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**November 2019** | Healthcare Financial Management Association

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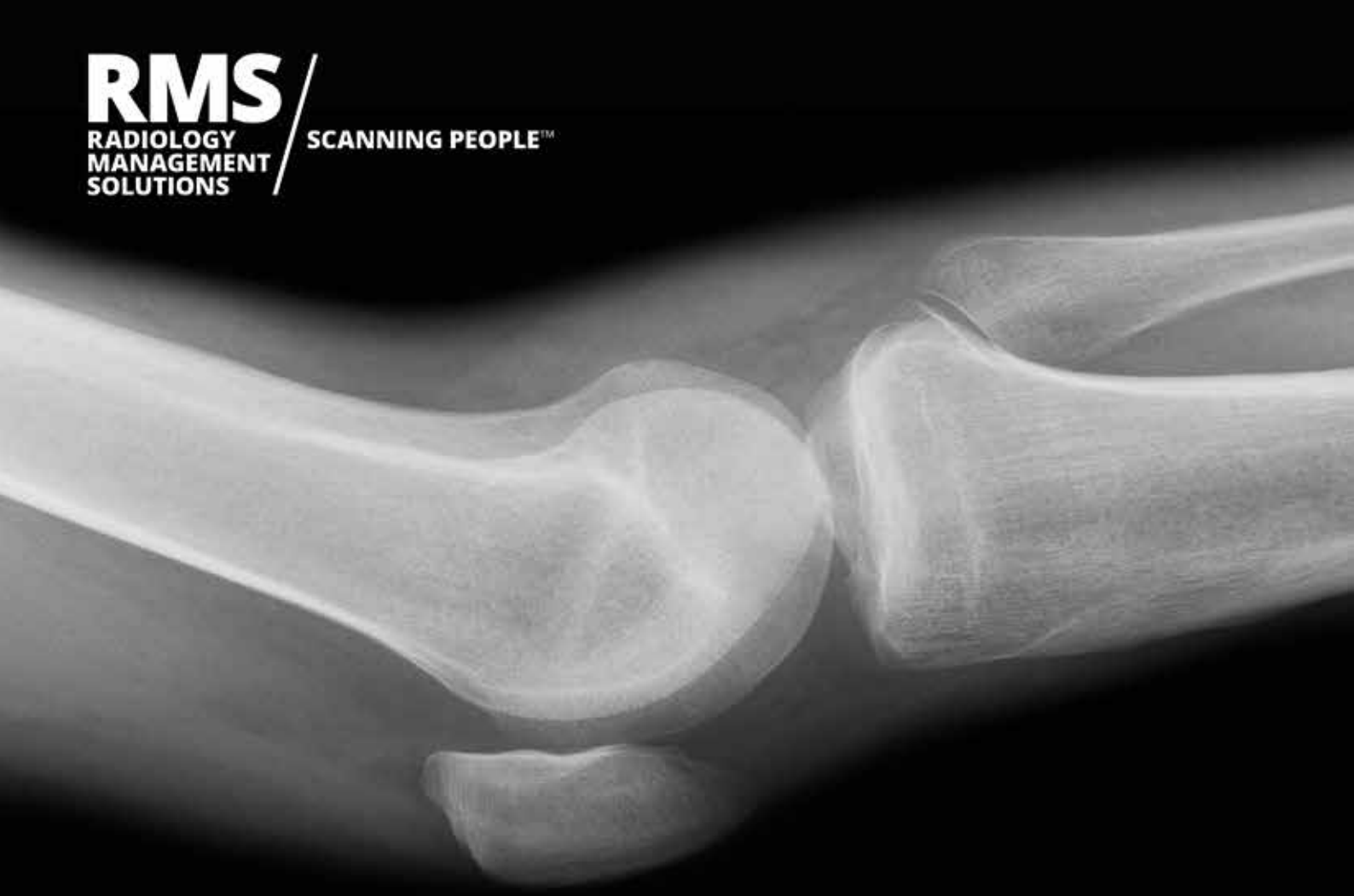

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# News

## Health set to be hot topic in December election campaign

**By Seamus Ward**

While Brexit is likely to dominate debate in the run-up to the general election on 12 December, health and care will also feature heavily and the battle lines are already being drawn.

During the opening skirmishes, prime minister Boris Johnson and Labour leader Jeremy Corbyn clashed over the NHS in the final prime minister's questions before Parliament was due to be dissolved. Mr Corbyn said the Conservatives had presided over funding cuts, which had led to rising waiting times for cancer and other treatments. If he wins the election, the Labour leader said that he would reverse the privatisation of the NHS.

Earlier, Labour warned that a post-Brexit trade deal with the United States would leave NHS services vulnerable to US companies. Drugs prices could increase under such a trade deal, putting NHS finances at risk.

The prime minister defended the Tory record on the NHS, highlighting recent spending commitments. He insisted voters faced a stark choice between his government, which was spending 'unrivalled' sums on the health service, and Labour, which would destabilise the economy, leaving less to spend on the NHS.

A majority of MPs agreed to go ahead with the general election after the European Union accepted the UK's request to extend the deadline for leaving until 31 January 2020.

Keith Willett, NHS England and NHS Improvement EU exit strategic commander, wrote to the service to explain that the NHS no-deal exit plans would not come into force on 31 October, as planned.

He said arrangements to monitor the operational impact of a no-deal exit have been paused until the next no-deal date approaches. The extension period would be used to review NHS plans for all scenarios, including a deal and no-deal, to ensure the service is as prepared as possible, he added.

**Arrangements to monitor the operational impact of a no-deal exit have been paused until the next no-deal date approaches**

An incoming government will face several decisions on health and care. It will have to decide whether to take forward legislation set out in the Conservatives' Queen's Speech in mid-October. This included several NHS bills, including one to smooth the implementation of the *NHS long-term plan*. Measures that could be part of the bill include greater tariff-setting flexibility and a reserve power to set foundation trusts' capital spending limits.

When the long-term plan was published, Labour welcomed its aspirations, but it warned that the NHS would continue to be held back by cuts and chronic staff shortages.

The next government will also face a strong lobby from the medical profession to reform pension tax rules that are said to have led clinicians to refuse additional shifts or even consider early retirement.

The NHS in England is due to be working its way back to financial balance – both overall and as individual organisations – over the first years of the next government.

The finance report for quarter one, published by NHS England and NHS Improvement in October, showed the overall revenue position for providers and commissioners was largely in line with plan over the first quarter of 2018/19. The forecast year-end position indicated an overspend of just under £84m against plan (the NHS has planned a balanced position across commissioners and providers).

According to the report, the forecast overspend was largely due to technical reasons.

Looking deeper at the figures, the forecast year-end position for commissioners was an underspend of £196m, against a planned £282m underspend. Providers plan to overspend by £282m, although the forecast predicts a slightly lower overspend of £280m.

In September, NHS chief financial officer Julian Kelly gave a headline report on the month 4 position, which showed a year-to-date overspend of £75m against plan (*see Healthcare Finance, October 2019*).

## HFMA Awards shortlist announced

The HFMA has unveiled the shortlist for its eight National Healthcare Finance Awards, which showcase best practice in financial management and governance.

A shortlist of four for the prestigious Finance Director of the Year Award includes: Karen Geoghegan, Brighton and Sussex University Hospitals NHS Trust and Western Sussex Hospitals NHS Foundation Trust; Hardev Virdee, Central and North West London NHS Foundation Trust; Stephen Sutcliffe, NHS Shared Business Services; and Sally May, Royal Cornwall Hospitals NHS Trust and Cornwall NHS Foundation Trust.

As with previous years, some NHS organisations made the shortlist for multiple awards. These include Leeds Teaching Hospitals NHS Trust, which is up for four awards – governance; Havelock; value and innovation; and Working with finance – Clinician of the Year. In the latter award, the Leeds trust has two nominees, Jacqueline Andrews and Liz Kay – the trust's David Berridge won the award in 2018. Mojgan Sani of North Tees and Hartlepool NHS Foundation Trust and Maggie Davies of Western Sussex Hospitals NHS Foundation Trust complete the shortlist.

In addition, Barking, Havering and Redbridge University Hospitals NHS Trust has been shortlisted for the costing and finance team awards.

The winners will be announced during the gala dinner at the annual conference in December.

• *For a full list of shortlisted candidates, please turn to page 20*

# Finance regime to support deficit and surplus trusts

**By Seamus Ward**

Trusts with good and improving financial performance will be handed rewards payments in 2020/21, NHS England and NHS Improvement announced, as they continued to flesh out the details of new financial and regulatory arrangements.

In a letter to the service, the national bodies said they will introduce a two-part incentive scheme for providers achieving breakeven or a surplus, alongside measures to help trusts that are in deficit. The aim is to improve the financial position of individual organisations and the NHS as a whole – the provider sector has been set a target of being in aggregate balance in 2020/21, while all providers and commissioners should break even by 2023/24.

The reset of the financial and regulatory regimes is being led by NHS England and NHS Improvement chief financial officer Julian Kelly (pictured), who has stressed the need for the service to return to financial balance.

The measures build on changes to the financial framework in the current financial year to encourage system working and build up to the removal of control totals from 2020/21. The letter said these include moving £1bn from the provider sustainability fund (PSF) into national prices, reducing the value of CQUIN quality and efficiency payments, and introducing the financial recovery fund (FRF).

The letter included details of organisations' financial improvement trajectory and indicative FRF allocations to inform strategic plans, which are to be submitted in the middle of this month.

'The FRF has been allocated to minimise the number of organisations that would require loan financing if they hit their deficit recovery trajectories, while at the same time ensuring that organisations requiring loan financing also receive an appropriate share of the funding available,' the letter said.

As previously indicated, any remaining PSF balance will be transferred to the FRF from 2020/21, supplemented by the Commissioner Sustainability Fund. And although clinical commissioning groups, as well as providers, will be eligible for support through the FRF, NHS England and NHS Improvement expect most of the funding to flow to providers.

'Crucially, this will allow us to begin to move away from nationally mandated surplus control totals, and, as a result, reset our regulatory relationship with organisations which are at least in balance,' the letter continued.

'We believe that such organisations should have the freedom to determine the levels of surplus appropriate to their circumstances and commensurate with their own investment and transformation plans. We will continue discussions with the sector on the supporting architecture and, in particular, the operation of the capital and loan funding regimes.'

Providers in surplus will not be eligible for FRF allocations and the PSF is coming to an end. However, they will have access to a new incentive in 2020/21. The first element of the incentive scheme will offer a one-year transitional reward payment of 0.5% of relevant income for providers in surplus (before sustainability funding) and that deliver a surplus in 2020/21.

Deficit providers that achieve break even during the planning period will also receive 0.5% at year-end and at the end of the subsequent year if they maintain their financial performance.

# Costing standards revisions promised

**NHS England and NHS Improvement have committed to 'more proportionate' costing standards to support the 2019/20 patient-level cost collection by acute trusts.**

**The HFMA's Healthcare Costing for Value Institute highlighted a number of concerns raised by costing practitioners in a letter to the national bodies in August and this has led to a promise of change. Chris Walters (pictured), the two bodies' director of pricing and costing, told a specially arranged HFMA webinar in October that the feedback was being taken very seriously. He said a decision had been taken in 2019 to issue standards that were highly prescriptive to manage the risk of transition to the new system.**

**He said this had paid off, with a very low rate of requested resubmissions for data quality reasons. 'This gives us some leeway to issue revised standards that are much more proportionate and that we can develop collaboratively,' he said. 'So we shouldn't see a return to the kind of burden you were placed under this year in future years.'**

**Work had already begun to revise the standards, he said, and the HFMA was supporting this work by making recommendations for change. Standards for 2019/20 will be issued for feedback this month, reflecting some of the issues raised (*see technical review, page 26*).**

**A revised online learning platform would be issued alongside the new standards, Mr Walters said. This would streamline existing resources, improve version control and enhance the peer-to-peer aspects of the platform with user groups and forums.**

**He accepted criticism that workbooks and data validation tools used in the collection process had not been sufficiently tested prior to issue.**

**'Partner working between us and third parties has not been as good as it should have been,' he said. New service level agreements between collection partners will guard against problems reoccurring in the future.**

**Mr Walters also addressed concerns that the patient-level costing programme could be exacerbating existing difficulties with recruitment and retention in costing teams. 'That shortage of cost accountants does exist and I have faced the same constraints myself,' he said. But he hoped the changes proposed would be seen as a sign of how committed the national bodies were to ensuring they did not compound the problem.**

## HFMA makes green statement

A switch to an environmentally accredited printer and changes to the paper used for *Healthcare Finance* are just two steps the HFMA has taken to reduce its environmental impact – part of a wide range of actions by the association.

'We take environmental sustainability very seriously,' said chief executive Mark Knight. 'We're here to meet the needs of the NHS finance community and our aim is to do that in the most environmentally sustainable way possible. Many of the steps we've taken are small in terms of our carbon footprint, but they are important and we will continue to explore options to improve things further.'

