NHSProviders

Briefing

15 December 2020

THE FUTURE NHS FINANCIAL FRAMEWORK

Our asks for the new system

This briefing outlines the proposed development of the NHS financial regime in 2021/22, summarises the strategic context and highlights the potential implications for providers and integrated care systems (ICSs). It also describes trust leaders' views on key elements of the new regime, including system funding envelopes, the development of blended payment approaches, and financial governance, and sets out our asks for the new system.

Key points

- The NHS financial architecture is undergoing significant transformation. Following the interim arrangements introduced in response to the COVID-19 pandemic, the pace of NHS England and NHS Improvement's planned shifts towards both system working and payment system reform has accelerated.
- Providers are positive about the opportunity to improve health outcomes, reduce health inequalities and promote sustainability via system working. It is widely agreed that the allocation and distribution of funding at ICS level can support these aims.
- Well-established payment and contracting processes between providers and commissioners will change in 2021/22. The introduction of blended payment models across most secondary care services will be based on providers' cost bases, rather than national tariff prices. This is a major departure, particularly for acute trusts whose contracts have previously been based on the payment-by-results framework.
- To maximise the chances of success, NHS England and NHS Improvement needs to:
  - be absolutely transparent in its decision-making
  - recognise different levels of ICS maturity by providing operating parameters that establish a clear direction of travel, while still allowing more mature systems to continue developing their own governance arrangements
  - clarify how the financial framework will align with the regulatory regime to define and reward good performance, as well as supporting those in deficit to return to a sustainable financial path
  - make sure the new financial framework works for providers of all type across acute, ambulance, community and mental health sectors
  - listen to providers, ensuring that the pace of change and expectations placed on them are realistic given ongoing operational pressures.

1 Context: financial changes in 2020/21

Initial response to the COVID-19 pandemic: April to August

When the NHS stepped up its response to coronavirus in March, block contracts were established across the entire provider sector to support a clear operational focus on the pandemic. By allocating fixed sums to providers, removing financial penalties, halting trusts' efficiency programmes, and compensating additional costs attributed to coronavirus activity, financial constraints were removed to enable necessary and rapid changes to services.

Contracting rounds between providers and commissioners were also suspended in 2020/21. This was welcome, as it would have been an unhelpful distraction while the NHS was responding to the first wave of the COVID-19 pandemic.

September to year end

In September, NHS England and NHS Improvement published contracts and payment guidance for the remainder of 2020/21. This detailed the introduction of the first system funding envelopes, and changes to the use of block contracts and top-ups.

Systems were given funding envelopes for the second half of 2020/21, built up from individual provider block allocations based on COVID-19 costs incurred during Q1 of 2020/21. An elective incentive scheme was also introduced, to encourage systems to reduce their backlogs of elective surgery and outpatient appointments.

Because systems were given the freedom to reallocate provider blocks, share out COVID-19 top up funding, and distribute elective incentives and penalties, this package represented a major step towards systems playing a more significant role in managing NHS finances. You can find NHS Providers' *On the day briefing* explaining these changes in more detail here.

Capital allocations 2020/21

NHS England and NHS Improvement also introduced a new approach to capital funding in 2020/21, establishing system-level limits which providers have to work together to prioritise spending within. This change was outlined before the COVID-19 pandemic. The majority of system-level expenditure on capital projects is self-financed by providers, though emergency capital projects can be financed via emergency funding from NHS England and NHS Improvement and the Department of Health and Social Care, provided the investment is affordable within system envelopes.

NHS England and NHS Improvement also established a specific capital allocation framework for COVID-19 related infrastructure projects (such as service reconfigurations in acute wards). This funding has been allocated centrally.

Proposals for the 2021/22 financial framework

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NHS England and NHS Improvement has not yet detailed in writing how the financial system will work in 2021/22, but has been holding conferences, webinars, and roundtable discussions, as well as engaging directly with providers during autumn 2020. As a result we are well briefed on their main proposed changes and strategic objectives.

