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Additional actions taken to protect or improve providers' financial position

Report for Monitor

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Contents

1. Introduction

The health sector in England is facing significant financial and clinical challenges.

An important part of the solution is improved efficiency. A lever that has been used to drive efficiency in the sector is the efficiency factor in the nationally mandated prices, which is now the responsibility of Monitor and NHS England.

Historically, the efficiency requirement in the National Tariff has been in the region of 4% per year. A lot of providers have been unable to deliver this level of cost savings, but this has not been fully reflected in the financial position of many providers. This disparity suggests providers have been undertaking additional actions to protect or improve their financial positions.

To help understand the additional actions that have been taken by providers, and in some cases supported by commissioners and national bodies, we conducted 27 in-depth interviews in the sector during September 2014.

To get tangible data and develop sufficient insight from the interviews, they were conducted on an anonymous basis, following a hypothesis-driven approach. These hypotheses were designed to understand the main sources of additional actions, their growth and relative importance to providers. They are set out in the following section.

Further to our Methodology and Who We Interviewed sections, this report presents our findings in two main parts:

- **The drivers and enablers of additional actions (Section 4).** Examining the driving forces and enablers that lead providers (or providers and commissioners) to take additional actions other than efficiency to protect or improve the financial position of the provider.
- **Our detailed findings on the additional actions (Section 5).** A detailed look at the additional actions other than efficiency that providers (or providers and commissioners) are taking to protect or improve the financial position of the provider.

Conclusions are presented in Section 6.

2. Methodology

Our investigation into additional actions within the sector was driven by a hypothesis-led approach. After discussion, we developed the following three categories of hypotheses:

I. Actions that increase tariff income	II. Other actions that increase provider income	III. Actions that (artificially) reduce costs

• Provider gets better at securing best practice or other top-ups, such as through:
a) Improved coding
b) Improved delivery
• Provider gets better at reducing tariff penalties
• Provider seeks to increase activity for high margin services
	• Provider is receiving commissioner support
	• Provider and commissioner moving to new ways of contracting
	• Actions that result in cross-subsidisies within core activites including
	  • Income from non-PbR services used to support other services
	  • Training and education, R&D
	  • Private patient income
	• Provider seeks other new sources of income, such as commercial opportunities
		• Provider reduces its cost in ways unrealated to service delivery (e.g. seeks to change services so that it can benefit from VAT rebates on contracted out services)

To test these hypotheses, we conducted a series of in-depth, structured interviews with a range of providers and commissioners of health care (see Section 3 for a list of these).

Each interview followed a set structure but encouraged the interviewee to focus on areas that concerned them the most; there was significant engagement from interviewees and discussions for the most part exceeded an hour.

In total 27 interviews were undertaken (35% more than requested). 22 of these were undertaken in person at the organisation's premises. In all instances apart from two, interviews were undertaken with senior executives from the organisations – either the chief executive or FD.

While the interviews were qualitative in nature, it was important to gain quantitative insight to determine the magnitude, trends and composition of the most pertinent or significant additional actions. We therefore designed and distributed personalised response cards (see Figure 2) that allowed our interviewees to quantify aspects of their financial performance and clinical operations.

The respondent organisations have been anonymised from the notes presented in this report. This was outlined as an important feature of the work as it helped to get better information from organisations.

Figure 1: Interview process

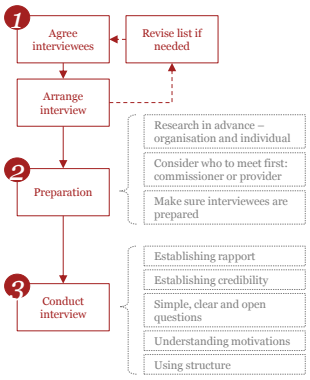
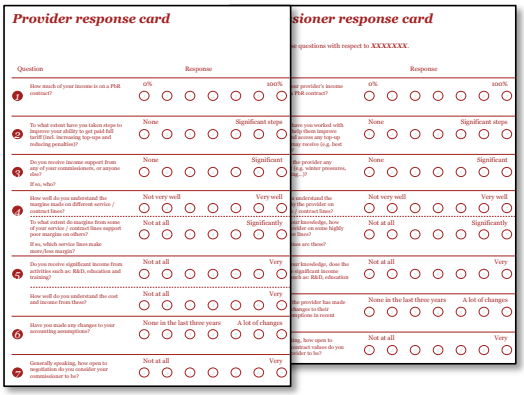


Figure 2: Response cards



3. Who we interviewed

We wanted a balanced, national sample of providers and commissioners that could really help us to understand the extent of additional actions in the sector. So our first priority was mapping a comprehensive series of health economies across England and, within each, speaking to those significant providers and commissioners whose data would yield tangible, representative insight.

The range of health economies we worked with were in London, the Midlands, the North and the South; in some cases they cross county borders (as displayed below). They included a mixture of providers and commissioners; within the provider segment we interviewed a mixture of providers (acute Trusts, and providers of specialist, community and mental health services) to get a balanced sample.

In total we undertook 27 interviews, the details of which are summarised in the table below; in 7 of the 8 health economies we met with providers and commissioners who shared a direct relationship.

- 27 interviews
- Senior executive grade
- A range of health economies
- 18 provider interviews with specialist acute Trusts, other acute Trusts, and non-acute Trusts
- 9 commissioner interviews
- Wide geographic coverage, from [redacted]
- Over 75% were conducted face-to-face

[redacted]

4. Drivers and enablers

The health sector is facing a large financial challenge, so it was clear that this was going to be one of the (if not the) main drivers of additional actions taken by providers (or providers and commissioners) at the outset of this work. It was also considered that a number of the additional actions would be accessible to organisations simply due to their unique position and / or as a consequence of some involvement from commissioners.

This section sets out in some more detail the financial pressures that came up in many of our interviews and also some of the evidence on the following enablers:

- Information gaps may allow a provider to improve its outcomes from settlement
- A provider with few competitors in a health economy (a degree of 'market power') may be able to use this to improve its terms and conditions
- Poor commissioning may weaken bilateral negotiations in favour of providers
- Commissioners may be explicitly collaborating with providers to help improve the terms and conditions for the overall health economy

This section sets out some of the evidence collected through the interviews in these different areas.

To preserve the confidentiality of the providers and commissioners, we refer to these by their assigned code – e.g. P1a represents one of the providers in Health Economy 1 ('a' signifies it was the first provider we spoke with in Health Economy 1), while C1 refers to the commissioner in the same health economy.