*Healthcare Finance* is now printed by a firm that holds environmental EMAS accreditation, using 100% renewable energy and chemistry-free plates. And the plastic wrapper used to send the magazine to readers has been replaced by a recyclable paper envelope.

Details of the wide-ranging changes the association has made across its services and at its Bristol headquarters are set out in a newly published environmental sustainability statement at **www.hfma.org.uk**. The use of single-use plastics and printed materials is being reduced at conferences, and the HFMA has invested in technology to enable virtual meetings and reduce travel time for members and staff.

While networking remains important, all committees are now encouraged to hold at least one virtual meeting a year.

• *A greener approach, page 30*

# Reduce reliance on financial support health boards told

**By Seamus Ward**

Achieving financial sustainability in NHS Scotland remains a major challenge, according to Audit Scotland.

In its annual review of the local NHS, the auditors said that half of all health service savings in 2018/19 were non-recurrent. At the start of the financial year, there was a rise in the number of boards predicting year-end deficits (nine compared with seven at the start of 2017/18) and total forecast deficits were higher than the previous year.

All health boards broke even in 2018/19, delivering an overall surplus of £4.6m. However, this was only possible due to additional financial support. Four health boards received a total of £65.7m in additional financial support to ensure overall break-even – up from £50.7m required by three boards in 2017/18.

The auditors said capital was an issue for health boards – capital budgets had decreased by 63% over the past 10 years and backlog maintenance stood at £914m.

The report acknowledged that the Scottish government had taken steps to help boards address the financial issues, as well as to improve access to care. These measures included moving from short- to medium-term financial planning. Financial plans and break-even arrangements are now over three years rather than one.

The government has also implemented a plan to improve waiting times and a scheme to develop NHS leaders.

However, Audit Scotland said it was too early to see the impact of these measures, adding that health and social care integration was too slow.

Without reform, the government predicts there will be a 10% shortfall in forecast health and social care funding by 2023/24 compared with demand. At this point, total funding is expected to be £18.8bn.

The report called for a new national health and care strategy and recommended that the government finalise a national capital investment strategy as a matter of urgency, to ensure capital funding is prioritised strategically.

It should also ensure health boards' three-year plans are finalised before the beginning of each financial year. The plans should be routinely managed and monitored, and include steps to reduce boards' reliance on additional financial support.

Caroline Gardner (pictured), the auditor general for Scotland, said: 'The NHS in Scotland is running too hot, with intense pressure on staff and a service model that will remain financially unsustainable without a much greater focus on health and social care integration.'

She added: 'We're beginning to see examples of new ways of delivering healthcare, but they're some distance from the system-wide reform the NHS needs. The challenge for the Scottish government and its partners will be to agree new priorities that enable large-scale change, which create a leadership culture that supports and respects all staff.'

# Northern Ireland faces pressure from rising demand

Northern Ireland's most senior Department of Health official has said that a projected year-end deficit of £20m in local health and care spending could be minor compared with rising pressures over the next few years.

In speeches in October – to the HFMA Northern Ireland Branch and at a CIPFA event – Department of Health permanent secretary Richard Pengelly (pictured) warned that services had to be transformed and that rising demand was making it difficult for local health and personal social services to remain within budget.

The forecast £20m deficit in the current financial year was 'only a small part of the escalating pressures and demands' local services will face, Mr Pengelly told a CIPFA conference.

Intensive work to balance trusts' books would continue, but the service could not afford to do all

the things it currently offers, never mind reduce waiting lists, increase pay and recruit more staff. 'In the next year alone, the competing demands and pressures could between them add hundreds of millions to an already very stretched health budget.'

Mr Pengelly told the HFMA Northern Ireland Branch: 'Despite our financial challenges, we are getting demands on an almost daily basis for additional spending. Our constant refrain is we cannot spend money we don't have. We need to go further than that, and encourage debate on priorities and how best to use the limited resources we have.'

Transformation was key, he said. 'We can't duck those decisions. If we do, we will be heading over the cliff edge into a full-blown crisis.'

# News review

## Seamus Ward assesses the past month in healthcare finance

**With the debate swirling around Brexit, October produced a rare political decision – a December general election. While political activists will be thinking up ways of distracting voters from the festive season, the decision to go to the polls will have knock-on effects for the health service. There will, of course, be a period of purdah, when public bodies or officials cannot do or say anything that could influence the outcome of the election. It could also mean Queen's Speech measures set out in mid-October may never become law.**

A decision over pension tax reform will be in the in-tray for any incoming government. Potential large tax bills have led many clinicians to turn down extra shifts, promotions or even consider early retirement. Boris Johnson's government moved to address the issue by proposing new flexibilities, allowing clinicians to vary their contributions to the NHS pension scheme to minimise or avoid pension tax. However, in its response to a consultation on the proposals, the British Medical Association said they were merely a sticking plaster that will not solve the current crisis. The doctors' trade union said the proposals would provide 'a much-needed but temporary mitigation' and that where a doctor has reduced their pension contributions, their employer's contribution must be recycled back to the doctor as salary. It called for the annual allowance and tapered annual allowance, which dictate how much a doctor could pay in pension tax, to be scrapped – a move that will require legislation.

NHS England has reached an agreement with the manufacturer of three cystic fibrosis drugs to make them available to patients in England. The national commissioning body had been in long discussions with Vertex Pharmaceuticals on the price of Orkambi, Symkevi and Kalydeco. About 5,000 patients in England will benefit and clinicians will be able to prescribe the drugs within a month. The Scottish government reached an agreement with the company last month. The Welsh government and Northern Ireland health department intend to make the drugs available to local patients. The legal agreement with NHS England requires Vertex to make equivalent terms available to the countries' health services.

Targets for the uptake of pre-school vaccinations in England were missed in 2018/19, according to the National Audit Office. A report, *Investigation into pre-school vaccinations*, said uptake of nearly all pre-school vaccinations had declined since 2012/13. The decrease could not be attributed to a single factor, though the report said there was evidence that the reorganisation of the health system in 2013 led to fragmentation in the way the vaccination programme is delivered.

The pay review body for doctors and dentists must take account of affordability when it makes recommendations for the 2020/21 pay round, according to health and social care secretary Matt Hancock. In a letter to the review body, he added the recommendations should also consider the need for workforce growth and improved productivity – the government will decide on pay awards in the context of planned workforce reform and productivity improvements. The government is not asking for pay recommendations for junior doctors or GP contractors as both of these groups have multi-year pay agreements.

Patients' ability to access the right care at the right time is having an increasing effect on the sustainability of health and social care services, the Care Quality Commission (CQC) said. In its annual assessment of health and

## The month in quotes

'While the proposals in this consultation offer short-term mitigations, they are merely a sticking plaster that fail to address the crux of the problem. Only by scrapping the damaging annual and tapered annual allowance will the government stem the flow of doctors refusing additional work or considering leaving the profession.'
**BMA pensions committee chair Paul Youngs says more action is needed on pension tax**

'The committee believes more must be done to communicate that hospitals are not always the best, most suitable option. This will reduce unnecessary calls to the GP, out-of-hours service and A&E, and help reduce costs and pressures on the acute service.'
**Lewis Macdonald, convenor of the Scottish Parliament Health and Sport Committee, says hospitals can have a negative impact on patients' health**

**'Once again, we've seen exceptional demand on NHS services in Wales. It is clear the demand we traditionally experienced over the winter months is now all year round.'**
**Darren Hughes, director of the Welsh NHS Confederation, says demand is rising and that service transformation is needed**

**'The UK has the second highest prevalence of cystic fibrosis of any country in the world, so [this] is an important and long hoped for moment for children and adults living with cystic fibrosis. That also means any drug company wanting to succeed commercially in this field needs to work constructively with the NHS.'**
**NHS chief executive Simon Stevens celebrates a deal to bring cystic fibrosis drugs to NHS patients in England**

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**Targets for the uptake of pre-school vaccinations in England were missed in 2018/19**

care in England, the CQC said that lack of access to appropriate care can lead patients to attend emergency departments and other inappropriate settings, or to delay accessing care before eventually needing crisis intervention. This year the *State of care* report focused on mental healthcare – while the overall quality picture for these services remains stable, the report said that this masks a deterioration in some specialist services.

The Department of Health and Social Care allocated the £200m in capital funding for new cancer screening equipment, announced last month. Health and social care secretary Matt Hancock said 78 trusts across England would benefit from the funding over the next two years. Efficiency would be increased, with the investment used to replace, refurbish and upgrade CT and MRI scanners, as well as breast screening imaging and assessment equipment.

NHS Wales recorded its worst performance on record for four-hour waits and patients waiting more than 12 hours in emergency departments, according to the Welsh NHS Confederation. While A&E attendances were 7.3% higher than in September 2018, only 75% of patients waited less than four hours this September – 5.3 percentage points lower than a year earlier and the lowest on record. In October, the Welsh government allocated £30m to support frontline care this winter, allowing patients to access care closer to home and to leave hospital when appropriate.

The NHS in England also continued to experience patient access problems. NHS England monthly performance figures showed that delayed transfers of care increased in August compared with 12 months earlier – a 1.4 percentage points increase in delayed days. However, the proportion of delayed days attributable to the NHS fell compared with August 2018 (60.4% in August 2019; 61.7% in August 2018). More patients on referral-to-treatment pathways were waiting longer for care – this August, 85% had been waiting fewer than 18 weeks, but it was 87.3% a year earlier. In both cases the 92% standard was not met.

An NHS manager who was jailed for fraud in 2018 has been ordered to pay back more than £220,000 to Newham Clinical Commissioning Group or face an extra three years in prison. Michael Inije of Ilford – who worked at North East London Commissioning Support Unit – was jailed for three years and nine months last year after pleading guilty to fraud by abuse of position. The CSU prompted a fraud investigation when concerns were raised over an invoice approved by Mr Inije – investigators found a further 24 fraudulent invoices, totalling more than £382,000, from a company where he was the sole director. The NHS Counter Fraud Authority established that Mr Inije had available assets totalling £220,431.48, which must be paid to the CCG to avoid extended time in jail.

A Scottish Parliament committee has highlighted the additional costs of keeping a patient in hospital compared with intermediate or care homes and care at home. A Health and Sport Committee report added that staying in hospital when they are ready to be discharged was bad for patients' health. Overall, delayed discharges had risen by 6% in Scotland over the last year and it called for an immediate focus on reducing unscheduled care and hospital admissions, while meeting patients' needs in other parts of the NHS.

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## from the hfma

Fraudsters are the only ones who benefit from charities failing to talk about fraud, according to Alan Bryce. In a blog for the HFMA website, the Charity Commission for England and Wales head of development, counter fraud and cyber crime said charities must share information on current and emerging fraud risks. They should also recognise and celebrate good practice in fighting fraud. Though the blog highlights Charity Fraud Awareness Week, which took place in October, its messages remain relevant, including the fact that the public expects charities, including those in the NHS, to play their part in the fight against fraud.

**Also in October, former NHS finance director and former HFMA chairman Bill Shields delivered the latest instalment of his blog on life as the Bermuda Hospitals Board chief financial officer. He reflects on experiencing a hurricane for the first time, as well as witnessing a new level of care in US academic medical centres. Meanwhile, the Bermuda Hospital Board takes initial steps towards a health system that incentivises value rather than utilisation.**

The association also produced several publications, including briefings on NHS recommendations on legislation to further integrate care by implementing the *NHS long-term plan*; supporting *Getting it right first time* using patient-level costing; and an update on its *Going concerns* briefing.

**www.hfma.org.uk/news/blogs**
**www.hfma.org.uk/publications**

# News analysis

## Headline issues in the spotlight

# A capital plan

**The new Health Infrastructure Plan aims to end the hand-to-mouth approach to NHS capital funding and support long-term planning. But the right level of funding will also be important. Steve Brown reports**

The Health Infrastructure Plan, or HIP, unveiled at the beginning of October, promises to build 40 new hospitals over the next decade at a cost of some £13bn. But while it came amid numerous other public sector spending announcements from the government, the HIP claims to be about much more than money.

The announcement was certainly eye-catching. Six trusts – including Barts Health NHS Trust and Leeds Teaching Hospitals NHS Trust – have been given an immediate go-ahead and will collectively receive £2.7bn to develop new hospitals over the next five years as the first phase of the plan.

This will be followed by phase two – covering 2025 to 2030 – when a further 21 schemes involving 34 hospitals will be built.

Although the Treasury has apparently committed to supporting the whole programme, the funding for phase one is seen as more secure – although the capital departmental expenditure limit (CDEL) for 2020/21, published in September's spending round, has not yet been revised (at least not publicly). Chris Hopson, chief executive of NHS Providers, described the funding for the second phase as 'less definitive' and said the service needed to see the impact of the promises on capital allocations in a 'Treasury red book-type document'.

The money is important (see box). But the HIP promises much wider benefits, with capital investment planned over the long-term, not issued in a stop-start fashion.

