healthcare finance

June 2019 | Healthcare Financial Management Association

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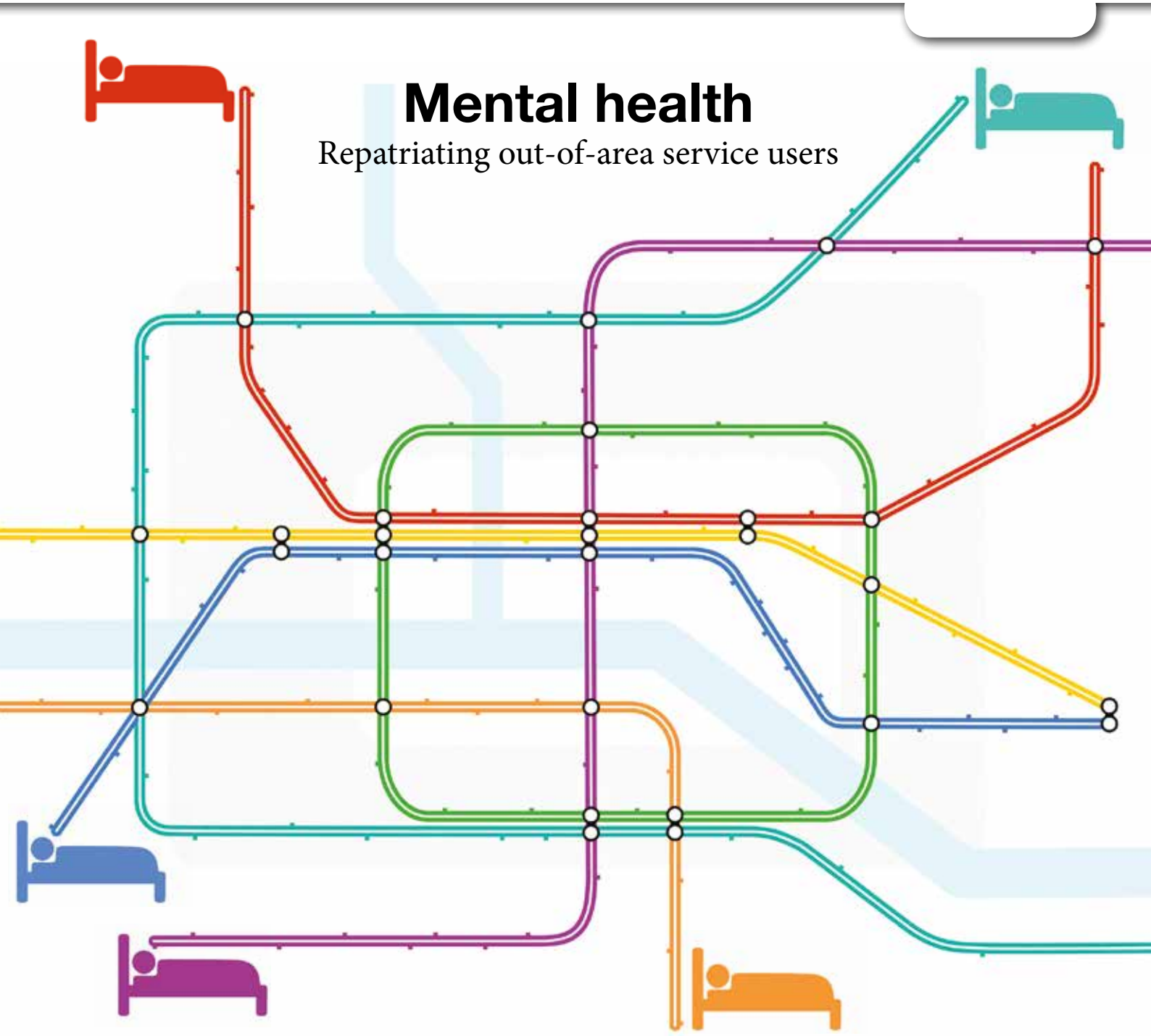

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- **Siva Anandaciva**, Chief Analyst, The King's Fund
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- **Alastair Campbell**, Author, British journalist, former political aide to Tony Blair and Time to Change Ambassador

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WHO NEEDS TO MAKE BIG CIP SAVINGS?
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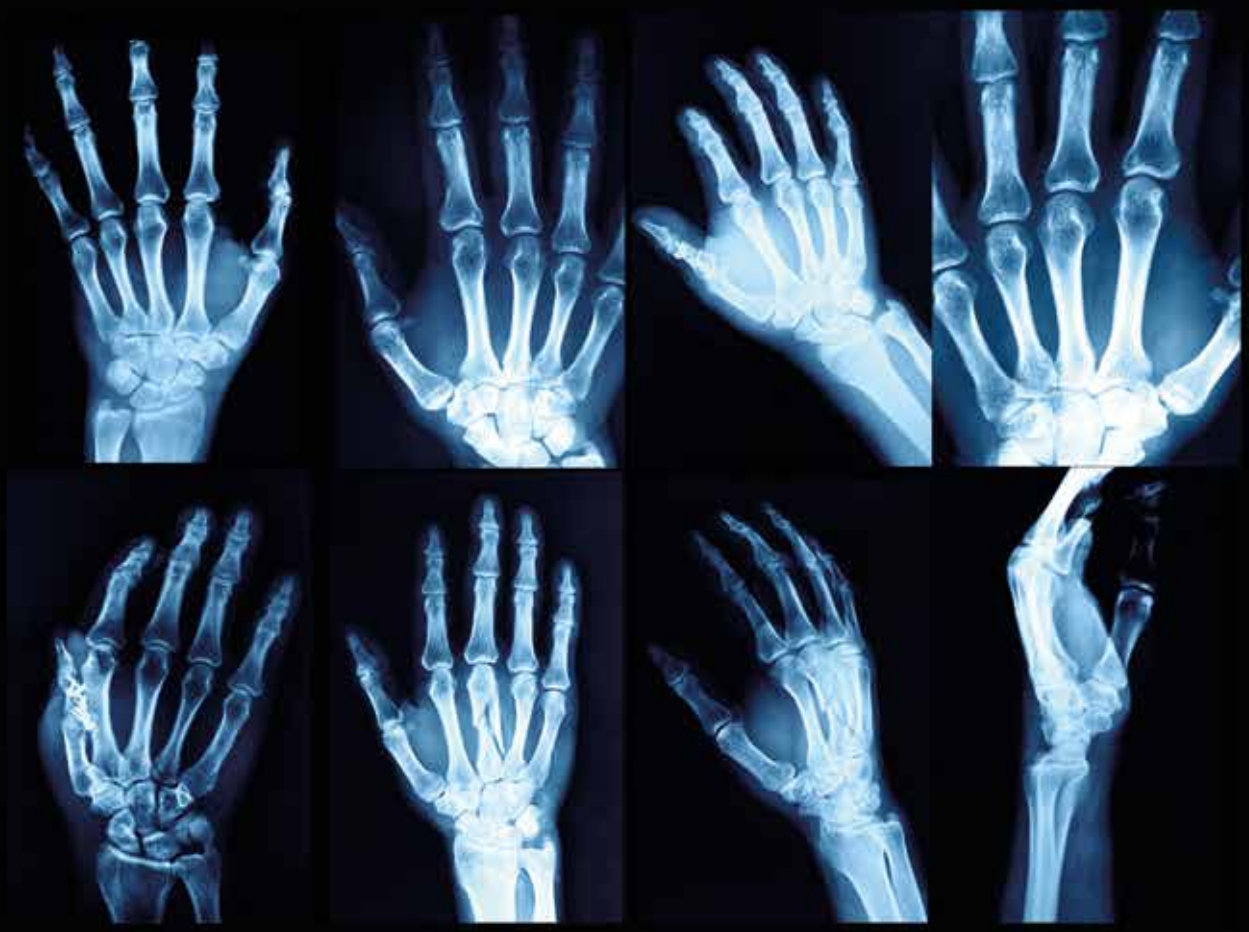

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News

Trusts call for short-term solution to capital problem

By Seamus Ward

NHS Providers has called for a 'quick, short-term solution' to the shortage of capital funds after trusts were told to revise their 2019/20 capital spending plans downwards.

In May, NHS England and NHS Improvement chief financial officer Julian Kelly (pictured) said initial planned expenditure was greater than the Department of Health and Social Care's capital spending limit. He wrote to providers warning that this 'would lead to the NHS unacceptably breaching its capital spending limit'.

NHS Providers chief executive Chris Hopson told *Healthcare Finance* that the capital funding gap was compounded by a mismatch between areas of likely need and those where funding was available – prior-year deficits will limit the funds that trusts have available for capital investment, for example.

Backlog maintenance was now at almost £6bn, which must be dealt with. But trusts also needed capital to address patient and quality concerns and invest in new services and facilities to meet demand and *NHS long-term plan* commitments.

Immediate action was needed for 2019/20. 'We'll need a quick, short-term, solution to this issue alongside the longer-term work required,' said Mr Hopson. 'It's vital that any solution is fully co-designed with providers and is not imposed on trusts from above. We are talking to NHS England and NHS Improvement about the best way of achieving this. But we all need to recognise this is a significant problem that has been building for several years and is now coming to a head.'

He continued: 'Trusts need three things: the government needs to set the right capital limits; make the right amount of actual funding available; and ensure a clear, transparent, rapid and easy-to-use system for accessing, prioritising and approving capital expenditure. Trusts tell us that all three aren't right at the moment and that they need more help and support, particularly in the forthcoming spending review.'

Mr Kelly said NHS England and NHS Improvement wanted to avoid imposing a top-down restriction on capital plans. Instead, there would be a 'more planned, proactive and collaborative approach' to spending on capital.

As a first step, providers were asked to work with their regional teams to review their plans, which were resubmitted by mid-May.

He insisted the new plans should include only 'absolutely urgent and critical expenditure', and trusts should consider deferring projects.

Although he hoped the reviews would significantly close the gap, he acknowledged that it was so large that further work would be likely. If that is the case, he would consult with providers before potentially asking them to work together across sustainability and transformation partnerships to prioritise the most urgent local schemes.

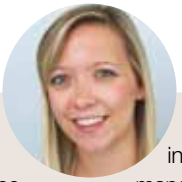
'We need this approach to work, and at rapid pace. If necessary, further information on this will be set out in due course. We will also consider whether, on the basis of your revised capital plans, further short-term in-year control measures are necessary,' Mr Kelly said.

Trusts should not begin spending on capital schemes until the process is completed, and funding is secured or a business case approved.

NHS England and NHS Improvement will work with trusts and other stakeholders over the coming months to develop a long-term capital and cash support regime.

• An HFMA briefing, *NHS capital: a system in distress*, last year called for a new capital system to be open and transparent, supported by clear guidance. Greater understanding of the different responsibilities and duties given to each organisation would support collaboration, it said. See www.hfma.org.uk/publications/

NHS objectives outlined



The government has set NHS England and NHS Improvement two high-level objectives for 2019/20 – supporting the *NHS long-term plan*, including returning to financial balance, and helping manage the impact of European Union exit.

The objectives are set in the 2019/20 accountability framework, published as a joint document for the first time.

After the current transitional year, a four-year framework, informed by the forthcoming health service long-term plan implementation programme and workforce plan, will be issued.

In 2019/20 the NHS will be measured against the five financial tests in the long-term plan – returning to financial balance; achieving annual cash-releasing productivity growth of at least 1.1%; reducing demand growth through integration and prevention; cutting variation; and using capital to drive transformation.

The framework, which includes the NHS England mandate and financial directions, said current financial pressures must be the first call for funds. More than half of trusts are expected to be in financial balance by the end of 2019/20. The national bodies must also increase spending in primary, mental health and community health services as a share of total revenue.

NHS England and NHS Improvement must help mitigate any adverse impact of EU exit and make a success of opportunities that emerge.

NHS Providers head of policy Amber Jabbal (pictured) said: 'Government will continue to play a central role in ensuring the NHS is well equipped to deliver the aspirations in the long-term plan. This includes ensuring we see sufficient funding for adult social care, capital, public health, and education and training, on which much of the plan is dependent.'

Value summit: focus on variation essential but change will take time

By Steve Brown

The elimination of unwarranted variation in clinical processes will take time, collaboration between clinical, finance and operational staff and support from technology, Royal Free London NHS Foundation Trust group chief executive Caroline Clarke (pictured, facing page) told May's value summit.

The summit – organised by the Healthcare Costing for Value Institute and Future-Focused Finance – brought together clinicians and finance professionals to discuss the move to value-based healthcare.

Ms Clarke – current vice-president of the HFMA – joined Royal Free colleagues to describe a major redesign programme that aims to standardise best practice across the trust's pathways and then use technology to sustain delivery.

She told the conference that it was vital to get everyone focused on variation and that clinical leadership aligned with financial leadership was essential. 'But this takes time,' she said. 'It has been a massive organisational change and we have totally changed the way we run the organisation. It is not an easy gig, but it is [a journey] that I think we all need to go on.'

Built on work at the US InterMountain Healthcare System, the London trust has created clinical practice groups (CPGs) to develop consistent patient pathways across all three hospitals in the group. Using quality improvement techniques, the CPGs have mapped out existing and preferred patient journeys, initially starting with 20 pathways for high-volume conditions.

Underpinned by its Cerner electronic patient record, the trust is digitising these pathways to

EVO: building confidence in data

The Healthcare Costing for Value Institute and Future-Focused Finance have teamed up to develop a new service for provider trusts. Trusts signing up to the new EVO (Engagement Value Outcome) framework will be supported to improve their understanding and use of patient-level information and costing system (PLICS) data.

Working with three specialties/services at each trust, EVO will bring together key staff from different disciplines who would benefit from using the patient-level data. Building on existing quality improvement work – for example, using *Getting it right first time* or Model Hospital data – the programme will help participants to interpret data and explore opportunities to reduce unwarranted variation.

The EVO framework aims to provide each participating trust with the necessary tools for self-implementation so that it can roll out the learning across further service lines.

The framework is currently being piloted at four providers, covering the acute, mental health and community sectors. Following an external review of the scheme, EVO will be formally launched in 2020. For more details contact **EVO@hfma.org.uk** or see the website **http://hfma.to/9g**

Integration requires strong local accountability

It is vital that trusts maintain strong local governance as the NHS moves to more integrated health and care delivery, according to NHS Providers.

In an update of its 2015 briefing, *We need to talk about boards*, the provider organisation seeks to reflect the changing landscape within which trusts are operating.

According to the updated briefing, provider boards, working closely with local partners, will play a key role in delivering the ambitions of the *NHS long-term plan*.

It said leadership and strong local accountability would be critical in managing risk and delivering high-quality care.