NHS England and NHS Improvement has emphasised that the financial system is intended to facilitate the sustainable recovery and transformation of services, to enable the delivery of the long term plan, and to encourage and enable system working. It is also likely that the financial environment in 2021/22 will be constrained, with an emphasis on encouraging providers to maximise their efficiency and productivity gains.

This section sets out the changes that are likely to be made next year, and outlines a series of asks for NHS England and NHS Improvement based on extensive engagement with trust leaders.

System funding envelopes

For 2021/22 NHS England and NHS Improvement is proposing that funding should be allocated to ICSs, combining core clinical commissioning group (CCG) revenue allocations with non-recurrent funds such as the financial recovery fund, and any COVID-19 funding.

Providers broadly feel that allocating funding to systems can work, but there must be a shared understanding of how ICS funding envelopes are calculated. Currently, NHS England and NHS Improvement determines the allocation of financial resources to CCGs using a published statistical formula, which is based on academic research and overseen by an independent external group. This transparency and rigour must not be lost.

We have heard concerns that some systems may not yet have developed a good enough collective knowledge of how all local services are run or funded. Where the specific financial issues facing, for instance, mental health or community services are not properly understood by the system as a whole, it could result in the case for investment in those services not being given adequate attention.

Likewise, financial problems related to structural issues, for example geographic factors including rurality, may not be fully understood by all members of an ICS. Systems without a well-established record of mutual support and joint working will therefore be less likely to make investment decisions based on a full, shared understanding of their collective challenges.

NHS Providers asks

- NHS England and NHS Improvement must set out the current legal underpinning for how funds will flow to and within ICSs, with regard to accounting officers and trust boards' statutory responsibilities (if funding flows change before any legislative proposals to place ICSs on a statutory footing are implemented).
- NHS England and NHS Improvement must publish its full methodology for determining ICS funding envelopes. This should account for how each constituent element is calculated, including the logic behind any provider-level allocations.

System capital allocations

We expect that ICSs will continue to be set capital envelopes, as has been the case since the beginning of 2020/21. Although providers remain legally responsible for maintaining their estates, and for setting and delivering their own capital investment plans, the rationale for system capital envelopes is understood and generally accepted.

Members stress the importance of business cases being prioritised in a consistent way to ensure that acute, mental health, community and ambulance providers have equitable access to funds. There is also a desire for flexibility – a common view is that individual organisations should have delegated authority to proceed with backlog maintenance and other small-scale works. Investment will be delayed unnecessarily, to the detriment of trusts' facilities, if trusts are not free to make decisions about less strategic items of spend, such as maintenance.

NHS Providers asks

- NHS England and NHS Improvement should report each year on how (and why) responsibility for capital budgets will be split between the national level, ICSs and individual organisations. Decisions on capital investment should be based on the principle of subsidiarity. It is essential that unnecessary complexity is not introduced into the business case approval process for capital funding.
- NHS England and NHS Improvement should publish clear guidance to help ICSs equitably prioritise business cases for capital funding across acute, mental health, community and ambulance services.
- NHS England and NHS Improvement should ensure that individual organisations have delegated authority to proceed with backlog maintenance and other essential works.

Financial governance

ICSs developed from different starting points and have not all done so at the same pace. Taking complex decisions concerning the distribution of funding and ensuring that allocations are spent appropriately will be new responsibilities for most systems, yet they are due to be given identical financial responsibilities from 2021/22 onwards. The risks of this approach include complex and protracted rounds of negotiation, and decisions made on the basis of local dynamics and relationships (rather than clear principles and processes).

Members tell us that giving ICSs a decision-making role over finances can work, as long as there is clear guidance on how funding should be distributed to individual organisations and a shared belief that the arrangement is fair. With systems taking an increasingly central role in local budgeting, it will be necessary to clarify the governance and accountability arrangements they will be subject to, and how these will interact with trusts' existing statutory responsibilities. It will be particularly important to set out how to resolve cases in which the interests of the system conflict with the interests of an organisation.

