South London Pathfinder programme

Playbook | *Phase 2*

December 2023

South London
Specialised Services Pathfinder

A partnership between
South London Office of Specialised Services and
NHS England

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Notes on this document

The Pathfinder programme was originally due to start in January 2023 and report in September 2023, with the intention to inform the ICB Pre Delegation Assessment Framework (PDAF) due in November 2023. As the PDAF submission was brought forward to September 2023, the Pathfinder programme board was asked to provide 'early' feedback on the lessons learned to help inform system PDAF development over the summer. As a result, the Pathfinder programme board is sharing lessons learned in two phases;

- Phase 1 – lessons learned and recommendations arising from the preparation for Pathfinder
- Phase 2 - lessons learned and recommendations arising from the implementation of Pathfinder and some resources to support systems in local adoption of some of the recommendations

This document is Phase 2. Since the commissioning of the Pathfinder programme from the south London systems there have been several changes to the national process including the change in timetable for establishing the commissioning hubs (now April 2025) and the likely 'mixed economy' of delegation to regions across England. This has resulted in some small changes to the achievable scope of the Pathfinder work, specifically those related to matrix working across BI, finance and contracting teams to deliver post-delegation efficiencies and integrated working.

As the London system is not taking delegation in 24/25 there will be no further changes to contracting but this Playbook does suggest how implementation of delegation could have worked, should delegation have gone forward.

The specific details of scope included in this Phase 2 report are highlighted in yellow at the start of each section. Elements without a highlight were completed in Phase 1; those now not being taken forward have a ~~strikethrough~~.

The document covers technical functions and is intended to be read by stakeholders within the NHS. It uses a certain amount of short-hand and terminology that is familiar within the NHS functions described – a glossary is included in the appendix. As is elsewhere covered in the document, the Pathfinder programme only covered finance, BI and contracting functions, not all elements of the commissioning cycle.

Lastly, the Pathfinder programme takes place in a specific context. The programme is focussed on two ICBs in South London with a combined annual spend in 22/23 of £1.1Bn (excluding high cost drugs and devices). The provider landscape comprises three tertiary hospitals and one specialist hospital. There are significant cross boundary flows with ICBs in the South East Region (with around 40% of specialised work inflowing to providers in South East London ICB and South West London ICB coming from Kent and Medway ICB, Surrey Heartlands ICB and Sussex ICB). ***Detail on the background and rationale of the Pathfinder programme and more detail on the local context can be found in the Phase 1 Playbook.***

Key Messages

Key Messages

Since the publication of the Pathfinder Phase 1 PlayBook there has been extensive engagement on the initial lessons learned and recommendations, including over 40 separate meetings at provider, collaborative, ICB, regional and national levels to share the first set of key messages. The Phase 2 PlayBook/Report builds on the original key findings and much of the detail expands on priority issues identified in Phase 1 (e.g. specifics around data access). New key messages arising from the engagement on Phase 1 and the detail in Phase 2 include;

- While the exact timetable for delegation has been subject to further change, and some regions have delayed delegation for another year to April 2025, **key planks for delegation have already been implemented and will impact the way in which services are commissioned and delivered in 24/25, whether formal delegation takes place or not.** The significant change from host region to ICB allocations took place in 23/24 and ICBs across the country can/should have significant influence in the commissioning of specialised services through extant Joint Committee arrangements.

- **Wherever in the delegation timetable, there is considerable scope for all ICBs to interrogate data now available** to - further understand the impact of allocation distribution, the impact of the new fair-shares changes to ICB allocations and the transformation opportunity (aligned with the triple aim – improving outcomes, reducing inequalities and reducing cost) in end-to-end pathway development so that the impact of delegation is understood, and the ambition is driven by ICB priorities.

- Delegation is a large and complex programme and some of the determinants of success relate to functions/change management programmes larger than just specialised (e.g. strategy for national DSCRO support, implementation of the new national ledger). **Even with the delays to the delegation programme, there are remain difficulties in determining and communicating how resolution to issues related to data access and specialised coding are being achieved**, as well as the sharing of key methodologies (e.g. allocation change convergence).

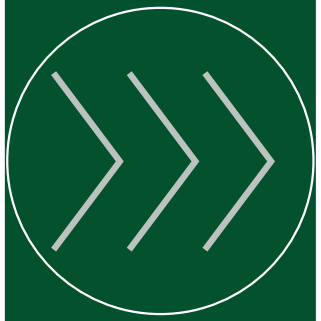
- **To improve the flow of communications related to specialised delegation it should be possible to use NHS Futures more consistently** and have information related to all functions of the delegation process – finance, contracting, BI, quality and transformation – regularly updated. This will ensure that ICBs can see/plan integration of all the functions ‘in the round’ rather than information flowing only down functional silos (e.g. through finance or BI or quality leads)

Workstream 1 - Data and transactional BI

Function	Objectives of Pathfinder	Success Criteria
Transactional BI	• Developing and testing data access • Alignment of specialised data with ICB data sources to create single data set • Triangulation with spend data and provider data sets • Application and monitoring of identification rules (IR) and correct allocation of ICB & service lines • Modelling actual ICB spend in relation to planned ICB budget • Calculating impact of future changes in allocations (i.e. shift to needs-based) • Liaising with Trust colleagues to validate assumptions from a data perspective • Designing reports and modelling tools as required • Supporting financial intelligence colleagues with in-depth data quality analysis • ~~Development of specialised BI matrix team approach (ICB and hub)~~ • Development of lessons learned document to inform 24/25 planning	• A system with excellent visibility and understanding of specialised activity flows and finances • Joined-up data infrastructure within each ICS, to ensure a holistic view across acute and specialised services. • A BI resource at each ICS that can provide timely and reliable insight to finance, contracting, quality and other teams across South London. • Ability to build on solid foundations to identify unwarranted variation and integrate into local PHM approaches

Data/BI - lessons learned and recommendations

Data/BI – Data Flows & Completeness



Data Flows & Completeness

Lesson Learned

Pathfinder Phase 1 identified how NHSE's view of SLAM data is different to ICBs' view of SLAM data, as the data passes through different organisations which process and disseminate the data in slightly different ways.

During Phase 2, the precise reasons behind this have been identified and learning shared amongst all stakeholders involved. These include:

- Provider data quality (leading to dissemination to NHSE only)
- Emailed data submissions (pre-Data Landing Portal)
- Providers submitting multiple, conflicting files
- Failure of NHSD's MESH system
- Errors in the local DSCRO's dissemination logic
- Errors in the local DSCRO's hosted provider table

Solutions to some of these issues have been implemented, and others have been captured to ensure any future analysis adjusts for missing data. Together this means that ICBs now have much greater confidence in using this data for financial monitoring and transformation.

Full details of these issues and (where applicable) their resolutions are found in Data Deep Dive 1.

The precise issues faced by ICBs will depend on their local DSCRO structure. London has a single local DSCRO and a unified provider submission process, but other regions may have multiple local DSCROs and providers making different submissions using different templates. Some ICBs will have AGEM as both their local and national DSCRO for specialised data processing, although even in this case their local SLAM data is likely to be different to NHSE's view for example due to local prices added post DSCRO processing.