Miriam Deakin (pictured), NHS Providers' director of policy and strategy, said: 'The delivery of high-quality healthcare involves a degree of risk, which is why good governance is vital in health and care, as in many other safety-critical industries.'

Understandably, the move to joined-up working can throw up unanswered questions for trust boards, such as whether system-based decision-making would be a better fit. But, she added, the best solution for trusts was to have a unitary board made up of executive and non-executive directors that was geared up to collaborate with neighbouring organisations.

'Collaboration between the different organisations in local health and care systems offers the potential to help integrate services for local populations, and make best use of limited, collective resources,' Ms Deakin said.

'But this does not dilute the value of good governance and accountability in individual organisations.

'For trusts, that means a strong unitary board able to look outwards and work with others, whilst maintaining a core focus on the quality of care for patients and service users.'

The HFMA has looked at the impact of the long-term plan on finance teams. Its briefing, *What does the NHS long-term plan mean for the finance function?*, examines each area of the plan, such as the new service model; maximising taxpayer investment; action on prevention and inequalities; and improvements in care quality and outcomes.

support clinical practice and ensure that preferred processes are maintained into the future.

There are high-level expectations that each pathway will deliver 6% cumulative savings (2% a year over three years), leading to a possible £20m savings.

In a further example of pathway change, clinicians and managers from Alder Hey Children's NHS Foundation Trust described its evidence-based approach to revising the bronchiolitis pathway that reduced length of stay for babies from 4.5 days to 2.9 days.

This involved a major education programme to reinforce a pathway that didn't use treatments where evidence showed no value, minimised unnecessary tests and prioritised earlier safe discharge.

The systematic review involved nurses, doctors and patients. However, the trust warned that, having improved the pathway, resources are needed to ensure it continues to be followed.

Muir Gray, founding director of the Oxford Centre for Triple Value Healthcare, called for a much greater focus on population value – how resources are being invested to optimise outcomes for a given population.

The government has promised to increase GP numbers by 5,000. But Sir Muir suggested the increase in laboratory testing in recent years was consuming additional time to review these tests, equivalent to nearly as many whole-time GPs. Was this really how the NHS would have planned to use this resource?

He said there must be much greater focus on how resources were allocated, with a value framework for different population groups that specified the outcomes that mattered to patients and populations and the resources available.

Public health pay rises: funding agreed

Rises in pay for public health workers will be funded from national budgets and not by NHS providers, the Department of Health and Social Care has announced.

When the new Agenda for Change deal was announced last year, the government promised it would be fully funded. NHS employers were given funds directly last year to cover the additional costs, but this year it has been incorporated into the tariff.

But it was unclear how Agenda for Change rises would be funded for staff who provide public health services that are commissioned by local authorities, such as health visitors and school nurses.

NHS England and the Department of Health and Social Care disputed who should pay, with the possibility it could fall to NHS employers if no agreement was reached.

The total cost of funding the pay rises is £50m, but the Department

and NHS England and NHS Improvement have moved to ensure that employers would not be out of pocket in 2019/20.

The £50m cost will be divided between the NHS budget – overseen by NHS England – and the Department, with the former paying the most.

A Department spokesperson said: 'As we, NHS England and NHS Improvement have communicated to the healthcare system, we have agreed that the costs of the Agenda for Change deal for eligible NHS providers delivering public health services will be covered by the NHS budget.

'The pay uplift for staff in eligible non-NHS providers will be covered by our budget.'

Ministers strike deal to resolve cross-border row

By Seamus Ward

Referrals of patients from North Wales to the Countess of Chester NHS Foundation Trust (pictured) have resumed after ministers in Cardiff and London reached an agreement to fund the activity.

The trust said in April it would no longer provide elective care for new Welsh patients as it was unable to agree funding with Betsi Cadwaladr University Health Board. The trust continued to take some patients, including maternity cases, patients waiting for treatment and those attending A&E.

The health board said the issue was over changes in the structure of the tariff system for 2019/20, making the care provided unaffordable. The tariff has risen, partly to cover the cost of the new Agenda for Change deal, which was funded through a separate funding stream in 2018/19.

It is understood the Department of Health and Social Care will provide funding to close the gap in 2019/20, with the Welsh government covering the cost in future years.

Welsh health and social services minister Vaughan Gething remained disappointed at the trust's actions, which he said were taken while negotiations were ongoing. However, he hoped such disputes would be avoided in the future through closer Welsh involvement in tariff setting.

He said: 'What is evident is that changes introduced to the tariff costs in England since 2017 have created a complex set of issues in relation to cross-border arrangements.

'Wales will now have a seat on [England's] tariff advisory group. We need to fully track policy developments in England that will potentially have an impact on the tariff in future to aid planning in the Welsh context.'

Countess of Chester chief executive Susan Gilby insisted that the trust was unaware of national negotiations on the matter when it took the decision on new referrals.

'We were clearly informed that there were no ongoing negotiations to address the issue of contracting for cross-border secondary (as opposed to tertiary) care prior to our decision. Nor are there any existing protocols which would mandate that we continue to accept underfunded elective referrals at the expense of investments in patient safety.

'Our focus remains the delivery of high-quality services to the population we serve.'

News review

Seamus Ward assesses the past month in healthcare finance

With council elections in England and Northern Ireland at the start of the month and the European Parliament poll at the end, not to mention two bank holidays, May was a relatively quiet month. However, there was still some notable news from across the UK.

The Scottish Parliament passed a safe staffing law covering health and social care. The Scottish government said the law would lead to better outcomes for patients and clients and 'embed openness in decisions about staffing across clinical staff groups'. Health secretary Jeane Freeman said the legislation was about putting 'the right skills in the right place at the right time'. New workforce planning tools will be used to calculate the recommended number of nurses and midwives for the workload.

The NHS in Scotland will also introduce measures to improve workplace culture after a report on allegations of bullying and harassment at NHS Highland. The measures include installing a whistleblowing champion in each health board by the end of 2019. Ms Freeman will write to each board asking them to reflect on the report findings and will hold a summit in the summer to consider how to improve workplace practice. She also launched a consultation on legislation to make the Scottish public service ombudsman the independent whistleblowing officer for the NHS.

Although Northern Ireland has been without a power-sharing executive since January 2017, talks between the political parties on restoring the executive have resumed. In the absence of a health minister, senior civil servants are constrained in what they can do, but they continue to act where they can under a broad consensus on service transformation.

Department of Health permanent secretary Richard Pengelly (pictured) said the transformation programme, *Delivering together,* has made significant progress, but further reshaping of services is the long-term answer to long waiting lists.

Work has started on a new 10-year cancer strategy for Northern Ireland. Chief nursing officer Charlotte McArdle, who is leading the work, said it was imperative that a strategy for 2020 to 2030 be developed. Between 2009 and 2013 an average of 4,347 male and 4,175 female cases of cancer were diagnosed each year but this is expected to rise by 43% for men and 40% for women by 2026.

The justice system in Northern Ireland is increasingly being used as the service of last resort for people with mental health problems, according to the Northern Ireland Audit Office. Its report, *Mental health in the criminal justice system*, said funding of mental healthcare had not kept pace with demand and individuals can struggle to access the care they need. It added that the Police Service of Northern Ireland receives more than 20,000 reports a year of incidents involving people experiencing mental health crises but where a crime has not necessarily been committed.

Welsh health and social services minister Vaughan Gething announced funding of almost £15m for the transformation of health and social care in the Swansea Bay area. He said the money would come from the government's £100m transformation fund, which was created to support implementation of the local NHS long-term plan, *A healthier Wales.* The funding will be split between two projects – £8.8m for a pilot of a whole-system model and £5.9m to bring services together so that patients experience seamless care.

The month in quotes

'Being open about decisions on staffing allows health boards to allocate staff efficiently and effectively. I want staff to feel informed about decisions relating to staffing requirements and safe to raise any concerns about staffing levels.'

Scotland's new safe staffing law gives staff a chance to speak up, says Scottish health secretary Jeane Freeman

'[This] report charts significant progress in the two and a half years since the publication of *Delivering together*, the 10-year roadmap for transforming the way services are delivered. Without this push for change, the system would now be slipping over the edge into irreversible collapse.'

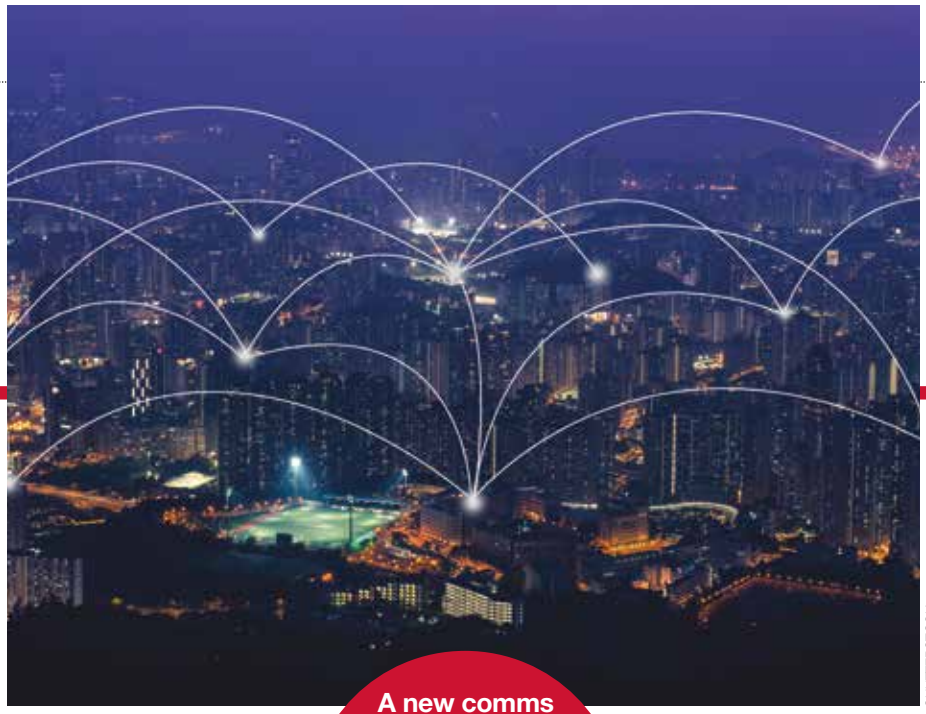
NI Department of Health permanent secretary Richard Pengelly on the local transformation of health and care services

'Older people deserve the best possible support and with many care home residents living with complex conditions, bringing in extra expert health advice will mean the NHS can reduce avoidable drug use, improve care and free up vital funding for better treatment.'

Placing specialist staff in care homes makes sense for everyone, says Alistair Burns, NHS England national clinical director for dementia and older people's mental health

'The success of the emergency services network is critical to the day-to-day operations of our emergency services that keep us all safe. The Home Office needs a comprehensive plan with a realistic timetable that properly considers risks and uncertainties. It has already been through one costly reset and is in danger of needing another unless it gets its house in order.'

National Audit Office head Amyas Morse issues a call to action on the new emergency communication network



SHUTTERSTOCK

A new comms network for ambulance, police and fire services in England, Scotland and Wales is set to cost £3bn more than planned

A new communications network for ambulance, police and fire services in England, Scotland and Wales is set to cost £3bn more than planned, the National Audit Office said. A critical report, *Progress delivering the emergency services network*, said the Home Office – the government department overseeing the project – now forecasts the new network will cost £9.3bn following delays and cost rises during implementation. The audit body warned the new forecast costs are uncertain and the network is unlikely to be ready for 2022. It said £1.4bn of the extra costs are due to the need to extend the use of the Airwave system. It is now due to be switched off in December 2022, three years later than planned.

MPs have insisted that the Department of Health and Social Care, NHS England and Public Health England must do more to ensure patients take part in health screening. A report from the Commons Public Accounts Committee – which looked at four of the 11 national screening programmes – bowel, breast and cervical cancers and abdominal aortic aneurism – said the government is 'losing grip' on screening. There was wide variation across England in the proportion of eligible patients who are being screened, it added.

Monthly operational performance figures continued to show a service under pressure. The proportion of A&E attendances transferred, admitted or discharged within four hours fell in April, with NHS England figures showing 85.1% of patients were seen within the target four hours. In March, it was 86.6%. However, the April figure was a 2.5 percentage point increase on April 2018 – despite a 6.6% increase in attendances over the 12 months. There was a slight drop in waiting list performance. In February this year 87% had been waiting fewer than 18 weeks, but this fell to 86.7% in March, failing to meet the 92% target in both cases. The number of completed referral to treatment pathways increased by two percentage points compared with March 2018.

The NHS continues to try to bear down on the pressures on hospitals and in May NHS England launched the roll-out of a programme to avoid unnecessary hospital admissions. Under a scheme that has been trialled in integrated care systems, clinicians, including 200 pharmacists and pharmacy technicians, will work in care homes to help avoid unnecessary admissions to hospital. NHS England said they would also improve residents' quality of life and reduce over-medication. Elderly care home residents account for around two million days in hospital each year and 250,000 emergency admissions. It is believed 35% to 40% of those admissions are avoidable through actions such as preventing over-medication, NHS England said. Studies have linked 10% of admissions of elderly people to medicines they have taken, it added.

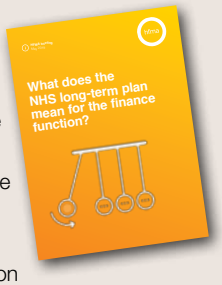
The multiple sclerosis (MS) drug ocrelizumab will be available on the NHS following a deal agreed between NHS England and pharmaceutical company Roche. The national commissioning body said the drug is given to patients with primary progressive MS every six months and costs around £190,000 per patient per year at the normal price. However, it added the commercial in confidence deal ensured that cost effectiveness estimates for the drug would fall in the range NICE considers an acceptable use of NHS resources.

from the hfma

HFMA Commissioning Finance Faculty chair David Chandler (pictured) argues that finance staff need a greater

understanding of NHS continuing healthcare (CHC). In a blog for the HFMA website, he says that for clinical commissioning group finance staff, CHC can represent an ever-growing overspend or pressure in the accounts. However, they can play a key role in ensuring continuing healthcare is delivered to the most vulnerable and that rules are applied consistently.

The HFMA aims to support finance staff and help them get to grips with CHC – a 'how it works' guide is now available, explaining the basics, eligibility criteria and organisational responsibilities; and the faculty also held a technical forum on the subject during May.



Another new HFMA briefing focuses on the implications of the *NHS long-term plan* for the finance function. In a blog outlining the key themes, association policy and research manager Sarah Day says the plan means new ways of working, the development of new skills and the need to build relationships across organisations that may traditionally have been viewed as competitors. Finance staff will be closely involved in delivering quality improvements and more efficient use of resources – using their skills to support the wider system and identify improvement opportunities, she adds.

