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The next edition of *Healthcare Finance* will be the February 2020 issue

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News

Financial position 'broadly on plan' but risks still remain

By Seamus Ward

The combined provider and commissioner financial position has deteriorated since month 4, with the sectors recording an aggregate year-to-date overspend of almost £130m against plan, but the overall position is broadly on plan.

Figures for month 6 show a year-to-date combined position of a £130m overspend against plan. At month 4, the year-to-date adverse variance against plan was £75m.

Halfway through the year, the overall forecast year-end position is a £69m deficit – NHS England and NHS Improvement have planned for a balanced position at year-end.

The figures were tabled in a financial performance report to the November NHS England and NHS Improvement joint board.

At month 4, around 25% (49) of clinical commissioning groups (CCGs) were showing adverse variances. At the time, NHS chief financial officer Julian Kelly commented that the commissioner financial position was causing more concern than providers.

However, it is anticipated this will improve. And in the latest report, Mr Kelly said it was expected that all but two clinical commissioning groups would breakeven by year-end.

Though CCGs had an aggregate overspend of £366m at month 6 – £152m more than planned – this was offset somewhat by underspends in direct commissioning and central programme and running costs, which brought the overall year-to-date overspend figure down to £59m.

The forecast year-end position for the whole commissioning sector is an overspend of £31m against a planned surplus of almost £282m, but this includes an adverse variance of £83m in technical and ring-fenced adjustments.

The report said this adverse variance reflected greater pressure than expected from the movement against provisions. If the established pattern of previous years is repeated, this pressure will reduce by the end of the financial year, it said.

"We are working with individual organisations and systems where we have material risk"
Julian Kelly (pictured)

Providers overspent on their planned £1bn year-to-date deficit by £70m after taking account of uncommitted funds from the provider sustainability fund, financial recovery fund and MRET (marginal rate emergency tariff).

According to the NHS bodies' report, the provider sector 'is forecasting to finish the year essentially on plan' – predicting a year-end overspend of £38m against a planned deficit of just under £282m. At the end of 2018/19, the provider overspend was £571m.

Mr Kelly told the board meeting: 'Year-to-date, the financial plan is holding. We have an adverse variance in provider and commissioner spend of £130m at the halfway point. In context, we have spent £60bn, so it's a 0.2% variance.'

The forecast coming back from providers and commissioners is also broadly holding to plan.

He added: 'There is clearly a significant amount of risk and we are working with a number of individual organisations and systems where we have got material risk to make sure we are bringing them in on plan or as close to plan as we can.

'This is not just so that we balance this year's budget, but critically so that we head into next year and the medium-term position in a good state of health.'

Detailed figures show the acute sector once again incurring the bulk of the deficits, with a year-to-date variance of £89m over acutes' planned £1bn deficit and a forecast £103m overspend against the year-end plan of £569m.

Mr Kelly pointed out that, at month 6, the NHS had spent £1.5bn in capital, £300m more than at the same point in 2018/19.

'This means that trusts with their own cash resources can deliver as fast as they can the plans they have,' he said.

'We are managing to release more capital to trusts that don't have their own cash resources to deal with some of the critical backlog issues, as well as progressing the transformation projects already agreed.'

The stage is set

Bill Gregory completes his year as HFMA president at the annual conference this month (4-6 December), having visited all 13 of the association's branches during his year in office.

To mark this achievement, he was presented with the Everyone Counts Award (inset) at the recent Northern Ireland Branch conference by branch chair Owen Harkin.

The annual conference, run under Mr Gregory's presidential theme, *Value the opportunity,* comes just a week before the general election – the outcome of which is likely to have an impact on the NHS, with all the main parties making promises for the future development of the service.

The annual HFMA awards will be presented at the conference, recognising best practice across financial management and governance. A special awards supplement will be sent to HFMA members during December.

• Follow coverage of the annual conference online at **www.hfma.org.uk/news** or using the myHFMA app.

HFMA highlights concerns about MH costing plan

By Steve Brown

The HFMA has raised concerns about plans to require all mental health trusts to submit patient-level costs next year.

NHS Improvement confirmed in February that trusts would be required to submit patient-level cost data for mental health services over a two-year period, with mental health trusts and integrated acute/mental health trusts submitting 2019/20 data next year.

The oversight body rejected calls for a delay as part of the original consultation on mandating patient-level costs for mental health, saying it would affect plans for community services and to end the collection of reference costs.

But the HFMA has written to NHS England and NHS Improvement arguing that the '2020 mandation is too soon'. The move follows feedback from mental health trusts during the autumn – many of which have taken part in this year's voluntary collection.

Practitioners report that software suppliers' and central bodies' current focus on the acute sector – which led the way with a first mandatory collection over the summer – is having an impact on mental health trusts' ability to implement patient-level costing.

Mental health trusts' experience of their voluntary collection this year, which was complicated by late guidance and very tight timescales, has raised further doubts that the sector is prepared enough for the switch next year. Trusts have also not been able to test the NHS Digital system that will be used in the mandatory collection.

Costing practitioners have identified problems with the standards issued to cover the costing work, describing them as 'overly complicated', 'challenging to implement' in places, and having 'too much focus on detail'.

Mental health trusts also questioned whether there was sufficient capacity in the sector to implement the costing standards. Trusts are starting from a low base in terms of infrastructure and those that are most advanced report that it requires significant additional investment. While mental health costing teams are typically small – smaller than those in acute providers – recruitment and retention are seen as challenges.

The HFMA and its Healthcare Costing for Value Institute have been strong advocates for robust patient-level cost data for a number of

years. And institute head Catherine Mitchell (pictured) believes progress across the NHS has been impressive. 'However, the overall timelines for mental health were set before this year's mandatory acute collection, and mental health trusts now have real concerns about the pace of change and the achievability of next year's submission,' she said.

The specific problems raised about the move to patient-level costing for mental health trusts come after the association highlighted concerns more broadly with the national cost collection this year. A document sent to the central bodies this summer highlighted general and specific issues with the standards, guidance, collection process and costing teams.

A November costing newsletter from NHS England and NHS Improvement said many of these issues had been addressed in new *Approved costing guidance*, which was published for comment recently. However, it promised a full response to the HFMA report would be published in early December.

Pathology network savings may exceed forecasts

Potential savings made as a result of establishing pathology networks are higher than initial estimates, according to NHS England and NHS Improvement.

In an update on the move to 29 pathology networks, due to be completed by 2021, the national bodies said almost all trusts are making progress towards networking.

And, as NHS organisations develop their cases for pathology networks, potential savings have emerged that are greater than initial estimates.

It was believed that the savings could reach £200m by 2020/21 on running costs of £2.2bn. But the report said this could be an underestimate – for example, trusts now using the network model have seen the average costs per test drop by 20%, while one network has agreed £18m in savings over five years through joint procurement.

The report does not put a new figure on the potential savings.

However, while 97% of organisations were engaged in the networking process and 84% had agreed a local partnership model, networking was on track for 2020/21 in only 76%.

The report urged the NHS to achieve efficiencies as soon as possible.

'We are reassured by progress and level of engagement to date, but networks need to act immediately to realise available efficiencies, while trusts and integrated care systems should continue to prioritise pathology networking,' it said.

'Using Model Hospital data, trusts can identify where to concentrate. Services must demonstrate adequate grip and control, as cost-efficiency savings can still be realised in-year while networks are formed.'

The pathology update was published as NHS England and NHS Improvement said 18 imaging networks will be created by 2023. Where possible, these will align with pathology networks.

They said imaging networks will reduce unwarranted variation in both pay and non-pay costs, provide a better service to patients and deliver savings.

The programme will be implemented in two phases – 24 networks will be established by 2022 and consolidated to 18 in the following year.

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MPs urge NI funding move

A longer-term funding strategy is needed to support the transformation of health services in Northern Ireland, or there is a risk that services will deteriorate to the point of collapse, according to MPs.

In its report, *Health funding in Northern Ireland,* the Commons Northern Ireland Affairs Committee said that if the Northern Ireland Assembly has not been reinstated by the end of the year – it has not sat for more than 1,000 days – the UK government must take action to address unsustainable pressures across the service.

A minimum three-year budget was needed. Services were struggling to meet demand and are without adequate financial support or strategic direction.

Committee chair Simon Hoare said: 'The stark reality is that the Northern Ireland health service is falling behind the rest of the UK. An approach to funding that simply keeps things ticking over, and an absence of overarching strategy in key areas, has left services at breaking point and this situation must end as soon as possible.'

Meanwhile, Department of Health permanent secretary Richard Pengelly said local services must continue planned transformation. He said the Department was examining responses to public consultations on stroke and breast cancer assessment services, and would decide on the best way forward soon.

NHS to remove impact of pension tax for clinicians

By Seamus Ward

NHS England and NHS Improvement have moved to reduce the impact of the pension tax issue by promising the health service will pay any bills that arise during 2019/20.

With the busy winter period ahead, trusts are becoming increasingly concerned about the effect on patients. The issue can lead to large tax bills for employees if a pension pot exceeds an annual allowance – the allowance can be tapered down further depending on income. There are reports clinicians have refused extra sessions or promotions to avoid the bills, with some considering retirement.

The government offered solutions over the summer, proposing new flexibilities to allow clinicians to reduce their pension contributions to limit or avoid the tax. It also promised a review of the taper.

While the move was welcomed, many in the NHS said it did not go far enough. In November, NHS chief executive Simon Stevens (pictured) said there was an urgent operational requirement to act, as the flexibilities had 'clearly not prevented large numbers of senior clinicians reducing their sessional commitments'. The election and postponement of the Budget meant that a substantive move to address the taper would be unlikely before the new financial year.

'We have heard loud and clear from local teams and national leaders that these rules are disadvantaging staff who only want to do the right thing by patients,' Mr Stevens said.

Clinicians who have a liability for this financial year should choose 'scheme pays' on their pension form – using the funds in their pension pot to pay the tax. The NHS will make a contractually binding commitment to pay the corresponding amount on retirement, ensuring they are fully compensated for the effect of reducing their pension funds. This will be nationally funded at no net cost to NHS bodies.

The new arrangements will be confined to doctors, nurses, allied health professionals and other clinicians in active clinical roles. Many organisations, including the HFMA and NHS Employers, believe changes should apply to all NHS staff.

The HFMA published the results of a snap member survey that showed more than half of respondents were considering actions to reduce or avoid pension tax bills.

Some of the 260 respondents told the association that they had already acted, such as opting out of the NHS Pension Scheme, not applying for promotion or not taking a pay rise. One respondent said they faced a £70,000 tax bill after taking an executive director of finance role.

In Scotland, from 1 December until the end of the financial year, eligible NHS staff can have their employer pension contributions paid as salary. The measure will be available to all staff who can prove they are likely to breach the annual allowance, leading to a tax charge.

The Welsh government said hospitals lost more than 2,000 outpatient, diagnostic, inpatient and day case sessions between April and August this year because of clinicians' concerns over pension tax. Health minister Vaughan Gething said that the NHS should use local flexibilities while waiting for the outcome on proposals from Westminster.

Boards face significant challenges, auditor says

Audit Scotland has delivered mixed reports on two local health boards, saying that while advances have been made, clear and realistic long-term service redesign plans were needed to drive operational and financial improvements.

Despite 2018/19 gains at NHS Tayside, when it achieved its financial plan and exceeded targeted efficiencies, challenges remained. The auditor said the board had received brokerage of £17.6m to achieve its 2018/19 financial targets, but it was £4.7m less than planned. Outstanding brokerage was £63.5m at 31 March 2019, though all territorial boards' outstanding brokerage at 31 March 2019 is due to be written off.

Auditor general Caroline Gardner (pictured) said: 'It's a positive step that NHS Tayside has a transformation plan, but moving away from the current ways of working will be difficult without well-developed and detailed implementation plans. So far there is little evidence of the sustainable service redesign and transformation that is critical to reducing costs while maintaining or improving services.'

In its report on NHS Highland, Audit Scotland said the board had identified savings of £50.5m in 2018/19 but achieved planned savings of £26.6m, with other savings and benefits of £5.9m. The board needed government loans of £18m to meet financial targets.

Ms Gardner said: 'NHS Highland urgently needs a clear and achievable plan to redesign services. This must go beyond the series of short-term fixes we have seen in the past. The scale of changes needed are such that the board is unlikely to become financially stable in the next two years.'

News review

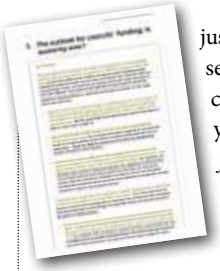
Seamus Ward assesses the past month in healthcare finance

The UK is in the throes of the general election, but there was little sign of the volume of NHS news falling in November.

