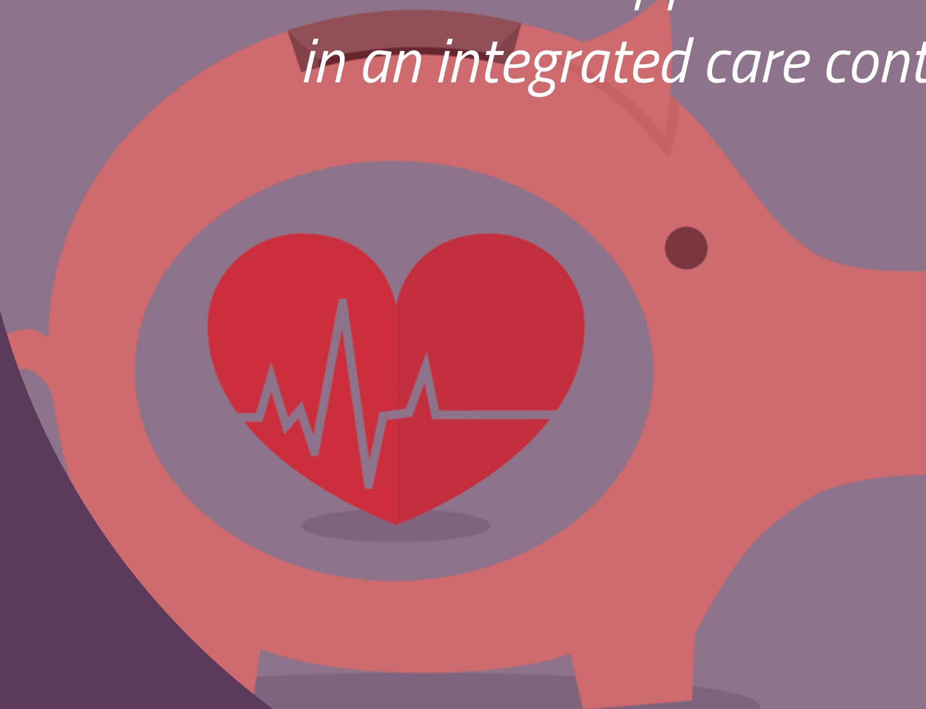
PUBLIC POLICY PROJECTS

System level finance in health and care

A stocktake of financial decision-making in an integrated care context



workday.

Foreword

Tim Wakeford,
Vice President of Product Strategy
Workday

The challenges facing the NHS are well known. In an increasingly difficult environment, CFOs and finance leaders, like many others working in the healthcare sector, are spending more time focusing on damage control rather than how they can add value to services and improve health outcomes?

However, there remains hope for the future. It's clear that the ICS model has the potential to transform how healthcare is delivered in the UK. Indeed, the research undertaken for this report shows there's widespread support among finance leaders with many feeling that progress has been made over recent years.

Workday has helped many organisations in both the public and private sectors undergoing significant transformation. While change is never easy, it's clear that true transformation is only possible with the right foundations in place.

To truly embrace the opportunity the ICS model presents, a system-level approach to financial decision making is required. This is only possible if CFOs join up back-office decision-making, enable system-wide collaboration and elevate their role to that of value creator.

Experienced financial professionals will already know this change is needed. They also know that the shift from traditional finance steward to value creator can be hard to achieve, as providing strategic insights with fragmented, poorly integrated data can be almost impossible.

