

healthcare finance



April 2019 | Healthcare Financial Management Association

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**Managing editor**

Mark Knight
0117 929 4789
mark.knight@hfma.org.uk

Editor

Steve Brown
015394 88630
steve.brown@hfma.org.uk

Associate editor

Seamus Ward
0113 2675855
seamus.ward@hfma.org.uk

Professional lives

Yuliya Kosharevska
0117 938 8440
yuliya.kosharevska@hfma.org.uk

Advertising

Paul Momber
0117 938 8972
paul.momber@hfma.org.uk

Subscriptions and membership

James Fenwick
0117 938 8992
james.fenwick@hfma.org.uk

Production

Wheal Associates
020 8694 9412
kate@whealassociates.com

Printer

BCQ Group

**HFMA**

1 Temple Way,
Bristol BS2 0BU

Executive team

Mark Knight
Chief executive
mark.knight@hfma.org.uk
Emma Knowles
Policy and research director
emma.knowles@hfma.org.uk
Alison Myles
Education director
alison.myles@hfma.org.uk
Ian Turner
Finance director
ian.turner@hfma.org.uk

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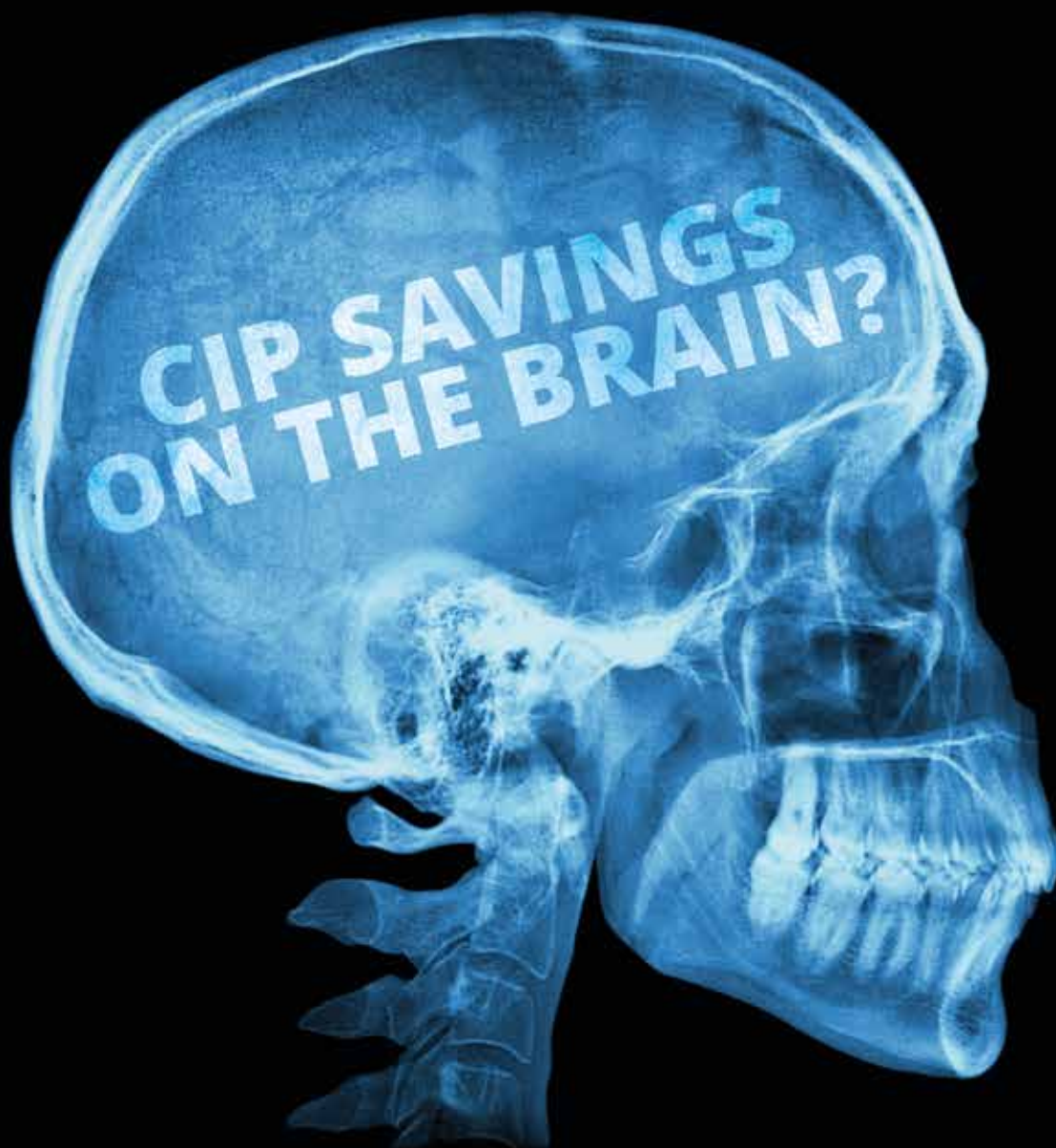
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News

Pressure groups call for £900m training budget boost

By Seamus Ward

The ambitions of the *NHS long-term plan* will be 'impossible to achieve' if the government does not increase training budgets by £900m in real terms and take steps on further ethical international recruitment, according to three health think-tanks.

The Nuffield Trust, King's Fund and Health Foundation looked at demand for nurses and in general practice, where shortages are particularly acute. It concluded that a radical expansion of nurse training was needed, with the government giving those in training cost of living grants of £5,200 a year.

The numbers entering nurse training as postgraduates should be tripled, it added. But, even if these measures are implemented, the gap between supply and demand cannot be filled domestically by 2023/24. An extra 5,000 nurses a year must be recruited from abroad to keep the NHS functioning. To achieve this, the think-tanks said, the government must make wide exceptions on proposed immigration salary restrictions and fund the visa costs that will be incurred by NHS providers.

The upcoming NHS workforce plan must embrace these actions or nurse vacancies will

double to 70,000 and GP shortages in England will almost triple to 7,000 by 2023/24, the report said. Such gaps in the workforce will make long-term plan goals such as improvements in general practice and better access to mental healthcare, impossible to achieve.

At the end of the third quarter, NHS providers in England had 100,500 whole-time equivalent (WTE) vacancies, according to NHS Improvement. This was about 5,000 WTEs fewer than at Q2, but the oversight body said vacancies, especially in nursing, remained a challenge. Providers have more than 39,000 WTE registered nurse vacancies – 316,000 WTE nurses are currently employed by providers.

Health Foundation research director Anita Charlesworth said workforce was a 'make or break issue for the health service'. She added: 'Unless staffing shortages

"Unless staffing shortages are substantially reduced, the recent long-term plan can only be a wish list"
Anita Charlesworth,
Health Foundation
(pictured)



Uncommitted PSF

Q3 provider figures show that uncommitted provider sustainability funds (PSF) will be £400m higher than planned at the end of the financial year. This reflects the higher than planned provider deficits and difficulties in meeting A&E targets.

The Q3 report from NHS Improvement shows a planned allocation of PSF of £1.7bn to providers that accepted their control totals. However, the forecast outturn is £425m less – increasing the uncommitted PSF available for distribution among providers at year end.

The £1.3bn of committed PSF includes bonus payments to trusts that have agreed in-year to increase their planned surpluses. The oversight body said 42 trusts had signed up to this.

In 2017/18, the uncommitted funding remaining at the year end was distributed between providers in three bonus lots – to those that had hit their A&E access trajectories; those that had signed up to their control total; while some was given to all providers.

• See *Pulling both ways*, page 8

are substantially reduced, the recent long-term plan can only be a wish list.

'Decisive policy change backed by targeted investment could eliminate nursing shortages over the next decade. But if the NHS is to have access to the skilled health workers it needs, the government must stop seeing funding for the workforce as a cost to be minimised and prioritise investment in training more staff.'

Candace Imison, workforce strategy director at the Nuffield Trust, added: 'If any of our lofty aspirations about better outcomes and digital technology are to become a reality, we need to get the budget for developing skills at least back to where it was.'

HFMA outlines community benefits

Switching care from acute settings to the community benefits patients, staff and the wider health and care system, according to an HFMA report.

The value of community services: comparison with acute settings acknowledges many studies showing community care is not a cheaper alternative to hospital-based care when considered on a like-for-like basis. But the picture changes

when the value of community care is factored in.

It argues that the value of community care must be analysed holistically and over time. It should include the impact of prevention and potential slowing of the deterioration of a condition.

The value-based care focus on maximising the outcomes that matter to patients at the lowest possible cost means

better use of resources and improved value for money. Better outcomes can lead to more self-care and fewer admissions and A&E visits.

A University of Birmingham study said patients felt more at home in a small hospital, while community services can offer more personalised care. Patients also attribute value to less travel time and disruption, and maintaining social networks.

The HFMA said staff employed by acute trusts, but delivering care in community settings, value increased autonomy and meeting patients in less formal environments. Community staff like delivering acute-style services, allowing them to gain or maintain skills.

The report said the value of switching services into the community were wider than direct cost savings.

Legal proposals could affect tariff and FT capital

By Seamus Ward

Proposed legal changes aim to smooth the implementation of the *NHS long-term plan*, making the development of new payment systems easier and changing the capital setting process for foundation trusts.

The proposals – published by NHS England and NHS Improvement – have been developed following an invitation from the prime minister to suggest changes in the law needed to implement the long-term plan. The national NHS organisations, which have announced a single management structure (*see page 6*), said the plan could be introduced without additional legislation, but their proposals would make implementation ‘easier and faster’.

The proposals include allowing national prices to be set as a formula rather than a fixed value, so the price payable reflects local factors. While the national tariff already offered significant flexibility to support new ways of delivering care, the national organisations said the change would make it easier to develop new payment models.

The changes would mean national prices were applied only in specific circumstances. For example, national prices for acute care would be allowed for out-of-area treatments, but

local commissioners and providers could agree different payment arrangements for services that patients receive from their main local hospital.

Adjustments to the tariff would also be allowed in-year – to reflect new treatments, for example – ending the need to consult on the whole tariff for even a minor proposed change.

Ian Dodge, national director of strategy and innovation, said two ‘highly targeted’ changes to the foundation regime were being proposed, ‘without changing the core FT model or freedoms’.

The first proposal would support mergers and acquisitions where they were clearly in patients’ interests. The second would mean NHS Improvement approving foundation trusts’ annual capital spending in the same way as they currently do for NHS trusts.

This change would ensure that NHS trusts are not disadvantaged compared with foundation trusts, he said. ‘This wasn’t an issue while CDEL looked pretty generous. But given it’s had to be substantially constrained in recent years, it’s become necessary for NHS Improvement to turn down what can be strong proposals from NHS trusts – for, say, A&E capital bids – simply because there is no constraint on annual FT capital spend, bearing in mind there is an overall



national limit. This is patently unfair for NHS trusts. I want to emphasise two things – we are not proposing to change the wider existing FT freedoms on capital. And the intention is that we will work closely with stakeholders on getting the detail of both of these provisions right’.

Other changes would remove the requirement for NHS Improvement to refer contested licence conditions or national tariff provisions to the Competition and Market Authority. The CMA’s role in reviewing mergers would end.

NHS Confederation chief executive Niall Dickson (pictured) welcomed the ‘broad thrust’ of the proposals. But he added: ‘We must be alert to the risk of unintended consequences where new powers or requirements may interact with existing statutory or board duties. We will be consulting our members about the potential impact of new powers for NHS Improvement to set foundation trust capital spending limits’.

An engagement period on the proposals ends on 25 April.

• See *Sharing the risks*, page 21

Simplify payment models, says King’s Fund

The NHS should introduce simple payment systems that encourage collaboration and collective responsibility, rather than develop new complex pay-for-performance arrangements, according to a new report by the King’s Fund.

Payments and contracting for integrated care: the false promise of the self-improving health system says policy makers have spent 30 years attempting to devise financial incentive schemes to improve the performance of health services. With existing activity-based payment arrangements now recognised as not supporting system working, the report says the NHS is again proposing new payment schemes based around capitation budgets with incentive schemes and risk share arrangements.

In the report, King’s Fund projects



director Ben Collins (pictured) asks whether the latest incentive schemes – ‘borrowed in large part’ from US accountable care

models – will be any more successful than their predecessors.

The report questions the service’s ability to identify appropriate outcomes, the practice of withholding payment for badly performing providers and the transaction costs involved with sophisticated payment models.

‘In a health system where services are being brought together in integrated systems and where policies to encourage choice of provider and provider independence are largely in abeyance, the tools of arm’s length

purchasing look increasingly redundant,’ said Mr Collins.

‘Rather than new complex schemes, commissioners should develop simple arrangements that allow resources to be allocated where they are most needed, make it easier to collaborate on improvement and promote a culture of collective responsibility for local health systems,’ he added.

He suggested trust-based models – such as adopted by New Zealand’s Canterbury health system or the use of aligned incentive contracts in Bolton – offer a better alternative to ‘existing toxic incentive schemes’.

These could involve a move to global budgets based on bottom-up estimates of costs and agreements to work together to manage risks around population need, demand or costs.

MPs call for audit action

The Department of Health and Social Care should set out within six months how it expects NHS bodies to respond to weaknesses reported by auditors together with potential sanctions for those that fail to improve, MPs said.

In a follow-up to a National Audit Office report on the public sector, the Commons Public Accounts Committee said one in five local public bodies did not have proper arrangements to secure value for money. NHS organisations were the worst, it said, with auditors qualifying 38% of their conclusions in respect of value for money arrangements – mainly the result of not meeting financial targets.

Government departments had to do more to hold local bodies to account as there were no direct consequences of receiving a qualified report from an auditor.

PAC chair Meg Hillier (pictured) said taxpayers must be sure their money is well spent. 'Particularly concerning are NHS bodies such as clinical commissioning groups and hospital trusts: last year almost two in five did not have adequate arrangements.'

- An HFMA briefing due shortly will help audit committee members scrutinise arrangements to manage finances and secure value for money. It will look at different auditor opinions and powers.



Long-term plan capital threat

By Seamus Ward

An ageing infrastructure, combined with substantial and growing backlog maintenance, is likely to undermine *NHS long-term plan* ambitions to transform the health service, a report has warned.

The Health Foundation said lack of capital investment could dent plans to improve cancer survival rates and make the NHS a world leader in technology-driven care.

The foundation's report, *Failing to capitalise*, said trusts have seen their capital funding decline by 21% over the past eight years – from £3.9bn in 2010/11 to £3.1bn in 2017/18.

This was mostly due to the transfer of capital to revenue funding in the past five years. This year alone, £500m has been transferred to revenue to cover the rising day-to-day costs of running the service, it said.

Backlog maintenance had risen from £4.4bn in 2013/14 to more than £6bn in 2017/18, about double the annual capital spending in trusts.

The foundation also calculated that, expressed as a share of GDP, NHS capital spending is half that in similar countries. Even without the capital to revenue transfer, spending would still be relatively low.

The NHS in England would have to spend an extra £3.5bn a year to bring capital spending up to the OECD average. This figure would have to rise to £4.1bn by 2023/24 for the NHS to continue to keep pace. The report warned that failing to outline a long-term capital funding settlement could affect future patient care.