Recommendation

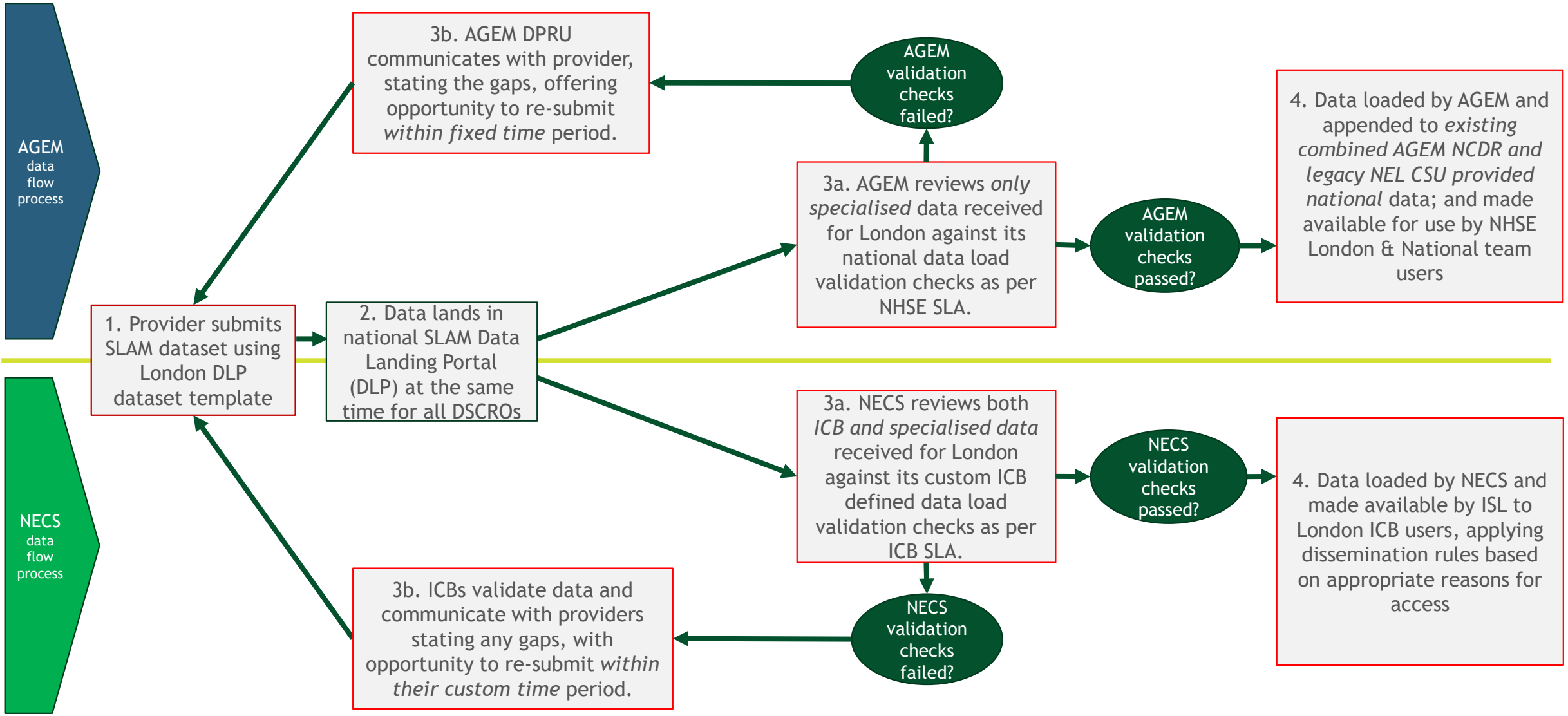
NHSE should review the DSCRO structure to ensure it is fit for purpose post-delegation. As ICBs are being asked to take on the financial risk for these services, they should also be able to 'own' the data flows and be able to work with a local DSCRO they have a contractual relationship with.

ICBs undertaking delegation may wish to conduct a similar process to that undertaken in South London, to understand their DSCRO landscape and provider submission process, and determine where differences exist between their view of specialised SLAM and NHSE's view. There may be issues with dissemination logic that can be corrected.

Data Deep Dive 1

SLAM Differences

SLAM Flows in London – Simplified Diagram



10 | **Note:** Red boxes indicate potential root cause area that can drive differences in the end stage data made available to London ICB users.

SLAM Data Gaps – Simplified Categories

The below table outlines the key categories of differences or gaps found in the two cuts of specialised SLAM data provided to London ICBs that needed to be investigated.

Category	Local NECS provided data (aka The LS data)	National AGEM provided data (aka The DC data)	Possible causes to be explored by DSCROs
Category 1	Data present	Data missing	Suggests provider has submitted data, but AGEM processing issue?
Category 2	Data missing	Data present	Suggests provider has submitted data, but NECS processing issue?
Category 3	Data present but total £ value different for same dataset in DC version	Data present but total £ value different to same dataset in LS version	Suggests provider has submitted data, but DSCROs omit some records due to processing rules?
Category 4	Data present but total £ value difference between ACM and PLCM, does not match DC version	Data present but total £ value difference between ACM and PLCM, does not match LS version	Suggests provider has submitted data, but DSCROs have different processing rules creating this difference?
Category 5	Data missing	Data missing	Suggests provider did not submit, but to confirm.

List of Issue Types Found

Investigation of the data gaps/differences found six main causes.

Detailed explanation of these causes can be found on the following slides.

Issue	Type	Scope	Further Action
1	Historic Provider Data Quality	Widespread	NA (DQ Improvement programme for prospective data)
2	Pre-DLP Submissions	Limited	NA
3	Conflicting submissions in multiple files	One provider – all years	Amend prospective submissions
4	Failure of NHSD's MESH system	Limited	NA
5	Error in NECS dissemination logic (residence responsibility)	All DrPLCM	NECS to resolve
6	Error in NECS hosted provider table	All data for certain ICB-provider combinations	NECS to resolve

1. Provider Data Quality

- A large number of issues found related to historic provider data quality problems.
- If providers have incorrectly entered the ICB/CCG code of GP registration and/or residence, then records are not able to be disseminated to ICBs.
- This has caused discrepancies between datasets – e.g. where fields have been completed in PLCM but not in ACM, causing a mismatch.
- Although these have not been resolved (as they relate to historic data, often during the pandemic), identifying that issues are caused by errors or omissions in original provider submissions has been useful to confirm that no DSCRO processing issues are at fault.
- Accurate completion of these fields will be key to population-based commissioning of these services. ICBs and London Region have been working with providers to significantly increase the quality of these fields from 22/23 onwards.

2. Pre-DLP Submissions

- A smaller number of issues were found to relate to submissions made before usage of the Data Landing Portal (DLP) was mandated or widespread.
- Due to submissions being made individually to DSCROs via other methods (e.g. email), errors were much more likely and this has resulted in missing data.
- As all submissions are now made via the DLP, we are confident this type of issue will not arise again.

3. Multiple Files Submitted

- The ‘copy recipient’ process ensures that both AGEM and NECS see provider submissions to DLP. Therefore most providers submit one combined file of activity, and the DSCROs import any relevant records contained in that (e.g. AGEM would previously only import records on directly commissioned services).
- However, one provider has consistently split out submissions into multiple files, one for each contract type. This meant it has not been obvious which files each DSCRO should process, and NECS/AGEM have decided to take different approaches.
- AGEM processed all files, but due to the way the files had been split up, there were some duplicate combinations of Provider Code, Commissioner Code, Month and Year. AGEM cannot accept duplicates like this, so this caused some records to be deleted where duplication occurred.
- London Region will work with the provider to amend the way they submit data, as there is no technical need for submissions to be split into multiple files.

4. Failure of MESH System

- One issue was identified to have been caused by a failure of NHSD’s MESH system to deliver data submitted to DLP by a provider, to one DSCRO.
- Steps have since been taken to improve the resilience of MESH, so this is less likely to happen in the future.
- Additionally, AGEM and NECS have put in place additional manual checks to ensure everything submitted via DLP reaches data warehouses.

5. Error in Dissemination Logic

- Records should be visible to ICBs for activity at non-hosted providers if their ICB is entered for either of the following fields:
  - The ICB of patient GP practice registration
  - The ICB of patient residence
- Records were being disseminated based on the above conditions for most tables, however an error was identified in the drugs (DrPLCM) table, where records were not being disseminated by NECS based on the ICB of residence.
- This has an impact on a relatively small amount of records (non-hosted providers, where ICB of GP practice is not the same as ICB of residence), but it is important for it to be corrected.
- We are awaiting confirmation from NECS that the logic has been corrected, and data re-pushed.

