills to ensure care is effectively coordinated and people are appropriately supported to make effective, safe and informed decisions. A further stretch target should be set to see 1m of the 15m people living with long term conditions holding personalised budgets by 2025.



## 8. Moving forward

*We face a combination of an urgent need for reform, a limited appetite for grappling with complex and challenging questions and a political environment in which Brexit, a minority government and increased pressure on Treasury resources all limit the political capital available to confront the challenge facing the NHS. The combination of political factors has the potential to defer big decisions being made about the structure of the health and social care sector.*

### **8.1 The challenges ahead**

#### **Wider political environment**

Not acting now represents a huge missed opportunity and could be highly detrimental to the service, both in terms of the financial sustainability of the sector and the sunk costs of investment in reforms during the last few years.

#### **We are not starting with a blank sheet of paper**

Trying to make fundamental changes to the NHS is a little like trying to redesign a plane while in flight. There is no opportunity to stop providing services in order to create space to make changes which might have a long term impact on both quality and finances.

In addition to the issues that arise here with double running, in order to make a new financial system work there would need to be a settlement for dealing with legacy issues that have been created over several decades. Long term financial commitments such as PFI contracts, Clinical Negligence Scheme for Trusts (CNST), fixed costs and commitments in the form of estates, long term historic provider deficits, IT infrastructure and other contractual relationships that might be held by individual organisations across the system, may need to be dealt with on a national basis.

Creating a new system has the potential to expose existing regional inequalities or create new ones. Change will need to be incremental.





## 8.2 The implications of change

Implied in our recommendations are some quite profound consequences for systems. Challenging cultural shifts will be required in systems already fatigued by change. From our survey, some of these changes will be welcomed, but others will be more divisive and present challenges.

There are both system implications and risks that will need to be mitigated against.

**1. The purchaser / provider split is likely over.** As a result of this, the roles of CCGs – and so those working in them – will change. Some of those capabilities will be required in ICO organisations and will potentially move to STP level. Some new capabilities will be required, and some may no longer be needed. Challenging decisions will need to be made regarding the way forward for CCGs.

**2. The focus of the NHS needs to change.** There is too much focus on process targets – A&E performance and waiting times – and not enough on outcomes that matter to people, such as quality adjusted life years. A shift to a more outcomes based approach to measuring success is necessary.

**3. How people democratically interact with the NHS is likely to change.** We envisage local NHS leaders being held to account by their constituents. Local leaders need to be prepared if this is to happen and ensure they arm themselves with the capabilities, and are given the levers, to make a difference.

**4. Focus will move away from foundation trusts.** It is increasingly difficult to see clear water when distinguishing between trusts and FTs. The free market philosophy is challenging to square with a single payer, monopoly provider system, and those inherent tensions become more apparent in place based, collaborative models.

**5. There is still a place for activity based payments within a place based model.**

As a mechanism for reimbursement of cost between systems, as a mechanism to empower patients to seek treatment from alternative providers, and as a vehicle for driving collection of comparable data with which to inform decision making.

**6. Nationally-negotiated contracts (e.g. GMS, AfC etc.) will require greater flexibility** to allow ICSs the freedom to truly align money flows with outcome objectives.

---

*Local leaders need to be prepared if this is to happen and ensure they arm themselves with the capabilities, and are given the levers, to make a difference.*

---

# Recap: Recommendations

---

## Short term simplification

---

1. **The capital funding system needs to be redesigned** to enable a longer term investment in out of hospital infrastructure and reduction in maintenance backlog. We make two main suggestions for achieving this:

- a. prohibition of capital to revenue transfers; and
- b. a National Restructuring Fund should be created, with clear access rules and prioritisation criteria, aimed towards development of the out of hospital assets and infrastructure (including technology adoption) needed to deal with the challenges of future care needs. This fund could also be used to deliver the resources needed to deal with structural issues causing significant deficits in some providers.

2. **Internal debt should be restructured.** A significant – and growing – proportion of internal lending has built up through funding historical deficits. This places additional pressure on the financial performance of NHS trusts that are already in difficulty and have little to no prospect of repaying the debt. This debt should be converted to equity Public Dividend Capital (PDC) and the future approach to providing working capital funding for providers in deficit approached in a similar way.

3. **Current thinking to replace organisation based control totals with system wide targets must be developed further.** The alignment of NHSE and NHSI should facilitate this, with commissioners able to speak with one voice in holding systems to account rather than just the individual organisations within them.

