Turning it around

A recent HFMA roundtable, supported by Baxter Healthcare, heard how elective recovery is beginning to gain ground. There is much work to be done, and the NHS has to be aware of the possible challenges – but finance should not be a barrier to change. Seamus Ward reports

SHUTTERSTOCK

Although Covid continues in the background, recovery is now the top priority for the NHS. Waiting lists are growing each month, albeit possibly stabilising in some parts, even though the service has made significant progress in reducing the number of those who have waited longest. There are pinch points – staffing, diagnostics, social care capacity, for example – that local health systems must understand and address if they are to make elective recovery a reality. But, as an HFMA roundtable heard in June, finance must not become a barrier to making the transformative changes needed.

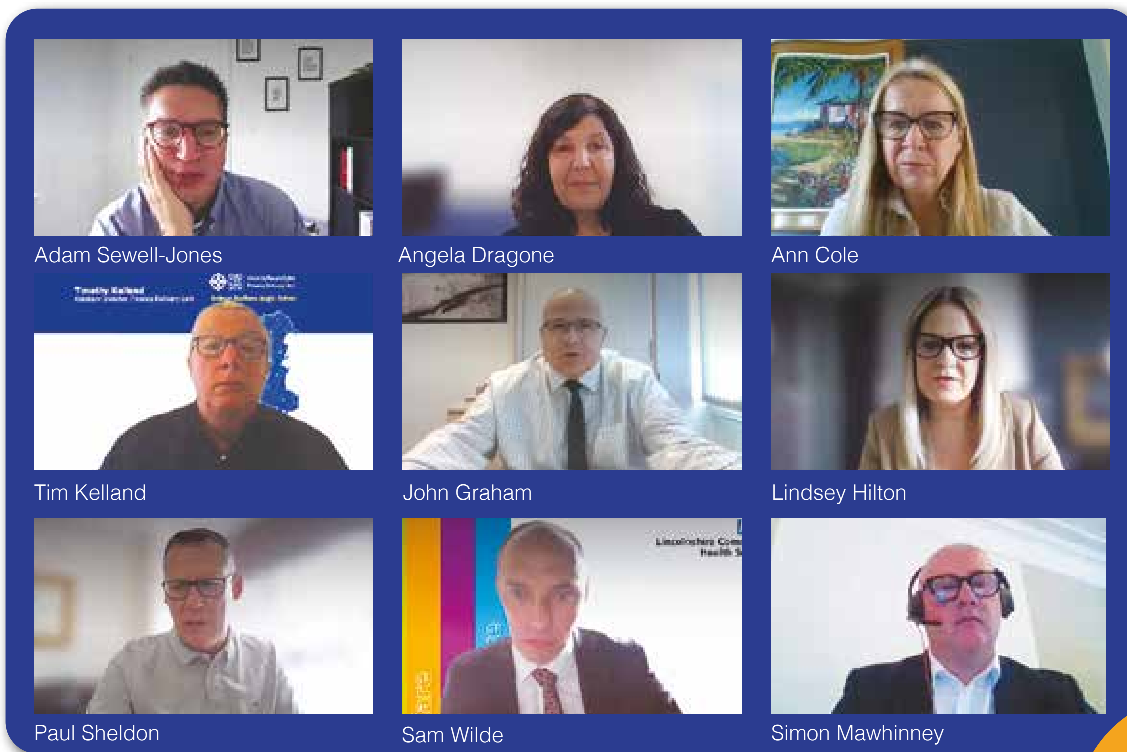
At the roundtable, sponsored by Baxter Healthcare, clinicians, industry and senior NHS leaders spoke about how they were addressing recovery and further changes that could be made to improve patient services.

NHS England elective recovery director and Northumbria Healthcare NHS Foundation Trust chief executive Sir James Mackey opened the discussion. Elective recovery became the government's top priority last summer, he said, when the funding settlement was agreed for the NHS. Omicron caused some disruption to agreement of the plan, and then delivery through the winter and spring, but elective recovery guidance gave a clear steer to focus on issues such as long waits, transformation, outpatients and the separation of elective streams.

The NHS is required first to eradicate 104-week elective waits by the end of July, end waits of more than 78 weeks by April 2023, and eliminate those of more than 52 weeks by March 2025. Activity will be ramped up to help achieve these targets, with delivery of 30% more activity by 2024/25 than before the pandemic.

The ambition in 2022/23 is to deliver more than 10% additional activity compared with 2019/20. This will be achieved through more completed referral-to-treatment pathways and more pathways completed in primary care with the support of specialist advice, measured by the number of onward pathways avoided.

