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Welsh Government

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Teitl: Gwella Gwerth drwy Effeithiolrwydd Dyraniannol a Thechnegol: Fframwaith Ariannol i Gefnogi Shift Gwasanaethau Eilaidd Aciwt i Ddarparu Gwasanaeth Cymunedol/Sylfaenol **Title:** Improving Value through Allocative & Technical Efficiency: A Financial Framework to Support Secondary Acute Services Shift to Community/Primary Service Delivery

Dyddiad dod i ben / Adolygu - parhaus
Date of Expiry / Review - ongoing

I'w weithredu gan: Byrddau Iechyd
For Action by: Health Boards

Angen gweithredu erbyn: parhaus
Action required by: on-going

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Amgaeedig: Y Fframwaith Ariannol
Enclosure(s): The Financial Framework

I am pleased to introduce the financial framework to support secondary acute services shift to community/primary service delivery. This framework has been developed by health board directors of finance working together with directors of primary and community care.

A Healthier Wales: Our Plan for Health and Social Care (2018) articulates our vision for health and social care in Wales. We want to see a 'whole system approach to health and social care', which is focussed on health and wellbeing, and on preventing illness. Specifically, the plan references services which are seamless, delivered as close to home as possible. It has been well recognised for some time that a shift of services out of hospital to the community is required, however this has proved challenging to achieve.

This framework seeks to provide a tool to support this shift. Whilst the framework is predominantly directed at the shift of services from secondary to primary and community care, the principles can be used in the broadest sense, considering alternative providers (such as local authorities and the third sector). The expectation is that this tool will be used to support the implementation of future service change plans involving shifting services from acute hospital setting into the community and primary care setting.

Improving Value through Allocative & Technical Efficiency: A Financial Framework to Support Secondary Acute Services Shift to Community/Primary Service Delivery

1. INTRODUCTION

The strategic direction for NHS Wales includes shifting care outside of the acute hospital setting. This framework provides a mechanism for Health Boards to use when dealing with service change plans involving shifting services from acute hospital setting into the community and primary care setting.

The objective should be to improve the value to patients through wellbeing and outcomes whilst improving technical value gain and efficiency/effectiveness of service delivery. This may include significant changes to prescribed drug regimes, the service delivery model and steps in the patient pathway of care.

The shift may need to be driven through multiple projects to release full costs or make releasing costs viable (i.e. 'Stacking' – the cumulative effect of alternative models having a greater impact on the acute sector to release costs).

Types of Shift

At summary level this includes 4 main types of shift:

Internal (most significant)	<ul style="list-style-type: none">• Between 'departments' within a Health Board
External (Repatriation)	<ul style="list-style-type: none">• From Private Sector Provider• NHS England Provider• Other Welsh Health Board or Trust

To ensure this financial/resource shift framework is effective a wider set of process parameters need to be established to enable it to operate successfully and avoid system problems and adverse outcomes arising.