Providers are facing sig financial pressures

The increased financial challenge in th has been well documented and this wa with the financial position of many of organisations interviewed. Indeed, ev providers were only achieving a small Figure 3 on the right).

There were four driving forces that ca strongly in a number of interviews:

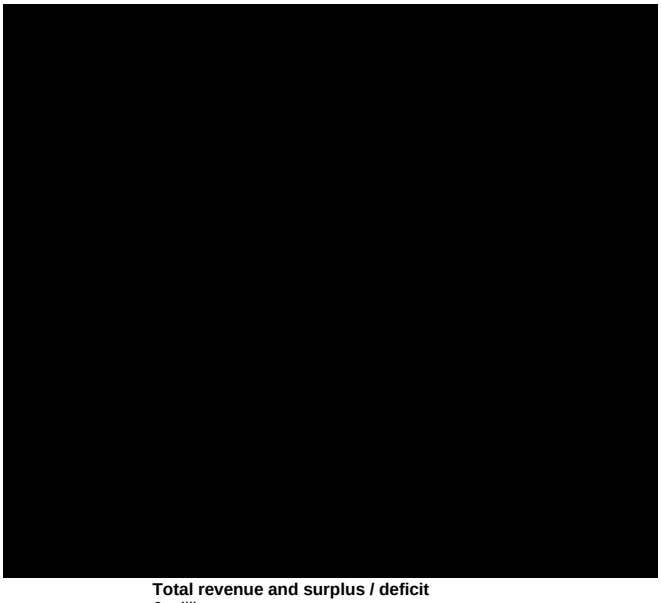
1. **Year-on-year efficiency.** Prov struggling to continue to deliver y efficiency targets of up to 4%. Pro P6c considered 1% efficiency to b doable, but anything higher to be especially when this was required This was echoed by a number of

2. **Staffing costs.** Substantial incr of staff due to: increased require particularly in the wake of the Fr (e.g. minimum staffing ratios); a increased reliance on agency staf economy, a provider reported a £ increase in agency staff costs, and many other providers that also found their agency staff costs to have increased significantly.

3. **Case mix.** In some areas, including Health Economies 1 and 4, less complex activity is being relocated to out of hospital settings. This means that within these hospitals the level of acuity may have increased, yet they are seeing maintained levels of activity - resulting in higher costs without improved remuneration under PbR (i.e. they argue that price does not reflect cost).

4. **PFI.** A number of trusts we interviewed faced considerable costs from PFI schemes. The high cost of servicing these schemes (the unitary charge) can have a significant effect on a provider's ability to make a margin on its activity. This included P1b and P5a.

While it is unclear how much of a provider's financial pressures are within their control (e.g. if they have an ability to improve the Terms and Conditions for existing staff to reduce the reliance on agency staff), it is clear that the majority of providers face substantial pressures that they are seeking to manage.



Total revenue and surplus / deficit
£ million

Source: Annual reports

[1] Guidance on safe staffing standards on services such as maternity are taking 'costs out of our hands', as suggested by P1b

Some providers are seeking to use information asymmetries and/or their strong bargaining position to create opportunities

Some providers have a position in their local health economy where commissioners and people that use health services have few alternatives. Some larger providers have this position in the national health economy.

While this position is not in and of itself a problem, it does create potential opportunities for providers to protect or improve their financial position through a range of additional actions that would not otherwise be available.

Additionally, there are frequent and significant information asymmetries (or gaps) between what a provider knows (or has the ability to know) and what a commissioner knows. This may result in a commissioner paying a higher price for a service than it would with greater transparency.

Set out in the points below are some of the examples from the interviews of the evidence that we consider support the existence of the above enablers:

- P1a, a large trust, reported having plans to continue to grow its activity (without regard for commissioner plans) and if needed would "run competitors into the dust" to win the activity.

- A commissioner (C7a) expressed concern over its own financial position, and a desire to move to new forms of outcome based contracting, but expressed despair over the willingness of the Trust to engage with the proposals that had been developed.

- A commissioner (C2a) that expressed concern over the value for money of a new service on a block contract, which they were unable to effectively monitor. Indeed, the commissioner had sought to micro-manage the resources being used for the service but was unsuccessful.

- A number of providers reported easier contract negotiations on contracts with locally negotiated prices than those with nationally set prices.

In some cases commissioners help promote additional actions

As set out above, some providers have been able to undertake certain actions as a result of information asymmetries or due to their position in a health economy.

It was also clear that, in some cases, providers were able to protect or improve their financial positions as a result of commissioner action (or inaction).

There are three ways that commissioners supported some of the additional actions:

- Explicitly supporting provider finances in the context of supporting 'health economy' finances;
- Not applying penalties; and
- Giving non-recurrent financial support to a provider to help their spending to match their budget ("land on the penny").

On the first point, many of our interviewees (providers and commissioners) reported on the idiosyncrasies of NHS England commissioning teams. It was clear that this sometimes translated to perceived weakness, particularly with some of the services where there have been the largest areas of growth, such as drugs and devices.

- A provider, P5a, described NHS England as potentially problematic because of a flawed contracting methodology and the fact budgets were allocated before they knew how activity would flow;
- A provider revealed a tension between the Trust and NHS England as both were focused on making their own savings; and
- A commissioner, C2a, was unhappy that they enforced CQUIN penalties but NHS England did not have the infrastructure to do the same. Provider P2a corroborated.

In addition, there were many examples where commissioners were actively supporting their local provider. Evidence to support this includes:

- A commissioner not imposing financial sanctions on Provider P5a;
- Commissioner C4a returning penalties from a financial sanction to a provider;
- A commissioner, C4b, providing surplus budget to a provider in the form of an end of the financial year loan (which was to be repaid in the new financial year);
- A commissioner, C6a, that provided additional income support (decoupled from any service delivery) to a provider; and
- A commissioner financing a local NHS Trust provider, P3a, for a non-recurrent 'transition' payment targeted at moving more care to the community (although no clear KPIs had been assigned to the funding).

The impact of the direct non-recurrent support (both local and national) from providers is shown in the figure below. This shows that the removal of direct commissioner support would result in 5 of the providers we interviewed moving into deficit in the last financial year.