For more, see www.hfma.org.uk/news/blogs

News analysis

Headline issues in the spotlight

Fit for practice?

A new study on GP numbers shows a service on a knife edge, but measures are in train to make primary care sustainable. Seamus Ward reports

Workforce shortages are felt throughout the NHS, affecting the quality and scope of services to patients as well as finances. For years, there has been concern about GP numbers, with claims of an impending cataclysm due to early retirement, though these were sometimes based on anecdotal evidence. However, a recent study suggests that the GP workforce could have reached a tipping point.

According to the research – by the Nuffield Trust for the BBC – the number of GPs in the UK relative to the size of the population has fallen in a sustained way for the first time since the 1960s. In absolute terms, the number of GPs (excluding locums, registrars and retainers) across the UK fell from around 43,600 in 2014 to 42,100 in 2018. The number of registered patients over that same time period increased from 67.2 million to 70.1 million.

The proportion of GPs across the UK has been rising steadily since 1970, when it stood at 42 per 100,000 population. It reached a peak in 2009 (67 GPs per 100,000) and plateaued at around 65 in the following years before falling sharply to 60 in 2018.

There are variations between the four nations – Scotland has the highest number of GPs per 100,000 population (76 in 2018), while Northern Ireland has 67 GPs per 100,000. Next is Wales with 63 and lastly England with 58.

The Nuffield Trust urges caution when interpreting the figures – questions have been raised over some of the data due to quality issues or changes in sources, for example.

Also, 70.1 million registered patients is clearly greater than the official UK population of around 66 million. The difference could be caused, in part, by so-called ghost patients – those who have died or moved (to another part of the UK and now registered at two practices or abroad) but not yet removed from GPs' lists.

It should be remembered too that GPs will be paid a capitation fee for all patients on the list, ghost or otherwise.

The Nuffield Trust said the fall in the proportion of GPs reflected not only an increased population, but also inadequate numbers of GP trainees in the past; failure to recruit enough GPs from abroad; and more family doctors taking early retirement. To have kept pace with population growth since 2014, another 3,400 GPs would have been needed.

BMA GP committee chair Richard Vautrey said GP numbers have been in 'freefall' for years as government pledges to boost numbers have fallen flat.

'Family doctors are under intense pressure to meet rising demand from a growing population, many of whom are elderly and living with increasingly complex conditions. In many cases, workload has become unmanageable, leading doctors to reduce their hours or retire,' he said. 'As more doctors leave the profession, the workload gets heavier still for those left behind, and the situation gets far more serious for patients and staff.'

A recent survey by GP magazine *Pulse* found that more than half of family doctors were working above safe levels, putting in an 11-hour day on average.

Dr Vautrey continued: 'Add to this punitive and confusing pension regulation that punishes doctors who take on more work; we have seen a perfect storm brewing for the GP workforce.'

The pension issue (*see Technical news, page 25*) is potentially a major headache for the NHS, with some doctors threatening to retire and others considering reducing their workload so

Nursing registrations increase

While GP numbers are declining, there was better news about nurses, even though there are tens of thousands of vacancies.

The Nursing and Midwifery Council (NMC) said a net 8,000 more nurses, midwives and nursing associates are registered to work in the UK compared with last year – raising the total registered to an all-time high of almost 700,000.

There were 698,237 registered nurses, midwives and nursing associates on the register in March this year, including around 653,000 nurses.

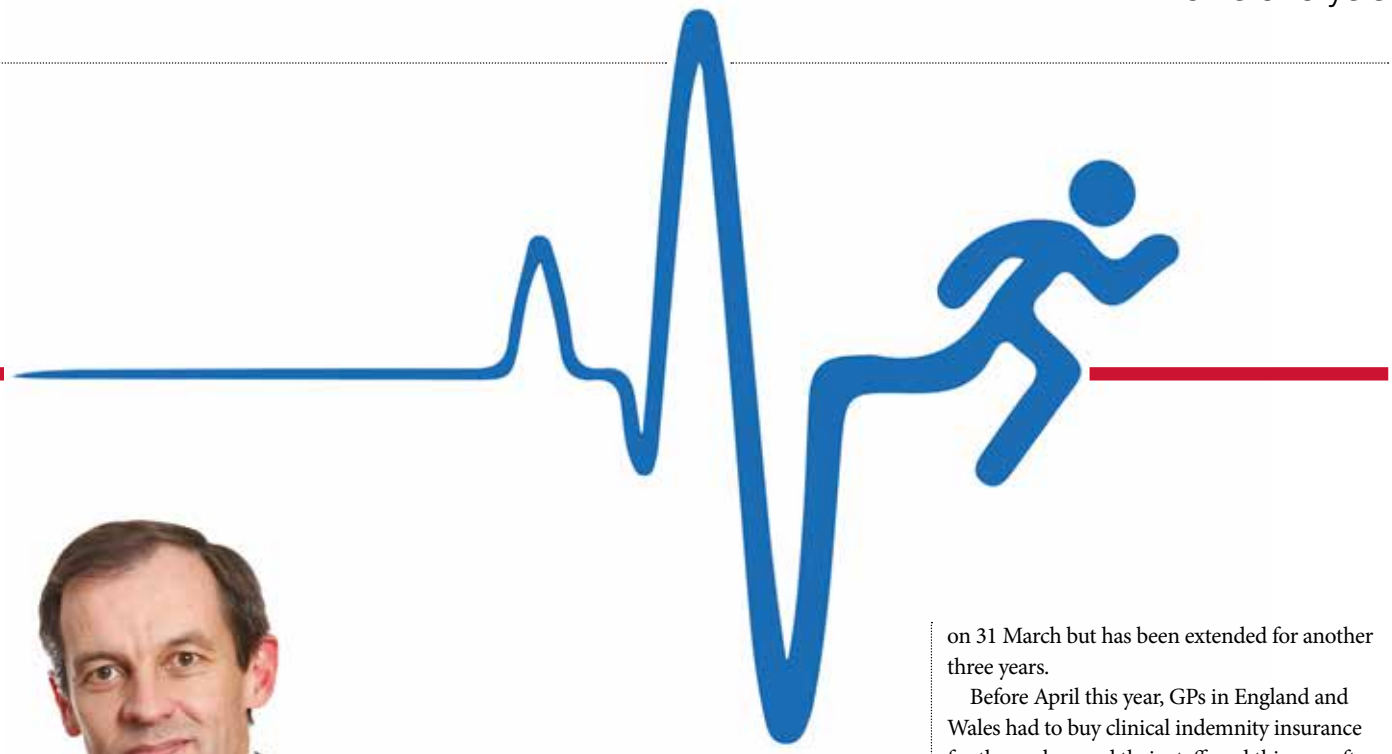
The bulk of the increase is made up of UK-trained professionals – 5,000 more than 2018, while the steady rise in midwife numbers continued with an additional 500 registered over the last 12 months.

The NMC said there had been a jump in the number of professionals from outside the European Economic Area joining the register.

However, more than 11,000 professionals left the register during the year. The main reason was retirement, but almost a third said they left due to workplace stress. The UK exit from the European Union was the top reason for nurses and midwives who trained in other EU countries.

NMC chief executive Andrea Sutcliffe said the NHS had a 'long way to go' before it

had adequate numbers to provide the best and safest care. 'And while there has been a drop in the number of people leaving the register, our survey fires yet another warning shot – that the pressures nurses and midwives face are real and must be taken seriously if we are to properly attract, support and retain the workforce we need now, and for the future.'



"As more doctors leave the profession, the workload gets heavier still for those left behind, and the situation gets far more serious for patients and staff"
Richard Vautrey, BMA

they do not have to pay additional tax.

The GP partnership model – where doctors acting as independent contractors 'buy in' to a partnership – is deemed too restrictive by many aspiring GPs. It's difficult to leave a GP partnership, contrasting sharply with their hospital-based colleagues' ability to move around the NHS with relative freedom.

GPs have pointed out that, as surgeries have expanded to accommodate the wider range of services provided in primary care, the value of premises has risen. As a result, the 'buy-in' cost has increased.

In Scotland, steps have been take to address concerns over premises. GPs who own their surgeries have been offered interest-free sustainability loans from a £10m annual fund to ensure they can keep their premises open. GPs who lease their premises can transfer the lease to their health board.

Reduced headcount and an increase in part-time GPs are having a knock-on effect on performance. The latest *British Social Attitudes* survey showed satisfaction with general practice at 63% – the lowest since the survey began in 1983. General practice is the one area where the annual survey has shown consistently high levels of approval – in 1990 satisfaction with general practice stood at 80% and was still around 74% in 2016 – but the recent sharp decline will serve as a wake-up call to primary care.

For those who told the survey they were dissatisfied with the NHS overall, the length of time it takes to get a GP or hospital appointment was the biggest reason for their discontent, closely followed by lack of staff. The links between these factors will not be lost on NHS managers and GPs.

However, there are signs this dissatisfaction could be turned around. In England, the long-term plan will bring significant additional investment in primary and community care – £4.5bn higher in 2023/24. The funding will be used to tackle demand pressures, expand the workforce and to develop new services.

The NHS is training more GPs – the government had promised an extra 5,000 qualified GPs by 2020 – but there are doubts this will be achieved in the timeframe. In April, however, Health Education England announced that almost 2,600 doctors had entered GP training. The education body said it was on course to hit its target of 3,250 for the year. In 2018, almost 3,500 trainees entered general practice – the highest number in NHS history.

The introduction of primary care networks promises an additional 20,000 primary care staff, including pharmacists, social prescribers and associate physicians in the next five years to take some of the workload off GPs.

NHS England has taken steps not only to increase the number of GPs, but also to free up GP time so they can care for the patients who need them most. For example, NHS England says its *Time to care* programme has freed up around 500,000 hours or £40m worth of time saved. The programme was scheduled to end on 31 March but has been extended for another three years.

Before April this year, GPs in England and Wales had to buy clinical indemnity insurance for themselves and their staff, and this was often cited as a major reason why young doctors decided against a career in primary care. However, state-backed schemes introduced in both nations means doctors no longer have to pay for the insurance out of their own pockets.

As well as addressing indemnity, the new GP contract for England opens up the possibility for GPs to work with other family doctors, particularly through primary care networks.

The BMA's Dr Vautrey said: 'We hope the addition of 20,000 additional practice staff over the next five years will have a real effect in beginning to tackle the workload problems. While these professionals will not replace GPs, they will, where appropriate, see some patients, and allow doctors to prioritise cases where their expertise is needed.

'While there is clearly much more that needs to be done by government, by utilising these additional resources, and allowing practices to work together via primary care networks, we hope that the pressures currently faced by GPs will ease, persuading more GPs to stick around, and enticing more new recruits to what is one of the most rewarding areas of medicine.'

Productivity and efficiency are central to NHS England's actions and, with a pro-technology health secretary, there will be more and more interest in the use of technology such as video consultations. Doctors' leaders remain frosty to some of the new tech-based service providers, but they have welcomed the additional funding, state-backed indemnity and the development of primary care networks.

NHS leaders aim to address young doctors' concerns, recruit more GPs, introduce technology and develop an alternative workforce to take some of the workload. By doing so, they hope primary care will be more attractive and once again suit patients' needs.

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Comment

June 2019

Systems and value

Joint working is the way forward and value techniques can drive improvement

HFMA president Bill Gregory

As we move into the summer months, annual accounts are behind us and we are starting to see how the financial year is beginning to take shape.

I have always found this time of year useful for putting things in train to ensure that the plans we set earlier get delivered.

System-wise, my sustainability and transformation partnership (STP)/integrated care system (ICS) in Lancashire is working well.

We have agreed a system control total and are now working more collaboratively than ever on the financial strategy to deliver it.

We know it isn't going to be easy, and there are some real financial and performance challenges ahead, including in my own sector, mental health.

However, we have a real sense of being in this together and I am optimistic we will end up in a better place, providing better health services to the residents of Lancashire as a result.

No two STPs are the same, and the more we can do to learn from each other about making the new system work, the better.

One of the real advantages of this more integrated approach is an opportunity to use the whole wellbeing and healthcare pathway to improve the effectiveness of

Finance's valued role

Finance staff will continue to be central to the delivery of value-based healthcare

Healthcare Finance editor Steve Brown

No-one would argue that value-based healthcare is now mainstream in the NHS. But there are signs that the NHS is moving in the right direction.

A packed value summit – organised by the Healthcare Costing for Value Institute and Future-Focused Finance – suggests there is growing interest among clinicians, finance professionals and operational colleagues. And presentations from the stage indicate that there are organisations and systems starting to put value theory into very real practice.

But it also underlined that this is a major undertaking. While it is essential – and arguably the only solution to meeting growing patient demand and living within an affordable budget – it is far from straightforward. It will require wholesale change to the way services are run and new ways of paying for those services.

The summit (*see news, page 4*) showcased how organisations at different scales are redesigning pathways to address variation in clinical processes and eliminate waste and unnecessary steps.

There were lots of common messages: the central role of data; the need for trust, across systems and between professions and in the robustness of that data; ensuring patients are a core part of any redesign.

Technology also has a part to play – for example, using electronic patient records and decision support systems to digitise pathways and support clinicians to sustain revised treatment protocols.

What also came across was the continuing importance of the finance profession to the delivery of value – while recognising that clinicians need to be front and centre as the agenda takes hold.

Finance staff have been central to work so far – as demonstrated by the championing role taken by the institute and Future-Focused Finance in recent years. Without finance's work to date, the value agenda would not be

"No two STPs are the same, and the more we can do to learn from each other about making the new system work, the better"

the care the NHS provides.

At the value summit at the end of May, some great examples of integrated working were showcased.

The work in Surrey and Sussex was an excellent example of how clinicians and finance professionals can work together using best value techniques to optimise the musculoskeletal pathway.

The concept of value remains a really powerful tool because it provides finance and clinicians with a common language for using data to improve services and outcomes.

For me, the evidence for this can be found in the number of clinicians who attend the HFMA value events – and the value summit was a great example of this trend.

As I have commented previously, this is too good an opportunity to miss. With the combined effort of clinicians and finance, solutions can be found to most challenges.

It is a chance to tackle unwarranted variation and it is also how we can start to look across whole pathways, not just the section within our own specific organisations.

I know finding the time to attend events such as the value summit can be difficult, but please take the time to read some of the outputs from the event as I am are sure you will find some real value.

The summer months also see the start of the first round of branch conferences during June and July.

I am looking forward to seeing as many of you as possible supporting your local branch – and hopefully finding time to catch up on what is happening within your region.

Contact the president on president@hfma.org.uk

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as advanced as it is. And it will continue to be at the heart of the value movement.

