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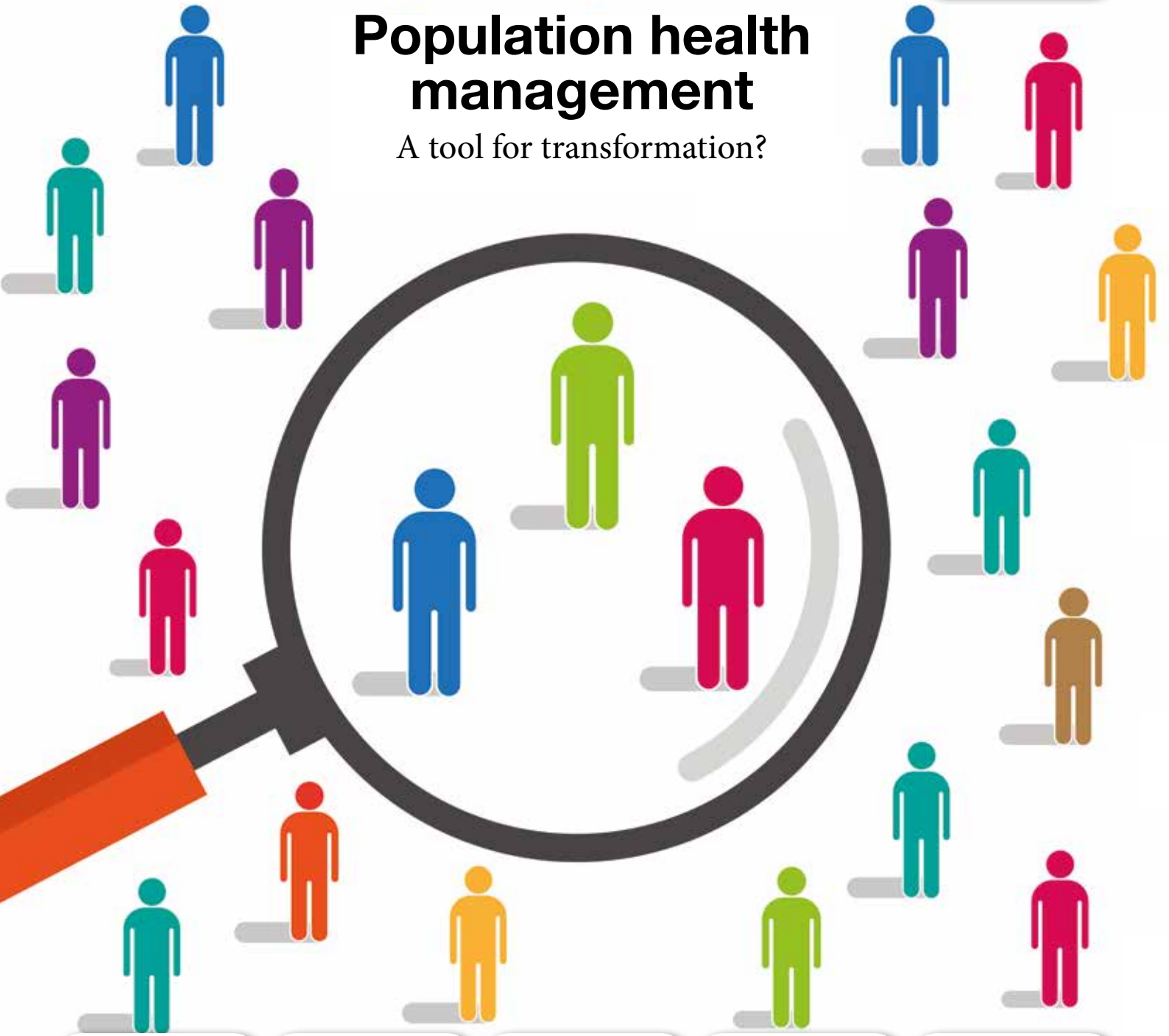

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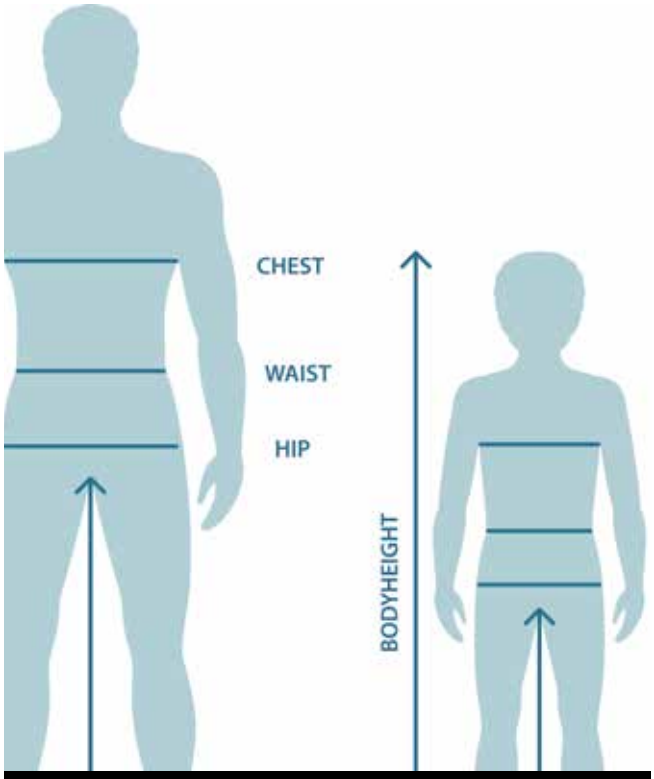

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Features

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Providers face capital lottery

Lack of capital funding is a challenge for English trusts, but some find it harder to access capital than others, according to analysis from NHS Providers.

Drawing on the Estates Returns Information Collection (ERIC) for 2017/18, NHS Providers said trusts faced a postcode lottery for capital. Its analysis found that half of the clinical service incidents that were caused by building or infrastructure issues occurred in the north of England (the North West and North East and Yorkshire regions).

London trusts had more high-risk backlog maintenance than the other six regions combined. But they received only 3% of the additional funding announced by the government in August. Just under 40% of community trusts are in the Midlands, yet account for 66% of backlog maintenance in community providers.

The analysis is part of an NHS Providers campaign calling on the government to set multi-year capital funding, commit to bringing capital funding in line with comparable countries and establish an efficient and effective needs-based mechanism for prioritising, accessing and spending capital.

'We need to rebuild our NHS, and give hardworking NHS staff the tools to create the 21st century health service that patients expect and that we can all be proud of,' said Chris Hopson, NHS Providers chief executive.

'We know the government shares our aim of a properly-funded and well-designed system of capital funding, but this analysis shows the urgent need for action right across the different sectors of the NHS and the country. The risk to patients is rising every day the government does not act.'

• *See Capital clamour, page 8*

News

Commissioner finances giving more cause for concern

By Seamus Ward

NHS England and NHS Improvement have more concerns about commissioners' financial positions than providers', chief financial officer Julian Kelly told the bodies' September board meeting in common.

He said around 25% (49) clinical commissioning groups were showing adverse variance to plan at month 4. Around a third of providers are showing an adverse variance to plan, though the variance per trust was much smaller than that for commissioners, he said.

'Looking at the forecasts, it's worth not too much money, but we are trying to assess the risk we are sitting on,' he said.

Bringing together the two national bodies means commissioner and provider financial positions can be examined in the round, he said. There was evidence of much better system conversations to solve financial and performance problems.

Mr Kelly said the overall year-to-date position for providers and commissioners was £75m off plan against expenditure of £39.5bn, while forecasting was broadly on plan.

But he added: 'We think we are sitting on a material risk of £500m to £600m, which in the scheme of about £120bn spend might not sound a lot but it would be hugely problematic.

'Different this year compared to maybe last, we have put the money out into the system, through the increase in prices and allocations and additional support through the provider sustainability fund and financial recovery fund. We absolutely do need systems, commissioners and providers to deliver against the plans they have agreed through the planning process.'

Mr Kelly continued: 'The risk is split about equally between trusts and commissioners, but probably this year, compared with last, we are more materially worried about the commissioner position. We have seen certain groups of commissioners in the North West and Midlands, in particular, showing material adverse positions.'

"We absolutely do need systems, commissioners and providers to deliver against the plans they have agreed"
Julian Kelly (pictured)

He reiterated his plea for trusts to improve their capital forecasting.

'We have a real requirement for taut capital forecasts from the provider sector as we are now at the mid-year point – in large part to work out whether we have the capacity to release some more funding to begin to do some catch-up work around critical maintenance backlog. We can only do that if we have taut forecasts.'

The meeting also heard that plans to allow NHS Improvement to set foundation trusts' annual capital spending limits have been rolled back. The government invited NHS England and NHS Improvement to make recommendations for new legislation following publication of the *NHS long-term plan.*

The board meeting heard that power to set foundations' annual capital limit should be a narrow 'reserve power' only. Each use of the power should be applicable to a single, named foundation trust and should automatically cease at the end of each financial year.

A paper on legislation tabled at the meeting said NHS England and NHS Improvement should be merged in full. The new body would be required to explain why the use of the capital limit power was necessary, describe steps taken to avoid its use and include the foundation trust's response. The information should be published to ensure the process is transparent.

NHS England's and NHS Improvement's proposals to have greater flexibilities in the tariff have been set out in the recommendations. These include the ability to set a blended tariff using a national formula, instead of a fixed national price.

Department bulks up cost recovery team as it advances EU exit preparations

By Seamus Ward

The NHS Improvement cost-recovery team will be expanded to increase the amounts reclaimed from overseas visitors who are not eligible for free healthcare, health and social care secretary Matt Hancock has announced.

The Department of Health and Social Care said it would back the expansion of the team, set up last year, with £1m in extra funding.

The team will work with existing trust cost-recovery managers to ease the burden on local staff by providing additional time and resources to identify patients who should be charged. It will also ensure the charging rules are understood and applied consistently.

The Department insisted this included making clear that urgent treatment should never be withheld. Care that clinicians say should not wait until a visitor's departure from the UK should be given, and recovery of charges can take place after the care has been provided, it said. Where treatment is non-urgent and can wait until they leave the UK, it must not be provided unless fully paid for in advance.

The expanded central team will help improve the reporting of income and debt collection, so debts are paid in full. Its remit will also include helping the NHS understand and implement charging rules for European Economic Area visitors after Brexit. EEA nationals living lawfully in the UK after Brexit will be able to continue using the NHS as they do now.

The Department said more than £1.3bn had been recovered from overseas patients since 2015, but significant unpaid debt remained.

Mr Hancock said it was 'only fair' to ask overseas visitors to pay their way. 'We're backing

No deal: significant work to be done

There is a risk of delays to supplies for health and social care if the UK leaves the EU without a deal, a report from the National Audit Office has warned.

Although the government has done a lot to manage the risk, there is still 'significant work to be done', the watchdog said. This includes improving the government's understanding of preparedness across the supplier base, ensuring sufficient freight capacity to carry priority goods and improving the readiness of the social care sector including nursing homes.

The report reviews the Department of Health and Social Care's preparations to make sure the UK has a steady flow of supplies for the care sector when it leaves the EU. It acknowledges that it is not possible to know exactly what will happen at the border if the UK leaves without a deal. However, the government's own 'reasonable worst case' assumption is that the flow of goods across the Channel could be reduced to between 40% and 60% of current levels on day one.

NHS Providers deputy chief executive Saffron Cordery said the report showed the level of uncertainty that remains just a month away from a possible exit. And she highlighted the lack of certainty about the readiness of social care providers as a key concern. 'Millions of vulnerable people will turn to the NHS for greater support should the sector be negatively impacted in terms of staffing and supplies,' she said.

'Confusing' prescription penalties slammed by MPs

The current penalty charge system for patients who incorrectly claim free prescriptions has been condemned by MPs as 'a heavy-handed rush to judgement' that penalises those who fail to understand complex exemption criteria.

The Commons Public Accounts Committee said it backed efforts to deter fraud, but the penalty system does not achieve this efficiently. It was not fit for purpose and must be overhauled.

In a report, the committee said the Department of Health and Social Care and NHS England were complacent about the problems in the penalty charge process. The Department acknowledges some patients may not seek treatment as they are afraid of being given a penalty charge, the report said.

The national bodies justified their approach as most exemptions are claimed correctly and the system generated income for the NHS. But the

PAC added: 'They seem to have lost sight of the fundamental importance of helping people claim what they are entitled to.'

Committee chair Meg Hillier (pictured) said the system was confusing – the Department had produced a 24-page booklet to explain a single-page prescription form. She called on the Department to set out how it will make exemptions more understandable and help the Department for Work and Pensions improve information for benefit claimants.

She added: 'A presumption of guilt means penalty charge notices are issued too readily, particularly where vulnerable people are concerned. Yet where there is clear evidence that people are persistently committing fraud by making false claims, there has been a failure to take effective action.'

The call for reform came as the Labour Party announced it would abolish prescription charges in England if it wins the next general election. There are no charges elsewhere in the UK.

At its conference in Brighton, the party said this policy would cost £745m a year. This cost included income of £576m from prescription charges that would no longer be received and an estimated extra cost of £170m due to increased uptake following abolition. Administration costs would be reduced by £1m, the party said.

"We're backing the NHS and giving it the support and tools it needs to ensure the rules are applied fairly and consistently"
Health secretary Matt Hancock, above

the NHS and giving it the support and tools it needs to ensure the rules are applied fairly and consistently. This drive will help recoup millions in unclaimed funds for our NHS, which can go back into frontline patient care, so the NHS can be there for all of us when we need it most.'

