The missing link

A financial framework that supports system working and behaviours is vital if integrated care systems are to achieve their ambitions. Steve Brown reports on an HFMA roundtable, supported by Newton Europe

HFMA ROUND TABLE

There is widespread support for the move to integrated care systems and a more collaborative approach to healthcare and improving the health of the population. But the simple creation of new organisations and structures won't deliver the desired outcomes. Instead, it will need a new set of behaviours across health and partner organisations and a financial framework that encourages this partnership approach rather than acting against it.

An HFMA roundtable in May, supported by operational improvement specialist Newton Europe, brought together chief finance officers and finance directors from across the UK to identify the key principles that should form the foundation for a system finance framework. And it explored the behaviours that also need to be in place across systems if the new structure is to achieves its goals.

The government recently published its white paper setting out legislative proposals for the move to a more integrated health and care system in England. NHS England has also consulted on a proposed new payment system that moves beyond the old payment by results approach and builds on the temporary finance regime that has been in place since the outset of the Covid pandemic in the UK.

There are also proposals for a system oversight framework to hold systems to account for their performance.

However, while these set out some of the mechanisms that will underpin integrated care systems (ICSs), significant levels of detail are still needed to understand how the full financial framework will operate.

Claire Yarwood, chief finance officer for Manchester Health and Care Commissioning, which brings together Manchester Clinical Commissioning Group with Manchester City Council in a single commissioning body, chaired the day's discussion. She started with a reminder of why the financial framework was important.

'The structures for finance often drive organisational behaviour and sometimes dictate decision-making structures – and this feels wrong,' Ms Yarwood said. 'Governance and decision-making should show the way the finances should flow.'

Underlining her point, she said that the financial strategy should come first with financial management helping to ensure the outcomes are delivered. And the financial framework should support the strategy, not dictate it. She also stressed that the different size and scale of systems would mean they took different approaches to integrating care – and the financial framework had to support these different approaches.

Ric Whalley, a director with Newton Europe, agreed. He said experience working across multiple systems showed why change was needed from the

current framework. 'I've worked with different finance systems and it can sometimes be like pushing water uphill,' he said. 'You often have to put lots of effort into working around the system rather than the system working for you.'

Keep it simple

Transparency and simplicity were two core principles needed in a system finance framework, the finance leaders agreed. Dawn Scrafield, chief finance officer of Mid and South Essex NHS Foundation Trust and finance lead for the Mid and South Essex Integrated Care System, said there needed to be complete clarity about what resources were available for a system. The current contract structure 'encouraged different parts of the system to measure money more than once'.

'You have to spend time taking out the duplication to understand the primary cost of delivering care, otherwise you get mixed understanding and mixed messages,' she said. 'So the key is transparency.'

Emma Sayner, chief finance officer for Hull Clinical Commissioning Group, led calls for simplicity in setting up a system framework. 'We need to keep things as simple as we can,' she said. 'There is so much complexity in the world in which we operate. Wrapping complex mechanistic arrangements around the financial regime will just create more problems than they seek to solve.'

There was a high level of agreement on this point. Jonathan Webb, chief finance officer of Wakefield Clinical Commissioning Group and lead director of finance for the West Yorkshire and Harrogate Integrated Care System, said his system had seen benefits since moving away from payment by results in 2017/18 – replacing it with an aligned incentive approach. This had changed the culture and conversations within the system.

'So, when I see a national approach moving to a blended payment model, my heart sinks,' he said. 'While the theoretical underpinnings of blended payments are fantastic, it doesn't send the right message or encourage the right behaviours.'

(NHS England and NHS Improvement have recently published proposals for an aligned payment and incentive approach to setting contract values for providers. This approach moves away from the language of blended payments and changes some of the approach, although it would still involve a fixed payment based on planned activity and local costs plus a variable element, which initially could be used to support additional elective activity above planned levels.)

Kathy Roe, director of finance at Tameside Metropolitan Borough Council and Tameside and Glossop CCG, echoed the concerns about overly complicated payment regimes.

'This risks undoing some of the way we are trying to focus on driving down costs and driving up outcomes,' she said. 'I'm concerned that we don't link things to the way we've counted and incentivised activity in the past.'

Ms Roe also said she would like to move away from using some language, given its connections to old ways of working. 'While we still need the skills involved, I don't want to be talking about providers and commissioning,' she said.

