10 Year Health Plan working group: finance and contracting

Co-chairs' report

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Background

The 10 Year Health Plan will help the government to achieve its Health Mission and deliver a health and care system that is sustainable and fit for purpose for 2035 and beyond. The central ambitions of the plan will include helping people stay healthy and manage their health in a way that works for them, providing accessible and high-quality care, ensuring people's care is centred around their needs and guaranteeing that people are treated in a fair and inclusive way.

Introduction

Context and purpose of this report

Financial flows and payment mechanisms play an important role in enabling high quality and efficient health services. At the moment they are fragmented and therefore can be a barrier to providing joined up patient care.

Our report sets out a range of options for the financial framework, intended to meet the objectives of the 10 Year Health Plan as well as government's ambitions around the delivery of constitutional standards, better service integration, inequalities in healthcare access and delivery, better access to primary care, prevention, financial stability and overall increase in healthy life expectancy.

The working group has agreed to adopt a segmentation approach to the development of recommendations. This approach aims to better address the health care needs, priorities and circumstances of identified cohorts of patients and will therefore optimise health outcomes, patient experience, efficiency and care costs which are all central elements of the desired end state.

In developing our recommendations, we have also tried to recognise that financial flows and incentives are one of a range for tools for influencing the behaviour of systems, organisations, teams. Other levers such as regulation, training and clarity of care model will need to be aligned and combined with financial levers to drive the expected changes.

The first step that the working group took, was to engage with recent analysis and research, such as the Lord Darzi's independent investigation of the health system (2024), to get a shared understanding of the core set of high-level challenges that any 10-year vision for the NHS must address. This helped to further identify NHS endogenous obstacles behind some of those issues and the patient groups facing both poor outcomes and experience of care as a result.

In response, the group saw its role as considering the range of potential changes to financial flows (both in revenue and capital allocations), incentives and rewards (both revenue and capital) that could help drive clinical and organisational behaviours towards improved outcomes and experience for those population and patient groups. There was agreement in the group that financial flows and incentives are most effective when influencing allocative efficiency and productivity, while quality of care will be better improved through peer review, clinical audit, regulatory oversight of professionals and organisations. The group also agreed that changes are always more effective when targeted at clinical behaviours and endeavoured to develop proposals which would reach that level.

High level challenges facing the NHS

The Lord Darzi's independent investigation of the NHS (2024) has helped draw a comprehensive and undisputed list of challenges facing the NHS along with their key drivers.

While some of those challenges have emerged from the pandemic, most of them are not new and would require a multidimensional response, including financial and contracting and policy changes.

The set of high-level challenges presented in the section are driven, at least in parts, by central NHS blockages that our conclusions and recommendations will aim to tackle.

Low public and patient satisfaction with the NHS

Findings from the latest British Social Attitudes survey (National Centre for Social Research, 2024) showed that public satisfaction with the NHS had fallen to its lowest ever level, with long delays to access care as the top reason for growing frustration with the health service. Fewer than 1 in 4 (around 24% of people) were satisfied with the NHS in 2024, a drop of 29 percentage points since 2020 which was unprecedented.

The Darzi investigation (2024) also revealed that the number of patient complaints was increasing, while patients are feeling less empowered to make choices about their care.

Poor health outcomes from major conditions and widening of health inequalities

Recent research (Marmot and others, 2020) showed that after decades of increases, the UK experienced a reverse in life expectancy improvements between 2010 to 2019. While many countries experienced a similar trend, the speed with which the UK experienced this regression makes it an outlier amongst peers.

Trends in healthy life expectancy are also showing either a stagnation or a regression according to the cohorts of patients and the different geographies within the UK (Marmot and others, 2020).

Those trends are indeed felt much more strongly by certain patient groups as inequalities in life expectancy keep growing. People living in more deprived areas of the UK tend to die earlier than people living in the least deprived areas and spend a greater proportion of their lives in poor health (The Health Foundation, 2025).

While wider determinants such as housing, employment and education contribute to overall health, and health expectancy, healthcare also plays a role. In the UK, a limited number of conditions constitute a set of leading contributors to overall mortality and/or life expectancy in the UK. These include cardiovascular diseases (CVD) and cancer, and while the 2020 population-based rates of CVDs and cancer mortality were higher in the UK than in many comparator countries, the survival rates were poorer (Major conditions strategy, 2023). This comes as a result of the UK lagging behind in providing timely and effective health care for those who develop CVDs or cancer.

A fall in productivity

While the NHS used to deliver productivity growth at a faster pace than the rest of the public sector and the wider economy, the pandemic brought significant disruption to the delivery of NHS services. In 2024, the NHS produced for the first time its own estimate of the productivity shortfall and revealed that productivity in 2023 to 24 was 11% lower than pre-pandemic levels, though it estimates this is now recovering (NHS England, 2024).

Over the last year, the NHS has been able to increase the number of patients treated in its hospitals in England at a greater rate that the increase in clinical staffing over the same period, which suggests an increase in workforce productivity (NHS England, 2024). More progress is however needed to see those improvements translated into a significant reduction of the elective waiting list and to reach pre-pandemic levels of productivity.