Jason Dorsett, chief finance officer at Oxford University Hospital Foundation Trust, said it had received 'huge support' from the overseas visitors improvement team. 'We have learnt alternative ways to identify chargeable overseas patients. The implementation of digital tools has reduced the administrative burden on previous methods resulting in a rise of income and cash recovery.'

Welsh budget delay

The Welsh government's draft budget for 2020/21 will be published later than in previous years, but finance directors will be supported as they prepare medium-term plans.

The government published the 2020/23 planning framework for the local NHS, together with a review of health bodies' progress on their 2019/22 integrated medium-term plan (IMTP).

The planning document said the Welsh government's draft budget for 2020/21 will be published later than previously due to the spending review and Brexit. The government will give finance directors advice, resource planning assumptions and guidance as soon as information is available. Financial allocations should be published in early 2020.

Health boards and trusts must produce IMTPs every year, setting out how they intend to use their resources and work together to meet ministerial priorities and improve care over the coming three years. Value-based care should be a central element of the plans.

Health and social services minister Vaughan Gething said he expected IMTPs to provide assurance that 'immediate and lasting changes' were being implemented. 'IMTPs continue to offer opportunities for NHS organisations to secure their trajectory for change,' he said.

The planning framework outlines the finance requirements for the 2020/23 IMTP, which must be financially balanced and include workforce and finance profiles.

The 2020/23 plans have to be submitted by the end of January 2020. Organisations that cannot produce a balanced and sustainable IMTP at that time will have failed their statutory duty. They must submit an annual plan for 2020/21, while also developing a three-year plan.

Spending round is missed opportunity, chancellor told

By Seamus Ward

NHS pressure groups have welcomed new funding for health and social care in the spending round, but warned that services needed greater certainty over long-term funding.

In the one-year spending round, chancellor Sajid Javid confirmed the previously announced £1.8bn boost to capital, adding that there would be a further £250m to back the introduction of artificial intelligence.

As part of this package, capital funding would increase by £1bn in 2019/20, Mr Javid said. NHS revenue funding was set last year in the five-year settlement.

The chancellor increased the Health Education England budget by 3.4% to support delivery of the *NHS long-term plan* and create a fund worth £150m for continuing professional development (CPD). This fund will provide a £1,000 central training budget over three years for each nurse, midwife and allied health professional.

The public health grant will increase in real terms and there was an extra £1bn for adult and children's social care. This would help local authorities meet rising demand for services and continue to help stabilise the system, he said.

The NHS contribution to adult social care through the Better Care Fund will increase by 3.4% in real terms, in line with the overall NHS long-term settlement.

The government will consult on a 2% adult social care precept on council tax bills that will enable councils to access a further £0.5bn, Mr Javid added.

But Nuffield Trust chief economist John Appleby (pictured) said the spending round was 'a missed opportunity to turn around years of cuts to the crucial budgets that support the NHS and the patients who depend on it.'

He added: 'There is new money here, and it is welcome, but it amounts to only about a third of what we calculated was required.'

The CPD funding was much less than needed to return ongoing training budgets to 2013/14 levels, while the additional social care funding was no more than a 'sticking plaster', Professor Appleby added.

NHS Providers chief executive Chris Hopson said that trusts welcomed the additional capital and training funding. However, he added: 'We still need concrete long-term funding commitments on capital, public health and education if the NHS is to deliver its long-term plan.'

• *See Capital clamour, page 8*

News review

Seamus Ward assesses the past month in healthcare finance

With the Brexit tug of war at Westminster seemingly more dramatic as each week passes, the Supreme Court ruling on the suspension of Parliament, more than a whiff of a general election in the air, a spending round and party conferences, September was a packed month. Brexit, of course, was the theme that ran through most political developments and was the central theme of a lot of NHS news.

While there were further developments later in the month on preparations for the UK's withdrawal from the European Union (*see News, page 4*), September began with a series of warnings of the impact of a no-deal Brexit. The British Medical Association claimed the NHS faced 'being ravaged' by a double-whammy of a no-deal Brexit coupled with the expected winter crisis. In *A health service on the brink: the dangers of a no-deal Brexit*, the BMA said a no-deal exit from the EU on 31 October would leave no area of healthcare unaffected. And the impact of no deal would come as the NHS gears itself up for the busy winter period. The BMA urged the government to answer 40 questions on topics such as access to medicines; reciprocal healthcare arrangements; healthcare in Northern Ireland; and medical research.

Thinktanks came together to warn that health and social care would feel the impact of no-deal Brexit most acutely in four areas. In a letter to MPs returning to Parliament after the summer recess, the Health Foundation, King's Fund and Nuffield Trust said no deal would risk intensifying staffing shortages. It could increase the cost of medicines and medical devices while new border controls could squeeze supplies. UK emigrants returning from EU countries could increase costs and demand pressures, and all impacts of no deal could put even more financial pressure on the NHS at a time when it is transforming care.

Away from Westminster, an access and finance problem may be brewing for the NHS in England. During the month, the Scottish government announced it had reached a five-year pricing agreement for the supply of medicines that will help people with cystic fibrosis. The agreement – with Vertex Pharmaceuticals, manufacturer of Orkambi and Symkevi – gives NHS Scotland access to the drugs at a discount, which remains confidential. The NHS in England has been unable to reach agreement with Vertex, though talks continue. In a response, NHS England said it was disappointed, alleging Vertex remained 'an extreme outlier' in its monopoly pricing.

NHS England published guidance on the strategic direction it is taking to tackle fraud, bribery and corruption, which are collectively known as economic crime. The document said that each year the NHS in England could lose up to £1.3bn as a result of economic crime. The guidance said economic crime is unacceptable, and the NHS must have a culture where fraud is neither ignored nor tolerated. NHS England's priorities on economic crime are addressing patient exemption and dental contractor fraud, as well as fraud investigations and the development of a proactive work plan.

Only 39% of trust leaders believe the current regulatory regime adopted by NHS England, NHS Improvement and the Care Quality Commission (CQC) is working well, according to NHS Providers. Its report found that only 8% of respondents said the regime was good value for money, while 39% felt NHS England had a good understanding of the pressures trusts faced. NHS Improvement fared better – 74% said it

The month in quotes

'Health and care services are already struggling to meet rising demand for services and maintain standards of care in advance of an expected difficult winter. The potential consequences of a no-deal Brexit could significantly impede services' ability to meet the needs of the individual patients and service users who rely on them.'

The Health Foundation, Nuffield Trust and King's Fund warn MPs of the potential ramifications of a no-deal Brexit

'Vertex has rejected the health service's offer, which would give access to the treatment for people with cystic fibrosis, at a price assessed as appropriate for the clinical effectiveness of the medicine. It was the largest offer the NHS has ever made for a treatment of its kind.'

NHS England responds to the agreement between the Scottish government and Vertex for Orkambi and Symkevi

'The likelihood is that this winter will be a very testing time for trusts. We anticipate that performance will slip even further, with patients waiting longer for treatment across various services.'

NHS Providers director of policy and strategy Miriam Deakin warns that high demand over the summer means a difficult winter ahead

'The safety and wellbeing of all patients and their families is my top priority and should be the primary consideration in all NHS construction projects. I want to make sure this is the case for all future projects.'

Scottish health secretary Jeane Freeman says that the public inquiry must uncover lessons for future building projects

SHUTTERSTOCK

Brexit was the theme that ran through most political developments and was the central theme of a lot of NHS news

had a good understanding, while the figure was 52% for the CQC. NHS Providers said there was a growing tension between the current organisation focus and the move to system working, with only one in five trusts believing regulators take adequate account for system working in their judgement of providers.

Northern Ireland's Department of Health announced a boost of almost £27m for local GP services in the current financial year. The £26.76m investment includes more than £18m for the acceleration of transformation schemes. The funding includes money for the development of multidisciplinary teams (£11m) and the delivery of elective care in general practice (£3.5m). Up to £4m has been set aside for investment in GP premises, with the aim of supporting multidisciplinary team working and expanding GP training.

There will be a public inquiry into buildings problems at two hospitals in Scotland. The Scottish government said the decision to hold the public inquiry follows concerns about the new Royal Hospital for Children and Young People (RHCYP) and the Queen Elizabeth University Hospital. The inquiry will focus on issues with ventilation and other key building systems. Health secretary Jeane Freeman also appointed a senior programme director to work with NHS Lothian on the delivery of RHCYP. The move follows the publication of an independent review of governance arrangements and an assessment of building compliance.

Clinicians would be given greater flexibility to choose their pension accrual level under proposals for changes to the NHS pension scheme, currently out for consultation by the government. The proposals respond to concerns that clinicians are limiting their NHS work to avoid breaching annual allowance rules, which can lead to significant tax charges. If implemented, clinicians could choose to pay a percentage of the normal accrual level (in 10% increments) and fine tune pension growth towards the end of a scheme year. The consultation also seeks views on whether this flexibility should be extended beyond the clinical workforce (*see Pension equity p10*).

Wales health and social services minister Vaughan Gething (pictured) has announced

that doctors working in Wales will receive a 2.5% pay uplift backdated to April. In a written statement to the Welsh Assembly, the minister said his decision was based on affordability, the ambitions set out in the *A healthier Wales* programme and the need to address challenges of equality, recruitment, retention and productivity in the medical workforce. The value of both the national clinical excellence and commitment awards have been frozen, and Mr Gething has asked the BMA and employers to jointly propose how this money could be used to reward the wider consultant workforce.

Staff 'passports', which will help workers move seamlessly between NHS organisations, will enable staff to work more flexibly and cut administration costs, according to NHS England and NHS Improvement. The national bodies said all hospitals in England were being urged to adopt passporting – this will reduce the need for staff to attend an induction (which can last two days) and cut red tape when they move between organisations. The bodies also confirmed there will be a £7m fund to support the nationwide introduction of e-rostering.

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from the hfma

There is increasing recognition that value-based healthcare – maximising the outcomes that matter to people at the lowest possible cost – is the solution to delivering high-quality, sustainable healthcare. But putting it into practice is challenging. In a blog, head of the Healthcare Costing for Value Institute Catherine Mitchell identifies four themes that pioneering healthcare systems are tackling in the pursuit of value. Putting patients at the heart of decision-making is key to success and there is an increasing focus on population health. A culture is needed that prioritises value-based healthcare and being able to make the case for change is also important.

Apprenticeships present a missed financial opportunity and a wasted chance to develop staff, Phil Kemp, HFMA head of professional development and apprenticeships writes in a blog. He says NHS organisations are contributing an estimated £200m a year in apprenticeship levy and there are suggestions a significant proportion of this is going unused within the 24-month cut-off point. The HFMA has been working with the NHS to design apprenticeships to meet employers' needs, and the first apprenticeship programme from the HFMA – the accountancy level 4 programme – will begin in January.

The HFMA published several briefings in September. The association's annual year-end survey highlighted concerns with the timeliness of audit work and audit sign-off. Meanwhile, a further two briefings have been published in a series on community services, which are due to be expanded under the *NHS long-term plan*. The two publications look at community services' role in system working and prevention.

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News analysis

Headline issues in the spotlight

Capital clamour

Prime minister Boris Johnson's announcement of an increase in capital spending for 2019/20 this summer was welcome. But the voices calling for more sweeping capital reform continue to grow louder. Steve Brown reports

The government spending round at the beginning of September confirmed an increase in capital spending for the NHS this year. But most in the service believe this can only be seen as a downpayment – with bigger increases needed in future years alongside fundamental changes to the way capital funds are allocated.

Chancellor Sajid Javid was simply confirming an earlier announcement in August by prime minister Boris Johnson of an extra £1.85bn. Some £850m of this will be spread over five years to upgrade 20 specific hospitals, while £1bn was to boost capital spending in the current year 2019/20. In fact, Mr Javid talked about increasing capital funding by more than £2bn, with '£250m for ground-breaking new artificial intelligence technologies', giving an overall capital departmental expenditure limit of £7bn (*see box, New spending limit*)

The increase to the 2019/20 capital spending limit was better news for trusts. Previous trust plans for capital spending had significantly exceeded the available spending limit and there was concern that cash build-up in some trusts, courtesy of the Provider Sustainability Fund, might enable providers to deliver these plans (*See Increased spending limit reduces capital concerns, but better forecasting needed, September 2019, p23*). Trusts had been asked to reduce these initial capital plans by 20% and the increased funding means this is no longer necessary.

NHS Confederation chief executive Niall Dickson welcomed the increase in capital funding but said that it was 'substantially short' of the £6bn needed to clear the massive maintenance backlog that has built up in recent years – a figure that has increased from £4.3bn in 2013/14.

'The government must increase capital funding to ensure that all NHS organisations can access capital investment to address crumbling buildings, failing equipment and outdated IT,' said Mr Dickson.

He is not alone in seeing the spending round funds as insufficient. Centre-left thinktank the IPPR last month called for a massive £5.6bn increase in the capital departmental expenditure limit (CDEL), with this rising further over five years (*see box, Solving the crisis*). And NHS Providers has also launched a capital campaign under the banner 'Rebuild our NHS'.

This calls for action in three areas. First, it wants a multi-year capital settlement that at least covers the five years of the existing revenue settlement and ideally the 10 years of the long-term plan period. Second, the current level of capital spend should be 'at least doubled' and then sustained for the foreseeable future. Third, it wants changes to the mechanism for prioritising, accessing and spending NHS capital with NHS organisations.

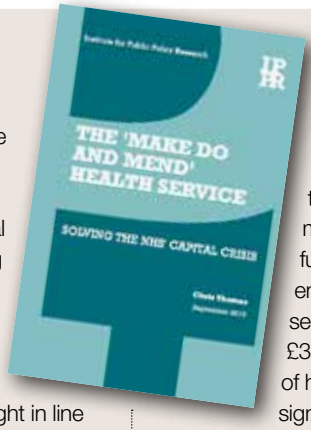
In reality, calls for capital reform have been growing over recent years. The Health Foundation earlier this year highlighted that the capital budget in 2017/18 was just 4.2% of total NHS spending, compared with 5% in 2010/11 – largely the result of capital-to-revenue transfers.