"Finance systems can be like pushing water uphill. You often have to put lots of effort into working around the system rather than the system working for you"

Ric Whalley, Newton Europe

More fundamentally, she suggested that governance arrangements of those bodies involved with service delivery would need to change as system working took hold.

'I'd be really keen to see directors of public health on the boards of providers, social care directors, lay members or primary care colleagues,' said Ms Roe. 'It has got to start feeling like we are doing something on a system level and understand each other's risks better. Transparency really needs to be fostered.'

System incentives

There was also discussion about the role of incentives, although there was concern about terminology. Mr Webb said any framework had to incentivise system behaviour and performance, and the focus should be on rewarding excellent performance, not punishing lesser performance.

'For example, the Cquin scheme, which took funding away and gave it back if you earned it, felt different to our first year as an ICS where we could earn provider sustainability funding if the system acted together to support each other,' he said. On balance, he thought the shared control total approach encouraged organisations to look at wider system performance.

Ms Scrafield was also keen to see organisations pushed more towards taking a holistic view. She suggested that a system oversight framework that really focuses on overall system performance should encourage providers to look beyond their own walls.

But she was concerned about the possibility of an oversight framework working at both system and organisational level. Providing a 'sub-score' for organisations within the overall system performance could 'create confusion and conflict in the system, because it will drive individual partners to behave in ways that respond to regulation', she said.

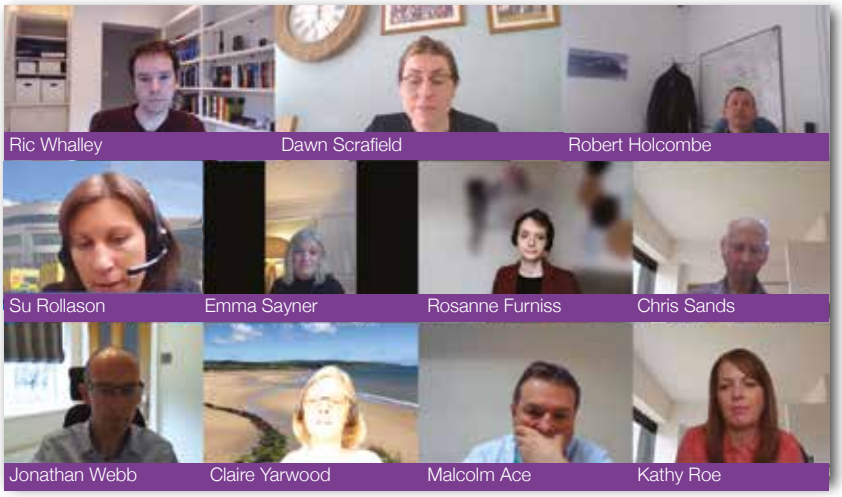
Mr Whalley said as well as encouraging a system-wide perspective, a system finance framework should also encourage NHS bodies to plan and take decisions for the longer term. However, the current annual focus of allocations and financial performance assessment worked against this. Mirroring local government's medium-term financial strategy process would be a step in the right direction.

Su Rollason, chief finance officer of University Hospitals Coventry and Warwickshire NHS Trust, and finance lead of the Coventry and Warwickshire Integrated Care System, agreed that the NHS should learn from elsewhere. There were lots of international health systems with different structures but common challenges. She also underlined the importance of a finance framework enabling systems to take a longer-term view. 'We need to be clear what time horizon we are setting, as it is linked to risk appetite,' she said. 'If you are expected to deliver within a year, it changes your risk approach.'

Mr Whalley also wanted a finance framework to incentivise the empowerment of places, where most integration of services will be delivered. 'Some organisations have enabled the ownership of finances down to a meaningful level, whether that is ward or specialty,' he said. This should be mirrored in systems.

Chris Sands, chief finance officer and deputy chief executive of Derbyshire Community Health Services NHS Foundation Trust, agreed about the importance of place within systems. 'It is also important at place level that we are allocating down to primary care network and neighbourhood level if we want to get the benefits of integration across wider health and social care,' he said.