Figure 4: Comparing a provider's FY 13/14 surplus / deficit (top number) with their financial position when centrally funded initiatives and local support are removed (bottom number)

Source: Interviews and annual reports

Figure 5: How enablers can be mapped to the additional actions

		Market position	Information asymmetries	Weak commissioning	Close relationship with commissioner
Actions that increase tariff income	Provider gets better at securing best practice or other top-ups	○	○	◑	○
	Provider gets better at reducing tariff penalties			○	◑
	Provider seeks to increase activity of high margin services	●	○	○	
Other actions that increase provider income	Provider receives commissioner support	◑	○		●
	Provider and commissioner move to new ways of contracting				◑
	Actions that result in cross-subsidies within core activities	◑	◑	○	
	Provider seeks other new sources of income, such as commercial opportunities	◑			
Actions that (artificially) reduce costs	Provider reduces its costs in ways unrelated to service delivery	●		◑	○

Key

● Evidence ◑ Some evidence ○ Limited evidence

Source: Interviews and annual reports

5. Detailed findings

Driven by our hypotheses, over the 27 interviews we identified a large range of additional actions that providers and commissioners have taken; we have sorted these insights into three main categories of additional actions, as outlined below.

Figure 4 overleaf shows the relative importance of the different actions that we identified. Section 6 then outlines our conclusions.

The three key sources are summarised below. Further detail is provided for each in the following section.

1. Developing the Trust's margins

a) **Activity growth.** If providers focus activity growth on high margin services, other services and activities are cross-subsidised.

b) **Improved coding.** Increasing the 'depth of coding' of activity that is undertaken to get the 'right' price (often higher than the original).

c) **Improved delivery.** Identifying areas where there are best practice Tariffs or CQUINs and improving the delivery in order to get paid for these (e.g. getting JAG accredited for endoscopy). This would also include seeking to reduce the amount of sanctions that may be applied by commissioners (see also local commissioner actions below).

d) **Training & Education, Research & Development.** Incomes for these activities are often significant and may be greater than the actual cost of provision.

e) **Private patient income.** Incomes for these activities are often significant.

f) **Balance sheet management.** There are a number of actions that can be done to a balance sheet that provides a one-off positive effect on income, such as stretching payables or deferring costs.

g) **Commercial and charity income.** Better utilising assets to grow commercial income, such as from car parking or telehealth services.

h) **VAT changing.** The structure of service delivery to benefit from VAT exemptions on contracted out services (e.g. pharmacy).

i) **Local prices.** Increasing margin through higher locally agreed prices.

2. Centrally funded support

a) Centrally funded/driven support for providers in general:

- **Winter pressure/resilience funding.** Annual non-recurrent payments to help providers manage the increased costs associated with higher winter demand.
- **RTT funding.** Annual non-recurrent funding to help reduce the Referral To Treatment times across the health sector.

b) Centrally funded support for specific organisations:

- **Project Diamond.** Large non-recurrent funding for London teaching hospitals to fund the increased complexity of their case mix.
- **Public Dividend Capital (PDC).** Cash support to providers with troubled finances in the form of cheap loans. While this does not directly impact surpluses and deficits, it does reduce the potential cost of borrowing.

3. Local support from CCGs

a) **Contract sanctions.** When commissioners either do not charge these ("penalising a troubled service will make things worse") or returning financial sanctions as investment in the provider.

b) **CQUIN.** Award of CQUIN payments even when targets are not met by the provider.

c) **Investment.** Commissioners 'investing' in the provider to help make sure they remain a viable entity. This may also include funding that is paid by commissioners to help them land on their budget position.

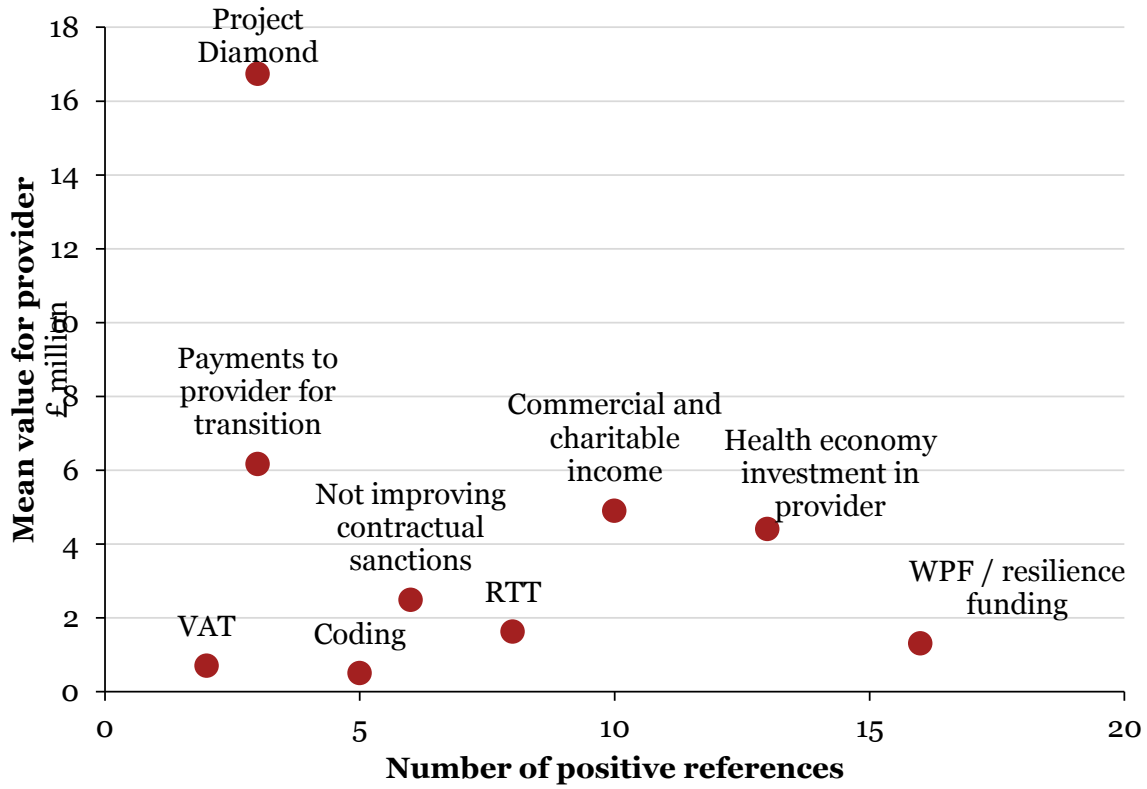
d) **Transition.** Commissioners paying providers for a 'transition' from their current system to a new one (e.g. linked to reducing bed numbers).

Figures 6 and 7 (below) present a summary of the outputs from our interviews. They show the number of (positive) appearances of the source and also the average amount reported. Please note that not all sources of additional actions from Figure 6 are mapped to Figure 7 as some actions cannot be quantified.

