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The road to sustainable services

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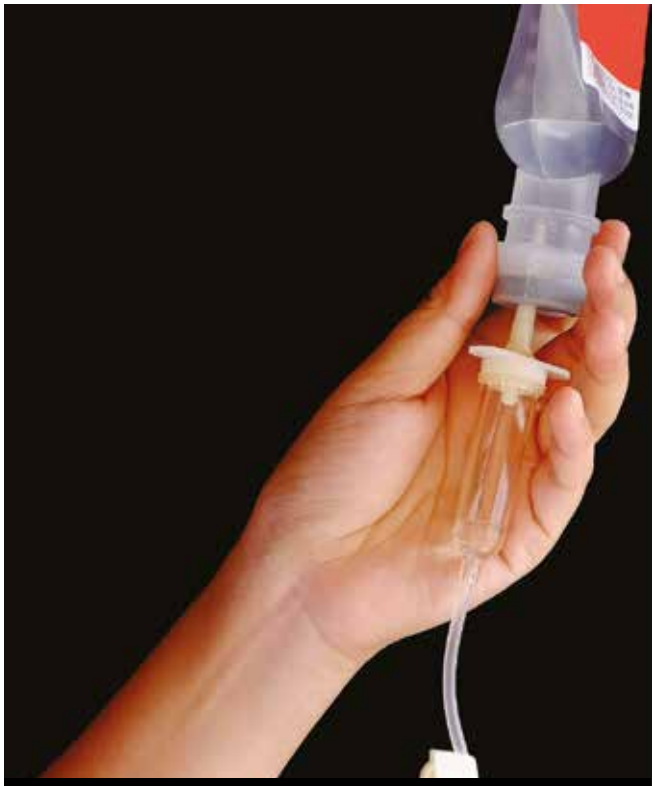

Features

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Improving data quality to deliver more accurate reimbursement

An NHS Foundation Trust in the East of England that provides acute hospital and community care services to around 280,000 people has taken steps to deal with significant financial pressures and a requirement to maximise value for money with the available resources. 3M's Health Information Systems (HIS) business enjoys a strong working relationship with the Trust's clinical coding team, which uses 3M™ Medicode™ Clinical Encoder as its primary clinical coding tool.

Project requirement

Complete, accurate clinical coding is essential in NHS Trusts. The Payment by Results framework means that a Trust's revenue is dependent on its coding quality. The Trust had previously engaged an external firm to review the quality of its coded clinical data, however this had resulted in a significantly increased workload for the senior coding team, as the suggested changes were often inappropriate and had to be reviewed carefully. The Trust's Clinical Coding Manager contacted 3M's HIS team to see how it could help the Trust to better use its resources to improve data quality.

Identified needs

3M's HIS team quickly recognised three key insights.

Firstly, it was important to build on the coding team's existing knowledge of Medicode clinical encoder. Secondly members of the existing senior coding team were best placed to identify and assess anomalies in their own data. Thirdly it was necessary to reduce data to a manageable quantity by screening out activity that did not require review.

The addition of three new 3M Medicode modules was proposed to improve the coding process, optimise data quality and maximise the capacity of both the clinical coding auditor and clinical coding trainer:

One of the modules was the 3M™ Data Quality Analytics Solution (DQA) which reviews all coded episodes and reports against the national clinical coding standards, alerting the user to potential errors. Target review areas are identified effectively and efficiently at episode level. DQA fits into the daily coding process where alerts can be reviewed by people trained to recognise the impact of errors.

The results

Financial benefit

£148k

A more accurate data submission has led to an income improvement of £148,000 in the first six months, meaning an average of £24,000 per month increase in appropriate reimbursement.

Increased data accuracy

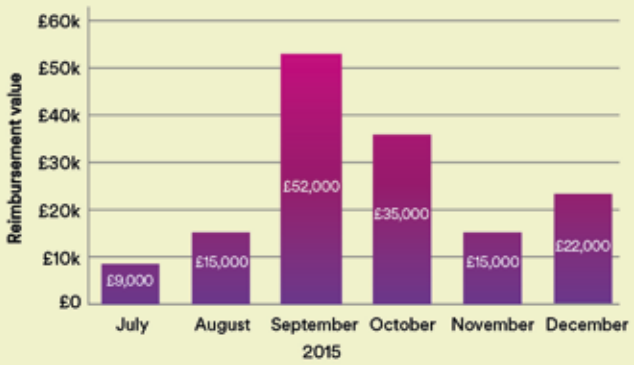
The new modules have led to improved accuracy and quality of data for both internal and external use.

Increased capacity for audit

The introduction of the new modules has meant that all coded data can now be audited internally using existing resources.

Development of people skills

DQA has allowed the existing team to optimise its efficiency and initiate a cycle of continuous learning and development.



First six months all saw improved reimbursement results, with £52,000 generated in September 2015 alone. Data on file with the Trust's Clinical Coding Department 2015.

"Twice-weekly running of DQA means that the coding team has immediate feedback, in more detail. Our month-end checks are fewer and completed nearer to the time of coding, meaning that we are able to quickly correct errors and feed back to the coders."

Clinical Coding Manager

For more information on the 3M DQA Solution:
Freephone **0800 626578** or email **help.his.uk@3M.com** or visit **www.3M.co.uk/his**

Financial results were produced by processing six month's data and amending codes, i.e. using a more specific code and also adding codes where DQA highlighted a potential error and on further investigation where extra codes could be added. Data on file 3M and Medicode are trademarks of the 3M company.

News

Commissioners' risk reserve to offset provider deficits

By Seamus Ward

The commissioning sector is on track to record a small year-end underspend and create an £800m risk reserve – but the funds will be used to offset provider deficits rather than being released for investment, NHS England chief financial officer Paul Baumann said.

The provider sector forecast an overall deficit of £873m at quarter three. Although NHS Improvement believes the position could improve by year-end, the reserve set aside by commissioners at the start of the year to cover risks across the commissioning and provider sectors will be needed to balance the overall NHS position.

Mr Baumann said 2016/17 was a difficult year for CCGs in particular and they faced an uphill struggle to make ends meet, while creating the lion's share of the £800m reserve.

This was reflected in the increase in the level of savings required from an average of 2.2% in 2015/16 to 3% in the current financial year. At Q3, NHS England is reporting a small £61m overspend across all budgets. But the sector is forecasting, before the release of the reserve, an effective break-even position at the year-end.

The risks to the delivery of that position had declined from more than £500m at quarter one to £148m at Q3.

'We have some way to go if we are going to identify sufficient mitigations to be confident about meeting our objectives, but we are heading in the right direction,' Mr Baumann said.

Most of the remaining CCG financial risks were likely to materialise, so the success of delivering the financial objectives depends largely on its ability to find additional mitigations elsewhere.

'Either way, we will deliver a substantial contribution to financial balance across the health sector when the £800m is brought into play,' continued Mr Baumann.

'In that context, I have to say that it does look very likely, if not certain, that the £800m reserve, regrettably, will need to be released to commissioners' bottom lines to secure overall financial balance rather than being available for investment.'

"We have some way to go... to be confident about meeting our objectives, but we are heading in the right direction"
Paul Baumann

NHS England chief executive Simon Stevens added: 'That £800m is dependent on CCGs not using any of the 1% or not increasing their overspend in support of their local providers.

'That money would come off the £800m, which is needed for the provider sector nationally, so it would not be a sensible thing to do. That is something we need to make sure is understood right through the system.'

Despite increasing the delivery of efficiencies by £538m compared with last year, at month nine, clinical commissioning groups reported a year-to-date overspend of £437m, with a forecast year-end £370m overspend.

However, this was balanced by the financial position of other commissioners. Specialised commissioning is expected to balance its books by the end of the financial year. While there were small underspends in other areas of direct commissioning, the big area of action was in central budgets, where NHS England was continuing to identify savings to offset overspends in CCGs, Mr Baumann said.

In its Q3 report, the provider sector had a £886m deficit, which was £202m more than planned. The year-end forecast deficit of £873m is £293m more than the deficit planned, though NHS Improvement chief executive Jim Mackey said the Q3 position was £1.3bn better than at the same point in 2015/16.

• *See Winter blues, financial reds, page 8*

Cost pressure warning for chancellor

Chancellor Philip Hammond (pictured) has been warned, ahead of his Budget this month, that the NHS will need more funding to cope with demographic pressures from 2019/20.

In its green budget, published every year in advance of the Budget statement, the Institute for Fiscal Studies (IFS) said NHS spending up to and including 2018/19 would exceed the extra funding needed to meet demographic cost pressures by £1.2bn. But this would not be enough to cover non-demographic costs such as advances in medical technology.

But spending in 2019/20 is set to be £1.3bn less than the amount needed to meet the demands of a growing and ageing population. Funding for social care has also been cut and, while the over-65s population grew by more than 15% from 2009/10 to 2015/16, adult social care spending fell by 6.4%.

Funding transfers from the NHS via the Better Care Fund had helped to ease the pressure, said the IFS, but had stretched NHS resources further.

Mr Hammond is due to deliver his first Budget on 8 March. The IFS said it was not surprising he faced calls to top up the NHS and wider Department of Health funding outlined in the 2015 spending review.

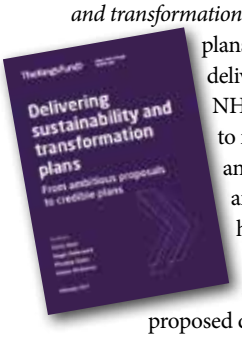
As *Healthcare Finance* went to press, there was no indication the chancellor would address health and social care funding.

King's Fund: government needs to back sustainability plan proposals

By Seamus Ward

Although sustainability and transformation plan (STP) areas must step up their engagement with staff, the public and patients, the government should back evidence-based proposals, even if this means substantially changing the role of a hospital, the King's Fund said.

In its report on STPs, *Delivering sustainability and transformation plans,* the fund said the 44 plans offered the best hope of delivering essential reforms of the NHS. They are an opportunity to move care out of hospital and closer to patients' homes and also to stem demand for hospital care.



Its analysis of the 44 STPs found that all areas proposed delivering more services in the community and aimed to boost their preventative work by, for example, addressing unhealthy lifestyles and promoting better mental wellbeing. As a consequence, some planned reductions in hospital numbers and cuts in the number of beds. Others looked to centralise services such as stroke and maternity on one site.

Some centralisation of care has been prompted by workforce shortages, which means all existing services cannot be staffed adequately, and a need to become more efficient. Other STPs wish to reorganise services to improve quality. In stroke care, for example, an overhaul of London's services in 2010 moved care to eight hyper acute units and the capital's stroke services are now regarded as world class.

Chris Ham, King's Fund chief executive, said: 'It is not credible for the government to argue that it has backed the NHS's own plan unless it is prepared to support changes to services outlined in STPs. Local plans must be considered on their merits, but where a convincing case for change has been made, ministers and local politicians should back NHS leaders in implementing essential, and often long overdue, changes to services. A huge effort is needed to make up lost ground by engaging with staff, patients and the public to explain the case for change and the benefits that will be delivered.'

The fund said plans to reduce hospital capacity would not work unless steps were taken to boost community and primary care services. Cuts in social care and public health budgets will make it difficult to strengthen services in the community and give greater priority to prevention, it warned.

The report called for greater realism about the time it will take to deliver changes. NHS Confederation chief executive Niall Dickson

Service change

A BBC analysis of STPs said the plans could lead to cuts or reductions in hospital services in nearly two-thirds of the areas. It highlighted 28 proposed changes to hospital services, ranging from full closure to centralisation of services, including A&E, on fewer sites. These included an option of a single site for maternity in Lincolnshire and a proposal to reduce the number of acute hospitals in Leicestershire, Rutland and Leicester from three to two.

It said a third of the 44 plans proposed reductions in the number of hospitals providing emergency care, while another third planned to consolidate elective care to fewer sites.

Birmingham's first as CQC ponders UoR approach

Birmingham Children's Hospital NHS Foundation Trust has become the first dedicated children's trust to be rated outstanding by the Care Quality Commission.

The regulator announced the overall outstanding rating in February following an inspection last year.

Although it is the first stand-alone children's hospital trust to receive the top rating, other children's services have been similarly recognised.

Guy's and St Thomas's NHS Foundation Trust last year received an outstanding rating for its children's services, which are delivered by its Evelina Children's Hospital on the St Thomas's site.

The Birmingham trust was rated 'outstanding' in terms of providing caring, effective and responsive services, 'good' in terms of being well-led and 'requires improvement' on delivery of safe services.

'The hard work of staff across the trust is exemplary and making a real difference to the lives of children, young people and their parents across the West Midlands,' said CQC chief inspector Sir Mike Richards (pictured). 'The trust should be proud of this outcome.'

February also saw the end of consultation by the CQC and NHS Improvement on their proposed new use of resources assessment, which would provide a broader assessment than the finance assessment currently used in the single oversight framework. Initially this would be presented alongside the CQC's existing quality rating.

But the consultation identified possible future options – combining use of resources with the five existing questions to produce an overall rating or creating a three-part rating based on quality, leadership and use of resources.

The HFMA's response to the consultation saw benefits in both approaches, but suggested the split assessment would give an increasing focus to resources and leadership. Other respondents have raised concerns. For example mental health charity Mind were strongly opposed to giving an equal weighting to financial capability.

• ***See technical review, page 28***

"What is being asked of local organisations is unprecedented and the STPs are having to drive this forward in extremely difficult circumstances"
Niall Dickson, above

agreed that patience would be needed but that health and social care were working together to change the delivery of care. However, the report provided more evidence that social care needed more funding urgently.