However, Ms Yarwood said this should stop short of the centre identifying the resources that should go to place level. 'The top-slicing of resources into a lot of national budgets, and then dictating the minutiae of must-dos, takes away the ability of a system to incentivise the right



"Wrapping complex mechanistic arrangements around the financial regime will just create more problems than they seek to solve"

Emma Sayner, Hull CCG

Participants

- Malcolm Ace, Hampshire Hospitals NHS Foundation Trust
- Rosanne Furniss, Newton Europe
- Robert Holcombe, Aneurin Bevan University Health Board
- Kathy Roe, Tameside Metropolitan Borough Council and Tameside and Glossop CCG
- Su Rollason, University Hospitals Coventry and Warwickshire NHS Trust
- Chris Sands, Derbyshire Community Health Services NHS Foundation Trust
- Emma Sayner, Hull Clinical Commissioning Group
- Dawn Scrafield, Mid and South Essex NHS Foundation Trust
- Jonathan Webb, Wakefield Clinical Commissioning Group
- Ric Whalley, Newton Europe
- Claire Yarwood (chair), Manchester Health and Care Commissioning

HFMA ROUND TABLE

delivery at the right spatial level,' she said. 'If funding is ringfenced and tightly defined, this disables systems that have invested and moved at a different pace to others.'

This working to specific national must-dos for specific budgets takes away the ability of local place to influence what is required locally. And the inability to spread expenditure over a number of years constrains localities' delivery of priorities.

Costs not income

There was also agreement that a new framework should encourage organisations to develop a shared understanding of system resources and costs. Ms Rollason said that in the new system world, cost trumped price. Decision-making had to be based on the costs of delivering care and improving outcomes, not the income it attracted.

Ms Sayner was keen to stress that the focus should be on 'the wider resources, rather than pure finance'. 'There should be mechanisms in place to allow the workforce to work across organisational boundaries,' she said. 'That will be far more beneficial to delivering integration than having approaches that move the money between organisations, which can be a significant barrier to system working.'

She called for support to be in place for systems to gain a better, more shared understanding of the fixed and variable costs that are in existence. This would allow costs to be stabilised where they need to be and modelled for what is required, now and into the future, across all sectors, including relevant local authority services.

Ms Yarwood echoed these comments – not having to recharge for staff working in other locations during the pandemic response had been 'incredibly powerful', she said. 'Moving back will increase transaction costs and create all sorts of unintended consequences.'

Mid and South Essex has started to develop such a shared view by pulling together a system operating budget based on costs of delivery. The byproduct of this could become contract sums, rather than these values being decided by conversations between silos across the system.

'We then converted this into looking at service lines across the system– what is the value of the respiratory service line, of frailty or diabetes?' Ms Scrafield explained. 'And we are starting to build that picture. We are now in the process of developing a system budget book, setting out what the resources are by service line.' The aim is to make accountability aligned more to service lines than organisations.

Ms Yarwood asked whether there was still a need for contracts. 'Can't we just allocate money to people who deliver services and jointly hold ourselves to account at the ICS board?' she asked.

Ms Roe agreed that 'commissioning, contracting and procurement are on the way out, while strategy, planning and design are on the way in'.

But Robert Holcombe, deputy finance director of Aneurin Bevan University Health Board suggested that 'commissioning' can add value. 'Moving to more of a planning system approach and the loss of commissioning in Wales lost rigour and removed the grit in the system. External accountability for delivery was lost and we are recovering it now through improved internal scrutiny,' he said.

'I'm not saying you need to have contracts, but you need to have a clear system of holding people to account within the ICS areas. Scrutiny by an 'external' body or partnership rather than an internal management process and the implications of not delivering to an agreement or contract does help promote delivery of objectives.'

Wales already has a higher level of integration than in England, with health boards effectively delivering system working with partners, as part of legislative responsibilities. There were other lessons Wales could offer for partnership working. Mr Holcombe said that despite the health board system, there was still an element of silo working across primary care, mental health, community and acute services. Simply creating a 'system' would not automatically stop silo behaviour.

And he said there were still challenges moving resources upstream out of acute and into the community setting even within a single board

structure. While this might be the ambition, it remained difficult in reality due to financial and service pressures with the need for pump priming to support double running costs.

In addition, he said, there needed to be a recognition that any headroom created in the acute sector would probably be filled, especially given the current backlog. 'So there are not actually pounds to move immediately, however other measures need to be in place to clarify the benefits of service change,' he said.

The Welsh experience with partnership working was that it was important for all partners to have ownership of the joint objective and to be clear over exactly the sum the partnership has control over, he added.