With capital spending relatively low, the

desire to put the NHS ahead of others in terms of technology- and data-driven care appeared unrealistic. IT spending had risen, but still made up less than 5% of the total value of NHS capital.

The government did not commit to increases in capital spending when it announced the additional £20.5bn for the NHS over five years beginning in April. It is expected the spending review will allocate capital, but timing is

uncertain – the chancellor announced in his spring statement that the timing would depend on agreement of a Brexit deal, though the aim was to announce the spending review conclusions with autumn's Budget.

Anita Charlesworth, Health Foundation director of research and economics, said capital investment was essential.

'Capital investment is not a nice-to-have,' she said. 'Failing to carry out repairs and invest in modern equipment and technology puts at risk the quality of patient care. It will also undermine the NHS's ability to improve and transform care in line with the *NHS long-term plan*.'

'Just bringing capital funding for the health service in England up to the OECD average would require around £3.5bn extra next year, rising to £4.1bn by 2023/24.'

Among the finance directors interviewed for the report, one said the age of equipment had an impact on productivity and efficiency. Another said some equipment was so old that spare parts were no longer available. Parts had to be machined to make them fit, which compromised resolution of the machines and affected the quality of care outcomes.



NI budget rises but service transformation needed

The Northern Ireland Department of Health budget will increase by 3.8% in 2019/20.

In the absence of a power-sharing executive at Stormont, Northern Ireland secretary Karen Bradley (pictured) announced the allocations to local departments. The rise for the health department will be 3.8% compared with actual funding in 2018/19, including in-year monitoring allocations.

Total resource funding will rise to more than £5.8bn, which includes £74m for increased



pension funding, with capital funding set at £280.6m. A Department of Finance statement issued alongside the allocations acknowledged local health and care would face difficulties.

'While challenges remain due to cost pressures increasing at a higher rate, this will allow the department to preserve key services, prioritise patient safety and support HSC staff

in providing the best possible care,' the statement said.

It added that £100m from the DUP's confidence and supply agreement with the Conservatives at Westminster will be invested in healthcare transformation projects.

The challenge facing the local service was demonstrated in the latest waiting time figures. At the end of December, inpatient and day case admissions had grown by 13% compared with a year earlier. While 64.6% of patients were waiting more than 13 weeks for

admission, just over 24% (57,000 patients) had waited longer than the 52-week target.

A Department statement said services were not keeping pace with growth in demand. Funding of £30m in 2018/19 had only slowed the overall growth in waiting times.

It added: 'Fundamental transformation remains the only long-term answer to this problem. While transformation is underway, sustained investment is also required to clear the backlog of patients waiting for treatment.'

News review

Seamus Ward assesses the past month in healthcare finance

March has been a momentous month – the ‘will it/won’t it happen’ of Brexit; the heating up of ‘no deal’ planning by the NHS; a spring statement from the chancellor that went by almost unnoticed; proposals to alter the basis on which access is measured; and significant changes at the top of health management in England.

Starting with the latter development, NHS Improvement confirmed that chief executive Ian Dalton is to step down following the introduction of a new joint structure for NHS England and NHS Improvement. A single chief executive – NHS England’s Simon Stevens – and chief operating officer will oversee both bodies. The latter will also be NHS Improvement chief executive, reporting directly to Mr Stevens and Dido Harding, NHS Improvement’s chair. The seven regional directors, the national director for emergency and elective care and the national director for improvement will report to the chief operating officer. Mr Dalton said the new role would be different in scope and nature to the role he took on at NHS Improvement when he first joined. As a result, he has decided to look for a new challenge but will help in the management of the transition to the new structure over the coming months.

The next spending review will be launched before the summer if a deal for exiting the European Union was agreed over the next few weeks, chancellor Philip Hammond (pictured) said in his spring statement. The chancellor said the review would cover three years and would be concluded alongside the autumn Budget. The review is expected to set health spending not included in the £20.5bn NHS England budget increase announced in June last year, such as for capital and public health, as well as social care.

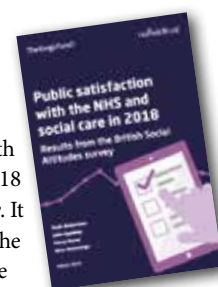


NHS performance against access targets feature regularly in this column, but the basis on which they are calculated in England would be rewritten under proposed changes. In the interim report on his clinically led review, national medical director Stephen Powis has proposed abandoning the four-hour waiting target in A&E in favour of rapid assessment and prioritisation based on patients’ needs. A one-hour treatment target would be introduced for patients with life-threatening illnesses and those with a mental health crisis. Other proposals include changes to cancer access targets. The

proposed changes will be field tested during 2019/20, which will be a transition year between the old targets and new standards.

A&E attendances were 7.3% higher in February than in February 2018, according to NHS England. It said 84.2% of patients were transferred, discharged or admitted within four hours – 6.3% more than 12 months earlier. Emergency admissions were up 5.7% in the 12 months to January. The number of completed referral-to-treatment pathways in the 12 months to January was 0.8% higher than the previous 12 months. Some 86.7% of those on the waiting list had waited fewer than 18 weeks – missing the 92% target.

Waiting times, staff shortages and inadequate funding were the top three reasons for dissatisfaction with the NHS, according to the 2018 *British Social Attitudes survey*. It said public satisfaction with the NHS is at its lowest level since 2007. The survey, published by the Nuffield Trust and the King’s Fund, said that there was a drop of three percentage points on the 2017 figures. It now stands at 53%.



The month in quotes

‘Now is the right time to look again at the old targets which have such a big influence on how care is delivered, to make sure that they take account of the latest treatments and techniques, and support, not hinder, staff.’

National medical director Stephen Powis calls for changes in the measurement of patient access to the NHS

‘In the short term at least, the promise of more money doesn’t appear to buy satisfaction. The public identified long-standing issues such as staff shortages and waiting times among the main reasons for their dissatisfaction and cash alone will not solve these.’

King’s Fund senior fellow Ruth Robertson says the NHS must fix other issues besides money to regain public approval



‘It has been a privilege to be part of the national leadership of the NHS. I therefore feel a degree of personal regret that I will not be part of the joint organisation that will turn the NHS long-term plan into action, but it is the right decision to make this change at this time.’

Announcing his departure, Ian Dalton throws his support behind the new joint management structure for NHS Improvement and NHS England



‘Standards must improve significantly as CCGs take on the commissioning of services across larger populations – a change that runs the risk of them losing focus on the particular healthcare needs of local people.’

PAC chair Meg Hillier argues that CCGs must improve if they are to deliver the long-term plan



SHUTTERSTOCK

There are proposals to abandon the four-hour waiting target in A&E in favour of rapid assessment and prioritisation based on patient needs

The think-tanks also said that satisfaction with general practice has also declined over the last 10 years and in 2018 was at its lowest level since the survey began in 1983. Almost a quarter (24%) of respondents were dissatisfied with the service – double the level of dissatisfaction in 2009.

○ MPs said they were concerned about the potential impact of commissioning reforms on patients. In a report, the Commons Public Accounts Committee said many clinical commissioning groups were underperforming. It insisted CCGs must improve, particularly as the reforms will give CCGs responsibility for commissioning services across a larger area. Under the *NHS long-term plan* integrated care systems (ICSs) will be established across England and it is expected there will be one CCG per ICS. This will mean a significant reduction in the number of CCGs. The committee asked NHS England to report back before the end of the year on the future structure and on actions it has taken to ensure all CCGs are performing effectively and have high-quality leadership.

○ Wales health minister Vaughan Gething (pictured) announced the introduction of a locum register for primary care from April. He said the *All Wales locum register* will be the first of its kind in the UK. It will help the Welsh government to understand the locum market better and how it can support general practice in future. Locum GPs will have to join the register to access the new state-backed indemnity scheme, he added.



○ NHS Improvement has placed Isle of Wight NHS Trust in financial special measures.

The trust, which is also in special measures for quality reasons, said its financial position had been getting worse over some time. This deterioration was due to investment in needed improvements and increased demand. Its costs had increased significantly, due to recruitment difficulties and other pressures related to its location. It is working with the local health and social care system to plan and deliver improvements, and with the NHS Improvement financial special measures team to ensure its clinical services are financially sustainable.

○ The nursing associate programme will be expanded with a £42m funding boost, Health Education England (HEE) has confirmed. HEE chief nurse Lisa Bayliss Pratt said the funding would allow for a further 7,500 trainee nursing associates by 2020. Around 1,800 nursing associates are expected to qualify in the early part of this year. The role is designed to bridge the gap between healthcare assistants and registered nurses.

○ The Royal College of Radiologists warned that a shortage of specialists could threaten the ability of the NHS to offer cutting-edge cancer care. Its census of 62 major cancer centres found that 7.5% of consultant posts were vacant, with most unfilled for more than a year. Services were being maintained through overtime – an average six hours a week per full-time doctor. Though doctor numbers in general are increasing, the college said this was not enough to meet demand, particularly given the number of doctors who are retiring.



from the hfma

Finance staff are going to have to get to grips with environmental sustainability as the NHS seeks to transform services to meet demand. So says Sandra Easton (pictured), chair of the HFMA Environmental Sustainability Special Interest Group, in a blog for the association's website. 'This will involve learning a whole new language and understanding data beyond the pound signs,' she adds.

The long-term plan highlighted NHS improvements in environmental sustainability, such as significant reductions in water consumption and its carbon footprint. But the plan says there is more to do, including further reducing the carbon footprint and cutting air pollution. The committee is well-placed to spread best practice, increase awareness and influence policy, says Ms Easton, who is stepping down as chair. Finance managers interested in joining or chairing the committee should email andrew.monaghan@hfma.org.uk



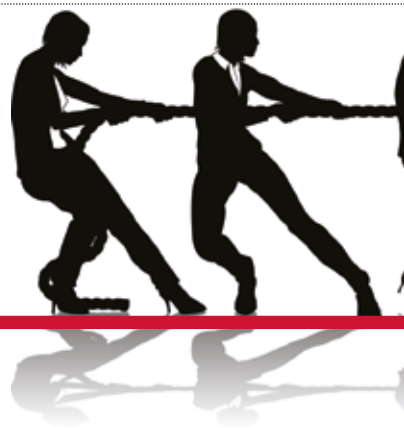
In a blog on health and social care integration, HFMA policy and research manager Sarah Day looks at the experience of the devolved nations. The NHS in England is moving in a similar direction, but presentations at the HFMA's fourth annual integration summit suggest the English system should know that it takes time and success is built on good relationships and trust.

More guidance is needed to effectively measure mental health investment, says Ms Day in a separate blog. The disparity between perceived investment and service transformation must be addressed to achieve the changes required in government policy, she concludes.

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News analysis

Headline issues in the spotlight



Pulling both ways

Provider finances in England have deteriorated, but the planned year-end deficit has been revised downwards once again. Seamus Ward looks at the confusing picture at quarter 3

The provider sector financial deficit deepened in the third quarter of 2018/19 as trusts struggled with familiar cost and income pressures, such as staffing, pay, contracting difficulties and emergency activity displacing elective income.

Providers reported an aggregate year-to-date deficit of £1,247m – £261m worse than plan, but £34m better than at the same point in 2017/18. At year-end, the sector is planning for a £394m deficit, but at Q3 it forecast it will spend £267m more than this – a deterioration of £148m since Q2 in spending compared with plan.

There are two points to note about the year-to-date and outturn financial positions. First, the year-to-date position would have been much worse had it not been for the consequences – in accounting terms – of the collapse of Carillion. The deterioration in the forecast financial position at Q3 compared with Q2 would have been £404m, not £148m. However, the forecast outturn benefits from an exceptional adjustment of £256m for part-donated assets – new private finance initiative hospitals at Sandwell and West Birmingham Hospital NHS Trust (£149m) and the Royal Liverpool and Broadgreen University

Hospitals NHS Trust (£107m) that were brought onto providers' books.

Second, NHS Improvement has further reduced the planned year-end deficit. At Q1, it targeted an aggregate year-end deficit of £519m, but warned that action would be taken to reduce the planned figure. A financial reset was launched in Q2, targeting incentive payments under the provider sustainability fund (PSF) to cut the planned year-end deficit to £439m. It has now reduced further to £394m.

So far, the planned deficit has been reduced by £125m compared with the original figure – at the time of the reset, NHS Improvement targeted a provider contribution of £254m to reduce the original £519m plan. Together with a £265m commissioner contribution, it hoped to get the system back in balance.

But with trusts missing their control totals and A&E performance still struggling in the face of huge demand, there will be increased amounts of unallocated PSF at year-end. This could be giving NHS Improvement the confidence to reduce the planned deficit. It is expected that, as with last year, remaining PSF – after funds have been

allocated to trusts for achieving control totals – will be allocated to trusts, though the basis for the distribution is not yet clear.

Under the PSF incentives initiative, NHS Improvement has offered providers additional bonus payments to improve their financial position. It said 42 providers had signed up and most are forecasting they will achieve this improvement by year end. It appears that during a short window before the publication of the Q2 report, trusts were offered £2 of bonus PSF for every £1 improvement in their position signed up to – subsequently the offer has been £1 for every £1 improvement.

Against the lower planned deficit (£394m), providers are forecasting they will overspend by £267m, giving a forecast position of a £661m deficit – £142m more than the initial plan.

Some 52% of the 230 trusts are forecasting year-end deficits – nine more than at Q2. Again, most of the trusts forecasting deficits were in the acute sector (95 – 87 in Q2). Among ambulance and community trusts, four providers forecast deficits, while in mental health and specialist trusts, there were 11 and six, respectively.

AFC deal impact

The sector reported a £1.1bn negative variance against planned pay spending in the year-to-date. NHS Improvement said a large proportion of this was due to Agenda for Change (AFC) pay costs. These were not included in plans at the start of the financial year and were introduced from quarter two. AFC accounted for around £620m of the pay overspend on a year-to-date basis – by year-end the overall overspend on pay is forecast to be £1.55bn, of which AFC will be £833m.

The government has pledged to cover the cost of the awards in full and has provided an estimated £780m for the full year. Potential further funding to make up the gap is subject to an application to the Department of

Health and Social Care that was due to be completed in the final quarter of 2018/19.