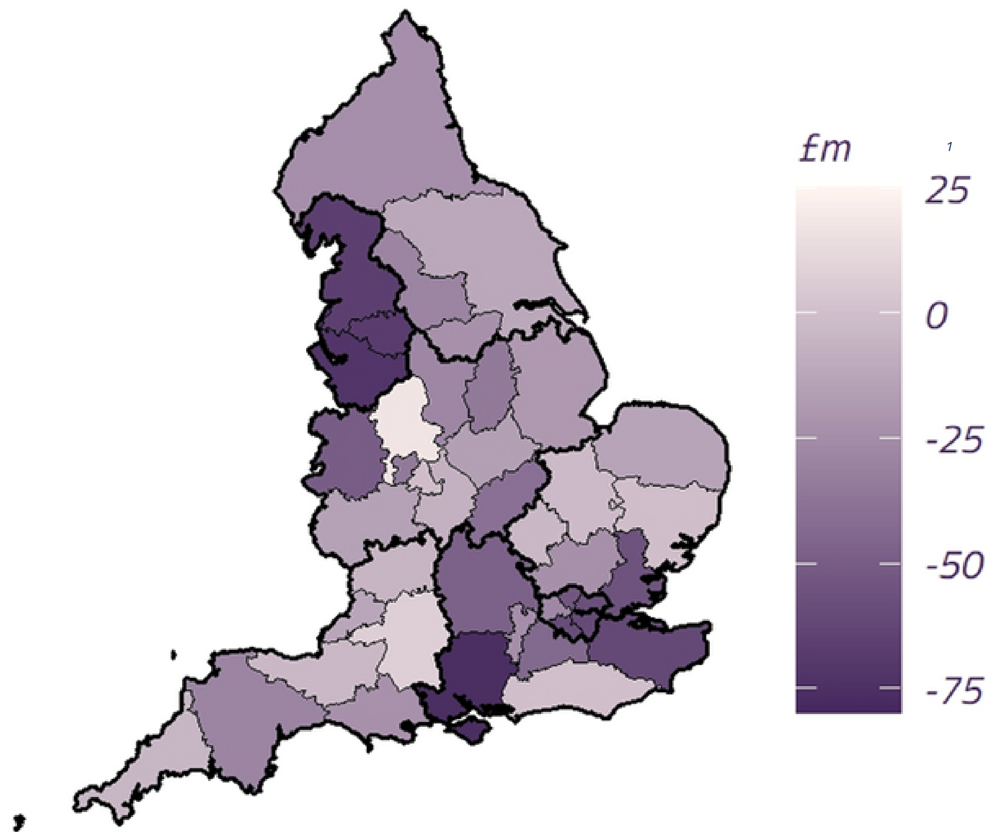
But imagine how their roles would be transformed if they could bring in high volumes of data from external systems; If they could reconcile, clean, transform and enhance that data; If they could even generate accounting of that third-party data and analyse it at scale. If they could do all that, and they could do it in one place that's connected to their core financial system, the potential would be enormous. It would enable them, as finance leaders, to make faster and more accurate decisions that enable system-wide collaboration and help to improve patient care.

Workday believes that businesses need an enterprise management cloud to turn uncertainty into opportunity. That means combining external and internal data to create a unified source of truth for a decision-ready organisation. Healthcare and public sector organisations are already using Workday to track value and surface the insights they need to predict what's around the corner and to enable them to respond to changes proactively.

While challenges are plentiful, it's clear there are also opportunities for those willing to embrace change. I'm extremely confident that those with the appetite for innovation will emerge even stronger and prepared for change whatever form that takes.

Introduction

Year-to-date financial surplus/deficit by ICS, December 2022*



PUBLIC POLICY PROJECTS

Source: ICB finance reports (2023)
*Some figures are from November 2022

In July 2022, integrated care systems (ICSs) were made statutory organisations, bringing with them a new opportunity to manage health and care resources at a system and 'place' level. Integrated care boards (ICBs), one of the statutory bodies of ICSs, are today accountable for £108 billion of the £168 billion NHS budget – and have been tasked with ensuring that spending within their local system does not exceed limits set by NHS England, and with balancing the finances across those systems. [1]

In February 2022, NHS England's Chief Financial Officer (CFO) Julian Kelly publicly admitted that ICSs were likely to post significant deficits for the 2022-23 financial year. [2]

While the scale of this deficit is ominous, it must be acknowledged that ICS are presently faced with a complex set of challenges, and that significant progress has been made to develop system-level approaches to financial and resource management.