'The government and NHS England deserve credit for putting in place a process and a large number of important schemes to transform services – but there is a need for patience for these and other initiatives to bring about the necessary change. What is being asked of local organisations is unprecedented and the STPs are having to drive this forward in extremely difficult circumstances,' he said.

• *See The way ahead, page 15*

12 more trusts may go into financial special measures

By Seamus Ward

Two trusts have moved out of financial special measures, but NHS Improvement confirmed that it was considering placing a further 12 into the turnaround regime.

Norfolk and Norwich University Hospitals NHS Foundation Trust and Croydon Health Services NHS Trust were removed from the list of eight trusts in financial special measures in February. However, NHS Improvement chief executive Jim Mackey said it could extend the scheme to bring trusts that are currently not delivering their financial plans closer to their plan by year-end.

NHS Improvement will meet with 12 financially challenged providers to determine whether financial special measures support is needed to improve their financial position. It said its work with providers previously in financial special measures had helped identify £100m of savings. And its financial improvement programme, which includes 20 trusts and will be expanded to a new cohort of providers, had found a further £100m in savings.

The trusts removed from special measures were delighted with the announcement. NHS Improvement challenged the Croydon trust to reduce its deficit by £7m more than planned in 2016/17, while achieving more than £14m of agreed efficiency savings and maintaining care quality and agreed trajectories for emergency care.

The trust is on course to achieve its agreed deficit control total of just under £33m at year-end.

Chief executive John Goulston (pictured) paid tribute to staff who had 'worked tirelessly' to increase efficiency without compromising care standards.

He added: 'Our recovery plan was carefully developed, with all savings schemes checked by our senior clinicians to ensure that we did not compromise patient care or safety. We are on track to reduce the trust's long-standing deficit by almost a quarter this year (2016/17) – but we know we need to keep a tight grip on money if we are to continue to make improvements.'

Norfolk and Norwich trust chief executive Mark Davies also thanked the organisation's staff for their hard work. 'We have designed and delivered this result together and I congratulate and thank every member of staff at the trust. This puts us on an excellent footing for the future.'

NHS Improvement launched a new wave of its financial improvement programme, inviting expressions of interest from trusts in February. Under the initiative, trusts pay for external consultant support to identify opportunities for efficiency savings.

• *See news analysis, page 8*

Carter launches new efficiency review

Lord Carter has extended his review of efficiency and productivity in the NHS to mental health and community trusts.

Lord Carter (pictured), now a non-executive director of NHS Improvement, published a report on acute hospital efficiency last February, finding unwarranted variation in areas such as running costs, sickness absence and procurement. He will mirror the approach used in his acute trust productivity and performance review. But NHS Improvement said his assessment would be tailored to community and mental health providers.

The oversight body added that the review would specify an optimal model for community or mental health trusts. It aimed to understand: what good looks like in mental health and community trusts; approaches

already in place and how these can be extended; and the metrics and indicators required to support the development of the models for the sectors.

A cohort of 23 trusts will engage in detail with the review team over the next six months. Lord Carter will also examine the potential to extend the new review to all other providers, such as ambulance and specialist acute trusts.

The HFMA is conducting a survey of mental health providers and CCGs, looking at investment needed to meet the *Five-year forward view* priorities and how this has been reflected in the 2017/19 contracting round. Members should receive an email inviting them to take part.

News review

Seamus Ward assesses the past month in healthcare finance

Plans to charge overseas visitors for elective care and the ongoing struggle over winter pressures dominated health news in February. While some commentators believed the announcement on overseas patients was merely an attempt to distract from the very real strains on the NHS, it created much debate.

The Commons Public Accounts Committee kicked off the discussion at the beginning of the month. It said the NHS must take urgent action to recover more of the cost of treating patients from overseas. In a report, *NHS treatment for overseas patients*, the MPs said the Department of Health should do more to ensure the public is confident the costs are being recovered. It added that it was not convinced that the Department was taking effective action and that its efforts were hampered because the NHS was not identifying all chargeable patients. NHS England and clinical commissioning groups were not doing enough, the committee added. It called on the Department to publish an action plan by June.

Only a few days later, the Department announced that hospitals will be required to check if patients must pay for their non-urgent treatment before it is given. The new measures will be implemented in April and will require trusts to charge those who are not eligible for free treatment. The Department said the regulations would play a key part in delivering its target of recouping £500m a year from overseas visitors not eligible for free care. It added that NHS Improvement will be working intensively with trusts with the most potential to recover costs in the coming months.

If the government did intend this to be a distraction, it only worked a few days, until NHS England published the latest figures for performance at A&E departments. A&E attendances continued to rise in December, with just over 1.9 million cases, an increase of 4.1% on December 2015. The figures showed attendances at all types of A&E departments were 4% higher than a year earlier and there was a 3.5% increase in the number of patients admitted to hospital compared with December 2015. Emergency departments once again breached their four-hour target, with 86.2% of patients seen in that time – 91% were seen in December 2015.

Scottish A&E performance was better. A&E departments there saw 92.6% of patients within four hours in December, according to official figures. There were almost 131,000 attendances during the month – the highest for the last month of the year since 2012. Health secretary Shona Robison said the performance was due to the dedication of staff. She added that a small number of emergency departments were facing challenges and the government would work with the appropriate health boards to provide the support they require.

Although the power-sharing executive in Northern Ireland has crumbled and there will be fresh elections on 2 March, health minister Michelle O'Neill (pictured) was able to publish a plan to reduce waits for elective treatment and diagnostics. She has been named as leader of her party, Sinn Féin, in Northern Ireland. The plan includes six commitments, including reducing the waiting list backlog while reforming secondary, primary and community care services. The first phase requires around £31m in non-recurrent revenue in 2017/18 to clear the backlog of people waiting

The month in quotes

'These figures reveal a service under enormous pressure. It was not designed to care for so many older people with long-term health conditions and it is unsurprising that this is affecting patient care.'
Responding to the latest NHS operational performance figures, NHS Confederation chief executive Niall Dickson calls for a redesign of the health and care system

'I'm proud of our achievements, but I want us to be more ambitious for 2017. I want us to continue to reduce planned care and diagnostic waits. I want us to build a health service that meets and delivers on the needs of our patients and that is sustainable, in spite of the challenges.'
Wales health secretary Vaughan Gething calls for further reform of the local service

'We are announcing plans to change the law, which means those who aren't eligible for free care will be asked to pay upfront for non-urgent treatment. We aim to recover up to £500m a year by the middle of this Parliament – money that can then be reinvested in patient care.'

Health secretary Jeremy Hunt says visitors must pay for elective care

'We're turning the corner on a decade of underinvestment in GP services but with new cash clearly tied to new ways of working that both improve patient care and support family doctors. While this new national contract is just one piece of the jigsaw, it's another concrete step towards more convenient appointments for patients and more time for GPs to look after frail older people.'

NHS England chief executive Simon Stevens hails the new GP contract

SHUTTERSTOCK

more than 52 weeks for a first outpatient appointment and inpatient/day case. The backlog of patients waiting more than 26 weeks for diagnostics will also be cleared by the end of the financial year, under the plan. However, the funding has not yet been approved.

The Department said the new regulations would help it recoup £500m a year from overseas visitors not eligible for free care

In February there was a fresh warning on inefficiency. NHS Providers and the Royal College of Surgeons said that lack of bed availability is creating inefficiencies. In a letter published in *The Sunday Times*, the organisations said cancelled operations delayed patient care and led to an inefficient use of staff time. Surgeons were 'kicking their heels' as they waited for a bed to become available so they could operate. They called on NHS England and NHS Improvement to learn the lessons from this winter.

Despite the earlier protests of doctors, the new GP contract for England includes a clause preventing GP practices that regularly close for a half day from receiving extended hours funding. However, announcing the new contract, NHS England, the government and the British Medical Association said practices that partner with others to offer more evening and weekend appointments would be eligible for additional non-contractual funding over and above the existing extended hours scheme. The change will be implemented in October. Also in the new contract, GPs will get a 1% pay increase, with a 1.4% uplift for expenses. An additional £239m will be added to contract funding, while negotiations on the Carr-Hill formula – used to calculate core funding for general medical services (GMS) practices – will begin shortly with a view to implementing changes in 2018.

The Welsh NHS Confederation called for a shift towards preventative services to improve health and reduce demand. It said the NHS and other public bodies must take heed of public support for prevention – a survey for the confederation found that the public believed prevention should be in the top four priority areas for funding. Wales health secretary Vaughan Gething (pictured) warned that longstanding and unacceptable performance issues would not be tolerated. Though progress had been made, he wanted further reductions in waiting for planned care and diagnosis. He added that he wanted to incentivise excellence and was looking at the best ways to achieve this.

The Department of Health has opened a consultation on a proposed fixed recoverable costs scheme for lower value clinical negligence claims. It said the proposed scheme would allow for quicker and more cost-effective resolution and more opportunities for early learning. The consultation closes on 1 May.

The HFMA has published a paper looking at environmental sustainability reporting requirements for commissioners and providers. The paper also examines the wider government requirements and where best practice and guidance can be accessed.

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in the media

With NHS finances firmly in the headlines, the HFMA has been widely quoted in the media over the past month.

The release of provider Q3 figures by NHS Improvement prompted the BBC to look at the reasons behind the overall deficit. HFMA policy director Paul Briddock told health editor Hugh Pym NHS staff had done a 'remarkable job in trying to keep services going while delivering over £2bn of efficiencies'. He told *National Health Executive* hospitals were a barometer of how the service is coping and the difficult winter was taking its toll on services.

Though published in December, the HFMA *NHS financial temperature check* continued to attract attention, particularly when assessing the state of NHS finances and the role of sustainability and transformation plans. In a comment for *National Health Executive*, Mr Briddock said the temperature check had shown initial support for STPs and a belief that they are encouraging greater collaboration between commissioners and providers. But finance directors had concerns over governance and risk management arrangements.The introduction of STPs was positive, Mr Briddock said, but they faced great challenges, including delivering efficiency savings and coping with other pressures, such as workforce planning and reducing agency spending.

News analysis

Headline issues in the spotlight

Winter blues, financial reds

The latest financial figures for NHS providers clearly demonstrate the financial consequences of one of the most challenging winters the service has faced. Steve Brown reports

Nobody should need evidence that the NHS has faced one of the most challenging winters on record. The impact on demand for hospital services and performance, measured largely in waiting times, has been all too clear. But providers' nine-month figures provide further confirmation and show the financial consequences of this sustained pressure.

NHS Improvement was quick to point out the unprecedented pressures facing providers – pointing to one of the 'toughest winters on record'. There was recognition and gratitude for the hard work to 'improve finances and deliver quality health and care'.

But this came with a clear message that providers needed to go even further to improve their financial positions. Current forecasts were 'both unaffordable and unsustainable'.

HFMA director of policy Paul Briddock said it was clear the mounting pressures over winter had taken their toll on services. 'The NHS workforce is trying hard to deliver services, efficiencies and value – but is now being pushed to the ultimate limit,' he said.

Keeping services going while delivering over £2bn of efficiencies to date was 'remarkable', but the increase in demand and activity meant that 'hospitals are simply being overwhelmed'.

The Q3 report highlighted that 200,000 more patients attended accident and emergency departments between October and the end of December than the same period last year. There was also a 3.5% increase in the number of patients requiring major further in-hospital treatment.

This led to underperformance on key standards – just 86.74% of patients seen within four hours in A&E, for example – and to the postponement of elective care. And the pressures were further compounded by a 28% increase in 'lost bed days' – lost because medically fit patients couldn't be discharged due to constraints on community or social care.

The demand has translated directly into financial performance. Overall, the provider sector as a whole is reporting an £886m deficit at month 9 – £202m more than planned at this stage in the year.

The forecast for the year-end is an overspend of £873m, some £293m more than the £580m deficit plan – although NHS Improvement believes that the position could improve.

Chief executive Jim Mackey highlighted the loss of elective income as a result of the focus on emergency treatment. 'Despite this, the sector's financial position is £1.3bn better than at the same point last year,' he said.

'In addition, 135 providers ended the quarter in deficit which is 44 fewer compared to the same period last year.'

However, the impact of recent service pressures was clear, with a £238m deterioration in overall position in the third quarter alone. And looking at the provider level position, these organisations were £435m overspent compared with plan (on a control total basis) at the end of December and are forecasting a year-end deficit of £1,410m – some £621m worse than their combined planned deficit of £789m.

"The NHS workforce is trying hard to deliver services, efficiencies and value – but is now being pushed to the ultimate limit"
Paul Briddock, HFMA

This is offset by £113m of technical adjustments and £424m of undrawn sustainability and transformation fund (STF) to give the overall sector position

The undrawn STF money includes £239m that had been allocated to providers but is now held centrally as providers have failed to meet key funding criteria.

NHS Improvement acknowledged that providers have been 'responding to unrelenting demand for hospital-based emergency and urgent care' since April. These pressures – heightened over the winter – have pushed operating costs up by 1.4% more than plan. However there has not been a corresponding growth in revenue, which has only grown by 0.5% above plan.

Pay has been a major focus for the NHS over the past 12 months, with a specific push to reduce agency staff spend. In total pay was 0.8% higher than plan at month 9 – although this reflected a relatively minor £43m underspend (0.1%) on permanent and bank staff and a £359m overspend (19%) on agency and contract staff. This means agency costs now reflect 5.9% of total pay costs compared with the planned level of 5%.