One piece of news directly related to the election was the announcement that Scotland will not see a 2020/21 Budget published until after Christmas. Finance secretary Derek Mackay said the postponement was unavoidable because the UK government Budget, scheduled for early November, had been cancelled due to the general election. The Budget for Scotland had been scheduled to take place on election day, 12 December, and a new date will be agreed as soon as possible, he added.

There is no doubt that there is a desire to improve diversity and inclusion in NHS finance – the challenge is to convert this into sustained actions, according to an HFMA and Future-Focused Finance briefing. As well as looking at the current diversity position in NHS finance, the document also explores practical steps that can be taken to make a difference.

Social care funding is a major issue in the election campaign, and the Institute for Fiscal Studies said local authorities will need an additional £4bn a year by the end of 2024/25



just to maintain current service levels. This assumes council tax rises at 2% a year. In a report, *The outlook for councils' funding: is austerity over?*, the IFS said the funding would also ensure there are no further cutbacks in services. With 2% annual council tax rises, the amount needed would rise to an extra £18bn a year by the mid-2030s, it added.

The OECD said the UK has fewer doctors and nurses than many developed nations and, while access to healthcare is relatively good, it is less so for long-term care. In its annual review of health and care across developed nations, the OECD said the UK spends almost 10% of its GDP on health (public and private spending) – one percentage point higher than the OECD average. The level is expected to hit 11.4% by 2030.

Patients in Northern Ireland face an uncertain winter after Royal College of Nursing members voted overwhelmingly to take industrial action, which will include strikes, refusing non-nursing duties or non-participation in bank work on designated days. The union said nurses' pay locally had fallen behind the rest of the NHS – by around 15% in real terms. Three dates have been set in December, where industrial action short of strike action will be taken. These will be followed by strikes later in December and the new year. NHS staff in Northern Ireland are unlikely to receive a pay award of more than 1% in 2019/20.

Health Education England will invest £18.5m in district nurse training in 2020/21. The funding will support community nurses who wish to study for the specialist practitioner qualification that allows them to become district nurses. Some of the money will be allocated to the district nurse apprenticeship programme in 2020/21. There will be further funds to support the development of district nursing.

The Welsh government and Northern Ireland Department of Health reached access agreements with the manufacturer of three cystic fibrosis drugs. One of the drugs, Kalydeco, is already available in Wales, but now patients there will also have access to Orkambi and Symkevi. A deal reached with NHS England last month stipulated that the manufacturer, Vertex, must offer the drugs on the same terms to health services in Wales and Northern Ireland.

Increasing the use of day cases for tonsillectomies could avoid costs of between £1.4m and £3.7m a year, according to a new *Getting it right first time* (GIRFT) report. The review of ear, nose and throat (ENT) services found that thousands more patients could be treated as day cases and overall it identifies potential cost efficiencies of between £21.7m and £30.8m a year.

Finance departments must embrace new technologies to give appropriate support to frontline changes, according to a briefing from the HFMA and cloud application provider Oracle. The document looks at examples of new enabling technologies, such as artificial intelligence and blockchain, and digital transformation in the NHS.

The month in quotes

'Increasing the use of day case treatment in ENT would benefit patients as well as ENT units and their trusts, making units more resilient to pressures on beds and allowing hospitals to free up beds for other people.'
Andrew Marshall, author of a GIRFT report on ENT services, talks up the benefits of moving to day cases

'While no nurse wants to take this action, unfortunately we have been left with no choice and we are now carrying out the instructions that our members have clearly voted for.'
RCN Northern Ireland director Pat Cullen says there has been no meaningful dialogue with the Department of Health

'The Scottish Budget should be published after the UK Budget, a view the Finance Committee have indicated they share. Without a UK Budget we would not know the final details of any Barnett consequentials from UK spending, or the impact of UK tax decisions.'

Scottish finance secretary Derek Mackay explains the implications of the December general election

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Key MHA results from a multi-site Acute Trust

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For more details talk to a member of the 3M Health Information Systems team on Stand B2 at the HFMA annual conference, 4–6 December 2019 or contact sales.his.uk@mmm.com

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2 NHSD National Data (England).

OMG56055.

News analysis

Headline issues in the spotlight

Spend, spend, spend

The NHS is never far from the headlines in a general election. But, unlike recent elections, all the major parties this year are committed to significantly increasing health funding. Seamus Ward reports

While the general election has been billed as the Brexit election, in the first few weeks of campaigning there was a strong case for renaming it the NHS election. As the parties rowed about funding, privatisation and US influence post-Brexit, the public elevated the health service to the number one concern affecting voting intentions.

This is not unusual – the NHS is usually in the top two or three public priorities with or without an election. The parties' health policies are for England only, with health and care devolved to national executives. When the public says it is concerned about the NHS, it usually means it wants the service to be given more funding. Whoever wins, more money will be available, with the traditional top three parties in England setting out spending increases after years of relative austerity for the NHS.

The Conservative government had already outlined its NHS England revenue spending plans up to 2023/24. This amounts to £20.5bn in real terms. To support his health spending credentials, Tory leader Boris Johnson told the CBI he would postpone a planned reduction in corporation tax to pay for increased funding to the NHS and other public services.

With the NHS needing to replace and upgrade buildings, and backlog maintenance rising to £6.5bn, Mr Johnson also promised higher capital funding. Under the Health Infrastructure Plan (HIP), £2.7bn has been allocated to six trusts in the first phase, covering the next five years.

However, the Conservatives' claim – reiterated in its election manifesto – that its funding would lead to 40 new hospitals over the next decade has come under fire. While six trust projects have been given £2.7bn funding, a further 21 have only been given seed funding to develop schemes. Critics claimed the funding is far from guaranteed and the cost unknown; the Tories said it was agreed by the Treasury.

Jeremy Corbyn's Labour Party has promised the biggest funding boost – £26bn by 2023/24. In addition, funding would be provided for free

annual dental check-ups, and the abolition of prescription and NHS car parking charges.

While removing parking fees would cost around £270m a year, Labour said free prescriptions could increase drugs costs by 5% – after adjusting for an increase in uptake. Earlier this year, Labour said removing prescription charges would cost £754m a year.

By 2023/24, annual capital spending under a Labour government would rise to £10bn a year. The party said the capital funding would be used to rebuild hospitals and community facilities, and clear the maintenance backlog. The overall amount would include capital funding for mental health, together with a £2.5bn fund to overhaul the primary care estate. And £1.5bn would be earmarked for an increase in CT and MRI scanners to the OECD average.

Liberal Democrats leader Jo Swinson said that, if elected, she would increase NHS and social care funding by £35bn over the next five years – £7bn a year paid for by increasing income tax by 1%. The party also promised a £10bn a year capital fund.

Workforce is a significant concern, regularly highlighted by finance directors as one of the biggest risks to the delivery of local services. There are currently 100,000 vacancies, including 40,000 vacant nursing posts. The Lib Dems said it would tackle staff shortages within five years by retaining freedom of movement for European Union citizens, reinstating nursing bursaries and creating a national workforce strategy that matches training places to future needs.

Labour also promised to reinstate nurse bursaries, while its manifesto pledge to increase NHS pay by 5% in its first year of government – followed by above-inflation awards in the following years – pleased health unions.

Labour pledged to recruit a further 24,000 nurses and expand GP training places to 5,000 to create 27 million more appointments with family doctors. The Conservatives promised to recruit 50,000 nurses and 6,000 GPs to create 50 million more appointments at GP surgeries.

But while Labour spoke about GP appointments, the Conservative plans indicate an increase in appointments across all staff in primary care. And the Tory nurse recruitment plans are said to include training 19,000 extra nurses (5,000 via apprenticeships) and retaining 18,500 who might otherwise have left the service.

Leaving aside the fact that around 12,500 would probably have to be found from overseas, there are question marks over how many nurses can be trained – nurse numbers have increased by only around 5,000 since 2010.

Labour said restoring bursaries would likely cost less than £600m a year by 2023/24, while training an additional 1,500 GPs would cost an estimated £273m.

The Conservatives removed nursing bursaries in 2017 believing universities would meet demand by creating more places. The bursaries were worth up to almost £10,000 a year, but there was a ceiling on places. According to the Royal College of Nursing, removal of the funding led to fewer applicants – in February this year, it said there had been a 30% drop in applications (more than 13,000) since 2016.

Now, the Tories say they would introduce a student nurse maintenance grant of between £5,000 and £8,000 a year. However, tuition fees would remain. The party said its plans on nursing recruitment, training and retention

BORIS JOHNSON, JO SWINSON: SHUTTERSTOCK; JEREMY CORBYN: CC BY 2.0

MANIFESTO PROMISES

	Conservative	Labour	Liberal Democrats
Funding increase by 2023/24	£20.5bn revenue; HIP capital funding (£2.7bn) • Almost £879m for recruitment and retention, plus smaller amounts for pledges on car parking	£26bn revenue, capital spending would rise to £10bn a year	£35bn (health and social care) • Establish cross-party health and social care convention on long-term sustainable funding
Workforce	Funding for staff training, student nurse maintenance grant • Recruit and retain 50,000 nurses – measures to cost £879m by 2023/24 • Recruit 6,000 GPs • Address 'the taper problem' in doctors' pensions	Bursary restored (£600m) • 5% pay rise in year one followed by above-inflation awards • Recruit 24,000 nurses, train 1,500 more GPs (£273m) • Review of tax and pension changes	End GP shortfall by 2025 • Restore nurse bursary • Produce national workforce strategy • Retain staff through more flexible working • 'Listen and act on pension crisis'
Mental healthcare	Treated with the same urgency as physical care	Extra £1.6bn a year • New standards in NHS Constitution • £2bn invested in modernising hospitals • End out-of-area placements	Ring-fence funding from the 1p rise in income tax for mental healthcare • New maximum waiting standards
Public health	NHS screening overhaul • Long-term strategy for empowering people with lifestyle-related conditions • Promote vaccination uptake	Invest more than £1bn in public health • Recruit 4,500 more health visitors and school nurses	Cross-government wellbeing strategy • Reverse cuts to public health budgets • Public health to remain council responsibility • NICE to evaluate interventions
NHS structure	Continue to move towards system working	Repeal of *Health and Social Care Act 2012* • Planned model of community care • Outsourced services taken back in-house • End competitive tender requirement	Reform *Health and Social Care Act 2012* to make NHS more efficient and joined up • End automatic tendering of services
Social care	Extra £1bn from April 2020 • Cross-party consensus sought on long-term reform	National Care Service to work with NHS • Free personal care • Lifetime cap on personal contributions to the cost of care	Bring NHS, social care and public health together seamlessly – pooling budgets and supporting ICSs
Other	Cancer Drugs Fund extended to Innovative Medicines Fund • NHS not on table in trade deals • 'Unfair' parking charges ended	Free car parking and prescriptions • Establish generic drugs company	Independent budget monitor similar to Office for Budget Responsibility

would cost £759m in 2020/21, rising to £879m in 2023/24. Increasing appointments in primary care would cost £399m next year, rising to £695m in 2023/24.

Mental healthcare remains a priority for all three main parties. The Liberal Democrats said they would introduce a range of mental health measures, including new maximum waiting times and giving patients with chronic mental health conditions free prescriptions.

Labour said mental health funding would increase by £1.6bn a year if it is elected – the funding would be drawn from the increase in the NHS England budget. A £2bn mental health infrastructure fund would abolish dormitory wards and invest in more beds to end out-of-area placements and a new fleet of crisis ambulances.

The Conservatives' plans for a limited abolition of car parking charges would produce a revenue cost of £93m, rising to £99m. Some £257m in capital funding would also be allocated to extend NHS car parks to meet the expected increase in demand.

There were pledges on other non-NHS spending. Labour plans to deliver a £1bn increase in the annual public health budget. Funding would also be available for the public health nurse workforce, delivering an extra 4,800 health visitors and school nurses.

King's Fund chief executive Richard Murray welcomed Labour's funding pledges. But he added: 'The success of any NHS funding policy will rest on the ability to recruit and retain enough workers to staff NHS services. Labour's pledge to reinstate a training bursary for nurses is welcome, although it will be critical to focus on retaining existing NHS staff over the next few years, at a time when many are leaving the service due to the intensity of their workload.'

Potentially hinting at structural reform of the NHS, Labour said it would scrap the *Health and Social Care Act 2012*, introducing a joined-up model of community care, with greater funding allocated to close-to-home services, and the internal market abolished.

The Labour manifesto said outsourced services would come back in-house, adding that its 'urgent priority is to end NHS privatisation'.

On social care, the Conservatives promised an extra £1bn a year in April 2020, while seeking a cross-party consensus on long-term reform. Labour said its commitment to free personal care and relaxing eligibility rules would cost almost £11bn by 2023/24.