PPP, in partnership with Workday, has produced a succinct snapshot into how financial decision-making is progressing across England's health and care system. Despite multiple crises within the NHS prompting calls for further reform to health and care, CFOs believe in the value of the ICS model and in its transformational potential – but they need more time and autonomy to deliver these benefits.

The immediate challenge: “Patient safety, financial sustainability”

It is important to acknowledge the multifaceted nature of the challenges ICSs face. These systems went into 2023 with a certain set of assumptions, such as that Covid-19 bed occupancy would remain at minimal levels and that inflation would be contained within current NHS budgets.[3] Due to a host of economic circumstances beyond the control of ICSs, these assumptions have not materialised.

the fact that the ICS is now making financial decisions as a system is more helpful than if we were doing it as separate organisations

Richard Chapman, CFO, Frimley ICB

Frimley ICS CFO, Richard Chapman, explained that “pre-pandemic, in ‘normal circumstances’, about 90 per cent of Frimley’s NHS acute bed capacity was utilised for urgent emergency care and about 10 per cent for elective procedures. If the length of stay for urgent emergency care goes up even slightly, then almost all spare capacity is focused on urgent care. The lack of attention to elective care pushes waiting lists up and drives productivity down.”

These pressures are part of a much larger trend. Historical capacity restraints and staff shortages combined with the hugely disruptive impact of Covid-19 has left the NHS with a long elective care waiting list without precedent.[4]

This lack of preparedness has been further exacerbated by a tightening labour market across health and care and the energy crunch (which has raised the price of producing and purchasing pharmaceuticals), placing further pressure on the finances of Frimley and other ICSs.[5,6]

Considering these issues, Chapman anticipates that Frimley will need to find cost efficiencies in the region of eight per cent to be able to operate within its means in the coming years. “It is a very tough situation. My priority as CFO is patient safety and financial sustainability. Right now, we are focusing on damage control rather than what is necessarily adding the greatest value to the system.”

Immediate capacity concerns are likely to limit the transformational potential of integrated care for the foreseeable future. Nonetheless, the introduction of ICSs has undeniably brought with it clear advantages for health leaders. Chapman notes that “the fact that the ICS is now making financial decisions as a system is more helpful than if we were doing it as separate organisations.”

ICSs came to the end of their first financial year as statutory organisations in significant deficit, but progress has been made in establishing system-level approaches to financial management.

Recommendation One: ICSs must be given time to implement whole system financial approaches before being subject to further wholesale reform – much of the current capacity pressures facing health and care were unexpected, forcing many systems into a focus on immediate pressures and into deficit.

From competition to collaboration

In July 2022, clinical commissioning groups (CCGs) were subsumed into ICSs, in a change which many system leaders feel has almost instantly removed the unnecessary separation between health providers. Before this, CCGs were often hesitant to reduce conflict and tensions between providers – even encouraging it in some circumstances – in the belief that it promoted innovation, competition and choice. Ultimately, however, this created fragmentation within the health and care landscape that hindered effective financial decision making.

In the old world, providers and commissioners may have thought that they had a system plan, but in reality, each provider was pursuing their own interests

Sarah Truelove, CFO, Bristol, North Somerset and South Gloucestershire ICB

Sarah Truelove, Deputy Chief Executive and CFO of Bristol, North Somerset and South Gloucestershire ICS (BNSSG ICS), recounted that "in the old [CCG] world, providers and commissioners may have thought that they had a system plan, but in reality, each provider was pursuing their own interests – this ethos led to consistent duplication and wasted resources."

Paul Brown reflected that for Staffordshire, Stoke-on-Trent ICS (SST ICS), the separation of commissioners and providers had led to some "pretty tense relationships," particularly between the legacy CCGs and NHS trusts. The system currently has the highest number of intersystem arbitration disputes in the country and the separation of commissioning functions caused highly toxic relationships.