Limited ability to drive change and/or adopt innovation

Similarly to other large-scale systems/organisations, the NHS has long had difficulties in adopting, spreading and embedding new innovations at pace and at scale. This is particularly the case for new models of care, technologies and other existing opportunities for transformation.

Lack of motivation and incentives, capacity and capabilities are often quoted as key drivers behind the NHS limited ability to drive and embrace change. However, as the recovery from the pandemic is prolonged and new challenges emerge, it has never been a more important time for the NHS to test itself and demonstrate how it might be able to improve the successful uptake of new ideas and practices.

NHS blockages

We have identified several NHS obstacles that contribute to this core set of challenges facing the NHS:

1. GP access - following rapid decline over the past decade, the number of fully qualified GPs to patient population has, since 2023, been increasing again (Institute for Government, 2025). However, while practices are seeing more patients than ever, public satisfaction with access to general is deteriorating. Patients are finding it harder to make appointments, and feeling increasingly dissatisfied with waiting times and the types of appointment offered. This often leads to avoidable presentation to A&E services, admission to hospital and longer stays than is necessary. A recent survey has revealed that more than a quarter of people of all ages visited A&E because the waiting time to see a GP was too long and 41% of under 35s have visited A&E as an alternative to waiting for a GP appointment, despite 2024 seeing a record high (370 million) GP appointments delivered (Livi, 2025).

2. The experience of care provided to patients who present a combination of complex and health and social care needs and are often frequent users of many services, is unacceptable. This cohort of patients, which has been estimated at around 7% of the population and associated with 46% of hospital costs, according to NHS England analysis, often require support from multiple integrated services and organisations. Currently no single clinical professional or providing organisation take full responsibility and accountability for their support and care. This leads to the same set of consequences listed above (A&E presentation, hospital admission and ambulance delays for time-critical conditions). Success in the management of this cohort or of group of patients within this cohort, could lead significant benefits in terms of levels of independence, reduction in reliance on hospital care and long term residential and nursing home care.

3. One of the key drivers behind the NHS difficulties in providing efficient and timely care for people affected by one major condition such as cancer, diabetes and CVD, is the delayed access to accurate diagnosis and screening. Despite being a priority due to its impact on survival, no progress was made in diagnosing cancer at stage I and II between 2013 and 2021 (Lord Darzi, 2024). Since then, however, the success of the Targeted Lung Health Check programme, which has contributed to an improvement from around 54% (2021) to around 58% (2023) of early-stage diagnosis, generated key learnings to be applied elsewhere, such as the increased proportion of diagnosis being provided in the community (Darzi, 2024). While Important progress has been made in reducing the number of cancers diagnosed as result of an emergency presentation, important inequalities remain, with often the most deprived more likely to present as an emergency (Darzi 2024).

4. The difference in funding model between health and social care has resulted in poor outcomes for patients for the NHS and an overall cost ineffective system. As social care providers continue to struggle to absorb increase in non-funded demand, the NHS is seeing more and more people staying in hospital for longer that their medical needs require. This results in an increasingly burdensome experience of care for those patients and their families, and a difficulty for providers to use their resources more effectively. The impact of delayed discharges to social care services is equivalent to 13% of all NHS beds (Darzi, 2024). It drives UEC backlog, corridor care and poorer outcomes than necessary.

5. Over 6.2 million (or around 7.5 million cases) people in England, are waiting, too often for a very long time, to access elective care services (British Medical Association, 2025), with the pandemic being one of main drivers behind this disruption to efficient delivery of elective services. Those waiting for elective care are often at risk of seeing their conditions deteriorate as they wait for their first diagnostics or outpatient appointment. Those patients often suffer from anxiety and tend to be very dissatisfied with the service as they only receive sporadic information about their wait.

All these obstacles are connected and would need to be addressed collectively and at the same time through a co-ordinated and coherent set of proposals. Any emphasis on one of these at the expense of others, would only lead to displacing the problem.

Strategic priorities

Delivery of the changes described in the 10 Year Health Plan will depend on clinical and organisational behaviour change. Financial and contractual levers are only some of the options available to us deliver the changes we want to see; we have described these as one part of the commissioning and wider picture which includes regulation and workforce training as examples. Alignment between care model design and the financial framework is critical. As care models proposed by the 10 Year Health Plan become clearer, further work will be required to confirm how funding flows and contractual mechanisms will support the delivery of the new care models and shifts.

We have focused discussions on how we would deliver the key objectives of the plan and how financial incentives could improve the experience and outcomes for specific groups how are directly affected by the issues caused by the 5 NHS obstacles as set out above.