NHS Confederation chief executive Niall Dickson welcomed the Conservative commitments on recruitment and retention. But he said the Tories and other parties had ducked the need for a long-term settlement for social care for too long. 'We have some serious commitments, with the Lib Dems and the Conservatives promising they will work to deliver cross-party consensus and with Labour committed to free personal care,' he said. 'These pledges mean the next government will be committed to producing a sustainable long-term solution – and they will be held to account for that, no ifs, no buts.'

Whichever party wins the election, the NHS in England will receive more money – the devolved nations will get Barnett funding as a result. While this will be welcome, the NHS will remain worried about the future of social care and whether the same pressures will remain when the next election is called.

Comment

Strength in the branches

Tour of HFMA branches reveals strength in depth

HFMA president Bill Gregory

Just over a month ago, the idea of a December general election was the stuff of speculation. With the poll now confirmed for 12 December, the government has moved into full election mode with a clampdown on policy communications.

However, the promises for the NHS and social care have featured prominently in party manifestos. It would seem that, whoever forms the next government, the NHS – particularly its workforce and funding needs – will be a top priority. This is a great opportunity for us and will form a big part of our agenda next year.

The pre-election period of sensitivity has had an unfortunate impact on the availability of national speakers lined up for the annual conference. But despite this setback and late changes, HFMA chief executive Mark Knight and the team have created a great programme. We have an inspiring and entertaining group of speakers in place.

December has also brought some light at the end of the NHS pension tunnel, with arrangements being made nationally for managing the tax implications for some groups of NHS staff (*news, page 7*). It's a welcome development at this busy time of year for our patient facing services, though I'm sure we will hear

Designs on the future

The NHS needs to plan now for the finance function it wants in the future

If the NHS is to meet the ambitions set out in the *NHS long-term plan*, it will have to change dramatically over the coming decade. New models of care will be required that harness new digital technologies. Care will need to be more personalised to meet the specific needs of different parts of the population.

It will have to make good on the promise to rebalance its activities in favour of more prevention – reaching people before they get ill or before their condition deteriorates into a more complex problem.

And if it is going to meet these challenges, it will need a finance function at the top of its game. That's the conclusion of a report from the HFMA, Future-Focused Finance and PwC. *NHS finance: designing our future* (see page 22) sets out a vision for a future NHS finance function and seeks finance practitioners' views on this vision.

It is a valuable and necessary exercise. We can't just expect to have the right number of clinicians to meet future demands unless we plan for it. That means understanding how care will be delivered in future, the different roles that doctors, nurses and therapists will fulfil and the skills they will need. That's why the NHS produced its interim people plan earlier this year.

Well, it's exactly the same for NHS finance. Without planning for the future, there is no guarantee that the function would have the right skills and be working in the right way to meet the demands of the NHS in 10 years' time and beyond. If we don't think about these issues now, the function may never achieve its potential.

Healthcare Finance editor Steve Brown

more about how this gets implemented, particularly as the issue affects staff in various roles and pay grades.

This month also brings to a close my association branch visits, many of which I have made this autumn.

I have written before about how impressed I am with the way our branches are supported up and down the nation. Branches have also embraced my *Value the opportunity* theme.

All the branches do things a little differently – this is one of the strengths of the HFMA. The 13th and last branch conference, traditionally the Northern Ireland Branch, was held at the end of November in the Titanic Centre, Belfast. It was moving to hear Reach for the Stars – an inspirational choir including people with learning disabilities from the local Larne Adult Centre – entertaining us with seasonal and popular songs.

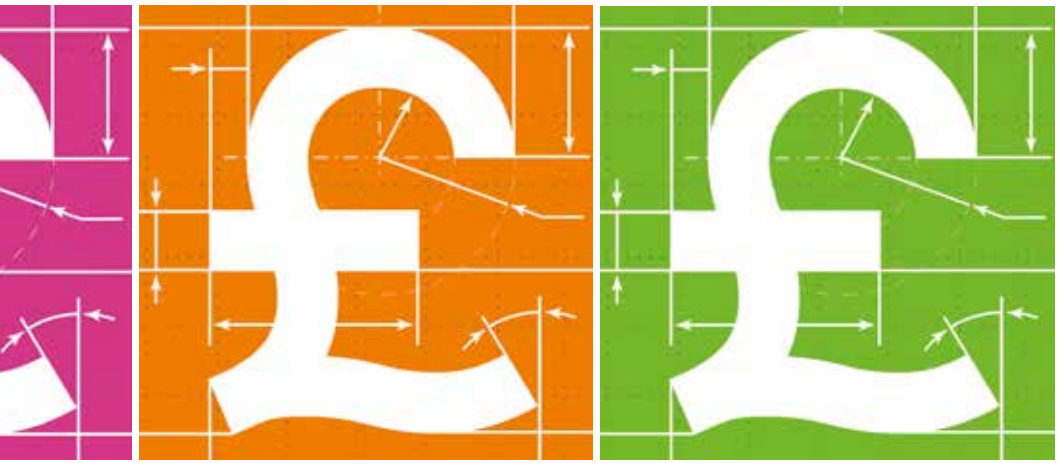
The Northern Ireland Branch conference was also an opportunity to congratulate Owen Harkin, currently Northern Ireland Branch chair, who will serve as national HFMA vice-president for Caroline Clarke in her year as national president 2019/20.

The Northern Ireland Branch will shortly elect a new chair to take over from Owen, and this reminded me that more than two-thirds of our branches have a new branch chair taking on the role in 2019/20. These are important local roles for the HFMA, and I ask you all to support your local branch chair and committee in the fantastic work they do.

I will be handing over my presidential duties to Caroline at the national conference, but it has been real privilege to have served as your president for the HFMA over the last year.

I have made many new friends during the year, and enjoyed the opportunity of seeing first-hand the great work you are doing across the country in the healthcare finance profession. Thank you all for your support.

Contact the president on president@hfma.org.uk



"*Designing our future* is just a start in trying to understand how the NHS finance function needs to adapt"

The report is clear that finance has a lot to offer. It already contributes in a major way to the success of the NHS. But the function arguably has an even bigger role going forward as the service focuses increasingly on the delivery of value and starts exploring the potential of approaches such as population health management.

There is a lot to think through. Technology is set to revolutionise the NHS – from genomics to virtual consultations and the use of big data to target support at different parts of the population. But it will also transform finance departments.

First the function must explore the best ways to harness this technology. How can it make use of robotic process automation to take on high-volume, low-complexity manual tasks? What role could blockchain play in improving the efficiency of payments and reconciliations?

Then it must think about the additional skills and attributes needed by finance staff to work in this new environment. Greater automation should free-up finance staff time to take on more business partnering roles (*Working together, page 19*), spending more time on data analysis and supporting clinical teams and less on data gathering and manual processing.

This implies a major staff development exercise. Individuals will have to take responsibility for developing the skills to prosper in this new world. Organisations and national bodies must provide the right opportunities for that development.

The function will also have to ensure it retains its existing talent – people who have specifically chosen to work in NHS finance to make a difference to people's lives. In addition, it has to be able to attract the best people from other sectors. And to maximise its effectiveness, it will need to focus on diversity and inclusion.

The NHS faces significant challenges over the coming years, but it will also be an exciting place to work, and finance professionals have a major part to play in enhancing care for patients and the value delivered for taxpayers. *Designing our future* is just a start in trying to understand how the NHS finance function needs to adapt – the aim is now to consult widely with the function and get its feedback and enhance or refine the vision. But it's a good start.

Reduce, reuse,

The NHS is trying to reduce its impact on the environment and has made some progress, with some organisations finding green policies are leading to savings. Seamus Ward reports

The NHS is a significant polluter and user of natural resources. In 2017, its carbon footprint was just over 27 mega tonnes of CO_2 or 6.3% of the total carbon footprint of England, according to the NHS Sustainable Development Unit (SDU). Health and care related travel accounts for around 5% of all road journeys in England each year. The NHS generated nearly 590,000 tonnes of waste in 2016/17. But while this may all sound negative, the NHS is addressing and reducing its impact on the environment.

The figures mentioned above are significant improvements on the picture in 2007 – since that year, the carbon footprint has been cut by 18.5%, equivalent to the annual emissions of Cyprus. This was despite a 27% increase in patient activity over the decade. Most of the service's waste is incinerated or used for energy generation.

However, the focus on further reductions will remain. The *NHS long-term plan* said the service faced a significant challenge to deliver the *Climate Change Act 2008* target of a 34% reduction in the carbon footprint by 2020 and 51% by 2025. A shift to lower carbon inhalers alone will deliver a 4% reduction (*see box overleaf*) and, overall, the UK is committed to net zero carbon emissions by 2050.

Some individual trusts have made good progress – Guy's and St Thomas' NHS Foundation Trust, for example, says its sustainability programme has reduced its carbon emissions by 15% since 2007, exceeding the 2015 target of 10%. Its energy efficiency projects will save £1.5m a year and reduce carbon emissions by a further 10%. Overall, the sustainability programme saves the trust £3m a year.

Recently, three trusts (North Bristol NHS Trust, University Hospitals Bristol NHS Foundation Trust and Newcastle upon Tyne Hospitals NHS Foundation Trust) and the Greater Manchester Health and Social Care Partnership declared a climate emergency, recognising the impact of climate change on the world. All four bodies have made progress on limiting their impact on the climate. In Greater Manchester, Wrightington, Wigan and Leigh NHS Foundation Trust and Bolton NHS Foundation Trust have cut their annual carbon emissions by 11,000 tonnes, saving £1.7m a year, by installing combined heat and power systems and LED lighting.

The Newcastle trust also has a combined heat and power system and, when it needs this on-site generation to be topped up, buys additional energy from 100% renewable resources. No waste goes to landfill.

North Bristol NHS Trust has taken action on energy use, getting energy from sustainable sources, reducing vehicle emissions and using sustainable food sourcing.

Chief executive Andrea Young says: 'To provide high-quality care, the NHS uses huge amounts of energy, food, water, medicine and equipment – all of which contribute to our carbon footprint.

'We can also harness the power of thousands of staff who are highly motivated to make a difference and improve people's lives. We want to publicly acknowledge the huge threat of climate change, do as much as possible to tackle it ourselves and, as anchors in our community, encourage collaborative action.'

SHUTTERSTOCK

recycle, reward

The Bristol trusts are also reducing their use of Desflurane, an anaesthetic gas that has a greater environmental impact than alternative anaesthetics. Reducing use of the gas could contribute to a 2% reduction in the overall NHS carbon footprint. In September, NHS Greater Glasgow and Clyde said its switch to Sevoflurane – which releases 60 times less CO_2 – was the equivalent of 350 fewer cars commuting to its hospitals each day. NHS Highland has reportedly seen a 75% reduction in Desflurane use since January, saving £73,000.

With plastic pollution reaching alarming levels globally, NHS England and NHS Improvement are focusing much of their efforts on cutting up to 100 million plastic straws, cups and cutlery from hospital canteens. Last year, the NHS bought at least 163 million plastic cups, 16 million pieces of plastic cutlery, 15 million straws and 2 million plastic stirrers.

From April, high-street outlets found in hospitals, such as Marks & Spencer, have committed to avoid the use of plastics, starting with straws and stirrers. Plastic cutlery, cups and plates will be phased out by 2021.

NHS chief executive Simon Stevens said: 'It's right that the NHS and our suppliers should join the national campaign to turn the tide on plastic waste. Doing so will be good for our environment, for patients and for taxpayers who fund our NHS.'

Plastics pioneer

NHS England has highlighted Yorkshire Ambulance Service NHS Trust (YAS) as a pioneer in reduced use of plastics. But Alexis Percival, the trust's environmental and sustainability manager, says it has a wide range of environmentally friendly schemes that it has been implementing over many years. Having completed her own plastic-free year, Mrs Percival began to look at alternatives to plastic used in the trust's canteen in September 2018. The first step was to replace plastic milk cartons with glass bottles. This was achieved within two weeks. In total, the trust has eliminated 200,000 plastic items a year, of which 104,000 were plastic-lined paper cups.

Paper cups have now been replaced with reusable mugs – users pay a £1 deposit, which is repaid when the mug is returned. Ceramic bowls and plates, and metal knives and forks have been introduced, while paper and cardboard have replaced plastic wrapping – for sandwiches, for example – for those leaving the canteen.

The trust has reduced its plastic use by four tonnes a year, though it still uses around half a tonne. However, as Mrs Percival points out: 'We are saving about £5,000 in procurement costs a year through reduced use of plastic. It's not just about consumption, but also about disposal – so we are not double-paying for something that has a single use and then gets thrown in the bin.'

'The only product we need to dispose of now is the plastic cups for water dispensers, which we will probably be able to do over two weeks as well – these single-use plastics are relatively easy to replace, but it's more problematic to remove plastics in the rest of the NHS. There are a lot of challenges as we now package products that historically we would have autoclaved – we now have them as single-use products to prevent the spread of infection, such as MRSA and other infectious diseases.'