'The point is to turn the capital expenditure of the NHS into a strategic, organised plan and system,' health and social care secretary Matt Hancock told the Commons Health and Social Care Committee's inquiry on NHS capital in October.

He added that it was part of taking a holistic approach to capital investment and the NHS needed to move away from living 'hand-to-mouth and year-to-year'. The HIP was a new approach where 'everything is upfront and on balance sheet'. 'It is an attempt to turn it into a system of strategic planning rather than piecemeal decision making,' he said.

Mr Hancock acknowledged that the old system had not met the needs of all providers and this was, in part, down to the different controls on capital spending that applied to different types of organisation.

'Half of the system – foundation trusts in good shape – are able to spend my national budget without my say-so,' he said. 'So, we have to balance the capital budget by altering the decisions over individual projects of non-foundation trusts and foundation trusts that aren't in good financial shape that we do have the power over.'

The current 'balancing process' can lead to late decisions on central capital investments, once the Department is confident that

## Capital demand and funding

The UK spends less on healthcare capital – including buildings, equipment and IT – as a share of GDP than most other similar countries, according to a report by the Health Foundation.

Large growth in capital spending between 2004 and 2009 brought the UK up to the average of comparable countries at just over 0.5% of GDP, according to the report, *Failing to capitalise,* published in March. However, by 2016 this had fallen to 0.27%. Capital-to-revenue transfers only explain some of this reduction in spending and the UK would need to almost double its capital spending as a share of total health spending to move back to the average for OECD countries.

New analysis from the thinktank, released in October, underlined this disparity, showing that the value of capital per healthcare worker in the UK has fallen by 35% between 2000 and 2017, while many other countries have seen significant and sustained rises. Of the countries analysed, the value of capital per healthcare worker in the UK is the second lowest, above Greece, and only just over half the average value. The UK is also investing less in equipment and machinery as a share of its total capital. It now has the lowest number of CT and MRI scanners per capita among comparable countries – and less than a third of those in Germany, which may partly explain why the UK lags behind other countries on cancer survival.

The need for increased capital can be seen in the rise in backlog maintenance. This stood at around £4.4bn in 2013/14, but the latest estates return from NHS Digital now puts this at £6.5bn.


NHS England chief executive Simon Stevens told the health and social care committee that about a third of the critical backlog maintenance related to just one London trust and that the planned major upgrade of facilities would deal with this in 'one fell swoop'. However, he accepted that remedial investment was needed in the meantime.

Various commentators have come up with estimates for how much the NHS needs to spend on capital. According to NHS Providers, 'we should be aiming to at least double the NHS current capital spend and sustain that growth'. The IPPR effectively agrees, with a report in September calling for a £5.6bn boost to CDEL next year to bring the service in line with the OECD average capital spend per person.


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there is headroom within the overall spending limit – which does not fit with a planned approach to capital investment.

'We need a proper planning envelope that then cascades to each local area so that each integrated care system will live within its capital budget in the same way as trusts now have indicative budgets for how much they need to live within on the resources side,' he said.

The HIP talks about splitting allocations into three types:

- Allocations for providers for operational investment, which would be 'system-driven' and self-financed
- A further pot for national strategic projects covering major schemes that require national investment and prioritisation
- A third budget for other capital investment such as technology programmes and screening system updates.

It further talks about providing 'indicative multi-year planning envelopes over a rolling five-year period' with these envelopes confirmed annually. This may not be capital spending limits for individual providers – NHS England and NHS Improvement have proposed a reserve power to set such limits for single named foundation trusts as part of possible legislative changes. But it sounds very much like system-level capital spending controls.

NHS England and NHS Improvement chief executive Simon Stevens admitted to the committee that the business planning and approval process had 'almost been an implicit capital rationing mechanism across the NHS'.

'And so in a period now where capital investment is increasing and set to increase further, frankly we need to take a lot of that delay out of the system,' he said.

**"We need a proper planning envelope that then cascades to each local area so that each integrated care system will live within its capital budget in the same way as trusts now have indicative budgets for how much they need to live within on the resources side"**
**Matt Hancock, health secretary (pictured)**

This will see the business case process streamlined, changes to contract documentation and a single approvals process rather than separate processes involving NHS England, NHS Improvement and the Department.

An expert estates team will also provide support for systems in developing capital plans. However, Mr Stevens said the service's ability to undertake this streamlining would be 'greatly enhanced if we have a multi-year capital budget for the health sector as a whole'.

The government has previously indicated that it will consider a multi-year capital settlement for the NHS in its next full spending review, which was bumped into next year after the Treasury's decision to run a one-year spending round this year. The case for additional funds above those already announced, and increased certainty about future levels of funding going forward, were further strengthened in October by two publications.

First, NHS Digital published its latest *Estates return information collection* covering 2018/19, which showed that the total cost of eradicating backlog maintenance had risen to £6.5bn – with more than half of this classed as high or significant risk. The headline figure has increased from £5.9bn in just a year and the report also showed that just £434m was spent last year on reducing this backlog.

Meanwhile, the Health Foundation claimed that the UK was falling behind most similar countries in terms of what it spent on healthcare capital. Its analysis showed that the value of capital per healthcare worker in the UK had fallen by 35% between 2000 and 2017, while many other countries have seen significant and sustained rises.

The figures reinforce the thinktank's earlier data showing that the UK also lags behind on healthcare capital investment as a share of GDP (see box).

The promise of a more streamlined system will be welcomed by NHS providers. Certainty over future capital budgets will also support more long-term planning, vital to the transformation of services. However, the new system will only operate effectively if there is sufficient funding in the overall capital budget.

And as many commentators have pointed out, the capital increases announced over the summer are only a downpayment on the level of funding that is actually needed.

# Comment

November 2019

## Fall back, spring forward

### Reasons to be optimistic about financial planning

HFMA president Bill Gregory

**The clocks going back** normally signals the end of autumn half-term. With virtually nobody on leave, the roads and trains are at their busiest and so, with less daylight, this all conspires to make the daily commute to and from work more challenging than ever.

It also means that Christmas is just around the corner, and for many of us that means focusing on all the things you want completed before the end of the year.

This is also the time when we start to get news of what next year might hold for the health service and our patients.

From a financial planning point of view, we already know quite a bit. We may still await a formal multi-year capital settlement, but the Department of Health and Social Care has unveiled its Health Infrastructure Plan (HIP), with the promise that this is the start of a rolling five-year programme of capital investment.

In addition, we've had confirmation of control total, efficiency, incentives and financial support arrangements for the next few years.

As ever the full picture won't emerge until we see the detailed planning guidance, which would typically emerge around Christmas time. However, given the ongoing government distraction with Brexit and now a general election, it would not be a surprise if there were delays to the usual process.

This may also hamper the conclusion of a meaningful public sector spending review within the original timescales, with an inevitable impact on the level of

## Equity and security

### Capital processes will be rebuilt as part of the HIP, but funding remains crucial

Healthcare Finance editor Steve Brown

**The focus of media coverage of the** new Health Infrastructure Plan (HIP), unveiled at the start of October, was the money. A £13bn programme would see 40 new hospitals built over the next decade, with £2.7bn supporting six hospitals given an immediate go-ahead.

However, the attempt to introduce a more strategic approach to capital allocation is arguably the bigger story.

This new approach attempts to give certainty to organisations and systems over their capital plans going forward. And it also attempts to provide a fairer approach to the allocation of capital – not influenced by the legal status of the bodies involved (foundation trust vs trust) or their financial position.

There are lots of questions about how the new system will work in practice – questions that will hopefully be answered when full technical guidance on the capital systems for 2020/21 is published before the end of this calendar year.

The proposed approach will break capital down into three discrete pots – one for providers (system driven), one for major

hospital builds and one for centrally funded programmes such as technology capital.

The problem for the centre has been that it doesn't have control over all organisations' capital spending. As health secretary Matt Hancock put it to the health and social

**"It is such a breath of fresh air to have regional teams back in place across the system"**

information that can be provided in as timely way as we would all like.

The quite rapid change in NHS capital investment policy should be welcomed, particularly as the first-wave hospitals include sites where the physical estate is an obstacle to the highest quality care.

Getting these schemes from conception to finished hospital within the timescales outlined in the plan will be crucial to building confidence that the NHS can manage significant building projects and capital expenditure again.

While the headlines have all been about the big hospital rebuild projects, the infrastructure plan also holds out hope for proper investment across the system in backlog maintenance and renewing medical equipment. I look forward to seeing more detail on these initiatives, which should have a more rapid impact on our biggest areas of underinvestment across the system.

Some of the details of the new financial regime have also emerged, together with control totals and efficiency targets aimed at returning the provider sector to balance over the next few years. The pace of change is welcome.

I am sure many questions remain about how targets have been set – not least because they are predicated on everyone achieving plan this year. However, it is such a breath of fresh air to have regional teams back in place across the system.

Colleagues up and down the country are expressing optimism that the regional oversight will bring some much needed local insight and pragmatism to solving local problems.

As I near the end of the branch conference season, I wanted to say how impressed I have been with the way each branch puts together its event. While slightly different, all share the common thread of a dedicated branch chair and committee, supported by their local HFMA members, who have attended these local events in their hundreds.

This is a great reminder that our association's strength comes from its branches and individual members!

*Contact the president on president@hfma.org.uk*

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care committee in October (see page 8), foundation trusts in surplus are able to 'spend my national budget without my say-so'.

The new system will not give foundation trusts formal capital spending limits – although a limited reserve power could be created in future as part of legislative proposals. But each integrated care system or sustainability and transformation partnership will be given its own 'capital envelope' and be expected to 'ensure organisational plans are consistent with these'.

The HIP makes it clear that staying within this envelope will be linked to the system's eligibility to continue receiving central funding for strategic investments.

One of the key outstanding questions is how system envelopes will be set – how much account will be taken of systems' capital needs and how will equity between systems be delivered?

However, the system will only work if there is sufficient funding in overall terms to meet the capital needs of the NHS as a whole. With insufficient funds, the service will continue to firefight and funding will have to flow to deliver emergency fixes at the expense of planned developments that will support transformation.

The government has made a welcome start to addressing the funding shortage after years of underfunded budgets exacerbated by capital to revenue transfers. It has published a bewildering set of headline figures for new funding over the past few months: £13bn, with £2.7bn immediately, to support HIP; a £1bn increase in this year's CDEL; £850m to support the redevelopment of 20 hospitals outside of the HIP; and £200m for diagnostics.

The timescales for this funding are often over different periods. The £1bn increase to CDEL was for the current year. The £850m covers capital that will be drawn down over five years. And some additional funding for artificial intelligence will be made available over three years.

The bulk of the funding for the HIP is not even in place yet, although the government says that the Treasury is committed to the funding despite not yet having held its spending review.

**"The system will only work if there is sufficient funding in overall terms to meet the capital needs of the NHS as a whole"**

In the meantime, the government continues to announce successful loan funding for new trusts – not new money, but just a step in the approval process from resources already earmarked. It creates an impression of capital largesse, but it is far from transparent.

The NHS continues to need a significant boost to capital budgets for both backlog maintenance and more strategic projects. And it needs visibility on how those budgets will change over time.

A fairer, more transparent allocation process might have been overlooked in the coverage of the HIP. It appears to be a good step forward, but if the new process is not underpinned with the right level of funding, it will simply break down.

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# Value the opportunity

## HFMA annual conference 2019

**4-6 December, Hilton Metropole, London**

## This year's closing address will be delivered by…

## Katya Adler, BBC Europe editor

After working at the BBC for 20 years, Katya is now their leading voice on Brexit and the EU. Her extensive interviews with political leaders across the continent has given her unique insider knowledge on European attitudes and intentions regarding a Brexit deal.

Katya will be closing this year's comprehensive programme by reflecting on 2019's political landscape, commenting on what the future holds for the NHS in light of Brexit.

Full plenary and workshop programme are available from **hfma.to/hfma2019**

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# child support

**Clinical negligence incidents in maternity services are driving increases in indemnity payments and settlements to patients. But NHS Resolution is tackling the rising costs with schemes that promote safer clinical care. Seamus Ward reports**

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Having a child is a joyous time for most families, but there are risks in childbirth and sometimes – though fortunately rarely – things can go seriously wrong. When they do, cases can be complex, and it can take up to two years for the full effects of the incident to become clear. Financial settlements, particularly if the courts are involved, can take years.

NHS Resolution, which runs indemnity schemes for the health services in England, believes a system based on litigation does not work well for families or trusts and has been moving towards a more collaborative and preventative model to help families sooner.

As well as the moral argument for helping patients and their families, there is also a financial need to fix the system. Settlements to patients and their families for all clinical negligence claims through the Clinical Negligence Scheme for Trusts (CNST) continue to rise. Provisions for potential future liabilities are also rising year-to-year. But maternity negligence claims are a major component of these liabilities and NHS Resolution is keen to reduce the costs.