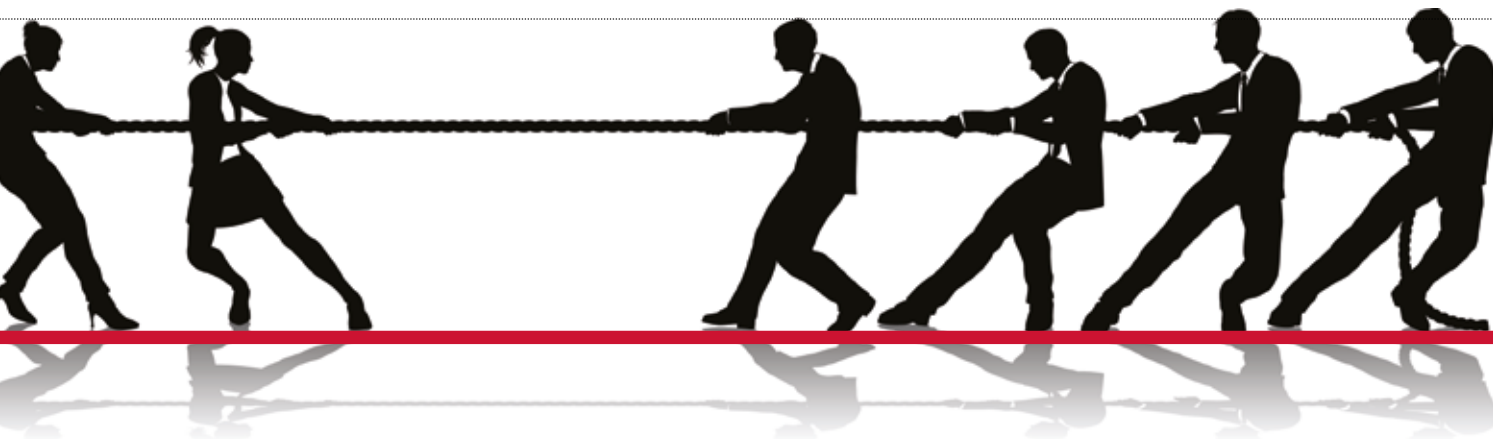
Leaving aside the overall picture on funding for the pay award, individual trusts are feeling under-compensated for the increases in their pay bill. The Q3 report notes: 'Providers say AFC is causing cost pressures, and this is having a serious consequence for a small number of providers as it has impeded their ability to achieve their PSF funding.'

Non-AFC factors account for £474m in the year-to-date overspend against plan, rising to a forecast £719m by year-end.

Temporary staff costs were a key driver in non-AFC-related spending as trusts used these workers to manage rising unplanned

demand. Bank staff overspending was £393m above plan and agency £139m over the ceiling set by NHS Improvement. At year-end, overspending against plan in these areas is expected to rise to £486m and £170m, respectively.

NHS Improvement said bank and agency spending was £316m (8%) up on the same period in 2017/18, but the increase was due to more temporary staff employed rather than price rises – the average price per shift was 6% lower than for the same period in 2017/18. But NHS Improvement warned that agency costs could rise in Q4 and the year-end outturn (currently forecast at £2.37bn) could be between £2.4bn and £2.5bn.



Excluding PSF, 73 trusts forecast they would be off plan by year-end (37 more than at Q2). But when PSF was included, the number forecasting they would be off plan rose to 106 (23 more than at Q2). Some 38 providers said they would be off plan by more than £10m at year-end, after the inclusion of PSF.

Trusts said pay, principally Agenda for Change (AFC) salary rises, is one of the biggest reasons for the overspend against plan (see box). Income during Q3 was 1.5% (£937m) above plan, much of it due to the central funding of AFC awards.

Winter pressures were again evident in the profile of trust income. More non-elective income than planned was recovered by trusts – £362m or 3.3% above plan, while A&E income was 3% (£53m) and high-cost drugs income 11.3% (£373m) above plan. This was offset by lower-than-planned income from elective care (£162m or 2.2%). NHS Improvement said profit-making elective care was being ‘crowded out’ by loss-making non-elective care and zero-margin pass-through drug costs.

NHS Improvement chief executive Ian Dalton said the service treated record numbers of emergency patients during the early winter. ‘The NHS focus on treating the high numbers of patients across urgent and emergency services

was one of the key reasons why the provider sector as a whole reported a year-to-date deficit of £1.2bn,’ he added.

This is £261m more than planned but £34m better than the same period last year.

‘We continue to work with the trusts that are in deficit to achieve their plans,’ said Mr Dalton. ‘The *NHS long-term plan* will help trusts eradicate their deficits by 2023 by providing more support to acute hospitals where most of the deficit is concentrated.’

However, King’s Fund chief analyst Siva Anandaciva said the Q3 figures told a familiar tale of rising costs in the face of demand pressures. The revised planned deficit looked optimistic, but the trusts willing to stretch further and improve their bottom line could be the reason for NHS Improvement’s optimism.

‘It might make a difference to the reported position and it’s a way of moving cash out of NHS Improvement and onto the balance sheets


“The long-term plan will help trusts eradicate their deficits by 2023 by providing more support to acute hospitals where most of the deficit is concentrated”

Ian Dalton, NHS Improvement

of providers. But it plays into the narrative that trusts just need to try harder to achieve financial balance. Those that make it are rewarded and those that don’t miss out. This leads to greater variability in financial performance.’

Despite the difficult conditions, trusts continued to generate efficiency savings, though the amount delivered by Q3 was less than planned. The planned cost improvement programme (CIP) by this stage of the year was just over £2.3bn (3.5%), but the actual amount delivered was £244m less. Achievement of CIPs was affected by operational pressures and high vacancy levels, NHS Improvement said, though it added that CIP delivery tended to strengthen in the second half of the year.

As in recent years, trusts under-performed against planned recurrent savings – providers planned recurrent CIPs of just over £2bn, but achieved £1.49bn. However, non-recurrent schemes overperformed against plan, delivering savings of £602m – the planned level of non-recurrent savings was £279m.

Efficiency savings delivery tends to rise in the second half of the year, but with Q4 figures also including the impact of the bulk of winter pressures, it is difficult to see a major improvement in the financial position. 

SHUTTERSTOCK

Pay and agency costs

	Year-to-date at M9 2018/19				Forecast outturn 2018/19			
	Plan £m	Actual £m	Variance £m	Variance %	Plan £m	Forecast £m	Variance £m	Variance %
Medical staff	9,967	10,323	(356)	(3.6)	13,270	13,679	(409)	(3.1)
Nursing staff	15,693	16,026	(333)	(2.1)	20,912	21,435	(523)	(2.5)
Other staff	14,149	14,554	(405)	(2.9)	18,832	19,452	(620)	(3.3)
Total employee expenses	39,809	40,903	(1,094)	(2.7)	53,014	54,566	(1,552)	(2.9)
Of which ...								
Bank	2,089	2,482	(393)	(18.8)	2,779	3,265	(486)	(17.5)
Agency ceiling performance	1,656	1,795	(139)	(8.4)	2,200	2,370	(170)	(7.7)

Comment

April 2019

Capital ideas

Informed debate is needed on how to support capital investment

I am writing this towards the end of March, so by now you will have a pretty clear idea where your financial position will land for 2018/19 – good or bad. And so, I am sure attention will have moved to getting the new financial year off on a firm footing.

I know from canvassing views from organisations in

Lancashire, that despite the ‘extra money’ in the system, the process of agreeing plans and contracts for 2019/20 is proving to be very challenging. When we are dealing with knotty problems like this, it’s always worth reminding ourselves that our patients come first. In my experience with that mindset, most problems can be worked to a satisfactory conclusion.

I have mentioned in previous pieces the challenges around capital investment, particularly in the acute sector. While the purse strings feel like

they are getting ever tighter on capital, the alternate financing methods are not always that easy to navigate.

I think the time is right for an informed debate about where we go with capital investment as a service, and what realistic alternatives are available. For example, can the various LIFT companies be used to finance this badly need investment?

The HFMA made a good start in this debate with its *NHS capital – a system in distress?* briefing last year, suggesting the characteristics needed in a new capital regime. It was good to see

**HFMA
president
Bill Gregory**



Moving targets

Comparing actuals to plan is a staple of performance management – but what if the plan isn’t fixed?

NHS Improvement’s performance report

for quarter 3 makes for difficult reading. I don’t mean difficult in terms of a service continuing to face a tough financial position – although that is certainly true – but in the sense of trying to understand exactly how the provider sector’s performance relative to plan is changing as the year goes on.

The latest report shows that at Q3 providers were forecasting to overspend their planned position by £267m. This compares with year-end forecasts at Q2 that the plan would be overspent by £119m. On the face of it, there is no news here. A worsening of the financial position between Q2 and Q3 is not a major shock, especially given it includes the first period of winter.

However, it only tells part of the story as NHS Improvement has also changed the planned position. So providers’ performance against plan is this year being judged against a moving target.

In fact, the planned financial position has changed twice during the year. NHS Improvement made it clear from the outset that the original plan for a combined £519m deficit was unaffordable – and that further work was needed to ‘close the residual local planning gap’.

**Healthcare
Finance
editor
Steve Brown**



“The time is right for an informed debate about where we go with capital investment as a service, and what realistic alternatives are available”

the Health Foundation making its contribution to this key topic during March (see page 5).

And the government is now consulting on how best to support private investment in infrastructure, given that it has already announced it will no longer be using the private finance initiative or PF2 models.

However, solutions are

needed quickly if we are to realise the ambitions of the long-term plan.

During the past month, HFMA chief executive Mark Knight and I hosted the branch chairs conference at 110 Rochester Row. This provided a good opportunity to update the branch representatives on the association's progress with our education strategy – particularly the development of our formal qualifications that are increasingly valued by staff across NHS finance. We also updated participants on the work of the Healthcare Costing

for Value Institute and our policy team.

On the subject of the policy team, I would also like to congratulate Emma Knowles on joining the HFMA executive team as director of policy and research.

Many of you will be familiar with Emma's work with the association. With this role now becoming part of the HFMA executive team, it highlights the contribution Emma has made but also the importance we place on our policy and research work and how this can influence the development of policy

across the four nations.

I was tempted to steer clear of Brexit altogether this month, but I have to admit the machinations in Parliament have been fascinating. By the time I write my next comment, we should know when and if Brexit will happen... but then again maybe not.

In the meantime, we can comfort ourselves that while our jobs in NHS finance are always challenging, our world is not quite as bizarre as European politics.

Contact the president on president@hfma.org.uk



An initial reset brought the 'planned' deficit down to £439m at Q2 – with provider sustainability fund bonus payments offered to providers willing and able to commit to an improved financial position. This plan revision continued into Q3 with a new plan set at £394m.

But changing the planned position seems odd for two reasons. First, it is not usual practice. The plan is the plan. Any changes or savings generated during the year to improve performance against that plan are exactly that – in-year changes. Those revised plans were not in place at the beginning of the year.

You might argue that major unforeseen changes might justify a change to the plan – for example, if the chancellor, without notice, changed the VAT rate mid-year, increasing costs for trusts unable to reclaim all their VAT on goods and services. You might argue that rather than show trusts as overspending against a plan that predated the announcement, it was more meaningful to reflect these unavoidable higher costs in the plan and then judge trusts' performance against this revised position.

However, it is difficult to imagine such a scenario – and such circumstances do not exist in this case.

“Retrospectively changing the planned position seems an odd take on transparent financial management”

Second, the reduction in the planned position flies in the face of the actual increase in the forecast deficit. Providers' forecast deficit of £661m (£267m above the revised plan) is in fact £142m higher than the original planned deficit of £519m. And the £661m is after an exceptional technical adjustment relating to the accounting treatment of private finance initiative hospitals being brought onto providers' books after the collapse of Carillion.

Without this, the forecast deficit would be £917m, £523m above the new plan and (closer to but still) £398m above the original.

Perhaps none of this really matters. They are only numbers, albeit very big numbers. But retrospectively changing the planned position seems an odd take on transparent financial management, especially when you are only taking account of negotiated changes that move the planned deficit down, while actual forecasts are moving in the opposite direction.

Switching on

Virtual consultations – for GP and outpatient appointments – were central to the long-term plan’s vision for healthcare. But, in reality, technology is behind much more of the proposed transformation of the NHS. Steve Brown reports

New technology is at the heart of the *NHS long-term plan*. The digital enabling of primary care and outpatients grabbed the headlines, but the proposed changes are wide-ranging. If the vision is realised over the next decade, technology will be in the vanguard of the prevention and patient support movement.

It will enhance safety and efficiency by giving clinicians anyplace access to patient records. High-quality clinical care will be supported by increased use of decision-support systems and artificial intelligence. Patients will make virtual visits to their GP practice and outpatients and systems will use powerful population health

management tools to help them predict the individuals most likely to benefit from different support and interventions.

James Hawkins, director of strategy at NHS Digital, acknowledges that it can be difficult for NHS organisations under constant pressure to deliver critical services to adopt new technology and digital systems. But he believes the NHS is starting from a good base.

‘We’ve made great strides in technology in the NHS over the past few years, helping to lay the foundations for the now and working towards the demands of the future,’ he says.

He points at the NHS spine, one of a series

of platforms operated by NHS Digital on behalf of the NHS to connect organisations across the health and care system. He says it carries a volume of transactions similar to major credit card systems. More than 90% of England’s 7,300 GP practices use electronic prescribing, enabled by the spine. And the e-referral platform covers every hospital and GP practice.

Even so, Anne-Marie Vine-Lott, Oracle’s UK healthcare director, believes that the NHS needs to get the right IT architecture in place if it wants to realise the ambitions set out in the long-term plan.

‘The back office, including IT, has suffered from significant underinvestment due to financial constraints over a number of years,’ she says. ‘NHS trusts all come from a different starting point, but there needs to be a focus on getting the basics right to improve security and enable interoperability – both of which will lead to greater digitisation of care.’

‘We have very fragmented systems that have been taken forward at a varying pace across the numerous organisations that make up the NHS, each with different levels of investment, capability and knowledge,’ she adds.

In some places, this is as basic as organisations not working on up-to-date operating systems. There is also limited use of new technologies such as machine learning to reduce processing, and predictive analytics to support planning.

Modernising IT and back-office operations such as finance will drive productivity and provide information and analytics to support more efficient, effective decision-making. This is essential for developing new service models that will better support the front line through digitisation and the use of technology, which covers everything from wearable technology to complex electronic patient records.

‘Health and care systems should have an overarching digital strategy, with partnering organisational delivery plans aligned with this. And they need to start with getting the basics in place,’ says Ms Vine-Lott. ‘Digital strategies are too often based on what organisations want

EPR improves patient flow

Nottingham University Hospitals NHS Trust is aiming to deliver clinically led, mobile-facilitated ICT as part of a paperless hospital by 2020.

The focus for Nottingham is to enable safe patient flow despite unrelenting demand for, and pressure on, A&E and inpatient beds. Its solution is built on a phased adoption of mobile technology, underpinned by Nervecentre’s Next Generation electronic patient record.

The trust has made substantial progress, with 4,000 mobile devices in use across the trust. But it has not been achieved overnight – the first deployments of Nervecentre started in 2010. The long-term plan promises to accelerate the roll-out of EPRs and associated apps.

Initially, the focus

at Nottingham was on junior doctors and consultants, supporting task management, escalation and specialist referrals. It then moved on to supporting nurse-led functions such as the capture of vital signs, early warning scores and handover information.

The trust introduced bed management functionality in 2017, building on the core modules: Hospital at Night; eObservations; and eHandover.

Along the way the trust has added extras such as an electronic tool for screening sepsis, an eCoroner solution and functionality to support integrated discharge planning.

Using the bed management module, clinicals can escalate pathways, expedite

discharge and identify barriers to patient flow.

According to Mark Simmonds, consultant in acute and critical care medicine at the trust, the introduction of mobile technology has driven a step change in communication. ‘We’ve got a mobile device in the hands of all our clinicians – our nurses, our healthcare assistants, our doctors – so that the crucial bits of information about a patient are available to everyone all the time,’ he says. ‘We can be on a corridor half a mile away from a patient and still know their physiological status through their early warning score and observations but also know what we are waiting for.’