Providers were forecasting a year-end £118m overspend on permanent staff and a £488m overspend on agency – which would mean a 1.2% overspend on staff overall.

However, NHS Improvement said this still reflected improvement. Year-to-date agency expenditure was £505m lower than in the same period last year, when agency costs stood at £2.7bn and represented 7.5% of total pay costs. Two-thirds of trusts have reduced their agency spend since agency rules were introduced in October 2015.

If trusts remain on their forecast trajectory, by the year end, the year-on-year reduction in agency spend will reach £771m. However, the

THEODORE WOOD

"The sector's financial position is £1.3bn better than at the same point last year. In addition, 135 providers ended the quarter in deficit – 44 fewer than the same period last year"
Jim Mackey, NHS Improvement

forecast outturn agency spend would still be £488m above plan and £418m above agency expenditure caps.

NHS Improvement has promised new rules to ensure providers stay focused on this agenda. These will include requiring chief executives to sign off all shifts costing more than £120 an hour.

Overall, the full-year forecast for pay would mean pay costs had grown by 3.3% compared with the planned level of 2.3%. This reflects the need for additional staff to manage the extreme winter pressures.

However, the oversight body also highlighted analysis suggesting a reduction in real-terms pay costs per weighted activity unit. This suggests that, while the workforce may be costing more in absolute terms, it has become more productive or the average cost per employee has reduced.

Acute activity growth of 2.2% is identified as the key driver behind a £495m overspend on non-pay budgets at month 9.

Drugs and supplies make up nearly half of this overspend, with percentage increases close to the activity growth. But the overspend on consultancy is a more dramatic 13%, although it only amounts to £21m.

Capacity constraint is an increasing issue. Trusts have so far spent £123m on waiting list initiatives and £302m on outsourcing to other providers. Outsourcing is a particular cost pressure, with providers expecting a full-year spend of £402m.

Delayed transfers of care – 28% higher than last year – are also having a damaging impact, both operationally and financially. Three-quarters of the way through the year, these delays have cost providers £124m directly and could reach £169m for the full year – £24m more than last year. And these costs are, in fact, likely to be 'much higher' than estimated, according to NHS Improvement.

Continuing the consistent message of most trusts 'doing well but need to do better', providers delivered £2bn of savings through cost improvement programmes (CIPs) during the first nine months – reducing total year-to-date expenditure by 3.3%. While this was £101m more than the first three quarters last year, it was still £207m short of plan. Shortfalls of £217m and £66m on planned pay and non-pay savings were offset by £75m over-performance on income generation schemes.

Three quarters of the savings were through recurrent schemes, below the planned 92% level, with an increase in non-recurrent savings making up the slack. At the year-end, providers expect to deliver savings of £3.14bn, which would be £229m below plan.

NHS Providers chief executive Chris Hopson described provider CIP targets as 'unrealistic' – typically 4%. 'This is double what was originally intended and it leaves no margin to cope with the inevitable pressures that emerge during the year,' he said. 'It's no surprise that some trusts fall short.'

An 'intensive review' process before the figures were published saw providers' initial full-year deficit forecast of £973m reduced by £100m. And NHS Improvement believes that a number of measures in the final quarter will help to bring the final forecast deficit into the range of £750m to £850m. This is close to the £800m risk reserve that commissioners have been required to set aside.

These measures include a possible expansion of NHS Improvement's financial special measures programme to a further 12 trusts. It is also working with providers to help them recover elective losses.

More generally, it is promising to focus support where it is most needed. Although all trusts face major financial pressures, there are 121 currently forecasting a deficit. Some 74 are forecasting a collective overspend against plan of £492m, and £280m of this is attributable to 13 providers. These trusts will be subject to more stringent oversight. A number of land and property transactions may also provide some non-recurrent improvement.

Summarising the views of many commentators, Richard Murray, policy director at the King's Fund, said: 'There is no doubt these are worrying figures that highlight how serious the NHS's financial position is, both in this year and the years ahead. Even if the Department of Health manages within its spending limit this year, the prospects for the rest of this Parliament are extremely challenging.'

Thanking 'most providers' for their hard work to improve finances and deliver high-quality care, NHS Improvement's Mr Mackey added that the job was 'not done yet'.

With many cost improvement programmes phased to deliver more in the final quarter anyway, and January's continuing service pressures yet to be factored into reported figures, that might count as one of the year's biggest understatements.

Comment

March 2017

The NHS rocks!

Amid the headlines, there are positives if you are prepared to look

If January was all about the extreme demands being placed on the NHS, then February was dominated by the financial impacts of those winter pressures. Of the quarter 3 figures for commissioners and providers in England, it was without doubt the provider numbers that grabbed the headlines.

Last month, I reflected on the need to exit 2016/17 in the best possible financial shape. And with the Q3 report documenting a £238m deterioration in the sector's financial performance in the third quarter alone, this challenge looks tougher and tougher.

How might the chancellor, Philip Hammond, react as he prepares his 8 March Budget? We should probably not expect any major changes of direction. It is widely expected that the task facing the NHS finance community and the service in general in the near term will remain fundamentally unchanged.

That means delivering this year as close to the plans that we individually and collectively signed up to, in order to create the best possible platform upon which to start next year.

Yes, this is as obvious as it is clear, but this year the necessity for each of us to 'do what we said we'd do' feels to me to be on an escalated scale of importance.

It is hard not to see the NHS – and social care – on the cusp of a landmark decision as we enter the next political cycle – for politicians and the public. Either it needs a strong reaffirmation, with the appropriate funding to take

HFMA president Mark Orchard

In defence of our managers

An NHS crisis hasn't begun until someone questions the role of management

It makes me cross – and I'm no NHS manager. So I can't imagine how it makes you feel. It only takes a few headlines about service pressures and financial problems to get someone suggesting we could address at least some of the current challenges by sacking a few managers and replacing them with various coloured scrubs.

The question of management costs came up again in a recent special debate on Radio 4, examining what needs to give to enable the NHS to cope with its current pressures. There are plenty of examples in recent national and international politics where people want to grasp overly simple solutions to complex problems, but this one just never goes away.

The late Tony Benn famously riffed on the topic in a debate in the House of Commons in 1995, when he referenced a mythical boat race between the NHS and Japan. All you need to know is that NHS managers didn't come out well from the anecdote. It was a clever way of getting across his view that the NHS was over-managed – you'd expect little else from the distinguished parliamentarian. But for those in the service, the constant brickbats must get beyond a joke.

Back on the BBC debate, NHS Providers' Chris Hopson mounted a sterling defence of current management levels in the NHS, insisting NHS management and administration costs were a third of those in the US and half of those in 'efficient Germany'.

Given 1.4 million staff and a £115bn budget, wouldn't you want good HR and finance departments? With the NHS seeing one million people every 36 hours, wouldn't

Healthcare Finance editor Steve Brown

"So much care and kindness... We are privileged indeed to have such first-class facilities"

account of demanding but realistic transformation and productivity expectations, or the signal of a new direction.

It can be tough working in an NHS finance environment when the mood music is so negative. National media coverage of the financial position was, inevitably, overwhelmingly negative.

However, there were positive angles if you were prepared to look. Higher levels of cost improvement programme savings, reductions on agency staff spend and reductions in pay costs per weighted activity unit, suggesting higher productivity. Delivered in the face of rising demand and what NHS Improvement recognises has been 'one of the toughest winters on record', these may be seen as significant achievements.

As I make my way round our 13 branches, I will be reminding colleagues to celebrate the great work of our teams in supporting the growing demand for frontline care.

Amid the negativity in the media, we should also remind ourselves how valued our services are by those who most depend on them.

A letter to my trust's local newspaper recounted one woman's experience of the NHS when her husband took very ill. She praised the 999 service operator and the 'brilliant, professional, calm and reassuring' paramedics who responded. 'Within half an hour, we were in A&E. The treatment my husband received was top notch, so much care and kindness.

'Every single member of staff was professional, positive, caring and patient. My husband is home safe now,' she wrote. 'We are privileged indeed to have such first-class facilities. The NHS rocks!'

All our services will have earned similar public reactions and it is important that we keep sight of this. Our own role, providing support to the frontline, is just as vital in ensuring we can continue to deliver these important services in as streamlined a way as possible while also planning for the most effective service in the future.

Everyone counts. And right now, I'll bet that someone is counting on you.

Contact the president on president@hfma.org.uk

you want people ensuring effective flow? When operating theatres are so expensive to run, don't you want people ensuring they are as efficient as possible? If anything, he argued, the NHS was undermanaged.

It is a point made previously by the King's Fund. It is six years since the respected research body's commission on NHS management. It recognised the difficulty in defining management but suggested 'best estimates' put the cost of management and administration at about 8%. Its analysis also concluded that, given the complexity of healthcare, the NHS was more likely to be under- rather than over-managed.

To be fair to the clinicians involved in the BBC debate, they mounted their own defence of management – a surgeon suggested her surgical team couldn't operate without the management skills that get people to the right place at the right time. Where there were concerns, it was more about what managers were being forced to spend their time on.

For example, there are plenty of people (managers and clinicians alike) who see waste in the continued operation of an internal market – though many functions would still need to be undertaken (such as understanding local population needs) whatever the system architecture. And there remains open hostility to the money spent on external management consultants (although the alternative would presumably involve more internal management resource).

Politicians over the years have often encouraged the simplistic perception of 'frontline good, management bad'. There

"When operating theatres are so expensive to run, don't you want people ensuring they are as efficient as possible?"

remains a push to examine shared back-office services and there has been no mention of not pursuing Lord Carter's recommendation for acute trusts to cap corporate and administration function costs at 7% of income by April 2018.

But in general, there seems to be a greater central appreciation that the challenges facing the service won't be addressed without a support function that has the right skills and the right numbers.

However, it must be hugely demoralising to hear the same accusations trotted out again and again – effectively questioning the contributions of important support services.

Doctors, nurses and allied health professionals do fantastic jobs. But ignoring the important contributions of all the other health service workers is at best naïve. And at worst, it will demotivate a crucial part of the workforce when we most need them.

Yes we scan

One year into the NHS e-procurement demonstrator projects, Seamus Ward looks at how the scheme has developed

What's in a name? Compare 'the Department of Health e-procurement strategy' and 'Scan4Safety'. Though e-procurement is more broadly based, the names have been used to describe the same project – the adoption and use of GS1 barcode standards across the NHS in England. The former sounds a little niche, a bit techy. The latter emphasises that it is a way of improving the safety of patient care and not just a procurement scheme or a way of saving money. That message is vital as the project enters its second year.

Scan4Safety (S4S) has caught the eye of health secretary Jeremy Hunt – well known for his support for technology as a means to deliver improved safety. In late December, he praised the scheme, saying it could save lives and money – potentially £1bn over seven years.

A little over a year ago, six demonstrator sites for the then e-procurement project were announced, with each given around £2m over 24 months. While the NHS remained way behind the commercial sector in its use of technology in procurement, all six were at the forefront of implementing e-procurement in the NHS.

They included Derby Hospitals NHS Foundation Trust and its point of use scanning, which links items used to its stock management and financial systems. This allows the trust to see the procedure performed, the clinicians involved, equipment and prostheses used and time taken in an end-to-end procurement system (see *Healthcare Finance,* October 2014, page 12).

The project has six elements, including three core enablers – catalogue management through using GS1 GTIN (global trade item number) barcodes, patient identification using GS1-compliant wristbands and global location numbers (GLNs). These are standards that ensure a trust can identify a person (patient or staff member), place and product.

The successful implementation of these standards will allow value to be generated in the three primary use cases – purchase-to-pay, inventory management and product recall. The PEPPOL standard, which allows organisations to exchange documents electronically, is allied to GS1 barcodes as it supports NHS and supplier computer systems to communicate, underpinning efficient purchase-to-pay systems.

The key enablers and use cases mean that with the patient and product scanned together with their location each time they are moved, treated or product used, not only will a trust know where a patient or a product is, but also can look at their electronic patient records to see which implant or batch of drugs has been received.

In the event of a product recall, this could save days poring over paper records to uncover this information. And, taking it a step further, if clinicians also scan their own ID barcodes, the trust will know who delivered the treatment. In the back office, items should be reordered automatically, while the purchase-to-pay cycle should operate seamlessly, with little human intervention.

GS1 UK head of healthcare Glen Hodgson says that S4S is about people, products and place. While most of the demonstrator sites will complete their programme between October this year and March 2018, he says the Derby trust is due to have its key enablers and use cases in place by this month.

Overachieving on savings

Although the numbers are not huge – running to a few million pounds – overall the demonstrator sites are overachieving on forecast efficiency savings. 'The important thing is that this is not a technical project. It's not about systems, it's about culture, being transformational and communicating what you are doing, why and how this impacts on patient safety,' says Mr Hodgson.

He says trusts other than the demonstrator sites continue to show an interest in developing their GS1 compliance. At a national level, the Department of Health and the Treasury are working through a business case that would see S4S rolled out to another 148 acute trusts in four annual waves. This would cost £312m for a return of just over £1bn over seven years – the same return referred to by Jeremy Hunt at the end of 2016. At the moment, the plan is to roll out to 25 trusts in 2017/18 and then around 50 a year from 2018/19.

Healthcare Finance spoke to a number of the demonstrators, each confirming they have made progress and seen benefits. Andy McMinn, chief procurement officer at Plymouth Hospitals NHS Trust, says that during the first 12 months it focused on delivering the core enablers.

The trust has ensured each space has a GLN – helped, he admits, by being in the unusual position of having a software system with every space identified. 'It goes to show how challenging this is – just the GLNs

took us 12 months. For others, it will take another three or four months.'