6. Hosted Provider Table Issue

- An issue was identified where an ICB was receiving more data for a non-hosted provider than they were expecting (i.e. seeing records for patients registered at other ICBs, as if they were the host).
- NECS identified that the table which maps providers to ICBs had not been updated and needed to be amended to reflect current ICB-provider relationships.
- We are awaiting confirmation from NECS that the table has been corrected, and data re-pushed.

Outcome

- Thanks to the efforts of DSCRO and ICB colleagues between meetings, the group identified a cause behind each of the issues raised.
- Some of these causes (e.g. dissemination logic & hosted provider table) can now be resolved by NECS, once for the whole of London.
- Other causes (particularly provider data quality issues in historical submissions) cannot be easily resolved, but can be recorded and taken into account when looking to do analysis using data from previous years.
- As the reasons behind the data gaps have been identified, organisations within South London will now have much greater confidence in using specialised SLAM data for financial analysis.
- Given that this is a new data flow for ICBs, this has also been a useful process for ICBs to explore the nuances of the data and learn from expert colleagues from both DSCROs and NHSE London.

Conclusions & Future Recommendations

- The introduction of specialised contract monitoring data flows to ICBs means that identical data is being processed simultaneously by two different DSCROs. This duplicative process is unnecessary and could lead to differences in contract values when viewed by NHSE and the ICBs.
- The process also means that providers may face multiple communications from both DSCROs if there are issues with their submissions. Slightly different acceptance criteria could potentially mean that a submission that is acceptable to one DSCRO is not acceptable to the other. There is no clear 'lead' DSCRO that providers should work with for specialised data.
- Given that 'green' specialised services are being delegated to ICBs, with the associated significant transfer of funding, the view of the South London ICBs is that local DSCROs should lead on processing data for delegated specialised services, in the same way that they do for other ICB-commissioned services.
- As ICBs are being asked to take on the financial risk for these services, they should also be able to 'own' the data flows and be able to work with a local DSCRO they have a contractual relationship with, in order to effectively resolve any data quality or processing issues that arise relating to the services they are commissioning. ICBs do not have a contractual relationship with the national DSCRO (currently AGEM).
- However, it is also important that any changes to data flows do not create any extra burden for providers. In London, providers make one single submission, which flows to both DSCROs via the copy recipient process. Any new submission process introduced must not require providers to make multiple (different) submissions.

Data/BI - Data Quality 1

Data Quality

Lesson Learned	Recommendation
Pathfinder Phase 1 identified that key data fields allowing data/cost dissemination are the ICB of GP responsibility and service line code. During Phase 2, detailed work to understand the levels of activity missing a valid code in either of these fields has been undertaken. This work needs to be conducted with the assistance of NHSE, as ICBs may not have visibility of records that do not have a valid ICB code. The results showed that due to the ongoing work to improve data quality, only 2.6% of ACM value had no service line assigned, and 4.8% had no ICB assigned. The majority of activity missing these fields was adjustments and block payments, rather than specific activity. Whilst these are relatively low, ICBs have been working with providers to improve this position. Some barriers have been identified however (see next lesson learned).	ICBs and NHSE should work together to identify where SLAM data entries are missing either of these key fields, so providers can be made aware and work to rectify where possible. Any financial modelling undertaken will need to take into account the proportion of activity that cannot be assigned to a specific ICB or delegation status.

Data/BI – Data Quality 2

Data Quality

Lesson Learned	Recommendation
In South London, **HIV and Prosthetics** services are often not reported on a population/ICB basis, but instead reported as a single block per provider. As these services are proposed for delegation, this undermines population-based reporting. Work is undergoing to understand if these blocks can be split, but it appears Prosthetics in some areas is essentially funded on a host-provider basis, which means it is not simple for providers to report on a population basis.	ICBs should review specialised SLAM for their host providers to determine whether any service lines are routinely being reported as a single block per provider. **NHSE should scope, nationally, as to whether providers are currently able to consistently report HIV and Prosthetics services on a population-basis. If providers are unable to do this due to the nature of these services, NHSE should review whether it is suitable for these services to be classed as 'green' and delegated on a population-basis. They may be more suited to the amber or blue categories.** NHSE should explore whether there are any other service lines (e.g. fetal medicine) which providers do not tend to report on a population-basis, to understand whether this can be rectified or if these service lines need to be taken out of the 'green' category.

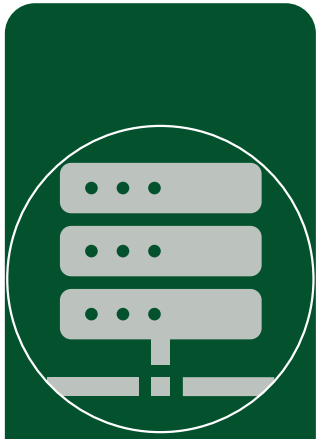
Data/BI - Reporting

Reporting

Lesson Learned	Recommendation
NHSE regions can support ICBs by co-creating population-based reporting tools using their (national DSCRO) view of the data. In South London, NHSE London created a 'Pathfinder Report' which enabled ICBs to begin tracking ACM-reported provider income against allocations on a population basis, while they built up their own internal reporting capacity.	NHSE regions should work together with ICBs to co-create reporting tools.

Lesson Learned	Recommendation
ICBs have a large number of existing reports, many of which may benefit from eventual inclusion of specialised services data. Some reporting tools (particularly those based on SUS) may already include specialised activity, but could benefit from additional functionality to be able to view data by service line or delegation status.	ICBs should review their existing reporting tools to scope where additional functionality on specialised reporting could be added.

Data/BI - Other Resources & Datasets 1

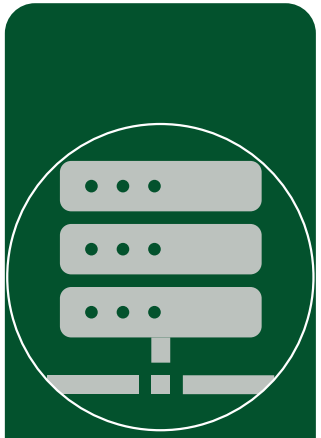


Other Resources & Datasets

Lesson Learned	Recommendation
The Service Portfolio Analysis (SPA List), which classifies each service line into green, amber, red or blue, is a key document in the analysis of specialised services. All partners in the system need to use the same list in order to determine who is responsible for commissioning each service line. The published version of this document is significantly out of date and is not comprehensive. Updated versions have frequently been received from the national team, however there is no formal version control and some valid service lines are still missing. We are also aware that a significant number of new service lines will be added to the Identification Rules and PSO Tool from 23/24. This may add additional complexity for providers to begin using these codes at the same time as delegation goes live.	**NHSE should ensure that every possible valid service line is assigned a delegation category**. The SPA list should then be published in an accessible location, ideally on a publicly accessible website, in spreadsheet format. **A formal governance and cascade procedure should be put in place for when updates need to be made to the list (e.g. for new service lines or status changes).** Communications should be released to regions, ICBs and providers, and a version control system should be introduced to ensure all partners are aware of which version of the list is in use. **NHSE should consider the impact of the number of changes in service lines on providers**, and work with providers to share resources and tools as far in advance of the change as possible, to ensure they are able to apply the new codes from April 24.

Lesson Learned	Recommendation
Allocation setting data uses service lines as they were in 19/20 (as this data is based on the baseline reset exercise). However in contract monitoring data, providers will use current service lines, of which there are many more than in 19/20. This means that modelling spend against allocation by service is very difficult and will show significant variance just due to service line changes.	**NHSE should update allocation setting data when the list of valid service lines is updated**, so that allocations are based on the actual set of service lines valid in a particular year (e.g. 24/25). This would enable providers, ICBs and regions to model variance by service in a reliable way.