Desired end state

The recommendations in the following sections are centred around adjustments to financial flows and incentives which can help address some of the NHS obstacles and

high-level challenges listed and deliver the desired end state and benefits to the public. These include:

- by the end of the decade, the public will benefit from improved access to their GP, which would result in better experience and management of care overall. This will also lead to a reduction in avoidable A&E attendance and NHS 111 calls

- high intensity users of healthcare service will receive more co-ordinated support from multidisciplinary teams working as part of neighbourhood integrated teams across community and primary care settings, resulting in reduced unplanned hospital activity

- frail people will receive care closer to home and away from hospitals as better responsibility and accountability mechanisms are established between the NHS social care and other providers (charities, independent)

- these changes will also result in better value for the taxpayer, as the reduction of unplanned bed days would contribute to more capacity for elective episodes. Combined with further progress on productivity and efficiency, this would allow for a significant reduction of the waiting list without overall increases in hospital beds or staff

A number of principles informed all our discussions, including:

- pursuing the fairest possible distribution of both capital and revenue resources and delivering financial discipline within the resources provided to the NHS by Parliament

- delivering system goals through better alignment of financial incentives for organisations, teams and individuals

- ensuring that funding flows are designed along patient pathways

- ensuring that the new financial and contracting framework incentivise sustained productivity improvement

While this report is not making specific recommendations about NHS contracts, beyond renewing our commitment to reform of the dentistry contract - as announced in the 2025 to 2026 planning guidance (NHS England, 2025) - some of our proposals will have implications for those and will need to be considered pre-publication and also be part of future programmes of work beyond the publication of the plan.

Principles for the NHS financial framework

1. Ensuring fair distribution of resources to populations

We are clear that the fair distribution of resources should remain an important principle of the financial framework. We should continue the current approach of seeking independent, objective and evidence-based advice from the Accounting and Corporate Regulatory Authority (ACRA) around how to distribute resources under formulae to integrated care boards (ICBs), increasing the overall proportion of funding allocated through formula and reducing the proportion held for national programmes.

There are areas in which existing approaches will need to evolve (such as updating to reflect post-COVID patterns of care) but we also identified some areas in which the depth of understanding and evidence based might usefully be extended through a programme of review and evidence-building, including:

- refreshing constantly our understanding of ‘fair’. For 50 years, the aim of the target allocation has been equal opportunity of access for equal need. Health inequalities were added as a focus about halfway through that time. Progress in data collection and modern analytical methods may provide an opportunity to adopt other aims, such maximising population health or wellbeing

- extending the evidence around addressing unmet needs. There is limited evidence around exactly how unmet needs should inform the allocation formula, requiring judgement to be applied. We should actively seek to extend our understanding of these issues through research given the clear potential link to reducing health inequality

- extending the evidence base in certain sectors. We still have areas in which historic patterns of resource consumption are driving allocations to a significant extent (for example, dentistry). We should actively seek to extend the evidence base to support clearer evidence-based advice on allocation

A particular focus of our discussions was the allocation of resources to individual GP practices. Although ICB resources are allocated using a needs-based formula (subject to the continuous improvement recommendation we make above), practice funding entitlements are driven by the ‘Carr Hill’ formula. The Carr-Hill formula should be reviewed. That review should look at the available evidence of how unmet need and health inequality is best addressed through primary care services and appropriately reflect that evidence in the funding of transitional general practice models versus alternative approaches. Transition to any new funding formula would need to be carefully managed to minimise

service disruption as it secured the benefits of change and may be dependent on the level of funding available.

Any change to the Carr-Hill formula will create winners and losers. The age of the formula means these may be significant, and they may be further exacerbated by a more radical switch from a workload-based model to, say, a need-based model.

A transition approach will have to be agreed and involve balancing sharp changes with protection of losers either using an extended implementation period or putting in additional funding. It will be necessary to ensure funding shifts are accompanied by the development of service delivery models well-suited to meeting currently unmet need.

The review should be widened to consider other approaches to funding primary medical care. One option would be to continue to flow most funding through the General Medical Services contract, with an improved payment formula. Other options might also include capitated budget based on GP registered populations.

But the review should also consider keeping a greater share outside the main contract and using it to directly incentivise staff participation and support enhanced services in the most challenged areas.

The group also suggested that beyond the review of the Carr Hill formula, future discussions on the GP contract should consider how it could be used as a vehicle to further incentivise prevention interventions.

2. Harnessing the benefits of investment standards and ringfencing schemes

Reflecting on the growing consensus towards more subsidiarity, the group recommended that we should minimise the unnecessary use of national funding pots and ringfences. However, it suggested that national leaders should retain the right to use ringfences or investment standards where we have evidence that these levers can work (for example on the roll-out of lung health checks).

Investment standards and ringfencing schemes support focus on longer term investment strategies and innovation which may not otherwise be prioritised. They contribute to setting clear prioritisation and can speed up change (for example, digital transformation in primary care). They are likely to be particularly effective when there is a consensus that investment in a particular area should be prioritised or when there is a clear model, the costs of which can be reliable estimated, and where it is clear what the investment should be made in for the desired outcome. Some members of the group see a clearer role for using such levers to drive shifts to prevention, community and digital and ensure the evidence on benefits is converted in full.