Figure 6: Summary of the frequency and value of additional actions

Source	Number of positive references #	Mean value for provider £ million
Developing the Trust's margins	**16**	**5.1**
Improved coding	5	0.5
Cross-subsidies between different services	12	NA
Training & Education, Research & Development	3	NA
Private patient income	7	NA
Commercial and charity income	10	4.9
VAT	2	0.7
Centrally funded / driven support - general	**16**	**2.1**
Winter pressure / resilience funding	16	1.3
RTT funding	8	1.6
Centally funded support - specific organisations	**6**	**16.7**
Project Diamond	3	16.7
PDC	3	NA
Local support from CCGs	**15**	**6.0**
Not imposing contract sanctions	6	2.5
Paying CQUIN regardless	2	NA
Health economy investment in provider	13	4.4
Payments to providers for transition	3	6.2

Figure 7: The average value of additional actions to providers



Source: Interviews conducted by PwC and Swan Partners throughout September 2014

Note 1: Aggregate data in this figure has been calculated based on the total value of each source, divided by the total number of providers that report this income.

Note 2: Some providers within this sample will receive multiple sources of income. Where we didn't have a value, these sources were omitted from our calculations.

1. *Developing the Trust's margins*

Introduction

There are a broad range of actions that providers are taking to secure their financial sustainability. These range from increasing activity paid at a price above marginal cost through to developing new commercial opportunities, such as charging for baby scan prints.

Key sources

a) Activity growth (e.g. on high margin activity)
b) Improved coding
c) Improve delivery
d) Training & Education, Research & Development
e) Private patient income
f) Balance sheet management
g) VAT
h) Commercial and charity income
i) Locally negotiated prices

Key characteristics

- Sums of money are generally small compared to clinical income, but contributions can be significant
- There appears to be a move towards new income and better commercialisation of existing assets

Observations

- As discussed in section 4, the scope for increasing income (and margin) from activity growth appears to have declined in most health economies as commissioner finances have tightened. The exception is for some of the larger specialist Trusts that are still seeking to actively grow their activity. For example, a large provider identified increasing activity as 'key to [their] success'
- Most Trusts are now looking to generate income from a range of additional sources
- Most organisations were open about cross-subsidies between service lines, but none admitted making margins on T&E or R&D
- Some sources of additional income may be questionable, such as outsourcing services that then benefit from greater tax efficiency (e.g. claiming back VAT from outsourced pharmacy functions)
- The biggest areas of growing importance for providers were commercial and charitable income, followed by private patient income

a. Activity growth

Increasing activity can help providers to generate more income (e.g. to the PbR tariff. Where this is at a marginal cost less than Tariff, it can generate significant income.

In most of the health economies this source of additional funding appears to be limited in aggregate due to increased financial pressure on commissioners. But there are some (high margin) service lines where providers do appear to have focused growth.

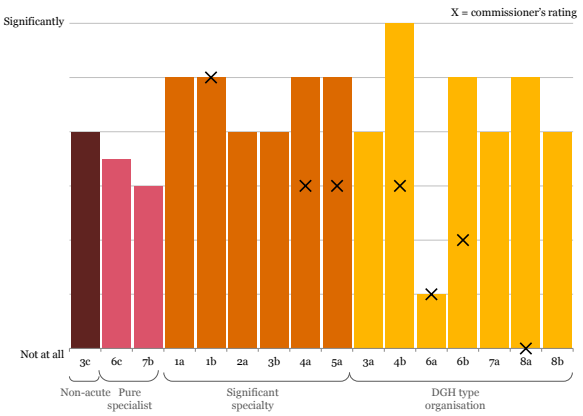
Providers were very clear that this does happen – this was validated both in interviews and also in response cards (see Figure 8).

While it is unclear how significant these cross-subsidies are, there were some commonly cited 'winners' and 'losers' – see Table 1 below.

Table 1 – Winning and losing service lines

Winners	Losers
• The 'ologies'	• General surgery
• Simple orthopaedics	• A&E
• Dermatology	• Renal

Figure 8: Response card question 4b – Providers - To what extent do margins from some of your service/contract lines support poor margins on others? Commissioners - To the best of your knowledge, how reliant is the provider on some highly profitable service lines?



Source: Provider and commissioner response cards
Note: (1) Y-Axis shows the values respondents gave when asked to score their response along a 1 to 7 range.

b. Improved coding

Improving the 'depth of coding' can help providers to identify a gap in the money they receive over what they could be paid.

This increase in price is not associated with any additional activity, but the quality of data would likely increase.

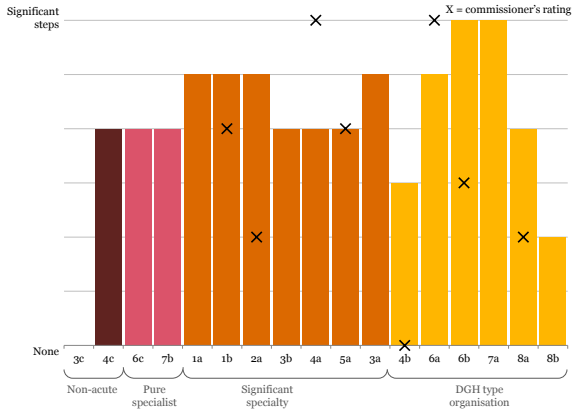
While this has been the big focus of a number of organisations (as evidenced by both interviews and the response cards – see Figure 9 below), providers suggest they are now focusing on commercial income instead.

Vignette: P4a and C8a

Increased granularity might aid providers, although another – P5a – argued that complex work (liver, in this instance) can be delivered without being mapped through to complex coding, which means full cost recovery isn't achieved

Figure 9: Response card question 2 – Providers - To what extent have you taken steps to improve your ability to get paid full Tariff?

Commissioners - To what extent have you worked with the provider to help them improve their services and access any top-up payments they may receive (e.g best practice tariffs)?



Source: Provider and commissioner response cards
Note: (1) Y-Axis shows the values respondents gave when asked to score their response along a 1 to 7 range.

c. Improved delivery

Improving the quality of delivery can help providers to get paid best practice Tariffs or CQUINs.

In interviews, a number of providers discussed the efforts they have undertaken to ensure they can access these additional payments.