The HFMA has also prioritised the issue. Its 2018 briefing *NHS capital – a system in distress?* underlined the current gap between available resource and need for investment and called for the system to be simplified.

Solving the crisis

A report in September from centre-left thinktank the IPPR – *The 'make do and mend' health service – solving the NHS capital crisis* – said recent NHS history was defined by very low capital investment.

It had rarely spent above the OECD average on capital and, when controlling for population size, it invested the least in capital per head across the OECD. Only the private finance initiative had introduced competitive levels of capital money into the health system and this had ultimately proved to be 'particularly poor value for money'. The NHS has only paid around £25bn of the expected £80bn total cost of PFI, acquiring just £13bn of assets, the report said.



The thinktank called for capital spending to be brought in line with the OECD average per person – requiring an uplift of £5.6bn for CDEL in 2020/21, which should then be maintained. This should be split into two funds. A maintenance fund would enable the service to clear £3bn worth of high and significant risk maintenance by the end of the five year settlement period. The rest of the funding would form a transformation fund – £4bn in year one – to support place-based reform, allocated through a bidding process.

The thinktank also wants the PFI legacy addressed through a 'right to enfranchisement' allowing PFI tenures to be transferred into a freehold tenure through a one-off standardised payment.

Trusts paying more than 5% of income on unitary charges should receive direct financial support in the meantime, the report argued.

Chancellor Sajid Javid talked about increasing capital funding by more than £2bn, with '£250m for ground-breaking new artificial intelligence technologies'

SHUTTERSTOCK

NHS Providers has a particular concern about the current system of loans that sees trusts paying interest. 'Some providers are never realistically going to pay these back,' said Adam Wright, a policy adviser with the representative body. 'The trusts in need of loans are likely to be the ones with the biggest and most entrenched deficits – it doesn't make sense to be slicing further money off their income.'

There is also an issue with fairness, with those trusts in most need of capital investment not necessarily having access to funding. Trusts with the worst deficits will often be unable to self-fund capital programmes through surpluses or, in recent years, PSF receipts. They either have to go without the capital investment or are forced to use a loan system that will exacerbate their financial position – widening the gap between the haves and have nots.

'We should have a financial system where a well-run trust can make a surplus each year and then has the ability to invest that surplus into its capital programme,' said Mr Wright. Separate mechanisms would be needed for larger system-scale investments and new hospital builds.

However, such a system – effectively the original system envisaged for foundation trusts – could not be turned on overnight and would need a health service with greater financial headroom than it currently has. Mr Wright said NHS Providers would continue to explore options with members and is planning a more detailed report as part of its campaign.

The current loan-based system builds on the idea that there should be consequences to decisions around the management of estate – capital should not be seen as a free good. The previous system – with capital allocated by issuing new public dividend capital (PDC) – also had costs attached. Trusts had to pay a dividend payment set at 3.5% of net relevant assets. (Some PDC continues to be issued.)

Although this dividend rate is higher than the 1.5% interest rate at which capital loans start, PDC comes at a distinct advantage. First, trusts in special measures can pay up to 6% on loans. Second, PDC was largely viewed as not repayable – or certainly not over the short term.

A glance at the section 40 financial assistance report published alongside each year's Department of Health and Social Care accounts shows that for most trusts, loan repayments dwarf interest payments. In 2017/18, trusts made loan repayments of more than £204m, compared with interest of just over £90m, according to figures from former health minister Stephen Hammond at the end of last year.

"We should have a financial system where a well-run trust can make a surplus each year and then has the ability to invest that into its capital programme"
Adam Wright, NHS Providers

Last year's HFMA briefing discussed a range of measures that might address aspects of the current system. In terms of moving to a simpler, more transparent mechanism, it suggested system allocations could be explored as an alternative to repayable loans.

As a further refinement, it said allocations could be made to organisations to cover backlog maintenance, with additional system allocations accessed based on business case submissions, judged on clear criteria.

However, even with a clearer system, it said that this would not resolve the historic deficit positions for some providers.

It appears there is growing recognition that the low level of capital funding in recent years cannot be allowed to continue. The consensus is that this year's spending round has made a step in the right direction. Now it must be backed up by a long-term settlement that increases funding levels and certainty. And the underpinning system for allocating and prioritising capital spend also needs rapid reform.

New spending limit

Budget 2018 set the capital departmental expenditure limit for health at £6.7bn for 2019/20. To get to the starting position for the 2019 spending round, this needs to be reduced by £471m to allow for capital to revenue transfers. Some £250m of this was agreed as part of the 2015 spending review and the rest to fund part of the first year of the NHS's long-term settlement.

Roughly £300m more also needs to be taken off, representing a capital receipt the Treasury expects the Department to make this year, bringing the capital limit down to around £5.9bn. The additional £1bn of capital spending announced by prime minister Boris Johnson in August, plus an element of the £850m spread over the next five years for specific hospital upgrades, brings the 2019/20 CDEL to the spending round figure of £7bn.

Comment

Homework time

The four nations' health services offer huge learning potential

HFMA president Bill Gregory

I recently attended the Wales Branch conference, held at the Vale Hotel near Cardiff. What an excellent event the Welsh team put on, and so pleasing to see my *Value the opportunity* theme translated into real examples.

One of the conference sessions focused on genomics and the difference that intelligent use of this technology can make to the cost of treatment and speed of diagnosis for a number of relatively common diseases.

We are all familiar with the diagnostic process of blood tests, scans and other diagnostic procedures – all aimed at narrowing down the diagnosis for individual patients. We heard from Sian Morgan, head of the All Wales Genomics Laboratory, on how sensible deployment of gene testing, which can cost as little as £50, can accelerate this process and eliminate unnecessary steps – a great value example if there ever was one.

As well as getting an opportunity to speak to members of the Wales Branch, my trip really brought home to me the reach of HFMA across our four nations. Since the devolution of political power to Scotland and Wales, there has been increasing divergence in health policy and the way the NHS is run in each of the four nations. Structures and management

Pension equity

Pension flexibilities should not be restricted to clinicians

Healthcare Finance editor Steve Brown

Restricting new flexibilities within the NHS Pension Scheme to clinicians seems wrong in principle and there is a good argument for it being available to all scheme members.

The Department of Health and Social Care issued a consultation on a second set of proposals in September amid concerns that potential tax demands related to pension allowances were starting to have an impact on the delivery of patient care.

The issue has arisen because of dramatic reductions in an annual allowance – limiting the amount of tax-relieved savings that can be made to a pension – and the introduction of a taper that lowers this allowance from £40,000 to £10,000 for the highest earners.

Although the arrangements have been in place for a number of years, the ability to carry forward unused allowance from previous years has meant the full impact has only started to be felt over the last 12 months.

The focus has been on clinicians – and understandably so. In the face of significant workforce challenges, the NHS relies on its clinical workforce to take on additional sessions on a regular basis. However, clinicians have been refusing additional programmed activities and waiting list initiative work, as well as promotions and

further responsibilities, because the tax penalty can be higher than the pay for the additional work. Even uncertainty over the impact of the tax rules can be a deterrent.

In more extreme cases, clinicians have been retiring or withdrawing from the pension scheme.

But while it is understandable that the government's knee-jerk response is to simply fix this issue for clinicians, that doesn't make

"There is much to learn from how the NHS across the four home nations deals with familiar pressures"

approaches are different and there are differences in the way social care relates to health.

However, we share common values and face very similar challenges, particularly around the delivery of integrated care and increasing moves towards the management of population health (*see Under scrutiny, page 16*).

We often talk about the potential to draw lessons from international health systems. But the operation of the NHS across the four home nations gives us all an opportunity on our doorstep and there is much to learn from how each service deals with familiar pressures.

One aspect I was interested to learn about is the way the Welsh senior finance teams work with their national team, something we are starting to see mirrored in our re-energised regions in England.

I am now about halfway through visiting the branch conferences, and I have been really impressed with the enthusiasm out there. It is particularly pleasing to see our younger members attending these events. I have seven further branches to visit over the next two months, and I am already looking forward to seeing the excellent work of finance teams across the country.

Many of the branches now have their own local systems of awards and recognition of achievement at their conferences, mirroring the national awards that will be being judged through the late autumn ready for the national conference in early December. I hope as many of these local award winners are able to participate in these national awards as possible.

Next stop is Kent, Surrey and Sussex in October.

Contact the president on president@hfma.org.uk

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it right. Clinicians are vital to the NHS – in the front line of patient care, they are clearly the most visible members of the healthcare team. But 'team' is the key word here. In a care system that is increasingly talking about the importance of multidisciplinary working, it seems odd to be making a special case for just some of the team members.

Managers may not take on extra paid shifts – although clearly many are working far in excess of their contracted hours – but they are in their own way fundamental to the delivery of effective and efficient care.

We don't know how many non-clinicians are disadvantaged by the annual allowance rules. But we are not talking about isolated cases. It is becoming clear that managers are responding in much the same way as clinicians to the pension tax issue – not applying for promotions, not taking pay rises, reducing working hours and leaving the NHS pension scheme (at least temporarily).

A clinical example in a research report for NHS Employers, published in June, highlights the specific dangers of pay rises and cliff edges. It shows how a consultant on £90,000 with £20,000 of private clinic income on top and taking on a managerial role with a pay rise of £14,000 would face an annual allowance tax charge of about £18,000. But increase the pay rise by just £1,000 to £15,000, and the tax charge jumps to £32,000.

In recent years, there have been efforts to support senior finance managers to make the step up to the most senior roles. It would be a shame if the impact of pension tax rules were inhibiting this progress.

Attention is clearly focused on the very high earners and primarily those with legacy pensions in the older final salary-related

"Attention is focused on very high earners ... but the way the system works means that more modest earners can also be hit"

schemes. But the way the system works means more modest earners can also be hit as they receive a pay rise related to a promotion.

The Department has asked as part of its consultation whether its proposals should be made available to other staff or all staff in the NHS. It would seem equitable to suggest that any flexibilities should be open to all staff. Perhaps more junior staff would welcome the chance to reduce contributions to make them more affordable, even though existing variable rates allow for this to an extent.

The HFMA is keen to understand how the tax rules are affecting finance staff in practice. Are finance managers thinking twice about applying for promotions or turning down pay rises or even thinking about responses that would reduce the financial skills available to the service? Would staff who are unlikely ever to be affected by the annual allowance taxation issue welcome a more flexible pension scheme? You can find a survey link at **hfma.to/a9** and the survey will be open until Monday 7 October.

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on the way down

Hospital drugs spending has more than doubled in less than a decade and the NHS is committed to tackling the upward trend. Seamus Ward speaks to health service organisations about how they are reducing their drugs bill

In 2017/18, drugs spending in hospitals surpassed that in primary care. It was a significant moment. Although the medicines bill in primary care is still rising, efforts to keep spending down – such as no longer prescribing ineffective drugs and national negotiations to keep down spending on branded and generic drugs – appear to be working. But spending in hospitals more than doubled between 2010/11 and 2017/18 and this is now being targeted across the country.

According to NHS England, the overall drugs bill is increasing by 8% a year and much of this rise is being driven by hospital spending. At the beginning of this decade, hospital drug spending was less than half than the value of prescriptions dispensed in primary care – hospitals around £4bn; primary care £8.6bn. Growth in primary care spending slowed, reaching £8.9bn by 2017/18, but over the same period hospital spending increased to £9.2bn.

The reasons for the rapid growth in hospital drug spending are complex. Last year, the King's Fund published a report, *The rising cost of medicines to the NHS*, which warned about the increasing drugs bill. Leo Ewbank, a King's Fund researcher and one of the report's authors, says it is difficult to figure out what is driving the rapid increase in hospital costs at national level.

'I can't be sure, and I don't know if the national bodies know what's going on,' he says. 'We found it hard to get a grip of the numbers in a way that felt solid.'

Local providers will have a better grip on the reasons for their costs increases. But, generally, it appears that activity increases, rises in the cost of medicines and greater use of specialist drugs are behind it, he says.

A national medicines value programme set up by NHS England aims to ensure that patients can access treatment that is clinically effective, up to date and as low-cost as possible. To reduce waste and increase safety, the programme also wants to give patients support to use their medicines as intended, with appropriate medicines reviews to ensure that outcomes match patients' expectations.

As well as national policy framework governing access to and pricing of medicines and negotiating commercial agreements with manufacturers, the national value programme plans to optimise the use of medicines. This could include encouraging the uptake of cheaper generic and biosimilar drugs, where appropriate.

Meanwhile, at a more local level, commissioners, providers and systems are also working to bear down on costs while maintaining or increasing safety and quality. These efforts are often carried out under the badge of medicines management, medicines value or medicines optimisation.

North Devon Healthcare NHS Trust, for example, has improved its medicines

Cheshire and Merseyside projects		
Project	Estimated benefits	Lead
Acute macular degeneration	£0.6m	Acute provider chief pharmacist
Better use of patients' own medicines	£0.2m	Acute and CCG lead pharmacists
E-transfer of prescriptions	£11m	Innovation agency
Medicines Value Team (improved value from high-cost drugs and biosimilars)	£1.2m	Acute provider chief pharmacists
Anticoagulation medicines	£5m	CCG with tertiary provider
Mental health safety and value projects	£1.2m	Mental health pharmacist
Stoma prescription management hub (five CCGs)	£1m	CCG collaboration

management pathway for patients receiving acute, unplanned episodes of care. As a first step, paramedics prompt patients being taken to Northern Devon District Hospital to bring their medicines with them. The trust's mantra is 'getting medicines right' – for example, by ensuring it is easier to refer patients to a pharmacist following admission. This can lead to better discharge planning.