These levers can however hinder local commissioners and providers freedoms to determine the most effective use of total resources to meet local population needs, especially when resources are constrained. They may not drive optimal productivity, especially if the only focus is on the input and not what it is to be spent on and deliver. When we nationally direct spending, it should be accompanied by a clear evidence-based view of what the investment should be made to achieve the aim and how that can be done to maximise productivity and value.

There should always be an appropriate plan to transition in the long term to local decision-making arrangements and a collation of the evidence of what works. The implementation of any nationally designed service should also allow integration with local services.

3. Deciding how to spend resources

While decision making is further devolved to local leaders and their teams, we should continue to build on existing opportunities to standardise approaches which deliver proven optimal outcomes and productivity and ensure that evidence on those approaches is shared widely and rapidly.

We should continue to develop the evidence base, and tools used to determine how resources are deployed across local areas by commissioners, challenging ourselves to disrupt historic service patterns to keep them focused on need and inequalities. This will in part be achieved by expanding how available analysis assists commissioners in those decisions (for example place-based allocation tool).

ICBs should remain responsible and accountable for strategic decisions about NHS resource deployment and commissioning strategy. However, there are strong arguments for developing the financial and risk sharing arrangements with other local partners.

In the case of local authorities, this could focus on the opportunities around economic growth, work and health as well as the interdependence between local authority services, demand for NHS care and discharge from NHS services. We should explore options to transfer the responsibility for paying the hospital costs associated with longer than necessary stay to the provider responsible for enabling the discharge, including local authorities and NHS bodies. All these approaches would be supportive of system productivity. While a section of the working group agreed with this suggested policy change, others thought it would be too disruptive and would not deliver the expected outcome.

We should also explore options for outcome-based payment or proxies thereof. One option worth considering is more patient experience-influenced payment mechanisms to drive up quality and potentially productivity. This might mean partial payment for an episode of care

would only be released to the provider, if patients confirmed they were satisfied with the care they receive.

We should be conscious about the risk associated with that approach as sometimes clinicians might make a choice that patients would not agree with, such as legitimately not providing a fit note, and that would need to be considered in the design. This requires consideration of the appropriate question to be asked. Another option to consider includes the introduction of payments which incentivise reducing avoidable admissions, worse health outcomes and higher costs, which is not captured as part of the patient experience assessment.

Members of the group have also suggested exploring how this type of financial levers could help improve GP access. Practically, this could mean partial payment for a GP practice would only be released if a certain proportion of patients confirmed they were satisfied with the waiting time before their appointment.

Payments for quality and good practice, drawing on the evidence from the quality outcomes framework (QOF), commissioning for quality and innovation framework (CQUIN), and others, can deliver targeted changes effectively but there is some evidence that the impact of incentives can stagnate over time as the ‘newness’ of the funding fades and income is assumed. There is also anecdotal evidence that incentives are not always transacted where that leads to financial difficulties for providers, negating the incentive effect. In challenging financial circumstances this is particularly likely, and all these impacts need to be taken account of in design.

4. Delivering financial balance

Despite clear moral, legal and professional duties for NHS organisations to deliver balance against the budgets allocated to them, the current financial framework has not delivered balance across the NHS. This is not just a matter of financial discipline; overspends in one place effectively misdirect resources that should be spent elsewhere in a fair distribution.

Over time the model for setting budgets and holding organisations should account more clearly for structural reasons that costs are higher (for example, configuration of services and providers). We need to be single-minded about financial management beyond this and where that is within the control of commissioners and providers. Government should explore further whether there are ways to enhance accountability where this is not delivered. This might include linking executive and non-executive pay to delivering on system goals, including improvements in health outcomes, inequality, patient experience and financial objectives linking retention and achievement of clinical excellence awards to productivity, best practice implementation and value.

We should also structure capital flows to support change and reward success.

We would err to giving more capital as part of total system allocations (rather than nationally determined pots) tied to delivering 3-to-5-year performance and/or health goals and individual organisations having more freedom to spend cash they have generated (see following section).

The group agrees that delivery of best value, efficiency, productivity and financial balance require engagement of staff throughout provider organisations. Some members of the group would support performance related pay for clinical teams. The consensus is that we must improve the engagement of clinical teams with financial objectives and should allow management teams to incentivise staff through investment in service improvement which might be facilitated by accrued entitlements to additional capital arising from incentive schemes or rights to spend surpluses. This would need to be designed to balance the risk that such incentives could undermine the fair allocation of resources over time.

Other options to explore include the delivery of shared goals and purposes for clinical teams and managers, and the benefit of increasing engagement of managers and finance teams with clinical and population health goals.

5. Driving value in everything the NHS delivers

Whatever the NHS buys, commissions and delivers, there should be a relentless pursuit of the best value. It is not optional to balance the NHS's budget and to live within the means granted to the Health Service by Parliament. We should deploy financial incentives to this end as well as other levers. In the financial environment foreseeable over the proximate years of the next decade, productivity will need to be at the heart of our approach.