Plastic is a major presence in frontline healthcare – from surgical gloves to the wrappers of small, high-use items such as syringes. Mrs Percival says the trust is working on a national project with the Royal College of Nursing and the College of Paramedics to reduce the eight billion single-use plastic gloves used in the NHS every year.

The Gloves Off campaign has run for a number of years and serves to remind staff when they should wear gloves, but also when gloves are not needed, and effective hand hygiene is preferable. This will mean reduced

glove use and best practice care for patients, and is also likely to reduce issues with skin health for staff, such as contact dermatitis. 'We are different from acute care, but there is a lot of plastic in the system that doesn't need to be there, Mrs Percival adds.

Needles, for example, are wrapped in plastic that cannot be recycled – the need to reduce carbon emissions for deliveries has led to a focus on lighter packaging, but the plastic is now too thin to recycle.

She says: 'You have to go back to the system and ask why these things are being put in plastic packaging or even packaging at all. Are there alternatives? Can we create a circular economy with returnable packaging? Unfortunately, we are so used to having things packaged up. I am working closely with our infection prevention and control lead in the trust to ensure we review the plastic use, but maintain safe standards of practice for our patients.'

NHS Greater Glasgow and Clyde said its switch to Sevoflurane – which releases 60 times less CO_2 – was the equivalent of 350 fewer cars commuting to its hospitals each day

Travel impact

The NHS accounts for almost 10 billion journeys each year – around 7% of all road travel – as staff and patients travel to work and appointments and medical supplies are delivered. Some trusts have taken steps to reduce the environmental impact of this. Guy's and St Thomas', for example, recently set out plans to cut 36,000 truck deliveries each year. Now, these supplies are delivered to a hub close to the M25 and only supplies needed each day are sent to the hospitals. The trust is due to pilot electric delivery vehicles early in 2020.

The trust says the new hub will reduce deliveries by 90% and is part of its 'ambitious strategy to reduce our carbon footprint and improve our sustainability while ensuring critical deliveries are made every day across our central London hospitals'.

The *NHS long-term plan* commits to cutting mileage and air pollution from rapid response vehicles, patient transport and staff journeys by a fifth by 2024 and ensuring nine out of 10 vehicles are low emission within a decade.

The long-term plan also pledges to use technology to make 30 million outpatient appointments redundant, sparing patients unnecessary trips to and from hospital.

However, speaking at a clean air summit earlier this year, Simon Stevens said he wants to go even further and called on vehicle manufacturers to seize the opportunity provided by plans to upgrade the ambulance fleet. In his words, the NHS would turn blue lights green.

Yorkshire Ambulance Trust has three support vehicles powered by a hydrogen fuel cell and battery. Mrs Percival says it has ordered a further 10 vehicles so 1% of the fleet will be electric and hybrids by the end of this financial year.

YAS has signed up to the Clean Van Commitment, which works towards eliminating the emissions from all vehicles below 3.5 tonnes by 2028. The trust aims to make its entire fleet as environmentally friendly as possible, but there are issues to resolve for frontline, rapid-response vehicles, which can do up to 400 miles in a 12-hour shift.

Changing lightweight vehicles to electric would be relatively easy – in financial terms leasing of electric vehicles is now comparable to diesels as lease car companies are dropping the monthly lease charges. Swapping from diesels to vehicles powered by alternative fuels, as leases come up for renewal, is a reality now, she says.

The biggest challenge is to create a zero-emission frontline ambulance ensuring that there is the necessary range needed to perform as a

functional vehicle within the ambulance service. Pure electric battery vehicles would have a range of around 100-120 miles before refuelling is required, but when the equipment, crew and patients are added, the range is reduced to 50 miles.

While this might work in a city such as London, alternatives are needed for the urban/rural mix covered by other ambulance services. Hydrogen fuel cell/battery technologies may well provide the only option for a frontline zero emission ambulance for the future.

Vehicle limitations

There are other practical issues – electric vehicles have speed limiters to give them a greater range, which would have to be removed to ensure emergency ambulances and first responders could reach patients as soon as possible. However, this would reduce the range of the vehicles.

Electric charging infrastructure is also critically important. Currently, ambulance stations across the country hold 20 days' fuel as a resilience measure so an electric fleet would require an equivalent recharging infrastructure. On-site and off-site charging will be critical to ensuring that the ambulance service can function in an electric-centric future.

Hydrogen is a viable option for zero emission vehicles as hydrogen takes the same length of time to refuel a vehicle as diesel/petrol.

Mrs Percival has been designing the ambulance station of the future, which would ensure that stations will have to generate electricity on site and have battery storage capability. Renewables would be an essential part of the energy infrastructure.

'Our estate is a critical part of the ambulance service refuelling network. How will we charge or refuel the zero emission vehicles of the future? We need an estate that supports and provides us with resilience in the case of a power cut, for example,' she adds.

Despite these issues, the trust is looking at other ways of reducing the impact of its vehicles on the environment. More than 110 ambulances in Leeds have solar panels on their roof to provide energy to the auxiliary – potentially another source of power when the trust moves to electric hybrid vehicles.

Over the past 10 years, YAS has been working to reduce its carbon footprint by: implementing LED lighting across the estate; upgrading boilers; creating aerodynamic lightbars for ambulances, increasing the efficiency; installing insulation and solar panels; trialling and testing new vehicles to the market; as well as plastic reduction programmes and behavioural change programmes.

Implementing green technologies in organisations makes good business sense and into the future will make a lot of financial savings, Mrs Percival adds.

As part of the NHS commitment to sustainable healthcare, health service bodies are expected to produce sustainable development management plans (SDMPs). These identify waste reduction opportunities, financial savings and address national priorities, such as carbon reduction, and outline plans to tackle these issues. While many trusts have produced SDMPs, clinical commissioning groups are less likely to approach environmental sustainability in this way.

However, some are developing SDMPs, including Dudley Clinical Commissioning Group. Finance manager Paul Sharkey, who has produced a draft plan for the CCG, says trusts have a greater impact on the environment due to their estate and workforce. 'This has contributed to a view that SDMPs are something that trusts need to do and that CCGs do not need to be particularly concerned about them,' he says.

He believes commissioners should be taking a stand on environmental sustainability. 'Providers have done lots of great work to date – for example, in how they heat and light their estate. But in co-operation with providers, CCGs can lead in establishing new models of care.

'By taking many aspects of healthcare out of expensive and over-stretched acute and other large provider settings and nearer to the patient, we can realise the congruent benefits of improved health outcomes and general population wellbeing, reduced costs, and reduced environmental impacts associated with transportation and hospital admissions and attendances. Linking improved patient care to financial sustainability is not new but perhaps we should add an 'E' for the environment to QIPP?'

The CCG and local providers have been looking at reducing non-elective admissions of frail elderly people from care homes to acute providers by providing wraparound services in the community. Patients benefit – close-to-home or at-home services can prevent emergency situations – it can save money and the environmental impacts of ambulance use and hospital admissions are avoided.

Mr Sharkey says: 'CCGs should seek to reduce the environmental impacts of their business activities and lead by example in their local economies.'

The NHS, like many other areas of the economy and private households, is keen to take action to reduce its impact on the environment. Not only is it the right thing to do, saving on some costs now, but it could also contribute to better public health, potentially avoiding costs in the long-term.

Inhaler impact

Though seemingly innocuous, the asthma inhaler has a large environmental impact, with University of Cambridge researchers likening their environmental impact to that of eating meat.

Inhalers that create a spray of medication – called pressurised metered dose inhalers (PMDIs) – use greenhouse gases as propellants. According to the British Lung Foundation, the UK has an unusually high prevalence compared with other countries, with more than 65 million inhalers prescribed every year. Yet for most people, alternative inhalers are equally effective.

The NHS is committed to reducing the environmental impact of asthma inhalers as part of its contribution to the sustainability targets of the *NHS long-term plan*. There are alternatives, including dry powder inhalers, which don't use propellant gases. Earlier this year, the National Institute for Health and Care Excellence encouraged the use of dry powder inhalers, where patients can receive the same benefit as with PMDIs. It said that in other European countries fewer than half of inhaler prescriptions are for PMDIs, while in Sweden it is 10%.

PMDI (left) and dry powder

NHS England says that it will be improving information and guidance to enable healthcare professionals to support patients who would prefer to use a more sustainable alternative. PMDIs account for nearly 4% of NHS greenhouse gas emissions, and researchers estimate that replacing even one in every 10 with a dry powder inhaler would reduce CO_2 emissions by the equivalent of 180,000 return car journeys from London to Edinburgh.

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CIPFA The Chartered Institute of Public Finance & Accountancy

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For more details visit www.cipfa.org/NHSpathway

HFMA Annual Conference
4-6 December 2019
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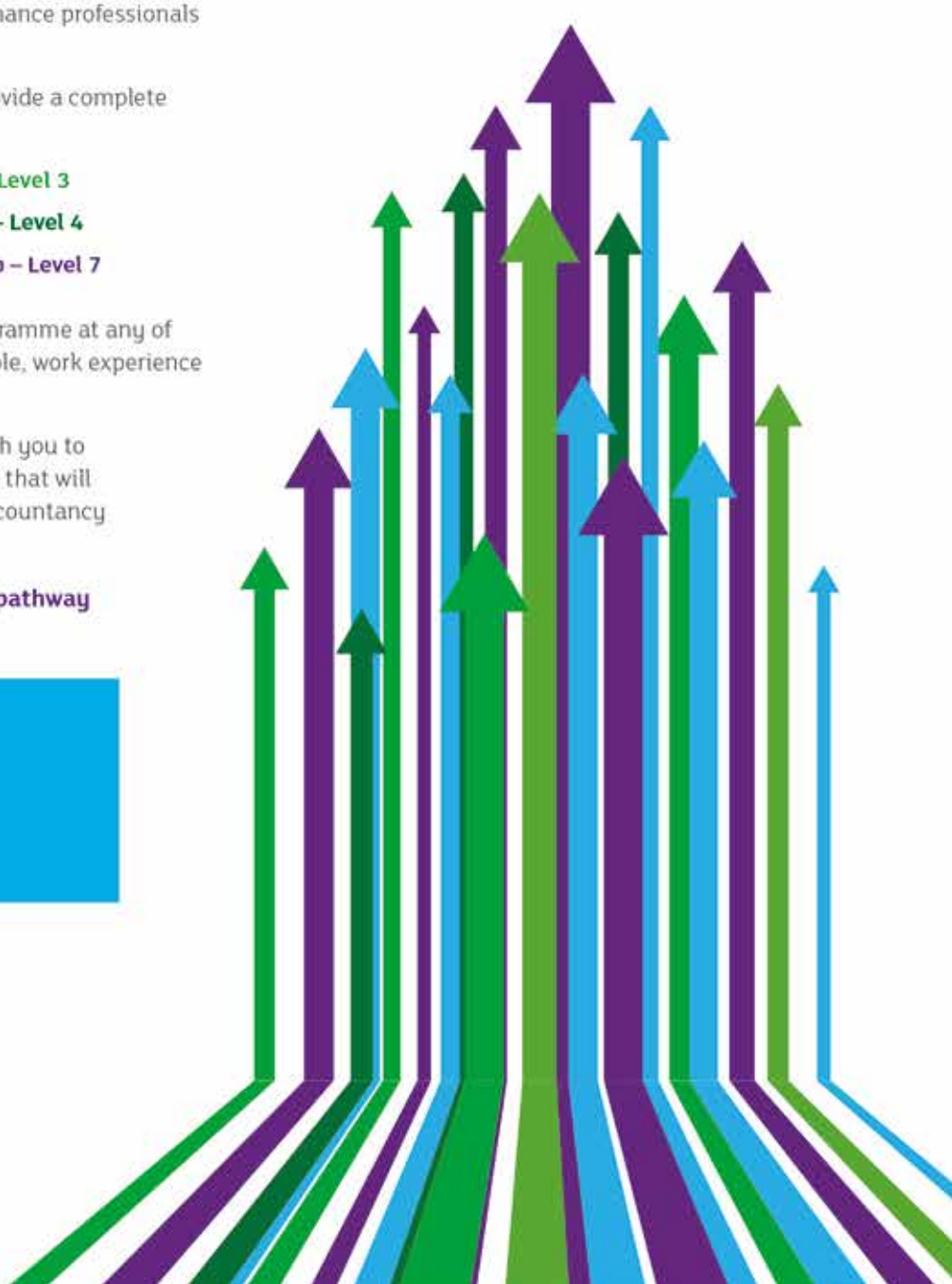

hfma Corporate Partner

Working together

Though the role of finance business partner is a relatively new one to the NHS, it promises much – both for employing bodies and the individuals taking the posts. The HFMA, Future-Focused Finance and ACCA have put together a briefing looking at what it means in the NHS and how the role could develop. Seamus Ward reports

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Over the last few years, the phrase finance business partner (FBP) has crept into the rich vocabulary of NHS finance. It is a role that can offer something different to the well-established and defined jobs within the finance function. Although the job description and line management can differ from organisation to organisation, the main focus of the role is on enhancing value by working closely with clinical and operational managers, providing a link between frontline care and the finance department.