## Claims record

In 2018/19, CNST provisions stood at £78bn – and 70% of that related to potential maternity claims (circa £55bn). As CNST members, trusts pay a general premium covering non-maternity clinical services, plus a maternity premium. The latter is based on the number of births at the trust and in 2018/19, maternity contributions totalled more than £735m. Individual trust contributions ranged from £121,000 up to £19m.

Samantha Steele, NHS Resolution national obstetrics clinical fellow, says that the number of maternity claims is relatively small. There are fewer maternity claims than there are for A&E or orthopaedics, for example, she says. Maternity claims accounted for 10% of all claims by volume in 2018/19 – claims relating to A&E accounted for 13%.

However, the value of maternity claims is much higher than any others, due largely to the long-term need for care. Overall, in 2018/19 there were 10,678 clinical negligence claims, including 1,068 obstetrics claims. The value of all claims received in 2018/19 was just over £4.9bn, although 50% of this relates to obstetrics claims, which totalled almost £2.47bn.

Primarily to reduce the risk of harm to babies – and, as a consequence, avoid spending on CNST maternity contributions, settlements and litigation costs – NHS Resolution has launched two programmes over the last two years.

The maternity incentive scheme offers trusts a 10% rebate on their maternity premium if they achieve 10 safety actions (see box overleaf). NHS Resolution says trust maternity contributions ranged from £120,000 to £19m in 2018/19, so the 10% rebate was worth £12,000 to £1.9m for trusts.

Trusts that do not achieve all 10 actions can still receive a partial rebate. This is calculated on a trust-by-trust basis, based on the steps needed to achieve the incomplete actions. They must draw up an action plan and use the funds to achieve the remaining actions.

The scheme is currently in its second year. Dr Steele says

that while the safety actions are the same in outline as in year one, they have been stretched to push trusts further. 'For example, one of the first actions is on using the perinatal mortality review tool. In year one, hospitals signed up to using the tool, but in year two the stretch is to bring the number of reviews using the tool up to 50%.'

Dr Steele says the safety actions are similar to the old maternity risk standards, but in the new scheme trusts self-certify compliance.

'The new incentives scheme puts the emphasis on trust boards to certify the trust and report back to NHS Resolution. Each safety action has been developed by the relevant bodies, such as the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives when the action is around training or staffing,' Dr Steele adds.

'It's quite a collaborative piece of work nationally, coming from clinicians rather than the legal side.'

**"The stretch is to bring the number of reviews using the perinatal mortality review tool up to 50%"**
**Samantha Steele, NHS Resolution (pictured)**

## Achievement impact

Jenny Hannon, director of finance at Liverpool Women's NHS Foundation Trust, says achieving the 10 actions in the maternity incentive scheme is incredibly important to the trust.

'It's fundamental, as maternity is a big part of what we do,' she says. 'The introduction of the standards has been fantastic in terms of supporting these improvements. It's been positive and has gone down well with the maternity division.'

The trust did not achieve all 10 actions in year one of the scheme, but is confident it can do so in year two. 'We were really hard on ourselves in the self-assessment in terms of evidence. Unless it was 100% there, we did not sign ourselves off,' Ms Hannon says.

After self-certifying that it had only met nine of the 10 actions in year one of the incentive scheme, the trust developed an action plan and received some funding from the incentive scheme pot to tackle the outstanding issues in year two. The focus of this work has been to strengthen in-house multidisciplinary training. Ms Hannon says: 'We received around £170,000 to put towards getting ourselves to that higher standard. We invested in staffing and gave people headroom to get it done. The response of the teams has been positive, and they've refocused the way they train.'

While patient safety, service quality and outcomes are the driving factors, the 10% incentive rebate remains important. The trust's total maternity contribution is £9.6m in 2019/20, so it stands to receive around £960,000 if it achieves all 10 actions this year. Ms Hannon says this rebate is a significant element in the trust's cost improvement programme.

She feels the board focus on the maternity incentive scheme has been particularly strong because it is a specialist women's trust.

'We are close to this as a board of directors and we are working closely with the service to support it. It has a greater impact on us than other providers and the positive impact of achieving the standards is potentially more far-reaching.'

Across England, in year one (2017/18), 75 of the eligible 132 trusts met all 10 actions, receiving their 10% rebate and a proportion of the remaining funds. The 57 trusts that did not meet all 10 received some funding, linked to their action plans.

## Leeds safety actions

Leeds Teaching Hospitals NHS Trust achieved all 10 safety actions in 2018/19, and Sue Gibson, the trust's head of midwifery, says the maternity team worked extremely hard to do so.

'We had to review our systems and processes for each of the 10 safety criteria, and when we analysed them in detail there were gaps,' she says. 'We had to put in place processes for all of the 10 actions and ensure they can be easily reviewed and monitored.'

Despite this, she feels the new actions are more relevant to day-to-day practice than the old NHS Litigation Authority risk management standards.

It is important the work is not seen as a financial project and is clinically led. 'When talking to clinicians, we stressed it is about safeguarding them and our patients, being competent and up-to-date with

their training. It shows we value them, and competence adds quality and safety to the patient experience,' she adds.

Meeting standard 2 – contributing to the maternity services data set to the required standard – was particularly challenging, and IT resources were key to delivering it.

The incentive scheme means there is a potential financial benefit, though safety remains the overriding consideration.

Marie Dearman, assistant director of finance at the trust, says: 'The incentive scheme is another lever to encourage us to implement the standards, but it's not the main driver. At 10% of our maternity premium, it's a significant sum for us.'

She adds that there is a cost involved in investing in training and putting the right systems and processes in place, but it is the right thing to do.

The Leeds trust feels the safety actions have been a positive step, improving care and helping build relationships – not only through greater collaboration between management, IT and clinical staff to deliver the 10 actions, but also externally.

'The requirement for the safety action standards to be discussed with commissioners is really important,' Ms Gibson says. 'It helps build those relationships and helps them understand our challenges and how they can support us in these aims.'

NHS Resolution said the actions have made a demonstrable impact, including a significant improvement in the quality of reporting to NHS Digital (maternity data sets) and to its second safety programme, the early notification scheme.

## Early notification scheme

The early notification scheme is a good example of NHS Resolution's efforts to move away from litigation and towards a more collaborative approach to clinical negligence claims.

Under the early notification scheme, trusts must notify cases of potential severe brain injury to NHS Resolution within 30 days of birth. Liability investigations begin straight away. In 2017/18, 746 cases were notified, and investigations were carried out in 26% of these cases.

At the conclusion of the case, admission of liability leads to the family being given a case manager, an explanation of what went wrong, a formal admission of liability and an apology.

Under the old system, this process could take years. Now, where it is clear a child needs extra help, the early admission of liability means NHS Resolution can offer financial support to access additional care and respite services.

Sangita Bodalia, NHS Resolution's head of legal (early notifications team), says the early notification scheme has three aims. First, NHS Resolution believes it will speed up the liability investigation, which can take years to complete. Second, learning from the investigation can be shared with the provider and, if appropriate, other trusts to improve clinical quality and safety, she adds.

Outputs and knowledge gained from the early notification scheme and other sources are used to inform the maternity incentive scheme safety actions each year.

'The final aim is to improve the experience of families,' says Ms Bodalia. 'Families don't always get the care and support they need. An early identification means we are able to look at the support the family needs.

'I always say to the trust that they need to keep the dialogue going, as often care is continuing at the trust. When the investigation is concluded and the family has an outcome, we support the hospital trust legal team and the family is supported with what they need. In the past we were perhaps too reliant on the courts.'

Previously, a significant amount of time could elapse before NHS Resolution became aware of a potential claim. 'We didn't have the opportunity to investigate it early,' Ms Bodalia says. 'But under the early notification scheme, rather than waiting for the claim to come in, we hear as soon as the incident has happened, so we are involved right from the start. It gives us a chance to look at the incident, gather the information and read the medical records.'

She adds: 'We are taking a holistic approach, rather than just making large payments. We are trying to take this approach so families get the right support and the compensation paid is fair and reasonable. By reporting early and capturing a potential claim early, there's an aim to accelerate the investigation and improve value to reduce costs throughout the process. Of course, reducing costs is not the primary aim.'

The maternity incentive and early notification schemes work in tandem to drive improvements in care quality and safety.

Ms Bodalia says: 'With the early notification and maternity incentive schemes we can get to the heart of the incident a lot more, accelerate the liability investigation, share learning and improve the experience for families. But everybody needs to buy into it – every stakeholder needs to engage.

'We don't want a blaming approach for individuals; we want to ensure that we can share learning. The blame culture is still out there, but we are trying to eradicate that and introduce a just culture rather than a blame culture.'

While health problems caused by clinical negligence during births are thankfully rare, clinicians and managers are keen to minimise incidents through prevention and best clinical practice.

The incentive funds will always be useful, and there is a need to ensure best use of public money, but trusts insist that the overriding factor will always be safety.

## 10 safety actions

1. **Are you using the national perinatal mortality review tool to review and report perinatal deaths to the required standard?**
2. **Are you submitting data to the maternity services data set to the required standard?**
3. **Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into Neonatal Units programme?**
4. **Can you demonstrate an effective system of medical workforce planning to the required standard?**
5. **Can you demonstrate an effective system of midwifery workforce planning to the required standard?**
6. **Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?**
7. **Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?**
8. **Can you provide evidence that 90% of each maternity unit staff group have attended an in-house multi-professional maternity emergencies training session within the last training year?**
9. **Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with board-level champions to escalate locally identified issues?**
10. **Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's early notification scheme?**

**"We are taking a holistic approach, rather than just making large payments. We are trying to take this approach so families get the right support"**
**Sangita Bodalia, NHS Resolution (pictured)**

# Making the

**Most people subscribe to the concept of value-based healthcare, but turning it into practice at scale is a daunting challenge. A Healthcare Costing for Value Institute symposium brought value pioneers together from across the world to offer insight into how they are making the jump from theory to reality. Steve Brown reports**

Value-based healthcare – or VBHC – makes sense. But despite winning a theoretical argument in the UK, there are few examples of organisations or systems that have embedded a formal approach targeting the delivery of value across all services.

That was the issue October's international symposium set out to explore, pulling together some of the pioneers of VBHC from across the world to discuss their critical success factors.

The first point tackled by the speakers was ensuring the value being delivered is value as defined through the patient's eyes – what is it that the patient wants/needs, not what is it that the service can provide? That means having patients involved in the design and improvement process from the outset.

Paediatric consultant Helen Leonard said that if true co-production was the goal, then healthcare professionals would need to 'give up some power'. It would also call for work and investment.

'Often decisions are made and then someone is invited along afterwards to ask what they think and it's: "Tick, we've done patient engagement"', she said. 'You need to invest in people from the beginning of the design process, and to do that you have to share some of the power and skill people up. You can't bring people into a strategic or planning meeting if they don't understand the language.'

## Start with patients

'Our mission is to include patients in everything we do,' said Samyra Keus, VBHC lead for the Santeon group of hospitals in the Netherlands. Santeon is a network of seven acute hospitals that collectively provide more than 10% of all Dutch hospital care. It formally introduced a VBHC approach in 2016 across five patient groups: breast cancer; prostate cancer; lung cancer; cerebrovascular accident; and hip arthrosis.

As part of this, multidisciplinary teams for each patient group are established at each hospital, with one hospital taking the lead in developing a scorecard identifying 15-20 key outcomes, cost and process metrics.

Patients feature heavily in the process. For outcome measures, Santeon uses the International Consortium for Health Outcomes Measurement indicator sets, which have been put together with patient input.

However, these can be supplemented with other measures and Santeon's own patient representatives are at the table from the beginning, including overseeing the metric selection and creation of the scorecards.

The outcome measures include both patient-reported outcomes and experiences (PROMs and PREMs). The multidisciplinary team also tracks patient journeys to ensure it maintains a patient's view of services.

As well as ensuring the hospitals focus on the things that matter to patients, patient involvement has led to real service change.

For example, one patient representative challenged the various lifestyle restrictions suggested post-hip surgery to avoid dislocation. They suggested these were confusing and difficult to comply with.

Research by the trust found little evidence for many of these restrictions and this led to their removal or alteration as part of changes in key literature. Subsequent monitoring has shown that the number of dislocations has in fact gone down.

Even cost indicators are patient driven. 'If a patient has fewer scans for the same outcome, that is better for the patient and better in terms of costs,' said Ms Keus. 'We talk about length of stay, not euros, and about the percentages of patients getting X-rays or MRIs. So even the indicators on cost are important to patients.'

The group is also working on a government sponsored project to create a decision-making tool for patients in three areas – breast cancer, stroke and chronic kidney failure.

'We are looking at outcome indicators and transparency for shared decision-making,'

# LEAP

*Global symposium: Steve Wilson (facing page), Samyra Keus (left) and Hille Witjes (above)*

said Hille Witjes, a breast cancer surgeon from OLVG hospital in Amsterdam. 'The idea is that the patient should be able to see the outcomes they can expect if they choose a specific treatment option.'

## Population focus

Improving population health has been the focus for value work in Manchester as part of the devolution programme.