Value starts with ensuring that every patient receives care based on the best evidence. We should continue to expand the evidence what works, and the NHS should be ruthless in ceasing to deliver care where there is no evidence for efficacy or where cost effectiveness is relatively poor. We should therefore:

- ask relevant clinical bodies and National Institute for Care Excellent (NICE) to look at the relative cost effectiveness of different NHS procedures, interventions, and activity rather than assessing against a threshold of cost effectiveness. This would ensure the NHS had clear guidance on best value clinical practice

- review services which have progressively absorbed a higher proportion of the NHS budget and assess the efficiency objectives attached to them

- continue to use incentives to optimise the use of clinical resources, including through the reduction of unnecessary appointments and procedures (for example, use of outpatient follow ups)

- considering incentives to focus on handoffs between settings to reduce waste, improve system productivity and improve patient experience

- consider incentives for providers to collaborate for economies of scale and comparative advantage exploitation. This should be explored through gain share arrangements as a result of productivity gain within a formal rules framework

We should continue to apply realistic efficiency and productivity assumptions into the overall settlement but also to different areas of service, commensurate with the opportunities afforded by investment (for example in technology) and operational process. This should be informed by clearer estimates of releasable efficiencies based on specific changes that we are expecting the NHS to deliver and clearer benefits frameworks.

Where we are investing in technology or other improvements on a basis justified by efficiency and productivity we should more clearly follow the realisation of benefits through the planning and financial frameworks into the actual operational cost base, learning as we go about how to improve implementation and estimate future benefits.

Capital

Explore the opportunities associated with a hybrid model of capital funding flows

The group considered how capital funding flows (CDEL cover and cash) should be adjusted to ensure available funding is spent on those projects that represent the greatest value for money in terms of improving health services in a local area.

It also considered how we can ensure that capital funding flows form part of an effective system of incentives which help encourage the strategic transformation, and operational and financial performance both in terms of the estate and health service provision more generally.

Our proposals aim to set out the conditions so that:

- provider organisations would be responsible for generating headroom to reinvest in improving their estate with NHS England accommodating CDEL implications in the larger settlement. This would be dependent on sufficient funding in all providers contracts, and may require NHS England to rebalance cash, given some very large balances

- ring-fenced funding will help recover maintenance backlogs for a period and but that responsibility with then fall back to provider organisations. Where necessary, further ringfences such as legal trust funds, could be introduced to ensure all providers can absorb lifecycle costs

- strategic commissioners would be given the ability to invest in shifting capacity in line with their service strategy

- large-scale cross system and/or regional requirements funded directly by NHS England (New Hospital Programme schemes, new pathology or genomic lab capacity and technology common infrastructure systems)

The options and proposals for consideration to achieve this end state include a shift from the current system of capital fundings flows which currently aims to support:

- providers to maintain and improve their estate to deliver more activity more productively. In the current system CDEL is made available to cover capital expenditure that providers can afford and chose to make to support activity delivery

- commissioners and providers to distribute and spend capital in line with their assessment of relative need and priority, informed by the strategic plan for the development of health services in their area

- providers to deliver on nationally-defined priorities through schemes that meet national requirements (New Hospitals Programme, Community Diagnostic Centre Programme) through CDEL and cash for capital expenditure flows from national teams

The first element of the current system of capital funding flows creates a virtuous cycle of incentives with those responsible for the assets also responsible for generating funding to maintain them and bearing the consequences of their effectiveness in doing so. The second element enables scarce capital to be distributed rationally according to need and local priority, and in alignment with the strategic plan for the local area rather than current and past performance. The last element ensures funding delivers projects aligned to national priorities and nationally defined best practice and informed by specialist expertise.

We should consider the development of a hybrid model which would harness the benefits of different types of capital spending and would be built on the following funding principles:

- The opportunity for provider institutions to set aside depreciation and generate a surplus to both maintain and improve their estate to deliver more activity more productively and deliver on their strategic plan priority and identified needs.

    - allocation of CDEL to systems that is distributed between:

    - essential maintenance for providers unable to fund their own requirements. This would go hand in hand with financial performance improvement interventions

    - expanding or creating new service capacity to meet demand growth or improved service specifications or expectations

- providing the infrastructure required to deliver strategic reform plans - for example, expansion of integrated neighbourhood services

- Continue a national New Hospitals Programme for replacement schemes of a scale that mean they cannot feasibly be absorbed in reasonably stable system allocations

This hybrid would build on changes made for 2025 to 2026 such as the proposed introduction of some freedom for providers to spend prior year surpluses on capital and the issuing of indicative allocations of national programme funding to systems for them to plan against. It would however be going substantially further in moving back towards management of trusts through cash rather than capital limits, and in shifting the balance of capital decision-making from national to local.