2. KEY ISSUES

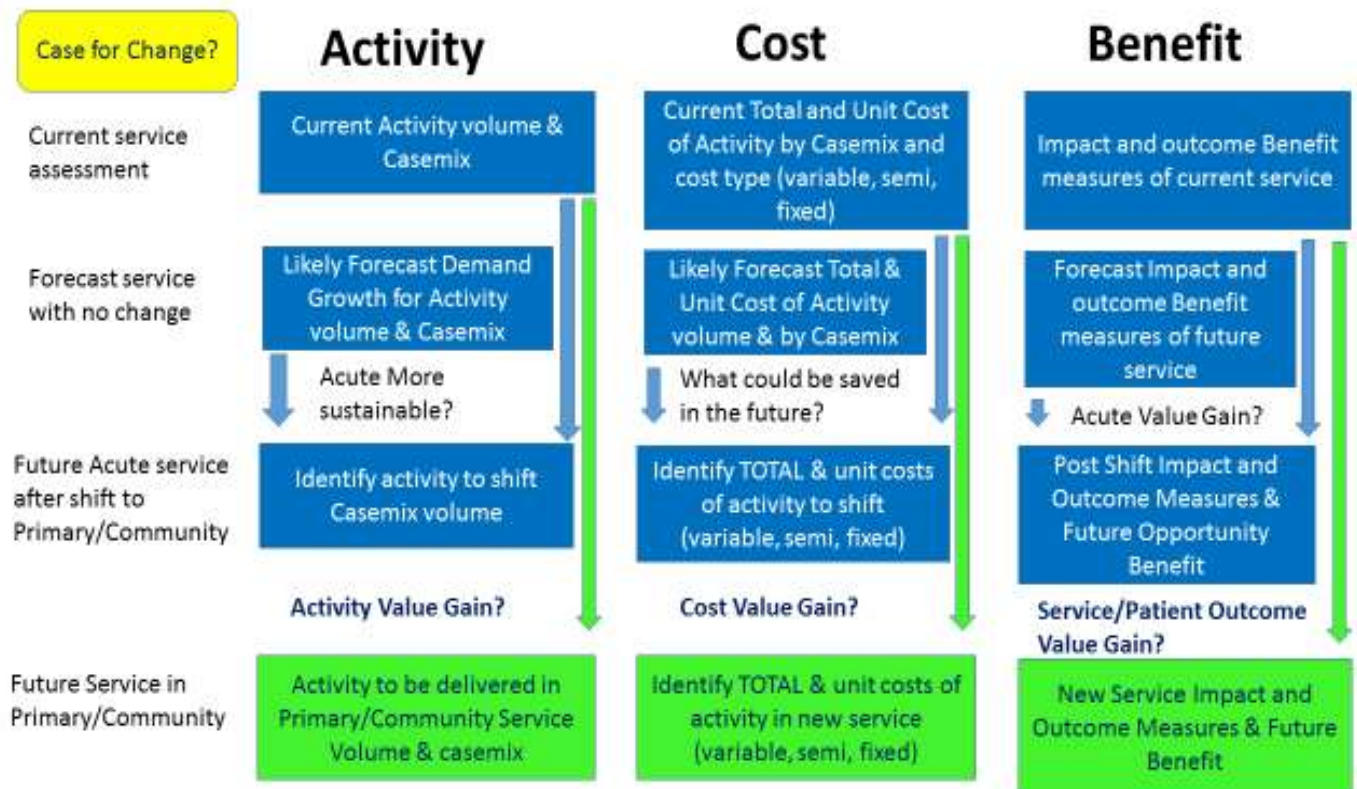
Points to consider before embarking on shift of service delivery and reallocation of resources

Business Case Approach

- Need robust business (case) process.
- Must be a 'discrete' case (to avoid wider service activity confusing delivery shift).
- The acute department should not assume the 'surplus' resources are available to them for backfill.
- Business case should be best practice and be clear on costs, prices, activity and outcomes benefits. Both for the current service model and the proposed service model.
- **Mapping the pathway of the care model now and future for both current and future services.**

- A 3 year planned approach would be advised to test delivery and assumptions of benefits.
- If wellbeing or 'learning for health' focussed a longer term plan of benefits may be required, along with more explicit outcome value gains. The benefit impact may be multi-specialty if condition based.
- **What 'contractual model' or funding mechanism may be required – is it a VAT efficient model - can be a major financial factor (especially drugs).**
- Limiting factors need to be accounted for, especially related to future sustainability.
- Proposals should be evidence based to test achievability and delivery.
- Are there waiting lists of patients breaching RTT targets that need to be treated, is this non-recurrent – under which model?
- A Contingency and Exit Strategy may be needed for 'innovative' or pilot schemes. Risk analysis and costed risks need to be included.
- Timeframes for implementation are critical along with a longer term post implementation evaluation timeframe.
- **There may be a requirement for double running and thus costs incurred and for what transition period need to be identified.**
- **The extent/proportion of the shift will be cost relevant i.e. A 'whole' service or just a 'partial' shift – this will affect overheads as well as variable and marginal costs.**
- Residual activity may grow unless referral routes changed and complied with – reducing the benefit expected.
- **Demand changes in the future need to be factored in (activity growth or reduction) for both the current and future model – particularly unmet demand emerging (use prevalence/incidence data).**
- Consider the cultural/political dynamic – consider using finance to 'incentivise' the shift, either non-recurrently or recurrently – could be general policy or specific to a case.
- Does Procurement need to be involved? (e.g. EU compliant, VEAT)