The trust says the technology has contributed to reduced length of stay and low readmission rates.



Embracing digital

The role of technology in the future delivery of healthcare will be explored in an HFMA conference in May, which is free to HFMA members. *Embracing digital technology* takes place on 15 May and is being run as part of HFMA president Bill Gregory's *Value the opportunity* theme. For details, visit www.hfma.org.uk/education-events

to achieve; they need to be more about how the vision will be realised and who will do what.'

She adds that the service also needs to change its approach to building business cases, as years of funding restraint have led to short-termism in investment strategies.

'At the moment, unless programmes can deliver savings today, there are often no available monies. But we need a longer term approach that recognises strong technology investments will become self-funding over time and make a significant difference to both patients and staff.'

Key focus of the plan

The long-term plan envisages technology being used in five key areas:

- Empowering people – using apps to access the NHS and support specific conditions and giving people access to care records (see *Phone support*, page 15)
- Supporting health and care professionals

– increased use of mobile devices and improved digital skills

- Supporting clinical care – digital options for providing advice and care, accelerated roll-out of electronic patient records (see *EPR box*, page 12) and new digital exemplars
- Improving population health – deploying predictive tools to identify people at risk of adverse health outcomes
- Improving clinical efficiency and safety – using pathology and diagnostic networks and developing decision support and use of artificial intelligence.

One of its most eye-catching commitments is the promise to give every patient the ability to access a GP digitally and opt for a virtual outpatient appointment, where appropriate,

within five years. In fact, January's new GP contract framework goes further than this, saying online and video consultation will be live by April 2021 in areas where it is realistic to make early progress.

Babylon Health's service, GP at Hand – hosted by a four partner GMS practice in Fulham, south-west London, and involving up to 200 mostly salaried part-time GPs – is perhaps the highest profile example of a digital first practice.

It is available to anyone living or working within 40 minutes of one of five London clinics, using the out-of-area

registration scheme to sign up patients from a broad catchment.

The service provides access to video or telephone consultations via a dedicated

"Digital strategies are too often based on what organisations want to achieve; they need to be more about how the vision will be realised and who will do what"

Anne-Marie Vine-Lott, Oracle

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Phone support

smartphone app or the website. Appointments are available 24/7 and the service claims patients are usually 'seen' within two hours of making the booking. Face-to-face appointments can be arranged if needed.

The service has proved popular. Launched London-wide at the end of 2017, it now has more than 45,000 people signed up – reportedly including health secretary Matt Hancock. In February, Babylon was given the green light to expand to Birmingham.

It has proved to be a classic disruptive technology and not been without criticism. GPs have complained that the service cherry-picks young, tech-savvy patients, while people with more complex conditions stay with physical practices. However, Twitter and NHS review sites reveal plaudits for a fast, efficient service as well as concerns where things haven't always gone smoothly.

Impact on CCG

The service has also had an impact on the practice's host clinical commissioning group – Hammersmith and Fulham, which picks up the bill for prescribing costs and for patients referred into secondary care who would previously have been outside the CCG's catchment area. In March, the CCG confirmed it had taken GP at Hand costs of £10.2m to its bottom line after failing to get any assurances that this would be paid by NHS England or CCGs outside of north-west London.

Addressing the cherry-picking claim, Paul Bate, Babylon's director of NHS services, says the age profile of its list is reflected in the practice's funding. Average funding for GP at Hand per patient is about £90 compared with the national average of £140. This is because of GP at Hand's younger than average population.

And while he acknowledges that the service could be attracting healthier patients within a particular age/sex band, its patients have also made an active decision to change service and this could be an indication that they are more likely to access services.

'We also run services 24/7 and 365 days a year and 40% of our appointments are booked and/or take place out of hours,' says Mr Bate. 'So the accessibility of the service is much greater.' In other practices, patients wanting to see someone outside of opening hours midweek or at weekends would probably use 111, A&E or out-of-hours services. But GP at Hand patients are more likely to call their online GP – leading to increased activity.

The **NHS Apps library** went live for patients in February following successful beta testing. It provides a collection of digital health tools that aim to help patients make better choices about digital health and care. All the apps and digital tools included in the library have met standards designed by NHS Digital in areas including clinical safety, usability and security. The library has more than 80 apps and digital tools, including apps for the top five chronic conditions as well as many health and wellbeing apps. Some support services in specific areas and there are paid-for and free apps included. Examples include:



Engage This self-care app from lumiraDX Care Solutions currently supports patients receiving warfarin anticoagulation

therapy. It provides step-by-step tutorials that teach users to self-test their INR (international normalised ratio) and send the result to their care team. The team can then send back the patient's tablet dosing schedule, giving a daily reminder of the tablets they should be taking and the date of their next test. This aims to increase the time that INR values are kept within the therapeutic range, improving health outcomes and reducing the chance of stroke.

myCOPD

The app helps patients with chronic obstructive pulmonary disease to manage their condition independently and reduce reliance on GP and hospital appointments. It helps users to improve their inhaler technique providing videos and educational resources.



Clinicians can also use the app to check in with patients remotely, track their condition, update medication and improve overall care.

NHS app The official NHS app allows users to check symptoms using a reliable source of information. Where their GP surgeries are connected to the app, users can book or manage appointments and get secure access to their medical record. All surgeries should be connected by July 2019.

Uwise breast cancer

This app allows patients to track their cancer treatment and wellbeing. They can record fatigue, appetite, pain and other health facts to spot trends and help improve their care. Patients can also record conversations with their doctor to listen back to.



Mr Bate believes the use of these other services by people registered with GP at Hand will have reduced – he hopes an independent evaluation currently under way by NHS England will provide greater insight.

From this year (2019/20), further amendments are being made to the GMS funding system to acknowledge the arrival of digital first practices. These involve changes to the London weighting and rurality index payments, which on their own will reduce GP at Hand's income further by between 5% and 10%, according to Mr Bate. Babylon is paid on a capitation basis by the practice for providing its service and Mr Bate says this will remain the case. 'We don't want to be in a fee-for-service market in the NHS context,' he says, as this provides the wrong incentives.

Elsewhere, GP practices may look to meet the long-term plan goals by introducing video consultations alongside place-based services. In north-west Surrey, the NICS GP federation, covering 40 GP practices, has entered a

contract with digital care provider Livi (founded in Sweden, where it operates as Kry) to deliver extended access across the patch.

This does not replace traditional GP practice but extends its capacity – providing a more convenient way for some patients to consult a GP and reducing the demand on the practices' own GPs. If a patient calls a practice and there is no timely appointment available with one of the practice GPs, practices will try to offer an extended access face-to-face appointment.

If none of these is available that day, they might suggest the Livi service. In addition, patients can initiate contact with Livi directly through a dedicated app.

From a total population of 370,000, there had been 6,500 consultations by early March – the service went live last September. Usage has picked up to the point where there are now around 500 virtual consultations a week.

The service differs in one very obvious way from the GP at Hand model – Livi does not provide its own face-to-face consultations. Instead, if a patient needs to be seen face-to-face by a doctor, they would be referred back to the practice or to A&E as appropriate.

George Roe, chief operating officer at NICS, says the service is ideal for some conditions

"We don't want to be in a fee-for-service market in the NHS context as this provides the wrong incentives"

Paul Bate, Babylon Health (pictured)



with feedback suggesting it has worked extremely well for some types of patient.

'They won't do tonsillitis, chest infections or ear infections – because those things you need to hear and see,' he says. 'But it is perfect for people who don't need the continuity of going to see their own GP because it is a one-off type skin infection, for example. For these patients, the feedback is brilliant because you are giving patients very good access to a GP who is able to prescribe, see their notes, refer – everything a normal GP can do.' He adds that the service has also proved popular with patients presenting with anxiety issues.

The Livi service is being run as a 12-month pilot, with the federation paying on a per consultation basis. Mr Roe says an audit has shown that 80% of the consultations to date would normally have gone to see a place-based GP. Some 14% would previously have gone to A&E, while 6% would probably have managed themselves – suggesting the increased capacity is not driving demand in a big way.

'If these numbers continued, we'd be very happy,' he said. He adds that all system partners are interested to see the impact in terms of prescribing and referral rates.

The service has also attracted a wide age range, with over-60-year-olds a major group among the virtual users.

Mental health moves

The long-term plan sees a role for technology across the healthcare sector. But a report published in March by the Mental Health Network argues that the mental health sector in particular is ripe for digital disruption. It calls for NHS England to further expand its current global digital exemplars programme and for mental health services to be given

access to significant levels of dedicated funding for digital innovation.

In addition, *Using digital technology to design and deliver better mental health services* identifies the need for a national vision for digital mental health and

suggests that NHS England should consider commissioning some e-mental health services at a national level.

The report looks for lessons from emerging developments in Australia and the US. For example, it highlights the e-HeadSpace national digital delivery service for youth mental health in Australia, which provides online support and counselling to young people. It has proved particularly helpful for users making their first foray into mental health support and use of the service has grown by 12.5% a year over the six



Fall prevention

Coventry and Warwickshire Partnership NHS Trust (CWPT) has deployed a technology solution to help monitor dementia patients in their own bedrooms while respecting their privacy.

It installed Oxehealth's Digital Care Assistant in 12 bedrooms across two dementia inpatient wards at the trust's Manor Hospital. Most patients on the wards are designated as at risk of falling, with more than half of all falls at the hospital occurring in bedrooms and more than half of these happening at night.

The current standard of care is to risk-assess patients, and check they are safe, in person and at frequent intervals – often every 15 minutes in mental hospitals. These checks are time-consuming and can disturb patients' rest.

The Digital Care Assistant removes the need for such frequent checking by using a digital video camera sensor to detect movement. An alert is sent when a patient gets to the edge of the bed and again if they get out of bed, enabling a member of staff to get to the room to help. The system can also detect pulse rate (through skin colour changes) and breathing rate (through chest movements).

Charlotte Wood, Oxehealth's mental health director, insists the Digital Care Assistant is not about replacing staff; it helps staff to get the balance right between keeping patients safe, allowing them to rest and respecting their



privacy. 'Staff get more time for hands-on care and don't spend as much time on routine, security-based tasks,' she says. 'It can help trusts to allocate their most valuable resource, clinical time, in the best evidence-based way.'

There are further benefits. Only 15% of falls involve a head impact. But if patients fall unobserved – and more than 80% of falls are not seen by staff – strict neurological enhanced observations must be undertaken for the next 24 hours. These tests are intrusive and, again, take time for staff to perform (estimated at a cumulative two hours per fall).

So working with CWPT, Oxehealth developed a feature that enables staff to 'replay' a fall under strict information governance protocols, avoiding unnecessary observations.

In an initial study, part funded with a West Midlands Strategic Clinical Network research grant, the trust saw a 33% reduction in falls at night, with a significant reduction in fall severity – moderate falls down from 8% to 2%. The trust estimates this is saving it 460 clinical hours a year, with a further 7,800

clinical hours saved on enhanced observations – which equates to potential cashable savings of £154,000 per year.

Neil Mulholland, the trust's deputy finance director, says: 'There are direct savings to be found in bank and agency staff spend, in terms of no longer needing to carry out as many enhanced observations. We need to test new models of care to see if further savings can be realised from redeploying staff time on the ward. The data suggests this could be done, but we need to see if it would work in practice.'

With a strong clinical case, the trust is optimistic about making the system 'business as usual' and has already expanded the technology to a further 65 bedrooms across its psychiatric intensive care unit and acute inpatient wards. 'The main benefit on the mental health wards is staff not having to be physically there to do an observation, which means the patient gets a better night's sleep, which can lead to them having a better following day,' he says.

Staff response has been positive and Mr Mulholland hopes that making the trust a better place to work will also have an impact on staff recruitment and retention.


Costs depend on the site, but Ms Wood says payback can be within a few months. The system is currently installed in nine mental health trusts and one acute trust, as well as a number of care homes.

years it has been open. Report author Rebecca Cotton, director of policy at the Mental Health Network, insists resources are needed to support innovation.

'The opportunity is here to capitalise on the potential digital technology offers us,' she says. 'We can ensure more people have access to high quality treatment, advice and support.'

It is an argument that could be applied to all

parts of the NHS. People are surrounded by technology facilitating different aspects of their lives. There is a growing expectation that they should be able to interact with health services in this way – and that health services should be making the most of digital technology.

The NHS long-term plan sets its sights on this. The challenge for the NHS is turning the potential into reality. 



UNDERSTANDING THE VALUE OF PATIENT SUPPORT PROGRAMMES

Providing care tailored to the individual receiving it will be one of the big challenges for the NHS over the next decade. It has long been recognised that a “one size fits all” approach will not necessarily get the best outcomes for the patient and for diverse communities – and potentially will cost more.

While having a standardised approach to a patient in cardiac arrest, for example, may be lifesaving, the need for more individualised approaches is clear in the treatment and management of chronic diseases where people may be taking medications for a lifetime.

Offering the care each individual needs may also help the NHS to cope with the expected rise in the number of patients with long term conditions and ensure they are treated closer to home, whenever possible. Enabling patients to manage conditions at home with support from localised NHS services, and thus minimising their need to be admitted to hospital has been a key part of the NHS’s plans – both in the Five Year Forward View (in 2014) and now the Long Term Plan.

As the proportion of the population with long term conditions increases, this need may become more pressing. Currently there are over 15m people in England with one or more long term conditions but that number is growing and, within it, an increasing proportion have multi-morbidities. Care for those with long term conditions dominates the NHS. The House of Commons health select committee* found they account for:

- 55 per cent of GP appointments
- 68 per cent of outpatient and A&E appointments
- 77 per cent of inpatient bed days.

But self-management often involves input from the NHS upfront, helping patients understand what they need to do to stay as healthy as possible, informing them of the likely effects and side-effects of treatment, and ensuring they have individualised support if problems develop.

There has been significant progress in enabling some patient groups to self-manage in this way, but it is not universal across the range of chronic diseases. Financial constraints can play a part in this, as can the complexity of the condition, its treatments and the type of patients most likely to be affected.

Some patients may feel daunted by the prospect of self-management and need additional support which the NHS may struggle to provide at the moment.

A number of healthcare providers and pharmaceutical companies have developed an answer to some of these challenges – patient support programmes (PSPs), which deliver services supplementary to those of the NHS aimed at improving patients’ ability to manage their care more effectively.

These are often funded by the companies themselves at no cost to the NHS or to the patient. PSPs are normally paid for by pharmaceutical companies but the service is delivered by a third party, which means the pharmaceutical company has no direct contact with the patient.

* <https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/401/401.pdf>



While the package of care on offer may differ from condition to condition, and from company to company, they can include:

- ensuring a reliable supply chain leads to timely home delivery of patient medications
- training on effective self-medication and administration of medicines – which may be much more complex than simply taking a pill twice a day
- information on appropriate management pitched at a level suited to the patient
- motivational training to improve adherence to medication regimes. Some medications take a long time to show benefits and patients need to be encouraged to continue
- telephone hotlines – including out-of-hours – to access advice from qualified healthcare professionals.

The level of support to the patient is very much based on their individual position and what support they need and want to access. In some PSPs, peer mentors will be used to help patients overcome challenges in adherence.