Finance staff are crucial to the compilation of cost data that is fundamental to the value equation as defined by Porter. They are also best placed to support clinicians in using this data to shine a light on existing pathways and opportunities to address variation and improve services.

Variation in practice could be compared without attaching pound signs. But the simple truth is that it is often the linkage with costs that really underlines the impact of that variation (*see Community progress, page 21*). It is also worth saying that finance staff are motivated by exactly the same things as their clinical colleagues. They may not have direct patient-facing roles, but they are just as committed to improving outcomes for patients.

Finance staff will also be crucial as the value agenda moves into new territory. While delivering value-based healthcare is challenging enough across pathways within individual organisations, it needs to start being applied to whole pathways and at the population level.

The question needs to be not simply 'how does my organisation deliver value for the patients we treat?' but also 'how do we deliver value for the patient overall?'.

"Without finance's work to date, the value agenda would not be as advanced as it is. And it will continue to be at the heart of the value movement"

Undertaking the best and most cost-effective hip replacement is not delivering value if, for example, physiotherapy further upstream could have prevented the need for a hip replacement altogether.

And even more difficult, value means challenging exactly how resources are currently allocated to different programmes of care – population value. People will look to the finance profession to design payment systems to facilitate these changes and to model the impact of potential changes in funding flows.

The value summit suggests the journey to value-based healthcare is under way. Speakers were clear. Don't expect changes to be made overnight. Quality improvement needs to be rigorous and methodical and it takes time. But finance professionals look set to retain a fundamental role in its delivery alongside clinicians.

medicinal value

New clinical pharmacists working in general practice could take some of the workload off GPs, as well as contribute to the wider agenda around medicines optimisation. Steve Brown reports

Prescribing budgets are a key concern for clinical commissioning groups. It is hard to ignore a budget that makes up around 10% of overall spending. The focus on increasing levels of lower cost generic prescribing has shifted in recent years – with this particular battle largely won. But the need to counter inflationary pressures on drug bills remains – especially in such a difficult financial environment – and there is a belief that CCGs can improve the value delivered by their spend on medicine.

Perhaps one of the most eye-catching promises in the long-term plan was to increase primary care staff by 20,000 by 2023/24. These staff will work in new primary care networks across local general practices and

Getting behind the variation

There is a significant amount of primary care prescribing data to support CCGs with medicines optimisation and the delivery of cost improvements.

The source data comes from NHS Prescription Services at the **NHS Business Services Authority**, which processes around one billion prescription items for pharmacists each year. It makes this prescription data available via its ePACT2 online system, with data online six weeks after the dispensing month. It provides analysis, reports and dashboards.

There are also other complementary ways to interrogate this rich source of data. **Openprescribing.net** – built by EBM DataLab at the University of Oxford – enables the BSA raw prescribing data to be examined by CCG or general practice.

For example, CCGs can look at their relative performance across more than 70 standard measures, such as the high-cost proton-pump inhibitors as a percentage of all PPIs, or their prescribing of low-value items. It also highlights the biggest cost saving opportunities for each CCG each month.

PrescQIPP started in 2010 as a programme run by the East of England Strategic Health Authority and is now a UK-wide not-for-profit community interest company funded largely by subscriptions from CCGs, commissioning support units and health boards.

It produces evidence-based bulletins and analysis (see chart, right) on therapeutic areas and enables users to drill down to practice level for all its scorecards. It also provides skills training and e-learning.

NHS RightCare provides a range of data for CCGs based on different programmes of care. Where-to-look data packs identify where the biggest

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clinical pharmacists will be one of the first two of five primary care roles to be funded (along with social prescribing link workers, physician associates, physiotherapists and community paramedics).

By 2023/24, a typical network of 50,000 patients could have its own team of six whole-time equivalent pharmacists in place. On the face of it, the move is about taking pressure off GPs. In 2015, the government committed to increasing the number of doctors working in general practice by 5,000 by 2020. Although training places have increased, it seems unlikely that this target will be achieved. And in May, the Nuffield Trust highlighted that the number of GPs has recently seen a sustained fall relative to the size of population (*see Fit for practice?, page 8*).

Patient-facing roles

The new scheme to boost the wider primary care team is an attempt to meet growing patient demand in a different way. Pharmacists will take on some direct patient-facing roles. Job descriptions in January's new GP contract framework to support the long-term plan make it clear that these new clinical pharmacists will be prescribers – or train to become prescribers – and will take responsibility for the care management of patients with chronic diseases.

But it is not just a workforce fix. These pharmacists will undertake structured medication reviews, in particular focusing on the elderly, people in care homes, those with multiple long-term conditions such as COPD and asthma, and people with learning disabilities or autism. They should also take a lead role in ensuring antibiotic prescribing is in line with guidance.

"Rather than assuming there's a pill for every ill, increasing specialist health advice in care homes will mean residents get more personalised treatment"
Keith Ridge, NHS England

NHS England's chief pharmaceutical officer, Keith Ridge, believes too many patients are prescribed medicines that they either may no longer require or which might need adjusting and the new pharmacy teams will help address this. 'Rather than assuming there's a pill for every ill, increasing the availability of specialist health advice in care homes will mean residents get more personalised treatment, reduced chances of being admitted to hospital and people will have a better quality of life, for longer,' he says.

This initiative is in fact a key component of a broader push on medicines optimisation. A medicines value programme led by NHS England was launched as a follow-up to the *Next steps on the NHS five-year forward view* and the Carter report on acute hospital productivity. While medicines are a key component in many people's treatments, there are a number of issues that suggest room for improvement.

For a start, around 5% to 8% of hospital admissions are medicines-related and many of these are preventable. In 2017, NICE calculated that potentially avoidable adverse drug reaction-related non-elective admissions were costing the NHS some £529m based on 2012/13 costs. And a more recent research paper has suggested that definitely avoidable adverse drug reactions are costing the NHS nearly £100m a year.

It is estimated that up to 50% of patients don't take their medicines as intended, which could have an impact on their health. But some estimates suggest that waste of drugs in primary care costs the NHS £300m a year. Overuse of antibiotics is leading to bacteria becoming resistant to them. And polypharmacy is an increasing concern, with some figures suggesting that more than one million people – often the elderly – now take eight or more medicines a day.

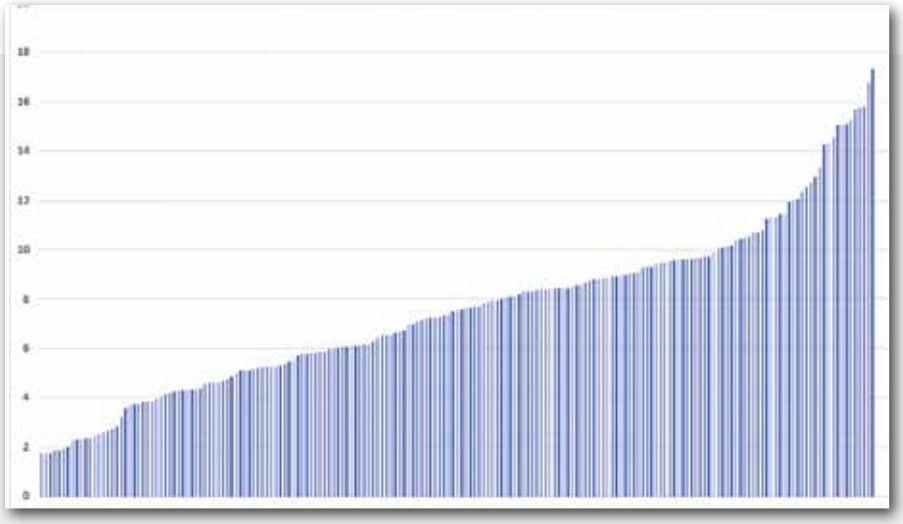
The medicines value programme has four strands covering: a framework for access to and pricing of medicines; the commercial arrangements that influence price; developing the infrastructure to support the supply chain; and optimising the use of medicines.

It is in this latter area where commissioners – supported in some initiatives by regional medicines optimisation committees – can play their own part in optimising use of medicines locally.

According to the latest report from NHS Digital, drug costs are evenly split between hospitals and the community. After significant spending increases for hospital medicines in recent years, primary care prescribing now accounts for just under 50% of the total £18.2bn cost of medicines in the NHS in England.

Primary care prescribing costs have increased by just 2.6% between 2010/11 and 2017/18, falling by 1% in that final year. However, while there are much bigger increases in hospital drug costs – driven by many of the new drugs for cancer and other areas – prescribing remains a key issue for CCGs. Spending can be volatile and subject to pressures outside of CCGs' control – some £350m of CCG overspend on overall budgets related to exceptional levels of concessionary prices for generic drugs in 2017/18, for example.

So, keeping an eye on costs remains a major focus. Carol Roberts, chief executive of PrescQIPP – a not-for-profit NHS-funded organisation that produces evidence-based resources for CCGs to improve medicines-based care – says there continues to be huge pressure on CCGs to reduce or contain prescribing costs year-on-year.



opportunities exist for improvement both in terms of outcomes and spend.

As part of this analysis, the packs provide data on primary care prescribing in the different programme areas (such as cancer, respiratory and musculoskeletal), comparing each CCG with 10 similar CCGs and the 'best' five of these CCGs.

Figure 1 (PrescQIPP data): High-dose opioids average daily quantity per total analgesics (BNF 4.7.1. & 4.7.2) COST based STAR PU, December 2018 to February 2019

Tackling opioid dependency

The use of opioid painkillers has dramatically increased in the UK over the past 20 years, rising by a third between 1998 and 2016, according to the National Institute for Health Research. Yet there is growing concern about the risks for patients, especially given there is little evidence that these drugs are helpful for long-term pain.

Many CCGs are now looking at this area of prescribing practice, in part driven by the inclusion of immediate release fentanyl on NHS England's list of 18 items that should not routinely be prescribed.

Mid Essex Clinical Commissioning Group (CCG) has been looking at this area for a number of years, but chief pharmacist Paula Wilkinson (pictured) says that the national programme helped the work to gain traction.

Typically, the number of patients taking opioid medication above a safety threshold of 120mg/day can be small – but the costs can be significant. At the start of the programme, the CCG was spending around £500,000 annually on immediate release fentanyl. This has now reduced to around £300,000 across just 13 patients.

Ms Wilkinson stresses that the improvement has needed a comprehensive package of support and is a journey. 'This has to be done in partnership with patients,' she says. 'It takes time and you need to help them to reduce dependency on the product gradually, perhaps moving onto a morphine equivalent dose as a first step.'

The CCG publishes all its prescribing policy statements online and has produced an opioid resource pack to support GPs in ending all new prescribing (other than in connection with hospice care) and reducing prescribing and developing treatment plans for existing patients. The work around fentanyl is part of a wider programme to reduce prescribing and dependence on all high-dose opioids across the CCG (involving some 650 patients).

Recognising the time needed by GPs to spend time discussing this with patients, the CCG has been exploring setting up a dedicated service to which GPs could refer dependent patients. It is now hoping to take this forward as part of support provided through the new primary care networks.

'We are looking to see how we could use some of the funding to support GPs through PCNs to engage with pharmacists or funding additional time for existing pharmacists working in general practice,' says Ms Wilkinson.

It has also been redrafting its pain pathway, looking to move patients onto non-pharmacological treatments – such as cognitive behavioural therapy and improved exercise – once the acute phase of treatment is over.

Once the new service is operational later this year, Ms Wilkinson says the CCG could have supported all its patients off immediate release fentanyl within 18 months.

This would release further significant resources, which will help support further and more appropriate services for patients living with chronic pain.

'It is getting a lot harder to look for savings,' she says, 'all the easier stuff has been done.'

Reducing the use of medicines with low or no clinical value has been a fruitful area for many commissioners. In partnership with NHS Clinical Commissioners, NHS England published initial guidance in 2017 on 18 medicines that should no longer be routinely prescribed in primary care, which could lead to savings of up to £141m across England.

This was followed in March last year with guidance on 35 conditions where over-the-counter medicines could be used instead of being prescribed, saving the NHS a further potential £100m. A third wave of nine items has recently been consulted on and guidance issued limiting gluten-free products on prescription to bread and/or gluten-free mixes.

Sunderland Clinical Commissioning Group acknowledges that value-based prescribing has helped reduce spending over the last year and improved both safety and quality. It allocates around 10% of its programme budget to prescribing, and in 2018/19 reported a 7.5% reduction in prescribing spending compared with the previous year.

'On a national level, we also saw reductions resulting from "no cheaper stock obtainable" (NCSO) prices agreed centrally, which last year had caused a pressure of around £140,000 per month and this year reduced significantly,' says CCG chief finance officer and deputy chief officer David Chandler. But a new mechanism around repeat prescribing also made a significant contribution.

'Our in-house medicines optimisation (MO) team has led the implementation of a repeat prescribing ordering scheme with practices, which has reduced waste in the system by cutting the number and value of drugs being inappropriately dispensed,' says Mr Chandler. 'Based on similar schemes in Luton, Coventry and Rugby, South Sefton and Southport CCGs, we believe this will save around £1.5m recurrently, which we will be able to reinvest into other frontline services.'

The scheme ends the practice of pharmacies automatically issuing repeat prescriptions and puts the patient back in the loop – leading to a noticeable change in prescribing activity.

The CCG also operates a gain share scheme with practices and has established a system-wide medicines efficiency group, including the local acute trust and neighbouring CCG, to enable a more integrated approach to medicines optimisation.

CCG head of medicines optimisation Ewan Maule echoes PrescQipp's Ms Roberts, stressing that simple improvements (such as increasing generic prescribing) are no longer available. 'Now we are tackling more entrenched prescribing issues that are systemic and take more unpicking,' he says.

For Sunderland, this includes looking at the issues around the prescribing – and potential over-prescribing – of analgesics and opiates in particular. Many areas are looking to tackle this (see box).

In other prescribing areas, CCGs will have different challenges and opportunities to improve the value from their use of medicines. There are significant resources to support CCGs looking at variation in prescribing activity (see box, page 12) – far more than for hospital care. The hope is that with the existing pharmacy teams in CCGs, combined with new cohorts of clinical pharmacists in general practice, the NHS can make further inroads into this variation where it is unwarranted.

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Coming home

Out-of-area placements have been on the rise in the last few years, potentially increasing lengths of stay and affecting recovery. But the NHS aims to reduce them to almost zero by 2021, as Seamus Ward reports

Over the past few years, there has been an outcry over the number of mental health patients – adults and children – sent far from their homes for treatment. It's not just that this practice is at odds with the mantra of treating patients closer to home, but there is concern that without family and friends for support, patient lengths of stay are longer. This is not good for patients, and it also means the NHS is not making the most of mental health funding at a time of rising demand.