The diagram below presents the 'case for change' approach in summary.



3. TYPES OF SHIFT – Financial Implications

Understanding the costs of 'current' service and the costs of the alternative 'proposed' service is critical, how this then relates to releasable costs can be considered.

Appendix 1 provides a 'Simple Step Schematic' of actions recommended. It is the releasable costs (or prices) from the current service that is shown as different types below.

4.1 External (Repatriation) – Releasing Payments for funding alternative service model

From Private Sector Provider (Price release)	<ul style="list-style-type: none"> This should be straight forward in terms of releasing the funding at full cost from the existing provider, subject to contract terms. However the 'alternative' needs to be properly costed to understand the impact.
NHS England Provider (Price release)	<ul style="list-style-type: none"> As the majority of services are Payment by Results (PbR) this should be straight forward in terms of releasing the funding at full cost from the existing provider, subject to contract terms which may have been historically agreed outside of PbR, which may mean longer notice periods to release 100% of costs.

	<ul style="list-style-type: none"> • However the ‘alternative’ needs to be properly costed to understand the impact.
<p>Other Welsh Health Board or Trust (Price release)</p>	<ul style="list-style-type: none"> • This is more complicated due to the nature of NHS Wales sustainability and historical prices being linked to resource mapping exercises, which may no longer equate closely to actual costs incurred by the provider. • Usually average specialty prices are used for the majority of the contract, these are not usually sensitive to case-mix changes. However mapping the case-mix through may be critical to releasing the resources where a part of a system of care is being changed. • The Collaborative Commissioning Framework for Service Change, agreed by Health Board CEO’s provides the structure for releasing costs in this instance, this is similar to the ‘Scampion Rule’ established in the North of England, where a timeframe for releasing full (including fixed) costs is agreed. • The ‘alternative’ needs to be properly costed to understand the impact. <p>Key Points:</p> <ul style="list-style-type: none"> - Need transparency and honesty from both parties - Clear analysis of current service cost make up – variable, semi-variable, semi-fixed and fixed elements. - Understanding how these costs compare and fit with LTA prices – Benchmarking, costing returns and albatross can help understand the case-mix position. - Variable costs for release should be reduced from the LTA from year 1 (ie. price less variable cost), with a period of release for the full costs to be negotiated (say) over 3 years. Cost release should not be more than price paid per unit of activity. - Commissioners may consider leaving a small residual value in the provider to cover fixed costs which cannot be reasonably expected to be released. However the following factors may impact that decision – ability for HB provider to re-utilise internally, ability to ‘re-sell’ capacity to other commissioners, potential shift of workforce and assets to ‘primary’ service (like TUPE), ability to decommission service/facility. <p>Cost release factors to consider:</p> <ul style="list-style-type: none"> - Whole service removal is easier to negotiate full cost removal than partial service shift. - Partial service removal will need to be monitored to ensure referral compliance and avoid unexpected growth in residual secondary care LTA. - Residual LTA prices could be adjusted at unit cost

	<p>level or a block value identified for a fixed overhead.</p> <ul style="list-style-type: none"> - Likely future LTA growth or demand should be factored into any decommissioning decision & how costs/prices may move going forward. - Delivery risk of the 'alternative' is critical to consider along with timeframes for full implementation –these will influence the LTA adjustment and funding release.
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4.2 Internal – Releasing costs incurred for funding alternative service model

The majority of health boards deliver both acute and community/primary services to the local population they serve (excepting Powys THB). As such, this type of shift is considered the most likely scenario that Health Boards will face to release funds and will be the main focus of this framework.