4. **The National Expansion Plan for personal health budgets must be accelerated** if the target of 100,000 patients holding their own budget is to be reached by 2020 (7,646 had personal budgets in 2015/16, an increase of 74% on the previous year). This will require investment in out of hospital infrastructure and skills to ensure care is effectively coordinated and people are appropriately supported to make effective, safe and informed decisions. A further stretch target should be set to see 1m of the 15m people living with long term conditions holding personalised budgets by 2025.

---

## Longer term restructuring

---

1. **Payment systems for healthcare delivery should be re-designed to reward outcomes rather than volume of activity.** Local systems should be given the power to determine their own internal contractual mechanisms, with guidance from the centre on the pros, cons, risks and mitigations associated with different contractual arrangements in different scenarios.

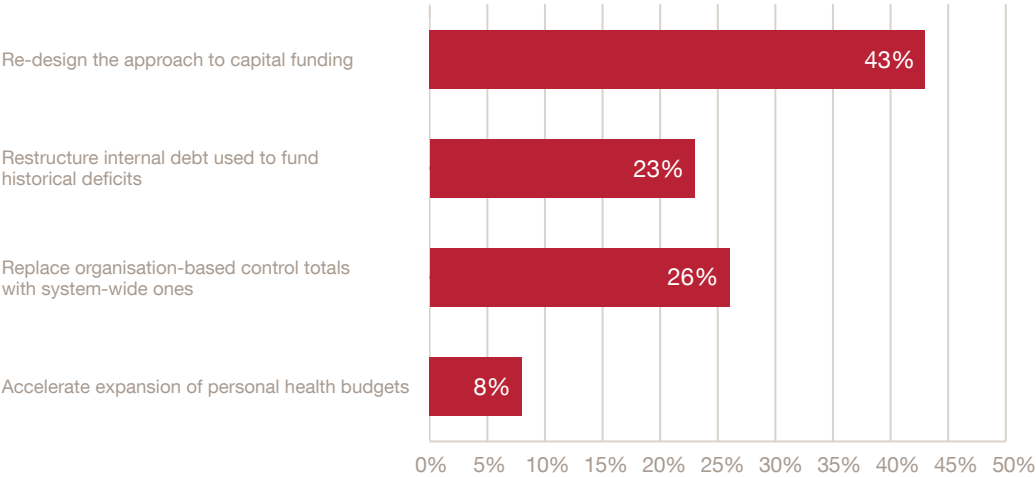
2. **Local health, social care and public health budgets should be brought together** using either new powers or the existing statutory mechanism in s75 of the National Health Services Act 2006, a small number of which are already in place, and through increasing the numbers of joint appointments between the NHS and local government, as has been seen in Greater Manchester.

3. **If and when a long term financial settlement is reached for the NHS, this should be replicated within the system** to give local health economies the ability to plan and invest for the long term (c.5 years).

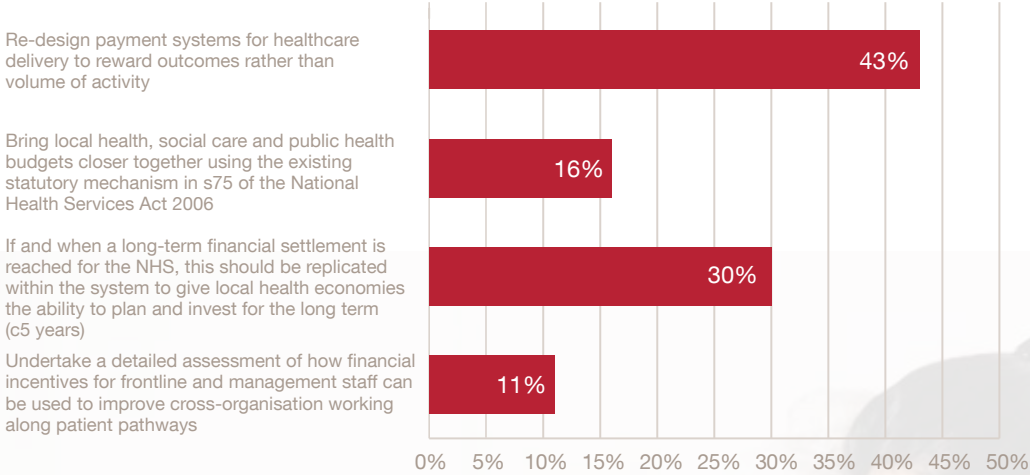
4. **A detailed assessment should be undertaken of how financial incentives for frontline and management staff can be used to improve cross-organisation working** along patient pathways. In particular this needs to reflect the sharing of risks and benefits between sectors and organisations to encourage and enable integrated service delivery. Finding ways of engaging and incentivising primary care to enter in to arrangements with Integrated Care Systems (ICSs) is key.