As the NHS faces ever tighter budgets and is desperately short of staff – especially nurses – PSPs may offer an opportunity to reduce pressure on parts of the service while improving care for patients. But what are the barriers and solutions to making their use more widespread?

BARRIERS TO WIDER USE OF PSPs

1. Knowledge and understanding of PSPs

One of the most fundamental barriers to PSPs is a lack of knowledge and understanding of them among NHS staff in particular. We know that even now, in a technologically driven information age, patients trust medical professionals more than other professions.

This trust and reliance on them is still high – although it varies within different communities – and has continued even though shared decision-making has grown in importance. This means that PSPs are unlikely to be recommended or asked for by patients and those around them simply because neither healthcare professionals nor patients know they exist.

NHS staff and others who are aware of them may have relatively scant knowledge of how they work and their benefits. For example, knowing that they are provided free of charge to the NHS and have the potential to reduce other costs for the NHS. If patients ring a helpline rather than seeking help through their GP, hospital or A&E, pressure on the systems can be reduced.

There is also confusion about what is meant by the term patient support programme and the possibility of confusion with other programmes both within and outside the NHS, and therefore a misunderstanding of what PSPs can offer.

Many other support programmes will not focus on particular products in the same way as PSPs and may be more generic.

This confusion can extend into other terms such as “home care” – often provided as part of a PSP – which may have a different meaning to those who are working in social care and those working in and around the NHS. Many NHS staff will not realise that patient support programmes are highly regulated and governed. This could affect their willingness to refer patients to them, as non-regulation is a key referral barrier for clinicians. The National Homecare Medicines Committee – part of the NHS’s Specialist Pharmacy Service – oversees PSPs and there is a standard contract in place across the NHS. In addition, the pharmaceutical companies have to work within robust guidelines laid down by the Association of the British Pharmaceutical Industry. This level of regulation could offer reassurance to the NHS about how PSPs operate.

2. Fitting into the infrastructure of the NHS

PSPs potentially impact on many parts of the NHS – often very positively – but don’t have an automatic “home” in the infrastructure of the NHS as it stands. Many patients will first encounter PSPs after they have been in contact with secondary care services and have been prescribed a particular medicine – for example, they have had a hospital admission – but much of their ongoing care may be provided by community teams or through their GP practice.

However, many patients receiving a PSP also have other conditions and may be in contact with other parts of the NHS about these. Lack of communication between different parts of the service is a known problem with patients often not receiving a joined up service. How PSPs then interact with these different parts of the system – all providing some care to the patient – is a challenge. Where there are benefits as a result of PSPs – such as avoiding admissions – they may not be obvious to all parts of the system and any financial benefits will not be shared due to the silo nature of NHS funding.

3. Information sharing

As PSPs are provided by non NHS bodies, there are issues around sharing data, which has to be done with the patient’s consent. Where this is held in an electronic form, there may also be technical problems about how this could be shared and incorporated into the patient’s records.

Sharing information would be one way to boost the visibility of PSPs and make the NHS aware of their benefits. It could also allow greater coordination, allowing NHS staff to request greater support if a patient was struggling with adherence or they required information about the patient held by the PSP provider, to be summarised for the NHS staff involved in their care.

4. Reluctance to get too close to pharmaceutical companies

In some parts of the NHS there is a reluctance to be seen to be working too closely with pharmaceutical companies and a suspicion about their motives in providing services. This can affect “buy in” to value-based programmes such as PSPs even when there is no direct cost to the NHS and they are provided as an unpaid service to patients. Ways to increase uptake of this service may be as simple as emphasising PSPs to make the medicines the NHS does pay for work better – and therefore deliver better value.

5. Access to the underlying medication

PSPs are specific to the medication a patient has been prescribed – and are therefore only available to patients while they are on certain medications, even if elements of the PSP “offer” would be useful at other points in their patient journey or to other patients. This can mean access to PSPs is very dependent on the use of the underlying medication – which may be restricted or just not favoured by some clinicians.

SOLUTIONS

1. Promote understanding of the role of PSPs

For the NHS, the PSP may be a useful tool in the armoury to tackle long term conditions, improve patient experience and reduce the overall cost to the system – but that requires greater understanding of what PSPs are and what they can do. Greater knowledge of them and understanding could help break down some of the concerns about the involvement of pharmaceutical companies in them.

Patients probably know little about PSPs until they are receiving one. More active, informed and engaged patients could help their spread by questioning why they are not receiving this level of support. The role of communities and patient-led support agencies in advancing the use of well-reviewed PSPs should not be under-estimated.

2. Develop an evidence base for the impact of PSPs

Arguments for increasing use of PSPs would be bolstered by an evidence base showing their benefits for the NHS and patients who access them. These benefits might include improved adherence to medications and better outcomes for patients, using both clinical indicators and patient reported measures. Existing evidence could include reviews on websites such as “I want great care.”

Other areas which could be looked at would include PSPs’ contribution to greater patient activation, using recognised measures of this and greater community engagement in decision-making about local services. This could recognise that PSPs may have spillover effects and impact on how patients look after their health and engage with services more generally.

Such an evidence base is likely to draw on the experience of NHS staff with patients in PSP schemes who may see the outcomes of these. Specialist nurses may be the staff who see the value of PSPs most, as they are well placed to see the impact on patients. Consultants may not see or be aware of the impact in the same way. Sharing relevant information between multi-disciplinary healthcare professionals could be key.

3. Understanding costs and benefits

There are some obvious benefits to the NHS of PSPs. First of all, they may be doing work which would otherwise either be picked up by NHS staff or left undone to the detriment of the patient. Patients who adhere to medication regimes may be less likely to need or seek care from GPs or hospitals, and may need less input from community nurses; in some cases, PSPs may prevent expensive hospital admissions.

If they take their medication correctly and adhere to the regime, the NHS is more likely to get full value from the medicines. This links into the 'Getting It Right First Time' agenda. "Monetarising" these benefits would help to make a case for PSPs. While these potential savings are relatively easy to cost, there are other benefits which largely accrue to patients. These may be improved outcomes in terms of the primary condition they have and also a reduction in stress and anxiety if they know help is available – such as through a telephone helpline.

All these benefits are rarely costed or quantified in a way which would make the case for PSPs compelling – especially as they come at no added cost to the NHS. This could help, especially as the NHS is very obviously struggling with the resources available. This could provide a way for PSPs to be recognised and increased. Such costing can present challenges but is worth pursuing.

4. Being seen as part of a wider movement

The NHS is looking to provide person-centred care: PSPs fit within the ethos of this with their focus on tailored help for the individual and those around them who may be involved with medicines administration and adherence. The emphasis on empowering people to live with and manage their long term conditions also resonates with key NHS aims. PSPs should try to be seen as part of a plurality of interventions aimed at improving patient experience and empowerment.

PSPs could also link with community prescribing, a deeper more community-led approach than social prescribing where an alliance of community providers work with GPs to deliver services. In some communities there had been resistance to social prescribing being "imposed" as it was seen as outsourcing financial problems. However, this opposition had vanished when the community was engaged in developing a new model of community prescribing. Public and patient engagement of diverse communities in designing care could produce more effective schemes because it would improve take up and adherence.

5. Working with those responsible for coordinating care

The NHS has many initiatives aimed at improving care for people with long term conditions. In some areas Primary Care Home – which works across communities of 30,000 to 50,000 people – acts as mechanism to drive personalisation of care.

In others, multispecialty community providers link GP practices, trusts and other services. Linking into these could help PSPs become more mainstream. However, the landscape of the NHS is changing rapidly and new bodies and ways of working are emerging which could help PSPs become a recognised and valued part of the wider system – and potentially develop at scale.

The development of more integrated ways of working, culminating in integrated care systems in some parts of the country, is aimed at creating a more joined up seamless service for patients that also reacts to patients at an earlier stage in their condition – or even before they develop any.

The prevention of expensive hospital stays through early intervention ties in with the ideas behind PSPs, with the focus on providing help when the patient feels they need it rather than letting problems become a crisis.

Improvement methods could be needed to spread some of this best practice and improve care for those with long term conditions. Creating a seamless well-performing service can be easier if certain factors are in place. Co-terminosity between local authorities and NHS bodies helps, and there is evidence that NHS leaders with a long tenure are also associated with better performance. Real community engagement is also required where partnerships develop with patients and people providing services.

PSPs will need to link into the models which do emerge and to have contact with those organising a personalised package of care around the patient so that they are, for example, embedded in the care plan.

6. Link to health inequalities

Health inequalities are high on the agenda for many in the NHS. PSPs can improve treatment for people who may be affected by health inequalities – for example, because they live some distance from hospital and would find it difficult to attend training or seek help there. More widespread use of them could potentially even out some of the differences in the care received by patients.

WHAT YOU CAN DO

1. Consider whether patient support programmes could contribute to the care of patients in your organisation, perhaps identifying groups of patients with chronic conditions who could benefit from them.



2. Talk to potential partners in the pharmaceutical industry about what would be available to these groups.

3. Look at how such schemes could be introduced and who would need to be involved or consulted to make this happen.

Acknowledgements

This advertorial is based on a briefing paper originally written and published by NHS Confederation following a roundtable held in October 2018. The roundtable was hosted by the NHS Confederation in partnership with AbbVie and attended by senior leaders from: AbbVie, NHS Confederation, NHS England, Health Foundation, NHS Newham CCG, King's College Hospital Foundation Trust, ReThink Mental Illness.



NHS Improvement and NHS England believe risk sharing mechanisms working with new payment approaches could support the delivery of integrated care. Steve Brown talks to the team developing guidance

Sharing the risk

NHS payment models – whether based on crude block contracts or more detailed approaches – can often leave one party unfairly out of pocket. Block contracts can leave providers covering the costs of additional activity outside of their control with no additional payment. Activity-based systems could leave commissioners paying full rates for additional activity that only incurs a marginal cost or leave providers unable to cover fixed costs if activity falls short.

Mechanisms to share some of these risks are not new. Caps and collars – perhaps in a crude way – have been used to limit the financial impact when activity or costs go off plan. The marginal rate emergency tariff was a high-profile attempt to balance out some of the risks of under- and overperformance on non-elective activity.

But some of these approaches dampened the incentives created in the primary payment model. And in some cases they were driven by the need to cap spending rather than ensure commissioners paid and providers received a fair amount to cover legitimate costs.

In recent years, attention has turned to developing new payment models in England, recognising that the incentives in the current

activity-based payment by results approach do not align with the partnership working needed to deliver system working and more integrated care. Capitation-based systems are widely seen as a better mechanism once integrated care systems (ICSs) are in place, ensuring payment mechanisms don't get in the way of pathway changes such as moving activity from acute settings to the community.

Formal risk-sharing arrangements are seen as an important component alongside new population-based budgets, and the NHS Improvement and NHS England joint pricing team have worked to support the development of ideas in the former vanguard sites and pioneering ICSs.

Into practice

But with all areas – through sustainability and transformation partnerships – now actively pursuing greater system working, the joint pricing team is keen to explain how risk could be shared both with existing contracting arrangements and as new approaches emerge. It has started to do this through an introductory series of webinars, which got under way in February.

'This is an attempt to give people the tools

to share risk more optimally rather than saying this is exactly what works,' says Chris Skilbeck, head of pricing engagement at NHS Improvement, stressing that there are no plans to mandate any approach.

'As we move to less episodic ways of doing things, there is a whole range of mechanisms – such as the break glass arrangements in the new blended payment approach for emergency care – that need to be part of the new landscape. These things may be routine in a few years, but we need to break the back of it now and get a few of them in and working.'

He suggests that classic examples of where risk sharing might be appropriate include when systems are looking to transfer activity into the community – or increase community service provision that leads to reduced acute activity. 'What happens if you reduce the acute activity below a viable level or if the activity left with the acute is more complex?' he says.


Another example might be where systems are looking to implement the *Getting it right first time* hub and spoke model, consolidating more complex or less frequently undertaken activity in a single trust. This may ensure the trust undertakes sufficient procedures to maintain quality, but what happens if the

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length of stay goes up because of the more complex casemix, or if the activity displaces less costly elective activity?

Payment reform is a slow-moving beast. While it aims to change behaviours, it wants to do it in a way that doesn't fundamentally destabilise health systems. The joint pricing team's new blended payment for emergency care builds on an approach first proposed by the two bodies five years ago. Their original three-part payment model for urgent and emergency care (UEC) would have had a fixed, core funding element supplemented by further elements for volume and quality. The quality component does not form part of the new blended payment system.

A form of activity risk sharing is built into the blended payment approach, with the big difference between it and the previous marginal rate tariff (apart from the value of the marginal rate used) being a more realistic, locally agreed level of planned activity.

Specific risk sharing mechanisms are seen as assisting the move to integrated care. 'Together, blended payment and, where appropriate, risk sharing models should help to align financial incentives to support each system's healthcare goals and strategic aims,' says Mr Skilbeck.

NHS Improvement's webinars introduce two

types of risk sharing currently being explored. Finance-based risk sharing aims to share the risks of deviations in expected costs and/or revenues, while activity-based risk sharing caters for when activity or utilisation levels are not as expected.

A question of need

Lily Tang, NHS Improvement's pricing strategy lead, says the first thing to look at with any risk sharing arrangement is whether it is needed. 'If the primary payment is allocating finance or activity risk to the most suitable organisation(s), it is unlikely a risk-sharing mechanism is needed,' she says. 'And if it isn't allocating risk appropriately at all, changing the primary payment approach would probably be the most beneficial first step.'

In between these two extremes, risk sharing may have a role where the primary payment mechanism is only allocating some of the risks appropriately.

Matthew Marsh, senior pricing development manager at NHS England, stresses that local areas need to decide what they are trying to achieve and ask if risk sharing helps them to do that. Recognising criticisms of overly complex payment approaches (see box), he says risk sharing must have a point. It may only

be needed while the impact of new pathways on demand and activity is understood. Once activity is more predictable, for example, a blended payment approach might be sufficient.

Finance risk sharing is probably best seen as a system risk-sharing mechanism – ensuring no one organisation carries all the risk of transformation (such as a shift of activity into the community). NHS Improvement senior analyst Darren Keogh says this could involve financial position sharing – sharing gains or losses when there are deviations between the reported financial positions and the pre-agreed baseline – or involve the use of a shared resource pool to manage risks as they arise.


He suggests that organisations in a system could agree to share only surpluses with the aggregate surplus shared equally and then applied to each organisation – improving the reported position of any organisation in deficit.

NHS England analyst Fiona Earnshaw describes activity-based risk sharing – previously referred to as gain/loss sharing in whole population budget guidance drafted to support proposed integrated care organisations – as more 'mechanistic and formulaic' than finance risk sharing as it is based around activity plans and unit price.

'It can be set out and agreed in advance and written into contracts, but it can be flexible,' she says. 'It is generally more suited to specific services and care pathways rather than at system level.' It can improve the sharing of utilisation risk and give partners a stake in a specific new care model.

The national bodies have sketched out four initial applications for activity-based risk-sharing arrangements involving simple bilateral contracts between a commissioner and single provider and more complex multi-lateral arrangements. These are starting points, but with the flexibility to be tailored locally.