The key objective is to enable resources to move between 'departments' within a Health Board. ('department' is used as the generic title for ease. This covers the potential for multiple departments' implications too e.g. acute shift to community therapy service, a GP service, social care or 3rd sector as an alternative).

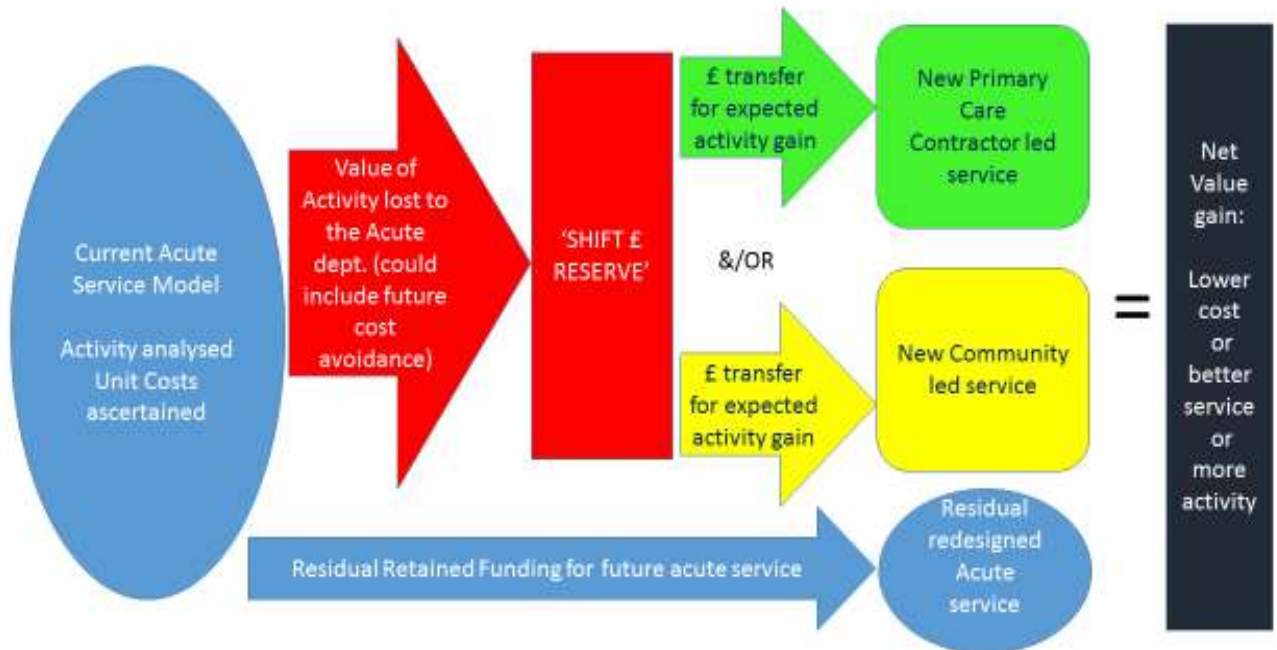
To make the best use of resources in delivering value, the current and proposed service model costs need to be identified and analysed. This should be supported by a clear picture of activity delivered and to be delivered, by case-mix.

Costs may be cash releasing or cost avoidance – it is important that both are captured, clarified and quantified.

The delivery plan may be multi-year to allow for full cost release and evaluation of delivery.

FUNDING TRANSFERS – it is recommended that a central reserve is identified and is used as the 'banker' for transparent and clear budget management. Thus removed budget from the acute department goes into the 'shift reserve'. The department requiring the budget is funded out of the 'shift reserve'. This will remove potential disputes and delays associated with department heads agreeing the transfer.