However, there is hope that the trend in placements could be reversed, thanks in part to the new priority given to mental health. The *Five-year forward view for mental health,* published in 2016, said the practice should be ended as soon as possible. And the recent *NHS long-term plan* spells out an ambition to all but eradicate placements outside a patient's home region by 2021. Officially, the aim is to eliminate them completely, but there may be good reasons why a patient is placed far from their area, including legal rulings.

There will be support to achieve the 2021 target. The forward view for mental health programme is working with units with a long length of stay, aiming to bring the typical length of stay down to the national average of 32 days. This will increase local capacity and contribute to ending acute out-of-area placements by 2021, allowing patients to remain in their area – maintaining relationships with family, carers and friends.

It is also expected that capital investment will be made available in the forthcoming spending review to upgrade the physical environment for inpatient psychiatric care.

Getting it right first time (GIRFT) will look at issues around out-of-area placements for under-18s as part of its review of child and adolescent mental health services (CAMHS).

According to GIRFT, one in eight clinical commissioning groups sent an under-18 more than 320km from home in 2017/18, with one child placed 460km away.

Guy Northover, a consultant child and adolescent psychiatrist, who will be carrying out visits to CAMHS and crisis services as part of the review, says: 'It's not just a capacity issue – there has been a big increase in CAMHS beds over the years, and bed occupancy last year was around 72% – which means we need to look at where these beds are and how they are being utilised.'

Despite the national support, there is concern over whether the 2021 target can be reached. Data shows that the number of placements is increasing. At the end of February, 810 out-of-area placements were active, according to NHS Digital – 775 were inappropriately placed outside their region because of the lack of an available bed locally. A month earlier there were 675 active placements – 645 of which were deemed inappropriate.

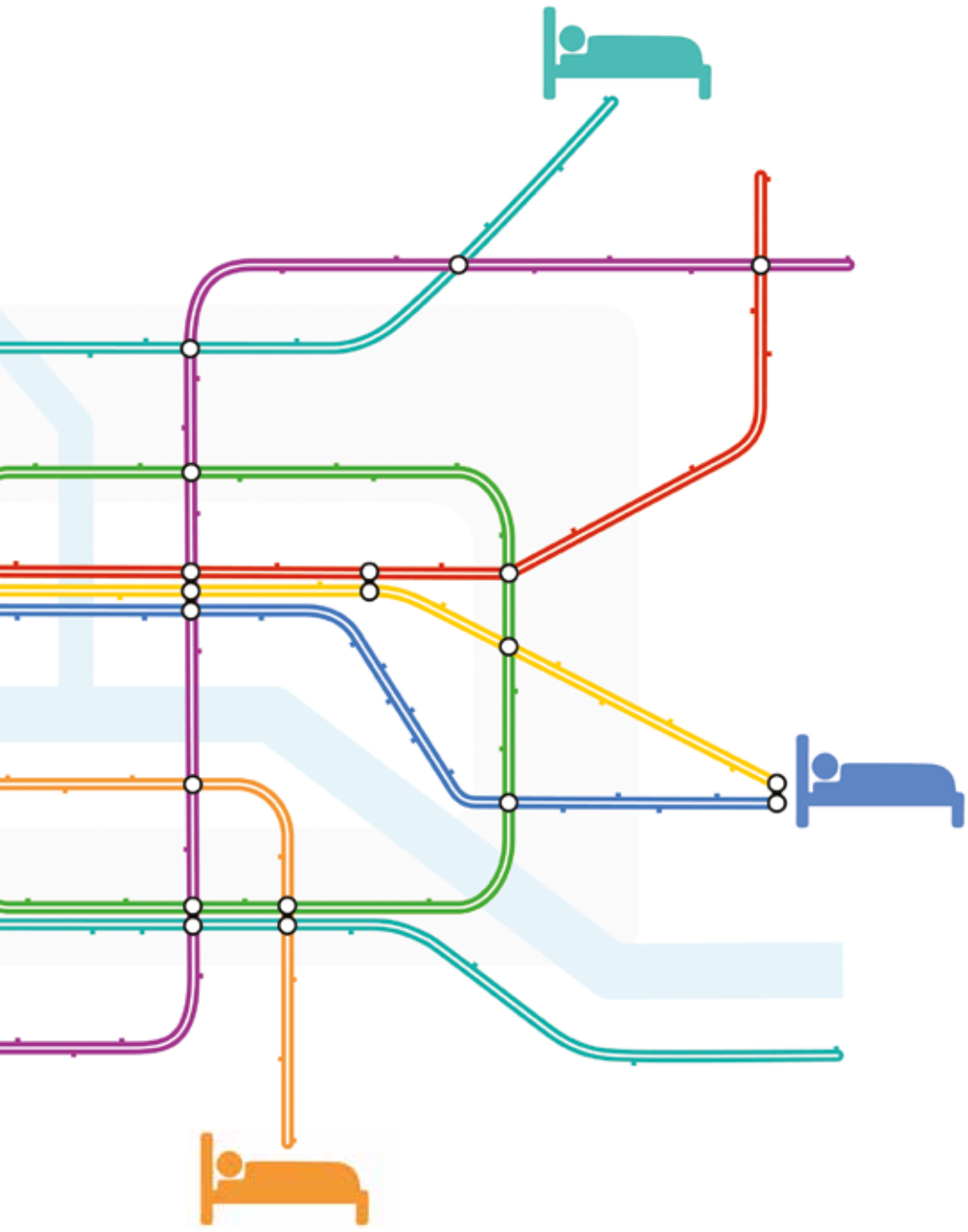
Upward trend

Though NHS Digital asks the figures be treated with some caution, they do appear to show an upward trend at a time when the focus is on bringing them down – in February 2018, there were 640 out-of-area placements, meaning placements have jumped more than 25% over 12 months.

During February, almost 21,000 out-of-area placement days were recorded, costing more than £10m. A look at out-of-area placements active at any point in February shows that more patients were travelling further for an inpatient bed – 335 patients travelled between 100km and 200km; 145 travelled 200km to 300km; and 45 more than 300km.

"The proposed change to a more blended payment model should have a positive impact"
Ella Fuller, NHS Providers

Ella Fuller, senior policy officer at NHS Providers, says the increase has been due to a rise in demand and acuity of people's conditions. 'The level of care and support people need at the point they are accessing that care is greater,' she says. 'It's important to note that the reasons for the rise in demand



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are quite complex – demand has increased due to greater awareness of mental illness, for example. There is less stigma around mental illness and this is a welcome development.

'Other factors behind rising demand are socioeconomic, but lack of beds and alternatives to hospital provision are also key factors contributing to the rise in out-of-area placements.'

In its recent report, *Mental health services: addressing the care deficit*, NHS Providers examined the causes in a survey of mental health trusts. It described a number of barriers to reducing out-of-area placements.

Trusts told NHS Providers the prevalence of block contracts in mental health was helping to fuel out-of-area placements. 'They are inflexible and, once agreed, don't reflect changes in demand in year,' Ms Fuller says. 'The proposed change to a more blended payment model should have a positive impact.'

A blended model would pay trusts a fixed amount linked to expected activity levels plus a volume-related amount to reflect actual activity. However, Ms Fuller warns that accurate activity baselines must be set to ensure blended payments work. 'Given the gaps in data and lack of knowledge about unmet need, setting these baselines will be difficult, take time and is likely to require a significant resource commitment,' she says.

Lack of capacity is creating the need for placements out of area, however the choice of services being commissioned is also an issue, she adds. 'Out-of-area placements become more likely if the type of provision available locally is not what's needed, so it's important that trusts are commissioned to provide the right types of services.'

Workforce roadmap

As with most NHS services, workforce can limit the capacity to provide mental healthcare. In 2017, Health Education England set out a high-level road map to increase the mental health workforce in *Stepping forward to 2020/21*. By that financial year, it said, the NHS in England will employ a further 19,000 staff, many in community-based teams.

Increasing the workforce to the required levels will be a huge ask, Ms Fuller says. More community-based teams will increase capacity – preventing admissions and taking patients out of hospital when they are ready to step down. However, resourcing them adequately will be a challenge.

Around three years ago, with demand and costs escalating, NHS England decided a different approach was needed to the commissioning of specialist mental health services. It set out to test new care models in tertiary mental healthcare, with the aim of reducing out-of-area placements and lengths of stay to make sure people get the support they need as close to home, their family and friends as possible.

There were six sites when the programme went live in April 2017 – four adult medium and low secure mental health services, and two CAMHS tier four (inpatients) – with a further wave joining in 2018.

NHS England says feedback from the sites is promising, with more than 257 patients brought back into care in their home area in 2017/18. In the same period, length of stay and median distance from home have both reduced, particularly in CAMHS. As a result, a total of £10.7m was released for reinvestment in local mental health services in 2017/18.

Devon Partnership NHS Trust is the lead provider for South West Regional Secure

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Case study

Optimising outcome, performance and reimbursement improvements through data quality

The Information Department and Clinical Coding Team of a Midlands-based NHS Foundation Trust have taken steps to deal with significant financial pressures and meet targets set through the NHS Cost Improvement Programme. The Trust serves a population of approximately 360,000 people and provides local healthcare through acute and community services.

Results

2017 Realised reimbursement improvement

The Trust's first eight months of using the 3M™ Data Quality Analytics (DQA) module showed significantly improved reimbursement with an average of £47,913 per month. By June 2017 the Clinical Coding Team was fully trained on using DQA, hence the financial increase. July to September was impacted by the period of annual leave within the team, December alone, however, generated improvements of £60,964.

> "I would recommend DQA as a great tool for data analysis because this Trust has successfully used it to:
>
> - demonstrate significant financial results
> - reduce incidence of error and therefore improve quality of the coded clinical data
> - deliver the Cost Improvement Programme (CIP) target
> - target training gaps in the clinical coding team"
>
> **Clinical Coding Manager***

Financial benefit

The Trust has benefited from income improvement in the first eight months of:

£383,309

An average increase per month in appropriate reimbursement of:

£47,913

Increased data accuracy

The 3M DQA module has led to an improvement in data accuracy and quality whilst presenting real-time actionable data in a dashboard available to the Trust's management teams. An alert on the dashboard allows for the review of episodes that exceed an expected length of stay. The drill in episode level data may reveal omitted comorbidities, procedures or even an inaccurate primary diagnosis. Correction of this coding improves data quality and may change the Healthcare Resource Group (HRG) with a consequent financial impact.

Team development

Training gaps have been identified through the 3M DQA module and are addressed with the entire team at weekly meetings, therefore reducing potential future errors.

Complete, accurate clinical coding is essential to the Trust and its revenue is dependent on its coding quality. 3M Health Information Systems worked closely with the Information Department and Clinical Coding Team to optimise data accuracy and therefore income improvement.

Building on the Clinical Coding Team's knowledge and skills acquired through the 3M™ Medicode™ Clinical Encoder, the 3M™ Data Quality Analytics (DQA) Solution was implemented. The DQA module reviews all coded episodes and reports against the National Clinical Coding Standards, alerting the user to potential errors. The Clinical Coding Manager uses the tool to identify gaps in training needs. The amount recognised is directly proportional to the time invested in reviewing the DQA outputs and correcting errors.

*Clinical Coding Manager. Names withheld by request.

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Services – the wave one adult medium and low secure new care model pilot, which launched in April 2017. The trust is leading a significant clinically led programme to transform the way in which adult medium and low secure services across the South West of England are commissioned. The trust leads a partnership of eight providers – five NHS, two from the independent sector, and one community interest company. Its geography is across 22,000 sq km and a population of five million, with a budget of £70m.

'Prior to the pilot going live the region had 380 patients in low and medium secure services, but more than half were placed outside the South West, with care costing between £175,000 and £250,000 a year each,' says programme director Anne Forbes.

'Those who were out of region had extended lengths of stay – up to double of those in-region – and only 20% of the women needing care were receiving it in region, which demonstrated the urgent need to commission appropriate services within the South West.'

This pilot enabled a key change in the way commissioning is led. NHS England devolved responsibility for commissioning to the lead provider, allowing it to address local needs, including repatriation. 'We are now commissioning on a population basis – we are responsible for the population regardless of where they are placed in the country and have started bringing people closer to home,' Ms Forbes says.

Positive results

Ms Fuller agrees the shift to provider commissioning of specialist services has made a positive impact. 'We are already seeing examples of new care models for eating disorder services substantially reducing out-of-area placements, for example. New care models have the potential to make a difference – by allowing more flexibility on what can be offered, earlier intervention to prevent escalation and movement between tiers of provision. But providers need to be properly resourced to undertake these extra responsibilities.'

In the South West, an extra 78 beds were commissioned locally, within existing resources, and existing beds used more fully. And a new community forensic team has been established to work with individuals in the community, ensuring safe, earlier discharge.

The South West New Care Model pilot has won two national awards during the past year, including the HFMA Innovation Award 2018. Judges were impressed by the level of clinical and financial collaboration shown, together with an approach that spanned providers and the whole population. In two years, the region has repatriated 107 patients and reduced lengths of stay – with a closer connection to their local care teams, families and friends.

Jason Fee, the programme's clinical director, says: 'One person we repatriated was 100 miles from home and we brought him back into care in the South West, after four years living in a secure unit out of area. Ever since, his family has been able to visit on a weekly basis, rather than a few times a year, and he's been engaging well in therapy sessions and started going out into the community with them, to places like the local college and library.

'The difference in him has been remarkable. He's got more hope and can visualise a future in his own community.'

The number of women treated in region has increased from just over 20% to more than 50%. Ms Forbes says the service changes and subsequent savings came at the right time for the region as they coincided with an increase in admissions from prisons. 'We've been able to manage this because we made the savings from the new care model. Over two years, we made clinical efficiency savings of about £15m, but our cost pressures were £16m. At its peak, our admissions from prisons tripled the historic levels, but the extra costs were absorbed by the savings. But the most important thing is that demand for services has been met.'

"We have started bringing people closer to home"
Anne Forbes, Devon Partnership NHS Trust

Despite the positive work nationally, concerns remain over the ability of NHS mental healthcare providers to achieve the 2021 target.

'Providers are committed to reducing the number of out-of-area placements,' Ms Fuller says. 'However, eradicating placements by 2021 is a big ask and will need the right investment, particularly in community mental health teams and the wider workforce. Making sure the other approaches to reducing demand are in place and working is also crucial.

'Greater investment in mental health is welcome but a lot of the focus is on specific programmes rather than investment in broad provision. The long-term plan is an ambitious programme. There is concern about how many commitments can be delivered, and how fast, given the scale of the challenge.

'A clear implementation plan will be really important so that trust leaders can balance the transformation and new demands with managing ongoing operational challenges.'