The proportion of patients bringing their medicines to hospital rose from 7% in July 2017 to 67% in February 2018 – ward staff can talk to patients about whether the medication is causing any problems. Nursing time is saved as more patients administer their own medication, unintended omissions have reduced and there was less waste.

One system tells *Healthcare Finance* that it has set up several projects to reduce spending, including a gain share agreement to combat recent growth in high-cost drug costs. This is introducing oversight and cost reduction, influencing the provision of drugs for home care and the choice of product. The gain share is operating for a fixed period, incentivising providers to switch patients onto lower cost biosimilars. 'There is an incentive to ensure the process is done rapidly and to ensure there are enough resources to enable the transition to take place,' it says.

Elsewhere, a system-wide medicines optimisation programme has been set up under Cheshire and Merseyside Health and Care Partnership. The collaborative programme is led by independent chair, Helen Poulter-Clark, chief pharmacist from The Clatterbridge Cancer Centre, and Chris Harrop at NHS-hosted assurance and advisory service MIAA Solutions, with non-recurrent funding from the sustainability and transformation partnership.

The programme aims to increase and sustain a minimum 90% uptake of biosimilar medicines. It is also leading on other, at scale, projects, such as e-transfer of prescriptions; promoting better use of patients' own medicines and encouraging optimal prescribing of alternatives to traditional anticoagulants like heparin and warfarin. These alternatives are known as direct oral anticoagulants (DOACs).

Previously, two groups were looking at medicines optimisation locally – one developed by NHS England with a commissioner perspective on high-cost drugs and biosimilars; the other provider based. The latter was examining a limited list of drugs that it felt it could influence, such as medicines used to treat some cancers and age-related macular degeneration. 'It struck me that it didn't make sense to look at it from just one perspective and, over the course of about six months, we started to pull together a common agenda,' says MIAA's Mr Harrop. 'We have achieved a great thing in having one group looking at medicines optimisation across the whole region.'

Mr Harrop doesn't pretend Cheshire and Merseyside has got everything right, or that its approach is unique. 'It's a work in progress,' he says, adding that the biggest difference is the system-wide nature of the medicines optimisation programme.

Initial meetings between the groups were followed by a series of workshops and now the establishment of four core project groups. Each core project (see table) is led by a chief pharmaceutical officer.

Savings from the medicines value project could be in the millions, he says. 'Providers in Cheshire and Merseyside are already doing quite well on a range of medicines optimisation indicators, but to get to 90% uptake of biosimilar medicines for all providers, for example, could lead to millions of pounds in potential costs avoided.' Sharing learning and intelligence across the system is invaluable, he says.

Ms Poulter-Clark adds: The programme offers the opportunity to collaborate beyond traditional working networks and has enabled local expertise to achieve cross-organisation benefit. We are beginning to see real change and are keen to make sure lessons are shared in the NHS with national programmes.'

Susanne Lynch (pictured below), head of medicines management at South Sefton Clinical Commissioning Group and Southport and Formby Clinical Commissioning Group, says the two Sefton CCGs have a well-established shared medicines management team made up of clinical pharmacists, technicians and an analyst.

'The team is always looking for savings, efficiencies and innovation to optimise prescribing in primary care, but the Cheshire and Merseyside work is an opportunity to work with colleagues across the sectors and to start thinking as a system,' she says. 'From a financial perspective for some projects we could look at, both commissioner and provider will gain. In some, it will be one party, but that's the challenge of system working. It's not about them and us.'

She welcomes the system-wide working. The days are gone when it was enough to switch a drug locally for a cheaper option to achieve financial balance and best patient outcomes. The future requires managed medicines optimisation across systems and sectors. 'It's a real opportunity for pharmacists to start to make a difference and to share best practice,' she adds.

Locally, the South Sefton and Southport and Formby CCGs' medicines management team is working with primary care networks (PCNs) and local trusts to review, optimise and reconcile patients' medicines after hospital discharge. 'We are working with our community pharmacy colleagues and care homes to support patients post-discharge with regard to medication changes and making adjustments to meet personal needs,' says Ms Lynch. 'This will ensure quality and safety and a smooth transition from hospital to community.

With system working, pharmacists can really support patients, she says. National investment in clinical pharmacists along with investment from

individual CCGs in medicines management teams such as in the two Sefton CCGs enables working at scale rather than in silo.

Joined up leadership is also key. 'What we do as a team is not all about saving money, as when we visit or speak with patients, we can make interventions or signpost patients, which delivers quality outcomes for everyone. It is important to listen to what matters to a patient about their medicines when reviewing them,' she adds.

'If pharmacy teams are doing good quality reviews across the sectors in a joined-up way, there could be significant savings to the system, along with benefits for the individual patients.'

Use of DOACs

The use of DOACs is increasing locally and nationally. Cheshire and Merseyside is focusing on how DOAC prescribing can be better optimised. Clinicians want to be sure patients are getting the best medical outcomes from this new group of drugs in a cost-efficient way. The potential savings are significant across the system.

Ms Lynch is leading the project. 'The programme is about reviewing patients being prescribed DOACs to improve quality and where appropriate deliver cost savings. Scotland has undertaken work already in this area, so I've been in touch with them – it's great to learn from others what's working for them,' she says.

Mr Harrop says the cost benefit of the DOAC project could be around £5m, based on clinical and cost effectiveness studies undertaken elsewhere in the UK. In mental healthcare, there is a potential further opportunity to improve patient safety by reviewing patients in certain high-risk groups more frequently, he says. Based on evidence from within Cheshire and Merseyside, this could avoid costs of £1m to £1.5m by reducing exacerbations and improving compliance, for example by being sure the person is taking the medicine as intended. However, he adds that the opportunities will need to be validated with the three local mental health providers.

'There is a clear narrative of making sure all these projects are sustainable through support from clinicians, patient safety and cost avoidance,' Mr Harrop says.

While there is an opportunity to bring clinicians together from across the system, there is an acknowledgement that, at place level, the situation can differ. A place with one acute provider, a mental health trust, local authority and clinical commissioning group will be less complex than a city like Liverpool, which has general and specialist providers. 'You have to be careful to make sure you disaggregate the work and ensure ownership of projects within place,' he adds.

The programme is speaking to other areas interested in replicating what it has done. 'It could be used elsewhere, but it would be difficult to replicate the relationships and understanding of the people in the system. The approach would be the same – bringing people together on a common agenda with common reporting.'

The NHS must get to grips with the growth in hospital drugs spending if it is to ensure that it is getting value for money from every pound spent. Local and system-wide schemes, complemented by national programmes, appear to be having an effect. But, as is often the case with collaborative projects, those most likely to succeed are the ones where relationships are strong and organisational requirements are secondary to those of patients.

Resources required

Realising the benefits of medicines optimisation and value work often depends on having the resources at ward level to ensure any changes are introduced safely and effectively, says Pippa Roberts, director of pharmacy and medicines optimisation at Wirral University Teaching Hospital NHS Foundation Trust, and system lead for the Wirral medicines optimisation programme.

She says Cheshire and Merseyside medicines optimisation work focuses on hospitals' approach to value, safety and cost-effectiveness. Collaboration is helpful, ensuring the spread of best practice and that effort is not duplicated.

The speed of adopting a change in medicine use varies between hospitals, often due to a lack of implementation resources. Introducing drugs is not just a question of the product being available, but having pharmacists and clinicians ready to shepherd them safely and effectively into the front line, she adds.

Initially, it was estimated that the medicines value team's focus on high-cost drugs and biosimilars would save £1.2m a year across the health and care partnership. However, the actual savings could be higher.

Bringing in biosimilar drugs, particularly bringing all trusts up to the same level of use, has been a priority for Cheshire and Merseyside.

'Our work has identified that the introduction of biosimilars requires resource, and while some trusts were doing the work by redirecting available internal resource or as a result of local funding, an impasse has been reached for some, due to a lack of pharmacy resource to safely drive the switch,' says Ms Roberts. 'Resource has been inextricably linked to the speed of adoption with these medicines and has led to lost opportunities where trusts have not been on the front foot with the resources to plan in advance and implement at the earliest opportunity.

'In the Wirral, we have received resource as part of an invest to save scheme agreed with Wirral Clinical Commissioning Group to introduce biosimilar versions of "mab" drugs.'

These drugs can be used in a range of health conditions, including Crohn's, ulcerative colitis and psoriasis, and includes adalimumab (used to treat rheumatoid arthritis), the service's most costly drug. Last year, NHS England reached an agreement with manufacturers of biosimilar versions of the drug, which could save the NHS £100m a year.

Overall, savings from the introduction of biosimilars in place of mab drugs have reached almost £3m in the Wirral since the review programme started. Ms Roberts says this was only possible because her team was funded and prepared. 'We had the resources in place when the biosimilars came – we switched 90% of the patients on adalimumab in the first month and we had been communicating with them on the change six or seven months prior to that.'

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Under scrutiny

Population health management uses wide-ranging data to understand what is driving outcomes across whole populations. With the *NHS long-term plan* suggesting all systems should be moving towards its adoption, Steve Brown asks what it is all about

The NHS is on a mission to move from a reactive system that responds to health problems to a proactive model focused on earlier detection and intervention, taking account of the wider determinants of health. Population health management (PHM) is how it hopes to make the change.

The approach gets plenty of attention in the *NHS long-term plan,* with multiple references to population health and the adoption of PHM solutions. These solutions would support integrated care systems to understand the areas of greatest health need and match services to meet them, the plan says. In fact, PHM capabilities are described as key capabilities of a mature integrated care system in the plan's implementation framework

According to NHS England, population health – perhaps self-explicably – is an approach aimed at improving the health of an entire population. It aims to improve the physical and mental health outcomes and wellbeing of people, while reducing health inequalities within and across a defined population. It also includes action to reduce the occurrence of ill health, including addressing the wider determinants of health. This is important, as some reports suggest just 20% of a population's health and wellbeing is linked to access to good-quality healthcare.

Tool for change

PHM is the tool that systems can use to deliver this, using historical and current data to understand what factors are driving poor outcomes in different population groups. This might help identify steps that could be taken to prevent conditions developing or worsening – primary secondary or tertiary prevention. It could even highlight the conditions that make people susceptible to poor health in the first place – air quality and housing, for example. Proactive models of care or other interventions can then be designed to improve these outcomes.

Techniques such as segmentation and stratification are often an important first step, enabling areas to focus on specific sections of the population and consider their different needs and outcomes.

At the beginning of 2019, NHS England ran a development programme with four accelerator systems in Leeds, Dorset, Lancashire and South Cumbria, and West Berkshire. The programme ran intensively for 20 weeks, supported by consultancy Optum, with the aim of giving systems analysis, support, coaching and workshops to help build the systems' PHM capability.

Leeds was not starting from scratch. 'Our journey started three to four years ago,' says Gina Davy, head of system integration at Leeds Clinical Commissioning Group. 'There was a real desire in Leeds across the health and care system to explore a different approach to commissioning and contracting on the basis of population health outcomes, and to deliver on our health and wellbeing strategy to be the best city for health and wellbeing, where people who are the poorest improve their health the fastest.'

Leeds was also building on a strong history of integration – with integrated neighbourhood teams, strong health and care partnership working – including a thriving voluntary and community sector and a linked data set already in place.

At the time, the city's three CCGs were also moving towards merger (which took place in April 2018) and had ambitions of adopting a more strategic approach to commissioning.

As part of this early work, Leeds had broken down its population into eight separate segments – enabling it to better focus on the different needs of different parts of the population. There are four overarching segments – end of life; people living with frailty; long-term conditions; and the healthy population. Long-term conditions and healthy segments are further broken down into three different age groups.