NHS Providers ask

- NHS England and NHS ImprovementI must recognise and support different levels of ICS maturity. It can do this by establishing universal system accountabilities and default governance arrangements that outline who has the power to make decisions, the decision-making process and how this all aligns with providers' existing statutory responsibilities. More mature systems should be allowed to develop their own governance arrangements, as long as they abide by the same overarching accountabilities and have mechanisms in place to ensure that funding envelopes are fairly distributed to individual organisations within the system.

Regulatory framework

There has been very little discussion to date of how financial regulation could work at a system level. For example, the consequences associated with a loss of financial control within a system have not been set out, either in terms of a formal special measures regime or any other regulatory action. Finance leaders are not yet clear to what extent accountability for financial challenges will sit with provider and/or system financial leads.

It must be made clear to trusts and systems what the consequences of success or poor performance will be. The regulatory framework must keep pace with the evolution of the payment system, and financial regulation needs to stay aligned with operational performance and quality and safety.

NHS Providers ask

- NHS England and NHS Improvement should ensure the new financial responsibilities of ICSs are accompanied by a robust regulatory framework, which supports the assurance of operational performance, quality and safety.

Blended payments from 2021/22

One of the policy goals of the NHS long term plan was to move away from activity-based payments and block arrangements between commissioners and providers. The wider changes to the 2021/22 financial regime outlined above will be accompanied by changes in the payment and contracting arrangements, which will also involve a departure from the traditional use of the national tariff. In a bid to provide greater certainty over income and to simplify the incentives framework, NHS England and NHS Improvement intends to introduce the 'blended payment' across most secondary care services.

Under the blended payment model, a fixed payment will be agreed, forming the core of local contract values. This element will be based on the costs of delivering activity levels in line with the ICS system plan. Although NHS England and NHS Improvement proposes retaining mandatory national tariff prices for diagnostic imaging, this is a major departure from the payment-by-results (PbR) framework used across much of the acute sector for many years, as it means contractual values will no longer be based on universal tariff prices.

The blended system will be used in all sectors: acute, ambulance, community and mental health sectors. Moreover, in acute settings it is likely that a variable payment will be introduced to incentivise reduction of the elective and diagnostics backlogs, and to support ICSs to develop their system plans. Trusts recognise the benefits of basing contract values on providers' cost base rather than national tariffs. For example, this will help providers account for local variations in facilities costs, workforce constraints and geographical limitations that have an impact on efficiency gains. However, some providers have told us they do not want to lose the rewards associated with good financial performance which were built into the PbR system, nor the focus on containing costs.

The feedback we have received to date suggests that providers are concerned that the calculation of the fixed element of blended payment may prove complex for some systems, particularly when patient-level data is limited.

NHS Providers asks

- NHS England and NHS Improvement should publish a default methodology to help providers and commissioners agree the fixed element of blended payment based on cost base. This needs to be accompanied by clear guidance on dispute resolution and how changes in the external environment, such as subsequent waves of COVID-19, can be accounted for. NHS England and NHS Improvement should also set out the circumstances under which alternative approaches to the blended payment model would be permitted.
- NHS England and NHS Improvement should clarify how good financial performance at both system and organisational level will be defined and rewarded, and how providers in deficit will be supported to return to a sustainable financial path. A shared understanding of each provider's starting position, including their relative cost efficiency, is essential.
- NHS England and NHS Improvement must ensure that the productivity and efficiency gains expected of providers are realistic given ongoing operational pressures.

Financial incentives

NHS England and NHS Improvement is planning to streamline existing financial incentives, such as removing some financial sanctions and retiring some best practice tariffs (BPTs). Having been suspended during 2020/21, commissioning for quality and innovation (CQUIN) indicators will continue to apply in 2021/22, with the total possible value of CQUINs retained at 1.25%.