The placement of patients with mental health needs many miles from their home can be distressing for patients, their families and friends, and the NHS is determined to challenge it. Repatriation is simply an example of a clinical decision that is good for patients, and, as a result, good for NHS finances.

Transformation model

Over the past two years, a project to transform secure mental health services in the south of England has exceeded its expectations for the number of patients repatriated to their area.

The Thames Valley and Wessex Forensic Network new care model covers secure adult mental health services in Oxfordshire, Berkshire, Hampshire and Isle of Wight, Dorset and Milton Keynes. The network is made up of NHS providers of secondary and tertiary mental health care services in these areas.

Given new care model status by NHS England, Oxford Health NHS Foundation Trust became responsible for managing the secure care budget, including holding the funds, managing expenditure and delivering services. It has introduced a revised clinical and service delivery approach, increasing the input of senior clinical leadership in accessing secure services to reduce lengths of stay and numbers of patients in placements out of the network.

The Oxford trust says that over the two years of the pilot, 49 patients have been repatriated into the network area (19 in year one and 30 in year two). '40% of patients recorded as placed out of network 2016/17 were supported to return closer to home. In terms of our performance, our original plan forecast between 16 to 24 patients would be repatriated over the pilot, so this is an excellent achievement credited to the good work of the network. A reduced number of out-of-area placements not only benefits patients but provides significant efficiencies for the whole system.'

The arrangements have been extended for a third year while NHS England refines new care models into the mainstream, including establishing delegated commissioning arrangements to provider networks.

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Community progress

Community services arguably have a harder challenge than other sectors in moving to patient-level costing. But one trust in Gloucestershire has shown how much can be achieved in a relatively short period of time. Steve Brown reports

NHS England and NHS Improvement's deadlines for its Costing Transformation Programme – now known as National Cost Collections – are demanding for all NHS providers. But it is providers of community services that arguably face the biggest challenges. Gloucestershire Care Services NHS Trust perhaps offers some encouragement about how much can be achieved in a relatively short period of time.

Acute providers will this year make their first mandated submission of patient-level costs covering admitted patient care, outpatients and A&E. Next year, they will be joined by mental health trusts and ambulance trusts. And it is likely that providers of community services – including acute and mental health providers also delivering community services and dedicated community service trusts – will be required to submit patient-level costs from 2021 (covering 2020/21).

The whole of the NHS has found this demanding. Trusts have had to move away from a top-down, allocative approach where they report average costs of a specified currency (healthcare resource groups or outpatient appointments in acute care or therapist/nurse contacts, for example, in community services). And they've replaced this with a bottom-up approach – building up and reporting the specific costs of treating individual patients. But the lack of electronically captured activity data, and a lower national profile for costing generally, has given community service providers a bigger mountain to climb.

Even understanding what constitutes a community service has proved quite challenging, although four out of five NHS providers deliver some form of community services and together they constitute about 10% of total NHS spend.

The experience of Gloucestershire Care Services NHS Trust demonstrates that, even over a short time period, real transformative

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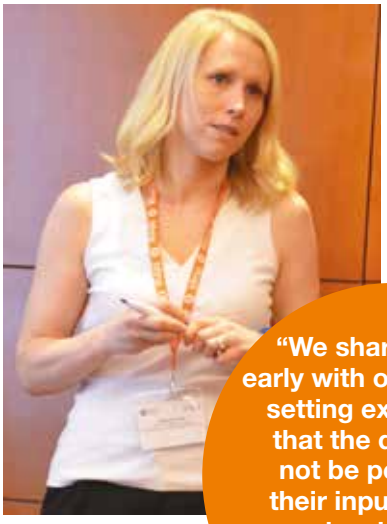
change is possible in community sector costing. 'Before the changes were made, our costing data wasn't used at all in any meaningful way,' says Jenny Richards, costing accountant at the trust, which has more than 1.2 million contacts with service users each year and runs seven community hospitals.



There was no real way to validate activity data and very limited engagement outside of the finance team. 'The focus was on meeting the mandated reference costs, the reference cost index and satisfying ourselves that we understood any key movements,' she says.

"We shared results early with our clinicians, setting expectations that the data would not be perfect and their input would be invaluable"
Jenny Richards, Gloucestershire Care Services NHS Trust

Fast forward a couple of years and the trust is one of the pioneers of patient-level costing in the community sector. As one of NHS Improvement's roadmap partners since 2017, it has helped shape the development of community costing standards, made two reference cost submissions using a patient-level methodology and taken part in a national voluntary patient-level cost submission using the new centrally set methodology.

More than this, it has started to use the more granular data to challenge existing clinical practice and inform decision-making.

The trust's patient-level cost journey began in earnest in January 2017, when it bought the Civica CostMaster costing system and signed up to become a roadmap partner. But it was starting from solid ground. 'One of the key foundations is to have an electronic clinical system recording contacts and activity,' says Steven Wainwright, the trust's commercial manager. And the trust had just spent two years rolling out the SystmOne clinical system across the trust, with practitioners and community teams using mobile devices to input contact data. At the time, the then soon-to-be-published community services data set also helped firm up what the trust had to collect to meet central requirements.

Close collaboration between costing and analytic team colleagues led to the specification and implementation of a 'bible' to deliver automated activity datasets to support costing calculations and subsequent desired internal reporting.

Even so, the fact that the trust was able to make its reference cost submission in July the same year, based on patient-level data – with costs for 75% of services available at the patient level – was an impressive turnaround. Especially given its costing resource amounts to less than one whole-time member of staff.

'There were two distinct phases,' says Mrs Richards. 'We made our original reference cost submission using our existing method but built up at patient level.'

Clinician pay costs were attributed to patients in proportion to the

Sector view

Subject to consultation later in the year, community trusts may be required to make their first mandatory patient-level cost submission during 2021. With some trusts still needing to implement appropriate costing systems, IT hardware challenges (*see Healthcare Finance, May 2019, page 14*) and often small costing teams, NHS England and NHS Improvement recognises this is a challenging agenda.

However, the Costing Transformation Programme – or National Cost Collections, to give it its new title – is no stranger to big challenges. In getting to the point where all acute providers will submit patient-level costs this summer, the service has met a number of similarly demanding deadlines. And the experience of trusts such as Gloucestershire Care Services NHS Trust (see main feature) shows what can be achieved in a relatively short period of time.

Community service providers – both those providing services alongside acute or mental health services and those focused solely on community provision – have been aware of the timetable since the programme began. And there is a lot of guidance and support that they can draw on.

The healthcare costing standards – which set out a consistent approach to patient-level costing – have been published where possible as integrated standards relevant to providers in any sector.

In addition, there is community sector-specific guidance on the information requirements and some costing methods, including the costing of sexual health services, dental services and wheelchair services (with audiology being considered for possible further guidance next year).

Early implementers can also access NHS England and NHS Improvement's online learning platform, which provides additional examples to supplement the standards. Trusts have the opportunity to participate in a voluntary collection during 2019.

However, for providers not yet in a position to participate, the advice is to start looking at all the resources available.

Fiona Boyle (pictured), the programme's community services costing manager, suggests there are different challenges facing integrated and dedicated providers of community services. 'For many integrated acute and community providers, there is a focus on acute activity to ensure they can meet their first mandated submission in 2019,' she says. 'So, while they may have systems in place and reasonably sized costing teams, their attention can be on other areas and there may be a preoccupation with national tariff type issues. For the dedicated community provider, it may not have a suitable costing system or clinical system in place and costing resources can often be less than one whole time equivalent.'

All of this adds up to a case for getting costing on the agenda now. Given the lead times for tendering processes, Ms Boyle believes that system requirements need to be a priority. Beyond that, costing teams should ensure they are familiar with the guidance and make a start on mapping their finance ledgers to cost ledgers, so that they have the right starting position for the costing process.

Three community providers took part in January's voluntary submission of patient-level costs and more than 25 have signed up for this year's voluntary submission in the autumn, this time including integrated acute and community and mental health and community providers.

In 2021, a total of roughly 180 trusts (out of 227) are expected to be submitting costs for some form of community activity.

Annual mental health finance conference 2019

17 October 2019, 110 Rochester Row, London

The NHS long-term plan has pledged a record level of investment in mental health services and promises faster access to services nationally. The plan is extremely welcome for those working within mental health services, however questions remain around how this ambitious plan is going to be delivered.

For more information and to book visit:
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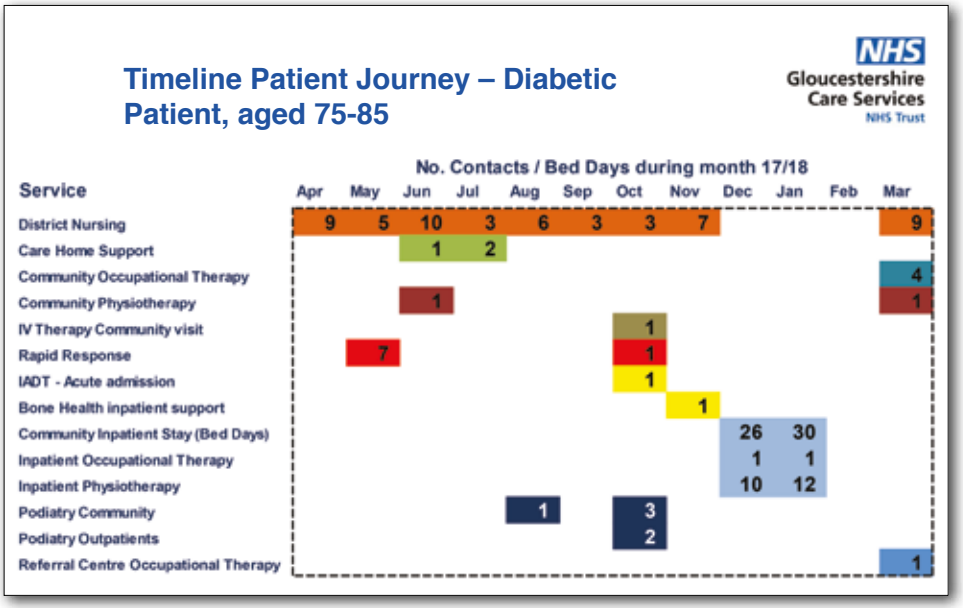

duration of clinician contact time with the patient, as recorded on the relevant electronic clinical system. This, importantly, created a direct link between the cost results and the patient clinical record.

'We made the conscious decision to share results early with our clinicians, clearly setting expectations that the data would not be perfect, and that their input would be invaluable,' says Mrs Richards. 'This has proved successful as service leads have helped us and continue to help us to iteratively improve the quality of costing data.'

The 75% patient-level mark was reached by focusing on the major service areas where the trust was confident of its data – adult and non-specialist services. This approach continued in 2018, adding in specialist nursing and specialist services as well as children's, dental health and sexual health services. This meant that the trust's costs were now 98% at the patient level.

The trust identifies a separate, second phase where it started to apply the new Costing Transformation Programme (CTP) patient-level costing methodology developed by NHS Improvement, involving the breaking down of costs into resources and then activities. In January this year, the trust made a voluntary 'proof of concept' patient-level submission, reflecting the new methodology and using a new version of the CostMaster software.

While the trust still needs to file its 2018/19 reference cost submission, it is also working towards a further voluntary CTP patient-level submission later in the year, when it hopes to submit costs for all in-scope activity alongside a wider group of early implementer community service providers (*see Sector view, page 22*).

Mr Wainwright stresses that it is an iterative process and that getting started and getting people engaged should be priorities for all trusts. Some jobs are time-consuming – mapping the finance ledger to the cost ledger, although this is largely a one-off piece of work and a crucial building block. And the sooner you share and analyse the results, the sooner you can iron out issues.

Identifying inconsistencies

'There is nowhere to hide at the patient-level,' he says. 'Data quality issues are uncovered, giving you the opportunity to address them.

'For example, patient-level scrutiny of the activity data for the trust's integrated community teams identified inconsistent recording of some contacts across the distinct district nursing, occupational therapy and physiotherapy services. Subsequent close collaboration with operational colleagues has largely eliminated this, and improved the accuracy of recorded activity across the three services by different professional staff groups.'

While the focus has been on getting the data into a useable format and improving clinicians' and operational teams' confidence in the data, the organisation has also started to put the more granular data into use.

One area the trust has explored has been to examine the variation in how services are delivered across its five localities. 'Operational leads are starting to look at a wider dataset to understand how they are deploying different bands of clinicians across different localities to administer the same type of care,' says Mrs Richards. With district nursing contacts also broken down by type of contact (including diabetes, continence, respiratory and cancer), operational teams are starting to understand how pathways look in different areas.

Knock-on impact

Other service leads, motivated by the work with the district nursing service, are now looking for a similar breakdown. For example, currently occupational and physiotherapy contacts are only identified as first or follow-up appointments and whether the contact was face-to-face or not. SystmOne is now being revised to enable a more granular analysis. 'That will mean we can have the same conversations about OT and physio to understand how the same interventions are delivered by different people in different localities,' says Mrs Richards.

The analysis by locality has gained a level of sophistication. For example, with a wide-ranging skill mix across services in different localities, there are many different costs per contact. But looking at the same data by episode shows that the locality with one of the highest costs per contact has the lowest cost per episode. This gives operational teams a real opportunity to compare their service delivery approaches and optimise the approach across the whole health economy.

A powerful tool for clinicians has been charts showing different patient journeys and how disjointed they can be (see example above). 'When you show this to operational leaders and then put in the pound signs highlighting this has an annual cost of £30,000, it can stimulate debate around opportunities to improve patient outcomes and experience,' says Mrs Richards.

Even insights such as the £350 it costs to keep each of the 200 inpatient beds open each day can motivate teams to review pathways.

The ultimate goal is to develop this pathway view across the whole health economy. 'We have a local population health approach that the Gloucestershire Integrated Care System is working on and the aim is to be able to report our use of resource by locality, looking at how a patient touches all our services – acute, mental health, community and ideally primary care – in a year. We want to build up a picture for the whole county,' says Mr Wainwright.

That vision remains some way off and there are a number of information governance issues to overcome. But with a common patient identifier in the NHS number and all sectors now developing patient-level cost data, it is seen as a realistic target.

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Annual allowance taxation rules threaten to exacerbate workforce challenges

Technical

Increasing concerns are being raised about how complex pension rules could be leading to senior clinicians reducing their hours, turning down requests to cover for vacancies and, in extreme cases, taking early retirement.

While the issue could affect senior people of all disciplines in the NHS, it is the impact on clinicians that is of most concern. The BMA wrote again to the chancellor in March claiming that the issue is leading to 'four-, five- and six-figure charges' and has 'become a problem that will affect all full-time consultants'. If unaddressed, the problem threatens to exacerbate the service's workforce challenges.