Value Gain achieved through Acute to Primary/Community Care activity & resource Shift



Appendix 2 provides an example timetable for service change plans and cost release.

Current Service Situation

The current service model and pathway needs to be identified and costs need to be analysed, ideally on a pathway basis (TDABC could be used, or a more pragmatic approach like Albatross/costing returns).

Cost drivers need to be identified and split between variable, semi and fixed elements. Including:

- Workforce (by type)
- Variable Non-pay
- Drugs
- VAT
- Support services – Theatres, Pathology, Radiology
- Service Overheads
- Equipment costs/maintenance
- SLAs
- Facilities
- Fixed apportioned costs
- Capital & capital related costs
- Note - Primary Care contractor costs/prices

There needs to be clarity of the activity and case-mix driving these costs to understand what is releasable that relates to the proposed shift in service.

- A unit cost should be aimed for. Alternatively, a time based cost model could be used as a cost of a whole service for an hour/week/year etc.

- The timeframe for releasing fixed costs needs to be assessed and be reasonable, a residual may not be releasable.
- The volumes of activity (by casemix) also need to be identified in total and for the shift (could use HRG data).
- The future demand and activity should be estimated for the current model.
- Are there waiting lists that need to be dealt with or transferred – how much will these cost to be dealt with in current service?
- What workforce, equipment or other assets may shift into use by the new service.
- What limiting factors relate to the resources being shifted (i.e. Availability of skilled workforce).
- What qualitative outcome measures are available and recorded.
- Is the current service model 'prudent'?
- Are there sustainability issues and future risks in the current service which can be costed?

Future Service Situation

Project management costs need to be assessed and costed.

The proposed service model and pathway needs to be identified and costs need to be analysed, ideally on a pathway basis (this should be able to be bottom up costed).

Partial pathway shifts will require greater clarity to avoid double running a service inadvertently.

Project management & establishing referral management compliance and costs need to be considered.

Does the set-up, implementation and delivery timeframe match with the closing/double running plan for the current service? What are the risks of double running over-run?

Cost drivers need to be identified and split between variable, semi and fixed elements, including non-recurrent set up and capital costs. This should be outlined in a timetabled plan. Including:

- Workforce (by type)
- Variable Non-pay
- Drugs
- VAT
- Support services – Theatres, Pathology, Radiology
- Service Overheads
- Equipment costs/maintenance
- SLAs
- Facilities
- Fixed apportioned costs
- Capital & capital related costs
- Note - Primary Care contractor costs/prices
- There needs to be clarity of the activity and case-mix driving these costs to understand how the new service shifts 'activity' FROM the current service.

- A unit cost should be aimed for. Alternatively, a time based cost model could be used as a cost of a whole service for an hour/week/year etc.
- Clarify timeframe and cost offset from the workforce, equipment or other assets that may shift into use by the new service.
- If a Primary Care contractor enhanced service is the future proposal a pricing methodology needs to reflect costs and a reasonable profit margin (see appendix 3).
- Benchmarks should be used to assess the future cost model for reasonableness and test check the bottom up costing.
- The volumes of activity (by casemix) also need to be identified for the new service in total for the shift (could use HRG data).
- Residual activity and forecast of future growth in the old and new service models need to be factored into the financial plan – for the discrete service shifting.
- Is the new model avoiding growth? – if so, quantify it, by casemix.
- Are there waiting lists that need to be dealt with or transferred – how much will these cost to be dealt with in current service?
- What limiting factors relate to the resources being shifted (i.e. availability of skilled workforce)
- What is the double running period and costs? Are there ‘decommissioning’ costs in the acute service?
- What qualitative outcome measures are best recorded and how will they be costed, captured and compared with current available data to prove the value benefit of the proposed service?
- How will referral compliance in the new model be managed?
- Is the new service model ‘prudent’?
- Are there sustainability issues and future risks in the new service model?
- Does the new service model mitigate the sustainability risks of the current service – can this be costed and added to benefits?
- Will there be a contingency or exit plan – what are the costs of either/both?