Though each interviewed ICS leader noted that the ICB construct did not formally provide CFOs with more direct autonomy, Truelove, Brown and Chapman all suggested that the shift towards integrated delivery has helped to facilitate collaboration across healthcare providers. In fact, Brown went as far as to argue that the role of a 'facilitator' of relationships and collaboration between stakeholders and providers is the most important frame through which to view ICSs.

Brown insisted that "these latest reforms [i.e. ICSs] had to happen," and that for SST ICS, "the CCG construct inhibited effective coworking." This reflects a general sentiment from other system leaders that ICSs have more 'skin in the game' and are more committed to collaborative working than their CCG predecessors ever were.

Brown has worked with ICS colleagues in Staffordshire to create a system approach to finance across SST. This has had a dramatic effect on the financial health of SST ICS – which now has one of the largest surpluses of any of England's 42 ICSs. SST ICS recently won the HFMA Finance Team of the Year award for their effective financial planning.[7] Brown attributed this progress to a system-level approach to finance. "We have a long way to go, but our system-level relationships are now very strong."

Chapman explained that the new statutory responsibility of ICSs to create system level plans will eventually help get Frimley ICS into a break-even position, saying, "we now have a regulatory responsibility to break even as a system, as opposed to as individual organisations." This shared responsibility, Chapman insisted, has facilitated significant levels of collaboration across the system.

In the context of this system-level approach to finance, the extent to which payment by results (PbR), the ethos which largely defined CCGs approach to funding allocations, should be used to determine health finances has become increasingly controversial. As ICSs grow and mature, the evidence base for PbR and activity-based financial incentives shrinks, and it increasingly appears that this type of financial activity does not support the population health objectives of ICSs.

"The sector should not stray back into volume-based PbR," said Brown who insisted that "a more meaningful look at population health approaches can only be delivered through an outcomes-focused approach." Truelove also criticised the PbR model and insisted that the BNSSG ICS could "not be in a more different position" to PbR with regard to its financial decision making.

"We have built a really strong network of directors of finance from across the system and we've developed a medium-term financial plan," she said. "We have a clear route through on how we recover our financial position over the next few years with a path to delivering a break-even plan next year."

A sentiment was expressed in each interview that PbR and its reliance on competition runs contrary to the ethos of integration – which is rooted in collaboration. From 2020, NHS England began opting for a more blended payment model.

"Our system has only made true progress in measuring integration since the introduction of the fixed payment system," insisted Brown. Of course, the success of the fixed payment model relies heavily on the maturity of the system implementing it, and nationally, the results are mixed.[8]

With CCGs being subsumed into ICSs, barriers and tensions between NHS organisations caused by competition are gradually being replaced by collaborative approaches.

The intelligent fixed payment system, introduced in 2020, constituted a move away from the PbR system, which saw health care providers paid for the quantity of patients seen, as opposed to the quality of care delivered.

This shift has eased tensions within health systems by enabling providers to collaborate and divide resources more effectively to develop more locally responsive strategies rooted in prevention and population health. However, should the continued support of financially flexible ICBs not be seen as a health care priority there is a danger these tensions will re-emerge.

Recommendation Two: DHSC and NHS England should resist reverting to competition-based healthcare models; many health leaders favour a collaborative approach to commissioning and competition runs contrary to the ethos of integrated care.

Recommendation Three: Activity-based payment models such as PbR should be eschewed in favour of long-term fixed payment models, which are more conducive to population health management approaches to care delivery.