Data/BI - Other Resources & Datasets 2



Other Resources & Datasets

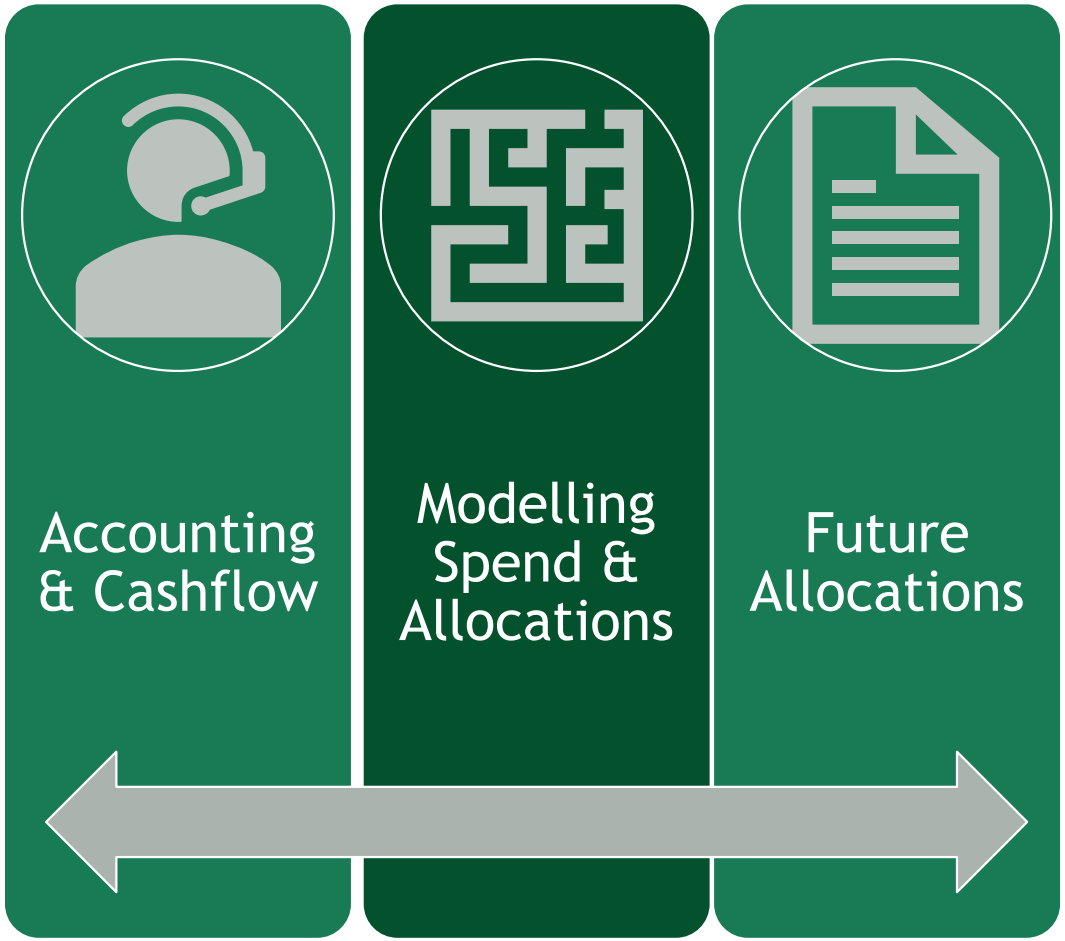
Lesson Learned	Recommendation
Pathfinder Phase 1 identified that there are other clinical databases (e.g. HARS, SSNAP) used in the commissioning of specialised services, which ICBs do not have access to. During Phase 2, very limited progress has been made on identifying these datasets and determining whether ICBs need to gain access in order to effectively commission specialised services.	NHSE have a project underway to identify which datasets are used in the commissioning of specialised services, and whether NHSE can facilitate ICB access. Although this project has not concluded, NHSE should widely circulate a list of identified datasets as soon as possible, to give ICBs visibility of the datasets potentially in scope. While ICBs do not have direct access to these datasets, regional teams should make extracts available if/when necessary in the meantime. **NHSE should prioritise arranging full ICB access for those datasets which NHSE directly hold.** In the meantime, regions should facilitate access by providing extracts if/when required.

The BI objectives of triangulation of spend data, modelling spend in relation to budgets, and assessing the impact of needs-based allocations were carried out jointly with the Pathfinder finance workstream. Lessons & outcomes can be found in the following finance section.

Workstream 2 - Finance

Function	Objectives of the Pathfinder	Success Criteria
Finance	• Planning and safe transition to ICB allocation on ledger • Testing of accounting, cashflow and other national SOPs. • Testing attribution of financial flows to populations • ~~Development of specialised finance matrix team approach (ICB and hub)~~ • Aligning finance and contracting approaches • Risk management – including understanding impact of allocation formula change • Preparing ground for transformation opportunities (including whole pathway costing) • In depth work across NHSE, ICBs and providers to test comparability of service line reporting and costing ('like for like') – feedback to NHSE re impact on rebasing • Preparation for and management of impact of EPIC implementation in three tertiary trusts in 23/24 • Development of lessons learned document to inform 24/25 planning across regions and ICBs	• A low transactional cost system • A system with high levels of accuracy and timeliness • A process in which partners (providers, ICBs, regions, national team) feel engaged and recognise the final proposals for 24/25

Finance - lessons learned and recommendations



Finance - Accounting & Cashflow (1)

Accounting & Cashflow

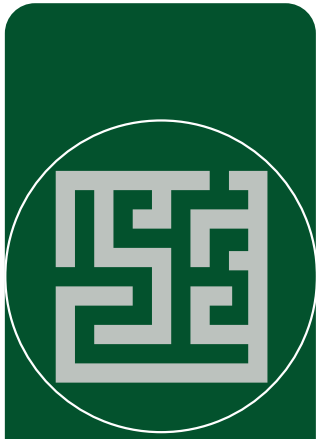
Lesson Learned	Recommendation
Complexity of multiple, iterative small changes to budgets/allocations has potential to cause confusion and miscommunication.	**As undertaken in Pathfinder, it is recommend that NHSE continues to pool all specialised budgets, with a split between delegated and non delegated, and by service line colour, with ICBs and Providers having sight of this.** Also recommended to consider how these iterations are shared and version controlled, so all parties have sight and access to latest information and history. NHS Futures may be an option here.
Steady State Funding is the best course of action, with ERF and NTPS recommended variable elements considered to be the only items to be adjusted for performance in year (i.e. Chemotherapy)	**Providers and ICBs will need steady state of funding in at least the first year of delegation to ensure a balanced placement of risk across systems and NHSE**. Payment for variable activity elements relating to ERF will vary in year in accordance with NHSE monitoring/national targets. The ERF variable values within contacts should also be matched to the ERF targets (this has been the course of action within South London in 23/24)
ERF has the potential to be difficult to administer if each ICB has to report separate performance for Specialised and Non Specialised activity across all their contracts. There is also non delegated activity which will remain with NHSE and would have to factored in, as it features in baselines.	During Pathfinder, the ERF for South London Providers was hosted by a single ICB on behalf of the whole country, and held the entire ERF allocation. It may be best course of action to continue to do this in 2024/25 given the complexities involved of assigning activity to populations, with NHSE retaining responsibility for many services and likely difficulties in determining relative performance split between delegated v non delegated services. What would need to be clarified is where clawback risk would sit however.