At the heart of the problem is a limit – the annual allowance – on what individuals can contribute to their pension scheme each year. Introduced in 2006, it was greatly reduced in subsequent years and has been £40,000 since 2014. But from April 2016, a taper was introduced to restrict pensions tax relief for high earners. This taper should affect individuals with 'adjusted' income (including the value of any pension contributions) of over £150,000. For the taper to apply, the individual must also have a 'threshold' income (excluding pension contributions) of more than £110,000. The taper can reduce the annual allowance to £10,000.

Calculating if someone is affected by the taper and the charge for which they are then liable is complicated. A new briefing from the HFMA explains how the annual allowance works and signposts online resources, including worked examples from the BMA and others (see box).

The annual allowance applies to private and public sector schemes. For private sector defined contribution schemes, it is relatively straightforward to ensure pension contributions do not exceed the allowance. But with defined benefits schemes, the allowance does not focus

on contributions but instead represents the maximum amount a pension can grow in the financial year without incurring additional tax.

Depending on which NHS scheme a doctor is in, any increase in pension growth is multiplied by a factor of between 16 and 19. This means small increases in pensionable pay can lead to large deemed pension growth, and this is added to earnings for the calculation of adjusted income and may contribute to further tapering of the annual allowance. Doctors who are members of two NHS schemes (for example, with a legacy pension in the 1995 or 2008 scheme, but who were moved to the 2015 career average scheme) are hit particularly hard.

Any pension growth above the calculated annual allowance is taxed at the individual's marginal rate.

Chancellor Philip Hammond defended the reforms to pensions and the tapered annual allowance in a Parliamentary debate in May. He said they were 'necessary to deliver a fair system and to protect the public finances' – affecting only the highest earners and raising about £6bn a year. 'However, I do accept that there is some evidence that the annual allowance charge is having an impact on the retention of high-earning clinicians in the NHS,' he said.

Reports suggest the Treasury and the Department of Health and Social Care are discussing a solution known as a 50/50 pension, where healthcare staff would only pay half the usual amount into their pension for a set period – receiving a smaller pension when they retire. A similar system is used in local government.

If adopted, it might enable doctors to reduce their contributions from the usual 14% of salary to 7% for up to 10 years. However, a blog from Rob Harwood, chair of the BMA's consultants committee, said the BMA had modelled this solution extensively and it 'does nothing to remove the tax cliff that occurs at the threshold income of £110,000.' It added that under the proposal, consultants would still incur significant annual allowance tax bills in some years and under pay into their pension in others.

Worked examples

Comments on the BMA website (mostly anonymous) reveal real examples of doctors facing five-figure tax bills, resigning from additional roles or pulling out of extra sessions. However, there are a number of worked examples on the internet demonstrating a range of different circumstances.

In one BMA example, a doctor is promoted from specialised registrar to consultant and his pensionable salary increased by £30,781. However, the total change in his pension benefit value is £160,228. Taking into account the annual allowance and assuming he is carrying forward an annual allowance of £50,000 for the past three years, he will have to pay tax on £70,228 – at 45% this will be £31,603. An example from investment group Tilney also shows how a 58-year old GP could be almost as well off taking early retirement and working as a locum just 2.5 days a week.

Technical review

The past month's key technical developments

Technical

NHS England and NHS Improvement has released summarised data from the 2017/18 **voluntary submission of patient-level cost data**. There are separate reports for: acute (81 submissions); mental health (18 submissions); and ambulance services (seven submissions). The acute report, an Excel spreadsheet, shows the average cost per episode for different healthcare resource groups, filterable by point of delivery and specialty, and also covers outpatients. The mental health report shows average cost per cluster day and per contact. The ambulance report shows unit costs for different ambulance currencies (hear and treat or refer; see and treat or refer; see and treat and convey; and other). http://hfma.to/9a

A new *How it works* guide from the HFMA looks at **NHS continuing healthcare** (CHC), providing an overview of the rules and process and explaining commonly used terms. It also covers the new requirement for personal health budgets as the default option for CHC supporting people living in their own homes. The briefing is intended to provide a basic understanding for those working in NHS finance teams and provides links to further reading and guidance. http://hfma.to/continuinghc

NHS England and NHS Improvement has updated technical information and definitions of **maternity services** in its non-mandatory prices workbook – part of its national tariff guidance for 2019/20. It had been identified that maternity pathway prices covered some public health services, which cannot be subject to national prices. New non-mandatory prices are now provided, known as benchmark prices, and are intended to be a starting point for local price-setting discussions. http://hfma.to/9b

The demands on costing teams to support patient-level costing and the use of the data by service teams to inform decision making are significant. A new case study from the **HFMA Healthcare Costing for Value Institute** describes how Stockport NHS Foundation Trust expanded the reach of its costing team by formally engaging the wider finance function. It did this by providing training and setting patient-level cost objectives for the management accounting team at all levels. http://hfma.to/9c

The Department of Health and Social Care has published the ***Group accounting manual 2019/20***. The manual includes mandatory annual reports and accounts guidelines for clinical commissioning groups, NHS trusts and foundation trusts and arm's length bodies. It lists six key changes from the 2018/19 manual, including amendments to remuneration reporting guidance; incorporation of text for IFRS16 deferral; and clarification where there is uncertainty over income tax treatments under IAS12. http://hfma.to/9d

NHS England and NHS Improvement has published webpages summarising progress towards **new payment systems to support integrated care**. The *NHS long-term plan* sets an ambition for the whole of England to be covered by integrated care systems by April 2021. These may be supported by population-based funding approaches, supporting the redesign of care across providers and moves to more preventative care models. An integrated care provider contract is also being developed enabling a single integrated organisation to take contractual responsibility for providing services to a defined population paid for by commissioners using a pooled whole population budget. The pages also signpost resources on blended payment approaches and risk sharing. http://hfma.to/9e

Helping to detect neurological conditions

Technical: NICE

May saw the publication of six clinical guidelines, unusually outnumbering the number of technology appraisals, *writes Gary Shield.*

NICE's new guideline on *suspected neurological conditions: recognition and referral* (*NG127*) is the first to offer comprehensive information on neurological conditions to help non-specialist healthcare professionals identify people who should be referred for specialist assessment and care.

The guideline aims to make a difference to anyone who might have a neurological condition by making sure:

- GPs can recognise when symptoms could have a neurological cause
- GPs and doctors in emergency units know when to refer people to a specialist at once and when to do more tests first
- People who most need to see a specialist can see one sooner
- People are not referred to a specialist if they don't need to be.

Where clinical practice changes as a result of this guideline, there will be no significant change in resource use – any cost is likely to be offset by savings and benefits.

Elsewhere, NICE published new or updated guidelines on: *Stroke and transient ischaemic attack in over 16s: diagnosis and initial management; Crohn's disease: management; Ulcerative colitis: management; Prostate cancer: diagnosis and management;* and *Hyperparathyroidism (primary): diagnosis, assessment and initial management*.

It also recommended three new technologies (*TA578, TA579 and TA581*) for use in the Cancer Drugs Fund, as well as medical technology *MTG43 PICO negative pressure wound dressings for closed surgical incisions*. Cost modelling suggests PICO negative pressure wound dressings provide extra clinical benefits at a similar overall cost compared with standard wound dressings.

A resource impact template is provided to help organisations assess the local costs and savings of using the dressings.

Gary Shield is NICE resource impact assessment manager

NHS in numbers

A closer look at the data behind NHS finance

Service costs

Technical

NHS accounts – be they national or local – are very good at telling us what has been spent on NHS services and the costs of staff, drugs and other resources in delivering services overall. But they tell us very little about how much it costs every time a patient is admitted to hospital, attends an outpatient appointment or is visited by a district nurse.

However, average costs of specific interventions can be found in an annual reference costs publication – the latest of which, released in November last year, covers 2017/18.

The cost data is used in a number of ways. It informs both the national tariff that sets the prices commissioners pay to acute hospitals, where activity based contracts are in place, and local prices. It is used in benchmarking data and to estimate the value of improvement opportunities, such as those highlighted in the Model Hospital and *Getting it right first time*. In addition, it helps Parliament to see how funds are being spent.

While there are issues with the data, it does provide useful information of the costs of simple and complex interactions with the NHS.

The most recently collected reference costs (for 2017/18) cover £68bn of expenditure (62% of total NHS spending in England).

This includes core admitted patient care costs (APC) of £27.7bn, mental health costs of £7.2bn, community care £5.5bn and ambulance costs of £1.9bn.

Breaking the costs down further, day case expenditure increased from £3.8bn in 2013/14 to £4.4bn in 2017/18 (15.8%), while A&E costs increased from £2.3bn to £3.2bn (39%).

Costs increased in every department – as well as mental health, community and ambulance – except in elective inpatient, where they remained relatively stable at around £5.4bn each year.

It cost £742 on average to treat a patient in a day case setting, while this increased to £3,894 on average for an elective inpatient episode – although this excludes the costs of excess bed days (days beyond a number set for each intervention). Days beyond this trim point then cost an average of £346 per day. The average cost for an A&E attendance was £160, while for an outpatient attendance the figure was £125.

Reference costs by department, 2013/14 to 2017/18, £bn

Total cost by department	2013/14	2014/15	2015/16	2016/17	2017/18
Day case	3.8	4	4.3	4.5	4.4
Elective inpatient	5.3	5.4	5.5	5.4	5.4
Non-elective inpatient	15	15.6	16.7	17	18
Sub-total core admitted patient care (APC)	**24.1**	**25**	**26.5**	**26.9**	**27.7**
Other acute services	10.8	9.9	10.6	11	11.4
Outpatient attendance	8.1	8.5	8.8	8.9	9.3
Outpatient procedure	1.3	1.5	1.6	1.8	1.8
Accident & emergency	2.3	2.5	2.7	3	3.2
Sub-total all acute services	**46.6**	**47.4**	**50.2**	**51.6**	**53.4**
Mental health	6.6	6.7	6.9	7.1	7.2
Community health services	5.1	5.3	5.4	5.6	5.5
Ambulances	1.6	1.7	1.7	1.9	1.9
Total	**58.3**	**61.2**	**64.2**	**66.1**	**68**

Source: https://improvement.nhs.uk/resources/reference-costs/

In mental health, around 63% of expenditure (£4.5bn) was costed against clusters, with the balance costed against different units of activity – usually care contacts or single attendances.

The cost of the initial assessment (£301) may cover a number of attendances, though it is usually expected to be complete in two contacts. The unit cost per cluster day (£18 in 2017/18) is the total cost of the cluster period divided by the number of days spent in the cluster.

A reference cost index (RCI) provides a way of measuring relative cost difference between NHS providers – with an RCI of 100 equating to national average costs. A cost schedule provides the average cost of all activity broken down by the currency used in each sector.

> "The NHS undertook nearly 24,000 major hip procedures in 2018/18 at an average cost of £6,061. Spreading the cost of excess bed days for this HRG across all episodes would add another £60 to the average cost"

For example, acute activity is reported in healthcare resource groups (HRGs), arranged in different specialty chapters.

So, for example, hip replacements would be found in the musculoskeletal chapter, with most of the uncomplicated ones falling in the HRG HN12F – *Very major hip procedures for non-trauma with CC score 0-1*.

The NHS undertook nearly 24,000 of these procedures in 2017/18 at an average cost of £6,061. Spreading the cost of excess bed days for this HRG across all episodes would add another £60 to the average cost.

Reference costs are being replaced by new more granular patient level costs. Reference costs are calculated by allocating costs down to HRGs. But patient-level costs are built up from the costs of treating individual patients. This enables trusts to explore what is driving average costs that are higher or lower than the national average.

Inside track

MBA student Luca Paderi (pictured) talks to Steve Brown

News and views from the HFMA Academy

Training

Luca Paderi is one of eight students to have embarked on the new MBA in healthcare finance developed by BPP University. All eight students began the programme in February, having successfully completed the *HFMA advanced higher diploma in healthcare business and finance*.

Mr Paderi says the higher diploma has already improved his confidence and ability in his day job and believes the MBA programme will help prepare him for the introduction of integrated care systems across the NHS.

He took three modules back-to-back during 2018 to complete his advanced higher diploma. He is very clear about his motivation – to improve his understanding of the NHS and increase confidence when dealing with divisional directors. 'I moved to the UK in 2004 from Italy, having completed a degree in economics, business and finance,' he says.

Having settled in Nottingham, he worked in a number of finance roles in the private sector gaining his CIMA qualification in 2010. But he admits that joining the NHS in 2016 – keen to do something that made more of a difference – was a bit of a shock to the system.

'I joined the Nottingham University Hospitals NHS Trust at a relatively senior level and I realised there was a gap in my experience,' he says. Initially working with the pathology service, Mr Paderi is now finance business partner for the medicine division, which includes the emergency department, acute medical, diabetes, cardiology and geriatric care among other services.

Part of his role is to influence and advise divisional directors. Mr Paderi saw the qualification as a way of supporting this – improving his overall understanding of how the NHS worked and helping him gain more detailed knowledge around areas that would support him in his day job.

The order of his three modules – *Comparative healthcare systems; Managing the healthcare business*: and *Creating and delivering value in UK healthcare* – was deliberately chosen to start at a high level and then drill down into more specific issues around governance and value.

Mr Paderi believes the qualification has already achieved its goals. 'I feel better able to challenge service leads on more issues, and it really helps to have a better grasp of what is happening outside my own trust,' he says. 'And I'm much more involved in reviewing pathways and supporting teams to add value.'

He admits the workload has been challenging, especially given family commitments outside work. But it has been rewarding and he says it became easier as he became better able to judge which items of reading material were essential and which could be looked at in less depth.

With no real break, Mr Paderi signed up to the MBA programme, keen to keep his gained knowledge as fresh as possible. He says the teaching style is slightly different and students are expected to find a lot of the reading material for themselves. But he says it has led him to engage with stakeholders and to network more.

The one-year programme includes two modules (*Project change and leadership* and *Strategic management*) and a project.

And content is again proving to be very relevant to the current agenda in the NHS. As the subject for his assignment within the strategic management module, Mr Paderi has chosen to focus on the integration of geriatric health and social care – an issue that is likely to be a major priority in the national move towards integrated care systems.

• For more on HFMA qualifications, visit hfma.to/qualification

HFMA support for MBA students

The HFMA is aiming to offer further support to MBA students choosing to undertake a project that's seen as valuable to NHS finance. Following an initial group session and one-to-ones to discuss ideas, students would present research proposals to the HFMA Policy and Research Committee and be assigned a non-academic sponsor. The sponsor would offer support for the research project (starting in October) and comment on a draft. BPP University would continue to provide the academic supervision.