The right behaviours

The roundtable discussed the behaviours that must be developed as part of the move to system working. While the financial framework should encourage transparency, individuals would also have to commit to real partnership working and trust. And 'system first' was as much a mindset as the by-product of payment systems and oversight mechanisms.

'We need to be driven by the principles and the quadruple aim – so it's about population health as much as the money,' said Mr Sands. 'We talk a lot in our system about the Derbyshire pound and we find that really engages people – particularly local authorities.

'And it has helped us to understand our individual and collective financial positions from an incremental as well as a full-cost perspective. That helped to build trust, particularly among the finance directors, around that transparency.'

He added that chief finance officers needed to think about their financial leadership role. 'Having worked in an environment that is very competitive under payment by results, how do we move to a much more collaborative partnership approach and how do we bring our boards, finance and operational teams with us? Examples of where things have worked well through collaboration are really helpful.'

Mr Holcombe underlined the need for the development of mutual trust between partners and the key role finance leaders can have in developing this, suggesting: 'Our finance teams need to be financial ambassadors, not just accountants.'

Rosanne Furniss, a director with Newton Europe, said there needed to be an acceptance that a system approach would mean real funds being moved.

'One of the interesting things I've seen in two large systems I've been working with recently is that one had a focus on getting the financial framework right first and using that to drive the operational behaviour, and the other wanted to get the ways of working and operational behaviour sorted and then have the finance catch up,' she said.

The need for trust and transparency was clear in both cases. 'Where they were trying to get the financial framework right first, the operational team pushed back because they wanted it to be driven by patient outcomes, not finance,' said Ms Furniss. 'But where the operational team set the direction of travel, it then hit a reality boundary – where money had to move from one organisation to another – and it gets blocked at the last minute.'

Malcolm Ace, chief finance officer of Hampshire Hospitals NHS Foundation Trust, said the boards of foundation trusts had to acknowledge they were operating in a different world now.

'Our non-executive directors were recruited into a world where we are dealing with a hermetically sealed population, the finance and performance results are very orientated towards what we do,' he said. 'In future, there must be greater collaboration and a greater willingness to accept a marginal hit on the organisation for the greater benefit of the population.' Addressing health inequalities would often mean a shift in

"Having worked under payment by results, how do we move to a much more collaborative partnership approach? How do we bring our teams with us?"

Chris Sands, Derbyshire Community Health Services

funding flows. He added that these decisions would get more difficult from now on. 'So far, ICSs and sustainability and transformation partnerships have made decisions that are largely win-win,' he said. 'But increasingly these will be "lose" for one partner and "win greater" for the system. We have to find a mechanism in the financial framework where that behaviour is encouraged and allowed.'

System leaders will also need to stand up and be counted at times. Ms Roe said health bodies had to get involved with the wider determinants of health and look to the longer term if they wanted to tackle demand management, which relied on a true system approach.

She described how in Tameside this had involved building a four-year risk-share arrangement. Money flowed from the local authority to the CCG and the acute provider agreed it would bust its control total, missing out on accident and emergency capital funding as a consequence. It took two years for the CCG to get its Qipp target down to an achievable level and the local authority provided some support for the development of the A&E.

'You'd never seen a council support a foundation trust before that, but we managed because we had all the conversations – we had all the members, the GPs and the foundation trust board in the same room, dealing with the same risk and we just cracked a different solution,' added Ms Roe.

Ms Yarwood, who had been finance director of Tameside and Glossop Integrated Care Foundation Trust at the time, said that the bravery and experience of the individuals involved were the key factors in getting a good outcome.

Ms Sayner agreed that leaders needed to show strength of character and not be afraid to take on difficult, albeit constructive, conversations. But she added that 'actions can speak louder than words'. 'Sometimes people can talk system but act differently – we need to be able to have an open environment where this behaviour is discussed. It is not easy, but it is really important.'

Summing up, Ms Yarwood said there was still a lot of detail needed on how a system financial framework would look and operate. There were continuing concerns that the accountability of organisations versus the accountability of systems had not been fully addressed. Language would also be important in ensuring clarity and supporting the development of the right behaviours. And with financial leadership so critical to system success, she encouraged NHS England and NHS Improvement to involve the finance community more, not just with the finance framework, but with the overall governance of the system.

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