Vignette: P1a

CQUINs represented [redacted] of their income

d. Training & Education, Research & Development

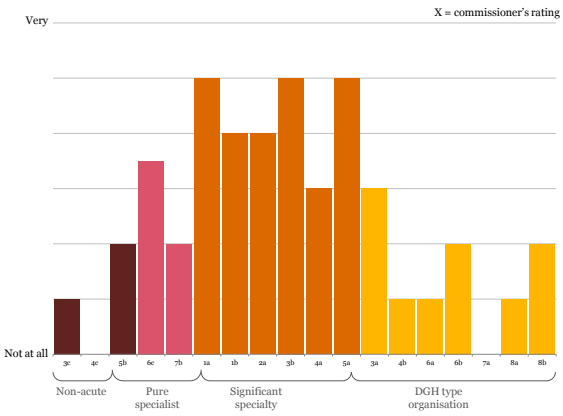
An often cited source of positive contribution was income from training & education and research & development. These were also referred to in interviews with respect to 'other organisations' that apparently make significant margins from these areas.

Although there were a number of providers that reported receiving income from these areas, while also understanding the cost of providing these services, none claimed to make significant margins.

Vignette: P3b

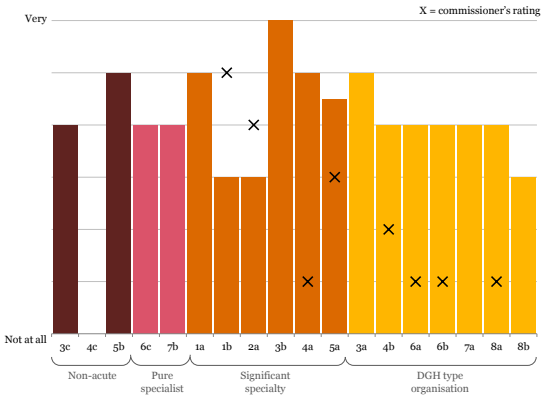
The move to the new Tariff for T&E is reducing surplus (often to the tune of millions for teaching hospitals), but Project Diamond is easing the burden for London teaching hospitals affected by the switch.

Figure 10: Response card question 5a – Do you receive significant income from activities such as: research & development, education & training?



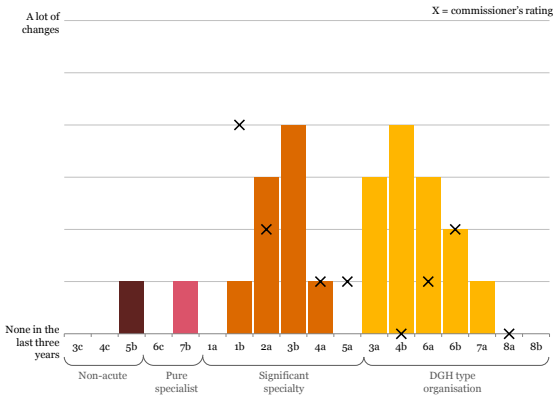
Source: Provider response cards
Note: (1) Y-Axis shows the values respondents gave when asked to score their response along a 1 to 7 range.

Figure 11: Response card question 5b – How well do you understand the cost and income from these?



Source: Provider and commissioner response cards
Note: (1) Y-Axis shows the values respondents gave when asked to score their response along a 1 to 7 range.

Figure 12: Response card question 6 – Have you made changes to your accounting assumptions?



Source: Provider and commissioner response cards
Note: (1) Y-Axis shows the values respondents gave when asked to score their response along a 1 to 7 range.

e. Private patient income

Private patient activity can bring in additional income although magnitude depends on a range of factors (e.g. available capacity).

Seven providers reported significant private patient income, and a number of others (acute and non-acute) were looking to grow in this area.

The total value of private patient income for providers interviewed was £74.6 million, across 7 of the providers interviewed.

Vignette: P3b

Private patient income growth of c. 33% in 2014/15 to almost [redacted]

f. Balance sheet management

There are a number of balance sheet actions that will provide a one-off positive effect on income. These include:

- Stretching payables
- Deferring costs
- Changing depreciation assumptions
- Revaluing inventory
- Changing pension assumptions
- Capitalising expenses

There were some examples of this, but these were not significant. In any case the 'benefit' would only be a one-off impact. This was supported by the response cards.

g. VAT

A couple of providers reported changing their service structure to benefit from the VAT exemption that NHS providers benefit from on contracted out services.

The main examples of these were of two providers that had done this for their pharmacy services.

h. Commercial and charitable income

A number of providers reported seeking additional income from commercialising various aspects of their business. These included a wide range of schemes, such as:

- Car parking
- Earned income from Trusts' charitable foundations (c. P5a, P6c, P7b)
- A new business venture offering Telemedicine to nursing and care homes
- Innovative targets for departments – e.g. selling maternity scan photos
- Putting aerials on top of hospital roofs and leasing them to telecommunications firms

These schemes represent a growing area for a number of Trusts.

Vignette: P2a

This Trust receives [redacted] **per year** in car parking revenue

i. Locally negotiated prices

A number of providers reported "easier" contract negotiations on services that were not on national Tariff.

This may reflect the greater negotiating ability on services where providers can benefit more from holding better information.

Vignette: P2a

30% of the Trust's income is on local prices, although the commissioner is driving a gradual transition to national tariff

Case study

Small DGH that is coterminous with its CCG and, while facing financial challenge, has used a wide range of additional actions to keep itself in balance.

- FY14 revenue of [redacted], of which [redacted] is from their lead CCG
- Small surplus in FY14, despite significant impairment
  - Lead commissioner thinks that Trusts are good at maximising revenues but not profits; their local market power and relative autonomy gives them an upper hand in negotiations
- 87% of income from PbR; Trust often gets this paid in full and receives Best Practice top-ups
  - Their lead commissioner is concerned, however, that the Trust is unwilling to agree any kind of risk-share arrangements or new commissioner contracts
  - Some contracts may be 'new money for old rope' – and the commissioner admits that they do work with the Trust so that they 'land on the penny' (Winter Pressure Funding and non-recurrent subsidies)
- Remainder of income from non-PbR sources: including Telehealth [redacted] and community service contracts [redacted]
  - Telehealth may only generate a small amount of income but there is also a cost saving from reducing admissions from local nursing homes
- Trust collects information through SLR but not PLICs
  - Lead commissioner doesn't think the Trust are as open as they could be
- Trust activity has been flat for elective activity, but non-elective activity has increased significantly over the past few years (c. 4-6% p/a); significant cost in terms of lost revenue from the marginal rate on non-elective activity.

2i. Centrally funded programmes

Introduction

There are a number of centrally funded schemes that help financially support providers. These schemes are generally small in value (c. £1m-2m), but have become critical to Trusts both in terms of financial health and crucially in terms of planning, as many now budget for these amounts.