Steve Wilson, executive lead for finance and investment of Greater Manchester Health and Social Care Partnership, emphasised that devolution was about much more than health, although health was an important part of the bigger picture.

Other sectors such as transport and education have an impact on health, and the need for healthcare and health services can support growth in the city.

'There are pockets of really strong economic development and growth, but still enormous pockets of deprivation and as the growth has expanded, that gap has grown,' he said. 'The fundamental issue behind devolution was to deliver sustainable growth and to close that gap.'

There was a clear recognition that poor health in some of the population was actually limiting what the city could hope to achieve with its growth.

To ensure prevention is at the heart of everything, a system architecture has been established that operates at three levels:

- Neighbourhoods, covering 30,000-50,000 population
- Ten localities that bring together community and mental health services, primary care and social care services
- Greater Manchester as a whole, where things need to be done once for the whole population.

'This [architecture] has allowed us to try to create a population health system that looks at population health as the number one way of influencing health and wellbeing rather than interventions in acute or community settings,' said Mr Wilson.

The partnership is targeting three areas to make a difference:

- **Focusing on the big killers** Half of all premature deaths are still linked to preventable factors such as unhealthy diet, inactivity, smoking and alcohol and premature mortality is twice as high in more deprived communities.
- **Health creation in every policy** All public services in Greater Manchester have health benefits as a recognised objective.
- **A unified model of service delivery** Based on integrated neighbourhood services.

Mr Wilson said that people needed to think differently about the return on investment in population health, with sometimes higher returns that could take longer to deliver. Currently just 5% of healthcare funding is spent on preventative care. Changing this would mean joining up commissioning budgets so that their scope covered the wider determinants of health.

'We have invested £0.5m of transformation funds to support work to modify a series of road junctions to improve cycle access,' he said. As well as obvious public health benefits, this could have a short payback period in terms of eliminating treatment for avoided accidents.

'This has been matched by investment of up

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to £0.5bn through the Highways Agency and Transport for Greater Manchester,' said Mr Wilson. 'The money we put in is tiny but the opportunities to work with other partnerships is enormous.'

## Culture change

Several speakers talked about how systems needed the right culture in place to deliver VBHC. In Santeon, while the group board decided value would be the guiding principle, this wasn't simply imposed on the hospitals. 'They didn't give us the goals, but they did give us the freedom,' said Ms Keus.

This local ownership was key to the programme's success, as was a focus on quality rather than costs. The centre then supported the individual hospitals by providing project leads and data analysts to support the development of a learning environment.

A similar message came from Michigan, home to the largest value-based reimbursement system in the US outside of the Medicare programme. Insurer Blue Cross Blue Shield Michigan (BCBSM) runs value partnership programmes for both ambulatory and hospital-based care.

'You have to start with quality, then you can look at cost and, as you build trust in the data and build partnerships, you can address patient experience,' said Thomas Leyden, value partnerships director at BCBSM.

Ultimately, you can move on to look at appropriateness – the best quality care at the lowest cost is not value if the procedure was not needed in the first place.

'Our job is to convene and catalyse,' said Mr Leyden, 'and to provide dollar rewards for the transformation of care, because it takes funds to transform performance.'

**"We do 'facilitated implementation' – not just sharing practice but creating toolkits or doing site visits to help target problems"**

**Scott Flanders (above)**

He echoed the Dutch presentation in warning against imposing programmes on medical staff. 'It has to be about empowerment,' he said.

A value-based culture also needed to encourage transparency and sharing. Having 40 hospitals delivering bariatric care, or 33 hospitals involved with breast surgery, provided a powerful database to identify and explore variation.

Scott Flanders, chief clinical strategy officer for the University of Michigan Health System, told the symposium that transparency and being open, in particular about problems, was a key characteristic of the required different culture. Dr Flanders leads one of Michigan's multi-hospital value programmes looking at hospitalised general medical patients. Current initiatives include hospital-associated venous thromboembolism, intravascular devices and inpatient antimicrobial use.

Each hospital – between 40 and 50

organisations can be involved at different times – brings a team to a collaborative workshop on a quarterly basis. Together, the teams create robust data registries and use the data to decide best practice. 'Then we do "facilitated implementation"', said Dr Flanders. 'This is not just sharing practice but sometimes creating toolkits or doing site visits and patient walkthroughs to help target some of the problems.'

Hospitals are scored on agreed performance measures, with scores affecting payment, although Dr Flanders said organisations and clinicians were just as motivated by wanting to improve their position.

'Transparency is critical not just in areas where we are doing well but where we struggle,' he said. Hospital performance data is not anonymised and struggling hospitals are encouraged to share their challenges.

## Making the case

Many trusts want to see a business case for value-based healthcare. However, speakers said organisations simply had to get stuck in. They emphasised that quality improvement was the way in and that efficient use of resources would follow. Ms Keus advised organisations to 'start small, be pragmatic and base work on trust' and successes would lead to a snowball effect.

Dr Flanders believed that putting a figure to savings could be difficult. However, Michigan's work on venous thromboembolism had led to significant improvements. The Michigan hospitals had in general experienced increased use of pharmacologic prophylaxis (blood thinners) to guard against blood clots for hospitalised patients, in line with national guidance. However, its own study found no better outcomes in hospitals with the higher rates of prophylaxis.

Further work identified a smaller subset of patients who would benefit from this approach, with different strategies employed for other patients.

Implementation of this across its hospitals led to 850 fewer blood clots over a year, with 1,200 fewer clinically significant bleeding episodes. With a deep vein thrombosis costing up to $11,000 on average and a pulmonary embolism costing up to $17,000, the possible savings that could be linked to these changes are significant.

## Value in action

Paediatric consultant **Helen Leonard** (pictured below) said that the NHS was good at identifying good outcomes for single-issue 'fixable' conditions, such as a heart attack or trauma, but it fell short for complex patients where there were multi-factoral needs.

Drawing on her own disappointing initial experiences of health and social care with her son Matthew, who was born with severe learning disabilities, physical disabilities and cerebral visual impairment, she said patients and their families had to be seen as the 'most useful assets' in determining what would constitute success or value in individual cases.

Personal health budgets offered a way of delivering real value – effective support for patients at lower cost – and should be offered more widely.

**Petri Kivinen** (pictured below) is chief medical officer of Siun Sote, the joint municipal authority for North Karelia's social and health services in Finland. He told the conference that delivering value demands working across silos. This means health and social care professionals working together to develop better pathways and using a common budget.

But he said it was also important to co-operate with bodies outside of healthcare, such as schools and emergency services. As a minimum, this meant sharing data.

**Gunther Jonitz**, president of the Berlin Chamber of Physicians, described a prostate cancer network that has been developed to really harness patient power. Progether is an ambitious project that aims to establish a database of prostate cancer knowledge.

While it is currently operational in Germany, the intention is to extend the project globally. Patients can monitor their cancer online and collect and enter cancer data, tests, treatments and patient reported outcome measures (PROMs) in an organised way – helping them to learn more about their disease and informing the development of treatments.

**Paul Buss**, consultant paediatrician and medical director of Aneurin Bevan University Health Board, has led a five-year value-based healthcare programme at the Welsh board – arguably the UK's most advanced VBHC organisation.

The approach involves forensic analysis and discussion of variation across its services and, where applicable, establishing a best practice model. It collects wide-ranging outcome measures and other data. For example, a renal care programme has been exploring outcomes for different dialysis interventions alongside frailty scores to inform shared decision-making.

'The aim is to be able to say that, if you have this treatment in this place, it will be likely to have this effect on you if you started with this frailty and comorbidity,' said Dr Buss.

And with the work having been disseminated across the country, influencing the published guidelines, it has had a far wider impact too.

One message was clear. Value-based healthcare has to be a way of operating. It is not a one-off improvement programme, but has to become the way that services develop going forward. Improvements have to be sustained, which involves monitoring, and dips in performance have to be corrected. And, as issues get fixed, other issues can be prioritised. In this sense, it does not have an end goal.

None of the health systems featured in the symposium claim to be the finished article in terms of delivering embedded value-based healthcare across all services.

They would all recognise improvements that could be made in terms of patient involvement, looking more broadly at population health rather than just healthcare.

They would also identify issues that could be improved in their own culture and recognise the continued need to demonstrate that value is being delivered. But they are very definitely on the road to delivering better, more sustainable care. And they would all encourage others to join them on the journey.

• *Healthcare Costing for Value Institute members can access presentations and videos from the symposium at* ***hfma.to/ah***

15 Year Anniversary

# HFMA

AWARDS 2019

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## HFMA Awards 2019 shortlist announced!

### Finance Director of the Year

sponsored by PRIME

- Karen Geoghegan, Brighton and Sussex University Hospitals NHS Trust and Western Sussex Hospitals NHS Foundation Trust
- Hardev Virdee, Central and North West London Foundation Trust
- Stephen Sutcliffe, NHS Shared Business Services
- Sally May, Royal Cornwall Hospitals NHS Trust and Cornwall Foundation Trust

### Deputy Finance Director

sponsored by Meridian

- Eva Horgan, Liverpool Women's NHS Foundation Trust
- Gareth Lawrence, St Helens and Knowsley Teaching Hospitals NHS Trust
- Helen Wells, The Walton Centre NHS Foundation Trust

### Finance Team of the Year

sponsored by PA

- Barking, Havering and Redbridge University Hospitals NHS Trust
- Wrightington, Wigan and Leigh NHS Foundation Trust
- Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups
- Pennine Care NHS Foundation Trust

### Working with Finance - Clinician of the Year

- Prof Mojgan Sani, North Tees and Hartlepool NHS Foundation Trust
- Dr Maggie Davies, Western Sussex Hospitals NHS Foundation Trust
- Dr Jacqueline Andrews, Leeds Teaching Hospitals NHS Trust
- Professor Liz Kay, Leeds Teaching Hospitals NHS Trust

### Costing Award

- Gloucestershire Care Services NHS Trust
- Barking, Havering and Redbridge University Hospitals NHS Trust
- Maidstone and Tunbridge Wells NHS Trust

### Governance Award

sponsored by noviniti

- Epsom and St Helier University Hospitals NHS Trust, Sutton CCG and Surrey Downs CCG
- 360 Assurance and Audit Yorkshire
- Leeds Teaching Hospitals NHS Trust

### Value and Innovation Award

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- St Helens Cares
- Leeds Teaching Hospitals NHS Trust
- MIAA and the Cheshire and Merseyside Health and Care Partnership

### Havelock Award

- Leeds Teaching Hospitals NHS Trust
- East Lancashire Hospitals NHS Trust
- Countess of Chester Hospital NHS Foundation Trust

For more information, please visit hfma.to/awards or contact awards@hfma.org.uk

**There is a long-term plan commitment to increasing the availability of online and phone GP consultations, but this could upset the primary care funding model and potentially financially destabilise CCGs. Seamus Ward looks at measures NHS England hopes will ensure stability**

# primary numbers

In recent years, general practice has struggled to meet patient demand, while at the same time facing calls to make appointment times less rigid and more in keeping with a 24/7 society. There has been some success with recruitment to increase capacity, but to an extent this has been nullified by retirements. And while there have been extended opening hours programmes, these have further stretched the GP workforce and appear to have failed to satisfy demand.

Alternative providers in the shape of online practices have stepped into this landscape, aiming to improve access and convenience by, for example, offering video or phone consultations. Appointments are often offered within hours of a patient's request, whereas it can take days in traditional practices.

The new providers have been backed by the NHS in England and the Department of Health and Social Care. According to the *NHS long-term plan,* the NHS will offer a digital-first option for most patients – by 2023/24 every patient in England will be able to access a digital-first primary care service, it says.

In some cases, the digital-first services are an extension of existing GP practices, while in others they are new online practices. The latter – in the shape of Babylon's GP at Hand – has been high profile, registering more than 60,000 patients in London.

But the development of the online model has led to a number of concerns. Would technology-based primary care attract mainly younger, more healthy individuals, leaving traditional practices to tend to the old and chronically ill? Could the finances of a CCG be destabilised if there is an influx of patients from outside its area registering with the new providers? In the case of GP at Hand in London, this was potentially the case until NHS England agreed to intervene financially.

## GP at Hand

GP at Hand in London is based in the area covered by Hammersmith and Fulham Clinical Commissioning Group, but only around 5,000 of the provider's 60,000 patients are from the CCG's area.

According to the finance report tabled at the CCG's September meeting, at month 4 the year-to-date costs associated with GP at Hand were £6.2m, with a forecast outturn of £19.1m, excluding further list growth. The digital-first provider had an impact on various budget lines – mainly acute and delegated primary care – but this will be

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fully mitigated centrally in 2019/20 through an agreement with NHS England. The CCG is working with NHS England on a mechanism designed to recover costs from other CCGs.

In May, an independent report for the CCG evaluating GP at Hand found that its patients were generally younger and healthier than an average practice, though they did use the service more than expected.