At a presentation of our report findings on 16 May, we asked members of the HFMA Provider Finance Faculty to prioritise our recommendations:

**Prioritisation of our short term recommendations at the HFMA Provider Finance Faculty**



**Prioritisation of our long term recommendations at the HFMA Provider Finance Faculty**



# Tomorrow's healthcare today

Healthcare matters to us and it matters to our clients. We all want better healthcare, sooner and the potential is there to make it happen. New technology, new breakthroughs, new ideas. But while there are opportunities, there are challenges too: constrained budgets, an ageing population and an increase in chronic conditions. At PwC we're working with clients to steer a course to success in this new health economy so we help improve healthcare for all.

We're working with the NHS, nationally and locally, as well as the private sector and the pharmaceutical and life sciences sector to deliver real, workable solutions to today's challenges. We're delivering transformation and integration projects with patient outcomes at their heart. And we're supporting organisations through testing financial times, often developing bespoke operational and digital systems.

We give strategic support to organisations across healthcare and pride ourselves on convening different parts of the system to solve problems. We also bring insight and expertise to healthcare as well as engaging in the public policy debate. For more information, sign up for our Health Matters blog at: [www.pwc.blogs.com/health\\_matters](http://www.pwc.blogs.com/health_matters)

## Our research team



### **David Morris**

Partner, Healthcare  
M: +44(0)7841 784180  
E: [david.x.morris@pwc.com](mailto:david.x.morris@pwc.com)



### **Josh Walker**

Government and Health Industries  
M: +44(0)7808 035514  
E: [joshua.h.walker@pwc.com](mailto:joshua.h.walker@pwc.com)



### **Jude Simpson**

Government and Health Industries  
M: +44(0)7725 633392  
E: [jude.f.simpson@pwc.com](mailto:jude.f.simpson@pwc.com)



### **Lee Lindley**

Government and Health Industries  
M: +44(0)7525 281 228  
E: [lee.lindley@pwc.com](mailto:lee.lindley@pwc.com)

## Health industries: our people



### **Quentin Cole**

UK Government & Health Industries Leader  
T: +44 (0)20 7212 6784



### **Lucy Stapleton**

Partner, Pharmaceuticals and Life Sciences Sector Lead  
T: +44 (0)20 7804 2629



### **Andrew McKechnie**

Partner, Private Health Sector and Deals Lead  
T: +44 (0)20 7212 6327



### **Rt Hon Alan Milburn**

Health Industries Oversight Board Chair  
T: +44 (0)20 7212 6784



### **Mike Farrar**

Public Sector Health Board Chair  
+44 (0)20 7804 4019

### **About PwC**

At PwC, our purpose is to build trust in society and solve important problems. We're a network of firms in 157 countries with more than 223,000 people who are committed to delivering quality in assurance, advisory and tax services. Find out more and tell us what matters to you by visiting us at [www.pwc.com](http://www.pwc.com).

This publication has been prepared for general guidance on matters of interest only, and does not constitute professional advice. You should not act upon the information contained in this publication without obtaining specific professional advice. No representation or warranty (express or implied) is given as to the accuracy or completeness of the information contained in this publication, and, to the extent permitted by law, PricewaterhouseCoopers LLP, its members, employees and agents do not accept or assume any liability, responsibility or duty of care for any consequences of you or anyone else acting, or refraining to act, in reliance on the information contained in this publication or for any decision based on it.

[www.pwc.co.uk/healthcare](http://www.pwc.co.uk/healthcare)

### **About the HFMA**

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For more than 60 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has a particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

#### **HFMA**

1 Temple Way, Bristol BS2 0BU  
T: +44(0)117 929 4789  
F: +44(0)117 929 4844  
E [info@hfma.org.uk](mailto:info@hfma.org.uk)

Healthcare Financial Management Association (HFMA) is a registered charity in England and Wales, no 1114463 and Scotland, no SCO41994. HFMA is also a limited company registered in England and Wales, no 5787972. Registered office: 110 Rochester Row, Victoria, London SW1P 1JP

[www.hfma.org.uk](http://www.hfma.org.uk)







[www.pwc.co.uk/healthcare](http://www.pwc.co.uk/healthcare)

© 2018 PricewaterhouseCoopers LLP. All rights reserved. In this document, "PwC" refers to the UK member firm, and may sometimes refer to the PwC network. Each member firm is a separate legal entity. Please see [www.pwc.com/structure](http://www.pwc.com/structure) for further details.

Design Services 31297 (05/18).