In addition, admitted patients have a GS1 wristband that uniquely identifies them. However, Mr McMinn acknowledges that there is still some way to go to giving all 85,000 products in its catalogue a GTIN – currently around 16% have a GTIN.

'That is because it relies on the suppliers adopting GS1 and attributing codes to each of their products. It will take time, but each week we get more and more GTINs,' he says. The trust is being proactive – it has around 2,300 suppliers and is focusing on the top 80, he adds.

Chris Slater, associate director commercial and procurement at Leeds Teaching Hospitals NHS Trust, says it uses around 30,000 different products and, before Scan4Safety, had a number of projects to streamline its supply chain at ward and theatre level. Higher value items had traditionally been ordered by the department that used them, but the trust needed to exert some control so it has also applied inventory management to these items.

Mr Slater says the process of moving the 30,000 items used by the trust to GS1-compliant barcodes is a slow one, but it is progressing as suppliers acquire GTINs for their products and update their packaging.

As with other demonstrator sites, Leeds has focused on areas and items with a high risk or value, such as theatres and hip and knee prostheses, and will continue in this vein. It is currently scanning product barcodes to patients in 29 of its 64 theatres.

'It's very much about visibility and transparency. If you link a product to its usage you can ask, "Do we need to hold as much inventory as we have?" You get real time visibility. We have taken about £750,000 of inventory off the shelf since we started the project and this can be reinvested in other things rather than sitting on the shelf.'

Plymouth does not currently scan products at the point of use, though it is developing a system to do this with its partner Genesis that is due to launch in theatres this month. Mr McMinn argues that the problem is that products can contain a number of barcodes with varying information, even when they are from the same supplier. Clinicians cannot reasonably be expected to know which to scan. He says its new system will capture all the barcode information, whatever the standards used, and translate it to information that can be shared across its IT systems.

Though he cannot, as yet, go into detail, he adds: 'This is about reducing variation and making processes more reliable. Over the next year we will significantly operationalise and broaden point of care scanning. I think that is an exciting development for the NHS.'

Creating value

The trust is going into the second phase. 'We are moving to the value-creating element of the project – in inventory management, purchase-to-pay and product recall. We are beginning to run GLNs and GTINs through PEPPOL, matching purchase orders to GS1 numbers from machine to machine and aligning them with invoices.'

Initially it will concentrate on a number of areas, such as trauma and orthopaedics, cardiology and pharmacy.

Its finance and accounting provider, NHS Shared Business Services (SBS), is closely involved in the project. Mr McMinn explains: 'From an SBS perspective, a request placed through a catalogue, generating a purchase order that has GTINs and GLNs and sent through the PEPPOL infrastructure will be processed in the fastest manner. No human hand will be involved. The goods are shipped to us in the shortest lead time and the supplier will be paid quickly.'

The trusts contacted by *Healthcare Finance* have initially focused on higher value products and meeting the Department of Health expectation that class 3 medical devices (prostheses and other implants) can be tracked to individual patients by the end of the first year.

Mr McMinn says this covers 40% to 50% of a trust's inventory and 25% to 30% of its expenditure. 'These are high-spend areas for any hospital and the benefits from a financial perspective are around less waste, better budget setting and more accurate reporting.'

Eventually, he wants to be able to scan all products, though he says it will be several years before all suppliers are GS1 compliant.

David Berridge, deputy chief medical officer at the Leeds trust, believes that although patient safety is one of the key drivers behind the work, operational and financial efficiency follows on from implementing the technology.

GLNs provide a good example, says Mr Berridge, a consultant vascular surgeon. 'For the first time, we can ensure our clinicians know where their patients are 24 hours a day, seven days a week. For example, there are lots of occasions where a porter goes to a ward to bring a patient for an endoscopy, a CT scan or other test and the patient is not there. For one reason or another, they have been moved to another ward and the information has not been updated. Scan4Safety updates the information in real time, so you won't get wasted clinical slots.'

Linking patients, patient records and procedures and treatments will also reduce never events, he adds. 'There's less money sitting on shelves and less risk of products going out of date or, even worse, then being

"This is not about systems, it's about being transformational and communicating what you are doing"

Glen Hodgson, GS1

> **"It brings to clinicians a realisation of the cost of what they're doing. Often you don't need to do much more than point out the data"**
> **David Berridge, Leeds Teaching Hospitals NHST**

used on patients. It will free up nursing time so they are able to do what they are trained to do. There will be more clinical efficiency, more financial efficiency.'

Mr Berridge accepts it will be a culture change, though the trust will emphasise the benefits of saving clinician time in the long term.

Clinicians will also see the benefit of comparing surgeons performing the same procedure and, adjusting for casemix, reducing unwarranted variations, he adds. 'If you are more efficient in your list, there's the potential to add another patient for the same resource. You will also reduce your sterilisation costs and improve patient safety.

'It brings to clinicians a realisation of the cost of what they are doing. Often you don't need to do much more than point out the data – surgeons are competitive and they wouldn't want to be seen as an outlier among their peers.'

The demonstrator sites must pass on their learning – something they are keen to do – but do they have any advice for other trusts? Mr McMinn says: 'I have one golden rule for other trusts – speak to the demonstrator sites and soak in as much information as you can.'

Leeds' Mr Slater adds: 'It's a change management project and this needs to be understood, not just in financial terms, but also in clinical terms and in terms of the benefits to the patient. We are one of the biggest trusts in the country, so if Leeds can do it, anyone can.'

E-procurement has a patchy history in the NHS, with many false starts in recent years. The service will be keen to hear the decision on the roll-out business case, but with a mandate to implement GS1, the strong support of the health secretary and its potential to deliver safer care more efficiently, it looks like Scan4Safety will go NHS-wide.

Salisbury stays ahead

Salisbury NHS Foundation Trust is well known for being advanced in many aspects of e-procurement, but the Scan4Safety demonstrator programme has helped it move further, faster, according to Rob Drag, its GS1 and PEPPOL programme manager.

He says that around 12 months ago the trust used some inventory management and was well advanced in catalogue management, but was less so in terms of patient wristband identification. S4S brought together workstreams across the trust and has also given the patient ID programme a shot in the arm.

'We identified the areas where it would be beneficial and then the challenge was to change the systems,' he says. 'Previously, a nurse would have to log onto the system and choose the right patient, but now they just have to scan the wristband and the system immediately goes to the patient.'

The scheme has been piloted on a surgical ward, with a full roll-out planned. Though hard cash savings are hard to quantify, there have been benefits. For example, it can help stop patients being given the wrong blood product, with the potential to alert the clinician on a mismatch at a number of points in the process.

The trust has also made progress towards ensuring all parts of the hospital have a location code. Mr Drag says the first step was to ensure computerised or CAD drawings were up to date; the next is to assign barcodes to locations and use them.

The trust is working with suppliers to ensure compliance with GS1 barcodes and rolling out an inventory management system with hand-held scanners. In cardiology, one of the first areas of the trust to use the technology, a scan will show a product expiry date, giving extra protection for the patient before it is used. The information also automatically feeds into the service line reporting and costing systems, generating valuable management information.

The system will be rolled out next to orthopaedics and will eventually cover all departments, 'from catering to cardiology'. The complexity of inventory management depends on the needs of each specialty or service. At one end of the spectrum, surgical specialties might require detailed track and trace capability; at the other, non-clinical areas will need less sophisticated tracking.

Inventory management means clinicians spend less time ordering stock, he says. It has led to stock reduction, saving £148,000 in pharmacy, £65,000 in theatres and £30,000 in cardiology. In orthopaedics, the trust has identified £50,000 worth of out-of-date stock, which, as a one-off, the supplier has agreed to swap for in-date products.

The way ahead

Sustainability and transformation plans have had a rough ride so far, and the public views them with suspicion. Seamus Ward takes a closer look at what they propose

Stories of secret NHS plans to shut down hospitals; local councillors leaking plans they disagreed with; and, when finally published, the public complaining that the wording of their local sustainability and transformation plan (STP) was gobbledygook. It's been a tough time for STPs and it will probably only get harder as NHS leaders consult with the public, implement their plans and try to realise the clinical and financial benefits.

Setting aside the opposition and fear, however, what are the emerging themes from STPs? As you would expect, the high-level messages are of collaboration, improving health and social care experiences and outcomes, tackling inequality and delivering financially sustainable services.

Their system-wide, partnership approach has given many commentators hope they will be able to tackle the tough issues facing the NHS. In December's *NHS financial temperature check*, the HFMA asked finance directors for their initial views on STPs. Their responses showed that they believed STPs had led to valuable strategic discussions and that there was a general acceptance of the worth of the

SHUTTERSTOCK

process, particularly regarding deficit reduction. But there were concerns about governance arrangements.

The King's Fund believes STPs offer the best hope of securing a sustainable NHS. Senior policy adviser Helen McKenna says: 'We welcome the broad direction set out in the STPs in terms of how they seek to progress and implement the vision in the *Five-year forward view*. We support the ambition to reduce the dependency on hospitals and to provide more care in the community, as well as the place-based approach that STPs are taking, with organisations coming together to tackle problems.'

Care networks

The fund published a report on STPs in February, and found consistent themes. 'Broadly, [STPs] want to deliver more services in the community, by, for example, putting GPs at the heart of networks, with some seeking to bring together primary care, community services and social care. A lot of the plans place a greater emphasis on prevention, tackling unhealthy behaviours and promoting mental health and wellbeing.'

For example, Lancashire and South Cumbria proposes shifting more care out of hospital to a beefed up primary and community care sector (see below).

Measures to take forward the Carter agenda are evident in all plans, as STPs seek to improve productivity and efficiency, and close their local funding gap. Ms McKenna adds that some STPs propose a reduction in the number of hospitals in their area, cutting the number of hospital beds or centralising services on a single hospital site.

For example, North West London's STP includes a proposal that has been under development for several years to reduce the number of major hospitals from nine to five. Two local authorities oppose the proposal.

Meanwhile, Nottingham and Nottinghamshire proposes to cut more than 200 beds through more timely patient discharge, while the Derbyshire STP estimates the area will need 400 fewer beds by 2020/21 following the redesign of care delivery.

The Cambridgeshire and Peterborough plan proposes that a number of services be considered for centralisation, including orthopaedics, stroke, maternity and paediatrics. The proposals for stroke services would lead to all stroke and neurological rehabilitation care being delivered on a single site instead of being spread across a number of sites, though the two hyperacute stroke units in the area would be retained.

The STP expects the move to improve the quality of services provided to patients and deliver efficiencies.

Ms McKenna says a number of STPs have a focus on the workforce and the impact of shortages of staff on care. 'Lots are trying to be innovative when trying to solve the problem – for example, through proposing the use of physician associates or care navigators to support plans to shift care out of hospital.'

Some are looking at using the new apprenticeship levy. Devon's STP suggests creating new roles such as care apprentices and exploring more flexible career pathways that will allow staff to rotate between local organisations.

Gary Raphael, chief finance officer of the Lancashire and South Cumbria (L&SC) STP, says its STP is not so much a plan as an indication of a potential future, especially since the precise nature of changes has yet to be consulted on and agreed locally.

'I think calling our STP a "plan" at this stage gives the wrong impression to the public. We have a shape for something that delivers what we need – meeting FT/trust control totals and CCG business rules. But our actual plans are being developed and will be subject to further debate and consultation.

'I think STPs have to be clear about the status of their plans. In areas such as Greater Manchester, a lot of work had been done prior to the requirement to submit an STP and they were probably able to call it a plan.

'Other STPs may not have been in a position to develop a coherent plan in time for submission and yet others may have been in the middle of formulating system-wide plans, but may not have had them completed. I think L&SC falls into the latter category.'

Nevertheless, a document has been submitted to the national oversight bodies. 'The broad shape of our STP is that we are not looking to substantially downsize our acute trusts. We are looking to hold demand to the levels we have this year (2016/17) and stop the growth in acute care. We think the only way to achieve that is to take a radically different approach to the way out-of-hospital services are organised.'

The STP area has a do-nothing gap of £572m across health and social care on a turnover of £3.7bn. Over the next four years, local health commissioners will be receiving an additional £345m – growth of 11.3% over the period.

'The reason we have a problem is partly because some of the organisations already have financial problems, but mainly because the growth in costs is higher than the growth in allocations and income,' says Mr Raphael.

It has proved difficult to get the message through to the public that the STP is trying to avoid costs rather than planning to take £572m out of existing budgets.

"We are not looking to substantially downsize our acute trusts. We are looking to hold demand to the levels we have this year (2016/17) and stop the growth in acute care"

Gary Raphael, Lancashire & South Cumbria STP

'We are looking to stop the cost increase to commissioners in acute care and invest our growth money in primary, community and mental health services,' he says.

Where service change is proposed, convincing the public will be difficult, Ms McKenna says. The perceived secrecy around STPs has made the public and local politicians wary. 'Proposals must be sufficiently stress tested, but where the evidence does mean reducing a service is the right proposal, how do STPs communicate that to the public and local politicians? STPs face immense challenges in winning support.'

Some proposals are driven by the need for clinical sustainability. 'I think each of these proposals has to be considered on its own merits, but it appears that some of the proposals will be right for the reasons of clinical quality because there simply isn't the workforce to sustain high-quality services at a number of sites,' she says. 'Where they are evidence based and credible, these proposals need to be supported.'

The report argues that bed cuts are not credible unless investment is first made in community services. Ms McKenna says this includes making the most of existing community services by greater integration of out-of-hospital services.