Key sources

- Winter pressure funding, now known as resilience funding
- Referral to Treatment Time funding

Key characteristics

- Funded centrally by the Department of Health and NHS England
- Relatively small sums of money
- Not clearly linked to service delivery or change, but rather to temporary 'pressures' on the system

Observations

- Growing reliance on non-recurrent funds
- Expectation of 'the centre' providing support when needed, which is unrelated to efficiency or service transformation
- RTT fund has been considered 'a reward for poor performance'
- Some Trusts appear to have started to plan to receive the income in their annual planning, while others feel they could get better value if they knew the funds were coming

a. Winter pressures/resilience funding

In 2012 the Department of Health released funding to help health systems cope with greater demand from bad winter weather.

In FY14, this funding was allocated by the Department of Health, although this year FY15 the funds are being channelled through CCGs as 'resilience funding'.

Most of the organisations we interviewed received this funding, although the quantum varied both in the absolute and % (see Figure 13).

While this funding is non-recurrent, in many cases Trusts have started to plan for a level of income around the same level as in previous years. This planning assumption may be at odds with some of the plans being considered by commissioners who in a number of areas are considering different uses for the fund, such as to support community services with out of hospital programmes.

A number of Trusts considered that the money could be used more effectively if it was recurrent and allowed them to plan.

b. RTT (Referral To Treatment) funding

A key performance metric is the 18-week RTT target. In recent months, meeting the RTT target has been particularly challenging for many organisations across the NHS. To help improve delivery, central funds have been made available for RTT funding.

It is unclear that the funding is linked to the delivery of change. Rather, the funding has helped organisations to maintain their work load.

One complaint from a number of Trusts was that 'organisations performing worse' on the metric received greater amounts of funding - this link between 'poor performance' and 'higher payments' was considered perverse.

Figure 13: Resilience/RTT funding received FY 13/14

Source: Provider response cards

2ii. Central support to specific organisations

Introduction

There are a few examples where spec
organisations have received significa
the Department of Health or NHS Er
there are two types of organisation th
support: organisations in severe fina
and organisations that are considere
the high complexity of their case mix
common than some other sources of
income, as our data analysis shows, t
very significant where it occurs.

Key sources

- Project Diamond funding
- PDC cash injections to struggling organisations

Key characteristics

- Funded by DH and NHS Englan
- Very large sums of money involv

Observations

- Trusts are reliant on the funding which would be likely to cause si detorioration in their financial h
- The methodology for the calcula funding/support is not clear, so it is uncertain how this funding is determined and / or whether its level is linked to robust calculations
- These large sums of non-recurrent support could create significant financial risk if they were quickly reduced or removed

a. Project Diamond funding

Project Diamond funding was introduced to address the needs of certain specialist Trusts in London which have a 'more complex than usual case mix' (P1a).

We interviewed three organisations who were in receipt of Project Diamond funding. They received over £16m on average.

[2] Defined as being in sustained annual deficit.

In addition to being significant, London providers are increasingly reliant on this income. Its removal would, in most cases, result in those organisations in financial surplus moving into deficit – see Figure 14.

Figure 14

Source: Interviews and annual accounts
Note: Figure shows financial position before and after PD funding and does not include any reduction in costs.

b. PDC cash injections to struggling or failing organisations

Public dividend capital (PDC) support is significant both in the scope and manner in which it is distributed from the centre to its recipient organisations. It can entail large sums of money and the fact that it is paid as cash support means that it doesn't appear on a Trust's income & expenditure (I&E) statement. Rather, it is designed to be a loan of sorts, whereby the organisation can leverage the support against its ongoing financial difficulties or particularly complex case mix.

3. Local support from CCGs

Introduction

Most providers and commissioners reported having good relationships – this was evident in many of the interviews and also in the response cards. These good relationships appear to be resulting in some non-recurrent support from commissioners to providers as 'health economy investment' or 'transition funding'. While potentially good investments, it is not clear how these funds are actually being used by providers.

Key sources

- CCGs not imposing financial sanctions on Trusts, or sanctions later being returned as investment in the local health economy
- CCGs investing year-end surpluses into Trusts
- Transition payments to support change

Key characteristics

- This type of financial support appears to be a function of: (1) provider financial need; and (2) commissioners' financial ability to pay
- While support accounted for less than 5% of each provider's FY 13/14 revenue, providers did appear to be reliant on this support, which by its nature is non-recurrent.

Observations

- The payment of this local support is usually clearly related to some expected change, but it is unclear if this happens
- There is a risk that sums of non-recurrent support could in some cases be considered a state aid and challenged by an independent organisation
- Generally related to provider need and commissioner ability to pay. More financially challenged commissioners are less likely to provide support of this nature

a. Not imposing financial sanctions

Under existing payment systems, there are a number of sanctions that commissioners can levy on providers that do not deliver against key metrics.

Six health economies reported that they did not charge/were not charged financial sanctions as 'it did not make sense to fine a service that was struggling'.

Equally, in some cases providers were paid CQUIN income when they had not achieved the targets.

b. Health economy investment

Five providers reported receiving 'investment' from their lead commissioner.

These investments were usually paid to the provider to support their continuity or as a result of surplus funding available to the commissioner (support funding).

In the interviews it was apparent that these income streams were both non-recurrent (as they depend on funds available to commissioners) and also not clearly linked to service improvement or change.

Investing in health economies was corroborated by the response cards collected from providers. Figure 15 shows relationships between: 'providers reporting good relationships with commissioners'; 'providers receive support from local commissioners' and provider surpluses / deficits.

In addition to provider financial need, a reported driver for this was to help the commissioner 'land on the penny' of their 1% surplus target.

Figure 15: Perceived quality of provider-commissioner relationships by providers, compared with the amount of commissioner support received and the provider's FY 13/14 financial position

Source: Provider response cards and FY13/14 accounts

Note: The size of the bubble is equal to the size of the surplus / deficit. Surpluses are in grey, deficits in red.

c. Transition funding

In addition to (or instead of) health economy investment, a number of providers/commissioners reported the payment of transition funding.

This funding was usually earmarked to fund the transition from one care setting to another, or for some other change to take place.

Case study

Large Foundation Trust that has started to explore new income generating opportunities in recent years.