Ms Tang believes that the approach is about sharing risks that are appropriate to share across the system. For example, it should not be used to recompense a provider delivering higher unit costs than predicted for costs within its control – a risk the provider should in most cases bear itself. Nor should it attempt to share quality or outcome risks, where other rewards or penalties might incentivise the delivery of best quality care. However, it is not always possible to identify the specific causes of finance deviations.

There is no deadline hanging over finance professionals to introduce risk-sharing arrangements, although the joint pricing team is encouraging systems to shadow test proposed arrangements. Risk-sharing guidance is currently under development and should be published soon. 

Call for simplicity

The NHS should ditch complex payment systems in favour of simple arrangements that allow resources to be allocated where they are most needed, and promote a culture of collective responsibility for local health systems, according to a new report from the King's Fund.

Payments and contracting for integrated care: the false promise of the self-improving health system argues that policy makers have tried for 30 years to devise financial incentive schemes to improve the performance of health services but these have failed. It says there are now proposals to move to whole population budgets with new incentive frameworks and gain/

loss sharing mechanisms, as well as plans to use payments and incentives in the development of primary care networks.

The report questions 'whether these latest incentive schemes will be any more successful than their predecessors' suggesting that the approaches are copied from insurance-based health systems.

Other tax-funded healthcare systems have headed in a different direction, says the report. 'A number of these countries are now foregoing complex financial incentive schemes in favour of partnership arrangements between funders and planners and

groups of service providers, with the focus on effective joint working to make best use of healthcare resources.'



It cites Canterbury District Health Board in New Zealand as an example of a system built on 'high trust and low bureaucracy with simple contracts' (see *Lessons in integration, Healthcare Finance June 2017*).

It also puts forward Bolton NHS Foundation Trust and the local clinical commissioning group's aligned incentives contract as another model of how organisations could work together (see *In place of strife, Healthcare Finance July/August 2016*).

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network solution

Primary care faces demand and workforce pressures, but NHS England plans to tackle this with GP-led multidisciplinary teams. Seamus Ward asks what these new primary care networks are, and how they could change patient care

General practice is not flying high. GPs are pivotal to the NHS, acting as gatekeepers to secondary care, and primary care accounts for most patient contacts with the NHS, but the recent British Attitudes Survey found satisfaction with general practice is at an all-time low – fuelled, perhaps, by difficulty in booking an appointment. Recruitment is tough and there remains a large group of GPs aged 50 or more who could retire soon.

It may seem a doom-laden picture, but general practice is changing. For several years, practices have been responding to demand and workforce pressures by working together, usually by creating federations to cover extended hours or by merging into super practices with huge patient lists. The *NHS long-term plan* aims to take these partnerships a step further by organising practices into primary care networks (PCNs).

The networks will include practices covering populations of 30,000-50,000 people and, to reinforce their place-based credentials, must be geographically contiguous – meaning a practice in one PCN area could not join a different PCN.

PCNs will be vital to the long-term plan's aims of moving more care out of hospital and into the community and placing a greater focus on preventative care. NHS England has said PCNs are the building blocks of the new integrated care systems (ICSs).

Coming together

Primary care collaboratives are not new. The British Medical Association says 88% of GP practices in England are already involved in a network of some kind – either coming together to discuss the best way to care for local patients in neighbourhoods and localities, or agreeing more formal arrangements in federations or super practices. In the 2018/19 planning guidance, clinical commissioning groups were urged to encourage all local practices to be part of a PCN, but the long-term plan goes further, saying all practices should be part of a PCN by 1 July this year.

In Wales there are 64 GP clusters or primary care networks, which work with their local health boards and community-based health professionals to shape community services. Set up in 2014, they are around the same size in population terms as those proposed in England and offer a range of services, including pharmacy and physiotherapy.

In a report in October 2017, the Welsh Assembly health committee voiced frustration at the lack of pace in cluster development. However, the Welsh government recommitted to developing clusters in its long-term health and social care plan, *A healthier Wales*, last year. This said GPs and other healthcare professionals would develop their collaboration, focusing on prevention and early intervention.

In England, funding will be provided to kick-start PCNs from the £4.5bn announced in the long-term plan to boost community-based care. Practices will be funded to take part in PCNs via a reformed and





extended GP contract (whether GPs are on the general medical services, personal medical services or alternative provider medical services contracts). Most GPs also have a directed enhanced services contract – to provide additional opening hours, for example – and this will now be added to the primary care network extension to the core contract. Additional funding and staff – shared across the local network – will come with the enhanced contract.

Initially each network will include GPs, existing practice staff, a pharmacist and a social prescribing lead. But from 2020 they will also employ first contact physiotherapists and physician associates. In 2021, there will be funding for increased numbers of these staff plus community paramedics. And from 2022 a typical network should have five clinical pharmacists; three social prescribers; three physiotherapists; two physician associates; and a community paramedic. By 2024 there should be an additional 22,000 staff in primary care.

‘The difference patients will see is in the new types of staff coming in,’ says King’s Fund senior fellow Beccy Baird. ‘We are not going to have lots of new GPs any time soon, so the government has focused on professions where there is a surplus of staff and is trying to get them into

general practice. They are starting with pharmacy and physiotherapists and will then move on to other groups. If you go to your practice with back pain, you will go straight to the physiotherapist. Pharmacists are really good at managing people with complex, long-term problems, helping to manage their medicines, and also with minor illnesses. Paramedics are good at triage and emergency home visits.’

Ms Baird says that, in principle, bringing GP practices together is a good idea. It can mean practices can offer a wider range of services and it makes sense for community services to be reconfigured around the networks. But she adds: ‘We have some concerns about them coming together – this takes a lot of time and trust to develop. Good collaborations have taken years to develop, but they are being asked to do this quickly. They need to do it right because GPs are really busy.’

In 2019/20, NHS England will fund 70% of the clinical pharmacists’ salaries – 30% will have to be provided by each network – and all of the social prescribers’ salaries, including on-costs. Each PCN will have a lead clinician or clinical director selected from the member practices and funding will be provided for them to spend an average of one day a week on PCN work (based on a population of 40,000).

During 2017/18 and 2018/19, CCGs were asked to invest £3 per head of population in primary care transformation. This was discretionary,

Networking Dorset

Dorset Clinical Commissioning Group is not getting hung up on the organisational forms that will be taken by its PCNs, preferring to build on clinical collaborations that already exist.

So says GP Karen Kirkham (pictured), the CCG’s assistant clinical chair. She is also a locality chair leading one of the emerging PCNs, and is working with NHS England to inform national work on the networks.

The CCG has 13 localities, which will be the building blocks for its primary care networks, but she believes it will probably end up with 16-20 PCNs once large rural areas are factored in.

Around two years ago, the county’s NHS started a primary and community care transformation programme, which has reinforced joint working.

‘We started by looking at high-impact changes and the workforce needed as a group of practices rather than individual practices,’ she says.

It also sought to bring in other providers, including community, mental health, social care and acute, to build its care models and provide improved and joined up out-of-hospital services. Localities were asked to settle into natural geographies – precursors to PCNs.

Dr Kirkham says there are good examples of collaboration, which will help when building the new networks. One is a network of 10 integrated care hubs across the county – practices working with community

services, as well as social care in many cases, in multidisciplinary teams to support patients with the most complex needs. Care can be provided in the community, a hub, a hospital ward or in the patient’s home in a virtual ward where the community teams care for patients in their own home.

In Dr Kirkham’s locality, Weymouth, GPs work with other carers, including district nurses and social workers, to identify patients who would benefit from the integrated care hub services, such as those with rising frailty.

Another collaborative programme in Weymouth provides proactive care to patients living in care or residential homes, as well as those who are housebound. A team of doctors, advanced nurse practitioners and nurses work together

to undertake a comprehensive needs assessment and an anticipatory care plan. In its first year, GP visits to the homes were reduced by 60% by this proactive care planning approach.

‘We are now trying to level up this multi-professional approach and spreading it at scale through the whole of Dorset. It takes time, but it is beginning to happen,’ Dr Kirkham adds.

The local hub also co-ordinates an acute visiting team. Made up of nurse practitioners and paramedics, the team cares for housebound patients when they need urgent support, linking back to the GP or the multi-professional care team in the hub where extra care is identified.

Dr Kirkham says a shared IT system is essential to ensure the team can access the patient’s records and deliver safe care.

Though she believes the Dorset work is far from the finished article, these projects and others have put the building blocks in place for local PCNs and some of the new services they will provide.

As ever, funding will be important. ‘I don’t think it can be done without transferring resources,’ Dr Kirkham says, ‘and our CCG has been very supportive and consistent in transferring money into our local areas.’

Nationally, she adds, NHS England is not being prescriptive about organisational form and which body should hold the contract. ‘Work out what works for you and don’t spend years recreating organisational forms.’





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but from 2019/20, NHS England will require them to commit £1.50 per head recurrently to develop and administer primary care networks. The financial support should be provided in cash, not in kind, and should ensure 100% coverage by the beginning of July at the latest, it says. Practices will also receive a payment for engaging with their PCN.

Following the transfer of the directed enhanced service for extended hours, networks will receive the associated funding (about £1.45 per patient). New access arrangements are to be implemented in 2020, which will lead to the transfer of another £6 per head to the networks. This funding is currently routed through the GP forward view scheme to improve access.

From 2020, seven new services – and associated funding – could be delivered by PCNs. These are:

- Medication review and optimisation
- Enhanced health in care home services
- Anticipatory care
- Personalised care
- Supporting early cancer diagnosis
- Cardiovascular disease prevention and diagnosis
- Tackling inequalities.

QoF changes

There will also be changes to the quality and outcomes framework (QoF), including the introduction of a Quality Improvement (QI) element, being developed jointly by the Royal College of GPs, the National Institute for Health and Care Excellence and the Health Foundation.

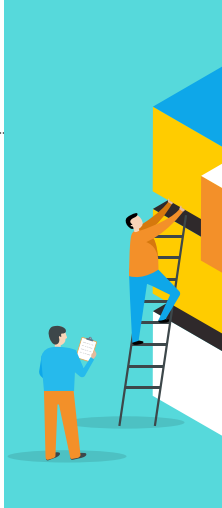
NHS England says the least effective indicators will be retired, and the revised QoF will also support more personalised care. A fundamental review of GP vaccinations and immunisation standards, funding and procurement will take place this year to support the goal of improving immunisation coverage, targeting variation and groups and areas with low vaccine uptake.

Sustainability and Transformation Partnerships or ICSs must ensure that networks are given primary care data analytics for population segmentation and risk stratification, together with local data. This will allow PCNs to understand in depth their populations' needs for symptomatic and prevention programmes, including screening and immunisation services.

Though details are scant, NHS England says it will offer PCNs an incentive scheme, offering them a share of savings from reduced avoidable A&E attendances, admissions and delayed discharges, as well as reductions in avoidable outpatient visits and overmedication.

The King's Fund's Ms Baird says the funding flows will change under the new arrangements for PCNs. In the past, practices have been asked to bid for pots of funding from their CCG or NHS England – to employ clinical pharmacists, for example. However, under the new arrangements funding will be paid directly to the networks. 'It's a way of channelling new money directly to general practice,' she says.

CCGs around the country are pulling together PCNs, with some more advanced than others, building on investment in 2018/19. Bristol, North Somerset and South Gloucestershire CCG, for example, allocated £473,000 to support the development of local PCNs. A recent CCG



primary care commissioning committee paper said most localities had laid good foundations for the development of PCNs, dealing with issues such as scale, integrated working and managing resources.

The committee identified areas for accelerated support and additional funding. These included improving organisational and leadership development to help practices work more collaboratively; introducing a new frailty model of care across the area, taking account of local needs; and the development of population health management in primary care.

Nationwide, CCGs have encountered technical challenges in setting up these new bodies. One of these relates to uncertainties around the treatment of VAT. The crux of the issue lies in the organisation hosting the PCN. If this is an NHS organisation, such as a community trust, there is no problem as they sit within the NHS divisional VAT registration. But VAT complexities arise where CCGs are commissioning directly from organisations established as limited companies (as in some early PCNs). There are good reasons to form such an organisation – it could provide strong local leadership drawn from the practices that will be providing PCN services. And in some areas, community trusts do not have the capacity and knowledge to lead PCNs and transform primary care services. But it may be challenging to demonstrate that these limited companies are providing the frontline patient services directly and/or have the direct clinical responsibility for delivery of frontline healthcare services, thus calling into doubt the healthcare provision VAT exemption status. The result is a risk that a further 20% cost could be added into the system for some of this expenditure.

This has forced some CCGs well advanced with their preparations for PCNs to take specialist VAT and legal advice, which has confirmed the risk and led to CCGs making provisions to mitigate the associated financial impact.

In a statement, NHS England says: 'We will shortly publish information alongside the forthcoming specification for the primary care network contract directed enhanced service, which we hope will provide reassurance and help general practices and commissioners consider whether and how any VAT costs might arise.'

While NHS England is aiming for 100% coverage of patients by July, GPs will not be forced to join PCNs. However, if they do not, they stand to lose out on current and potential future funding. The BMA backs the creation of PCNs, saying they offer new support and safeguards and handing collaboration control back to practices.

However, not all GPs are supportive. 'Good news for the prawn sandwich industry,' quipped one GP in response to the announcement.

A joke perhaps, but one that shows a fear of being diverted away from frontline care into endless meetings. But NHS England believes PCNs will free up GPs' time to allow them and their multidisciplinary teams to not only deliver more care, but also more effective care. Another GP believes the new staff will hit practices in the pocket – not only will PCNs have to find 30% of clinical pharmacists' salaries, but also NHS England has set pharmacists' pay below the going rate. There could be a further

cost pressure for PCNs as the clinical director funding – which is based on an average of all GPs' income – is lower than that of a GP partner.

GPs might grumble, but it seems unlikely that they will stand in the way of PCNs because they will want to access network funding. It will take time to get them up and running fully, but if the programme is successful, the NHS could create a responsive local service that manages demand before it reaches hospital. ○

"It's a way of channelling new money directly to general practice"
Beccy Baird, King's Fund
(pictured)



hfma professional lives

Events, people and support for finance practitioners

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People

Guidance removes doubt over asset life used to calculate depreciation

Technical

Every year, there seems to be one issue that dominates the preparation and audit of the annual accounts, writes *Debbie Paterson*.

This year, it is a clarification issued by RICS to its guidance for valuers, which was published in November and applied from mid-January.

IAS 16 requires that the residual value and the useful life of assets are reviewed at least at each financial year-end and, as most NHS bodies use the asset lives provided by their valuer, the impact of this clarification needs to be considered by all NHS bodies.

Where the useful asset lives are revised, they are accounted for as a change in estimate in accordance with IAS 8.

The revised guidance relates to paragraphs 11 and 12 of the RICS UK valuation practice guidance application (VPGA) 1.10. These paragraphs discuss whether, and under what circumstances, the useful life of an asset for the purpose of calculating depreciation can be longer than the physical or economic life for valuation purposes. The guidance, published in November, clarifies that this can only be the case when the impact on the overall levels of depreciation and the remaining useful life will be relatively small.

The guidance also discusses the impact of splitting assets into their component parts where different components have significantly different asset lives, which would have an impact on the asset life or valuation of the overall asset.