Community model

Expanded primary and community care represents the flip side to changes in secondary delivery. One potential model for enhanced primary and community care is emerging from Lancashire – the Fylde Coast multispecialty community provider vanguard. Its care model, known as extensive care, focuses on the over-60s with two or more long-term conditions, supporting them to stay out of hospital. It looks at those who use services most and applies risk stratification to predict when a patient's condition could be about to decline and require hospital admission.

All health and social services are wrapped around the patients, so services they may have received in hospital previously, such as a diabetes or COPD programme, are delivered in the community.

'The assessment was that the top 2%-3% of [all] patients were consuming nearly 50% of acute resources, so by wrapping this service around them you can start to avoid hospital admissions and do things more effectively for them,' says Mr Raphael.

'We aim to improve their health and enable them to better manage their long-term conditions by working with them and their families to develop services that meet their needs and ensure they comply with their treatment regimes, which are often very complicated.

'The vanguard is moving away from a reactive process to using predictive analysis – having daily reports on the status of individuals means you can predict what's going to happen.'

Changes to funding flows were relatively uncomplicated, as the vanguard includes an acute, community and mental health provider (Blackpool Teaching Hospitals NHS Foundation Trust).

'We were able to say to the trust that this is a shift from one of your services to another, though there was an element of pump-priming to assist the trust in that shift,' says Mr Raphael.

He says the initial modelling suggested the savings made on hospital care would be similar to the amount needed to fund the services in the community.

However, diverting funds to establish the extensive care sites meant the building blocks were in place to take a neighbourhood approach to improving primary and community services for patients with one or more conditions. 'That is where you start making inroads into the overall spend on our

Capital questions

There is not enough capital funding available to support STP plans, according to the British Medical Association.

The BMA contacted all 44 STPs, and 36 responded, with their total projected capital requirements coming to £9.5bn.

According to the figures obtained by the BMA from freedom of information requests, three-quarters of STPs believe they will need £100m or more, while six said they will require more than £500m.

The Cambridgeshire and Peterborough STP has the highest potential requirement (£800m), though it claims the funding – spread over the period until 2021 – is almost entirely for business-as-usual investments and not in support of consolidating hospital capacity.

The second highest – Cheshire and Merseyside STP (up to £755m) – recognised in its plan that capital funding is limited and some schemes may not be approved. It adds that it will need to focus investment on schemes that provide the greatest benefit.

In England, capital funding has been set

at £4.8bn a year, up to 2020/21. However, the BMA points out that in the past financial year, £1.2bn was transferred to revenue to reduce the deficit.

Senior Department of Health figures have acknowledged that this is undesirable but likely to continue.

Factoring in estates returns, published by NHS Digital last October, which showed that around £2bn would be needed to eradicate a high and significant maintenance backlog risk, the BMA claimed the capital available would be closer to £1.6bn.

BMA chair Mark Porter (pictured) said: 'The NHS is at breaking point and the STP process could have offered a chance to deal with some of the problems that the NHS is facing, like unnecessary competition, expensive fragmentation and buildings and equipment often unfit for purpose. There is clearly nowhere near the funding required to carry out these plans.'

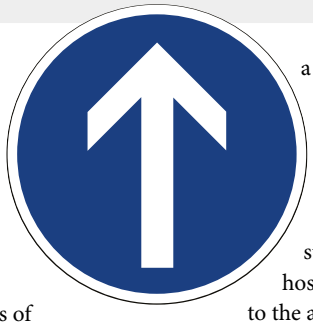
However, calculating available capital is not as simple as subtracting the potential capital to revenue transfer and the cost of urgent backlog maintenance from the total capital allowance.

The NHS does not fully address its backlog maintenance. In some cases it would be wasteful to do so – backlog maintenance can be in old buildings that are due to be demolished or replaced, for example.

And the NHS does not eradicate its significant or high-risk backlog each year – according to the NHS Digital returns, it spent just over £350m in 2015/16, with similar amounts in previous years.

The STP total capital requirement will be spread over a number of years.

While capital requirements may well be greater than funding, the amount of capital available could be higher than the BMA believes.



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29 March, 14.00

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3 May, 14.00

Coaching and mentoring for challenging conversations
31 May, 14.00

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27 June, 14.00

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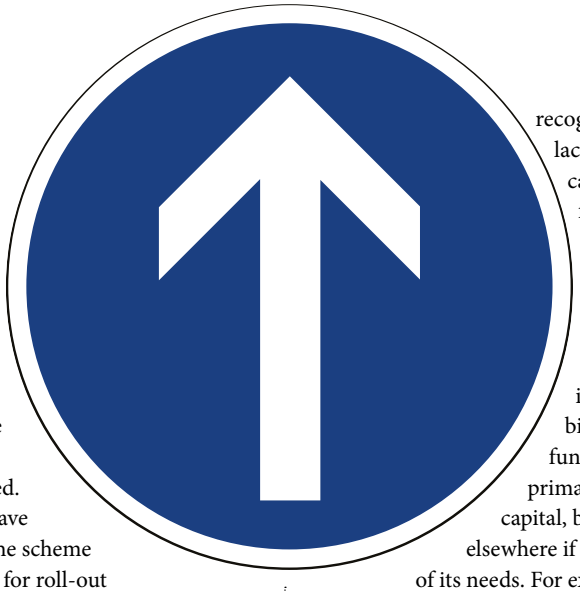


patients,' he says.

The vanguard is currently examining its results, but Mr Raphael says initial work indicates that savings are being made – though perhaps not where the modelling originally suggested. Once the results have been confirmed, the scheme will be considered for roll-out across the STP area.

A small number of STPs wish to move to accountable care systems (ACS), including Devon and Coventry and Warwickshire. The latter's STP lead, Andy Hardy, says that the ACS would break down organisational boundaries. 'We know that care is inefficient and less effective at the touch points between organisations,' he says. 'This is how we can provide a better offering to our population.'

He says the STP deliberately chose the name ACS rather than an accountable care organisation. 'By its very nature, ACO implies one organisation and you need mergers and takeovers to get there, which take time and resources and could prove to be a distraction.'

He adds that the bad publicity over STPs in general has galvanised local partners to get around the table. 'We are having those difficult conversations that we knew were needed but weren't taking place.'

Capital funding

Capital funding will be required to ensure that buildings meet the requirements of reconfigured services. Research by the British Medical Association (see box, page 17) shows capital requirements varying from £20m to £800m. However, last December NHS Improvement chief executive Jim Mackey said the capital proposals in STPs outstripped the amounts available.

Many STPs acknowledge the shortage of capital. Staffordshire and Stoke STP says that 'given the constrained capital environment, we have limited our capital requirements to £20m. This is to fund two £10m schemes over 2017/18 and 2018/19'.

It adds that, although small in value, the schemes should deliver £19.5m in savings.

Mr Hardy says Coventry and Warwickshire's relatively small bid of £36.5m was a recognition of the lack of available capital and the fact that its current estate is largely in good condition, with a number of capital schemes in train. It has bid for national funding as its primary source of capital, but will look elsewhere if this falls short of its needs. For example, it has proposed that capital receipts should be retained, which would require a change in policy at national level.

'We have talked about keeping the receipts within the Coventry and Warwickshire health economy, rather than potentially losing them to a central pot at the Department of Health or the West Midlands Combined Authority.

'We are not talking about large amounts, but we could use it for transformation, reinvest it or use to cover double-running costs,' he adds.

With the Lancashire and South Cumbria STP potentially moving services out of hospital and consolidating some hospital specialties, capital funding will be required.

According to the STP, a total of £264m could be needed – £100m for development of the primary care estate and £164m for a combination of existing trust capital bids and the consolidation of any fragile specialties across existing hospital sites, should this be required.

Mr Raphael says the figure is a combination of the estates element of local CCG bids for the estates, technology and transformation fund and what trusts told him would be needed to facilitate consolidation.

He insists nothing is set in stone, though the overall figure is close to the area's fair share of the national capital allocation.

The STP is working with local authorities. Although they have their own financial issues, low interest rates mean they do have access to reasonably low-cost loans.

Collaborative bid

It is also bidding for funding under the *One public estate* capital scheme. Local authorities and the STP believe they could benefit from this – funding collaborative work to help councils rationalise their estate and the NHS to expand community and primary care sites.

STPs must engage meaningfully with local authorities, staff, patients, the public and the third sector, says the King's Find's Ms McKenna. National bodies must 'stand shoulder to shoulder' with the NHS and local authorities and ensure their messages are consistent.

'The big question for us is whether the direction set by STPs can be delivered at the scale and pace they have been asked to do it and at a time when hospitals are so stretched and financial resources are in such short supply. STPs must be given a more realistic timescale for implementation.'

Sustainability and transformation plans point the way forward, but with public consultation yet to take place, the nature and pace of change is far from determined.

"We know that care is inefficient and less effective at the touch points between organisations. This is how we can provide a better offering"

Andy Hardy, Coventry and Warwickshire STP

flow control

Limiting the use of procedures where evidence shows there is limited value makes sense. But putting such mechanisms into place can be fraught with difficulties. Steve Brown examines how the issue has hit the headlines and looks at one area's detailed approach to review treatment policies

Increasing numbers of clinical commissioning groups are reviewing commissioning guidelines in attempts to ensure they maximise value from thinly stretched budgets. This has been portrayed in some media as rationing of services, driven by the need for efficiency savings. But others suggest it is essential prioritisation of spending at a time when the service cannot afford to spend scarce resources on procedures with limited benefit or to undertake invasive procedures when other interventions could be more appropriate.

The issue hit the headlines at the end of January, when three clinical commissioning groups in the West Midlands – South Worcestershire, Wyre Forest, and Redditch and Bromsgrove – changed the threshold for routinely funding hip and knee replacement surgery. Headlines suggested patients would now have to prove that pain was keeping them awake at night before a joint replacement would be sanctioned.

The three CCGs acknowledged that surgery guidelines had been revised. However, they said this followed a review of RightCare data that had highlighted spend on hip and knee replacement that was 'around £2m higher' than comparable CCGs. They added that the change in threshold for routine funding used a scoring system that recognises that many patients will benefit from physiotherapy and weight loss before considering surgery.

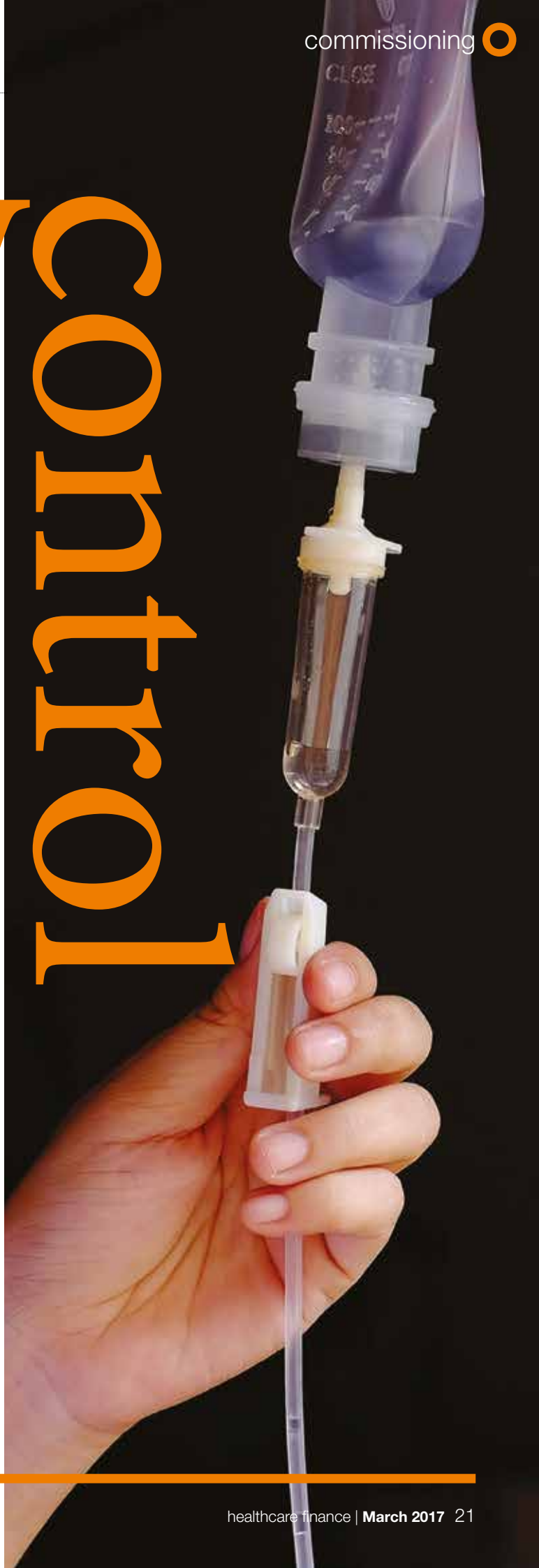
Oxford scoring system

Using the Oxford hip and knee scoring system used in the national patient reported outcome measures programme, the CCGs have reduced the threshold from a score of 30 to 25. '[This] brings the Worcestershire CCGs in line with what other CCGs already do and would help to reduce this spend difference,' a spokesperson for the three CCGs said.

They added that a number of CCGs across the country had an Oxford hip and knee score threshold of 20 or lower and that the individual funding request (IFR) mechanism still enabled patients not meeting the pre-set criteria to have the surgery in exceptional cases.