It would also be associated with a number of additional risks that we should also consider and for which mitigations and further work should be developed. These include:

- given the current financial context, it is highly likely that only a very limited number of providers will be able to generate a surplus, which even combined with depreciation will not be sufficient to address the around £14 billion backlog maintenance in the NHS estate. We may therefore need to delay transition to this proposed model until the RDEL position is less constrained, and we have made more progress in eradicating critical infrastructure risk

- the current capital regime enables ICSs to allocate operational capital in line with capital need. This hybrid model would effectively involve CDEL allocation aligning less to need and more to performance. This would strengthen performance incentives, but risk creating a vicious cycle for low performers. This is mitigated partly by systems being able to use their system allocation to cover essential maintenance where providers can't afford it. It would however still be the case that low-performing systems would need to find a route to improved performance which did not require upfront capital investment. This would mean the health system, the government and the public accepting increased variability in service quality around the country

- For this model to apply consistently across the health service we would need to ensure all contracts for providing health services included provision for maintaining and upgrading physical infrastructure. This would include specialist, community, mental health and primary care provision as well new neighbourhood health service models. This would need particular thought for primary care given the variety of ownership models

- systems allocations are arguably not the right route for funding investment in expanded or new capacity in specialised services which are commissioned on a

regional or national basis. This could be mitigated by funding being retained nationally for these purposes

- system allocations would need to be derived by a new formula based on future health need - including that arising from demographic growth - adjusted for the state of the current asset base. This might prove challenging to design and inevitably imperfect.

Beyond the development of the hybrid model for capital flows, we should also consider options for bringing new sources of funding through social impact bonds or social outcome partnerships. Social outcomes partnerships work as cross-sector partnerships that bring organisation together in the pursuit of measurable outcomes and help to deliver greater flexibility and accountability in service delivery and stronger accountability through near real-time performance data. They also support delivery of enhanced person-centred care, by ensuring services are more tailored to individual needs and could therefore help achieve some of the key objectives of the NHS capital regime.

Ensuring fairness and delivering at best value, will help achieve the shifts and bring a resolution to key challenges facing the service

1. Addressing the needs of high intensity users of healthcare services

Population budget held by an accountable provider organisation

NHS services are well-placed to offer leadership in the design of service pathways, taking greater responsibility for the allocative efficiency of service provision and sharing financial accountability for the outcome. Population budgets held by single provider organisations for segments of the population, with the 7% heaviest users of services as the first cohort, should be taken forward. Subject to the lessons learnt such an approach could be expanded in future to other cohorts of patients. However, there is a caution in the fact that existing integrated acute and community providers have struggled to deliver meaningful change in this respect despite already arguably having the financial incentive to do so.

There are different views about which providers would be best placed to take a leadership role in this way. GPs are natural leaders of a clinically driven population health approach whilst others looked to NHS Providers for that leadership.

This might point to considering how to bring the right thought leadership to bear as well as thinking about what sort of organisation might have the right character to manage a budget

in this way. A provider organisation involved in holding financial risk will need to have a track record, scale and financial standing commensurate.

Some have argued that provider organisations should be entrusted with that responsibility on behalf of a place-based partnership. Without all partners working together, the accountable provider will be unable to address properly the needs of the 7% heaviest users and beyond. This policy could helpfully drive primary care scale and build cross sector collaboration towards an Accountable Care Organisation (ACO) model.

This will require further policy thought. The profile and needs of the 7% heaviest users of healthcare services will differ across and within geographies and would therefore require different types of accountable organisations to ensure efficient service provision for this cohort and delivery of improved health outcomes and system goals.

The group carefully noted the need to ensure that any such involvement ensured ongoing public sector control of NHS services and decisions.

The group also recognised that the systems should learn from the establishment of population budgets for this first cohort and rapidly identify further cohorts for future application of this model. More policy thought would be needed to identify and select those, but some members of the group suggested targeting patients with or at risk of developing specific long-term conditions and for whom, more preventative interventions could deliver a step change in terms of care management and financial sustainability.

Some key features that drive adaptability, accountability and enhance person-centred care might be a system which is:

- locally embedded and trusted - leveraging local knowledge to build trust among providers and commissioners
- data-driven learning and management - establishing and maintaining a central data and performance management system
- identifying systemic challenges and mediating solutions - proactively improving services and fostering cross-sector collaboration
- encouraging adaptation and learning - continuously refining approaches based on insights from real-time data

Driving productivity beyond acute settings

There is an urgent need to improve the evidence on productivity outside of acute settings in primary and community care as well as mental health. Our focus should develop over time to think about productivity across the system and pathways of care, despite the

difficulty in capturing this well. This would mean having better activity, cost and outcome data in non-acute settings, through a digital and data improvement plan for those services - to be implemented at the earliest opportunity - as the whole strategy is underpinned by good data collection and understanding of the dynamics of service provision, cost and outcome.

Efficiency reporting across organisations needs to be standardised and focused on actual change in year-to-year operating costs so that cost improvement programmes represent real changes in efficiency.