Additional funding will be available against meeting an equivalent value-based activity target of 104% of 2019/20 activity. This will be facilitated by reducing follow-up outpatient attendances, and increased use of pre-referral advice and guidance, which could contribute six percentage points towards the completed



pathway activity target. NHS England estimates the contribution towards the value-based activity target will be smaller (less than one percentage point) because the value of these pathways is lower than the value of an average pathway.

Sir James acknowledged that the increased activity meant a 'painful' decision to move back to 'something that felt like payment by results' to drive up activity.

Waiting list progress

But progress had been made. In October 2021 there were potentially around 40,000 patients waiting two years. This would fall to around 3,000 at the end of June, with further progress in July, when the NHS is aiming for zero 'capacity' delays. The number needs to be as close to nil as possible by the end of July, but it looked like there would be a small residual number – largely patients who have chosen not to be treated elsewhere, or whose cases are too complex to move to another provider.

'This would be seen as a fantastic success for the NHS, but the next bit's quite hard because 78 weeks is much bigger in magnitude,' Sir James said. 'The first bit was about surgery, but this next stage is largely about outpatients. We have to change the game and we are keen to change the outpatient clinical model, which hasn't changed since 1948, because it frees up clinical time and helps us prioritise new patients. It's difficult but it's necessary.'

Finance staff must be closely involved in recovery, he added. The NHS faces greater scrutiny over the value it provides, from the Treasury and politicians, and must be able to demonstrate the gains made. 'The value the finance community can add is in improving decision-making, a focus on productivity, helping people with choices, making sure the money flows don't get in the way of what we need to do to support patients to move around, and helping people out when they have a backlog.'

Sir James, a former finance director, added: 'The finance community can help lead the process of getting back to normal disciplines again; asking what is the purpose of this thing, what are the numbers, and who is going to benefit from it? As a finance professional, I think there's no other part of the service that's going to break into that.'

And with capital in short supply, funding demands from other parts of the public sector, construction inflation rising rapidly and a difficult economic period ahead, the NHS may have to make do with the estate it has currently and smaller, transformational capital projects.

Participants

- Lee Bond (chair), Hull University Teaching Hospital NHSFT and Northern Lincolnshire and Goole NHSFT
- Ann Cole, Baxter Healthcare
- Clara Day, Birmingham and Solihull ICB
- Angela Dragone, Newcastle upon Tyne Hospitals NHSFT
- Tim Kelland, Finance Development Unit, Wales
- John Graham, Stockport NHSFT
- Lindsey Hilton, Baxter Healthcare
- Sir James Mackey, Northumbria Healthcare NHSFT
- Simon Mawhinney, NHS England
- Adam Sewell-Jones, East and North Hertfordshire NHST
- Paul Sheldon, Leicestershire Partnership NHST and Northamptonshire Healthcare NHSFT
- Sam Wilde, Lincolnshire Community Health Services NHST

Cost challenge

The timing of financial flows could be crucial in the presentation of in-year financial performance, the roundtable heard.

Adam Sewell-Jones, chief executive of East and North Hertfordshire NHS Trust, said trusts have modelled activity based on a level of elective recovery funding.

He continued: 'But to achieve the income we were modelling, we have also planned on significant cost, and therefore getting the benefit of the margin. But you take on the cost before the income comes through, so the challenge we may all have across acutes in our reporting is how we manage that under-delivery on ERF in the first few months and whether we will lose that money.

'Our deficits could make very poor reading at the beginning of the year, which could lead to knee-jerk responses. But we are assuming we will recover our plan because we are bringing on new procedure rooms and other facilities that will be a step change.

'We are probably artificially boosting our financial performance on the promise of what we will do, but how regional and national colleagues determine how everyone should be reporting could make quite a difference to the financial position.'

Demonstrating value

How can finance staff demonstrate that value is being obtained? Tim Kelland, Welsh Finance Delivery Unit assistant director, which is driving forward value-based healthcare in Wales, gave one example. He said the unit has analysed the number of leg amputations as a result of diabetes across the whole of Wales over the last three or four years.

'Any way you look at it, an amputation due to diabetes is a systemic failure, and it does consume a lot of resource. We found geographic variations – in areas where there was limited diabetic retinopathy screening, there were higher rates of amputations. And there were more amputations in areas with fewer podiatry services. That made us think we need to put these services in – they cost significantly less than the economic cost of a patient losing their limbs.'