They are not alone in examining service restrictions. In December, West Kent CCG launched a review of compliance with its existing procedures of limited clinical value list and other restricted services, such as alternative medicine and cosmetic surgery. Having previously undertaken a similar audit with its main NHS provider, this further review would focus on activity undertaken at independent providers.

With the relevant activity in the independent sector worth an



estimated £5m, the CCG has estimated that this could lead to savings of £375,000 in 2016/17 – on the basis of discovering 10% non-compliance and allowing for double counting. A spokesperson for the CCG said the compliance review 'should be completed by March'.

It is also considering changes to the access criteria under which cataract surgery is routinely funded, following similar changes to the pathway for hip and knee surgery last autumn. The hip and knee access changes introduced a triage and lifestyle advice service as an extra step to ensure patients' fitness to proceed to surgery where needed.

In a more media-eye-catching move, the CCG also suspended non-urgent activity for the rest of the current financial year to enable it to remain within budget for the year.

CCG chair GP Bob Bowes said the decisions were 'never easy but they are necessary' – if the CCG did overspend this year, it would be likely to mean more severe cuts in future. He also flagged up that exceptional cases would still be considered on a case-by-case basis.

'The reality is that here in West Kent, as across the country, the health and social care system is not set up in the right way to meet the changing needs of local people and make the best use of staff and funding available,' he said. The changes set out in the local sustainability and transformation plan would avoid having to take such short-term measures in the future.

The Academy of Medical Royal Colleges is leading a *Choosing wisely* campaign to address a 'growing culture of overuse of medical intervention' and challenge the idea that more is better. It encourages shared decision-making between clinicians and patients, ensuring patients understand any risks of treatment and alternative options.

As part of the campaign, all royal colleges were asked to identify five treatments or procedures commonly used in their field that are of questionable value and would warrant careful discussion with patients before being carried out. This seems in line with the idea of CCGs being clear about evidenced-based restrictions on routine commissioning. But it appears to be how lists are managed in practice – and the direct inclusion of financial considerations – that creates disagreement.

For example, both the above cases drew an angry response from the Royal College of Surgeons, which is involved with the *Choosing wisely* campaign. College president Clare Marx described West Kent's surgery suspension as 'unprecedented and unfair', with short-term savings potentially having major consequences for patients. 'Clinical decisions must not be made purely on a financial basis,' she said.

Vice-president Stephen Cannon similarly condemned the Worcestershire CCGs' threshold change for hip and knee surgery, based on 'arbitrary pain and disability thresholds' as 'alarming'. 'It is right to look at alternatives to surgery, but this decision should be based on surgical assessment, not financial pressures,' he said.

Support in principle

The college also raised concerns that similar restrictions were 'happening up and down the country affecting thousands of patients'.

In a statement to *Healthcare Finance*, the Royal College of Surgeons says it supports the use of lists of procedures of limited value in principle. 'However, we are also very clear that CCGs must base their decisions about what procedures are put on these lists on good clinical evidence and in accordance with NICE guidance. Too many CCGs are introducing policies that restrict access to certain procedures as a way of saving money, rather than because there is any clinical justification for their decisions.' It adds that the RCS found more than a third of

Robust review process

The current financial difficulties across the NHS have undoubtedly created a greater focus on where to draw the line in terms of funding for some services. But finance is not the main driver in all reviews.

For six West Midlands CCGs, having inherited a patchwork of different legacy policies from predecessor primary care trusts in 2013, the key motivation has been to establish a common approach across their area. Finance was a key part of the project team, but Solihull CCG chief contract and performance officer Neil Walker says 'finance was not at the centre of what we were doing'.

'Cost was not ignored,' he adds. 'But what drove the policies was not the financial considerations. The question was "Is it clinically appropriate to spend scarce clinical resource on these treatments when it could be allocated to other areas of care?".'

The process certainly appears to have been meticulous and robust involving initially seven, but ultimately six CCGs, in harmonising policies both to avoid any perceived postcode lottery from the patients' perspective and to avoid providers operating with different commissioning policies for different patients.

This was perhaps a particular priority for Solihull, Birmingham South Central and Birmingham CrossCity CCGs, as they are already working as a collaborative commissioning body. (The other CCGs involved in the policy review are Walsall, Wolverhampton and Sandwell and West Birmingham.) A project group brought together clinical leads with public health representatives, GP commissioners, commissioning managers and contract and finance staff.

The group identified 47 different procedures to consider in a first phase, 27 of which were various cosmetic surgery procedures, with the remainder ranging across procedures and treatments such as tonsillectomies, back pain treatment, cataracts, groin hernia repair, grommets and hip/knee replacements.

'We were looking at both the criteria for treatment – where we would not routinely commission treatment but require an individual funding request – and where treatment would be restricted,' says Mr Walker. 'In these restricted cases, treatment could proceed if clinical thresholds were met. The aim was to harmonise the categorisation of these treatments across the CCGs and make sure the supporting evidence that informed each treatment policy was as up to date and robust as possible.'

Examining existing criteria and policies alongside NICE and royal college guidelines was 'a significant piece of work', says Rhona Woosey, Birmingham South Central CCG network and commissioning manager.

'We scrutinised all the available evidence and did a lot of horizon scanning. And we met on a very regular basis with the clinical leads to confirm the challenge and the assumptions we could make on the back of the evidence and to maintain consensus,' she says.

In total the process took two and half years, including public engagement, with the new policies in place from the start of 2017. Although the policies have been completed, work is continuing to develop standardised and clear treatment policy literature to support GPs and clinicians when talking with patients about the appropriateness of surgical or non-surgical options.

The CCGs recognise that straightforward patient communication is vital. For a start, the CCGs have dropped the pejorative term 'procedures of lower clinical value' and replaced it with 'treatment policies'. CCGs' limited clinical value lists tend to contain very similar procedures across the country. Most will include cosmetic procedures, where there is a good consensus that value is lower. But they might also set criteria, for

CCGs had implemented policies that restrict access to surgery for smokers and obese patients and are in direct contravention of NICE guidelines.

It also has concerns that extending these lists to other procedures, or raising thresholds, will lead to a large increase in funding requests, making the system slower and leaving patients 'waiting too long in pain or discomfort'.

However, West Kent's Dr Bowes insists: 'The decision to stop non-urgent surgery involved a number of clinicians. It was agreed initially by the clinical strategy group, a group that mostly comprises GPs. And following that, the decision to implement was taken by the governing body of the CCG, chaired by myself and with a GP majority, and whose members include five lay and independent members.'

Julie Wood, chief executive of NHS Clinical Commissioners (NHSCC), says that in an environment of spiralling demand, finite funding and a requirement to balance the books, CCGs have to look at reprioritising their spend. Stopping or restricting access to certain services are the difficult consequences of this situation. But she says CCGs look to do this responsibly, informed by variations in the volume of activity delivered in different services across similar CCGs and guided by evidence of clinical and cost effectiveness.

'Decommissioning is an act of commissioning too,' she says, adding that achieving value for money (measured in outcomes, quality and cost) is the responsibility of providers and commissioners. 'If there are things in a hospital setting that add little value, hospitals should be doing their bit to stamp them out and CCGs need to reinforce this by making it clear that they won't pay for these activities,' she says.

Ms Wood stresses that a health service pound can only be spent once, and there is a duty to get the best value possible from it. That means taking some difficult decisions upfront, and commissioners are right to consider the thresholds used in their areas to access some procedures, which may vary from consultant to consultant even if presented with the same patient (see box below for how one group of CCGs has taken this review process forward).

"If there are things in a hospital setting that add little value, hospitals should be doing their bit to stamp them out"
Julie Wood, NHSCC

'If a patient needs an intervention, then the CCG wants them to get that intervention. But if you can put in place alternatives that mean they don't need that intervention – or put the patient in a better condition to have a successful outcome – that is the right thing to do,' she says.

Again, Ms Wood stresses that CCGs are not barring activities in most cases, but setting criteria for when they will be routinely funded. Mechanisms using IFRs are in place to enable exceptional cases to proceed. She accepts that if there are very high levels of these requests, this might suggest the threshold has been set at the wrong level. But she acknowledges that more CCGs are currently reviewing commissioning policies, driven by the extreme financial pressures placed upon them.

In January, the OECD published a report – *Tackling wasteful spending on health* – which suggested that about one-fifth of health expenditure currently makes no or minimal contribution to good health outcomes. Low-value procedures were identified as a contributor to this waste. 'Low-value procedures can be found at all stages of the care pathway,' it says, adding elsewhere that 'variations in clinical patterns are the main and most powerful tool offering insights into the magnitude of waste due to low-value care'. However, identifying 'waste' is far from straightforward and CCGs have found that any move away from the status quo can meet with opposition.

example, for hip and knee replacements, which are anything but low value when they are the appropriate treatment.

Transparency is also important and Mr Walker suggests that it can be difficult, even as a commissioning professional, to find and decipher CCG commissioning policies.

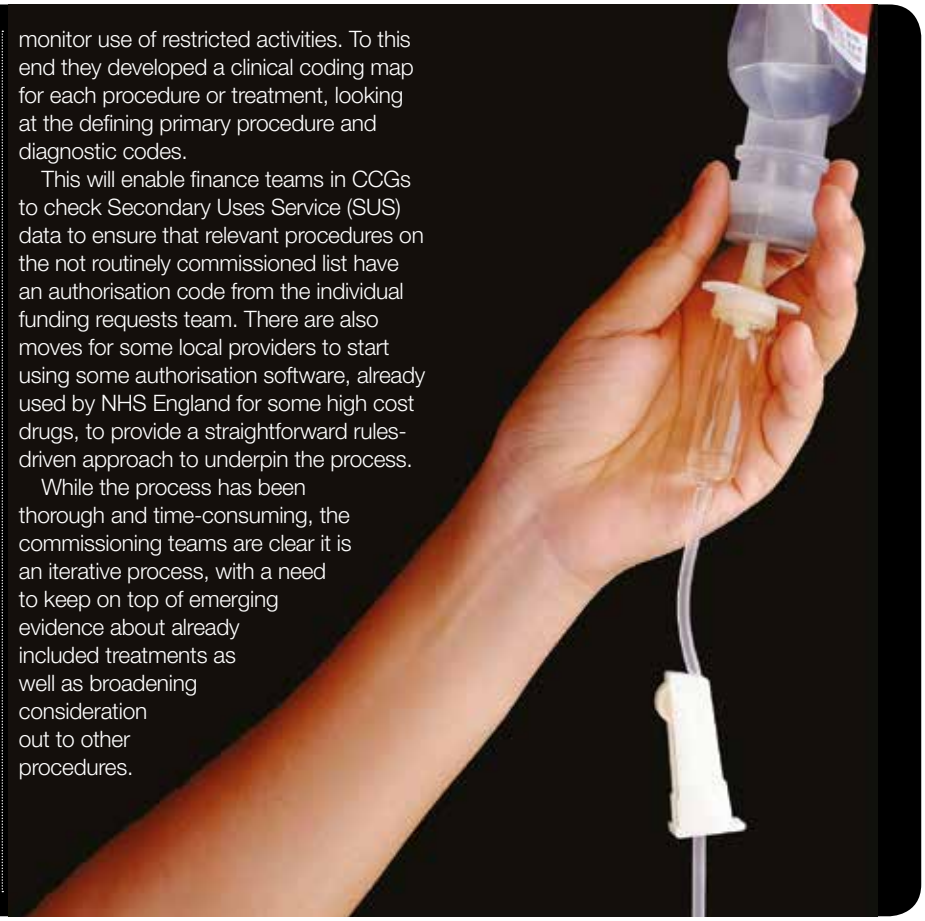
The three Birmingham and Solihull CCGs undertook public and professional engagement about the overall aims (such as stopping procedures with limited evidence base and ending the postcode lottery) and the specific procedure policies. Posters and leaflets were produced and the CCGs engaged actively with the Birmingham and Solihull councils' joint health overview and scrutiny committee and the media. Some 75 responses showed a broad level of support for the objectives and a more mixed response to the individual procedure policies – with feedback from professional bodies in particular leading to changes in the final policies.

Having set the policy, it is important it is followed in practice. Ms Woosey says providers and primary care have been engaged from the outset and in the consultation. The commissioning policies continue to be reinforced through ongoing engagement and bulletins.

The CCGs are also clear they need to monitor use of restricted activities. To this end they developed a clinical coding map for each procedure or treatment, looking at the defining primary procedure and diagnostic codes.

This will enable finance teams in CCGs to check Secondary Uses Service (SUS) data to ensure that relevant procedures on the not routinely commissioned list have an authorisation code from the individual funding requests team. There are also moves for some local providers to start using some authorisation software, already used by NHS England for some high cost drugs, to provide a straightforward rules-driven approach to underpin the process.

While the process has been thorough and time-consuming, the commissioning teams are clear it is an iterative process, with a need to keep on top of emerging evidence about already included treatments as well as broadening consideration out to other procedures.



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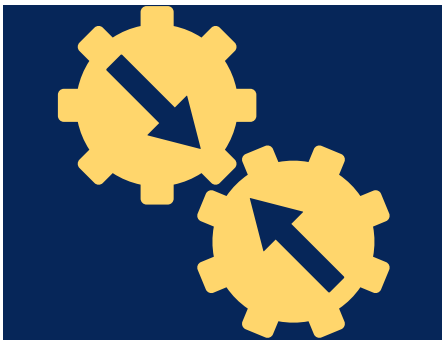
Slow progress



There is support for integration and better local working, but progress is slow. Steve Brown reports

Integration of health and social care has been slower and less successful than envisaged and has not delivered all the expected benefits for patients, the NHS or local authorities. This was the finding of a hard-hitting report from the National Audit Office in February.