Developing links with local government

While ICSs appear to have improved connections between NHS providers, the associated relationships between the NHS and its local government partners are yet to fully bed in. While integration necessitates clarifying and working towards shared priorities, the process of setting a shared delivery plan and pooling budgets can be complicated by the accountabilities of the different authorities who contribute to an ICS.[9]

In her recent review into ICSs, Patricia Hewitt called for the simplification and broadening of pooled budget arrangements, in particular between the NHS and local government.[10] Pooled budgets can help local leaders make more holistic decisions on how to allocate care provision. While £7.2 billion has already been committed to the Better Care Fund (BCF), this year NHS organisations only managed to contribute £8.43 per-head; down from £15.56 per head in 2017-18.[11] Boosting this fund will be crucial to aligning the interests of local government and NHS partners that make up ICSs and for developing system-wide financial strategies.

ICSs have yet to address certain cultural and financial barriers to closer collaboration with local government.

Chapman insisted that: "If we are to develop truly integrated care, we must align our goals more effectively with local government. The more we integrate care services, the more we should be looking at wider determinants of health: education, housing, social mobility – each of which we are limited in impacting due to the material barriers created by the disparate funding streams and accountability frameworks of these organisations."

Chief People Officer for Frimley ICB Caroline Corrigan also emphasised the importance of the relationship with local government, stating that it was vital to create a culture of trust and transparency between all system partners, especially local government. "We all need to spend time in each other's worlds," said Corrigan, who explained how she had spent time shadowing colleagues working in a local authority context to build greater trust and understanding between partners.

It was also noted that ICSs require more local autonomy to produce financial frameworks that accurately reflect the complexity and make-up of their local system. "Frimley has eight different local authorities operating within its boundaries," said Frimley's Chapman, "already making it a far more complex environment [than many ICSs]. What we are asking for is more flexibility to work to the needs of our own environment and upon our own regulatory set up."

BNSSG ICS is also dealing with a complex local authority landscape. System CFO Truelove remarked that there are still significant financial governance challenges that arise when working with the three local authorities within the ICS – but she also said that the ICS construct is helping to address these tensions and develop a more collaborative approach to finance and resource management.

Recommendation Four: ICS's should be given increased amounts of financial autonomy. Not only would this enable ICS's to deliver care and resource more effectively but enables a culture of trust between ICS's and local government that is vital for enhanced collaboration.

Considerations for the centre

In scrapping the Lansley Reforms' ethos of competition and opting for a collaborative approach, the 2022 Health and Care Act allowed the centre to assume more control over health providers while also seeking to create more locally responsive health systems. These principles have at times contradicted each other, which was a major motivator for the government to commission the Hewitt Review to closely examine the role of the centre in developing ICSs.

As mentioned in the Hewitt Review, decentralisation need not amount to a complete "letting go" by national organisations, rather, a move away from the volume of conditions that so often come with national funding and a move towards greater ICS autonomy – with ultimate accountability still maintained by NHS England.[12]

Frimley ICS Chief People Officer, Caroline Corrigan, argued that where the centre can offer huge value to ICSs is through "thought leadership and helping to establish an evidence base for high impact actions." Corrigan went on to stress that "there will always be value in not duplicating the same action 42 times [across each ICS]."

Highlighting estate strategy as an example of over-centralisation, Truelove outlined that "the model for integrated care should centre around improving out-of-hospital care. Yet, much of the will from the centre often leans towards building large scale hospital buildings – the type of building that will not necessarily facilitate the model of care we are trying to introduce as we integrate services in a locally responsive way."

Developing effective system level decision-making that can drive impact at a local level may require central bodies to re-evaluate existing contracts. For instance, the global sum payment is the main form of income for most GP practices – and this is calculated based on a weighted sum for each patient. That weighted sum is calculated using the Carr-Hill formula, which includes factors such as age and gender.

The Hewitt Review presents a unique opportunity to reset system approaches to health and care finance and commit to the ICS agenda more broadly.