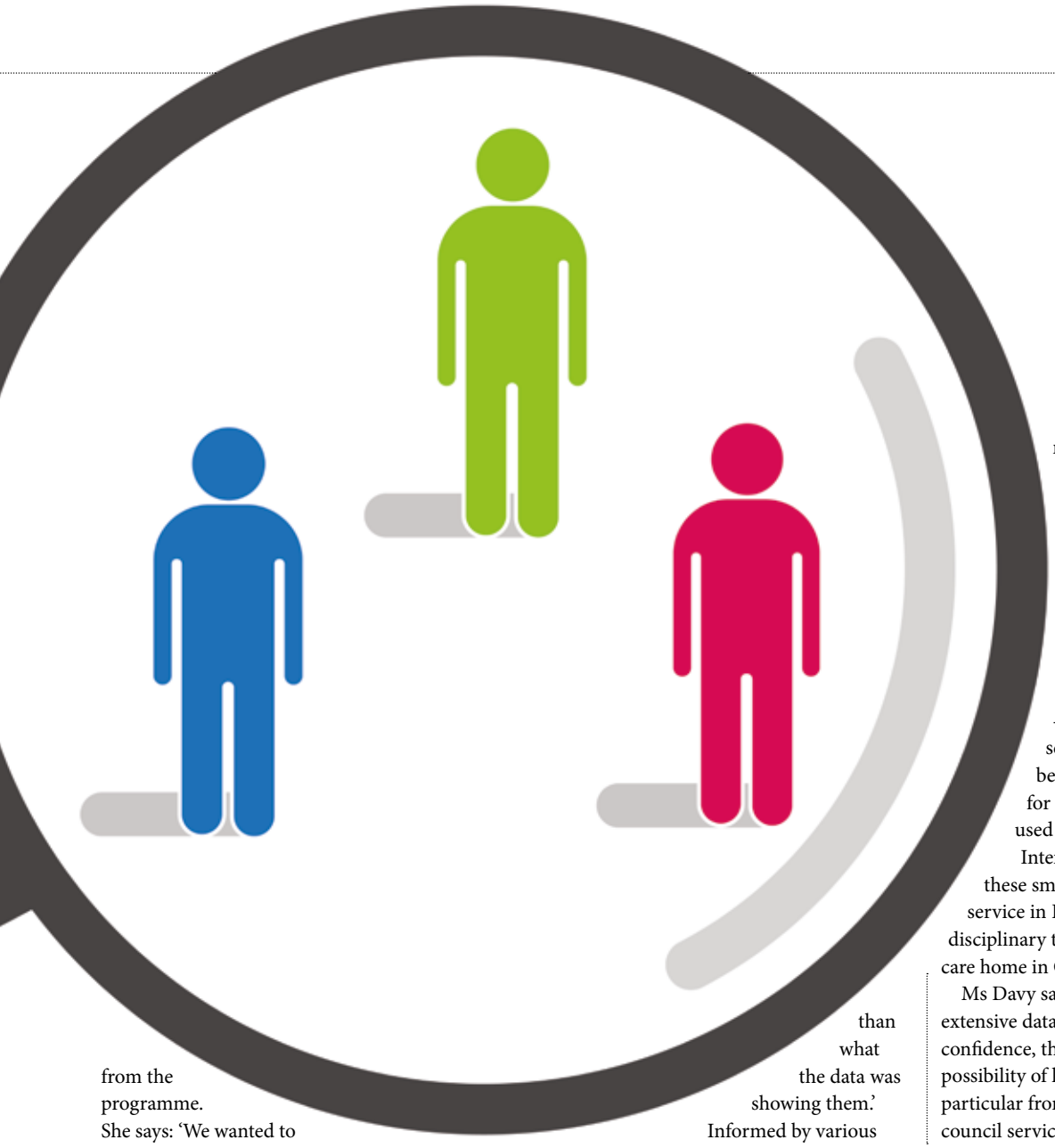
Leeds had also developed a linked data set incorporating data from different sectors, including primary care, acute, community, mental health and adult social care. The city had already been organised into 18 neighbourhoods or local care partnerships, each with populations of 30,000 to 50,000. Four of the most advanced LCPs – Pudsey, Garforth, Seacroft and Woodsley – were selected to be on the programme.

People living with frailty had been established as a clear focus for the city with an outcomes framework to support this. A clinical strategy group had also been set up to outline a high-level model for supporting this population. So, frailty was the obvious focus for the development programme. However, an actuarial model developed by Optum at the start of the development programme underlined this as a good choice.

Frailty challenge

The model showed that people living with frailty represented the biggest cost increase over the next three to four years proportional to the size of the population covered. (There are an estimated 32,000 people living with frailty across the city.)

According to Ms Davy, Leeds was determined that there would be a legacy



from the programme.

She says: 'We wanted to develop the capability to progress PHM when the programme was finished.'

Reflecting the partnership working in the city, the programme has been led by a team of people from across the CCG, public health, adult social care, the city-wide analytics team and with clinical leadership from the chair of the GP confederation. Workshops brought data analysts and finance leads together with the LCPs and representatives from the clinical strategy group. 'The data packs we looked at were very extensive and gave quite powerful information around specific local frail populations. And having this mix of people around the table meant the quality of the conversations – exploring and being curious – really enabled them to drill down on what made sense for them,' she says.

'Many of the practitioners were surprised by what the data showed them. And there was a feeling among the LCP leaders, when we evaluated at the end, that if they hadn't taken this approach, they would probably have gone down the road of someone's pet project, rather than what the data was showing them.'

Informed by various analytical tools – heat maps exploring the factors driving complexity and theographs showing how individual patients moved through various health services – different neighbourhoods selected different cohorts of people to focus on within the wider frailty segment.

For example, people with moderate frailty, balance issues, sleep disturbance and nutritional deficits were the focus in Pudsey, while Garforth concentrated on the frail elderly with dementia living in care homes.

The groups then identified smaller lists of specific people with whom they could intervene – identified by running various search criteria on GP systems, because the linked data set used for population analysis could not be used to re-identify individuals.

Interventions were developed for these small lists – a triage and outreach service in Pudsey, for example, and multi-disciplinary team reviews carried out in the care home in Garforth.

Ms Davy says the LCPs had access to extensive data sets, but as the teams grew in confidence, they began enquiring about the possibility of linking further data sets – in particular from third sector, housing and other council services that are already working with

Pictured: Gina Davy (second from left) and the cross-organisational team leading the Leeds PHM programme

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local populations. As a result, Leeds applied to become a social care digital pathway site to explore how it can take this forward.

Fellow programme system Lancashire and South Cumbria (see box) is also impressed with the power of linked data. Senior responsible officer Sakthi Karunanithi was particularly taken with the mitigated and unmitigated actuarial modelling, which he thinks should be used by all health economies to guide priorities.

Not yet having all the data an area would want is no excuse for not starting work on PHM, says Dr Karunanithi. Areas should start with the linked data that is available, coupling this with local knowledge. Local teams made progress in areas they would not have been able to if they had waited for all data sources to be linked, he says.

Start of the journey

Both Leeds and Lancashire and South Cumbria see the work done so far as a first step. Dr Karunanithi believes the approach is promising and is excited by the potential. But he is also keen to stress that the system is at the start of a very long journey.

There are challenges ahead – capturing all the data relating to individuals' housing, employment and disabilities, alongside health and patient activation measures, is a demanding goal, with significant practical and governance issues to be addressed.

Dr Karunanithi also points out the need for upfront investment – many of the interventions are proactively seeking people who will benefit from support. Although this might lead to system savings downstream, the new service lines must be put in place first.

'We need to find a way to shift capacity locked in hospitals into the community,' he says. 'We aren't seeing a level of impact on acute services yet, with any released capacity being filled up. And the benefits of this approach aren't falling in the same place as the investment is going.' System leadership will be key to addressing this.

Back in Leeds, Ms Davy agrees. 'We are tracking the impact and building the mechanisms to understand the financial impact and outcomes at population level, but it is early days,' she says.

'PHM has been a brilliant experience in Leeds and it is getting great feedback, but it is currently at a really small scale – the mantra throughout the programme has been to think big and start small.'

Both systems highlight the need for new funding and payment arrangements to support

Not all about the data

Lancashire and South Cumbria is an integrated care system made up of five local health and care partnerships – four integrated care partnerships (ICPs) and one multi-speciality community provider (MCP). It has some of the poorest neighbourhoods in the country – Blackpool is the second most deprived local authority nationally. For NHS England's population health management development programme, one neighbourhood was selected from each ICP/MCP – based on the primary care networks emerging at the time.

Chorley neighbourhood team and Dr Karunanithi (inset)

Much like Leeds (see main article), the Lancashire and South Cumbria ICS had already laid the foundations for a PHM approach. Its ICS board had agreed a population health framework and it had an integrated care record system in place.

'This is really about whether you are ready for delivering personalised care,' says Sakthi Karunanithi, senior responsible officer for population health at the ICS. 'We'd already started work looking at preventing diabetes and addressing suicide risk in the community. But we were really just looking at the data globally. We lacked a robust methodology. What we've learnt in the 20 weeks has been eye-opening. We've realised the power of connected information.'

Each team was given freedom to focus on areas of particular relevance or concern in their own localities. This was informed by a number of analytical tools. Dr Karunanithi says the data is a crucial starting point, but only 10% of the approach is about data – you'll only see meaningful change if the right culture is in place.

In Chorley, the team wanted to focus on patients aged between 45 and 60 who were moderately frail and had had more than 10 primary care appointments. The challenge was to narrow this group further to maximise the benefit of any support provided.

The lightbulb moment came when the team realised that the council held data on people receiving assistance with bin collections, which could be used as an indicator of frail people with fewer social links.

In Blackpool, staff knew that people with mental health issues living in houses of multiple occupancy needed more support. But the difficulty has always been locating these people as the information is not stored in healthcare records – and when the NHS does encounter them they have often hit a crisis point.

Again, linking with council data helped identify these people, who were targeted with health coaching and signposting to other psychosocial services.

Lancashire and South Cumbria has profiled its population into three groups: normal risk; rising risk; and high risk. It has not yet assigned people to life stage segments – such as long-term conditions, healthy, or end of life – although it plans to undertake this further work.

However, it has done some work on exploring how it can measure the impact of changes – adopting a patient activation measure across all of its primary care network areas.

future developments – especially as systems look to address the wider determinants of health. 'Population health cannot be improved just by health services acting on their own,' says Dr Karunanithi. 'While we don't have pooled budgets yet, we do have partner agencies working closely with our GPs and neighbourhood teams in aligning their resources to support the individual's need.

'We are exploring various ways, including pooled budgets, as we further develop our population health programme.'

> **"PHM is getting great feedback – the mantra throughout the programme has been to think big and start small"**
> **Gina Davy, Leeds CCG**

And there is recognition that the current payment mechanisms – with separate contracts for different providers, some based on block arrangements and others linked to activity – do not align with PHM.

'We need to create the conditions and incentives for providers to make PHM the best way for providers and commissioners to work together to achieve improved outcomes,' says Ms Davy.

Leeds' aspiration is to move towards contracting for population outcomes, with a network of providers given a defined budget for delivering these outcomes.

'This will create the opportunities for providers to shift resources to areas, services and support that address the wider determinants of health such as housing,' says Ms Davy.

The city is not there yet, although its next wave of LCPs participating in the programme will include representatives from other sectors such as housing around the table.

Jacquie White, NHS England's director of system development, says that scaling up will be about avoiding reinventing the wheel. This means disseminating good practice – for example, via a new PHM Academy – but it will also mean systems looking at sharing experience and approaches across different neighbourhoods.

She adds that it will also involve careful consideration of what should be undertaken or commissioned at system, place and neighbourhood levels.

Some systems, for example, are already pulling together organisation-level teams to set up system analytics functions to support care model design at all three levels. She acknowledges that there are constraints currently in the financial framework, but thinks there are existing levers that systems could be helped to use more effectively.

'How can we support systems to leverage the opportunities they've got with section 75 agreements and pooling budgets, for example?' she asks. She suggests there are particular opportunities for supporting cross-sector work to address the wider determinants of health.

Looking ahead

Ms White believes that the four systems have worked at pace, with the programme exceeding expectations despite initial ambitions being high. A second wave of the programme is already under way, with more than 10 further systems starting over the coming three months.

Support for the existing systems is ongoing. 'We will continue to work with wave one to help with that scale and spread question,' says Ms White. 'But we also want to continue our learning alongside theirs as to what PHM really means, if we get it right, for financial planning and contracting based on outcomes. We are scratching the surface at the moment in terms of possibilities.'

Acute responsibility

Acute trusts may traditionally have focused on simply treating the people referred to them or turning up at accident and emergency departments.

But increasingly they are thinking beyond this and looking to understand their own role in improving the health of local populations.

Angela Bartley, deputy director of public health at the Royal Free London NHS Foundation Trust, says acute trusts are turning their attention to population health, which has perhaps previously been seen more as a commissioning function.

'As we are starting to think more as a system, it's right that we should ask about our role in improving the health of the population,' she says. 'How should we be working differently to enable other people to improve the care they give? How can we prevent people coming here in the first place or coming back?'

She says the trust has run public health programmes in the past around smoking cessation, immunisations and getting people back to work, but it is looking to move beyond this, setting up a population health committee.

This committee includes the trust's chief executive, medical director and chairman and is chaired by non-executive and former King's Fund chief executive Chris Ham.

The committee's membership is an indicator of how seriously the trust takes this work. All the trust's work on integrated care systems and clinical pathway redesign is taken through it.

The trust is taking a particular interest in its role in addressing inequalities.

Analysis of various patient pathways by the index of multiple deprivation (an index that ranks neighbourhoods in terms of relative deprivation) revealed a startling fact. 'Everything we looked at had a sharper gradient for those who were the most deprived,' says Ms Bartley.

'They were much more likely to not turn up for their first outpatient appointment – so immediately not even on the pathway of care. They were also more likely to be readmitted.'

There is not a simple answer to this and more analysis is needed. But the board has asked to receive health inequalities data in future alongside the performance data on cancer and waiting times.

The answers may lie outside the NHS. Children may end up on the trust's wheezy child pathway, but the cause or exacerbating factor may be pollution or living in a house with smoking parents.

These issues will need a system response, but the Royal Free – and acute trusts in general – have a key part to play in this.