- Provider had FY14 revenue of [redacted]; deficit of [redacted], but seeking a surplus of [redacted] in FY15
- Vast majority on PbR, with c. 30% local prices for the remainder; transition to national tariff
- Several different sources generate commercial income for the Trust: [redacted] from private patients, [redacted] from car parking, and [redacted]
- Possible instances of cross-subsidisation between services – maternity and children's health are the most profitable service lines, whilst general medicine, surgery and cancer care made losses.
  - Individual departments are given objectives to grow revenue and commercial income
- Trust has a gain-share agreement with their commissioner on drugs: makes the FT c. £1m p/a
- They outsource pharmaceutical functions for VAT benefit: c. £1m p/a
- The CIPs target is [redacted] and has moved from a 70:30 split of cost to income to a 50:50 split. DoF expects length of stay schemes to become cost saving at some point
- Trust receives funding despite missing agreed targets (£3m should be deducted but has been waived)
- Trust receives centrally funded money for training, although they make a loss. The FT is a major training hospital, receiving c. [redacted] p/a. However, it 'costs [redacted] to provide [redacted] worth'
- Trying to reduce outpatient appointments by replacing with telephone follow-ups (25% of cost). However, commissioners are resisting paying for this

6. Conclusions

As outlined at the start, the sector faces a significant financial challenge and this was reflected in many of the interviews we conducted.

We set out to test a number of hypotheses (set out in Section 2) through a range of provider and commissioner interviews. These interviews identified a number of things:

1. The drivers and enablers of additional actions to protect provider finances; and
2. The range of additional actions being pursued by providers and commissioners.

As set out in Section 4 there are a number of drivers and enablers of additional actions. Providers and commissioners reported that financial pressure is driving providers to identify additional actions they can take to shore up their financial position. Most, if not all, of the providers we met have to some extent been able to use their position (where few if any alternatives exist) to enable some of these additional actions and in a number of cases commissioners have collaborated in these actions.

Through the interviews we also established support for a range of the hypotheses we set out to test. The table below summarises the evidence for these based on the interview findings.

There are a number of key findings from our work. These are set out on the following page.

Figure 16. Support for hypotheses from interview responses

Key

- ● Strong evidence
- ◑ Some evidence
- ○ Limited evidence

Hypotheses	Evidence from detailed interviews: Developing the Trust's revenue streams									Centrally funded				Local support		
	a.Activity growth	b.Improved coding	c.Improve delivery	d.Training & Education, Research & Develo	e.Private patient income	f.Balance sheet management	g. VAT	h.Commercial and charity income	i. Locally negotiated power	a.Winter pressure / resilience funding	b.RTT funding	c.Project Diamond	d.PDC (cash support)	a.No charging of contract sanctions	b.Health economy investment	c.Transition funding
I. Actions increase tariff income																
Provider gets better at securing best practice or other top-ups																
a)Improve coding		◑														
b)Improve delivery			◑													
Provider gets better at reducing tariff penalties														◑	◑	
Provider seeks to increase activity of high margin services																
II. Other actions that increase provider income																
Provider is receiving commissioner support									○	◑	●	●	●		●	
Providers and commissioners moving to new ways of contracting									◑							●
Actions that result in cross-subsidisies including																
a) Income from non-PbR services used to support other services	●								●							
b) Training and education, R&D				○												
c) Private patient income					○											
Provider seeks other new sources of income, such as commercial opportunities								●								
III. Actions that (artifically) reduce costs																
Provider reduces its costs in ways unrelated to service delivery						○	●									

The importance of (or reliance on) non-recurrent support

Support – whether centrally or locally funded – is being used to support the delivery of all manner of provider services. The level of support is significant in some cases and 8 providers we interviewed would have been in deficit in FY13/14 without it.

It is somewhat concerning that a lot of the support mentioned in interviews was not clearly linked to any tangible outputs or changes – rather it was non-recurrent support that was not linked to any tangible change.

Changing dynamics between provider and commissioner relationships

Collaboration between providers and commissioners may not always be born out of necessity, but we are seeing more collaboration. Sometimes this greater collaboration can be due to personalities, historic PCT/provider ties, a sense of mutual obligation for the greater good, or simply an acknowledgement from one side (usually the commissioner) that collaboration is unavoidable given the other's importance.

An increase in commercial income

Commercial income has become relatively more attrractive, not just for distressed (or pessimistic) Trusts, but also for those who are in a stable financial position. This is due to some of the challenges with cost reductions. As such, we believe that it is being seen by the sector as an important element for cost-saving challenges: whereby the impetus to cut costs can be offset, as part of CIPs, by a commitment to grow non-clinical income. And here, as evidenced in our research, commercial income is seen as a popular and relatively dependable means by which a Trust can quite easily expand its revenue base through a few simple (and repeatable) measures.

There is a need for greater transparency

Some of the additional factors outlined above are appropriate and may represent solutions that could endure and support long term financial positions. Telehealth and the pursuit of other viable commercial opportunities are good examples, and they may also benefit patients. Other additional actions, such as non-recurrent support packages, are less clearly linked to delivering a tangible short or long term benefit for patients or improving the long term sustainability of the provider, so there is a need for greater transparency to recognise when these actions occur.

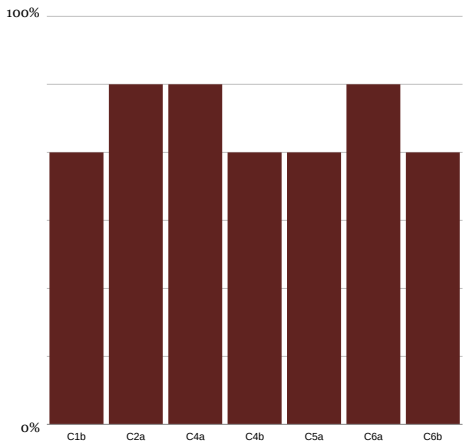
Appendices

Appendix A: Summary of commissioner responses

This appendix presents all of the data from the commissioner response cards. This is included to compliment the charts in the main report, which cover all of the provider responses. Sometimes a commissioner did not give a response for a particular question.

Figure A1 – Commissioner responses

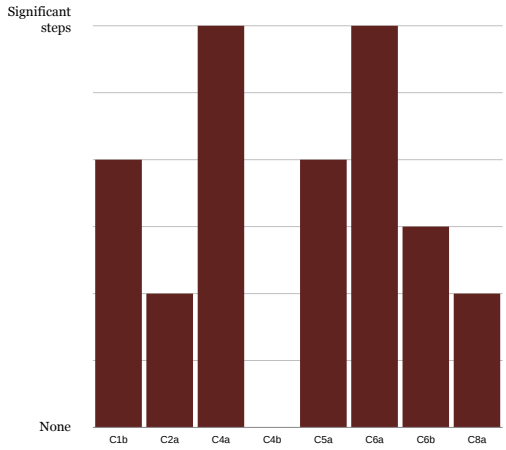
1. *How much of your provider's income from you is on a PbR contract?*



Note: Y-Axis shows the values respondents gave when asked to score their response along a 1 to 7 range.