Are there several community/primary schemes that could stack up cumulatively to support more cash release or fixed cost release from acute?

5. ISSUES TO MANAGE

Financial & Technical

MEASURES & METRICS – The activity measures used to identify the activity shift (before and after) should be case mix specific where possible, they need to be costed using an accepted source (bottom up, cost returns, Albatross etc.). Examples of metrics would include HRG or by Point of Delivery (Inpatient, day case, outpatient) or could be by a whole service divided by volume, to establish a unit cost.

In addition the future service measures and metrics, whilst identifying the actual activity delivery volumes, should identify the wider benefit ‘impacts’. These need to be measured and financially valued and could be offsets to other departments. ‘Where’ they will emerge is critically important to demonstrate and obtain shared ownership and acceptance – this adds to the ‘Value’ of the service shift.

Examples could be performance improvement &/or demand management in terms of DToCs, bed day reductions, A&E presentations, MAU/SAU assessments, GP appointments avoided, transport costs avoided, etc.

Appendix 4 provides a template for benefit measurement.

RELEASE OF FULL COSTS – if agreement cannot be reached the recommendation is to apply the ‘Scampion’ rule and require full fixed cost release (or a portion of) phased over 3 years.

BACKFILL OF VACANT ACTIVITY after the ‘Shift’ – This spend must be subject to a separate and new business case for investment. Depending on the residual fixed costs in the acute department, investment should be at marginal values.

FUTURE DEMAND CHANGES – this needs to be considered in the plan, including the unintended consequences of non-compliant referral patterns and unexpected growth issues on acute and community/primary service, unmet demand may skew the expected outcomes and targets. A timeframe to review the financial transfer needs to be built into the plan, annually for 3 years may fit for major change plans.

DRUGS – where service shifts involve significant values related to drugs, specific analysis of purchase prices, volumes and prescribing costs need to be included. Opportunities around delivery models should be examined. The potential for future years cost avoidance is particularly relevant. The contracting model should be VAT efficient. Also the procurement model and potential loss of patent in the near future needs to be considered. This is a specific cost driver that would benefit from a 3 year review, especially as service shifts may result in high cost NICE or AWMSG drug pronouncements affecting the services. Key risks related to formulary compliance need to be managed.

Management & Operational

DELIVERING THE CASE – ideally the 2 (or more) departments should consider the evidence and the case and agree a reasonable transfer of funds (during implementation and recurrently). Mutual ownership and responsibility by all stakeholders is key to success in delivery (particularly clinical).

INCENTIVISING SHIFT – Both/all departments need to recognise the project management demand to implement the shift, this may need to be financially resourced. The acute department may be incentivised through; improved future sustainability, reduced service demand pressure, ability to focus on higher value areas of work (Prudent). If a financial benefit is expected of the shift, a financial incentive could be offered, e.g. Non-recurrent funding for equipment, training, or recurrent investment for staff, etc.

FUNDING SOURCES – it is recommended that opportunities to invest in the community/primary service should be sought from new funding wherever possible. This would help pump prime a new service and mitigate double running cost pressures.

Point of Note

Investment in community and therapy services to support Primary Care/GP practices, as part of the sustainability agenda, may require consideration of whether GMS funds or GP practices should be contributing to the costs of those support services.

6. WELSH GOVERNMENT

Allocation & Policy Context

Where a 'shift' into a new Primary Care service has been achieved Health Boards may wish to request an allocation adjustment to demonstrate and formally recognise the shift, in line with strategic policy direction. (e.g. HCHS to GMS).

7. CONCLUSION

This Framework aims;

- To provide NHS Wales Health Boards with a systematic process for supporting the shift of services and resources from acute to out of hospital care and ensure a fair financial shift follows the service shift.
- To ensure factors other than financial are included, which are critical to the successful operation of this framework and achieving financial shifts as intended. Specifically, the activity and benefit measurement and corporate governance approach required.