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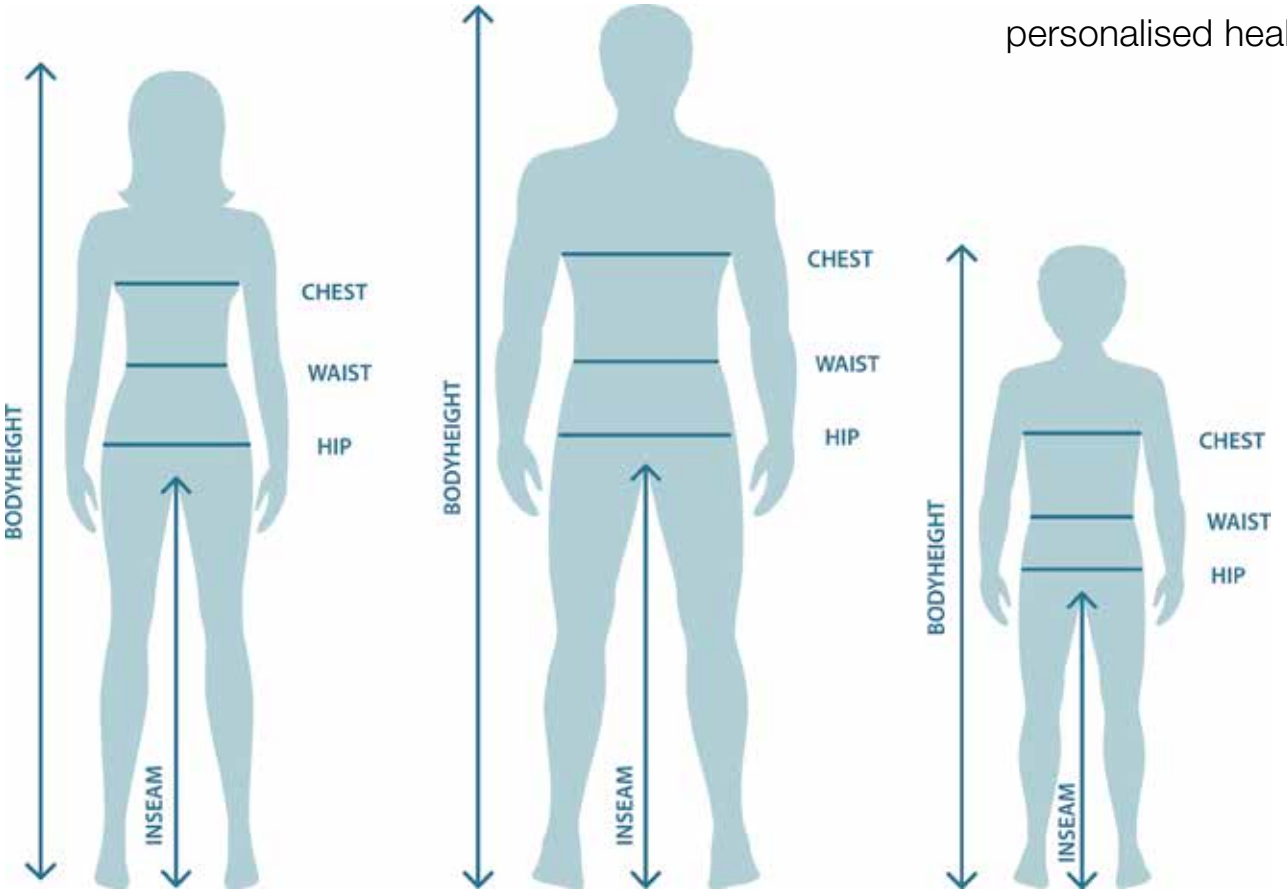

made to measure

Personalised care will become business as usual for 2.5 million people across the health and care system by 2024. But how can finance staff support its implementation? Seamus Ward reports

Personalised care and supporting people to manage their own health has been an ambition of the NHS in England for many years, but it is now at the forefront of thinking thanks to the *NHS long-term plan*. So far, much of the work has been with clinicians, but NHS England is also keen to ensure finance staff have the skills to help implement its vision.

The long-term plan named personalised care as one of the five key enablers to achieving its ambitions. But what does personalised care mean? Personalised care helps a range of people, from those with chronic illness and complex needs through to those managing long-term conditions, mental health issues or struggling with social issues that affect their health and wellbeing. It helps them make decisions about managing their health so they can live the life they want based on what matters to them, with clinical information from the professionals who support them.

This comes in response to a one-size-fits-all health and care system that simply cannot meet the increasing complexity of people's needs and expectations.

Evidence shows that people will have better experiences and improved health and wellbeing if they can actively shape their care and support. Increasingly, organisations are recognising the power of individuals as the best integrators of their own care.

'We are aiming to ensure people get the right service first time rather than having to navigate around the traditional system and having interventions that will not necessarily work,' says Sue Bottomley, NHS England head of finance, contracting and commissioning for personalised care.

Personalised care is based on maximising choice and control for people. 'It could be about having a different conversation with your GP, having a conversation to plan your needs around what matters to you, or getting access to community resources rather than always having to use NHS services,' she says.

The personalised care work is wide-ranging and can be implemented for all people in health and mental health services. It is also embedded as a key approach in the new primary care networks (PCNs).

Social prescribing has been a key part of this – implementing social prescribing has been one of the early milestones for PCNs. 'We have just invested into PCNs to employ 1,500 link workers whose role will be to look at alternative solutions to standard services,' says Ms Bottomley.

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Link workers will expand social prescribing, developing tailored plans for patients and bringing them together with local groups and support services. 'So, if you have diabetes, rather than medication, they would look at helping you join a local walking group or other ways of getting your weight down and examining the risk factors for why you got diabetes in the first place,' she adds.

Personalised care can be hugely beneficial for people with long-term conditions, targeting around 30% of the population. The aim is to make this cohort of patients fully aware of the range of treatments available – including potential outcomes and complications – so patients and clinicians can make shared decisions.

'In oncology, for example, you will want to ensure the patient fully understands the treatment that is being proposed and can give informed consent about that treatment. They might then want to choose a different treatment or approach.'

"We want people to have a personalised experience and I would like providers to flex their offer"
Sue Bottomley, NHS England

For people with more complex needs – about 5% of the population – personalised care will help them benefit from care that may be outside the traditional service model or where this model would not necessarily help. Personal health budgets (PHBs) could be used for this group of patients.

Since 2014, patients receiving continuing healthcare (CHC) and children and young people receiving continuing care have had a statutory right to have a PHB. This right is being extended to those eligible for an NHS wheelchair and those accessing aftercare services under section 117 of the *Mental Health Act 1983*.

NHS England is also hoping to expand the rights to have a PHB to maternity and end-of-life care.

However, the potential benefit of a PHB is linked to need rather than the patient's condition – for example, a patient using acute services frequently could be indicating that their current care provision is not working for them. In this case, they could be considered for a PHB.

Approaches such as shared decision-making and personalised care and support plans will be driven by national contracting approaches across primary care and PCNs, says Ms Bottomley.

Different thinking

However, PHBs in particular will require different thinking from finance staff – both in commissioning organisations and providers. Payment mechanisms are to be set up to facilitate the care of groups of people rather than individuals.

Ms Bottomley says: 'How do you begin to enable the system to support people with personal health budgets? We have to change the way transactions in finance move across the NHS. From a finance point of view, we have to become much more involved in looking at contracting and shifting the architecture of the NHS to enable people to have a more personalised experience.'

Extending PHBs to people in receipt of CHC is a relatively straightforward transaction from a financial perspective, she adds. However, disaggregating provider contracts will be more complex. 'We are looking at how we can enable contracts to be flexible enough so they don't destabilise the current provider. But providers must be able to flex their offer to help people make use of their personal health budget.'

NHS England is offering support to finance staff to gain the skills needed to enable personalised care. With NHS Improvement, it has published a personalised care finance, commissioning and contracting handbook. It is also working with the HFMA to develop training – an e-learning module is available to all staff through the electronic staff record (ESR). The association is also working with NHS England to develop a module for finance managers as part of its intermediate (level 4) qualifications, which include the *Intermediate diploma in healthcare business and finance*. An additional level 7 module is also in the works – it is hoped this will become part of the masters-level programme next year.

The regional directors of finance are also trying to influence workforce training to ensure contracts facilitate personalised care.

Ms Bottomley continues: 'In our work with the HFMA, we are replicating what we are doing with the royal colleges, asking how we start influencing finance managers in the NHS. The HFMA has a wide-reaching membership and this is an opportune partnership for us to influence how finance managers operate this programme.'

HFMA director of education Alison Myles says: 'The HFMA welcomes the opportunity to work with NHS England on this important agenda. We are keen to support people throughout the NHS to understand more about the universal personalised care model and we are pleased to be working in partnership to develop and expand training and learning opportunities for staff working in finance, commissioning and contracting.'

The NHS already uses the HFMA e-learning training courses and the module available on ESR is free to users, says Ms Bottomley. A number of bursaries are offered to those studying for the HFMA diploma and NHS England is looking into extending support to finance staff by offering bursaries for people taking the personalised care qualification modules. 'We are looking at making it a requirement when applying for senior management jobs in finance, contracting and commissioning that they have taken the level 4 or level 7 course in personalised care. I would like it to be part of the essential criteria, but it should at least be in the desirable criteria,' Ms Bottomley adds.

Personalised care means a shift in thinking for finance staff and the payment mechanisms developed to suit large volumes of activity may not always be appropriate. Spending on personalised care may never be more than a small proportion of the NHS budget, but NHS England is keen that providers in particular embrace the policy.

'From a provider's perspective, this could be seen as a real threat, but really it's an opportunity for providers to diversify and take some of the market share. We want people to have a personalised experience and I would like providers to flex their offer,' Ms Bottomley says. 'I think 80% of patients will be really happy with the service they are receiving, but some will want to have a different conversation and the top 5% need something radically different to meet complex needs. The regulations are there. Now the health service has to provide alternative care.'

See *Supporting finance to enable personalised care* hfma.to/9y

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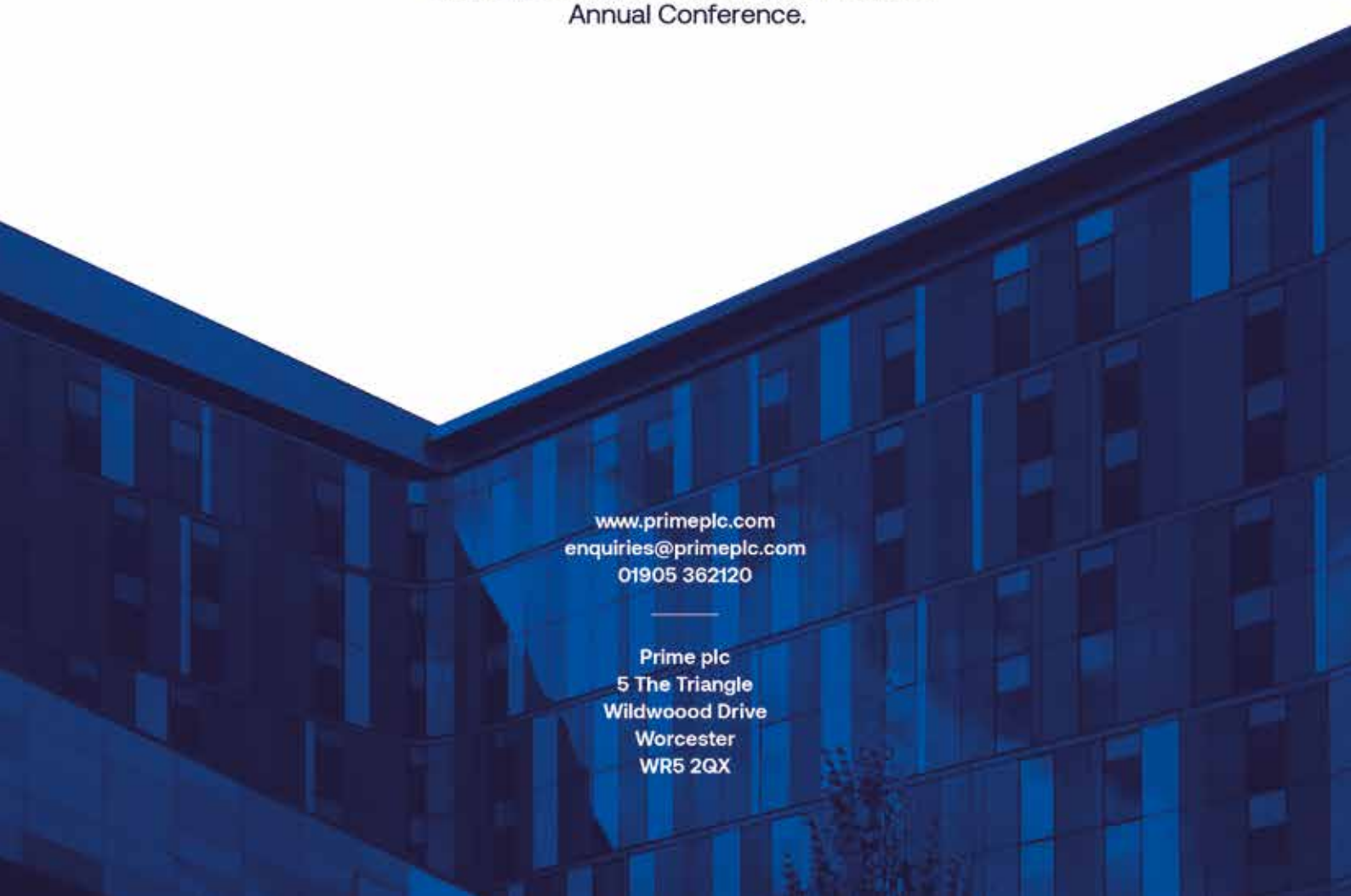

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NAO consults on enhanced reporting in new code of audit practice

Technical

The National Audit Office (NAO) is consulting on the draft text for the new *Code of audit practice*, which will come into force on 1 April 2020, *writes Lisa Robertson*. This will apply to audits of 2020/21 financial statements onwards.

The code is a principles-based document, covering local public services in England, including the NHS and local government sectors. Auditors of these bodies are required to comply with the code in meeting their responsibilities. Areas covered include: the audit of the financial statements; the auditor's work on economy, efficiency and effectiveness of corporate arrangements (value for money arrangements, or VFM); reporting the results of the auditor's work; the auditor's additional powers and duties; and smaller authority assurance engagements.

The new code comes at a time when audit is in the spotlight, particularly in light of recent corporate failures such as Carillion. In response to last year's Kingman review of the Financial Reporting Council (FRC), the council will be replaced by a new enhanced regulator, the Audit, Reporting and Governance Authority (ARGA). It will have a new mandate, new leadership and stronger statutory powers.

Alongside this reform, the key changes to the code focus on enhanced auditor reporting to ensure it is more meaningful and has a greater impact. The main changes for NHS organisations are the approach to assessing arrangements to secure VFM and reporting of the results of the auditor's work.