Payment systems

We should consider activity payments for community diagnostics and technology-based care; elective care in hospitals; and unplanned hospital episodes for the 7% heaviest users if introducing population budget approaches. A variable system of payment is likely to be most effective when the reimbursement level is known with relatively certainty up front, and care can be delivered effectively within that level of reimbursement. Simple elective procedures (like cataracts) are a good example. We should consider using prices to incentivise the right level of activity for population need as part of delivering long term on constitutional standards across specialities.

We should also consider new tariffs for digital services, such as virtual consultations or use of AI to analyse images, to support the shift from analogue to digital. There is also a need to swiftly accelerate into an entirely different gear current work on the introduction of new payment currencies into mental health and community services. This will develop data flows, help us understand true costs, redesign pathways and drive productivity and efficiency. We see attraction in paying for outcomes rather than activity or output, but some have expressed scepticism as those types of payment are not has easily implementable given the lags before outcomes emerge.

Simple incentive payments designed directly to encourage or discourage specific behaviours can really work to deliver simple changes. We have live examples of those encouraging specific activities or choice (medicines switches for example). These should continue to be one tool available but should not be applied as a means to solve complex problems which require a much more complex mix of leadership, cultural and behavioural change.

2. Reduce the waiting list through wider use efficient delivery costs

We should encourage widening use of benchmarking data with organisations across the NHS to look at productivity and the cost of delivery.

As this develops, we should expect those efficient costs could be translated into how we pay for care. That applies both to the construction of fixed elements of a payment system (where there are used) but also any variable elements. Variable prices should be set on the basis of a reasonably efficient cost, bundling expectations around use of the best value settings (for example, outpatient clinic from day case), use of materials (for example, best value devices and medicines) as well as practice and pathways.

Greater use of normative pricing will also prove instrumental in realising the benefits of the analogue to digital shift. We should explore the opportunity to design contracts and payments for outpatient activity based on all providers realising productivity gain from digital outpatients. This would mean setting up payments and contracts for additional patients per session equivalent to the costs of a session with optimal use of new technology in the management of delivery of outpatients.

In setting prices and global efficiency requirements there may be a need to adjust via commissioning for the difference in opportunity to operate at reasonably efficiency cost depending on factors beyond providers' control (for example, rurality, the state of the estate). We should consider whether the evidence supports pricing to reflect inequalities. We should also explore options to apply a type of payment equivalent to the pupil premium for providers based on agreed funding criteria.

We should also consider the duration of contracts and the transition. We should use normative pricing to create 'target' levels of payment to providers for expected range and volume of services and then agree trajectories over time to support the shift from the current cost base to the 'target', aligning provider contracts with allocations time frames (for example, 3-year rolling contracts). This would allow national leaders to hold systems accountable for delivering productivity without increasing the risk of deficit.

Conclusion and recommendations

Our discussions over the past 5 months have focused on key options for changes to the NHS financial framework to support a fairer allocation of resources, a drive towards productivity and efficiency in everything that the NHS delivers, and path forward for the delivery of government's ambition for the next decade, including the 3 shifts.

Our approach has been centred around key NHS obstacles (including GP access, inappropriate length of stay in hospital, elective waiting times, poor experience of care for those with complex health and social needs), responsible in parts for some of the more prominent challenges facing the NHS (low patient satisfaction with the NHS, productivity gap, poorer outcomes and widening health inequalities, difficulties in embracing innovation and change) which affect different cohorts of patients.

The ambitions behind the proposals to redesign funding flows in the NHS and harness the benefits of financial incentives include improvement to the experience and outcomes for those cohorts of patients, and in particular the group often qualified as high intensity users of healthcare services and which represent around 7% of the population and 46% of hospital costs.

The successful delivery of those proposed reform proposals will rely on strong and co-ordinated programmes of technical work which should start immediately following the publication of the plan and be underpinned by rigorous and flexible implementation planning and appropriate funding. The group believes that beyond achieving individual objectives, it is the combination and connection between those proposals which will help deliver the overall government's ambition for the NHS over the next decade.

While these were not part of the main group discussions, future policy development of the selected proposals will need to take into account the set of conditions to be met to ensure successful implementation of selected proposals. Those include effective regulation, financial margins to enable structural change, capability development, alignment with the Spending Review process and access to the appropriate level of data and information though an improved NHS data and digital infrastructure.

Annex 1: key recommendations from the report include:

Ensuring fair distribution of resources to populations

Recommendation 1. Continue the current approach of seeking independent, objective and evidence-based advice from ACRA around how to distribute resources under formulae to ICBs, increasing the overall proportion of funding allocated through formula and reducing the proportion held for national programmes.

Recommendation 2. Launch a review of the Carr-Hill formula which would look at the available evidence of how unmet need and health inequality is best addressed via primary care services through the traditional general practice model or alternative approaches.

Harnessing the benefits of investment standards and ringfencing schemes

Recommendation 3. While there is a growing consensus towards minimising the deployment of those levers, national leaders should retain the right to use, in exceptional circumstances and for a limited time, ringfences or investment standards to focus on long term investment strategies and innovation which may not otherwise be prioritised. Their use should always be accompanied by an appropriate plan to transition in the long term to local decision-making arrangements and a collation of the evidence of what works.