The report questioned whether the current method of funding GP practices – the global sum allocation or Carr-Hill formula – was appropriate in calculating funding for online services. The formula calculates payments to practices based on its registered patients, adjusted for a number of factors such as age, gender, practice list turnover, additional needs, a market forces factor and rurality.

Though its information on the cost of a digital-first practice was limited, the evaluation said the Carr-Hill formula may not work well in establishing the costs of providing digital-first care – and therefore the appropriate funding levels. It also concluded that the impact on the finances of GP practices and CCGs in other areas of London was minimal as the GP at Hand patients had previously been registered with a large number of CCGs and practices.

## Re-examining the rules

NHS England and NHS Improvement have recognised that practice registration, funding and contracting rules had to be re-examined, and they consulted on a number of measures earlier this year. The finalised policy emerged in September. It addresses two major issues – how practices are funded and how CCG allocations will be adjusted to reflect movements of patients between CCGs. The policy seeks to address a range of issues, including preventing problems that can arise when a CCG sees an outflow of patients to a digital-first practice based in another CCG.

**NHS England hopes the NHS could harness the potential of digital-first providers to reduce health inequalities – through national rules rather than local commissioning**

NHS England is keen that physical services remain when this occurs. Once a practice registers more than 1,000 patients from another CCG (CCG A), its main contract will be disaggregated. The practice will be awarded a new APMS (alternative provider medical services) contract by CCG A. This would allow them to offer patients normal physical practice services, alongside its digital-first programme.

However, NHS England and NHS Improvement do not believe many APMS contracts will be triggered. Based on September 2019 data, an internal NHS England analysis found that only one digital-first provider would trigger the threshold – Babylon GP at Hand in Hammersmith and Fulham CCG, creating 16 APMS contracts in other CCGs.

If the number of patients registered from a CCG remains under the 1,000-patient threshold, the digital-first practice will be paid under current out-of-area rules. Under these rules, practices receive the same funding and other payments (for enhanced services, for example) as they would for other registered patients.

Ed Waller, NHS England director of primary care strategy and contracts, told the September NHS England and NHS Improvement board meeting that the consultation questioned whether out-of-area patients should have less value in the GP funding formula than in-area patients. The reason is that the obligation to provide home visits is removed for out-of-area patients. 'We are clear that the proportionality of rejigging the entire NHS primary care allocation system for a small number of patients, most of whom don't receive home visits, would be totally disproportionate so we propose to leave that as it is,' he said.

Proposed changes to reduce the new registration payment that practices receive (a one-off 46% of their per capita payment to recognise additional clinical and administrative work) would not be taken forward. It would be disproportionate to the number of patients and risked destabilising some GP practices with a high turnover (student practices, for example), he said.

NHS England believes abolishing out-of-area registration rules or reducing the payment level would act as a disincentive for digital-first providers to register out-of-area patients.

Turning to CCG allocations, the consultation proposed that funding will follow the patient. There will be adjustments to CCG budgets, based on the age and gender of patients registering with digital-first practices and the practices at which they were previously registered, with funding recalculated quarterly. This would reflect patient movements of the sort seen with digital-first practices in London.

Mr Waller said there were several financial considerations, including the speed at which large-scale movements of patients are reconciled between CCGs. He confirmed this will be achieved through quarterly adjustments.

'That will take account of the demography of those patients, their age and their gender,' Mr Waller said. 'It will also take account of the practices' position from whence they came and the deprivation of the original practice.'

## Need for a cap?

Consultation respondents supported capping the amount a CCG could lose through the registration of local patients with a digital-first provider in another CCG. But NHS England and NHS Improvement believe a cap will 'emerge naturally' when a new APMS practice is established (when the 1,000-patient threshold is reached). Typically, before the threshold is reached, CCGs would lose or gain a minimal amount, they say. Once the threshold has been passed, a new APMS practice will be created and the resources associated with each patient returned to them.

The national bodies intend to test the data around the threshold further, but in the meantime, they have recognised that Hammersmith and Fulham CCG is a special case and will continue to make adjustments to support the CCG.

A Hammersmith and Fulham CCG spokesperson says: 'The overall impact on the CCG finances has been significant. We are working with

NHS England to agree a solution that will fully mitigate this position. The allocation changes set out in the digital-first consultation outcome will be one of the mechanisms used to enable this.'

Commissioning of new digital-first providers will be carried out nationally, though in future this could become the responsibility of primary care networks. Digital-first contracts will be targeted at areas of greatest need – under-doctored areas (CCGs in the bottom 20%-25%) or those with the longest waits for GP appointments. Contracts will ensure that digital-first providers offer good access to physical practices if needed, to ensure they integrate with local services.

The new practices will be required to meet three strict criteria. They must: demonstrate that the GPs they will be bringing into the local community are wholly additional; ensure the physical part of their service also covers the most deprived areas of the CCG; and actively promote their service to the most deprived communities.

## Reducing inequalities

NHS England hopes the NHS could harness the potential of digital-first providers to reduce health inequalities. This will be achieved through national rules rather than local commissioning. A list of approved providers will be established to limit the bureaucratic burden on local commissioners. Both the list of approved providers and the creation of APMS contracts will be in place for April next year.

GP practices must have in place safe, secure, effective and high-performing IT systems and services that keep pace with the changing requirements to deliver care. To support this, £57.5m in extra funding has been allocated to address weaknesses in the GP IT infrastructure and ensure it is sufficiently robust and resilient to threat.

Generally, the new policy has been welcomed. Hammersmith and Fulham CCG says: 'There are some helpful changes proposed that will address some of the issues that have been identified by the development of this particular model of digital-first delivery. For example, enabling more patients to be part of local primary care networks going forward.'

It adds: 'The document sets out proposals to reform patient registration, payment and contracting rules around digital-first providers. NHS England will want to ensure that patients have choice and access to integrated care, and harness the potential of digital providers to help with workforce shortages in a way that helps the most under-doctored and deprived communities.'

Babylon GP at Hand, which recently expanded into Birmingham, says the digital-first policy is a vote of confidence in its services. 'The proposals will enable patients across England to choose Babylon GP at Hand, and we welcome the commitment to retain our funding levels.'

A spokesperson says it is committed to further expansion. But it adds: 'It is essential that the new policy changes are not implemented in a way that disadvantages digital-first providers. We will robustly challenge any attempt to impose new requirements that are not reimbursed on a par with traditional practices.

'These new NHS policies will enable more patients to use Babylon GP at Hand and access the services that have made us so popular and we look forward to working with the NHS to make this happen.'

Clearly, digital-first primary care is at the forefront of government, NHS England and NHS Improvement thinking. It is also popular with patients, though, as yet, this may be limited to younger, more tech-savvy sections of the population. The acid tests for digital-first will be whether it can break through to older or more vulnerable patients, truly expand primary care capacity in under-doctored and deprived areas and do so while keeping CCGs and GP practices financially stable.


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# Final pay control concerns re-emerge to add to current pension issues

Technical

There are a number of issues relating to pensions that are exercising HFMA members at the moment, *writes Debbie Paterson.*The highest profile is probably the annual and lifetime allowance issue, which is resulting in high earners, mostly medics, receiving tax bills in a year that are larger than their increase in pay for that year.

This is the subject of consultation by the Department of Health and Social Care, and the HFMA is responding to this. The consultation sets out proposed flexibilities for some clinicians.

The HFMA response is that any new flexibilities should be available to all in the NHS Pension Scheme, not just clinicians affected by the tax issue – a case put forward in the editor's comment, *Pension equity,* in the last issue.

However, it is also concerned that the proposed arrangements are very complicated and will take a lot of time to work through – by staff members, by NHS bodies as employers and by the NHS Business Services Authority.

A less high-profile issue that has caused concern recently is final pay control invoices from the NHS Business Services Authority. These are the result of a scheme introduced back in 2014 to stop a perceived risk that employers would or could award employees large pay increases just before they retired in order to boost their pension.

In summary, final pay controls kick in if a member receives an increase to pensionable pay in any of the three years prior to them retiring or transferring out of the scheme that is more than an allowable amount. Where this is the case, the employer is liable for a final pay control charge in the year the individual retires or transfers out. The allowable amount is the smaller of three amounts that are calculated using the pensionable pay in the fourth year before the person retired and the consumer price index

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(CPI) in February of each of the three years before retirement. It is the difference between the pension that will be payable and the pension that would have been payable based on a final salary that had increased by the allowable amount. For further information, see section 8 of this year's NHS pension scheme regulations consultation – **hfma.to/ai**.

When the scheme was introduced in 2014, members were concerned about the additional cost pressure. However, very few invoices were received from the NHS Business Services Authority in those early years. This year, however, has seen an increase in the number of invoices received and some of them are for large amounts, meaning that final pay controls have moved up the agenda for finance teams.

An HFMA briefing was due to be published as *Healthcare Finance* went to press. It is worth noting that from 1 April 2018, the regulations governing the 1995 part of the NHS Pension Scheme have been amended to exempt pay increases resulting from the Agenda for Change pay award from the final pay control provisions.

The Department for Health and Social Care also announced in its response to the consultation on the amendment to the 1995 regulations that it will review the final pay control policy in conjunction with the NHS Pension Scheme Advisory Board.

Looking ahead, two Court of Appeal cases (McCloud and Sargeant) could have an impact on NHS pensions going forward. The court ruled – **hfma.to/aj** – in December 2018 that the taper arrangements put in place when introducing the career average revalued earnings (CARE) pension schemes in 2015 were discriminatory on the grounds of age.

The government has indicated that, although the cases related to schemes for judges and firefighters, the remedy would be applied to all public sector schemes.

Currently, it is not expected that these rulings will have a major impact financially on most NHS bodies, as any additional cost incurred by the NHS Pension Scheme will be subsumed in a future change to contribution rates. In accounting terms, there may be some impact on cash equivalent transfer values, which would have to be explained in remuneration reports.

A bigger impact would be on NHS bodies that are admitted bodies to local government superannuation schemes. They will have to account for their share of any pension scheme liability as the scheme is accounted for as a defined benefit scheme under IAS 19.

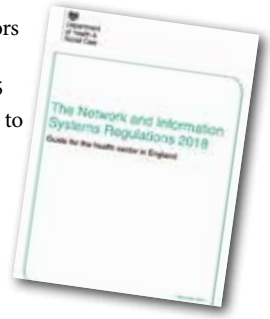
# Technical review

## The past month's key technical developments


**Technical** NHS England and NHS Improvement will undertake a three-week review and feedback process on the 2019/20 **approved costing guidance** this month. Updates to the costing standards, technical documents and collection guidance will be uploaded to the open learning platform on 11 November. The national bodies have also launched a survey on the timeframe for issuing costing standards. Under current guidance, the standards are formally issued in the January before the start of the financial year to which they apply – some trusts have raised this as an issue as it means updated standards are not applied until 18 months after publication. The survey seeks views on changing the issue date of standards so that they are issued in the January of the year to which they apply. hfma.to/ak

The HFMA has said it is 'broadly supportive' of changes to the format of the ***Financial reporting manual 2020/21*** (FReM). The Treasury has been consulting on the manual, including a revised structure. Although NHS bodies do not follow the FReM itself, it provides the framework for the manuals that they do use, such as the Department of Health and Social Care's *Group accounting manual*. In its response, the association said the FReM overall was improved as a result of the proposed changes, although it highlighted some areas where clarity or consistency of language could be enhanced. hfma.to/al

A survey has been launched to understand the impact of the Network and Information Systems (NIS) Regulations 2018, which have now been in place for over a year. The questions have been set centrally by the Department for Digital, Culture, Media, and Sport and the online survey should take around 30-40 minutes to complete. Details of the **cyber security** survey were sent directly to the senior information risk owner (SIRO) in all NHS trusts and foundation trusts. NHSX has asked SIROs – around half are finance directors – to ensure their trust completes the survey by 15 November as this will help to shape how the regulations work in the future. hfma.to/am




NHS England and NHS Improvement have published community and mental health costing assessment tools (CATs). Part of the **costing assurance programme**, the tools assess the quality of costing at each trust and the degree to which costing standards have been implemented. Community and mental health costing assessments should be submitted to NHS England and NHS Improvement by 20 December. (Ambulance trusts face a deadline of the end of November using an earlier issued CAT). hfma.to/an

The HFMA has updated its briefing on **going concern**. *Going concern – assessment and reporting in difficult times* summarises the interpretation of the IAS 1 requirements for the public sector and examines reporting requirements for NHS bodies. The auditor's role is also summarised – the updated briefing reflects changes in the auditor reporting requirements, as well as the publication of the 2018/19 annual reports and accounts. hfma.to/ao

NHS Improvement published a frequently asked questions document on the **implementation of IFRS 16** at the beginning of October. This followed the issue of implementation guidance at the end of September. The new standard, which will apply for NHS bodies from April 2020, changes how lessees account for leases, removing the distinction between operating and finance leases. The guidance includes an implementation plan with milestones. hfma.to/aq

## NICE adds treatment option for sialorrhoea

**Technical: NICE** New technology appraisal TA605, *Xeomin (botulinum neurotoxin type A)* for treating chronic sialorrhoea, provides another treatment option for treating chronic sialorrhoea (drooling) caused by neurological conditions in adults, *writes Gary Shield*.