The current code requires auditors to make an overall, binary conclusion about whether or not proper arrangements were in place during the previous financial year.

In the NHS, a large proportion of qualified conclusions have been issued in recent years, many related to failures to meet financial targets or problems with financial sustainability.

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The new code aims to maximise the impact of current local audit work already undertaken. It replaces the requirement for an overall conclusion with the requirement for commentaries on financial sustainability, governance and improving economy, efficiency and effectiveness.

The draft code also sets more detailed expectations about what effective reporting should look like. Auditors will be required to produce a report on the financial statements and an annual report. The annual report will bring together all audit work over the year, with a core element being the commentary on VFM criteria, including recommendations.

Making the best use of the work already done, actions that need to be taken should be reported to organisations and the public in a clear, readily understandable and accessible manner no later than 30 September.

The HFMA welcomes the proposed new audit approach to assessing and reporting on VFM and maximising the impact of local audit work. In the past, it has had concerns that NHS organisations may not fully understand the auditor's conclusion on the arrangements to secure VFM and the action they need to take as a result. The new commentaries, tailored to local circumstances, should be easier to understand and help focus NHS organisations' attention on the areas that need improving.

However, the association does have concerns about the potential impact of any extra work on audit fees, which would be an additional financial pressure on NHS resources. We are also aware that the 2018/19 accounts process was challenging for local government and NHS bodies, exposing a lack of audit capacity, exacerbated by the bringing forward of the local government audit deadline.

The HFMA will be working with members to review the draft code and assess its impact on audit resources, responding to the NAO's consultation by 22 November 2019. It is interested in your views to ensure it fully represents members. To share your thoughts, e-mail lisa.robertson@hfma.org.uk.

• The NAO will be exploring what the new code means for local organisations and audit committee chairs at the HFMA audit conference on 13 November. The NAO has also launched a strategic review on its future strategy and would welcome responses from HFMA members on its work, role and how it communicates.

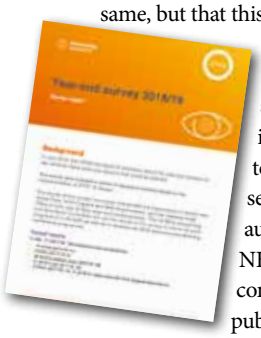
Lisa Robertson is an HFMA policy and research manager

Technical review

The past month's key technical developments

Technical

Audit was highlighted as the key concern in the 2018/19 accounts process, according to the HFMA's fourth sector-wide year-end survey. About one third of respondents said the audit process was worse than the previous year, with a further 10% saying it was about the same, but that this was a problem. There were two main issues. The first was the timeliness of audit work, which resulted in later audit queries and delays to the sign-off of the audit. The second issue was the experience of the audit team, with more junior staff with less specific NHS expertise. Looking ahead, NHS bodies are concerned about the application of IFRS 16 to the public sector in 2020/21. hfma.to/aa



NHS Improvement has reminded trusts to integrate the GOV.UK Pay platform with existing merchant services, asking them to encourage treasury and finance teams to do the same. It said the **online payment platform** offers a simple, secure and compliant way to take and manage online payments from service users. The platform also offered support in recovering costs from overseas visitors who are not eligible for free NHS care. hfma.to/ab

The HFMA's popular ***NHS corporate governance map*** has been further updated, adding new links to items including guidance on strategic planning, system governance and workforce. The map is aimed at NHS boards, governing bodies, audit committees and staff with an interest in governance.

It highlights published resources that support the development and maintenance of effective governance arrangements and is split into four sections: strategic framework; enabling good governance; specific areas for assurance; and devolved nations. hfma.to/govmap

The **National Audit Office** has invited finance staff to take part in a survey that asks for views on the NAO and what its priorities should be. It touches on a range of areas, such as which long-term risks to value for money should be examined and how it manages relationships. The survey, which the auditor said should take five minutes, is anonymous and has been launched in the wake of the arrival of new comptroller and auditor general Gareth Davies. hfma.to/sr

All acute trusts submitted **patient-level data** as part of the first mandated national cost collection, NHS Improvement said in September. With the collection closed, analysis of the submissions was under way in preparation for resubmissions from some providers. Trusts have also been invited to get involved in the voluntary education and training costs collection for 2018/19, with 33 trusts having expressed an interest so far.

The HFMA published two briefings in September as part of its series looking at how **services delivered in the community** add value to both the patient and the wider health and care economy. *The value of community services: helping people stay healthy, happy and independent* focuses on the role that community services play in preventing illness or reducing exacerbations. The final briefing in the series of three – *The value of community services: enabling system working* – looks at how community services can enable and support system-wide working. hfma.to/ae

Hypertension guideline supports CVD ambitions

Technical: NICE

NICE published four technology appraisals and four guidelines during the past month.

Under the updated guideline on the diagnosis and treatment of high blood pressure (hypertension) NG136, the level of a person's cardiovascular disease risk at which treatment for high blood pressure can be started has been reduced.

The updated guideline recommends that blood pressure lowering drugs should be offered to people aged under 80 who have a diagnosis of stage 1 hypertension and who also have a 10% or greater risk of developing cardiovascular disease within the next 10 years.

The guideline supports the direction of the *NHS long-term plan* and the CVD System Leadership Forum's CVD ambitions to improve outcomes in cardiovascular disease, including preventing strokes and heart attacks, through better detection and treatment of high blood pressure.

The estimated financial impact of implementing this guideline for England in the next six years is a net cost of £0.8m in 2019/20 rising to £3.1m in 2024/25.

Two antimicrobial prescribing guidelines for community (NG138) and hospital-acquired pneumonia (NG139) have also been published.

Among the technology appraisals, both olaparib (TA598) and pembrolizumab (TA600), have been recommended for use in the Cancer Drugs Fund. TA597 (*Dapagliflozin with insulin for treating type1 diabetes*) recommends the new technology for people with type 1 diabetes not controlled by insulin therapy alone in adults with a body mass index of at least 27 kg/m2.

Gary Shield is resource impact assessment manager at NICE

NHS in numbers

A closer look at the data behind NHS finance

General practice

Technical

General practice has a problem. It doesn't have enough people to do the work required. A five-year framework for the GP services contract, published just after the *NHS long-term plan*, acknowledged this. And it sets out plans to address the issue by increasing GP numbers but also increasing the wider primary care workforce to reduce GP workload.

The *General practice forward view* in 2016 promised to create an extra 5,000 doctors in general practice by 2020 (compared with 2014). However, January's *NHS long-term plan* acknowledged that any increase in new recruits had been more than offset by the number of early retirements and part-time working.

It recommitted to a net increase of 5,000 GPs, but this time it left the deadline more vague – 'as soon as possible'.

According to figures from the Review Body on Doctors' and Dentists' Remuneration (DDRB), in September 2018 there were 48,721 GPs in the UK (headcount) – with England accounting for 40,196 of these. This includes all regular GPs, but excludes locums. There were small increases compared with the previous year in all the UK countries, however in both England and Wales, the numbers were lower than in 2016.

The latest figures from NHS Digital for England in June show that if you include locums, the headcount number rises to 44,570, which equates to the arguably more informative figure of 34,114 full-time equivalent GPs.

This demonstrates the extent of part-time working in general practice. GP registrars (GPs in training) make up nearly 6,000 of the overall headcount figure.

The NHS Digital data demonstrates that this summer's full- time equivalent figure is actually lower than in September 2015 (34,262). (An apparent increase in headcount over this same period is explained by changes in how locum figures were collected.)

Between them, these GPs provided 309 million appointments in the 12 months from the beginning of August 2018. In July, there were 27 million appointments (although this figure covers various health professionals working in general practice. The vast majority continue to be delivered face-to-face.

However, there has been a 30% increase in telephone appointments (from three million a year ago to four million in July this year, and a 50% increase in online appointments (from 109,000 to 160,000).

This latter figure is being driven by the availability of services from organisations such as Babylon Health (GP at Hand) and Livi. And, according to the long-term plan, everybody should have the ability to access a GP digitally within five years.

In Scotland at the end of 2018, there were 4,994 GPs (headcount). While this was a small increase on the previous year, the figure had been roughly constant for the preceeding 10 years, at around 4,900. Earlier figures show this equated to 3,575 full-time equivalent GPs in 2017, a 4% decrease since 2013.

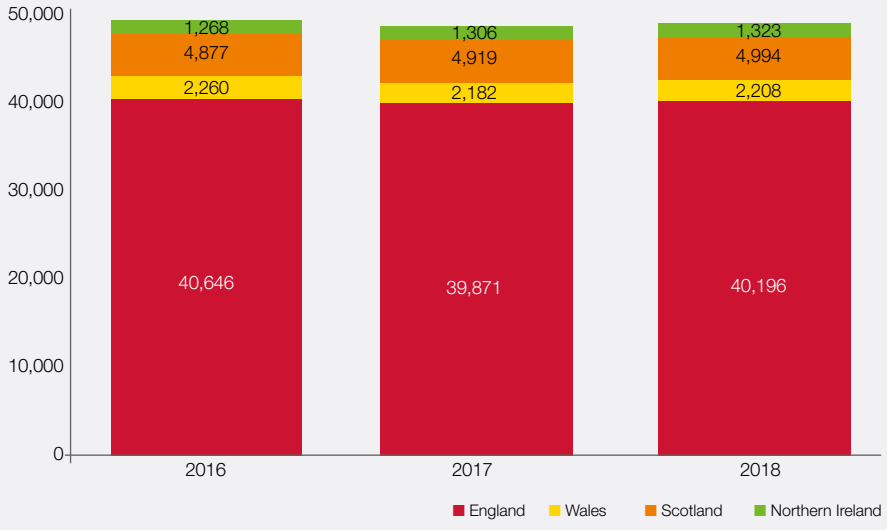
There are plans to increase GP headcount by 800 over the next 10 years, but Audit Scotland says that an ageing clinical workforce and problems with recruitment and retention will make this difficult to achieve.

In Wales last year, there were 2,986 GPs, counting all practitioners. In Northern Ireland, figures for last year (headcount) show there were 1,722 GPs excluding doctors in training, including 1,149 GP principals.

Further reference

- **Review Body on Doctors' and Dentists' Remuneration (DDRB)** hfma.to/9z
- **GP workforce, England, June 2019, NHS Digital** hfma.to/a0
- **GP appointments in general practice, July 2019** hfma.to/a1
- **GP workforce planning, Audit Scotland** hfma.to/a2
- **Wales, General medical practitioners, Sept 2018** hfma.to/a3
- **GPs in Northern Ireland, Health and Social Care Board** hfma.to/a4

Number of general medical practitioners (GMPs), UK headcount 2016-2018



Source: NHS Digital, ISD Scotland, StatsWales, Northern Ireland Statistics and Research Agency (excludes locums)

MBA offers research bonus

By Alison Myles, HFMA director of education

News and views from the HFMA Academy

Training

A spin-off benefit from the MBA in healthcare finance, which started with its first intake of students this year, is the production of potentially valuable research into issues relevant to NHS finance.

The MBA in healthcare finance is delivered by BPP University and graduates of the HFMA advanced higher diploma in healthcare business and finance are eligible for entry onto the programme.

Although eight students began the MBA programme in February, one has deferred and seven will undertake a healthcare consultancy project, worth half of the MBA programme's overall 60 credits.

The HFMA Policy and Research Committee agreed to provide non-academic support to the students for their projects, which will run over three months from October. As part of this support, each student has been assigned a committee member as a non-academic sponsor.

Students will have an academic sponsor assigned by the university and this is the key role in ensuring students meet all the academic criteria required for the project.

However, the non-academic sponsor will support the student with help on how the work fits into professional practice in the NHS and providing access to data, ideas and contacts from the NHS finance function.

The prime goal here is to help the students deliver a high-quality project that helps them towards achieving their MBA. But the committee was also excited by the potential to deliver some important research on key financial issues.

Policy and Research Committee member and HFMA trustee Lee Outhwaite described it as a win-win for students and the healthcare finance community. 'This is a chance to increase the capacity for research on healthcare finance,' he says. 'The NHS faces some significant changes as it looks to deliver the targets set out in the *NHS long-term plan* and in particular as it moves to system working. These changes will have implications for how the finance function will work in the future.

'The research projects put forward by the MBA students provide a great opportunity to think through some of these issues from an academic point of view. And it makes sense for the association to support this work where it can.'

> "The research projects put forward by the MBA students provide a great opportunity to think through issues from an academic point of view"

While students have been free to select their own project topic, the committee held a session with the students to discuss possible areas of interest, informed by this year's HFMA member survey. This was followed up by one-to-one sessions with each of the students to refine their ideas and offer feedback.

Then in September, the students presented their proposals to a full meeting of the committee, answering questions and listening to feedback. With just three months to complete the project, non-academic sponsors will have a formal meeting/call with their student a minimum of once a month, although contact is likely to be much more regular.

Projects selected by students – and endorsed by the committee – cover a range of areas. Integration is a key theme, with separate projects looking at the impact of integrated care systems (ICSs) on the finance function, the role of senior finance leaders in the transition to ICSs, and the merger of finance teams in the creation of a combined organisation.

Other projects will look at high utilisation patients and how culture affects the delivery of efficiency savings.

FFF value maker awards

Future focused finance

Future-Focused Finance's first Value Maker Awards were held at the FFF annual conference in London on 20 September.

There were a total of 28 nominations across the four categories, based on FFF's *Four strengths for NHS finance* framework.

NHS England and NHS Improvement chief finance officer Julian Kelly attended the event to deliver the keynote address and present the awards to the following winners:

- **Finance expert award** – Michael Shaw, Leeds Teaching Hospitals NHS Trust
- **Driving value for taxpayers award** – Naomi Simpson and Michael Harrison, costing team, Wrightington, Wigan and Leigh NHS Foundation Trust
- **Making change happen award** – Mohammed Bilal, Leeds Teaching Hospitals NHS Trust
- **Team player award** – Rikki Siddle, County Durham and Darlington NHS Foundation Trust.