FFF launches value-maker awards

Future focused finance

The value-makers at the heart of the Future-Focused Finance programme show continual enthusiasm and commitment in sharing best practice, resources and ideas across the NHS in England, *writes FFF programme manager Sophie Rowe*.

In the past year, the number of value-makers has grown to 665, so it felt right to celebrate nationally their achievements, hard work and commitment with the launch of the Value-Maker Awards.

Suzanne Robinson, senior responsible officer for value-makers says: 'We are delighted to launch our very own Value-Maker Awards. We've been overwhelmed by the number of value-makers who have signed up across the country and the examples of best practice emerging from every region are fabulous. We felt it only right to recognise individuals and groups whose contributions really stand out.'

The award categories are based on FFF's four strengths – the key attributes that the Finance Leadership Council wants the function to develop to play its part in a modern, patient-centred NHS: finance expert; team player; driving value for taxpayers; and making change happen.

Nominations are open and the awards will be presented at the Value-Maker Annual Conference on 20 September in London. The day is open to all value-makers, as well as those wanting to find out more, who we hope to inspire to join our network of NHS finance champions.

If you would like more information on the conference and or the awards, please get in touch at **futurefocusedfinance@nhs.net**

Diary

June

5 (F) Provider Finance: forum, Rochester Row (am)
5 (F) Mental Health Finance: forum, Rochester Row (pm)
5 (N) Webinar: workforce management and the future of nursing (12.30)
13 (B) West Midlands: annual conference, Birmingham
21 (B) Northern: keep stepping, Durham
25 (B) London: personal resilience using mindfulness techniques
27-28 (B) North West: annual conference, Blackpool

July

3 (B) London: VAT level 1
4-5 (N) HFMA summer conference, Bristol
17 (B) London: successful leading and managing change

September

12 (B) South Central: annual conference
16 (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
17 (I) Institute: costing together
17 (N) Mental Health Finance: conference, London
18 (B) Eastern: conference, Newmarket
24-25 (B) Scotland: conference
27 (I) Institute: technical costing update, London

November

7 (N) Estates forum, Rochester Row
7-8 (B) Northern: conference
12 (N) Charitable funds, London
13 (F) Audit conference, London
14-15 (B) East Midlands: conference
14 (F) Commissioning Finance: forum
21 (B) London: VAT level 2
21-22 (B) Northern Ireland: conference
28 (I) Institute: technical costing update

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

HFMA summer conference

4 July, Ashton Gate stadium, Bristol

Reflecting the move to system working in the NHS, the HFMA summer conference brings together the association's commissioning and provider finance network conferences. Now in its 15th year. this year's conference, *Connected thinking for the future,* will focus on integration, ill-health prevention and the use of technology in the health service. The conference has integration at its heart and 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 Julian Kelly, the chief financial officer of NHS England and NHS Improvement, and Tim Kendall, national clinical director of mental health at NHS Improvement. NHS Digital finance director Pete Thomas will examine the role of digital technology in delivering the ambitions of the long-term plan. Other speakers include King's Fund chief analyst Siva Anandaciva (pictured) and, from Public Health England, finance and commercial director Michael Brodie and Gregor Henderson, national lead for wellbeing and mental health. Members of the HFMA partner programme can receive discounted rates for this event.

• **To book a place, email josie.baskerville@hfma.org.uk**

Mental Health Finance annual conference

17 October, 110 Rochester Row

Improving mental healthcare is one of the health service's key priorities, as outlined in 2016's mental health five-year forward view and the *NHS long-term plan*. The latter promises record investment – an extra £2.3bn by 2023/24 – and faster access. Though the investment and the plan for mental health have been widely welcomed, there is some concern about how it will be implemented.

This one-day conference is aimed primarily at finance professionals in mental health, but it will also be of value to community finance colleagues, commissioners, non-executives, service managers and clinicians.

There will be opportunities to discuss progress on the five-year forward view and the long-term plan, as well as the development of mental health services in the future. As well as discussions with colleagues, delegates will hear from technical leaders and experts. Speakers will include Tim Kendall (pictured), national clinical director of mental health at NHS Improvement.

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

Moving forward

Association view from Mark Knight, HFMA chief executive

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

My HFMA

A big thank you to all our members who completed our member survey. I will discuss the results in the next issue of the magazine after we've analysed the results in more detail. It is vital we receive feedback, however small, so we can assess what we do for you as members and revise the support we offer to meet your needs.

Last month, the HFMA board met in Manchester to review progress against plan and consider how we can move forward. The current challenges are mainly financial – we are slightly adrift of plan for this financial year and working hard not to post a deficit. The big investment we're making in education has yielded great rewards, but arrangements are still bedding in.

There are also some Brexit impacts for us. Our investment returns are a little more subdued than they have been and Rochester Row bookings from our government business are slightly down. The board considered this and our longer term finances. We are not making the sorts of margin that we did, say, five years ago. In part, this is because we're following through on our strategy to produce more for members. Our small but expert policy team is on target to publish 35 briefings this year.

Many associations have dropped their printed magazine or resorted to a cheaper 'coffee table' type version. Ours is written to support the finance function, containing detailed professional content, good practice case studies and opinion. I'm very proud of it, and our online content and dedicated member app.

The board also approved our plans to become an apprenticeship provider, initially offering level 4 accountancy training. To find out more, email chiefexec@hfma.org.uk. The ultimate aim is to offer a senior leader's apprenticeship at masters-level – we'll be announcing more about this in the coming months.

Our conference schedule remains busy, with our early summer round of faculty events. Our numbers are holding up and we are hoping to unveil plans to reshape some faculty offerings. Currently we run director forums and we've received requests for more for staff further down the management structure. We're also looking at how we weave the needs of the new sustainability and transformation partnerships into our structure. So there's plenty to think about.

HFMA chief executive Mark Knight

Time is short before our summer conference, where we will hear from new NHS chief financial officer Julian Kelly. I've met Julian and he seems to be in listening mode as he starts what is by anyone's standard 'a big job'. We stand ready to assist the new regional structure in whatever way we can, as we see the emergence of a new system for the service. The summer conference is being held in Bristol in July and I'm pleased to confirm Alistair Campbell as the closing speaker.

Many of you will have had your annual review recently, as the new financial years kicks off. Is there something you could do for us? Contribute to a policy or research project? Write an opinion? Join a committee? Or just get involved in the branch? Being a volunteer for the HFMA is interesting, rewarding and can benefit your career. So please, don't just join HFMA, join in and make this an even better association.

Member news

Finance professionals at Western Sussex Hospitals NHS Foundation Trust have been busy fundraising for several charities. Karen Seabridge, assistant director of finance at the organisation and committee member of HFMA Kent, Surrey and Sussex Branch, is doing a 15-mile walk through London overnight to raise money for a cause close to her heart – St Barnabas House Worthing. To support go to www.justgiving.com/Karen-Seabridge3

Sarah Mercer (pictured), a head of finance at the Western Sussex trust, completed the London Marathon in four hours

11 minutes, raising over £1,200 for the hospital's charity Love Your Hospital and national charity Child Bereavement UK. To donate go to https://uk.virginmoneygiving.com/SarahJM

The South Central and South West branches held a joint *Developing talent* event aimed at finance staff studying or recently qualified. Delegates heard the career story of Kevin Davis, acting director of operational finance, NHS England and NHS Improvement (South West). One attendee said: 'The talk was inspiring. It encouraged me to continue to qualify as a chartered accountant and progress in a career in finance.'

For mental health awareness week, some members shared tips for coping with stress and managing mental health at work. You can find the tips at http://hfma.to/lookingafteryourmh

The Commissioning Finance Faculty Steering Group has vacancies open to members. If you are interested, please email joanne.hitchen@hfma.org.uk

Follow @HFMA_UK on Twitter and like our pages on LinkedIn and Facebook for more exclusive content.

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 **South West**

'There has never been a more important time to be able to take yourself out of the day-to-day and look at what's going on in the wider health and social care system,' says John Dowell (pictured), chief finance officer at Devon Clinical Commissioning Group.

'One of the ways you can do that is getting involved with your local HFMA branch. This not only gives you a chance to broaden your horizons a bit, but also allows you to help shape the branch training and development events.'

Mr Dowell was named chair of the HFMA South West Branch in January, having previously been its vice chair. The branch has continued to support the regional deputy directors of finance meetings and to offer networking and learning opportunities to its members.

Recently, the branch held a joint student, developing talent, event with the neighbouring South Central Branch. 'Student membership is really important to the branch, as it's keeping up with one of our core purposes – to provide good support for training and education for our finance leaders of the future,' Mr Dowell says.

At the next committee meeting, the branch will look at further ways to support member training and education locally, including the potential for joint events with the Wales Branch.

In his day job, Mr Dowell's main focus at the moment is to find the right balance between competing priorities. He says: 'The 2019/20 operational planning round has been particularly challenging. Financially, a number of our plans will be ambitious and will require significant changes in our systems.

'Juggling between managing this year's plan, while making a reality of system working and looking ahead to the changes demanded to deliver the longer-term plan is one of the biggest challenges for organisations not only in the South West, but also nationally.'

System working will also be the key focus of the South West annual conference, *Systems are doing it for themselves,* on 26 September. At last year's annual conference, the branch piloted *Proud moments*, a series of short sessions of best practice case studies from local organisations. The sessions were well received and will be back this year with a focus on the overall theme of the conference.

To find out more about the branch, visit **hfma.to/southwest** or email **amy.morgan@hfma.org.uk**

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Yorkshire and Humber laura.hill@hdft.nhs.uk

Appointments

John Ingham is now the joint chief finance officer for the five clinical commissioning groups in Norfolk and Waveney. Mr Ingham was previously chief finance officer at Norwich Clinical Commissioning Group and prior to that at West Norfolk Clinical Commissioning Group. The five clinical commissioning groups have also appointed a joint chief officer, **Melanie Craig**, and are creating a single staff structure that is expected to be in place by the end of the year.

Devon Sustainability and Transformation Partnership has named **Kirsty Denwood** (pictured) STP finance lead. Ms Denwood was previously chief finance officer at North East Essex Clinical Commissioning Group. She first joined the NHS in 2007 and has worked at East of England Strategic Health Authority and North East Essex Primary Care Trust before taking up her most recent position in 2012.

HFMA London Branch chair **Kate Anderson** (pictured) has been appointed director of corporate affairs at Lewisham and Greenwich NHS Trust, having acted in the role since July 2018. Ms Anderson joined Lewisham and Greenwich in 2015 as the associate director of finance. Prior to joining the trust, she worked within KPMG's London public sector audit team.

HFMA MBA student **Tracy Parker** is now deputy chief finance officer – finance, contracts and procurement at East Riding of Yorkshire Clinical Commissioning Group. She was previously assistant director of contracting at the organisation. Ms Parker received the Tony Whitfield Award for HFMA student of the year in 2017.

Rebecca Monck (pictured) is now senior finance manager at Derby and Derbyshire Clinical Commissioning Group, having moved from Greater Nottingham Clinical Commissioning Partnership as head of finance. Ms Monck first started her NHS career as part of the graduate financial management training scheme and is the HFMA East Midlands Branch student lead.

John Graham has been appointed director of finance at Stockport NHS Foundation Trust. He was previously director of finance at the Royal Liverpool and Broadgreen University Hospitals NHS Trust.

Cathy Kennedy (pictured) has become director of operational finance (Yorkshire and Humber) for NHS England and NHS Improvement in the North East and Yorkshire region. Mrs Kennedy was business director at NHS Improvement and has over 25 years' experience in senior NHS finance roles. She is president of the HFMA's Yorkshire and Humber branch.

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

"The finance function can bring a better understanding of their challenges to present opportunities and changes for the greater good of the NHS"
Mark Smith, NHS PropertyServices

Smith handed keys to NHS Property CFO role

On the move

New NHS Property Services chief financial officer Mark Smith is keen to drive the Department of Health and Social Care-owned organisation forward using his commercial experience and public-sector values.

He gives three reasons for wanting to join Property Services, which was set up in 2013 to manage assets formerly owned by primary care trusts and strategic health authorities. 'I believe in UK plc and, in any job I do, I want to be able to give something back to it, hopefully making people's lives better.

'Coming to work for an NHS organisation that is fundamentally about delivering healthcare across England means a lot to me,' he says.

'The second thing is the opportunity to sit with just over 200 finance professionals and help them develop and grow – that's always been important to me. I've always looked to focus on people's development as it's something that makes the finance function successful.'

The third attraction was the enthusiasm from the organisation's leadership. 'The board members I met during the recruitment process showed such passion, hunger and desire to do the right thing for the healthcare environment. It was infectious.'

Mr Smith, who succeeds Julian Pearce, has a background in communication and IT services, having spent 10 years at Fujitsu Services and 14 at BT/Openreach. He held several finance director roles at BT, particularly in IT, networks and infrastructure, and was involved in the integration of the EE mobile service into BT. He also has a background in risk and compliance and has experience in operational management.

'NHS Property Services is here fundamentally to deliver good services and property to healthcare. My strength is in understanding what good looks like, how to promote good cost control work and good supplier and customer relationships while delivering the best quality services you can.'

His finance team will play an important role in supporting the development of NHS Property Services. Mr Smith says: 'I have three themes when I go into an organisation – integrity, insight and impact. Every organisation is at a different stage. In the first instance, we are accountants – integrity always needs to be the starting point and we should be proud of that as an organisation, especially in finance.

'In terms of insight, we must always continue to learn and develop because the more we can learn about the organisation, the better insight we can bring to generate opportunities. From a business point of view, that means saving money to reinvest back into the healthcare estate.

'The finance function needs to have the capability and skills to lead that. It needs to drive good decision-making and choices on investment in a direction that moves the business forward. As I get to understand where the organisation is, I will focus on these three streams.'

NHS Property Services has a complex and diverse portfolio of 3,500 properties, spanning everything from local GP surgeries to hospitals. 'That's a massive challenge for any organisation from a property and services point of view. Finance has a big role to play here.'

For example, finance professionals can help understand the costs of running these buildings and advise on reducing overheads without affecting the quality of services provided within them.

'The finance function can bring a better understanding of their challenges to present opportunities and changes for the greater good of the NHS.'

Since 2013 NHS Property Services has disposed of surplus assets to the tune of almost £300m and Mr Smith says it will continue to look at sales on a case-by-case basis.

Funds released from the sale of surplus estate are returned to the Department to be reinvested in the NHS.

'We have our own capital budget to invest in new buildings and to maintain the existing estate. We have to get the balance right between these, but fundamentally it must lead to an uplift in the quality of our property and services,' Mr Smith adds. 'Capital has always been a scarce resource and, as a function, we need to make sure we are spending it in the best possible way.'

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