The Carr-Hill formula does not change from ICS to ICS, meaning that GPs are supported through a payment scheme that is agnostic towards the way that a GP practice supports the specific health equity goals of an ICS. As Chapman pointed out, the use of the global sum payment within GP contracts can often impact an ICS' ability to effectively allocate resource, and can result in the underfunding of GPs that serve deprived populations, many of whom experience health conditions at an earlier age than the Carr-Hill formula suggests.[13]

There are already compelling examples of ICSs developing more locally appropriate funding allocations. Leicestershire, Leicester and Rutland ICS, for instance, has worked with primary care providers to develop a needs-based allocation formula for primary care that weights funding towards those practices that serve the population with the highest need, recognising that age does not always equate to health need.[14]

Recommendation Five: Funding allocations should be determined, as much as possible, at local levels. Doing so enables a more targeted approach to care delivery that is respondent to local level needs. Thus, further creating a more effective financing and resourcing model.

A long term, system-level view to finance and resource management

Should concerns regarding the leveraging of resource go unaddressed, there is a risk that ICBs may instead be tasked with the responsibly of serving as a 'sub-regulator' within their local systems. Brown expressed concern that the development of ICBs may veer towards taking on the responsibility of auditing stakeholders within a local system, thereby creating additional blockers to the allocation of resource, as opposed to performing to role of facilitating collaboration between providers and authorities. Enabling ICBs to effectively act as facilitators will require funding streams to become increasingly integrated. There are concerns that the fragmentation of funding for projects can limit transformational impact.

ICSs need greater autonomy to align with public services and develop system-level approaches to finance and resource management, defined by an ethos of collaboration.

Discussing the development of an effective financial framework for ICSs, Richard Chapman noted that while "there will be problems with every mechanism you put in place", the short run-ins on many funding streams, combined with their fragmentation, complicate the development of integrated care hubs and other infrastructure that pools together resources from multiple healthcare silos.

While the planning of these projects may be complex, the use of multifaceted infrastructure that simplifies the process of receiving care is a key component of ICS and health equity strategy. As Sarah Truelove noted, "currently, there is considerable resource that is held back nationally and there are still bidding processes against it, or allocations that come out very late in the year.

While there is some concern over the length of settlements, ICS leaders have also noted that the advent of ICSs have improved financial flexibility within individual systems.

Truelove noted that the formation of ICSs had facilitated significantly enhanced financial flexibility, allowing for safeguarding some preventative measures such as establishing funds for anticipatory care; "I don't want to oversell what ICSs are able to achieve because we have had to place considerable focus on immediate pressures, such as bringing the NHS spend back to a more manageable level, but in our [BNSSG ICS] medium-term plans, we have been able to put £6 million a year for anticipatory care aside to help us get ahead with more preventative activities."

Much like how ICSs are harnessing data to develop place-based approaches for targeting health inequalities, systems are also taking system-wide views to workforce data to help manage resources more effectively. However, as mentioned in the Hewitt Review, if ICSs are to prompt a shift towards decentralisation, it is important that they do not become overly centralised bodies at a regional level.[15]

In the context of managing resources and enhancing workforce visibility, it is crucial, in Caroline Corrigan's mind, for ICBs not to simply replicate the work already being done at a provider level. "We are not trying to replicate the assurance frameworks that trusts will already have in place, but we want to be in a position where the ICB can examine things from an improvement discipline approach, present insights and a data track that reveal whether an improvement can be made."

For CPOs developing system-wide workforce strategies, an ongoing obstacle comes in the form of a lack of available insight into the care sector. "There are a plethora of workforce metrics that can be examined from the NHS side," explained Corrigan "but this is much more limited for the care sector." As Corrigan explained, NHS trusts benefit from weekly, and monthly data tracks in terms of workforce numbers, with a variety of data platforms and warehouses available to pull data alongside individual employers.

"We are not going to be able to reinvent the ESR (the main employment data warehouse for the NHS), and we do not have the resources to beef up skills for care's capacity to pull social care workforce data – so ICSs must work with what they have, which is good enough for now to work at a system level."