Some NHS bodies have been using different asset lives for the purposes of depreciation and valuations, resulting in a lower depreciation charge. While we do not know how many NHS bodies are affected by this, and to what extent, the impact of the clarification to the guidance has been raised at several HFMA committee meetings.

The *Conceptual framework for financial*



reporting discusses the fact that accounts are prepared using estimates and judgements. It identifies the two key characteristics of qualitative information as 'relevance' and 'faithful representation'. In relation to estimates such as valuations, in practical terms, this means that accountants should review assumptions, including for valuations and depreciation, against these characteristics.

One of the issues identified by the change in the valuation guidance is that the asset lives used for accounting and valuation purposes are not internally consistent, which makes it difficult to argue that they give a faithful representation of the asset base of the NHS body.

The role of management in relation to asset valuations is discussed in the association's draft briefing on the valuation and accounting issues relating to property, plant and equipment (see page 30).

NHS bodies need to discuss the clarified guidance with their valuers to understand the basis on which the asset lives for depreciation purposes have been calculated and whether

it still meets the requirements of the RICS guidance. Even bodies that are unaffected should expect to discuss this issue with their auditors. And they should review their valuation reports for internal consistency in respect of asset lives, but also in respect of the other assumptions that have been made.

For affected NHS bodies, it is likely that the reduction in asset lives will be made in-year either as a change in estimate or as the correction of an error. Where the impact is not material, the decision may be made to not make the adjustment and leave it on the schedule of unadjusted errors. Where there has been a valuation in the year, the impact needs to be worked through the accounts.

There is unlikely to be an impact on the closing valuation of property, plant and equipment in the statement of financial position and the impact on the net surplus/deficit may also be immaterial. The impact on reporting against the control total also needs to be considered.

Debbie Paterson is the HFMA's policy and technical manager

Technical review

The past month's key technical developments

Technical

- The Treasury is exploring a fiscally neutral **reform to the VAT refund scheme** for NHS bodies and central government to reduce the complexity of the current approach.

A policy paper will be published in the coming months. Section 41 of the *VAT Act 1994* allows NHS bodies to reclaim the VAT they have incurred on certain outsourced services. This was introduced to remove a disincentive to outsourcing, resulting from irrecoverable VAT costs. This is administered through a list of services eligible for VAT refunds. However this has led to disputes over interpretation and is viewed as complex and inefficient. The Treasury is exploring a change to allow refunds to NHS bodies on all goods/services purchased to support non-business activities. This would simplify the system but require an adjustment in departmental budgets to be fiscally neutral. The Treasury is currently gathering data to inform its proposals.



- commissioning groups and prescribed specialised services sets out a 'radically different approach' for 2019/20. **CQUIN** schemes for the new year are being reduced to 1.25% and there will be a maximum of five indicators for each CCG contract drawn from 11 areas of best practice – such as adherence to national antibiotic guidance and staff vaccinations. National indicators must be used where relevant. However, if insufficient relevant indicators are available, CCGs should offer local CQUIN indicators. <http://hfma.to/8x>



- The HFMA has issued an update on its briefing on accounting for leases in the run-up to the application of IFRS 16 *Leases*. The update reflects the recent Financial Reporting Advisory Board's November decision to defer implementation of the **leasing standard** for the public sector until April 2020. The delay reflects the recognition that IFRS 16 does not align with the European System of Accounts 2010 used to prepare the national accounts. The briefing says that further guidance from the Treasury on the implications for national budgets and accounts is due imminently. <http://hfma.to/8w>

- The HFMA has published a draft briefing looking at the accounting and valuation issues around **property, plant and equipment**. The briefing covers the initial and subsequent measurement of purchased assets and a table sets out the valuation basis for different types of asset and the circumstances in which the asset is being held. The briefing also covers frequency of valuations, modern equivalent asset valuations, the role of management and use of valuation experts. The briefing was published in draft format to be available to support practitioners over the year-end. However, a final version will provide more information on capitalisation of building projects and subsequent expenditure and accounting for depreciation (see page 29). Email debbie.paterson@hfma.org.uk to comment on the existing draft and on areas to be covered in the final document. <http://hfma.to/8y>



- New guidance from NHS England and NHS Improvement on the commissioning for quality and innovation schemes for both clinical

More people eligible for cochlear implants

Technical: NICE

NICE published six positive technology appraisals and two clinical guidelines in March, writes Gary Shield.

Cochlear implants for children and adults with severe to profound deafness (TA566) updates the previous guidance on cochlear implants. The guidance has been updated after a review of the criteria for defining severe to profound deafness and for assessing adequate benefit from acoustic hearing aids.

As a result, more people will be eligible for cochlear implants. Severe to profound deafness is now recognised as only hearing sounds louder than 80dB HL (decibels

hearing loss) at two or more frequencies without hearing aids.

A cochlear implant works by picking up sounds that are turned into electrical signals and are sent to the brain. This provides a sensation of hearing but does not restore hearing.

At the moment around 1,260 people in England receive cochlear implants each year. These updated recommendations could lead to a 70% increase in that number to 2,150 people, once a steady state is reached in 2024/25. The annual cost of implementing this guidance is predicted to be around £28.6m at year three.

Five other technologies were

recommended, including *Benralizumab for treating severe eosinophilic asthma* (TA565) and *Tisagenlecleucel for treating relapsed or refractory diffuse large B-cell lymphoma after two or more systemic therapies* (TA567).

On the guidelines front, neither guideline published *Intrapartum care for women with existing medical conditions or obstetric complications and their babies* (NG121) and the updated guideline *Lung cancer: diagnosis and management* are expected to lead to significant additional costs to implement.

Gary Shield is resource impact assessment manager at NICE

NHS in numbers

A closer look at the data behind NHS finance

Total spending

Technical

There are lots of questions about health spending in the NHS. Do we spend the right amount on mental health compared with acute services? What about primary care and community services? Do we get the balance right between treatment and prevention? And even within acute services, for example, should we be spending more or less on cancer compared with, say, cardiac services?

But there's a fundamental question. Are we spending the right amount of money on health in general? There is perhaps no objective right answer, so most people look at one key metric – how our spending compares with other European countries and health services across the globe.

The specific metric used is spending as a proportion of gross domestic product. And there are two things to understand before looking at the relative spending levels. First, are we comparing like with like? Is one country's definition of health spending, the same as another's and can this be identified from the national accounts? Second, gross domestic products can go up or down. So, if the total value of all a country's goods made and services provided in a year go down, health

spending as a proportion of GDP will increase – but no extra money has been spent on health.

According to the latest figures on the OECD website, in 2016 the UK spent 9.7% on health compared with an average across the 35 other OECD countries of 9%. While this puts it slightly behind the major European countries of Germany (11.3%) and France (11%) – and a long way behind the US (17.2%) – it is at the higher end of the pack.

Health spending as a proportion of GDP was famously highlighted in 2000 when then Labour prime minister Tony Blair pledged to bring the UK spend (6.3% at the time) in line with the average across the 14 other EU countries (8.5%) through increases in spending. Spending did rise significantly, taking UK spending to 8.8% by 2009, although this remained behind the EU14 average which had itself risen to 10.1%.

When comparing different countries, you also need to keep in mind that spending from all sources is included: government, out-of-pocket, insurance and charity-funded. Look out for Treasury references to UK public health spending, which, unlike the OECD figure, includes capital spending.

Comparing now with then is also difficult. Changes in OECD definitions in 2013 brought additional spending into scope. It wasn't new money – it was just newly counted. So, while UK health spending was falling as a proportion of GDP immediately prior to this, it leaped to around 9.9% as a result of the changes.

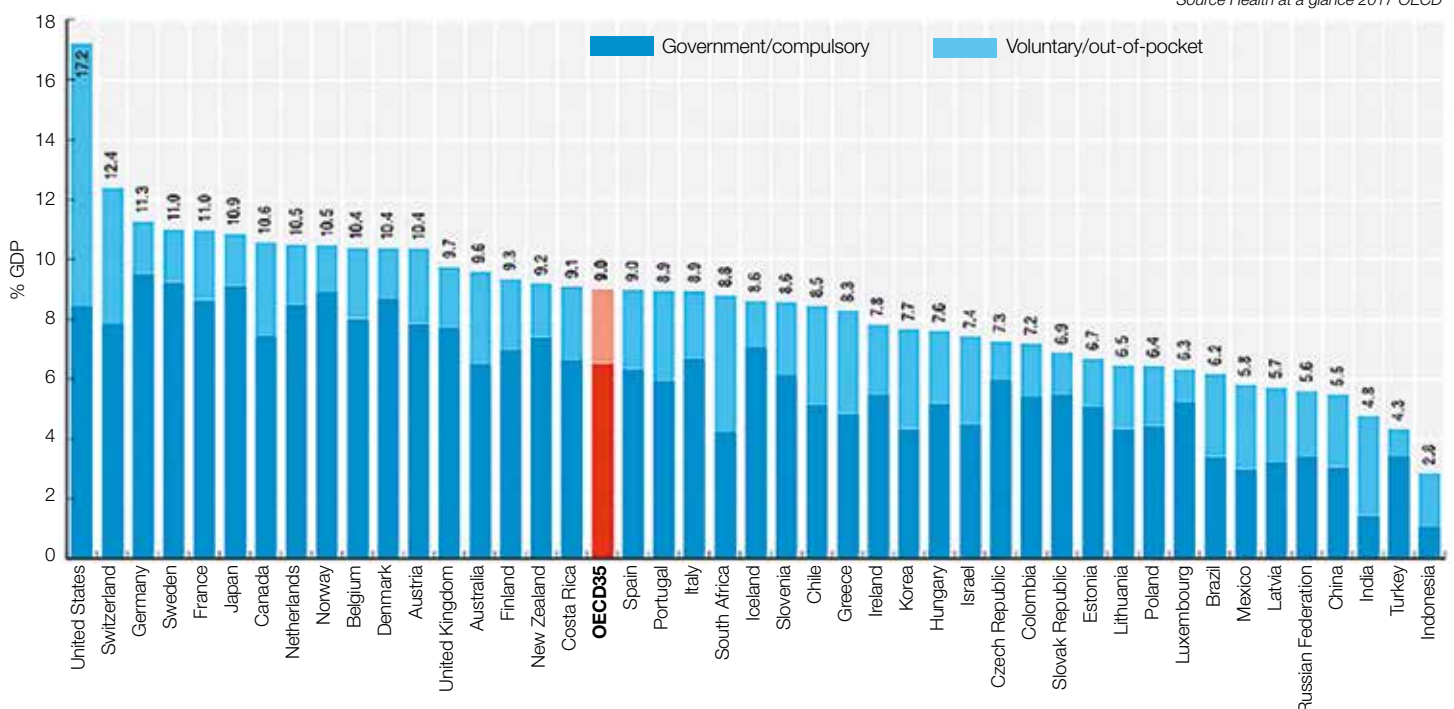
Spending only provides a partial view of whether a country is putting the right resources into health. You also need to look at outcomes. Low relative spending but better outcomes would not necessarily make a case for increased spending.

The Commonwealth Fund's regular *Mirror, mirror* comparison of 11 countries healthcare systems ranks the US last in access, equity, healthcare outcomes and next to last in administrative efficiency. The UK comes top in all areas other than outcomes, where it was ranked 10th in the 2017 report.

• Relative spending metrics were discussed in *Health + wealth, Healthcare Finance, June 2017* and is extensively covered in the HFMA's level 7 advanced certificate qualification (in the core *Making finance work in the NHS* and *Comparative healthcare systems* modules)

Health spending as a share of GDP (2016)

Source Health at a glance 2017 OECD



Apprenticeships – coming soon

Alison Myles, HFMA director of education

News and views from the HFMA Academy

Training

By the beginning of 2020, NHS bodies should be able to enrol staff on HFMA apprenticeships in accountancy funded through their apprenticeship levy, under plans currently being pursued by the HFMA Academy.

There is significant interest from NHS bodies in being able to use their apprenticeship levy funds, from their own digital accounts, to deliver finance training to existing finance staff, clinicians and others.

However, currently HFMA online qualifications – including the advanced (level 7) and intermediate (level 4) diplomas in healthcare business and finance – cannot be studied as part of an apprenticeship, which means that NHS bodies cannot draw on levy funding for these qualifications.

If this remains unused, NHS bodies could lose access to these funds at a time when staff development is so crucial to meeting the aspirations of the *NHS long-term plan* and to improving recruitment and retention across the health and care service.

There are two reasons for the current disconnect. First, the HFMA is not a training provider. And on top of this, 'healthcare business and finance' is not itself an occupation and so has no directly associated apprenticeship standard that sets out what the apprentice will do and the skills needed to carry out their role.

The association is addressing both these issues. The HFMA Academy has applied

to become a main training provider for apprenticeships. This means it would take the lead role in delivering training rather than simply being a subcontractor.

It has also looked to map the existing component parts of its existing qualifications to existing apprenticeship standards.

The initial focus has been on the level 4 accountancy technician standard. Delivery of an HFMA accountancy apprenticeship at this level would see the association work with a delivery partner. The technical accounting knowledge needed as part of the apprenticeship would be provided by following the syllabus of an existing level 4 qualification such as those provided by AAT, ACCA or CIMA.

In particular, the HFMA has had detailed discussions with ACCA.

Building the apprenticeship into something much more directly suited to the NHS, the HFMA will provide the specific health service context for the learning. The existing core module within the HFMA's intermediate diploma – *How finance works within the NHS*

"The HFMA Academy has applied to be a main training provider for apprenticeships – it would take the lead in delivering training rather than being a subcontractor"



– would be at the heart of this. But students would also study other HFMA components to understand specific details around NHS governance and costing and to learn about some of the different tools available to support decision making.

E-learning modules would also be used to provide learning in specific areas online.

The creation of new apprenticeship opportunities is a detailed and slow process. However, the association is working hard to meet members' demands in this area.

We should hear back about the association's application to become a training provider during April. And it is hoped that an HFMA level 4 accountancy apprenticeship could be available by the start of 2020.

The association is not stopping here. It is also looking at how its existing qualifications map to other apprenticeship standards, including the level 7 accountancy apprenticeship and those for operations manager (level 5), business administrator (level 3) and senior leader (level 7). It is also examining the potential for human resources and procurement apprenticeships in the longer term.

We will keep members and organisations updated about progress with HFMA apprenticeships, but if you have any questions in the meantime, please don't hesitate to get in touch at alison.myles@hfma.org.uk

Practical diversity event announced

Future focused finance

Future-Focused Finance (FFF) is holding an interactive diversity forum – *How you can make a difference* – on 9 July in central London, writes Grace Lovelady.

Feedback and outcomes from previous diversity events and meetings have shown that finance staff want to understand the practical things they can do when it comes to influencing change for diversity and inclusion. We are sure the vast majority of finance staff are aware of the concerns around diversity and inclusion in NHS

finance, but some are unsure what they can do for their team and organisation.

This event will focus on exploring practical and beneficial ways that you can start making a difference and influencing positive change. The agenda will include plenary sessions from diversity and inclusion experts and national leaders, plus a range of practical workshops.

FFF and the Finance Leadership Council encourage finance directors to allow staff members from all bands to attend this event, particularly those colleagues in lower banded

jobs who don't always get the opportunity to get out of the office. The event is aimed at all finance professionals and our target is to have one representative from each English NHS organisation in attendance.