The upshot of this slow start is that 'the government's plan for integrated health and social care services across England by 2020 is at significant risk', the report concluded.

The audit body examined three areas:

- Integrating health and social care
- The progress of national initiatives including the Better Care Fund
- Plans for increased integration.

It said rising demand for services, combined with restricted or reduced funding, was putting pressure on local health and social care systems. In particular, rising numbers of delays in hospital discharge were an indication that an ageing population was putting pressure on hospitals and social services.

Better integration of services – everything from joint care needs assessments to pooled budgets and integrated condition-specific services – is seen as both improving services to patients and service users, as well as being the key to responding to these pressures.

However, the Department of Health and the Department for Communities and Local Government had 'not yet established a robust evidence base to show that integration leads to better outcomes for patients', the report said. There had been no tests of integration at scale, and international examples of successful integration had occurred in different statutory, cultural and organisational environments.

It also found 'no compelling evidence' to show that integration in England leads to sustainable financial savings or reduced hospital activity – some of the very pressures that integration is seen as addressing. 'While there are some positive examples of integration at the local level, evaluations of initiatives to date have found no evidence of systematic, sustainable reductions in the cost of care arising from integration,' it said.

These evaluations had been inhibited by a lack of comparable cost data in different care settings and the difficulty of tracking patients through care settings, the report added.

Looking at national initiatives, it said the Departments' expectations of the rate of progress of integration were over-optimistic. Embedding new ways of working takes time, especially when working practices and cultures are so different. The Better Care Fund had incentivised local areas to work together, but had failed to meet its financial goal of £511m of savings in 2015/16. Emergency admissions to hospital went up, not down. And the number of delayed days, resulting from delayed transfers of care, also rose.

The NAO said that in 2014 the fund's saving assumptions were based on optimism rather than evidence. It also said the Departments recognised that performance metrics are affected by factors outside the fund's influence. The integrated care and support pioneers programme has also not yet demonstrated improvements in patient outcomes or savings.

On integration plans, the auditors acknowledged that the Departments were planning to publish an integration standard describing the core elements of an integrated system. But the watchdog said that governance and oversight across the range of existing integration initiatives had been poor. The lack of comprehensive governance was 'leading to uncoordinated effort across central bodies'.

Barriers to integration have been identified – misaligned financial incentives, workforce challenges and reticence over information sharing – but are not being systematically addressed.

More positively, the report said there was agreement that place-based planning was the right way to manage scarce resources at a system-wide level. However, local government had not been involved in the design of the sustainability and transformation planning process. While local authority engagement had improved, overall engagement had been variable, especially given the more formal engagement around the Better Care Fund.

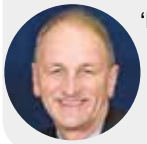
Making its value for money conclusion, auditors said joint working and integration could be vital to the financial sustainability of the NHS and local government. But the Better Care Fund had 'not achieved the expected value for money in terms of savings, outcomes for patients or reduced hospital activity…in 2015/16'.

Sustainability and transformation plans could be a vehicle for joint planning – but they aren't yet. To support more aligned planning, the report said, there was a need for robust evidence on how best to improve care and save money through integration and for a coordinated approach. 'The Departments do not yet have the evidence to show they can deliver their commitment to integrated services by 2020 at the same time as meeting existing pressures on the health and social care systems,' the report said.

Reaction to the report

'It is telling that, despite nearly two decades of initiatives to join up health and social care, the NAO concludes there is still no compelling evidence to show this leads to long-term financial savings or reduced hospital activity.' **Chris Hopson, chief executive NHS Providers**

'Integration alone cannot solve the financial challenges facing health and social care. Social care faces a funding gap of at least £2.6bn by 2020. Extra council tax income will fall well short of what is needed to fully protect the services that care for elderly and vulnerable people.' **Izzi Seccombe, chair, Local Government Association Community Wellbeing Board**



'Place-based planning and health and social care integration are the right ambitions for the NHS and local government. If they are to be realised, barriers to integration such as misaligned financial incentives and different planning cycles must be removed.' **Chris Ham, chief executive, King's Fund**

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professional lives
Events, people and support for finance practitioners

No major accounting changes but attention still needed to detail

Technical update

The 2016/17 accounting year is a quiet one in terms of changes to accounting standards or government reporting requirements, *writes Debbie Paterson*. However, the HFMA's annual pre-accounts briefing sessions at the end of January were well attended as usual. And it is worth a recap of the key issues that will impact on this year's year-end process and reporting.

The Department of Health's *Group accounting manual* (GAM) for 2016/17 has been issued (and updated) and the 2017/18 GAM is out for consultation.

As has been well trailed, the GAM applies to all NHS bodies in respect of their accounts so foundation trusts need to get used to looking in a different place for guidance. However, for the annual report, foundation trusts continue to follow the NHS foundation trust annual reporting manual, while everyone else refers to chapter 2 of the GAM.

Foundation trusts should be aware that the move to the GAM has resulted in changes for them and the best place to look for the details in relation to those changes is the GAM consultation response. None of these changes are expected to cause any major difficulties for NHS bodies.

The big change for everyone is that the staff costs note has been moved to the remuneration/staff report in the annual report. The accounts can still include the full note or a summary note cross referenced to the remuneration report. The note is still subject to audit and the information will still be collected in summarisation schedules for consolidation.

It is likely that the GAM will be updated again soon to reflect a change made by the Treasury to its *Financial reporting manual*, which is already reflected in the FT *Annual reporting manual*. The first column of the single total figure of remuneration table is 'salary', which until now has not included any severance or payments for loss of office. From now on this figure should include such payments.

The GAM was updated in December with the issue of eight FAQs – so ensure you are working from the most up-to-date version. FAQ 1 provides the discount rates for post-employment benefits and general provisions.

All the discount rates have decreased, which means that provisions will increase with a resulting impact on expenditure. Bodies reported that the change in the rate relating to post-employment benefits is resulting in a significant impact on their bottom line so revised provisions should be calculated as early as possible.

It is vital that forecasts and estimates provided to any consolidating bodies are as accurate and up-to-date as possible

The Department and NHS Improvement are still working on guidance on accounting for sustainability and transformation funding (STF), so there will be more FAQs as 31 March approaches.

This is likely to be the most complicated issue this year, as providers will have to estimate the amount of income they expect to receive when preparing their draft accounts based on their own assessment of whether they have met the necessary conditions.

Audit adjustments could affect the amount receivable, making accurate estimates for accounts vital. This means following the guidance to the letter. The STF will be part of the agreement of balances exercise and will be agreed with NHS England.

At the end of another difficult financial year, finance professionals should be confident in their own judgements and estimates, but must apply financial rigour. It is vital that forecasts and estimates provided to any of the consolidating bodies are as accurate and up-to-date as possible as they rely on them to determine their financial position.

Auditors are likely to be very interested in going concern assessments and disclosures, which should focus on any uncertainties in relation to funding in the 12 months following the date that the accounts are signed off. NHS Improvement will not be issuing any letters in relation to financial support this year.

Auditors also remain interested in the property valuations, particularly whether they are on an alternative site basis and whether they include or exclude VAT. Any valuation issues should be discussed with auditors as early as possible.

There are no major changes planned for the agreement of balances exercise because last year it went so well. So the message here is to keep up the good work.

Debbie Paterson is an HFMA technical editor

Technical review

The past month's key technical developments

Technical roundup

A 'more efficient and flexible' secondary uses service (SUS) will be up and running in April, NHS Digital has confirmed. The **new SUS+ system** will run in parallel to the existing SUS system until late in June when the legacy system will be decommissioned. NHS providers submit activity data to the data warehousing system, which supports secondary uses of this data to inform planning and commissioning and enable provider reimbursement under the national tariff. NHS Digital, which manages the system, said that SUS+ will feel very similar to the existing system but will process data faster and be more cost effective to operate. The period of dual running from April to the end of June will enable users to complete processing 2016/17 data with consistent data from SUS. SUS+ will support payment by results data for two previous historical years plus the current year. This will involve re-processing 2015/16 and 2016/17 data. Changes in processing such as simplified spell construction mean there may be marginal differences in results obtained by SUS and SUS+.

NHS Digital has also given notification of a new **commissioning data set** type for emergency care. It said the existing data had not kept pace with the increasing complexity of delivering emergency care and was not adequate to support effective service planning. Emergency departments may start to submit the new data in August, but must start doing so from October 2017 or 2018 depending on the department type.

The HFMA has broadly backed proposals by NHS Improvement and the Care Quality Commission for a new **use of resources assessment** (see *Healthcare Finance*, February 2017 page 31). However, in its response to consultation, it has called for terminology to be clarified to prevent confusion between the existing finance and use of resources assessment in the single oversight framework, which will continue to be reported monthly, and the new wider-ranging, annual use of resources assessment. In terms of how the new use of resources assessment could be combined in future with the CQC's existing quality rating, the HFMA recognises that adding a sixth question to the existing five (safe, effective, caring, responsive and well-led) would 'require less change and be easy to understand'. However creating an overall rating broken into three elements - with a quality element combining the safe, effective, caring and responsive ratings presented alongside leadership (well-led) and use of resources – would give an increasing focus to resources and leadership. The association backed proposed metrics as a good starting point and suggested other options. It also said in future assessment should move beyond individual organisations to look at whole system performance.

Many NHS organisations have historically commissioned a range of services from external audit suppliers that are not part of the statutory audit. Revised ethical standards from the Financial Reporting Council, effective for accounting periods starting on or after 16 June 2016, will affect the type and quantity of **non-audit services** that auditors can provide. National Audit Office guidance relating to the new standard, aimed at auditors of NHS organisations – *Auditor guidance note 1* – states that the total value of non-audit services provided by the external auditor to an audit client should not exceed 70% of the organisation's statutory audit fee. This requirement also applies to any associated controlled entities. Certain non-audit work that the external auditor is required to carry out, including assurance work on the quality account, is excluded from the calculation. There are also certain types of non-audit services that are now prohibited, including taxation and valuation services. Foundation trusts already set their own policies for commissioning non-audit services from their external auditors, but will now need to consider the introduction of the cap and limitations on the type of services that can be commissioned. The arrangements for external audit services for NHS trusts and clinical commissioning groups (CCGs) were previously managed by the company Public Sector Audit Appointments. As these organisations now appoint their own external auditor, they will also need to be aware of the new requirements when considering future arrangements for contracting and oversight of non-audit services.

Local tariff recommended for HeartFlow programme

NICE update

Mortality from coronary artery disease is the biggest single cause of death in the UK, *writes Nicola Bodey*. In 2014, 15% of male deaths and 10% of female deaths were the result of coronary artery disease (around 69,000 total deaths). British Heart Foundation figures for 2011 showed that 5.7% of all men (aged 16 and over) and 3.5% of all women in England had coronary artery disease.

Coronary CT angiography (CCTA) is a type of scan that shows detailed pictures of the heart and its blood vessels. HeartFlow FFRCT – the technology covered in new medical technologies guidance, MTG32 – is a computer program that uses images from the CCTA scan to estimate fractional flow reserve (FFR). This can help to identify narrowed blood vessels and better inform future treatment.

It may avoid the requirement for other non-invasive tests, invasive coronary angiography and revascularisation, which would result in savings to commissioners and providers.

Using HeartFlow FFRCT requires access to 64-slice (or above) coronary CT angiography facilities. NICE estimates that about 89,300 people are eligible for HeartFlow FFRCT each year. From year five after implementation, it estimates some 35,600 people will have HeartFlow FFRCT each year (based on 100% uptake). Savings for commissioners are estimated to be £1.8m in England in the first year of implementation, increasing to £9.1m in England from five years following implementation. This is equivalent to £16,800 per 100,000 population.

There is currently no national tariff for

Diary

March

2 B North West: understanding the impact on the NHS of employment tax changes from April 2017, Manchester
3 B Northern Ireland: final accounts workshop, Newtownabbey
9 I HC4V: introduction to NHS costing – regional networking and training (North), Leeds
13 B Eastern: CIP/QIPP, Newmarket
14 F Chair, Non-executive Director and Lay Member: NHS operating game, London
15 B KSS: HFMA/TIAA accounting standards technical update, Gatwick
16 F Provider Finance: capital forum

April

6 I HC4V: annual costing conference

May

11 F Commissioning Finance: continuing healthcare forum
11 B South Central and South West: developing talent conference, Bristol
17 F Chair, Non-Executive Director and Lay Member: forum, London
18 F Provider Finance: directors' forum
19 F Mental Health Finance: directors' forum

June

12 B London: annual conference, London
22 B West Midlands: annual conference, Wolverhampton
29-30 B North West: annual conference, Blackpool

July

5-6 N Annual Commissioning Finance conference, London
6 N Convergence conference, London
6-7 N Annual Provider Finance conference, London

September

19 F Provider Finance: technical forum
20 F Commissioning Finance: forum
20 F CEO Forum
21 F Chair, Non-Executive Director and Lay Member: forum
21 F Mental Health Finance: annual conference 2017

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

key B Branch N National F Faculty I Institute

HeartFlow FFRCT. Uncertainties around funding flows for provider organisations may be a barrier to implementation of the technology. Commissioners are encouraged to work with provider organisations to develop a local tariff to establish the use of HeartFlow FFRCT in interventional cardiology service provision.

This technology is commissioned by clinical commissioning groups. Providers are NHS hospital trusts.