For ICSs, bringing budgets and resource analytics together from across ecosystems continues to be a complex and challenging task, requiring dedicated and considered system leadership and management. Harnessing the tools available, such as holistic digital assets, will be crucial to building out a clear and common purpose within an ICS that can establish shared health and financial objectives while tailoring services to local population needs.

As found in the Hewitt Review, systems can play a crucial role in driving efficiency of care delivery with system partners, and NHS England should ensure that ICSs are able to draw upon the "full range of improvement services" and harness different tools at their disposal to understand productivity, finance and quality challenges and opportunities.[16]

As found in the Fuller Stocktake into integrating primary care into ICSs, forming "multi-organisational and sector teams" will require systemic cross-sector realignment central to achieving this is a full alignment of clinical and operational workforce and making 'back-office' transformation functions available to a broader range of stakeholders.[17]

This will allow ICSs and health providers within them, to reduce duplication, create greater resilience and spend more time on the core job – delivering joined up health services and improving patient care. The One NHS Finance Team have highlighted several case studies across the NHS about how data-driven dashboards are consolidating financial forecasts, minimising manual processes and developing more system approaches to financial decision making.[18]

Indeed, 'back office' integration is crucial to facilitating integrated care and population health management. In order to develop true population health within the means of the system, ICS leaders need visibility of local health data as well as HR, finance and operational data to drive transformational change.

Recommendation Six: ICSs must maintain oversight of constituent providers within an ICS, however they must be wary of becoming overly centralised organisations within individual localities.

Recommendation Seven: ICSs must be empowered and given the right tools to develop and implement system-level views to financial management, these include digital operational tools that enable 'back office integration'.

Conclusions: Empower the model to succeed

The ability of ICSs to implement system-wide approaches to finance and resource management is continuously impacted by factors outside of their control. Even still, systems are beginning to benefit from the ability to approach questions of health improvement from a joined-up, integrated perspective.

> **It would be unheard of in the business world for a major corporation to undergo a significant merger and for shareholders to expect instantaneous results. And yet, time and time again, this is the frame through which the NHS, which remains one of the single largest organisations in Europe, is discussed**
>
> Sarah Truelove, CFO, Bristol, North Somerset and South Gloucestershire ICB

There is an increasing desire for the public and government alike to 'give the model a chance', describing how concerns regarding recent NHS have led to calls for wholesale reform – even though many of these integrated systems have yet to fully take form and are already delivering benefits.

Asking for policymakers to remain patient with the ICS model, Sarah Truelove said "there is a constant discourse around how the NHS needs structural reform when the entire system has only just undergone its most significant structural change for a decade. Give us a chance to implement and work with these reforms," she urged. All ICS leaders interviewed insisted that long-term recurrent funding models were crucial to facilitating this – findings central to the recent Hewitt Review.

Reflecting on already large deficits seen across the majority of England's ICSs, Truelove asserted that "it would be unheard of in the business world for a major corporation to undergo a significant merger and for shareholders to expect instantaneous results. And yet, time and time again, this is the frame through which the NHS, which remains one of the single largest organisations in Europe, is discussed."

Few have been able to produce measurement frameworks of metrics to accurately assess the impact of integrated care. Even the government's own impact assessment of the 2022 Health and Care Act stated that "there is mixed evidence on whether collaboration can provide cost savings in the delivery of services."

The question from a financial point of view is how ICSs can be enabled to implement system-wide approaches to financial decision making. Part of this answer will lie in harnessing tools to practically join up back-office decision making and manage assets holistically and system-wide. More fundamentally, however, the ability of ICSs to deliver joined-up care and financial sustainability will depend on the extent to which NHS England and DHSC allow these systems to develop and grow in response to their own local issues.

Learn more about PPP's ICS policy programme

Learn more about Workday

This report was sponsored by Workday who have supplied a foreword for this report. Public Policy Projects retains full editorial control of content.

References are available here.

Copyright: Public Policy Projects 2023