When they looked at the type of patients having amputations, they saw that there were disproportionately higher numbers in men aged between 40 and 55. This was simply due to the reluctance of men in this age group to seek help. 'Now we're targeting investments in educating those individuals and we are starting to see a reduction in amputations,' said Mr Kelland. 'When you put a net present value to that, you see it's massively beneficial to the patient and the public purse.'

Clinicians have a big role to play in restoring financial discipline as they make decisions on using resources. But Clara Day, a renal consultant who is chief medical officer at Birmingham and Solihull ICB, said there is confusion among clinicians about payment mechanisms. They were used to activity-based payments prior to Covid. For two years of the pandemic, work was completed through block contracts, but now block contracts are used for emergency work, and cost and volume for electives.

'Clinicians who are running services are struggling slightly in this new financial regime as to how best to engage in this block contract mechanism around ways to transform, versus their previous activity-driven payments. I think there needs to be some thinking about educating clinicians because for those of us who haven't been in blocks before it's a different way of thinking.'

The roundtable looked at some of the practical changes that are being made to reduce waiting times. Dr Day said Birmingham and Solihull switched to a preferred option of advice and guidance in June 2020 in some areas. The programme offers GPs access to specialist advice, allowing care to be managed in the most appropriate setting and avoiding unnecessary outpatient appointments.

'In my specialty – renal – we only convert about 15% of referrals into appointments because a lot can be dealt with by giving advice,' said Dr Day. 'However, in other specialties, where you need to see somebody, it is less easy. Advice and guidance for me is about making sure we only see people who need to be seen, rather than automatically adding people to waiting lists because that's what we've done in the past.

'The issue with this is that it reduces new patient appointments. I don't know if it's in the ERF now, but there was almost a perverse incentive not to do that because of the associated decrease in your activity that was recorded and rewarded. It's the right thing to do, without doubt, and it's extra work, but how we financially balance that has been a particular interest for me.'

Sir James said he insisted on the guidance being specific that funds should not be lost under these circumstances. 'If you are going to do something that will have an impact on your volumes, all of that money will stay within the trust. You set out how you are going to change

Day case contribution

Finances should not be used as a barrier to a proposed development that will cut waiting lists and contribute to elective recovery. And though she admits it has created sleepless nights, Newcastle Foundation Trust finance director Angela Dragone is proud that funding did not get in the way of the trust's new day case unit.

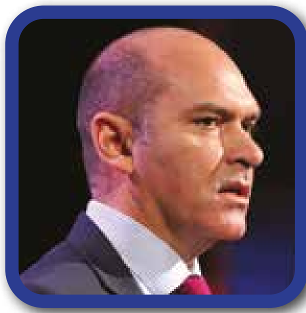
'Money can't be seen to be a problem and I think that's what we've ensured in Newcastle,' she said. 'We decided there was an opportunity to treat people on the list by building a day case unit, and retrospectively we had to make the money work. But behind all of that it's been a massive challenge.'

She said the trust now has to make the new unit, which is due to open in September, pay for itself through service transformation and through the elective recovery payment mechanism.

The capital build was funded under emergency powers during the pandemic. 'Capital was not the problem; it was income and expenditure that really troubled me most,' she said. 'The first challenge was that it was obvious that eventually these people would be treated so the income was non-recurrent but the spending involved in staffing a day case facility was recurrent.

'At the point we planned it, we weren't really sure how much we were going to get paid to cover the cost. We knew what the expenses would be, so it's been a bit of a battle keeping those expenses low until the income streams are clearer.'

The unit is a positive development, but the trust is mindful of risks attached, such as workforce. Ms Dragone was concerned that drawing in the permanent staff needed would destabilise other parts of the trust or neighbouring trusts. Clinicians' expectations had to be managed, too, within the block contract funding envelope. A sub-group made up of non-executive directors has been set up to monitor these risks. 'But finance can't be the thing that slows down the elective recovery. We have to be clear about the risks and manage them properly,' she added.



"We are keen to change the outpatient clinical model, which hasn't changed since 1948"
Sir James Mackey

it and we'll get that agreed. Nobody should lose any money if they are going to do something that's not captured in a traditional way.

'Even now, if people think they need to change their model, but they think it's going to cause them financial harm, just tell us and we'll find a way to sort it out.'

NHSE had some good data on when advice and guidance has most impact, Sir James added. 'In some places, nearly everyone who goes through advice and guidance gets an outpatient appointment, which feels completely pointless. It's clearly not being executed well. In other places, there's clear evidence that it is sorting out what's needed for the patient without having to go to a clinic.

'There's something about getting that out there so people understand that if it's executed in certain ways, you'll get more impact.'