Nicola Bodey is a senior business analyst at NICE

Events in focus

NHS operating game 2017
14 March, Rochester Row

The HFMA Chair, Non-executive Director and Lay Member Faculty will be holding an NHS operating game event for non-executives this month, which will be useful for non-executives and lay members new to the NHS. The *Operating game* is an interactive tool where participants work as a team to run a hospital, making strategic decisions to ensure it provides high-quality care at the best possible value. The simulation uses real-life examples as the patient pathway is followed from referral to discharge. Led by experienced finance director Chris Calkin, the session will help participants understand how the hospital operates, the relationships between commissioners and providers, how financial and clinical decisions are made and how the pressures and challenges in the NHS can impact on decision making.

The event is free to members of the faculty. For more information, see www.hfma.org.uk

Branch event: Developing talent conference
11 May, Doubletree City Centre, Bristol

This one-day seminar is aimed at all finance staff in the South West and South Central regions who are studying, have recently qualified or are about to embark on an accountancy qualification (AAT/NVQ or CCAB/CIMA). The day will provide a mix of practical plenary and workshop sessions. Workshops include: **self leadership** – helping understand the actions needed to lead yourself and others; **positivity in the workplace** – an interactive workshop showing how being positive and improving working relationships can improve work-life balance; and **finance career opportunities within the NHS** – Future-Focused Finance *Great place to work* SRO Loretta Outhwaite (pictured) will talk about the wide career options open to NHS finance professionals.

Sessions will also include updates from NHS England's Janet Meek (interim regional finance director, south) and NHS Improvement's Sam Maunder (head of finance – south west), as well as from Steve Webster, deputy chief executive officer and director of finance at Cwm Taf University Health Board.

Anya de longh, a patient leader and self-management coach, whose work includes supporting other people with long-term conditions, will deliver a motivational session from the patient's perspective. And there will be plenty of opportunity to network with other finance students and newly qualified colleagues from across the regions.

To book a place, email kate.wycherley@hfma.org.uk

Required viewing

Association view from Mark Knight, HFMA chief executive

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

My HFMA

I've been watching the BBC2 series *Hospital*, which followed staff and patients in the five hospitals of Imperial College Healthcare NHS Trust. It was absorbing viewing, sharing the highs and lows of patients and staff. Perhaps it should also be mandatory viewing, as it gave a brilliant insight into hospital life in general and the extreme pressures the service is facing.

A trust chief executive recently underlined for me the difference between 85% and 95% bed occupancy. It is not just that you are simply operating closer to your maximum capacity, but that at 85% you have freedom to act, while at 95% things start to break down, blockages appear and there can be big knock-on impacts.

The current debate about social care is vital. Delayed discharges continue to have a huge detrimental impact – the major increase in lost days highlighted in providers' Q3 report is a real problem for the service. It's bad for patients, more expensive than looking after them in more appropriate settings, and it eats into the service's available capacity and headroom, forcing cancellations of elective work and wasted energy and effort dealing with all the consequences.

Perhaps more than this, it changes the debate on what is achievable in terms of productivity and transformation in the NHS. NHS England's *Five-year forward view* made the point that patient demand on the NHS is partly a function of the availability of social care. The ability of the NHS to close the £30bn funding gap completely depends on funding in local government.

There may be a focus on declining performance in the A&E four-hour wait, but the plain truth is that A&E is a victim of its own success. There are few public services where you can just turn up in any of the 168 hours during a week, and waiting time performance shouldn't detract from the work being done in these services in the face of such unrelenting demand.

The Q3 figures have thrown the spotlight back on finances and this year's likely outturn. I think we might be okay this year as a whole health economy, but the settlement over the next few years suggests we will face significant challenges for some time to come.

HFMA chief executive Mark Knight

The association recognises the hardship in the system. However, we need to keep 'associating' because it is by meeting together, sharing intelligence and learning that we move forward in our own organisations.

A key plank of our 2017-20 strategy will therefore be to keep price increases to a minimum and value to the maximum. This includes continued investment in member services and a relentless push in our policy and technical work. We want to keep building and growing to help members and reach out to other groups and professions.

I am also pleased to report that our pilot groups undertaking the qualification have found the content and approach rewarding and challenging. This is great news as we assemble the initial groups starting in May. There are still places left if you are still thinking it through.

Finally, our annual conference is now open for bookings. We are looking at shaking things up a bit, with more TED-style, punchier talks and more focus on innovation and value. Get in touch with any ideas as we put the programme together at chiefexec@hfma.org.uk

Member news

Yorkshire and Humber Branch handed out several awards at its annual conference:

- Finance Team of the Year: Hull and East Yorkshire Hospitals NHS Trust (pictured)
- Finance Professional of the Year: Tom Burden, Leeds Teaching Hospitals NHS Trust
- Finance Student of the Year: Robert Taylor, York Teaching Hospitals NHS FT
- Innovation: Vale of York CCG
- Close Partnering and Collaboration: Vale of York CCG

Kate Anderson, associate finance director at Lewisham and Greenwich NHS Trust, will be the next chair of the London branch, taking over from Andrew Holden at the London branch conference in June.

The West Midlands Research and Development Committee is working on new projects on non-contracted activity, cash and capital and GP integration. It has also appointed three new members: Sarah Phillips, Laura Mitchell and Vishal Savjani.

Jill Sinclair, John Dowell and David Chandler are now vice-chairs of the Commissioning Finance Faculty. At the HFMA annual conference, Liverpool CCG chief finance officer Tom Jackson was confirmed as faculty chair, continuing to chair its technical issues group.

The Northern Ireland Branch 2016 Fred Armstrong Award was presented to Sinead Rowe of Southern Health and Social Care Trust. A senior accountant, she was recognised for her work in developing a business case database and making best use of available resources, workforce and technology.

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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

Network focus

My HFMA

Provider Finance Faculty

Sustainability and transformation plans are set to significantly change the way the NHS functions, making collaborative work within the service more vital than ever. To reflect those changes in the healthcare landscape, the provider and commissioner annual conferences will overlap on 6 July, merging into the HFMA convergence conference.

'The problems in the NHS are not just providers' or commissioners' problems – we are all facing the same issues,' says Scott Jarvis (pictured), director of operational finance at Derby Teaching Hospitals NHS Foundation Trust.

The HFMA convergence conference will give him and his peers from across different NHS organisations the opportunity to network and share best practice, he says. 'If we want to solve the problems of the NHS, we can't do it on our own – providers and commissioners will need to work together,' adds Mr Jarvis.

Derby Teaching Hospitals NHS Foundation Trust is a longstanding member of the Provider Finance Faculty and Mr Jarvis often attends the events organised by the network.

The faculty usually hosts two technical forums a year that look at diverse technical issues, as well as three directors' forums that provide both a networking and learning platform for directors of finance.

'Normally, the only contact we have with our regulators is performance focused and in a very formal setting. During the forums, you have a safer environment where you can ask questions of regulators about policies and changes and have discussions without it being about your trust's specific performance,' says Mr Jarvis.

The Provider Finance Faculty also operates a technical issues group (TIG) that meets four times a year to discuss key policy issues and to liaise with the Department of Health and NHS Improvement.

It also produces consultation responses, technical working papers and guidance as well as developing policy in technical areas

Recently during one of the faculty's events the delegates discussed off-payroll arrangements.

'The regulations are very complex so it was very helpful to come together as a faculty to understand them better,' says Mr Jarvis.

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Appointments

Sam Simpson, former director of finance at Manchester Mental Health and Social Care Trust, has become director of finance for Cheshire and Merseyside Sustainability and Transformation Plan. She started her NHS career over 20 years ago on the NHS National Finance Training Scheme and has worked in acute, community and mental health provision, commissioning and at strategic health authority level before taking on this new role.

Shropshire Clinical Commissioning Group has named **Deborah Hayman** as its interim chief finance officer, succeeding interim **Ray Davey**. She was chief finance officer on interim basis at North Tyneside Clinical Commissioning Group. Mr Davey is now interim chief finance officer at East Surrey CCG, succeeding **Richard Bates**.

NHS England has appointed **Adrian Snarr** (pictured) director of financial control. He was director of finance, informatics and infrastructure at Humber NHS FT, where **Peter Beckswith**, deputy director of finance, now steps up as acting director. Mr Snarr succeeds **Steve Wilson**, who is now executive lead – finance and investment – at Greater Manchester Health and Social Care Partnership.

Mark Dutton is combining his role as chief finance officer at South Worcestershire CCG with interim chief finance officer posts at Redditch and Bromsgrove and Wyre Forest CCGs. The appointment follows **Paul Sheldon**'s move to South Warwickshire CCG, where he is chief finance officer, succeeding acting officer **Liz Flavell-Smith**.

Sarah Lorking (pictured), currently deputy director of finance at North Staffordshire Combined Healthcare NHS Trust, will be leaving the organisation in April to become interim finance and performance manager at Circle Health. She has over 15 years' experience working in financial management, internal audit and financial accounting within the NHS.

Nicci Briggs is now acting director of finance at Kettering General Hospital Foundation Trust. She was transformation director at the organisation and takes over from **Kishamer Sidhu**. Before joining the trust in 2010, Ms Briggs worked in different accounting positions at Northamptonshire Police Force and Cambridgeshire County Council.

Paul Assinder (pictured) has become interim director of finance at Black Country Partnership NHS Foundation Trust, in addition to his existing role as interim FD at Birmingham Community Healthcare FT. The two FTs and nearby Dudley and Walsall Mental Health Partnership NHS Trust are working on a merger later this year.

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 government will be looking to the Bermuda Health Board to make efficiencies, as most healthcare systems are having to do. I have quite a bit of experience in that regard"
Bill Shields

Shields off to Bermuda

On the move

Bill Shields will shortly become chief financial officer at Bermuda Hospitals Board. And, although he acknowledges the attractiveness of the islands' climate and lifestyle, the challenge of the job is uppermost in his mind.

'I'm not going for a holiday, although this will be a different kind of challenge and quite clearly on a different scale to the work I have done in the past,' he says.

Mr Shields, who served as HFMA chairman in 2008/09, is expected to start his new job at the beginning of April. 'It's an opportunity to influence healthcare at a country level, albeit with a small island population. It's an organisation that has experienced financial challenges in the past and the government will be looking to the Bermuda Health Board to make efficiencies, as most healthcare systems in the western world are having to do. I have quite a bit of experience in that regard.'

Currently, the territory – made up of 181 islands – spends around 13% of GDP on healthcare, which is funded through a mixture of public and private insurance in a system similar to the United States. Mr Shields says that, like the US and other largely insurance-based systems, a long-term solution is needed on how services are funded and provided.

Bermuda's health system had financial problems in 2012. 'As in the US, it's based on fee for service, so not surprisingly that has led to significant levels of money being spent on health,' he says. 'Fee for service insurance systems are consistent with high levels of GDP being spent on health and Bermuda is no exception.'

He adds: 'There's also an opportunity to help the Bermudian government look at future funding options for healthcare on the island, so that it can become more sustainable.

'Only so much can be delivered on the island and, with an insurance system, the population expects it will be catered for. Often services are delivered off the island, particularly in the east coast of the United States. So it has to be determined what can be appropriately and safely provided on the island that is not currently done there. There may be some scope to expand services in an appropriate way.'

He foresees challenges in the recruitment and retention of finance staff. Alongside tourism, insurance and reinsurance are the islands' main industries. 'It may be a challenge to attract people with a financial background to the board rather than to the traditional financial services industry.

'There is also the question of long-term sustainability, so that next time they are looking to recruit a CFO, it will rightly be a Bermudian rather than an ex-pat.'

In his work as HFMA leader and as finance director at Imperial College Healthcare NHS Trust and elsewhere, Mr Shields has been closely associated with world-class finance. This included getting the basics right and ensuring the finance function is fit for purpose; talent management and developing finance leaders; comparing NHS finance with the commercial sector and international peers; and supporting finance staff through changes.

Will he be bringing any of the elements of world-class finance to the island? 'I will determine how appropriate some of the learning points are, as it is a very different context, culture and geography. In finance, they've recognised the need to move to finance business partners and away from the focus on transaction-based services. The move to a business partner role will no doubt present its own challenges. I will want to see how appropriate and transformative some of the learning points are and it is something I want to look at very carefully.'

Innovation in the spotlight

Future focused finance

NHS finance professionals are facilitating innovation, but could provide more resources to support service review and improvement, claims a report commissioned by Future-Focused Finance (FFF).

The report, *Future-Focused Finance national inquiry into innovation*, was commissioned by the *Great place to work* action area to provide insights into the role of finance professionals in innovation.

It found examples of finance professionals moving from a traditional custodian role to one facilitating innovation – creating new partnerships with clinicians; finance staff using their understanding of their organisation to overcome team or organisational challenges; and providing data for innovation as well as performance management. The report makes 15 recommendations on how finance leaders can provide better intelligence and data; improve skills; bring finance into every function; ensure sufficient resources for innovation; and create better partnerships with clinicians and the public.

Great place to work senior responsible officer Loretta Outhwaite said finance leaders were understandably risk averse. But she added: 'If we are to lead the NHS to a successful and sustainable future, as an NHS finance community we need to reflect on the inquiry's findings and identify practical ways to deliver and support innovation.'

Becky Malby, professor in health systems innovation at London South Bank University and a report author, said: 'If we can harness the focus, pace and data intelligence in the finance function, with its knowledge about the whole organisation, alongside clinicians' commitment to professional review and making the best decisions, we have a powerful partnership.'

• The report is available to download at www.futurefocusedfinance.nhs.uk

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Source: Patient Level Costing: Case for Change April 2016 (NHS Improvement)

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