But what skills do aspiring FBPs need? What are the common responsibilities? And how might the role develop? A new briefing from the HFMA, in partnership with Future-Focused Finance and ACCA, aims to shed light on these questions and more.

The briefing, *Exploring the role of the NHS finance business partner*, throws the weight of the three organisations behind FBPs. 'As a result of this research, FFF, ACCA and the HFMA strongly recommend that any NHS organisations without FBPs as part of their financial support to clinical and corporate services should consider implementing them and begin benefiting from the advantages they can bring,' it says.

FBPs often have titles such as divisional accountant or senior finance manager. For many FBPs, it will be the first finance role where they move away from day-to-day standard reporting and analysis, but that may require a step-change in their understanding of the clinical services being provided.

Each organisation may define the role of the FBP differently. Some will place the FBP in the operational team they support – others will keep them within the finance department.

According to ACCA, the FBP is a core part of the management decision team, and uses financial information to influence and shape outcomes, taking account of both financial and strategic objectives.

Together with PwC, ACCA introduced the four-box finance model in a report *Market change is faster than ever – is your finance function in the race?* The boxes, which describe the role of the finance function in an organisation, are: communicator; business partner; scorekeeper; and diligent caretaker. Scorekeeper and diligent caretaker roles are the traditional core accounting activities. The communicator and business partner roles move the focus to communicating the results of transactions and reconciliations and providing insights through the analysis of data. By moving their duties to the communicator and partner roles, the FBP plays a key role in decision-making and strategy.

FBP responsibilities can differ and overlap with colleagues in other finance roles (*see table overleaf*). Some will have no day-to-day

scorekeeper or caretaker duties – usually in a large organisation – and act as the strategic finance presence in a number of clinical divisions or services. Others have a wider portfolio that includes some of the traditional accountancy roles, but support a small number of clinical services.

Communication skills

With its outward-facing nature, the FBP role requires good communication skills, not just to engage with senior managers and clinicians but also to make strong links with all involved in the provision of services. This is central to the role, which can help to forge closer links between clinical and finance staff to enhance efficiency and productivity.

The FBP role has also emerged as automation reduces the time needed to complete scorekeeper duties such as invoicing and reconciliation, shifting finance teams' focus to value-adding work. FBPs now look at outcomes and other elements of value-based healthcare. Though the role is evolving and can include a range of duties, the FBP report says two abilities came up repeatedly when finance business partners and their stakeholders discussed what makes a good FBP:

- They must have a deep understanding of the business – knowing what drives the financial position of a care group or division, identifying who to speak to and being able to communicate the wider context, not just the figures. Shadowing operational colleagues, spending time in clinical departments and attending relevant meetings can deliver this understanding
- FBPs should also act as a link between finance and operational services – facing both ways, they should share their understanding of clinical activity with finance colleagues, and their financial knowhow with operational staff. This knowledge should be delivered in a concise and engaging way to help round out understanding of the organisation's operational and financial aims.

These skills mean FBPs are problem solvers, helping them and others identify the best option when facing questions such as resolving coding anomalies or how to achieve safe staffing within budget.

"You can tell a clinician: 'You can do five of those treatments or four of those'. If you give people this type of information they respond better"
Andrew Bone, NHS Lothian

The FBP role can make the job more stimulating, but the benefits are not restricted to individuals and extend to employers, the briefing says. These advantages include: the provision of expert financial advice to inform better decision-making; a financial presence at an earlier stage of developmental discussions; and improved relationships and understanding across operational and support services.

Lines of accountability

To maximise the chances of success, organisations must ensure that FBPs have clear lines of accountability. There must be an awareness across the organisation of the expectations for the role, and of how it fits with the other well-defined finance posts. While becoming an FBP might be a natural step for an NHS management accountant in some organisations – and some FBPs retain their management accounting duties – there is a question mark over how much management accounting work FBPs should be given.

The research found that where the role includes management accounting responsibility, it is important that this is not the overriding duty, allowing FBPs the time to focus on strategic objectives.

Location – whether FBPs are placed in operational teams or the finance department – was found to be less important than accessibility and visibility to the operational colleagues they support.

Where managed in the finance department, usually by a deputy or assistant director of finance, the operations director usually also has a role in managing the FBP, taking part in

FBP case study: NHS Lothian

NHS Lothian finance business partner Andrew Bone's role is as close to that of a mini-finance director as any of the FBPs interviewed for the briefing.

He provides finance support at one major hospital site, the Edinburgh Royal Infirmary, and for strategic programmes – scheduled care and cancer performance – that run across a number of NHS Lothian sites.

This involves meetings with senior managers and clinical teams, but also more strategic teams on, for example, waiting times or a business case being developed on emergency access to the Royal Infirmary.

Speaking to *Healthcare Finance* he says: 'Day to day, it's about being a partner who tries to influence hospital planning in the medium to long term; to think in terms of financial sustainability; and take into account non-financial

factors to deliver the right outcomes for patients.'

He adds that he must help design services that are as efficient as possible, considering factors such as maps of care, community settings, workforce sustainability and financial affordability.

'A big part of the job is making sure things like documents around financial planning and savings plans have been created, but also that programmes are driven forward, so there is a leadership role there too.'

He says finance staff are in a good position to make a difference because they can quantify resources and identify issues, and express both in a way people understand. This leads to more informed decision-making. 'We have a common language, which is money. You can talk to a clinician and say: "You can do five of those treatments or four of those – where do you want to prioritise?" If you give people this type of information they respond better when asked to make choices.'

Though he has no direct responsibility for everyday finance activities, Mr Bone says the reality is that many FBPs will still have to do this 'nuts and bolts' finance work. However, NHS Lothian has designed its finance function so its FBPs have taken a step away from duties such as month-end reporting.

'I need to have an understanding of the financial reports, but I don't have to worry about the day-to-day stuff. My eyes are fixed on the horizon and the planning and design of services in the medium to long term, with as much value as possible.'

appraisals and objective-setting. FBPs located in finance departments told the researchers they were more likely to spend most of their time in finance at month-end, while the rest of their time tended to be spent supporting operational and clinical colleagues in their departments.

In the field

In larger organisations, FBPs are often located and managed in operational teams, reporting to the operations director. However, the report says that if placed in a service team, the organisation must be mindful that an FBP's professionalism means they must remain objective. It adds: 'Being too entrenched within a service to be able to provide a robust challenge or offer new solutions to recurring problems is a risk that organisations and individuals need to be mindful of.'

The researchers found few reports of conflicts, though disagreements and differences of opinion were natural in an environment where all are trying to do their best for patients, the briefing says.

HFMA policy and research manager Andrew Monahan – the author of the briefing, who has worked as an FBP – says his research found that finance and non-finance staff were passionate and enthusiastic about the role and its ability to make a difference to patient care.

'This briefing provides an insight into what the role involves and the type of people who are likely to be best suited to it,' he says. 'Through the emergence of business partnering, the finance function is adapting to the changing needs of organisations and advances in technology in order to provide a more proactive, forward-looking support service that can really add value.'

As well as examining the current position, the briefing looks at how the FBP role could develop. It says FBPs could work across systems following the emergence of sustainability and transformation partnerships and integrated care systems.

This is happening in parts of the NHS in England and in Scotland (*see box*), where system working is more established. Working across systems could lead to greater autonomy for FBPs or higher levels of responsibility within an organisation – perhaps reporting directly to the director of finance.

The FBP role also gives finance staff a chance to develop the skills needed for senior finance roles and many current heads of financial management, associate directors and deputy directors – as well as some finance directors – have previously been FBPs.

"Through the emergence of business partnering, the finance function is adapting to the changing needs of organisations"
Andrew Monahan, HFMA

'The FBP is now one of the key roles in a trust's finance function,' says David Ellcock, FFF programme director. 'While it is not essential to have been in such a role to progress up the career ladder, it undoubtedly allows you to hone many of the skills that are essential to operate successfully at higher levels.

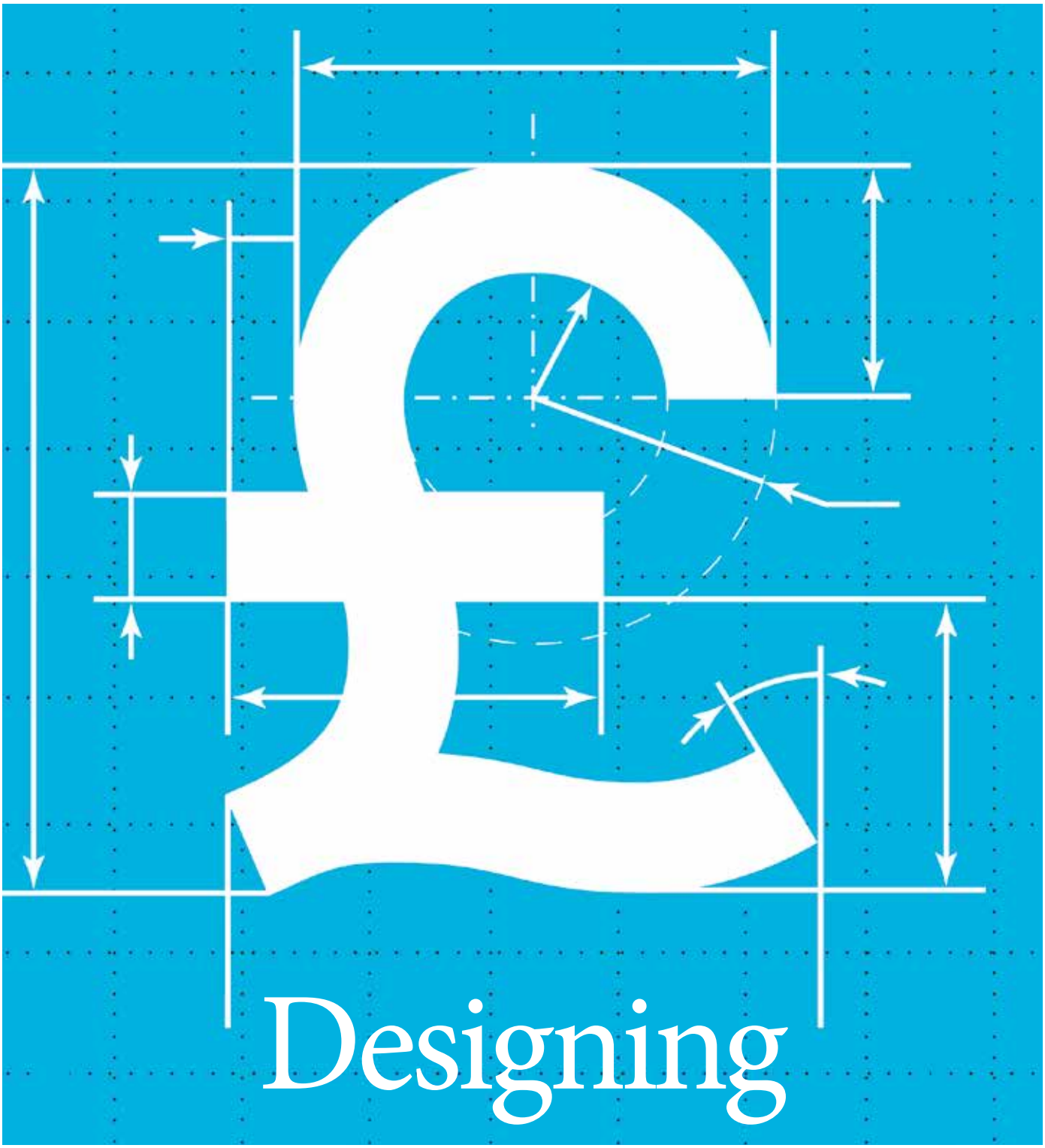
'Above all, it encourages you to see things from a clinical perspective and to understand what finance can, and should, do to help clinicians achieve their goals.'

A separate report from the HFMA, FFF and PwC, *NHS finance: designing our future* (*see page 22*), says the FBP role will grow, but they will need effective communication and analytical skills to help inform organisational and system strategy.

Finance business partner is a relatively new role that has great potential to help NHS accountants move into more senior finance positions, or even to develop an interest in operational management. But it is also a role for the times – if done well it can foster greater collaboration between finance and clinical teams, helping to reduce inefficiency and improve services for patients.