Mr Sewell-Jones insisted GPs must be supported to deliver advice and guidance. They needed reassurance from specialists that they were doing the right thing for their patients. There was also a danger of drifting into a position where most patients were referred to advice and guidance, then triaged. This erected a new barrier for patients, while GPs felt that it was adding to their workload.

'As we develop these new models, there has to be lots of clinical engagement, not just in terms of having a professional voice, but understanding the mechanics so we don't create more work in another part of the system and slow it down,' he added.

Dr Day accepted the introduction of advice and guidance meant an increase in work for GPs. Locally, the ICB is moving to advice and guidance for all patients in three specialties, with the agreement of general practice, because it feels this is the correct route. 'But you need to perform against that. You have to ensure your turnaround is appropriate,' she said.

She added that the system had learnt that secondary care practitioners did not necessarily need to see all patients on the waiting list – 1,000 of the longest waiters in dermatology were sent to enhanced primary

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Lee Bond

care practitioners to help clear the waiting list. Only those who needed to see a secondary care dermatologist were referred on by the enhanced general practitioners. The success of the project has prompted the ICB to use enhanced practitioners for patients waiting a long time in other specialties.

'We can't go back to the 1948 model for outpatients,' Dr Day said. 'Remote consultation does move some of that, but I still have to sit either in front of a video screen or in front of the patient – it doesn't free my time. You can't have almost a never-event, where you see someone by video and then have to bring them in to see them for a first appointment.'

Financial incentives

NHS England director of elective care recovery and transformation Simon Mawhinney said outpatients and non-admitted pathways provide the greatest opportunities for elective recovery. He was keen to understand how finance could incentivise activity rather than act as a potential block. He singled out areas, in addition to advice and guidance, where capacity could be released.

Of the 6.5 million people on the waiting list in England, more than five million patients are waiting for an agreed decision to treat, he said. 'It's an area where technology can play a role. What would prevent patients who are able to be seen virtually being seen in Devon rather than in Newcastle, for example? It's something we are keen to develop. How can we use mutual aid as an opportunity to use technology to its maximum to support patients?'

He said outpatient recovery needs to be a priority as, even within surgical specialities, you would normally only expect 20% to 25% of patients to convert to surgery. 'Around five million of the 6.5 million on the waiting list are outpatients, so you can see the size of the ask here,' he said. 'This is why we are very focused on outpatient reform.'

More work was needed on pre-assessment. 'There are real opportunities to maximise our outpatient capacity, so the patient who has to travel 40 miles to the hospital to be weighed, get their blood pressure done and answer 10 questions, does that themselves rather than come into the hospital.

'We know there are good examples of this, but where it isn't taking place we need to up our game because that could free up physical outpatient capacity.'

Sir James wondered if patients with chronic conditions could be empowered to choose when they needed outpatient appointments, rather than being called to an unnecessary regular check-up. The NHS app could play a role in this, potentially enabling a high level of interaction with clinical teams.

He continued: 'We would have to ensure we have other mechanisms for those unable to use it, but that could be a game-changer, where nearly everybody has the choice to say, "I'm perfectly stable, I don't need to see a physician", or if something happens and they need to see them, what's the normal response? Can we see them within 48 hours, for example, and make them feel safe?'

He accepted this would be a lot of work – a lot of detail, precision and investment decisions to unpack. 'Again, we need the finance community to help people through those decisions.'

HFMA ROUND TABLE

Ann Cole, Baxter Healthcare evolving health lead, asked how the medical technology industry could collaborate and partner with the NHS to the greatest effect. Newcastle upon Tyne Hospitals NHS Foundation Trust finance director Angela Dragone gave an example: a robotics partner had devised a risk-sharing solution that would allow the trust to replace a surgical robot.

'With depreciation, it is quite an affordable solution. In a block contract, especially since we're moving from payment by results to block suddenly, how are we ever going to keep pace with innovation?

'I think this may be the answer – creative ways of renting equipment that doesn't count as a lease, doesn't count against CDEL, but allows the organisation to grow.'

"Advice and guidance is about making sure we only see people who need to be seen, not automatically adding people to waiting lists because that's what we've done in the past"
Clara Day

Delegates said there was a lack of bandwidth in the NHS to take forward innovative ideas presented by potential partners.

Roundtable chair Lee Bond asked whether participants' organisations were using virtual wards and digital technology as an adjunct to aid their elective recovery programmes.