Discussions are ongoing regarding how to support continued elective recovery. One option on the table is for the variable element of blended payment to work much like the existing elective incentive scheme (EIS). Providers who we interviewed spoke about the risk of creating perverse incentives and some questioned how effective financial incentives are at driving improvements in performance.

NHS Providers ask

- NHS England and NHS Improvement should continue to work with providers to understand how good operational performance, service quality and patient outcomes can be rewarded. This should include consideration of both financial and non-financial incentives at ICS and provider level.

Specialised commissioning

NHS England and NHS Improvement eventually intends to devolve the majority of the specialised commissioning budget to ICSs. In 2021/22, it is considering allocating budgets on a population basis at regional level. Further information is expected in due course. Some providers are concerned by the overall direction of travel, as many specialised services cover a much larger geographical footprint than ICSs. Trust leaders tell us that it would be prudent to define a clear vision for specialised services before making major changes to the financial framework that underpins it.

NHS Providers ask

- NHS England and NHS Improvement should work with providers to define a clear vision for specialised services. Any subsequent changes to the financial framework should be appropriately paced, avoid introducing unnecessary complexity or risk, and represent the best interests of patients.

3 Membership engagement and next steps

We await the publication of the 2021/22 operational planning and contracting guidance, in which the parameters of the new financial regime should become clearer. NHS Providers will continue to engage with members about the operational impact of distributing funding at the system level, and ensure that any concerns about the pace of change are communicated to NHS England and NHS Improvement.

Looking further ahead, NHS England and NHS Improvement should maintain an open dialogue with ICSs and their constituent organisations to identify what is working well, what could be improved and how best to return to a sustainable 'business as usual' financial system.

NHS Providers asks

- NHS England and NHS Improvement must shape the 2021/22 financial framework based on meaningful engagement with acute, community, mental health and ambulance providers, with a particular focus on setting a realistic pace of change that reflects ongoing operational pressures and uncertainty about the impact of COVID-19 in the months ahead.
- NHS England and NHS Improvement should work with ICSs and their constituent organisations to formally review how well system funding arrangements are working after six months. The results should be made publicly available to help rapidly troubleshoot emerging issues and inform the 2022/23 financial framework.
- NHS England and NHS Improvement should work with ICSs and their constituent organisations to plot a clear path back to a sustainable and fair distribution of spend.
- NHS England and NHS Improvement must continue to listen to providers of all types to ensure the new system works for all sectors and does not inadvertently disadvantage any particular provider type, or particular services.

NHS Providers asks for 2021/22 financial regime

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System funding

- NHS England and NHS Improvement must set out the current legal underpinning for how funds will flow to and within ICSs, with regard to accounting officers and trust boards' statutory responsibilities (if funding flows change before any legislative proposals to place ICSs on a statutory footing are implemented).
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Financial governance and accountability

- NHS England and NHS Improvement must recognise and support different levels of ICS maturity. It can do this by establishing universal system accountabilities and default governance arrangements that outline who has the power to make decisions, the decision-making process and how this all aligns with providers' existing statutory responsibilities. More mature systems should be allowed to develop their own governance arrangements, as long as they abide by the same overarching accountabilities and have mechanisms in place to ensure that funding envelopes are fairly distributed to individual organisations within the system.
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- NHS England and NHS Improvement should work with providers to define a clear vision for specialised services. Any subsequent changes to the financial framework should be appropriately paced, avoid introducing unnecessary complexity or risk, and represent the best interests of patients.

Blended payment and contracting

- NHS England and NHS Improvement should publish a default methodology to help providers and commissioners agree the fixed element of blended payment based on cost base. This needs to be accompanied by clear guidance on dispute resolution

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Provider engagement

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Your feedback is very welcome. For any comments or questions please contact
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For more information:
www.nhsproviders.org/the-future-NHS-financial-framework

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