First-line treatment includes non-pharmacological treatment – bibs, speech and language therapy, occupational therapy and pharmacological treatments such as anticholinergics, of which glycopyrronium bromide is the most commonly used.

Clinical experts on the guidance committee highlighted a need for a targeted treatment such as Xeomin that avoids the side effects of anticholinergics. The mechanism of action of botulinum neurotoxin type-A products alter the production of saliva. This contrasts with current treatments, which can cause a dry mouth in a population who are likely to have swallowing difficulties.

About 34,000 people with chronic sialorrhoea are eligible for Xeomin, including those with Parkinson's, cerebral palsy, traumatic brain injury, motor neurone disease, stroke and multiple sclerosis.

Meanwhile, TA606 *Lanadelumab for preventing recurrent attacks of hereditary angioedema* provides a further treatment option for a small population and is not expected to lead to a significant additional cost to implement.

Among the guidelines published recently, NG140 *Abortion care* covers care for women of any age (including girls and young women under 18) who request an abortion. It aims to improve the organisation of services and make them easier for women to access.

Detailed recommendations on conducting abortions at different gestational stages are also included, to ensure women get the safest, most effective care. Savings are anticipated as a result of minimising delays in abortion services, and a resource impact template allows users to model potential local savings by implementing the guideline.

**• See www.nice.org.uk/guidance for guidelines and other resources**

**• Gary Shield is resource impact assessment manager at NICE**

# NHS in numbers

## A closer look at the data behind NHS finance

# Outpatients

Technical

The *NHS long-term plan* promises that outpatient services will be fundamentally redesigned. The aim is to avoid up to 30 million or a third of all face-to-face outpatient visits over the course of the next five years.

The latest figures from NHS Digital show that there were 96.4 million outpatient attendances in 2018/19 – representing 78% of all appointments made. Some 70% of the non-attendances were due to cancellations by either the hospital or the patient, while 30% were simple no-shows.

There has been a 60% increase in attendances (and a 65% increase in appointments) since 2008/09. Over the same time period, hospital cancellations have increased by 150% and patient cancellations by 124%.

Modernising outpatients is not about one new model. Virtual consultations will undoubtedly play a part. But there are other ways in which services can be reworked.

Examples already exist of consultants holding or supporting GPs in outreach clinics. Other areas have had success with direct referrals of potential orthopaedic patients to physiotherapy, making better use of consultant time.

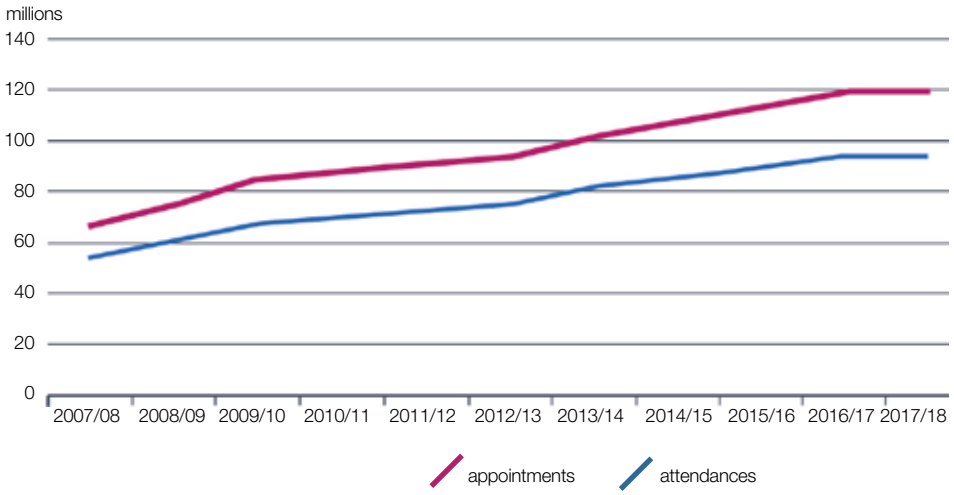
There are also moves to give the patients a bigger part in deciding whether they need a follow-up appointment – perhaps based on the use of patient-reported outcome measures.

Trusts have been encouraged to ensure that follow-up appointments are used only where necessary and this has been underpinned by the tariff payment system.

There are specific tariff prices for consultant-led outpatient appointments, with different rates for first and follow-up appointments based on average costs submitted by trusts as part of the reference cost exercise.

However, in order to incentivise a change in the delivery of follow-up activity, first attendances are over-reimbursed and follow-ups under-reimbursed. Different levels of frontloading are set for different service areas (defined by treatment function codes) ranging from 0% to 30%. For example, in this year's national tariff, a consultant-led first attendance in general surgery attracts a payment of £173, compared with a follow up at £72, after a 30% uplift to the first attendance.

**Outpatient appointments and attendances, England, 2007/08 to 2017/18**




Source: NHS Digital. Hospital Outpatient Activity, 2017-18. October 2018

Physiotherapy saw the highest number of outpatient attendances at 7.3 million, followed by trauma and orthopaedics at 5.9 million and ophthalmology at 4.7 million

In the current year, non-mandatory prices have also been published for non-face-to-face appointments and non-consultant-led appointments – again, the aim is to incentivise new delivery models with systems agreeing local prices informed by the published tariffs.

A non-consultant face-to-face first attendance in general surgery has a guide price of £107 – 60% of the consultant-led equivalent – and this drops to a guide price of £41 if the appointment is non-face-to-face.

Not all areas continue to use individual tariff prices for outpatient payments, although activity and price could be used to inform block contract values.

Outpatient attendances can be usefully broken down further by looking at NHS reference costs. The schedule for 2017/18 – the most up-to-date figures available – identify 75 million outpatient attendances and 13 million outpatient procedures, giving 88 million in total. The difference between this and the 94 million attendances highlighted in the NHS Digital figures is due to activity undertaken in the independent sector, according to NHS Digital.

Excluding outpatient procedures, physiotherapy saw the highest number of outpatient attendances at 7.3 million, followed by trauma and orthopaedics at 5.9 million and ophthalmology at 4.7 million.

According to reference costs, 70% of the 75 million attendances in 2017/18 were consultant-led, compared with 75% of 67 million attendances in 2010/11, suggesting there has been some small change in involving the wider healthcare team in outpatients delivery.

# Apprentices on the launch pad

**By Steve Horler, HFMA apprenticeship manager**

News and views from the HFMA Academy

**Training**

In January, the HFMA will break new ground in education, with the provision of healthcare-specific apprenticeships that lead to a professional accounting qualification.

This comes hard on the heels of numerous new studying opportunities from the association – including level 4 and level 7 qualifications and the potential to complete an MBA in healthcare finance. All of these qualifications aim to support healthcare finance practitioners and other staff in enhancing their skills, improving their own career options and helping the NHS to transform the delivery of services and value.

However, the apprenticeship meets a very specific need. Not only does it provide access to much-needed technical training wrapped in a specific NHS context, but it also enables organisations to meet the costs of the training from their own digital accounts.

These accounts are built up using their apprenticeship levy contributions, with organisations paying a levy equivalent to 0.5% of their payroll value. These funds are topped up by government, but can only be used to support apprenticeship programmes – with organisations losing access to the funds if they are not spent within two years.

There has been major demand from NHS bodies to have the training they want for staff made available as part of an apprenticeship. The HFMA believes apprenticeships provide opportunities for staff to gain skills at many different levels, including masters level. However, its initial focus is on a level 4 accounting apprenticeship starting in 2020.

Employers could target apprenticeship programmes at existing staff or use them to attract and train new staff.

Apprentices will study for a level 4 qualification. The aim is to allow students to choose from the AAT, ACCA diploma or CIMA certificate – although the first cohort in January will pursue AAT qualifications. Contextual study material will be drawn from the HFMA level 4 intermediate certificate, which focuses on how finance works in the NHS, with apprentices choosing five from 10 topics:

- How the NHS is funded and structured
- Changes in the NHS
- Politics, government policy and the NHS
- The NHS in England
- Commissioning
- Contracts and payments
- Expenditure
- The need for change
- Financial planning
- Integration and healthcare

More topics can be studied as 'enhancement to learning' and on completion, in addition to their accounting qualification and apprenticeship certificate, learners receive an HFMA certificate that exempts them from studying completed topics if they study a level 4 HFMA qualification.

The whole apprenticeship will last 18 months with the apprentice needing to take approximately 35 days of study leave over that period to undertake online study and for skills coach visits, group working and exam sittings.

The requirement for apprentices to have 20% off-the-job training is one that frequently concerns employers. In the main, this is likely to be consumed by the accounting qualification study. However, this doesn't necessarily mean one day a week away from the office, and the HFMA will work with employers to minimise the impact of any extra off-the-job time needed.

Various activities can count towards this overall requirement, including inductions, time off in lieu for study leave outside of work hours, secondments and development opportunities. The programme costs £8,000, which comes direct from the apprenticeship levy, with payments spread over the 18-month study period. There are also non-levy fees of about £400 for the accountancy exam entrance, which cannot be claimed against the levy.

To streamline setting up these programmes, funding can be accessed for up to three apprentices without using a procurement framework. See **hfma.to/apprenticeships**

## 2020 finance talent pool launched

**Future focused finance**

Applications are now open for the 2020 National Finance Leaders Talent Pool, *writes Sophie Rowe.*

Established in 2017, the pool is for finance leaders across England who are ready now, or in the very near future, to take on finance director, chief finance officer or equivalent roles in the NHS.

For the 2020 intake, FFF is working together with the five Aspire Together regional talent boards (RTBs), set up by the NHS Leadership Academy to take a more systematic and co-ordinated approach to managing senior talent.

This will enhance the existing offer by aligning to the broader formation of talent pools by the RTBs. The leadership teams of both FFF and RTBs are committed to the collaboration and can see the overall benefits for all stakeholders and ultimately the NHS workforce and the public.

The finance talent pool is supported by the Finance Leadership Council and NHS England and NHS Improvement regional finance directors.

'Our aim is to build a diverse pool of talent that improves the number and quality of applicants for finance leadership roles and that reflects the populations we serve,' says Cathy Kennedy, director of operational finance at NHS England and NHS Improvement, and FFF lead for senior talent management programmes.

Selection into the National Finance Leaders Talent Pool is through a competitive application and interview process designed to reflect the finance director/ CFO application procedure.

**For further information, please visit www.futurefocusedfinance.nhs.uk or email futurefocusedfinance@nhs.net – applications close on 6 January 2020**

**• Sophie Rowe is FFF's programme manager**

# Diary

## November

7 (N) Estates and facilities forum, London
12 (N) Charitable funds, London
13 (F) Audit conference, London
14-15 (B) East Midlands: conference
14 (F) Commissioning Finance: forum, London
15 (B) Northern: annual conference, Durham
19 (B) Eastern: accounting standards update, Newmarket
21 (B) London: VAT level 2
21-22 (B) Northern Ireland: conference
27 (I) Institute: technical costing update

## December

4-6 (N) HFMA annual conference, London

## January

14 (F) Annual chair's conference, London
15 (I) Institute: introduction to NHS costing, Manchester
22 (B) London: VAT training day level 3, London
24 (B) Wales: VAT training day level 2, venue tbc
29 (N) Pre-accounts planning, Leeds
30 (N) Pre-accounts planning, London
31 (B) Yorkshire and Humber: conference, Scunthorpe

## February

10 (N) CEO forum, London
13 (B) Wales: VAT training level 3, Cardiff
27 (I) Costing together (south), London

**For more information on any of these events please email events@hfma.org.uk**

key (B) Branch (N) National (F) Faculty (I) Institute

## All HFMA activities now CPD accredited

**Participation in all HFMA activities now counts as accredited continuing professional development (CPD) after passing assessment by the CPD Standards Office.**

**Delegates attending national events, branch conferences, webinars or roundtable discussions will be issued with an accredited CPD certificate of attendance for inclusion in their CPD records for their professional body, institute, regulator or employer.**

**Reading HFMA briefings or *Healthcare Finance*, studying via e-learning or taking part in board game activities will also count as accredited CPD.**

**Previously, participation in these activities would have been viewed as 'unaccredited hours', but some professional bodies are now insisting that up to 50% of CPD should be made up of accredited activities.**

**The CPD Standards Office is an independent accreditation body that supports best practice in the provision of CPD.**

## Events in focus

### HFMA annual conference
**4-6 December, London**

The HFMA annual conference is the main event in healthcare finance, bringing together finance staff from across the UK, alongside leading thinkers in value and efficiency.