Pictured (l-r): Julian Kelly, Mohammed Bilal, Michael Shaw, Rikki Siddle, Michael Harrison and FFF value maker SRO Suzanne Robinson. Naomi Simpson could not attend

The awards were a great way to recognise the individual and group achievements, hard work and commitment of FFF value makers and for them to be recognised nationally along with colleagues and friends.

For more on all of the award winners visit www.futurefocusedfinance.nhs.uk

Diary

October

1 (F) Provider Finance: NHS as an anchor institution, webinar
3 (I) Institute: international symposium, London
9 (N) A walk through the HFMA's level 4 apprenticeship programme, webinar
10 (F) Chair, Non-executive Director and Lay Member: forum, London
10 (B) North West: annual Liverpool quiz
11-12 (B) Kent Surrey Sussex: conference
15 (I) Institute: costing with informatics, webinar
17 (I) Institute: costing together (North), Manchester
17 (N) Mental Health Finance: conference, London
17 (B) West Midlands: student conference, Birmingham
18 (B) West Midlands: efficiency and innovation, Birmingham
18 (B) Eastern: conference, Newmarket
23 (N) Webinar: could the government digital service and GOV.UK Pay help my trust?
24 (B) Wales: VAT training day, Cardiff
24-25 (B) Scotland: conference
29 (N) Portion control in the NHS – understanding CCG allocations, webinar
30 (B) London: annual conference, London
31 (F) Chair, Non-executive Director and Lay Member: harnessing the power of internal audit, webinar

November

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

December

4-6 (N) HFMA annual conference, London

January

15 (I) Institute: introduction to NHS costing, Manchester
22 (B) London: VAT training day level 3, London
24 (B) Wales: VAT training day level 2, venue tbc
29 (N) Pre-accounts planning, Leeds
30 (N) Pre-accounts planning, London

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

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

Events in focus

Annual mental health finance conference

17 October, 110 Rochester Row, London

The *NHS long-term plan* and 2016's mental health five-year forward view have made improving mental healthcare a priority for the health service in England. The long-term plan pledged record investment and faster access for patients, but although this has been widely welcomed, there is concern about how these ambitions will be put into practice.

The priority being given to mental healthcare makes the HFMA Mental Health Finance faculty annual conference a vital learning and networking event. This one-day event, aimed primarily at finance professionals in mental health, will also be of value to community finance colleagues, commissioners, non-executives, service managers and clinicians. There will be opportunities to discuss progress on the five-year forward view and the long-term plan, as well as the development of mental health services in the future.

Delegates will hear from technical leaders and speakers will include Suzanne Robinson (pictured), director of finance and deputy chief executive of Pennine Care NHS Foundation Trust, and Tim Kendall national clinical director of mental health at NHS Improvement.

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

HFMA annual conference

4-6 December, London

The HFMA annual conference – a highlight of the NHS finance year – will showcase the theme of 2019 HFMA president Bill Gregory, *Value the opportunity*. Health and care services across the UK have received additional investment and there are plans for transformation and renewal as the nations seek best value coupled with the delivery of high-quality, safe services. But there are questions over workforce sustainability, the impact of the UK exit from the EU and rising demand in the face of an ageing population, along with uncertainty over the long-term funding for capital, public health and education and training.

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

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

CPD everything

Association view from Mark Knight, HFMA chief executive

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

My HFMA

With the country navigating some stormy political waters, we find ourselves in the unusual situation where the NHS isn't at the top of the political agenda at this minute. However, this is likely to be short-lived, with a general election looming around the corner.

The financial position of the service remains tight, even with *NHS long-term plan* investment. It remains to be seen how issues such as capital can be resolved, but our technical team are working hard internally on your behalf to feed in where there are concerns or potential solutions.

As I mentioned last month, the HFMA autumn programme is hotting up. We had three branch events in September and in October there are four more as we host the Eastern, Kent/Surrey/Sussex, London and Scotland branch events. We are really touching the four corners of the UK with our programme and our president Bill Gregory is putting in a shift for us – for which we are grateful. I'm also very grateful for the volunteer support from our members. Without our membership we would be nothing.

His theme of *Value the opportunity* has struck a chord with members. And the association has itself taken the value message to heart by working to ensure development opportunities are properly recognised. We are slowly rolling out a 'CPD everything' strategy across the HFMA's entire range of products.

We started with all our e-learning and moved to events – all these are now accredited with the CPD Standards Office. We are aiming to gain accreditation for reading policy papers and even this magazine, making it easier for you to demonstrate compliance with your annual continuing professional development requirements.

Of course, it's not about box-ticking; the training you receive should reflect your professional needs and be planned as part of a development programme through the year. But it helps to be able to record your activities accurately. Our CPD scheme is backed by an independent CPD assessment service, so you have the assurance that it is independently verified. I hope that in future years we can add reading content to some events, allowing you to be able to double-up on some events.

HFMA chief executive Mark Knight

SHUTTERSTOCK

At the time of writing, our awards programme was just closing. These will be announced at our gala dinner on the Thursday of our annual conference. Due to the shape of the venue, it's sometimes been hard to get everyone's attention after dinner, when naturally people want to chat. So, in a change this coming year, we will be holding the awards ceremony before dinner.

We are pulling together the final programme for the conference and it looks good so far. I encourage all members to attend on Friday morning to hear next year's president Caroline Clarke launching the HFMA's 70th anniversary year. It will also be an opportunity to hear about some of the exciting plans the association has at the annual general meeting.

There are places still available for the conference, but I advise you to book as early so you can to ensure you can get a place.

Member news

During its annual conference, the **South Central Branch** hosted its first ever awards ceremony. There were two categories – Berkshire Healthcare NHS Foundation Trust was awarded the Finance Team of the Year, while Solent NHS Trust and Portsmouth Clinical Commissioning Group won the Innovative Partnering Award. During the event, the branch also organised a raffle that raised £198.30 for the Team HFMA three peaks challenge in support of mental health charity Mind.

The **Wales Branch** also recently had its annual conference. During the dinner during the two-day event, Alun Lloyd, programme director at the Welsh government, was recognised for his longstanding service to the branch.

The **Wales branch** also appointed Kavita Gnanaolivu (pictured), senior manager at KPMG UK, as trustee of the association and chair of the HFMA Wales Branch, taking over from Huw Thomas. Ms Gnanaolivu is a longstanding supporter of the association and was finance management and research chair, leading on the branch research work.

Twenty new learners started their studies with the **HFMA Academy** in the September intake for the HFMA Level 7 qualifications in healthcare business and finance. With these new learners, the total number of level 7 enrolled students is 53. More learners will begin their studies in October, when a pilot of the level 4 governance and risk management module is introduced. To find out more, visit **hfma.to/qualifications**

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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

Healthcare in the Community Special Interest Group

Community services and their importance for the wider health economy take centre stage in the *NHS long-term plan*. To support this agenda and the potential for innovation in community services, the HFMA set up a Healthcare in the Community Special Interest Group in June 2018.

'There wasn't a space for that kind of discussion and networking, and it is one of the things the HFMA is fantastic at – bringing everybody together, starting the discussion, and influencing how we might support and improve things,' says group chair Ros Preen (pictured).

Finance professionals' role in the community sector is key. 'They need to bring alive the relative value of care delivered on a "home first" principle, and present information in a way that demonstrates system savings,' says Ms Preen. 'For a long time, the emphasis, the attention and the political energy has gone to identify the cost of acute care provision in that most payment mechanisms have been designed around those aspects of healthcare provision. Quantifying the cost of community services needs to have more of a focus now.'

The finance function in the community sector is tasked with 'finding some quantifiable and evidence-based way to demonstrate return on investment in community care provision. It can be really hard to do, and finance staff need to use all their skills to demonstrate why we should move away from the status quo – to promote investment in community services, to get some quantifiable gains – as opposed to somewhere else in the system,' Ms Preen adds.

The community sector covers a wide range of services and has many different interfaces. This means finance professionals need to work with colleagues from many different backgrounds, including the third sector, primary care and local authorities. 'It's a really interesting sector to work in, but the challenge for finance staff is to tailor what they are doing to accommodate different levels of skills, backgrounds or understanding,' says Ms Preen.

The SIG might be relatively new, but it already influences the association's work, including a series of briefings looking at how community services add value.

• To get involved, please email joanne.hitchen@hfma.org.uk

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Appointments

Mark Oldham is now chief finance officer at University Hospitals of North Midlands NHS Trust. He joins the trust from Mid Cheshire Hospitals NHS Foundation Trust, where he was director of finance for more than a decade. Mr Oldham started his career in local government and has experience in both the acute and community sector in a wide range of finance roles. He succeeds **Jonathan Tringham**, who was acting up in the position. Meanwhile, **Russ Favager** (pictured) returns to England after five years in Wales, taking over from Mr Oldham as interim director of finance and strategic planning at the Mid Cheshire trust. He brings with him 25 years of experience in the NHS, having previously been director of finance for an area team of NHS England and Wirral University Teaching Hospitals NHS Foundation Trust.

Peter Chapman has been appointed interim deputy director of finance at Chelsea and Westminster Hospital NHS Foundation Trust. The move follows the departure of **Stephen Aynsley-Smith**, who is now deputy chief financial officer at HM Land Registry.

Dorset Clinical Commissioning Group has named **Nikki Rowland** (pictured) chief finance officer. She is currently deputy chief financial officer at the organisation. Ms Rowland first joined the NHS in 2003 as financial accountant at North Dorset Primary Care Trust. She will take over from **Stuart Hunter**, who will be retiring in December. Mr Hunter joined the CCG in 2017, having previously been the director of finance at Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. His career in the NHS began in 1983 and he has held a number of senior positions in Dorset. .

Alan Sharples has joined the governing body of South Sefton Clinical Commissioning Group as a lay member for governance. He has over 40 years' experience working in the public sector, including in finance. Until recently, he was a non-executive director for the Walton Centre NHS Foundation Trust. His most recent full-time position was as finance director at Alder Hey Children's Hospital NHS Foundation Trust, where he spent nearly 15 years.

Sam Higginson (pictured) has been appointed chief executive of Norfolk and Norwich University Hospitals NHS Foundation Trust, taking over from **Mark Davies**. Mr Higginson joined the NHS in 2008 as assistant director of strategy at NHS London Strategic Health Authority and was director of strategic finance at NHS England between 2013 and 2017.

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

"It's believed the finance department is there to run the numbers and write finance reports. I want to see that change so we give more support but also robust challenge, so better informed decisions will be made"
Jon Evans, Oxford University Hospitals NHS FT

Evans takes on Oxford finance director role

On the move

The director of finance post at Oxford University Hospitals NHS Foundation Trust was too good an opportunity for Jon Evans to miss. Not only did it offer him the chance to step up the ladder in terms of taking on more responsibility, but it also allowed him to remain in an organisation to which he is committed.

Mr Evans has been director of financial performance and developments at the trust for almost four years – one of two deputies reporting to chief finance officer Jason Dorsett. But, following the departure of his colleague, the roles were revised and there is just one direct reporting role to Mr Dorsett.

Although it is a second-in-line role, his responsibilities include many of those given to board-level finance directors. As well as managing the finance department, Mr Evans works closely with non-executives, and takes the finance lead in a number of areas, including the trust input to the system-wide work led by the local integrated care system.

'The CFO sits on the board and is responsible for many areas, such as estates, finance, procurement and anything commercial or developmental in the organisation,' explains Mr Evans. 'It's a big agenda and covers about a third of corporate service, so I have a senior role to support him.'

He speaks glowingly of the trust and all its staff, describing it as the place he wants to be.

'It is an opportunity to move into a role where I oversee the whole of the finance department at one of the biggest hospitals in the country. It is an ideal next step for me.'

The role is key to Mr Evans' professional development, offering a wider range of experience but with 'safety net' support. 'It gives me the ability to go into the role and also to be developed as a potential successor. It's a good balance between development and succession planning with support,' he adds.

Before moving to the Oxford trust in 2015, Mr Evans spent more than six years as part of a forward-thinking finance team at Imperial College Healthcare NHS Trust. Its modernisation agenda focused on systems, processes and culture. He wants to bring some of this thinking to Oxford University Hospitals as he feels that finance at the Oxford trust is still seen as a back-office department.

It must increase its influence as a trusted business partner with slick processes and systems, he says.

'It's believed the finance department is there to run the numbers and write finance reports. I want to see that change so we give more support and information, but also robust challenge, so better informed decisions will be made. We are best placed in terms of skills and experience to help people make decisions. With trust, which we have to earn, we can reposition ourselves as expert providers of support.

'The flipside of that is around ensuring we modernise our internal processes, to make it easier for colleagues to comply with, rather than work around, them.'

Mr Evans is leading this modernisation. 'There will be significant change in the shape of the finance department in a positive way by refocusing people's priorities.'

His finance team is strong, he says. This is vital as the trust faces many other challenges, including delivering one of the highest control totals (a £38m surplus) and a range of commercial activities that require finance support. The latter includes the efficient use of its large estate. 'We have developed good relationships with the universities and others and work closely with them to get best value for our mutual benefit,' he says.

Mr Evans started in the NHS as a graduate trainee in 2004 and, more recently, has been part of the national talent development pool. As one of the most senior members of the first cohort, he had already been through much of the development it offers. However, the support given by the talent pool proved invaluable, offering him a new network of individuals and the support of a personal coach.

'My coach, Paul Miller, has been excellent. I have been able to work with him in a structured way to see my priorities. He has been invaluable in terms of career decision-making and also how I might approach day-to-day challenges.'

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