The draft programme is available at the FFF website (hfma.to/8v), where you can book your free place to attend. For more on FFF's diversity and inclusion projects, visit www.futurefocusedfinance.nhs.uk or email futurefocusedfinance@nhs.net

• **Grace Lovelady is FFF programme manager**

Diary

April

- 10 **I** Institute: costing conference

May

- 9 **B** South Central and South-West: developing talent (with SDN), Reading
15 **N** Embracing digital technology, London
16 **F** Chair, Non-executive Director and Lay Member: forum, London
22 **F** Commissioning Finance: forum, London
22 **I** Institute: the value summit, London
22 **B** Eastern: positive psychology

June

- 5 **F** Provider Finance: forum, Rochester Row (am)
5 **F** Mental Health Finance: forum, Rochester Row (pm)
13 **B** West Midlands: annual conference, Birmingham
21 **B** Northern: keep stepping, Durham
27-28 **B** North-West: annual conference, Blackpool

July

- 4-5 **N** HFMA summer conference, Bristol

September

- 12 **B** South Central: annual conference
18 **I** Institute: introduction to costing, London
19-20 **B** Wales: conference

- 23-24 **N** CEO forum and dinner, London
25 **F** Provider/Commissioning Finance: technical forum, London
26-27 **B** South West: conference, Bristol

October

- 3 **I** Institute: international symposium
10 **F** Chair, Non-executive Director and Lay Member: forum, London
11-12 **B** Kent Surrey Sussex: conference
16 **N** Charitable funds, London
17 **N** Mental health finance conference, Rochester Row
18 **B** Eastern: conference, Newmarket
17 **I** Institute: costing together
24-25 **B** Scotland: conference
28 **I** Institute: technical costing update

November

- 7-8 **B** Northern: conference
14-15 **B** East Midlands: conference
14 **F** Commissioning Finance: forum
21-22 **B** Northern Ireland: conference

December

- 4-6 **N** HFMA annual conference, London

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



key **B** Branch **N** National **F** Faculty **I** Institute

Events in focus

Embracing digital technology 15 May, Rochester Row, London

Technological advances have always played a role in the NHS and their importance has been highlighted in the *NHS long-term plan*. The service is looking to ideas such as video appointments with clinicians, the use of artificial intelligence and new testing and treatment methods to improve patient experience, outcomes and efficiency.

This event, part of HFMA 2019 president Bill Gregory's theme *Value the opportunity*, is free to all HFMA members. Non-members can purchase a delegate pass for £99 plus VAT. It is aimed at chief information officers, finance directors and other senior finance staff, who will learn about the latest advances and be given the opportunity to debate their uses with peers.

Speakers include Kevin Jarrold, joint chief information officer at Chelsea and Westminster NHS Foundation Trust and Imperial Healthcare NHS Trust, who will examine the changes he has overseen as one of the global digital exemplar sites. Delegates will also hear from Paul Bate (pictured), managing director of remote clinical consultation provider Babylon Health.



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

HFMA summer conference 4 July, Ashton Gate stadium, Bristol

The HFMA annual summer conference is now in its 15th year and brings together its commissioning and provider finance network conferences. The event, *Connected thinking for the future*, will focus on integration, ill-health prevention and the use of technology in the health service. Integration is high on the agenda, reflecting the move to system working across the NHS.

The conference is aimed at senior finance professionals from acute, community and mental health providers, and commissioning organisations, as well as those from arm's-length bodies.



Speakers include King's Fund chief analyst Siva Anandaciva, Tim Kendall, national clinical director of mental health at NHS Improvement, and, from Public Health England, finance and commercial director Michael Brodie and Gregor Henderson

(pictured), national lead for wellbeing and mental health. NHS Digital finance director Pete Thomas will look at the role of digital technology in implementing the long-term plan.

• Members of the HFMA partner programme can receive discounted rates for this event.

To book your place at the conference, contact josie.baskerville@hfma.org.uk

Getting on with the job

Association view from Mark Knight, HFMA chief executive

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



SHUTTERSTOCK

My HFMA

The political shenanigans going on in our country over Brexit have been breathtaking. The shambolic behaviour of politicians has left citizens feeling bewildered and let down. Who knows where it will lead? Meanwhile, the NHS continues to treat millions of people every week, the most vital public service and one I'm proud to be associated with.

We ourselves are in the middle of a reorganisation and I hope we can continue the positive dialogue with the new regional NHS England/NHS Improvement appointees. One is HFMA board member Elizabeth O'Mahony, who moves from chief finance officer at NHS Improvement to become regional director for the South West. We wish her every success in her new role, as we do all the new appointees.

We also welcome Julian Kelly as NHS chief financial officer. We hope to meet him shortly to identify how the association can be of assistance – though I guess signing off this year's financial accounts for the NHS might be more pressing!

The HFMA is busy on a wide range of fronts. December and our annual conference may be a long way off, but we are already working on the

line-up for what I hope will be a fantastic event. We are negotiating with a few headline speakers and hope to be announcing some shortly.

We also have our popular summer conference in July, with Bristol providing this year's venue. I'm delighted that we have the new NHS chief financial officer down to speak, as well as a host of others. It should be a great event.

We've been doing a lot of work on our apprenticeship offering, which we hope will be available by the start of 2020 (see page 32). If anyone wants to have a preliminary discussion about that, please do not hesitate to contact me at chiefexec@hfma.org.uk.

Our initial focus has been on a level 4 accountancy apprenticeship. We are looking to offer a programme tailored to the NHS environment, but fully portable. Our main



HFMA chief executive
Mark Knight

level 7 qualification continues to do well, with many students now having taken it or actively studying. We feel we have a very strong offering and the feedback is very good.

I'm also delighted that we have a small group who are now going through the MBA stage of the qualification with BPP University.

A real honour for me this past month was to attend and take part in the annual branches conference. This is an annual event where our local branch volunteers come together to discuss important matters within the organisation and provide us with feedback. It's at times like this that I realise just how much members love the HFMA and how much they want it to succeed – not just at their branch level, but also nationally.

We heard from a wide variety of people associated with the HFMA about our current strategy and what resources were available to branches. And we fielded questions about our present and future strategies.

As chief executive, I'm so grateful for all the work our volunteers do. Without it we simply could not function. Our members are why we are here. We may not have the power of the politicians, but we are getting on with the job.

Member news

● Barbara Gregory is the newly appointed chair of the HFMA Chair, Non-executive Director and Lay Member Faculty. She's an experienced professional who joined the NHS in 1993 as chief finance officer at the Royal Devon and Exeter NHS Trust. Since then she has worked in a variety of positions across the sector. She takes over from Phil Taylor, who stepped down as chair of the faculty after three years in the post.

● The HFMA Eastern Branch held an accounting standards update event and a VAT update at the beginning of March. The two events took

place on the same day – the first provided delegates with a comprehensive update on the current key accounting issues for NHS bodies. The second gave an insight into VAT issues in the NHS at a strategic level, including the *Making tax digital* programme. The day was designed so that delegates could attend the two events – and participants gave both excellent feedback.

● To mark International Women's Day, the HFMA celebrated diversity in the NHS finance function. The association published interviews of some of the female leaders shortlisted for the Finance Director of the Year Award 2018. For the first



time in the history of the HFMA awards, all shortlisted entries for the award were women. To watch the video interviews where Kathy Roe (pictured) and Sandra Easton talk about how we benefit from diversity in the finance function, go to <http://hfma.to/8march>. You can also visit <http://hfma.to/8u> to read the interview with Suzanne Robinson, who shares her childhood dream.

hfma

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

Wales

The *NHS long-term plan* focuses on integrating health and social care services in England. But how is integration progressing in Wales? What can be learnt from experience there, particularly in commissioning?

Wales operates differently to the English system. In 2009, it abolished the provider commissioner split and reduced the number of health boards to seven. From a social services perspective, there are 22 local authorities. And Wales committed to sustainability through legislation, which was commended by the UN as a world first in line with sustainable development goals.

'Wales and England are looking at ways to integrate health and social care services by adopting a population health approach and focusing on prevention,' says Chris Moreton (pictured), head of finance – national commissioning frameworks at NHS Wales.

Mr Moreton has been in post since February, having moved from Deloitte in London. A former HFMA London Branch committee member, he has joined the Welsh counterpart. 'I was introduced to colleagues working in NHS finance before I even moved across to Wales. It was brilliant to be able to establish a network so quickly,' he says.

A key difference he has



found since moving to Wales is collaborative commissioning at a national level. Mr Moreton works at the National Collaborative Commissioning Unit, which has worked with the Shared Services Partnership to implement a commercial framework for mental health and learning disabilities in hospitals and care homes.

'There is no requirement to use the framework but the benefits to health boards and local authorities are: pricing transparency, improved service quality through care standards and a legally compliant, good practice procurement route,' says Mr Moreton.

The branch is preparing for its annual conference on 19-20 September. 'The focus will be on how we are delivering value for *A healthier Wales* in line with government plans for health and social care, covering mental and physical health,' he says.

'There is a real opportunity for finance to drive the value agenda by supporting evidence-based decision-making and transformational change to more affordable and sustainable services.'

To find out more about the branch visit <http://hfma.to/wales>

branch
contacts

Eastern kate.tolworthy@hfma.org.uk

East Midlands joanne.kinsey1@nhs.net

Kent, Surrey and Sussex stuartwayment@nhs.net

London katie.fenlon@hfma.org.uk

Northern Ireland kim.ferguson@northerntrust.hscni.net

Northern catherine.grant2@nhs.net

North West hazel.mclellan@hfma.org.uk

Scotland alasdair.pinkerton@nhs.net

South West laura.ffrench@hfma.org.uk

South Central katie.fenlon@hfma.org.uk

Wales georgia.purnell@hfma.org.uk

West Midlands fleur.sylvester@hfma.org.uk

Yorkshire and Humber laura.hill@hdfnhs.uk

Appointments

● **Loretta Outhwaite** (pictured) has been named interim chief executive of the Institute of Healthcare Management. She has over 30 years' experience working in healthcare finance and management, most recently as chief finance officer and deputy chief officer at Isle of Wight Clinical Commissioning Group. Ms Outhwaite is also currently a tutor for the HFMA Academy and an NHS Future-Focused Finance value maker.



● **Lorraine Hooper** has become director of finance, performance and estates at North Staffordshire Combined Healthcare NHS Trust. She was previously deputy chief financial officer at Sherwood Forest Hospitals NHS Foundation Trust. Ms Hooper started in the NHS in 2004 and has held a number of roles, including supporting services in acute hospitals in Birmingham and head of financial management and planning at University Hospitals of Leicester. She is taking over from **Suzanne Robinson**, chair of HFMA's Mental Health Finance Faculty, who is now director of finance at Pennine Care NHS Foundation Trust.

● **Geoff Brian Dzeamesi** has been named Quality, Innovation, Productivity and Prevention (QIPP) programme management office manager at Bexley, Greenwich, Lewisham Clinical Commissioning Group. After studying in both Ghana and the UK, Mr Dzeamesi first joined the NHS in 2007 as financial accountant at Haringey Primary Care Trust and was most recently accountant – financial management and CCG assurance at NHS England.

● University Hospitals Coventry and Warwickshire NHS Trust have appointed **Antony Hobbs** director of operational finance. Mr Hobbs was acting up in the position for the past year, having previously spent eight years as associate director of finance at the organisation. He took over from **Su Rollason** who was appointed into the chief finance officer in July 2018.

● **Sarah Brampton** (pictured) has been appointed director of finance at University Hospitals Plymouth NHS Trust, where she previously served as director of financial services and deputy director of finance. She left in March 2013 to take up the post of director of finance at Devon Partnership NHS Trust and was later appointed deputy chief executive there in 2016. Ms Brampton has more than 20 years' healthcare experience and has worked within all sectors of the NHS, including acute, mental health and commissioning. She will be University Hospital Plymouth's first female director of finance. **Phillip Mantay**, Devon Partnership NHS Trust's director of transformation, is now acting director of finance at the organisation.



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**"In my first year I want to make sure
our A&Es are working well, patients
aren't waiting too long, and staff feel
good about working here"**

**Caroline Clarke, Royal Free London
NHS Foundation Trust**



Clarke takes over top job at the Royal Free

**On the
move**

Caroline Clarke has been appointed group chief executive of the Royal Free London NHS Foundation

Trust, the provider where she started her career as a finance trainee in 1991.

After returning to the Royal Free in 2011 as chief finance officer, helping it gain foundation status, she was named HFMA Finance Director of the Year in 2012. She became the trust's deputy chief executive in the same year.

'I am delighted,' she says of her promotion. 'I trained at the Royal Free and always had an emotional connection to it.'

Her predecessor, David Sloman, who is now NHS London regional director, helped her see the trust's potential, underpinned by its strong clinical leadership and academic capability through links with University College London.

'I was brought back to the trust to help lead it to foundation status and was really taken with what the organisation was trying to do. It has a brilliant, massively ambitious board that's global in its aspirations,' she says.

Ms Clarke's interest in how systems and relationships affect the delivery of care has increased. 'I have to make things happen and will still concentrate on rational information, but I also want to know how it feels to be a patient or member of staff here and bring to people that sense of hope and optimism.'

She knows difficult decisions lie ahead. 'The NHS is never going to have enough money, so we should just accept that we need to make

our cost base as efficient as possible. I am fairly pragmatic about that. The trust has a big underlying deficit, so we have to make difficult decisions in our system to address that. We also have a number of operational challenges, the biggest of which is having enough staff.'

Staffing issues were highlighted in the long-term plan, but trusts are also experiencing workforce difficulties now. 'We have a workforce that's delivering fantastic care, but we haven't got enough of the right staff in the right place.'

The use of new technologies, and digital capabilities, will also affect staffing needs. 'We need to take advantage of the data and use it to deliver care in different ways, but it means we will need a workforce able to do that.'

The trust is one of a small number that has moved to a group model – the trust includes Barnet Hospital, Chase Farm Hospital and the Royal Free, while North Middlesex University Hospital NHS Trust became the group's first clinical partner in 2017, and West Hertfordshire NHS Trust joined last year.

The group model provides economies of

scale and can help with analysis of the new data. 'If you operate at this scale, with this level of infrastructure, it allows you to do the work on data. For example, we have invested in sophisticated software – a population health management system – that allows clinicians to provide the best possible care.'

The group also offers the opportunity to give staff wider career opportunities and different working environments – from a leading teaching hospital, to a busy district general, to a newly built unit pioneering new technology to improve patient care. Ms Clarke is hopeful this will help the trust's recruitment and retention.

'In my first year I want to make sure our A&Es are working well, patients aren't waiting too long, and staff feel good about working here. Then we'll come back to harnessing the benefits of the group model. I am sold on provider collaboration – most providers are sub-scale for what we call back- and middle-office services.'

She joins the ranks of finance directors who have become chief executives. 'I've had a great response from the finance community. I have good role models, such as Suzanne Tracey, Jane Tomkinson, Sue Jacques and Andy Hardy, who have all given me great advice.'

She also becomes HFMA president in December. 'I thought long and hard about whether I would have enough time, but I have a supportive board and a fantastic team here, so I am really excited and looking forward to my year as president.'

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