Finance - Accounting & Cashflow (2)

Accounting & Cashflow

Lesson Learned	Recommendation
Continuing the process of detailed budget setting into 24/25 so that ICBs and Providers can understand the allocations they are to work with .	**In 2024/25, budgets/allocations continue to be linked to the baseline reset exercise so ICBs receiving allocation can understand the uplifts applied i.e. continuing the process utilised through pathfinder**. These budgets should continue to split by service type, NPoC code etc. This will help ICBs to understand the iterative changes to allocations over the years. Uplifts in 24/25 may then be informed by guidance and ICBs then to consider.
Managing in year allocations/ rules changes should be made as simple as possible.	**Updating allocations/payments is advisable to undertaken on a quarterly basis (rather than monthly) as inflationary adjustments/new funding streams are added**. This may also be made easier if all delegated funding was to be pass directly to ICBs post delegation i.e. in year inflationary uplifts/new funding streams, rather than be 100% passed to NHSE at first and then split into delegated and non delegated as happened in pathfinder. Recommend not rebranding service colours or PSS rules in year and only changing at the start of a year which cause further complications to in year variations.
Ledger reporting consistency across England.	**Instructions for ledger reporting will need to be shared nationally with ICBs to ensure Spec Comm reporting is reporting in a consistent way across the country**. Including this as a formal appendix to the delegation agreement is advisable.

Finance - Modelling Spend & Allocations



Modelling Spend & Allocations

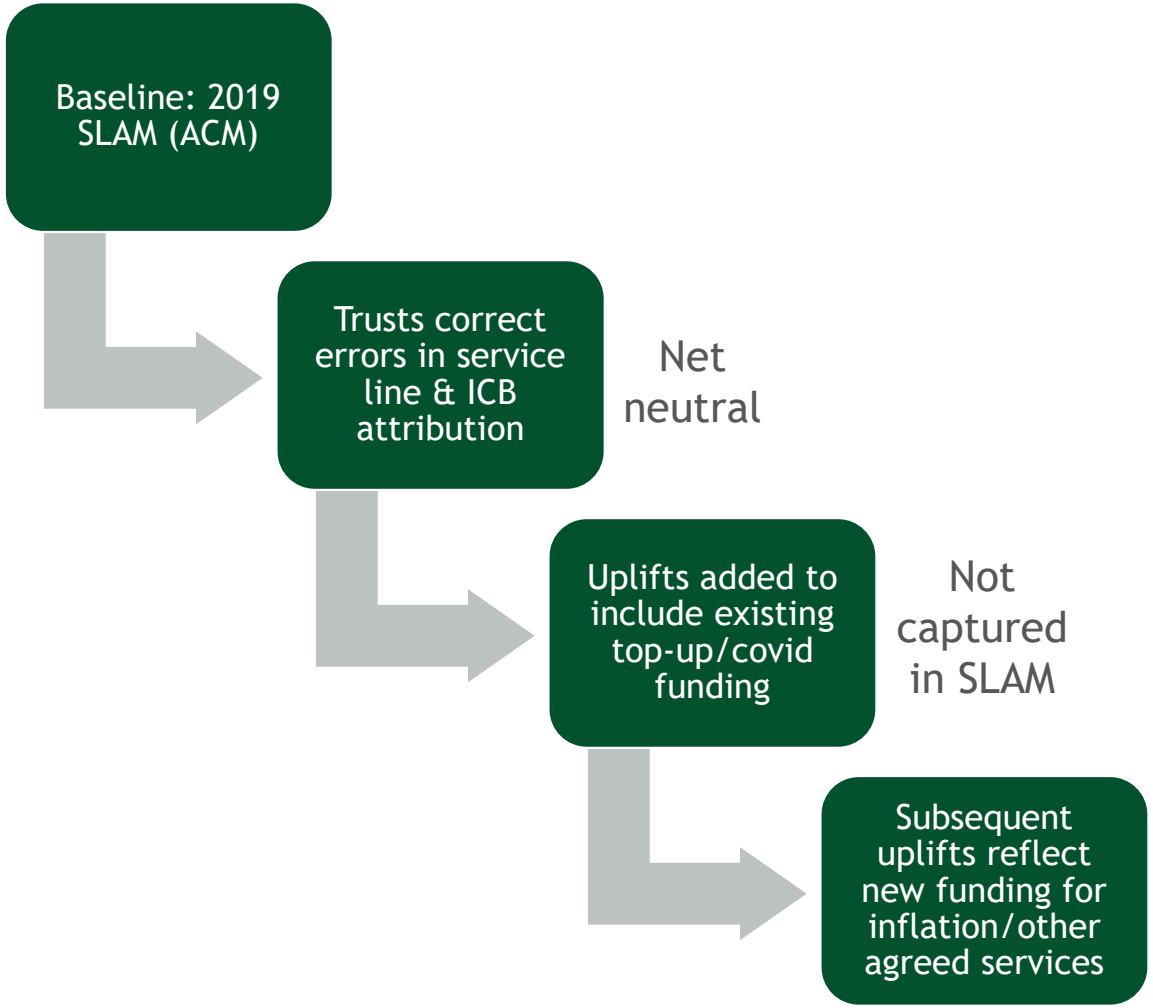
Lesson Learned	Recommendation
Modelling ACM-reported provider activity against allocations (on a provider and population basis) has consistently resulted in ACM values being 20-30% below specialised allocations. Significant amounts of work have been undertaken to understand the cause of this discrepancy, which has shown that, post-Covid, provider income has become detached from tariff price. In the course of the 'baseline reset' calculations within the allocation setting process, significant amounts of extra funding were captured within the allocations but did not see corresponding tariff increases. Therefore the value of payments to providers for specialised activity is significantly higher than the notional tariff value of that activity when reported through SLAM. This issue is not confined to South London and likely effects all ICBs and providers nationally, to varying extents. Additionally, there is also evidence to suggest this effect is being seen in acute (non-specialised) allocation monitoring. **Further detail on this issue can be found in Finance Deep Dive 1.**	Clarity from NHSE on this issue would be appreciated, to confirm that the situation is understood at a national level and that providers and systems will not be penalised for financial 'underperformance' against allocations. **When specialised services are delegated, ICBs will need to pass through baseline contract values to providers, rather than attempt to renegotiate contracts based on the notional tariff value of activity performed. Guidance from NHSE on how ICBs should approach this issue would be valuable.**

Finance Deep Dive 1

SLAM/Allocations Variance

Baseline Reset Exercise

The Baseline Reset underpins the specialised allocations. It was a multi-step process.



The process allowed providers to make net-neutral changes to correct errors in ICB or service line attribution.

However the main output was a set of allocations that contained the entirety of NHSE funding, including large amounts not captured in the SLAM baseline.

Essentially the 19/20 proportions (by ICB/Service Line) were significantly uplifted to add up to the actual 23/24 total funding envelope.

This process was necessary because SLAM does not capture the total flows from NHSE to providers for specialised services.

Uplifts Example

Selected Uplifts	% Change
20/21 to 21/22 Growth & Net Inflation £	+8.8%
22/23 Growth & Net Inflation £	+4.4%
Baseline Reset Value £	+13.4%
M6 Pay Award	+1.5%
CC beds	+3.3%
Net Tariff 1.80%	+1.7%
Acute Activity Delegated (green & orange)	+0.5%
Acute Extra Growth	+0.8%
2324 Covid Funding	+0.6%
Total difference - 19/20 Start to 30th Mar 2023	**+36.2%**

Some of these uplifts may be captured in SLAM (e.g. tariff increases), but the 'Baseline Reset Value' and other covid funding are unlikely to have been captured.

As specialised services has switched to population-based funding, these uplifts are not simply paid by a single ICB to their hosted providers. Instead, they are spread across every ICB/Service Line combination.