The event will showcase the theme of 2019 HFMA president Bill Gregory, *Value the opportunity,* and focus on the challenges and opportunities faced across health and care. Services across the UK have received additional funding and there are plans to transform the care they deliver. Improvements in quality and safety, and value for money will lead the plans. But as ever, the NHS will wish to avoid unexpected consequences of any changes and ensure reform addresses questions over workforce sustainability, the potential impact of the UK exit from the EU and rising demand in the face of an ageing population. Questions over the long-term funding for capital, public health and education and training remain.

Delegates to the annual conference will hear from leading thinkers on healthcare finance from home and abroad. They can catch up on best practice, network with colleagues and celebrate the best of NHS finance at the annual HFMA Awards ceremony. Speakers include NHS England and NHS Improvement chief financial officer Julian Kelly, NHS productivity and efficiency leader Lord Carter and BBC Europe editor Katya Adler (pictured).

**• Email josie.baskerville@hfma.org.uk or visit the HFMA's website for details**

### Pre-accounts planning
**29 and 30 January 2020, Leeds and London**

The popular annual events return in January, with the same programme offered on both days. The event aims to help those involved in the planning and delivery of the 2019/20 annual accounts process and there will be a mix of plenary and workshop sessions. The conference offers the opportunity to discuss changes to accounting and reporting requirements and to raise questions or give feedback to colleagues from NHS Improvement, NHS England and the Department of Health and Social Care. Issues that are likely to arise from the 2019/20 accounts preparation and audit process will be raised and debated.

Discounts are available for delegates from HFMA partner organisations. The event is CPD accredited with the CPD Standards Office.

**• For more details, email josie.baskerville@hfma.org.uk**

# A greener approach

**Association view from Mark Knight, HFMA chief executive**

To contact the chief executive, email chiefexec@hfma.org.uk

My HFMA

You may have noticed something different about your magazine this month. It now comes in a smart envelope and the paper has lost that plastic shimmer of the past 20 or so years.

We have moved to a printer that holds EMAS (Eco-Management and Audit Scheme) accreditation – one of only 10 in the UK to do so – and the magazine is now printed using 100% renewable energy and chemistry-free plates, with low levels of waste going to landfill. We're also printing it on Forestry Stewardship Council (FSC) standard paper, which means the paper is manufactured from wood from FSC-certified forests, recycled material, or controlled wood.

We considered several types of wrapping. Many of you will have seen the potato starch 'bag' used by the National Trust for its magazine, but we decided against this for a number of reasons. A key practical issue was that we are aware that when most of you open your magazine, you're at work. It's not clear what facilities are in workplaces to dispose of that type of packaging – many wrappers could just end up in the waste bin – but paper recycling exists in virtually every office, so a recyclable paper envelope seemed the right approach.

We've also moved our print and magazine wrapping operation to one location. That saves us time, but more importantly we don't need to move the magazine from one location to another – reducing carbon emissions.

We should save about 0.5 tonnes of carbon a year. That's not a lot in the grand scheme of things, but isn't that how change happens? Lots and lots of people and organisations making small adjustments.

You shouldn't see any differences in the content. You've told us in our member surveys that you value the magazine and we strive to preserve that. Let us know what you think about what we've done by tweeting @HFMA_UK or emailing me at chiefexec@hfma.org.uk.

At the upcoming annual conference we will be making more changes to improve our environmental performance, including providing all delegates with a fully recyclable, reusable cup.

HFMA chief executive Mark Knight

We are now in the final run-in to our biggest event of the year – our 69th event and my 20th as chief executive. Once again, our team has excelled, with a fine collection of speakers from the NHS, including the leading people, operations and medical officers. Julian Kelly, the new NHS chief financial officer, will be there too to give his first annual conference address.

In terms of personal development, on the Thursday, we will hear from Matthew Syed, whose book on 'black box thinking' challenges us to learn from our mistakes.

Talking of which, you don't completely escape Brexit. Regardless of your view on leave/remain, few could argue the process that has brought us to our current situation has been a success. If anyone is well placed to offer an insight into the lessons learned, it is our closing speaker – BBC European editor Katya Adler. It will be fascinating to get a perspective from her on the events in Europe over the past couple of years.

The conference will also bring to an end Bill Gregory's presidency and introduce our 70th leader, Caroline Clarke. Her theme will be challenging and I'm sure you will all get behind it as we celebrate 70 years of this great association.

## Member news

**Kent, Surrey and Sussex Branch** held its conference and awards in October. The winners (pictured below) were:

- Student of the Year: Beth Hale, Sussex Community NHS FT
- Training Award: Sussex Community NHS FT
- Costing Award: Kent Community Health FT and Maidstone and Tunbridge Wells NHS Trust

- Finance Team of the Year: East Sussex Healthcare System

The **South West Branch** hosted its annual conference, at which it presented five awards:

- Deputy Director of Finance: Alex Keast
- Finance Team: NHS England and NHS Improvement South West
- Innovation: David O'Sullivan
- Unsung Hero: Caroline Burgess
- Outstanding Contribution: Sheena Morrow

Dawn Scrafield is now chair of the **Eastern Branch**. She succeeds Andy Ray, who has chaired the branch for the past five years. Daryl Cockman is the new vice-chair.

Team HFMA has completed the **Three Peaks challenge**, in support of Mind, raising over £8,000. They were the only ones in a group of 38 who climbed all three peaks in 24 hours, despite challenging conditions. Support them at hfma.to/3peaks

The winner of the **Northern Branch** annual quiz (sponsored by Hays Senior Finance) was a team from NHS Business Services Authority.

## Member benefits

**Membership benefits include a subscription to *Healthcare Finance* and full access to the HFMA news alert service. Our membership rate is £65, with reductions for more junior staff and retired members. For more information, go to www.hfma.org.uk or email membership@hfma.org.uk**

## Branch focus

My HFMA **Northern Branch**

The Northern Branch has had a busy year with many social and training events. It's even supported a charity football tournament.

It has also implemented a successful HFMA champions scheme to encourage and empower more people in the region to get involved. Every finance director has nominated a member of their team to act as the link between the branch and the finance staff in their organisation. The champions have formed a network and demonstrate their commitment to training and development, as well as providing feedback to the branch.

'We've got some fantastic committee members and we've all been working hard to make sure every NHS organisation in the North East is engaged with the HFMA,' says branch chair David Chandler (pictured). 'If we have an event coming up, rather than sharing it just with finance directors or HFMA members, we also share it with the champions and they ensure that our colleagues, members or not, receive the information.'

The region's annual conference is already sold out and will focus on inclusion and collaboration, and the newly formed North East and North Cumbria Integrated Care System.

Mr Chandler is keen to hear the keynote address on diversity from broadcaster and author René Carayol – the subject's been on the branch's agenda for the past year.

'The North East is traditionally not the most diverse area in the country from a demographic point of view,' says Mr Chandler. 'We want to champion the benefits of diversity and being more active to take advantage of this. If you want a high-performing, well-balanced team, you need to be thinking about all aspects of inclusion and diversity such as age, gender, sexuality, race and social demographics.

'Maybe we have to work a bit harder on diversity up here, but the North East has always been a very friendly and welcoming place, which is a great foundation to build on.'

Over the next year, the branch is planning to host more events in the evening to allow members to learn more about a specific topic and network more regularly.

**• If you would like to get more involved, visit hfma.to/northern or have a chat with your local HFMA champion**

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# Appointments

**Pete Papworth**, previously director of finance at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, has been appointed joint director of finance at Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. This appointment represents another step in the merger of the two trusts, following the appointment of a joint chair and chief executive in January. Mr Papworth has more than 16 years' experience working in public finance, over 11 of which have been in senior positions within the NHS. Mr Papworth takes over from **Mark Orchard**, who was director of finance at Poole Hospital NHS FT and is now chief financial officer at Portsmouth Hospitals NHS Trust.

East Suffolk and North Essex NHS Foundation Trust has appointed **Adrian Marr** director of finance. He was previously director of operational finance at NHS England and NHS Improvement. Mr Marr has over 30 years' experience in NHS finance, working in both provider and commissioner organisations across the east of England. He takes over from **Dawn Scrafield**, who is now chief finance officer at the Mid and South Essex University Hospitals Group.

**Kevin Curnow** is now acting chief finance officer at Whittington Health NHS Trust. Mr Curnow first joined the organisation in May 2018 as operational director of finance. Before joining the organisation, he was director of finance at Hertfordshire Community NHS Trust.

**Clare Young** (pictured) has been appointed head of planning and performance at Southampton City Clinical Commissioning Group. Ms Young joined the NHS, and the CCG, in 2014 as a project management office manager. She recently graduated from the HFMA advanced qualifications programme in healthcare business and finance.

Medway NHS Foundation Trust has appointed **Paul Kimber** (pictured) deputy director of finance. He joins from Barts Health NHS Trust where he was head of finance. Prior to this, he was assistant director of finance at Royal Free London NHS Foundation Trust and head of finance at NHS London. Mr Kimber joined the NHS almost 10 years ago, after a decade working at Deloitte.

**Kingsley Peter** is the new interim chief financial officer at East London NHS Foundation Trust. A non-executive director on the trust board from 2006 to 2018, he has senior finance management experience in product distribution and engineering, as well as in the charity sector.

**Get in touch**
Have you moved job or been promoted? Do you have other news to share with fellow members? Send the details to seamus.ward@hfma.org.uk

"Rupert was a figure of absolute and unwavering integrity, astonishing speed of thought and sharp wittedness and had an overriding sense of fun. He always had patient care and service quality in his heart"

# Obituary: Rupert Davies

On the move

The NHS finance family was deeply saddened to hear of the recent death of Rupert Davies, aged 64, following a long and brave fight against cancer. A long-serving NHS finance professional, Mr Davies has been described as 'one of life's gentlemen' – an inspirational figure who loved his work.

Paul Assinder, former HFMA president, who knew Mr Davies as a friend and fellow West Midlands' finance director, said: 'He was someone who cared passionately about those fortunate enough to work with him over the years and particularly for the patients and service users his various organisations served.

'Rupert was a figure of absolute and unwavering integrity, astonishing speed of thought and sharp wittedness, and had an overriding sense of fun. He always had patient care and service quality in his heart.'

Mr Davies joined the NHS finance training scheme as a mature student in the early 1980s, having gained a degree (social sciences, University of Kent) and a masters (economic history, University of Leeds) before completing a PhD in economic and social history at the University of Leicester. CIPFA-qualified, he was a great supporter of the HFMA throughout his NHS career, where he worked predominantly in the provider sector, including time as a civil servant at the Department of Health.

In 2003, he joined South Staffordshire Healthcare NHS Foundation Trust, where, as deputy director of finance, he played a key role in the merger with the mental health sections of local primary care trusts to form South Staffordshire and Shropshire Healthcare NHS Foundation Trust. The merger was recognised in the 2007 HFMA Awards, when the trust was named Foundation Trust of the Year. He was also heavily involved with finance staff development, with the trust winning the Jon Havelock finance staff development award two years in a row.

In 2008, Mr Davies took his first director role as director of resources at the Worcestershire Mental Health Partnership NHS Trust. Again, he helped prepare organisations to bring services together. He left the organisation as it became Worcestershire Health and Care NHS Trust, combining the trust's mental health services with those previously run by Worcestershire Primary Care Trust's provider arm.

Joining West Midlands Ambulance Service NHS Trust as director of finance, IT and estates in 2011, he was central to the trust securing foundation trust status. He also helped it to increase its frontline workforce by more than 25% while staying in financial balance – marking the trust out from many other parts of the NHS at that time. The ambulance trust's chief executive Anthony Marsh said: 'It was a pleasure to have worked with Rupert – he was a hugely knowledgeable and well-respected individual.'

Mr Davies moved to his final role towards the end of 2015. He joined Dudley and Walsall Mental Health Partnership NHS Trust as interim director of finance, performance, IM&T and estates, stepping into the shoes of Mark Axcell, who had become the trust's chief executive. Once in position, he helped steer the finance team and wider organisation through the upheaval of the Transforming Care Together initiative, which had planned to integrate three local trusts before the proposals were dropped. Finance staff at the trust nominated him for a new distinguished career award to commemorate the NHS's 70th birthday at a staff awards event last year.

Mr Axcell recalls Mr Davies as 'an amazing colleague, professional and friend' with a distinct sense of humour. 'His board and annual general meeting presentations were always memorable – they delivered the message with good grace and humour,' he said. 'But you were never quite sure what jokes or historical analogies he was going to throw in – which always kept the board on their toes in public meetings.'

Outside work, Mr Davies loved walking with family and, despite being fluent in French, had recently joined a French-speaking class to 'brush up on his dialects'. He also loved opera and was a regular at Birmingham Hippodrome as well as enjoying trips overseas, including Verona, Italy, and Orange, France. In his final few housebound months, he taught himself woodwork, creating bird boxes for family and friends.

Since hearing the news of his death, many colleagues have paid tribute to him, referencing his unique ability to 'say it as it is' and get 'straight to the point' but always in a way that was respectful, humorous, and insightful.

Mr Davies is survived by wife Helen, his son Chris and two grandchildren.

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