Deciding how to spend resources

Recommendation 4. Explore opportunities for developing financial and risk sharing arrangements between integrated care systems (ICSs) and local partners. In the case of local authorities, this could focus on the opportunities around economic growth, work and health as well as the interdependence between local authority services, demand for NHS care and discharge from NHS services. We should explore options to transfer the responsibility for paying the hospital costs associated with longer than necessary stay to the provider responsible for enabling the discharge, including local authorities and NHS bodies. This will help address the issue around increasing number of people staying in hospital for longer that their medical needs require, deliver significant improvements to those patients' experience of care and allow providers for a more effective use of resources.

Recommendation 5. Explore options for outcome-based payment or proxies thereof. One option worth considering is more patient experience-influenced payment mechanisms to drive up quality and potentially productivity. This might mean partial payment for an episode of care would only be released to the provider, if patients confirmed they were satisfied with the care they receive. Another option to consider includes the introduction of payments which incentivise reducing avoidable admissions, worse health outcomes and higher costs, which is not captured as part of the patient experience assessment. Members of the group have also suggested exploring how this type of financial levers could help improve GP access. Practically, this could mean partial payment for a GP practice would only be released if a certain proportion of patients confirmed they were satisfied with the waiting time before their appointment.

Delivering financial balance

Recommendation 6. Explore further whether there are ways to enhance financial management accountability. This might include linking executive and non-executive pay to deliver on system goals which include financial objectives, linking retention and achievement of clinical excellence awards to productivity, best practice implementation and value.

Recommendation 7. Improve the engagement of clinical teams with financial objectives and allow management teams to incentivise staff through investment in service improvement. This should be explored in parallel with the delivery of shared goals and purposes for clinical teams and managers, and the reciprocal benefit of increasing engagement of managers and finance teams with clinical and population health goals.

Driving value in everything that the NHS delivers

Recommendation 8:

- ask relevant clinical bodies and NICE to look at the relative cost effectiveness of different NHS procedures interventions and activity rather than assessing against a threshold of cost effectiveness. This would ensure the NHS has clear guidance on best value clinical practice

- continue to use incentives to optimise the use of clinical resources, including through the reduction of unnecessary appointments and procedures (for example, use of outpatient follow ups)

- considering incentives to focus on handoffs between settings to reduce waste, improve system productivity and improve patient experience

- consider incentives for providers to collaborate for economies of scale and comparative advantage exploitation. This should be explored through gain share arrangements as a result of productivity gain within a formal rules framework

Recommendation 9. Continue to apply realistic efficiency and productivity assumptions into the overall settlement but also to different areas of service, commensurate with the opportunities afforded by investment (for example, in technology) and operational process.

Recommendation 10. Where we are investing in technology or other improvements on a basis justified by efficiency and productivity we should more clearly follow the realisation of benefits through the planning and financial frameworks into the actual operational cost base, learning as we go about how to improve implementation and estimate future benefits.

Capital

Recommendation 11. Consider the development of a hybrid model of capital funding flows built on:

- the opportunity for provider institutions to set aside depreciation and generate a surplus to both maintain and improve their estate

- the allocation of CDEL to systems that is distributed between essential maintenance, expansion of new service capacity and provision of the infrastructure required to deliver strategic reform plans

- the delivery of the national New Hospitals Programme for replacement schemes

Addressing the needs of high intensity users of healthcare services

Recommendation 12. Explore options for population budgets held by single provider organisations for different segments of the population, including the 7% heaviest users of

services as the first cohort, before moving to working adults. NHS services are well-placed to offer leadership in the design of service pathways, taking greater responsibility for the allocative efficiency of service provision and sharing financial accountability for the outcome.

Recommendation 13. Improve the evidence on productivity outside of acute settings in primary and community care as well as mental health. Our focus should develop over time to think about productivity across the system and pathways of care, despite the difficulty in capturing this well. This would mean having better activity, cost and outcome data in non-acute settings, through a digital and data improvement plan for those services.

Recommendation 14. Consider activity payments for community diagnostics and technology-based care; elective care in hospitals; and unplanned hospital episodes for the 7% group if introducing population budget approaches.

Recommendation 15. Consider new tariffs for digital services, such as virtual consultations or use of AI to analyse images, to support the shift from analogue to digital.

Recommendation 16. Accelerate current work on the introduction of new payment currencies into mental health and community services. This will develop data flows, help us understand true costs, redesign pathways and drive productivity and efficiency.

Reduce the waiting through wider use efficient delivery costs

Recommendation 17. Encourage widening use of benchmarking data with organisations across the NHS to look at productivity and the cost of delivery. As this develops, we should expect those efficient costs could be translated into how we pay for care. That applies both to the construction of fixed elements of a payment system (where there are used) but also any variable elements.

Recommendation 18. We should consider whether the evidence supports pricing to reflect inequalities. We should also explore options to apply a type of payment equivalent to the pupil premium for providers based on agreed funding criteria.

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