Finance - Future Allocations

Future Allocations

Lesson Learned	Recommendation
The needs-based allocations methodology is complex and the end-to-end process requires a significant amount of resource to understand. However the outcomes of the model and convergence factor calculation will have a significant effect on ICB allocations for specialised services in future years. The model calculates a 'distance from target' for each ICB. However this includes amber services and high cost drugs & devices, neither of which are delegated to ICBs. The exact methodology that NHSE use to remove these items from the modelled 'fair share' allocation will be critical to the final calculation of a convergence factor for green services only. **Further detail can be found in Finance Deep Dive 2.**	**NHSE should publish a confirmed methodology for calculating 23/24 convergence factors as soon as possible, so ICBs are able to understand the detail and the final impact on their allocations for next year.** The 'glidepath' (number of years taken to get ICBs back to target) should be subject to a consultation process in order to give ICBs time to calculate the level of savings required each year, and feed back on how realistic this would be. Confirmation on how regularly the needs-based model will be updated or re-run would also be beneficial, as this could cause re-calculations of the distance from target during the period that ICBs are on the glidepath to their 'fair share'. **All ICBs may wish to carry out a similar analysis** to understand how their relative need has been calculated, and whether they are below or above 'fair share'. NHSE will be publishing a benchmarking tool to provider further insight to ICBs.

Finance Deep Dive 2

Needs-Based Allocations

Relative Need Modelling

To estimate relative need for each ICB, a model has been created which takes into account various need and supply variables.

The model is successful at capturing 52% of the drivers behind variation in specialised services spend (compared to 82% for general & acute).

For deprivation, age, sex, household type and other sociodemographic factors, variables are sourced from small area statistics such as census records and other ONS publications.

For burden of disease, variables are sourced from SUS and Patient Level Contract Monitoring (PLCM).

Need variables	Supply variables
These are factors, such as in-patient diagnostic history, deprivation, age, sex, household type, that are *legitimately* influencing variation in use of services. **They form the basis for the estimation of relative need.**	Supply factors might affect how much healthcare people receive, but shouldn't influence our estimation of need. They include ease of access to the nearest hospital and local pricing arrangements. **The impact of supply measures is estimated and then neutralised in an area's allocation calculation.**

Could Incomplete SLAM Affect Modelled Relative Need?

SLAM data (for activity) is made up of ACM and PLCM.

ACM:

- The model does not use Aggregate Contract Monitoring (ACM) data. Therefore the issue of missing top-up or adjustment payments in ACM does not appear to affect the needs-based model.

PLCM:

- The model does use Patient Level Contract Monitoring (PLCM) data. This dataset has historically been of relatively poor quality, with ICB attribution particularly variable.
- ACRA have determined they can model a service using this data if it has at least 40% of its estimated activity captured in PLCM. The average coverage is 72%.
- The major services that do not meet the 40% threshold are HIV and Neonatal Critical Care – adjustments for these services are calculated in different ways and added to the model outputs.
- *"Variable levels of completeness do not affect modelling so long as we have a representative sample of complete records. However we are seeking to increase coverage to reduce the possibility of bias."*

Relative Need Outcomes

SEL: 1.06 (6% above average):

- Very young
- Very high HIV
- Average Market Forces Factor +8.5%

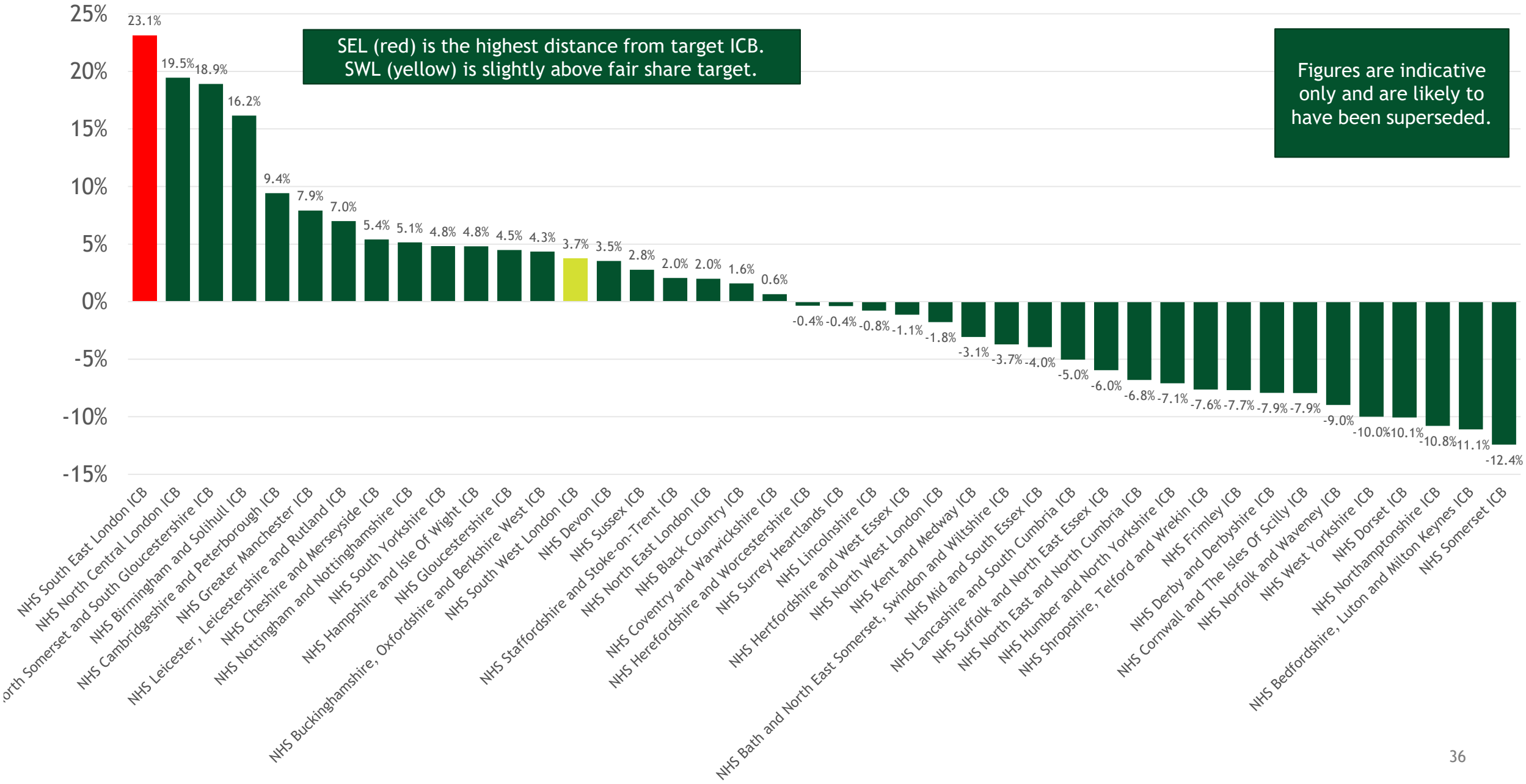
SWL: 0.98 (2% below average):