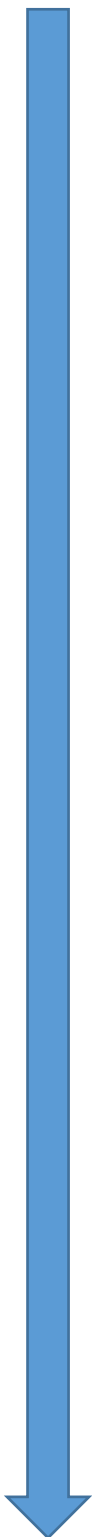











Appendix 1 – Simple Step Schematic

Appendix 2 – Example Timeframe for shift process & cost release

Appendix 3 – Primary Care Contractor – Pricing model for Primary Care Service

Appendix 4 – Benefit measures template

Appendix 1 – Simple Step Schematic

ORDER of Process	Current Acute Model	SHIFT TO	Future Proposed Model
	<p>What does it cost now?</p> <p>Which Costs can be released – fixed/semi/variable? Over what time frame?</p> <p>What are the Cost drivers?</p> <p>Will 'staff etc.' transfer?</p>		<p>What will it cost in future?</p> <p>What is the New service cost- Fixed/semi/variable? Non recurrent and Recurrent? Double running period & costs? What are the cost drivers?</p> <p>Transfer Offsets worth?</p>
	<p>What activity is delivered</p> <p>Describe the current patient pathway(s)</p>		<p>What activity will be delivered for shifted cohort in primary care? Describe the future pathway(s) How much is Replacement Activity? How much additional activity will be delivered? What activity will be left over in Acute?</p>
	<p>What is future demand growth estimates?</p>		<p>What is future demand growth estimates – primary & Acute</p>
			<p>Cash or Opportunity Cost Benefit from New Model?</p>
	<p>What is the IMPACT of current Model?</p> <p>What Benefit Measures are Used?</p>		<p>What is the expected IMPACT of Future Model: What Benefit Measures will be Used? What are they worth £? What Levels of Benefits are expected? & where will they materialise?</p>
	<p>What are limiting factors</p>		<p>How are limiting factors mitigated/improved?</p>
	<p>Sustainability risk now?</p>		<p>Acute residual sustainable? Primary sustainable?</p>
	<p>Current Quality/Outcomes in acute?</p>		<p>Patient Quality impact gain?</p>
	<p>Where is it planned the Acute service will be POST shift?</p>		<p>Assess Acute 'Fit' with New model & Technical efficiency gains achieved.</p>
	<p>Waiting times/list now?</p>		<p>Waiting times future – Acute & Primary</p>
	<p>What is Current Value Position?</p>		<p>What is Future Value Position? Will there be better outcomes for same cost or same outcomes for lower cost?</p>

NB. Red Arrows are critical reference points

Appendix 2 – Example Timeframe for shift process & cost release (Years are presented, but periods could be shorter)

Stage	Step/Year	Year -1	Year 0	Year 1	Year 2	Year 3
IDEA	Agree 'Idea' and drivers	X				
Feasibility	Feasibility check	X				
	Plan and Pathway - Current & Proposed	X				
	Activity Shift - Current to Future	X				
	Impact measures baseline & future	X				
	High level Resources assessment - current costs - variable, semi, fixed	X				
	High Level Resources assessment - future cost - releasable and transfer offset	X				
	Assess Demand Growth estimates - current & future	X	X	X	X	X
	Develop outline case	X				
FULL CASE	Detailed Activity Shift - OLD & RESIDUAL		X			
Jointly agreed	Shift plus NEW ACTIVITY IN FUTURE MODEL		X			
	Detailed estimates of IMPACT measurables - OLD & NEW		X			
	Financial costing analysis - unit costs - old & NEW		X			
	Set up and Double running costs		X	X		
	Impact measures baseline & future - COST analysis - cash/ avoidance/etc		X			
	Complete detailed business case - joint approval		X			
IMPLEMENT	Implement Service plan Shift			X		
	Implement financial plan shift - variable			100%		
	Implement financial plan shift - semi			50%	100%	
	Implement financial plan shift - fixed			30%	60%	100%
EVALUATE	Review & Evaluate activity/costs/impact -new compared to old and plan			X	X	X
	<i>NOTE: POTENTIAL FOR MANDATING FULL COST SHIFT AT 100% EARLIER</i>					
	<i>POTENTIAL FOR 'STACKING' CUMULATIVE EFFECT OF SCHEMES</i>					