Figure A2 – Commissioner responses

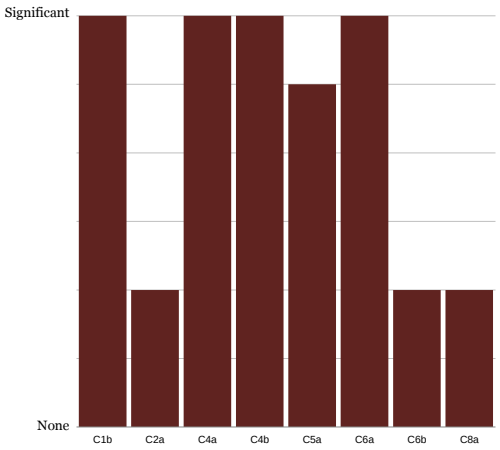
2. *To what extent have you worked with the provider to help them improve their services and access any top-up payments they may receive (e.g best practice tariffs)?*



Note: Y-Axis shows the values respondents gave when asked to score their response along a 1 to 7 range.

Figure A3 – Commissioner responses

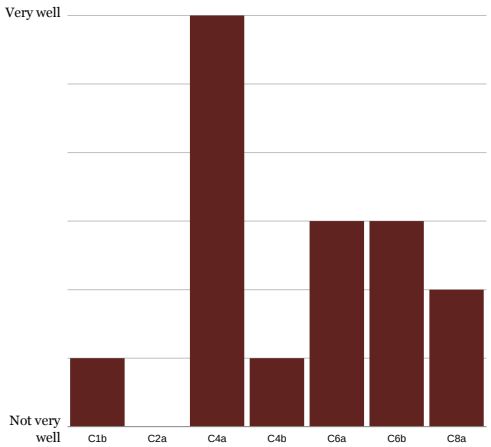
3. *Have you given the provider any income support (e.g winter pressures, transition funding…)?*



Note: Y-Axis shows the values respondents gave when asked to score their response along a 1 to 7 range.

Figure A4 – Commissioner responses

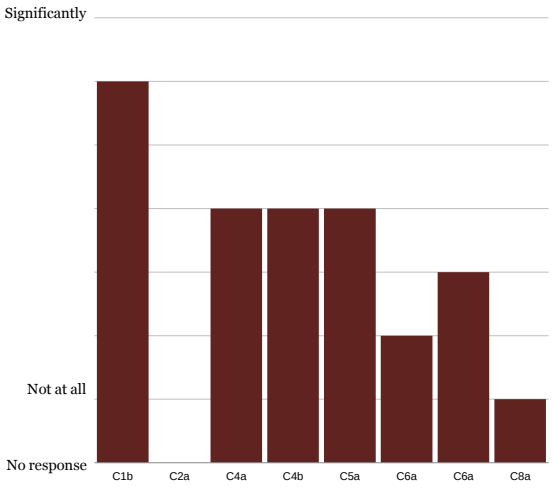
4. *a) How well do you understand the margins made by the provider on different service / contract lines?*



Note: Y-Axis shows the values respondents gave when asked to score their response along a 1 to 7 range.

Figure A5 – Commissioner responses

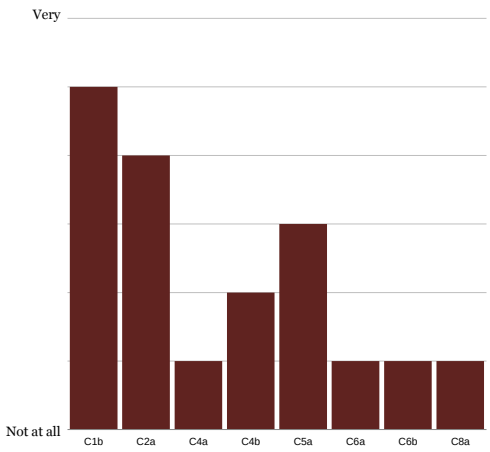
4. b) To the best of your knowledge, how reliant is the provider on some highly profitable service lines?



Note: Y-Axis shows the values respondents gave when asked to score their response along a 1 to 7 range.

Figure A6 – Commissioner responses

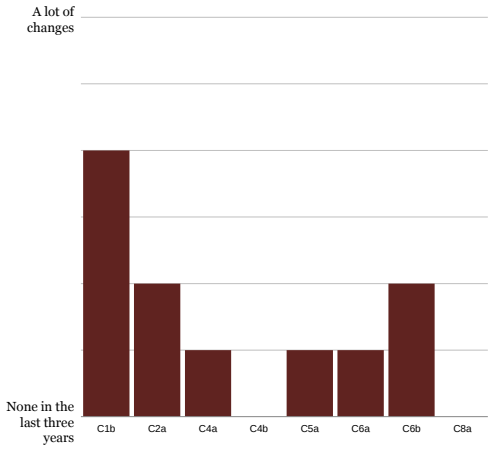
5. To the best of your knowledge, does the provider receive significant income from activities such as: R&D, education and training?



Note: Y-Axis shows the values respondents gave when asked to score their response along a 1 to 7 range.

Figure A7 – Commissioner responses

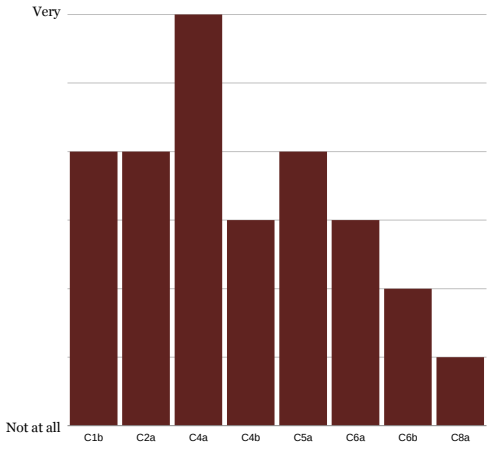
6. *Do you know if the provider has made significant changes to their accounting assumptions in recent years?*



Note: Y-Axis shows the values respondents gave when asked to score their response along a 1 to 7 range.

Figure A8 – Commissioner responses

7. *Generally speaking, how open to negotiation on contract values do you consider the provider to be?*



Note: Y-Axis shows the values respondents gave when asked to score their response along a 1 to 7 range.

Appendix B: Note summaries from 27 interviews

Please refer to the enclosed document for this appendix.

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