- Very young
- Affluent
- Average Market Forces Factor +7.75%

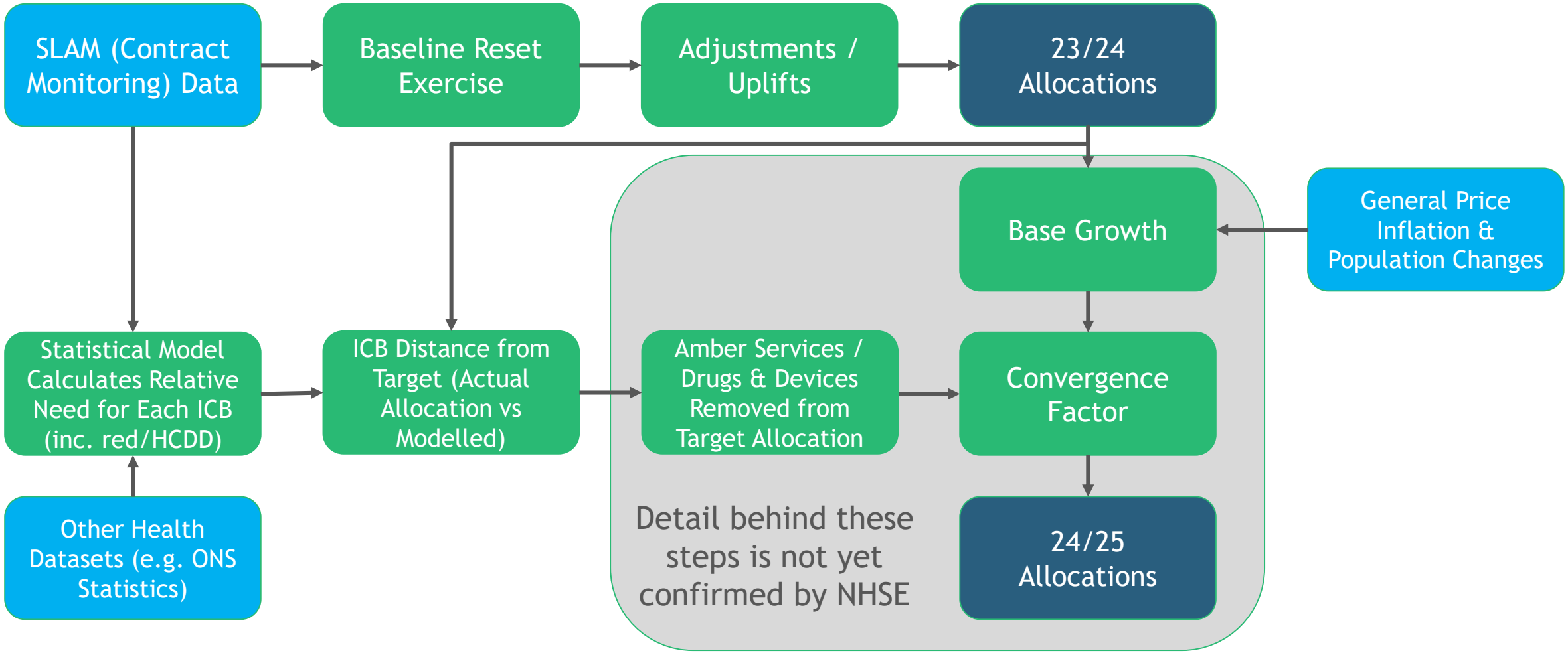
These results show that the modelled need in South London is only slightly below the national average in SWL, and above the national average in SEL.

Therefore the large distance from target in SEL is not due to the modelled need being significantly lower than other ICBs.

Distance from 'Fair Share' Target (%)



Allocations Processes



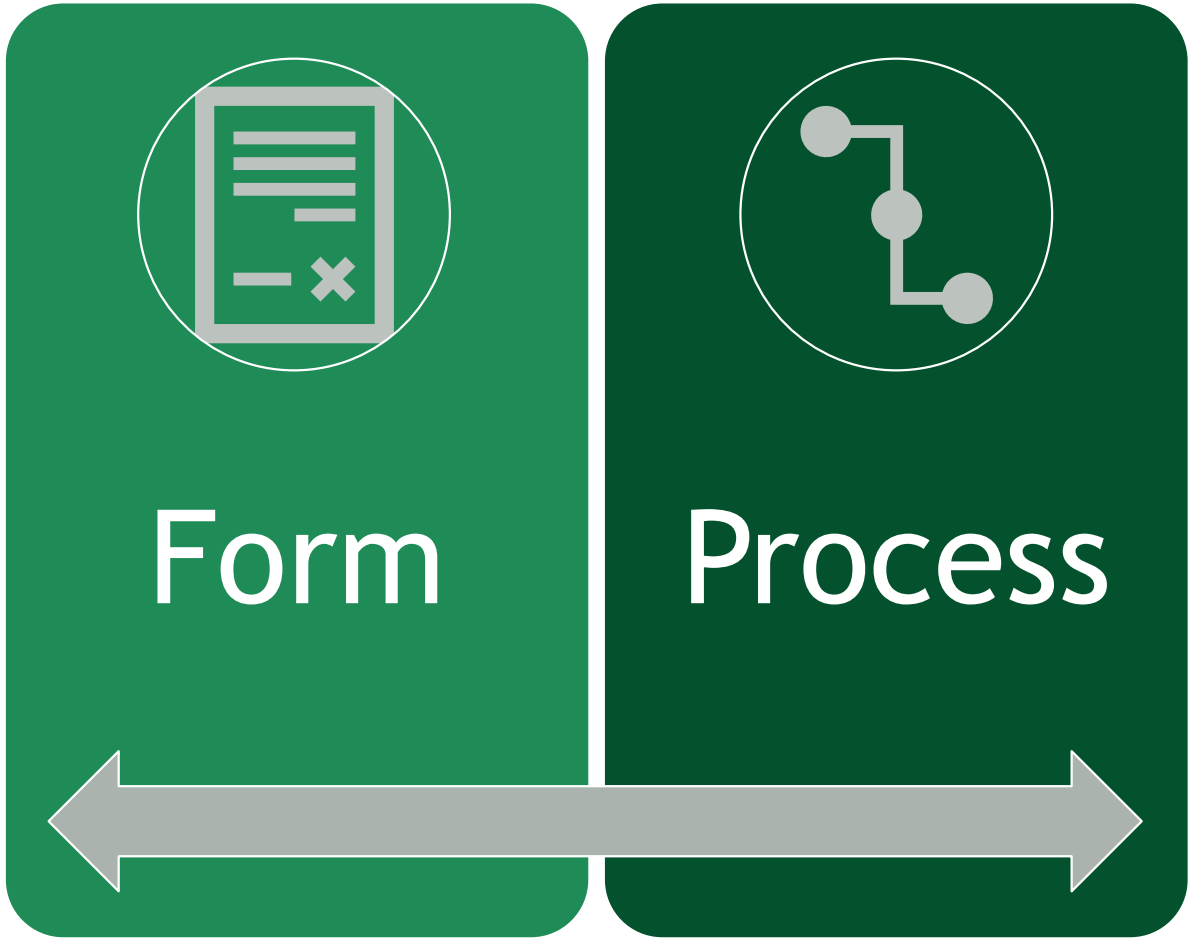
Conclusions

- There is no evidence to suggest that unreported adjustments or top-ups in ACM would impact the needs-based modelling.
- The **modelling may be impacted by poor quality PLCM data**, but the modelling team claim this is unlikely to be the case. It would be useful to see further analysis from NHSE on this point, potentially including the differences that would arise if other data sources were used for this calculation.
- The **methodology for stripping out HCDD** and creating convergence factors is yet to be published. The exact rules applied will be key to understanding actual impact on ICB allocations, and therefore NHSE should aim to publish this as soon as is possible.
- **NHSE's benchmarking tool** may provide much greater insight into the reasons behind the distances from target, provide clues as to whether the methodology is not working effectively, or suggest areas where future transformation/efficiency projects should be focussed. NHSE should ensure this tool is shared as widely as possible once it is published.
- ICBs may wish to perform a similar analysis for their own populations and providers, to begin to estimate the scale of future convergence factors. This will be significantly easier and more insightful once NHSE's benchmarking tool is published.

Workstream 3 - Contracting

Function	Objectives of the Pathfinder	Success Criteria
Contracting	• Agreed ways of working across organisations with accountable leads and workstream forums/ sub groups where required • Agreement of contract form, with defined schedules and legal Assignment • Engagement with key stakeholders and workstream interdependencies (especially Finance, Bi and Data workstreams) • ~~Working with NHSE London Region contracting team to align seven regional associate contracts to SEL and SWL led host arrangements and co-designing contract models and CCA.~~ • Establish process and implementation of testing phase. • Production of lessons learned document OR contribute findings to lessons learnt - agreement of measurements / milestones/ indicator that demonstrates success.	• Agreed principle of contracting approach (GC12 for pathfinder, assignment of responsibilities rather than full delegation) • Integrated working across key NHSE Regions (i.e. SE) • Integrated working across BI, Finance and Contracting workstreams • A process in which partners (providers, ICBs, regions, national team) feel engaged and recognise the final proposals for 24/25

Contracting – lessons learned and recommendations



Contracting - form

Form

Lesson Learned	Recommendation
As London ICBs are already the host commissioner for providers (both ICB and NHSE spend) the additional allocation for green services is relatively easy to transfer into the ICB part of the contract (with agreement across NHSE, providers and ICB on the spend transferring)	London region had implemented the change to ICB 'host' or lead commissioner several years ago. While there are other contracting models possible, the combining of the NHSE specialised spend within the main contract creates significant efficiency benefits and is easy to communicate to providers.