FBP RESPONSIBILITIES

Core FBP responsibilities	Potential overlaps with other finance roles	Management accounting function often undertaken by an FBP
Finance lead (mini-FD) for a care group/ division/locality	CIP/QIPP monitoring/delivery	Undertaking/overseeing month-end processes
Financial support and challenge for operational teams	First point of call for all things finance	Monthly reporting
Financial lead for business cases and tendering exercises	High-level budget-setting	Detailed budget-setting
Scenario modelling and financial planning	Structured finance training	Ad hoc requests for invoice processing, small budget adjustments and rota costings
Using costing information to improve service efficiency and productivity		
Interpreting finance data and providing a clear message of wider NHS financial environment		



Designing our future

The *Interim NHS people plan* aims to ensure that the NHS of the future has the right clinical staff working in the right way to meet its needs. Now a new report aims to do the same job for the NHS finance function. Steve Brown reports

The NHS finance function has a major and exciting role in delivering the *NHS long-term plan,* but it needs to change the way it works and ensure it has the right skills to play its full part.

This is the headline from a new report published by Future-Focused Finance, the HFMA and consultancy PwC – *NHS finance: designing our future* – that starts to develop a vision for the NHS finance profession and seeks the function's views on the opportunities and challenges it faces. It explores the impact that new technology will have on the role played by finance teams and how the function may need to adapt to support greater system working.

The report starts by underlining the point that finance professionals already make a significant contribution to the success of the health service – choosing to work in NHS finance to make a difference to people's lives. However, it also acknowledges that 'there is work to be done' if the function is to continue providing optimal support to ensure better decision-making leads to better health.

"There aren't enough people in outward-facing business partner-type roles and the people in these roles have too many distractions"
Josh Walker, PwC

Rising to the challenge

The report grew out of a challenge from the NHS Financial Leadership Council and looks to identify what needs to happen to build the NHS finance workforce of the future – just as the *Interim NHS people plan* focused on ensuring the NHS has sufficient, appropriately skilled clinical staff to meet its future demands. The goal (*see Vision statement, overleaf*) is for an innovative finance function that is highly rated with a make-up that reflects the community it serves and one that both develops its own staff and attracts the best from other sectors.

'As well as drawing on FFF and HFMA resources, we brought in people from outside the service because we deliberately wanted to ensure we explored more radical ideas and ideas from outside the NHS,' says David Ellcock, FFF programme director.

'Some 200 finance professionals have been involved in the thinking behind this report, but the intention was always to go back out to finance staff in the service as they need to own this vision. So we are very serious about wanting to hear the views of the function – and others – about this vision for finance. Does it make sense and, if this is the right vision, what do we need to do now to prepare for it?'

The joint report sets out the significant challenges facing the NHS in the coming years. An ageing population and increasing levels of long-term conditions will place additional demands on a service whose care model has stayed broadly the same since the NHS was created.

The NHS has identified a broadly supported plan of action – more personalised support and care with a greater reliance on digital technology, a greater focus on prevention and the wider determinants of health, and a more collaborative approach to delivering integrated care that meets the needs of patients. But it needs help getting there, especially given major challenges in terms of funding and staffing levels.

It will require a finance function on the top of its game and totally focused on the things that add most value. Increasingly, finance will be concentrated on the delivery of value across systems and at population level. Within the current structures and system of regulation, finance teams must continue to support individual organisations. But at the same time, they need to help systems to start looking more broadly at the implications of decisions on the whole system.

Mr Ellcock says finance must be at the forefront of the value agenda. 'Finance staff, working with informatics colleagues, have access to and the skills to turn wide-ranging data into information that makes sense to clinicians. They have to be in the driving seat on this issue, interpreting numbers and presenting data in a powerful way that helps to tell a story.'

Relationships with clinical staff – well established in some areas – will need to get closer and far more widespread, with finance increasingly working as business partners to address unwarranted clinical variation and support continuous improvement. More time will be spent on analysis and less on data gathering, with transactional activities increasingly automated, creating time for more value-adding work.

'There aren't enough people in outward-facing business partner-type roles and the people in these roles usually have too many distractions,' says Josh Walker, a director with PwC. 'They often spend more time data-gathering rather than rapidly interpreting that data and communicating with frontline teams to improve the decisions that will affect patients' health, staff experience and taxpayer value.'

Technology has huge potential to support NHS transformation. Understandably the focus is on its role in frontline services. Genomics will drive the personalisation of care. Virtual consultations will bring radical changes to outpatient and general practice services. And diagnostics and monitoring could be undertaken in people's homes thanks to advances in wearable technology.

Technology also has the potential to transform back-office data-gathering and routine processes. Cloud computing, blockchain, artificial intelligence and robotics all have the potential to help (*see box below*).

Working with technology

• **Cloud computing** is already being used in some parts of the NHS to give instant access to stored data from a range of network connections. But *Designing our future* says it has the capacity to further simplify data flows, improve standardisation and enhance communication across organisations and systems.

• **Blockchain** has potential to transform practices in the NHS finance function. It offers the possibility of recording and verifying transactions simultaneously in real time, eliminating overheads and the need for individual payments between organisations. The report says that, with a large proportion of transactions being internal, blockchain could be the catalyst for removing the inefficiencies of multiple payments and reconciliations.

• **Artificial intelligence** is set to have a major role in the move to population health management, enabling systems to understand patterns of need and forecast how these may change in the future.

• **Robotic process automation** (RPA) could take on many high-volume, low-complexity tasks that are often repeated daily, weekly, monthly or annually. This will speed up processes and free staff to work on more value-adding activities and potentially enhance accuracy and consistency. Faster speeds may also support the delivery of more timely information for decision-making.

Together, these technologies could help the finance function to deliver real-time data and insights, leading to better allocation of resources and improved investment decisions.

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INVESTING IN COMMUNITIES, BUILDING FOR THE FUTURE

Research carried out by PwC and commissioned by FFF – published alongside the *Designing our future* report – concludes that the NHS needs to urgently invest in technology to support NHS finance.

It calls for the number of separate systems used to be significantly reduced and functionality enhanced to provide 'real time, high quality insight'. According to the consultancy, this should involve standardising finance ledgers to enable faster consolidation, analysis and benchmarking.

'There is still a lot of time spent pulling data out of ledgers and putting it into spreadsheets to then send to the centre to be consolidated again,' says Mr Walker. 'There has to be a better technological solution that would improve accuracy, speed up the flow of information and free up senior time for better use.'

The *Designing our future* report recognises that the future finance function will look different. 'We need to be honest,' says Mr Ellcock. 'There will undoubtedly be fewer roles at the processing end of the spectrum – robotic process automation is coming down the line.'

"We are very serious about wanting to hear the views of the function – and others – about this vision for finance"
David Ellcock, FFF

Changing roles

However, at the same time, the function will need finance staff increasingly to take on business partner roles. For many people in NHS finance, this will mean more exciting and fulfilling roles and greater levels of engagement leading to better value.

A smaller number of organisations – initially as commissioners come together – will mean that not all senior posts will be at board level. So, instead of the classic hierarchical pyramid, the workforce will be shaped more like a flat-topped diamond.

Simon Worthington, director of finance at Leeds Teaching Hospitals NHS Trust and a member of the Finance Leadership Council, believes changes will emerge over time, pointing out that the report is a long-term vision. 'We need the right number of NHS finance staff to support the service,' he says. 'The team needs to support the service to be more productive and be more productive itself. We haven't tried, and won't be trying, to do a calculation of what this means for the workforce size.'

However, the service will need to think about how it makes the transition. Career paths will change and a finance function that wants to retain its staff and keep their experience will have to accommodate different working practices – part-time working mid-career, for example, or finance directors who want to remain working but step away from the most senior roles.

'Staff development will be key to all this and staff will need to be given the right opportunities to develop,' says Emma Knowles, director of policy and research at the HFMA. 'We need to have a clear idea of what we'll have to deliver and take steps now to make sure we will be in the right position to make that happen.'

This will mean establishing the finance function as a diverse group that can attract the best finance professionals to work in the NHS and provide relevant career development opportunities.

The report is also clear that this is not the sole responsibility of central authorities. Finance staff need to take personal responsibility for their own careers, taking advantage of personal development opportunities and understanding where they need to improve skills or develop new ones.

Even with greater process automation, staff will need to retain the corresponding technical skills in case of error or fraud and to be able to confirm the legitimacy of any warnings. But on top of this, staff will increasingly need analytical capabilities to interpret data and communicate it effectively across systems. And, as finance staff focus more on business partnering roles, they will need to need to build communication, influencing, planning and negotiating skills (*see Working together, page 19*).

The report also explores some specific challenges facing the finance function. The current underinvestment in back-office technology needs to be addressed to access benefits such as greater accuracy, efficiency and timeliness. But resources are tight and, understandably focused on frontline care. The report acknowledges that shared services could offer a solution. But it insists that this has to be balanced with retaining sufficient local flexibility to enable systems to report and monitor work to deliver local population health issues.

And what of the move to greater system working, with the establishment of integrated care systems by 2021? The report says that 'acting as a single finance function within the NHS' would help to enable this new way of working and asks finance practitioners for their views on whether finance teams or certain activities could be consolidated across wider areas. Mr Walker says this is not necessarily about merging teams, but about practical steps that would pool capacity within systems.

'Each month practitioners are pulling together reports that someone else in another organisation is also pulling together from the opposite point of view – that can't be the optimum way of doing things,' says Mr Walker. He would like to see organisations connecting finance people across the system at all levels and looking for opportunities where activities could be undertaken together rather than in isolation.

Mr Worthington says more joined-up working practices are emerging, with finance teams finding ways to work differently and be more productive as the service focuses on integrated care systems. 'This is something that will evolve differently in different places dependent on how local organisations and systems are structured,' he says.

It is now over to the finance function for its feedback and input. There will be opportunities to discuss the document in the new year at national and regional events, and this will be backed up by an online engagement platform that aims to give everyone in NHS finance the chance to have their say.

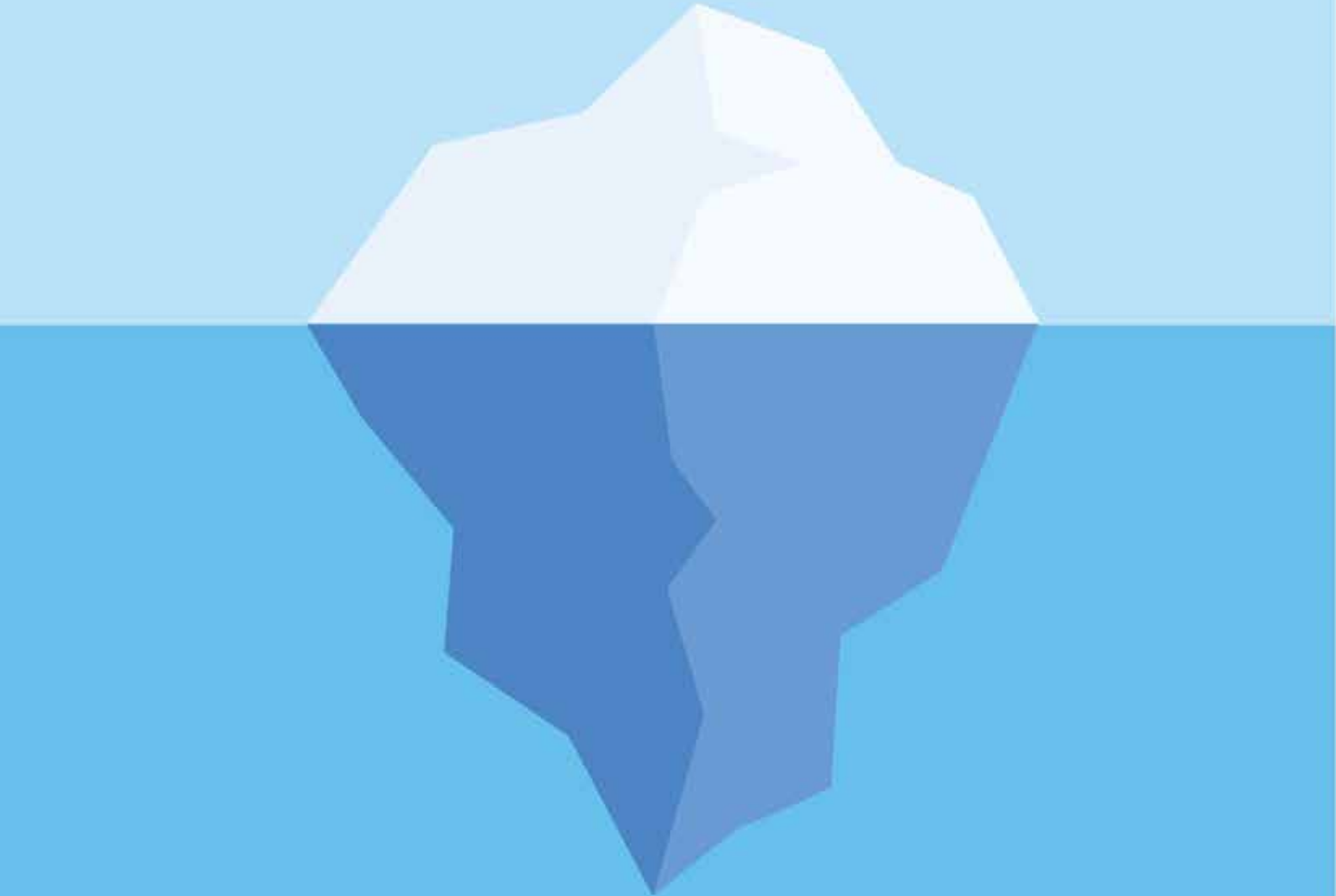
'*Designing our future* is currently based on the thoughts of 200 senior NHS finance staff,' says Mr Worthington. 'The report will not be finalised until all staff have had an opportunity to input and we have taken their views on board.'