Ms Dragone said virtual wards and digital technology help with patient flow. 'Virtual wards are interesting in terms of keeping your elective flow going through if your emergencies spike. Digital has great potential – it stops doctors having to go far for clinic and it stops patients having to come into hospital unnecessarily. With services such as dermatology and ophthalmology, which are quick outpatient appointments, the legacy patient record systems sometimes can't keep pace. It slows things down rather than speeds them up. We've all got legacy patient record systems that are dragging us under water.'

Mr Bond had found getting help from other organisations through mutual aid depended on multiple factors, including basic considerations such as the ability of both organisations to ensure the correct information flows were in place to support the transfer of patients. 'If you don't get that right, it takes time, and when you are having weekly performance conversations with the national team, time is not something you have a lot of,' he said.

Baxter Healthcare is looking at digital solutions, said Ann Cole. 'What resonated with me was that there's no point buying something if it doesn't deliver the value you need. The process we are working on comes back to the need for good quality information and in-depth assessment of a service.'

She pointed to OPAT (outpatient parenteral antimicrobial therapy) services, which allow medically stable patients who need intravenous antibiotics to receive treatment at home.

'At York and Scarborough Teaching Hospital, 438 patients in the last three years using OPAT delivered some 10,500 bed day savings worth nearly £3.9m to the trust. They're now asking: what if every patient who could have this service gets it? What are the limiting factors that prevent them from getting it? And how can we work in partnership through the national and global reach we have? We have to understand the challenges in a specific geography, and ask what we have already in other parts of the world or in the UK, and bring them into the partnership.'

NHS workforce is rarely far from the news and participants said this was a limiting factor that had to be understood as systems implemented their recovery plans. John Graham, director of finance at Stockport NHS Foundation Trust, was concerned about the availability of staff at opposite ends of the pay scale. Some higher paid staff continued to be worried about pension tax situation when asked to take on additional sessions, while some lower-paid NHS workers could be tempted by other opportunities.

Manchester Airport had just advertised a large number of vacancies that would be attractive to some local health service staff. 'We know we're already struggling to recruit staff such as healthcare assistants. I know everyone will have their own local context, but there is that challenge about securing and retaining the workforce to support this agenda.'

Mr Sewell-Jones said competition for staff could emerge between NHS employers. The finance community had to work hard across systems to offer similar rates to in-demand clinicians for completing additional waiting list work. This would build on earlier work on temporary staff costs, ensuring fees do not skyrocket because one trust is offering more than its neighbours.

Short v long term

There was a tension between delivering shorter term targets for recovery and building up services for the longer term. The roundtable agreed that finance directors had to take more, measured risks – by employing surgeons for the long term, not just to hit targets, say.

Addressing health inequalities while transforming services was another priority for roundtable participants.

Mr Graham said work was being done across Greater Manchester to understand the challenge. During Covid, endoscopy units that were labelled as system-wide assets were not used equally by all parties, potentially impacting on equity. The system was looking into this to understand why. 'Some of it is about people not being able to travel, but it affects equity of access, particularly for some of our poorer and more challenged populations.'

Lincolnshire Community Health Services NHS Trust director of finance and business intelligence Sam Wilde said an analysis of patients waiting longest, by ethnicity and deprivation, has been completed in the county. 'The results were surprising. It's been informative and led to some action, so using the data and looking through that health inequality lens can be helpful as we try to tackle this waiting list challenge.'

Paul Sheldon, chief finance officer at two community and mental health trusts in Northamptonshire and Leicestershire, said the former is working on a programme to move patients out of hospitals and into the community, working out how best to serve those well enough to live at home. The trusts are concerned about unseen waiting list patients yet to present in mental health.

Similarly, there is concern that while people are waiting for physical health interventions, their mental health is deteriorating. 'We've had conversations with our medical directors about how mental health trusts can help elective recovery and support people if needed. Given that we're talking about the immediacy of that, it's really difficult to implement, given the existing challenges in most of our services.

'Workforce is still a challenge. There's been investment in mental health services over the past two or three years. But that doesn't mean workforce is ready on the conveyor belt to bring those services up to the level of demand from a mental health perspective, let alone bringing that into the elective recovery piece.'

His trusts are building their mental health recovery strategy around an analysis of health inequalities and whole population management. 'This gives us an insight of where to target, whether that's geographically or a certain cohort of people out in the community. That is proving to be a valuable source of information alongside the cost information that goes with it. Aligning the health inequalities information and the cost of delivering services is driving our conversations about transformation of our services over the next six to 12 months.'

All parts of the NHS face a daunting challenge in making elective recovery a reality. But there is clearly a willingness to get it done, and flexibility at national and local level.