Lesson Learned	Recommendation
Through the implementation of Pathfinder, contracting teams started to test a model of assignment of commissioning responsibility and contracting form; for 23/24 the assignment process covered the functions highlighted in yellow on the next slide.	As London is not taking delegation in 24/25 there has not been the opportunity to explore the extension of this process for full delegation. The intention – and recommendation to other ICBs – is to use the contract schedules to identify the timing of assignment of contract responsibility to ICBs through to the point where there is a full transfer of contracting responsibility (recognising the complexity of timing i.e. NHSE lead contract negotiations to March 24 with a signed contract unlikely to be in place for 31/03/24.

Contract Schedules – commissioning responsibility (assigned)

23-24 SWL Contract Tracker	Management responsibility within Pathfinder 23/24
SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM	
A - Conditions precedent	NHSE
B - Commissioner Documents	NHSE
C. Extension of Contract Term	
SCHEDULE 2 – THE SERVICES	
A. Service Specifications	NHSE
B. Indicative Activity plan	NHSE
C. - Activity Planning Assumptions	NHSE
D. Essential Services (NHS Trusts only)	
E. Essential Services Continuity Plan (NHS Trusts only)	NHSE
F. Clinical Networks	NHSE
G. Other Local Agreements, Policies and Procedures	NHSE
H. Transition Arrangements	
I. Exit Arrangements	
J. Transfer of and Discharge from Care Protocols	NHSE
K. Safeguarding Policies and Mental Capacity Act Policies	NHSE
L. Provisions Applicable to Primary Medical Services	
M. Development Plan for Personalised Care	
N. Health Inequalities Action Plan	NHSE

SCHEDULE 3 PAYMENT	
A. Aligned Payment and Incentive Rules	NHSE
B. Locally Agreed Adjustment to NHS Payment Scheme Unit Prices	NHSE
C. Local Prices	NHSE
D. Expected Annual Contract Values	NHSE
E. Timing and Amounts of Payments in First and/or Final Contract Year	**ICB**
F. CQUIN	NHSE
SCHEDULE 4 – QUALITY REQUIREMENTS	
Local Quality Requirements	NHSE
SCHEDULE 5 - GOVERNANCE	
A. Documents relied on	NHSE
B. Provider's Material Sub-Contracts	
C. Commissioner Roles and Responsibilites	NHSE
SCHEDULE 6 - CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS	
A. Reporting Requirements	**ICB**
B. Data Quality Improvement Plans	**ICB**
C. Service Development and Improvement Plans	NHSE
D. Surveys	NHSE
E. Data Processing Services	
Schedule 7 - Pensions	

Contracting – process for transition

Process

Lesson Learned	Recommendation
Only two functions in the contract in 23/24 were assigned to ICBs from NHSE. If London region had been taking delegation in 24/25 then a proposal was in place to align; • Financial planning to integrate/triangulate specialised contract spend with providers and ICB control total/allocations through Q3 and Q4 • An assumption that NHSE would lead the contracting discussions for 24/25 (with ICBs in support) with a 'flip' moment agreed for ICB to take the lead with NHSE in support • An assumption that the contract would not be signed by 1st April 2024 so a transition period would be established that identified clearly for all parties where commissioning responsibility sat for each function.	Where ICBs are taking on delegated responsibility for specialised commissioning from April 24 they will need to agree; • How to integrate specialised activity and spend into 24/25 contract offers/integrated control totals • Consideration of the issues related to timeliness of contract signing and the 'owner' of the contract at any point in time • A due diligence approach so that every function within the contract is aligned through Q3 and Q4 leading to minimal change as the full contract responsibility moves from NHSE to ICB • Collaborative working across ICBs and specialised as well as between functions (Finance/Contracting/BI) – a continued focus on building relationships is key.

Glossary

Glossary

AGEM – *See* Arden and GEM

Aligned payment and incentive - API is a type of blended payment, comprising a fixed element, based on funding an agreed level of activity and a variable element, which increases or reduces payment based on the actual activity and quality of care delivered.

Amber services - Amber services include the 57 service lines considered to be “suitable but not yet ready for greater ICB leadership” as listed in the NHS prescribed services manual.

API – *See* Aligned payment and incentive

Arden and GEM – The Arden and Greater East Midlands Commissioning Support Unit (AGEM) serve as a partner to NHS providers and commissioners, and provide data services, such as development of the NCDR portal.

DA – *See* delegation agreement

Data services for commissioners’ regional offices – DSCROs de-identify patient data before it is passed to the Commissioning Support Units (CSUs) who act as the data processers for ICBs. This is because commissioners are not able to receive identifiable data (except for a few specific circumstances. DSCROS provide an intermediary service that specialises in processing, analysing and packaging patient information into a format that commissioners can legally use.

Delegation agreement – The delegation agreement details the agreement made between NHS England and an integrated care board on specialised services delegation.

Data Protection Impact Assessment – A DPIA is the process to help identify and minimise the data protection risks of a project.

DPIA – *See* Data protection impact assessment

DSCRO – *See* Data services for commissioners’ regional offices

Green services - Green services include the 109 service lines considered to be “suitable and ready for greater ICB leadership” as listed in the NHS prescribed services manual.

ICB – *See* Integrated care board

ICP– *See* Integrated care partnership

Glossary (cont)

ICS – *See* Integrated care system

IG – *See* Information governance

Information governance (IG) – How the NHS handles patient and sensitive information legally, securely, efficiently and effectively

Integrated care board (ICB) – ICBs are responsible for NHS services, funding, commissioning, and workforce planning across the ICS area.

Integrated care partnership (ICP) – ICPs are responsible for ICS-wide strategy and broader issues such as public health, social care, and the wider determinants of health.

Integrated care system (ICS) - ICSs bring together NHS, local authority, and third sector bodies to take on responsibility for the resources and health of an area or system.

Joint committee – Introduced in April 2023, this provided formal working arrangements for shared decision making between NHS England and ICBs across nine footprints, with a view to moving to delegated commissioning arrangements from 2023/25 (subject to system readiness assessment).

Joint working arrangement – Linked organisations exercising the functions of one or more of the organisations.

JWA – *See* Joint working arrangement

Multi ICB arrangements – MIA allows an ICB to form appropriate joint working arrangements with other ICBs in its patch.

MIA – *See* multi ICB arrangements

National Commissioning Data Repository - Consisting of two elements – a data warehouse to store national data and a reporting portal – the NCDR is considered the central data repository and provides a ‘single version of the truth’ to support commissioning. The NCDR portal is a web-based application primarily to support direct commissioning

NCDR – *See* National Commissioning Data Repository

PDAF – *See* pre delegation assessment framework

Remove

Glossary (cont)

Pre delegation assessment framework – The national NHS England process to assess ICB readiness for commissioning of specialised services, both as an individual ICB as well as part of multi ICB arrangements (see PDAF)

Red services - Red services include the 105 service lines considered to be “not suitable for ICB delegation and will remain nationally commissioned” as listed in the NHS prescribed services manual.

Secondary uses services – SUS is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

Service level agreement monitoring – SLAM is contract monitoring data.

SLAM – *See* Service level agreement monitoring

SUS – *See* Secondary uses services