Vision statement

Designing our future **says: 'Our vision is that working in NHS finance is something to which people aspire. It will be consistently rated as one of the best and most diverse employers in the country, developing its own staff and attracting the best from elsewhere. The profession will be recognised as a key ingredient to delivering world-class healthcare, innovating to drive value and enabling the best outcomes for patients.'**

WHY FREE CAN COST MORE

NHS expenses leader, Selenity, explains how the company is cultivating innovation and value for the healthcare sector.



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> Ultimately, we want to free up their time so they can focus on delivering the best possible patient care.

A large part of our work is of course around making working lives easier but equally it's about protecting people and keeping them safe. We know that driving is a big part of the job and with the NHS Agenda for Change stating that employers must ensure drivers and vehicles have valid documentation, Selenity is the only provider to incorporate MOT, licence, insurance and tax checks into the mileage claiming process.

We're also looking to take this a few steps further, integrating with third-party route planning applications and feeding that information directly into Selenity Expenses. Additionally, we're building accident support functionality into our mobile application. Whether a minor bump or something more serious, a road collision is a stressful time and it can be difficult to think clearly. From taking the details of the driver to taking pictures of the scene and recommending witnesses, our aim is to guide users through each step helping them to document any incidents whilst at the scene.

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We're looking at ways to automate the check in/check out appointment process and provide staff with another avenue of communication to supervisors and managers. With our app running in the background, we'll be able to track average visit times and flag instances where appointments take longer than usual – alerting managers when employees might need assistance. As healthcare workers become more mobile, working alone or remotely in the community, we're developing our products to meet the needs of NHS organisations and help them protect NHS staff.

> Our focus on innovation and customer service has saved the NHS on average £33 million each year.

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Neil Everatt, CEO, Selenity

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the right blend

Blended payments are seen as a way of supporting a more collaborative approach to service development and a step towards population-based funding. Steve Brown reports on plans to expand their use

The *NHS long-term plan* committed the NHS to reforming the payment system. The longer term aim is to move away from activity-based payments to ensure a majority of funding is population-based, potentially using capitated outcomes-based budgets to cover a broad range of integrated care services.

But the plan also set out the goal of moving to a blended payment model for all services. Having started the move this year, NHS England and NHS Improvement are now set to expand the approach in 2020/21.

Blended payments may not deliver on the population-based payment commitment – but they are seen as a stepping stone towards it. They are viewed as a better way of supporting more integrated care and the development of new patient pathways or models of care. While some fixed payments may initially be derived based on historical activity and current prices, the approach would allow for different mechanisms to be used in the future – such as linking payments to population-based information – once the data has been made available to support this.

Under traditional episodic payment approaches (and without further controls in place), increases in activity above plan might typically lead to increased cost for the commissioner and increased income for the provider. Shortfalls in activity might reduce income for a provider despite the fact that fixed costs remain in place. The financial incentives were not seen as reinforcing a collaborative approach to reducing avoidable demand or meeting that demand in a different way.

Blended payment aims to address these issues. It is described as a framework rather than a single approach and is inherently permissive, with the intention that it should be adapted to local requirements. In fact, it is suggested that there could be multiple blended payment approaches within one local health system, tailored to the needs of different patient groups or services.

The approach uses an 'intelligent' fixed element. It is 'intelligent' in the sense that it is based on

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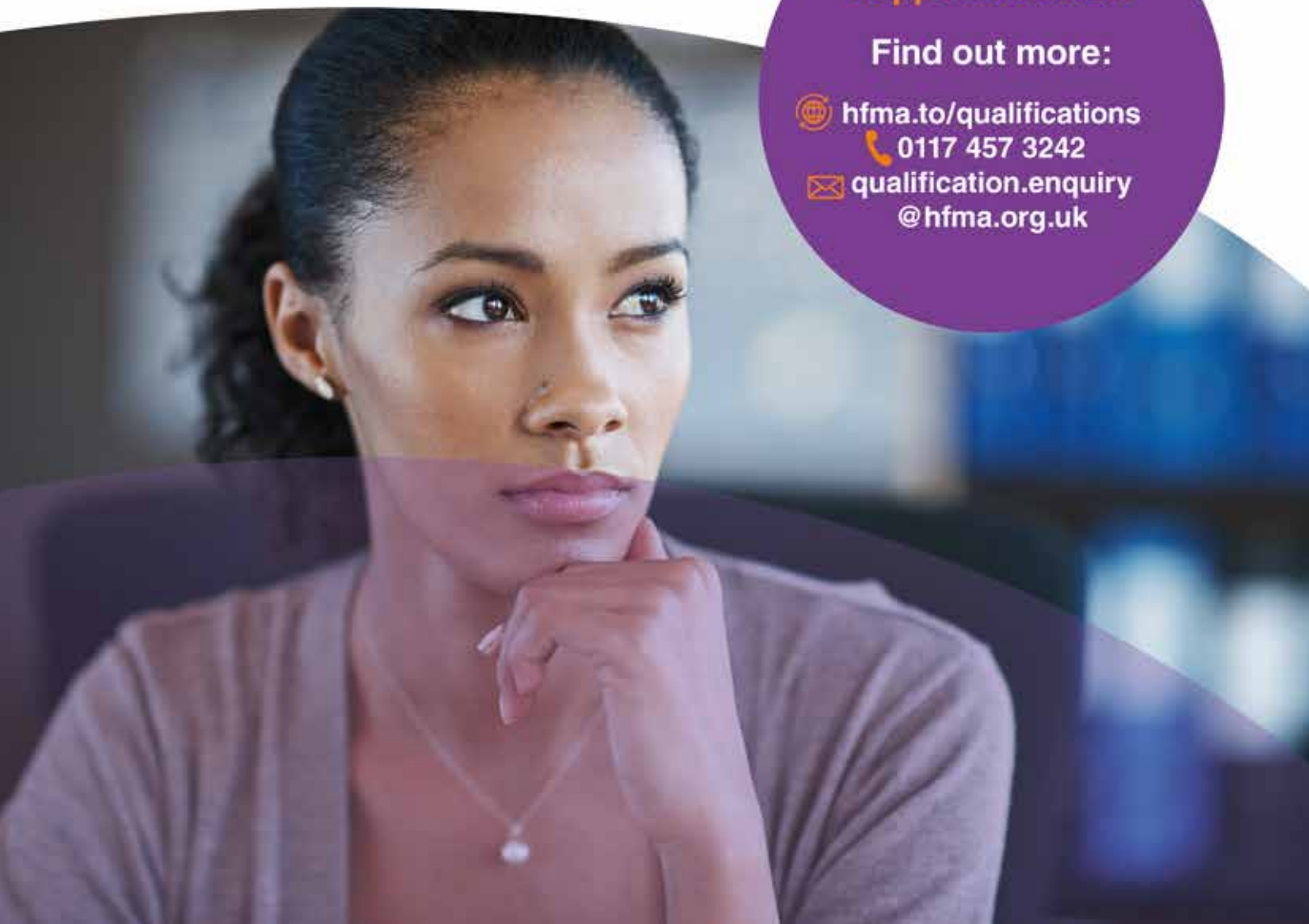

forward-looking forecasts of activity and best available cost data. This is a pronounced change on the approach used with the old marginal rate emergency tariff (MRET), where the activity was set at a baseline level from a much earlier year and often had little in common with current levels of demand. This fixed payment can then be combined with one or more of variable, risk-sharing and outcome-based elements.

The flexibility continues with the ability to assign different proportions of contract value to each of the elements, depending on the objectives that local areas are trying to achieve. It is even possible that the core, fixed element isn't the largest proportion by value.

The hope is that with a robust and agreed baseline for activity, organisations can share any financial and activity risks across all system players

And it is not being forced on local health systems. If systems have risk sharing mechanisms in place that work for the local system, there is no requirement to replace this with blended payments, although variations to national tariff approaches should be reported.

Emergency services

The move to blended payments began with the 2019/20 national tariff, when blended payment was established as the default approach for emergency care and adult mental health services. For emergency care, the blend included a fixed payment calculated as the value of the forecast activity at national tariff prices – reduced by the 2017/18 value of the MRET and 30-day readmission rules.

The fixed payment should allow for excess bed days. In principle, this creates an opportunity for providers and commissioners both to agree targets for reducing excess bed days, but also to agree what needs to be in place to enable the provider to move to earlier discharge. Ideally, this would involve other providers and commissioners with a role in supporting discharge or improving demand management. However, it inevitably becomes more complex the more partners that are involved.

In effect, there is then a 20% marginal rate for activity above or below this forecast, although this is actually calculated based on overall values. Where the value of actual priced activity is higher than the value of forecast activity (before MRET reductions), the provider would receive 20% of the difference. And if activity is below the forecast level of priced activity, the provider would retain 80% of the difference.

Lee Rowlands, contracts director at Manchester University NHS Foundation Trust and chair of the HFMA's payment systems and specialised services committee, says it is too early to call how the new approach has bedded-in. 'Some areas will have tried to run variations on it and some areas will already have had similar approaches in place prior to the national policy,' he says.

Within Greater Manchester, for example, a mixture of arrangements were already in place to share risk between providers and commissioners and across a wider range of services than urgent and emergency care. These were set up under local agreements using different models including fixed value contracts, caps and collars and aligned incentives.

NHS England and NHS Improvement publish details of local variations from national tariff rules. This is unlikely to be comprehensive, but shows a number of commissioners have adopted different payment arrangements with providers.

These variations range from remaining on payment by results activity-based contracts to block contracts with caps and different marginal rates. In one case the marginal rate ranges from 20% to 100% depending on the percentage of actual activity value compared with the value of planned activity.

Although there has been no official confirmation, it is believed that the majority of commissioners/providers have adopted something that is following the spirit of the policy. This could involve aligned incentive arrangements across a broader range of services, the blended payment arrangement as described in guidance, or a variation on it.

In previous years, there has often been a gap between the activity included in commissioner plans and that assumed by providers. This undermines attempts to deliver system-wide balance, as at least one of the plans must be based on wrong assumptions. This has continued despite calls to ensure agreement and was arguably reinforced by an MRET system that set an unrealistic baseline based on an old activity level. There is no information yet on whether the activity levels agreed as part of the new payment approach have more accurately tracked actual activity as the year has progressed.

Rather than arguing over activity levels, the hope is that with a robust and agreed baseline for activity, organisations can then share any financial and activity risks across all system players. And they can spend their time working together to address increases in activity and avoid unnecessary admissions.

Mental health

The context for mental health was different. The introduction of blended payment follows years of trying to move services away from the use of simple block contracts, which often fail to recognise rising demand and changing complexity, and to support the mental health investment standard increase in mental health funding.

In addition to fixed and variable elements, for mental health there is also an element linked to locally agreed outcomes. This builds on work in recent years encouraging local systems to link payment for mental health services to outcomes – arguably putting the sector ahead of acute services in this area.

For mental health, the fixed payment takes account of historic activity and unit costs. With no comparable national tariff in place, this is not as straightforward as multiplying forecast activity by published tariff prices.

However, it should enable providers to put issues such as rising complexity and increasing quality demands on the table. Providers have complained that under block contracts, the increased costs associated with rising complexity are normally overlooked. According to guidance, the variable price should then reflect the 'best possible estimate of the incremental costs of activity increasing or decreasing'.

An outcomes element – linked to outcomes such as access to cognitive behavioural therapy and the provision of crisis plans – was recommended to be worth a minimum of 2% of the total contract value.

These approaches to emergency care and mental health services payment will be rolled forward into 2020/21.

Outpatients

But under new proposals set out in the tariff engagement document *Key areas of work for the 2020 national tariff* – consulted on in November – the approach will be expanded to a number of new areas. For a start, blended payments will be used to support the long-term plan promise to redesign outpatient services, which aims to remove up to 30 million attendances a year over the next five years.

As an initial step, the proposal is simply to

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Need

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reimburse all outpatient attendances next year using blended payments. Then from the following year, activity would start to be grouped and paid for by specialty. It is believed that this second stage could allow outpatient attendances to be grouped, for example, into those related to an elective care episode and those supporting patients with long-term conditions.