Appendix 3 – Primary Care Contractor – Pricing model for Primary Care Service

Factors to consider when negotiating a Practice service price;

Has a rate been agreed elsewhere?

Does the service closely relate to a similar service already established which could provide a benchmark price?

What are the resources to be employed by the Practice:

- Direct Pay costs, by staff type, by time
- Direct Non Pay variable costs of consumables
- Equipment Costs – apportioned by expected activity (or one off purchase contribution – consider funding available in HB)
- Overhead Costs – contribution to premises and other overhead costs
- Set Up costs (non-recurrent)
- NOTE: Costs already reimbursed through the GMS contract should not be included

Are there costs to be borne by the Health Board in supporting the service? – relevant for cost comparisons.

What volumes are likely to be delivered, is there a need to factor in step fixed costs, semi variable costs as well as variable costs based on volumes? This may influence pricing.

Plus: Add a reasonable Profit Margin – dependent on market forces and need to incentivise.

The price should be locally negotiated and agreed consistently, consider liaising and negotiating with the Local Medical Committee as appropriate.

Appendix 4 – Benefit measures template

Benefit Profile

Administration	
Benefit Reference Number:	
Owner:	
Category:	Allocative Value

CURRENT STATE - ACUTE

Benefit Overview																	
Benefit Description:																	
Rationale:																	
Benefit Recipients:																	
Constraints/Assumptions:																	
Target:																	
Timescales:																	
Contribution to Strategic Goals:	<table border="1"> <thead> <tr> <th>Goal</th> <th>Contribution</th> </tr> </thead> <tbody> <tr> <td>Patient safety is increased</td> <td></td> </tr> <tr> <td>Positive patient outcomes increased</td> <td></td> </tr> <tr> <td>Healthcare system efficiency increased</td> <td></td> </tr> <tr> <td>Convenience of care is increased</td> <td></td> </tr> <tr> <td>Legal/policy compliance maintained</td> <td></td> </tr> <tr> <td>Patient confidence is increased</td> <td></td> </tr> <tr> <td>Overall health system costs decreased</td> <td></td> </tr> </tbody> </table>	Goal	Contribution	Patient safety is increased		Positive patient outcomes increased		Healthcare system efficiency increased		Convenience of care is increased		Legal/policy compliance maintained		Patient confidence is increased		Overall health system costs decreased	
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Convenience of care is increased																	
Legal/policy compliance maintained																	
Patient confidence is increased																	
Overall health system costs decreased																	

BASELINE - Measurement Overview	
Measure #1:	
Unit of Measurement:	N
Data Source:	
Collection Process:	
Collection Frequency:	monthly
Baseline Measurement Date:	
Measure #1 Cost Driver:	
Unit of Measurement:	£
Data Source:	
Collection Process:	
Collection Frequency:	Monthly
Baseline Measurement Date:	

FUTURE STATE - ACUTE

Benefit Overview																	
Benefit Description:																	
Rationale:																	
Benefit Recipients:																	
Constraints/Assumptions:																	
Target:																	
Timescales:																	
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FORECAST Measurement Overview	
Measure #1:	
Unit of Measurement:	N
Data Source:	
Collection Process:	
Collection Frequency:	monthly
Baseline Measurement Date:	
Measure #1 Cost Driver:	
Unit of Measurement:	£
Data Source:	
Collection Process:	
Collection Frequency:	Monthly
Baseline Measurement Date:	