With the right data collection to support this, this might then open up the possibility of payment being bundled into the elective care pathway rate or supporting a year of care for long-term condition patients.

The largest element of the blended payment would be fixed, calculated on locally agreed activity volumes and national prices, where these exist, and agreed local prices for other activity. It should also include the set up and running costs of advice and guidance services.

This would then be complemented by a risk sharing agreement. The proposal is that this risk share should not reimburse additional activity as a pure activity-based variable element.

Instead it would 'recognise that there may be either cost or performance implications if service demand increases outside of the direct control of the provider'. So, the risk share might distinguish between increased activity arising from GP or from consultant-to-consultant referrals. An optional outcomes-based element could also be incorporated.

In its response to the engagement document, the HFMA calls for further guidance to avoid difficult local discussions to set values. There were also concerns about extending the model to NHS England's specialised services.

"By moving from a transactional, confrontational approach to something more collaborative, relationships can shift quite quickly"
Gary Andrews, NHS England and NHS Improvement (pictured)

Maternity

The engagement document also suggests extending blended payments to maternity services with the relative stability of birth numbers and the importance of having capacity in place making it ideal territory.

Currently services are paid for using a three-part pathway approach. Providers receive one single prospective payment to cover all of a woman's antenatal activity – with three different levels of payment based on complexity – and then another to cover postnatal activity. Births are paid for on a birth-by-birth basis – with six different prices paid retrospectively and a single price for home births.

Under the engagement document proposals, this would switch to blended payments from next April – a separate blended payment for antenatal care, births and postnatal care.

The approach helps to tackle one of the current problems with the current pathway system – provider-to-provider payments triggered when a non-lead-provider undertakes antenatal or postnatal activity.

Matthew Jolly, national clinical director for maternity at NHS England and NHS Improvement described this as 'competitive cross charging chaos', when he spoke during an NHS England and NHS Improvement tariff webinar during the summer.

'There is currently a lot of administrative effort going into getting a small amount of extra money,' he said. 'Instead all of the financial reconciliation between units would happen at CCG level,' said Mr Jolly, 'reducing a huge amount of time, burden and stress.'

So for maternity services, the fixed payment would take into account planned activity at national prices plus any system investment. For example, this could include any recognition of transition costs that some areas may want to factor in when moving to a continuity of care model.

There would then be adjustments to provider payments based on the historic net income flows between providers in the local maternity system.

A risk share element would share the financial impact of risks – such as a different casemix than anticipated or other issues. 'For example, if there is an estimate on how much continuity of carer could cost the system included in the plan, there may be an estimating error and the system could agree to share that risk,' Gary Andrews, the new care models pricing manager at NHS England and NHS Improvement, told the same summer webinar.

There are also plans to pilot blended payments for adult critical care services. It is clear that NHS England and NHS Improvement see blended payments as the future – or at least a stepping stone to future payment systems. They are designed to support greater collaboration and system working to deliver more integrated care. But they accept that this will not happen overnight.

In fact, Mr Andrews told the webinar that the move to blended payments should be seen as an iterative process. While blended payments are likely to work best in mature systems, they should also help systems to develop better relationships. 'By moving from a transactional, confrontational approach to something more collaborative, relationships can shift quite quickly with a focus away from income chasing and arguments towards the management of system costs,' he said. 'So blended payment should improve relationships, which will in turn lead to better designed payments.'

On that basis, it is understandable that NHS England and NHS Improvement are keen for systems to adopt the new payment approach as soon as possible.

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Annual reports and accounts face major change to meet users' needs

Technical

The very last House of Commons select committee meeting before Parliament was dissolved ahead of the general election was a session of the Public Administration and Constitutional Affairs Committee (PACAC), *writes Debbie Paterson*. Members of the PACAC questioned Treasury officials on their review of government financial reporting.

The reason for the session was to follow up on PACAC's reports *Accounting for democracy: making sure Parliament, the people and ministers know how and why public money is spent* (published in April 2017) and *Accounting for democracy revisited: the government response and proposed review* (published in June 2018).

The central argument of these reports was that financial information in government had four purposes:

- To maintain and ensure the House of Commons' power over the government
- To enable the public and Parliament to assess the value for money of the delivery of public policy
- To provide a credible record that can be relied upon externally
- Internally to provide ministers and officials with the information they need to run departments.

To meet these needs, PACAC wanted annual reports and accounts to include the cost of policies, programmes and projects. The focus of the annual report and accounts would therefore be the best interests of potential users of them – with Parliament being the main user of departmental annual reports and accounts.

As a result of these reports, the Treasury has reviewed and revised its *Financial reporting manual* (FReM) for 2020/21. The consultation on the revised FReM has just finished and the HFMA responded to that consultation.

This is the first phase of a two-stage review process. So, the 2020/21 FReM has been amended to introduce the new requirements, concepts and principles that preparers are expected to follow. The second phase (in 2021/22) is intended to make the FReM as user-friendly as possible.

DHSC accounts would in future have to report progress against policy announcements such as the recent capital building programme

During the select committee session, Treasury officials indicated that they expect the amendments to the FReM to result in 'the biggest change in annual reports and accounts since 2014'. And this will call for a cultural change.

The proposed changes to the FReM focus on the front half of the annual report and accounts – the annual report. The FReM is moving from setting out the minimum requirements for the annual report to setting out best practice and making clear the requirements that must be met and those that are best practice.

Some requirements will be on a comply or explain basis – either the disclosure is made or an explanation is provided as to why it has not been made.

The performance report will have to include trend data to provide context for the user of the annual report and accounts. The only acceptable reason not to provide that data is if it is not available – then there would be an expectation that it will be collected and published in time.

The proposals are also to embed risk management in the annual report and accounts. For government departments, there will be requirements to set out progress against the single departmental plans.

Wherever possible, departments will be required to report by policy, programme or project and engage with their select committees to understand what their requirements are.

For the Department of Health and Social Care (DHSC), this will mean engaging with the Health and Social Care Committee. This aims to put the focus on outcomes rather than inputs.

The committee specifically mentioned that it would want to see the DHSC reporting against the recent announcements around building new hospitals.

Looking ahead, the Treasury is considering how annual reports and accounts are presented – currently they are hard copy with electronic versions of the print copy being available.

There may be a move towards more interactive/web-based accounts, although this will be for consideration after phase two of the FReM review.

All of this will apply to the DHSC in 2020/21 rather than NHS bodies themselves. However, because the GAM and the *Foundation trust annual reporting manual* (ARM) have to be consistent with the FReM, it seems likely that these changes will have an impact on NHS organisations in 2020/21 as well.

Debbie Paterson is HFMA policy and technical manager

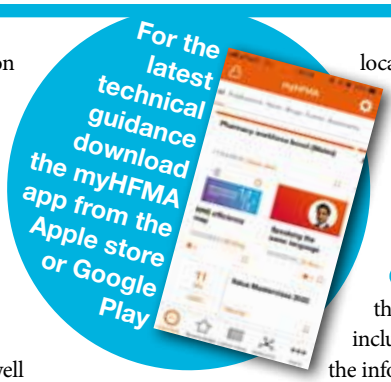
SHUTTERSTOCK

Technical review

The past month's key technical developments

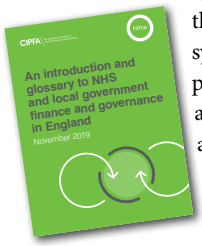
Technical

The HFMA has published a briefing on **accounting for leases under IFRS 16** to help non-finance staff understand this key change in accounting practice. The new standard will radically alter how lessees account for leases – removing the distinction between operating and finance leases. IFRS 16 will apply to NHS bodies in 2020/21 and the HFMA warns it cannot be dealt with by financial reporting experts in the finance team alone – engagement with staff throughout each organisation will be needed, as well as changes to systems and reporting arrangements. The briefing sets out what a lease is and how the accounting arrangements are changing. It identifies the potential impact on the financial position of NHS bodies as well as providing examples to allow non-finance staff to start to ask the right questions of their financial reporting colleagues. hfma.to/1aa



NHS England has published details of the **resource allocation models** for community services and mental health. The new community services model, developed for the 2019/20 allocations round, introduced a separate community services component for the clinical commissioning group services target formula. In previous allocation rounds, the resources for community services were distributed using the general and acute component of the formula. The mental health model is a refreshed person-based formula that more accurately reflects patterns of need and takes account of the use of improving access to psychological therapies (IAPT) services. Both publications provide practitioners with more details about these key changes to the allocation methodology. hfma.to/8at

The HFMA and CIPFA have updated an introduction and **glossary** to finance and governance in the NHS and local government in England, outlining the role of relevant national and local NHS and government bodies. It also covers partnership working between the sectors, including the use of pooled budgets and the move to sustainability and transformation partnerships and integrated care systems. hfma.to/7ar



NHS England and NHS Improvement have updated the **IFRS16 implementation FAQs**. New questions include the timing at which a CDEL charge is incurred, the information collected from NHS organisations and the application of Treasury guidance to subsidiaries that prepare accounts under IFRS 16 or FRS 102. hfma.to/4tr

The HFMA has responded to the National Audit Office's consultation on the ***Code of audit practice***, which comes into force in April 2020, applying to audits from 2020/21. Key changes apply to the auditor's work on economy, efficiency and effectiveness of corporate arrangements and reporting the results of the auditor's work. The association has welcomed the new audit approach to assessing and reporting on value for money and maximising the impact of local audit work. But it has highlighted the potential impact of any extra work on audit fees, which would be an additional pressure on NHS resources. hfma.to/8aq

The HFMA has raised concerns about the feasibility of implementing the blended payment model for maternity services, given the need for local systems to take on an extra financial planning role. The move to blended payment was proposed in a tariff engagement document setting out key areas of work for the **2020 national tariff**, published by NHS England and NHS Improvement for feedback in November. The association called for greater clarity on the transition to new market forces factor rates and details about the onward review of specialised top-ups. hfma.to/2ah

Ovarian cancer drug approved for drugs fund

Technical: NICE

NICE has recommended rucaparib for use within the Cancer Drugs Fund (CDF) as an option for maintenance treatment of relapsed, platinum-sensitive high grade epithelial ovarian, fallopian tube or primary peritoneal cancer that has responded to platinum-based chemotherapy in adults, *writes Steve Brown*.

The drug – recommended in technology appraisal TA611 – will be available at a reduced cost as part of a commercial access agreement between NHS England and Clovis Oncology. It is taken as a tablet, twice daily, and slows the progression of cancer by preventing cancer cells repairing, so slowing down the tumour's growth.

It is estimated that around 1,350 people per year in England will be eligible for treatment. The decision to recommend is a change from an initial decision, when there were concerns about uncertainties in the evidence and cost.

However, clinical trial evidence shows that rucaparib prevents cancer progression for twice as long as the placebo treatment, although it is not known if this will translate into overall extended life expectancy due to incomplete trial data. The drug has been included in the CDF to allow long-term data to be collected.

NICE has also recently published three other technology appraisals, two of which resulted in recommendations for use.

Pentosam polysulfate sodium for treating bladder pain syndrome (TA610) is expected to have a cost impact of less than £5m a year – £9,000 per 100,000 population.

Meanwhile, *Neratinib for extended adjuvant treatment of hormone receptor-positive, HER2-positive early stage breast cancer after adjuvant trastuzumab* (TA612), which reduces risk of disease recurrence, is expected to lead to savings of £1,800 per year in associated costs.

Two guidelines have also been supported by resource impact reports and templates, which allow users to model the local resource impact: *Cannabis-based medicinal products* (NG144) and *Thyroid disease: assessment and management* (NG145).

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NHS in numbers

A closer look at the data behind NHS finance

Community services

Technical

The expansion of community services features heavily in the *NHS long-term plan,* with a promise to raise the share of spending on primary medical and community health services across the next five years, increasing spending on these services by at least £4.5bn.

However, it can be difficult to tie down a definition of community services. They are delivered in a wide range of settings, from people's own homes to community clinics and even schools.

And while hospitals are typically linked with acute services, just to confuse matters there are community hospitals that may provide direct access to GPs and local community staff for local populations.

Services are delivered by a range of different providers. These include a small number of standalone community trusts and both integrated acute/community and integrated community/mental health trusts – 136 providers in total were registered with the Care Quality Commission last year, with just under 100 believed to be delivering significant levels of services. Services delivered in the community include:

- Adult community services (including district nursing)
- Specialist long-term condition nursing
- Planned community services (such as podiatry and speech therapy)
- Children's services
- Health and wellbeing services (including sexual health and smoking cessation)
- Inpatient community services.

Establishing how much is currently spent on community services is not straightforward. According to the King's Fund, community health services have about 100 million patient contacts and account for around £10bn of the NHS budget and one-fifth of the total NHS workforce.

However, NHS providers are not the only providers of community services – some estimates suggest that they hold just over half of the total value of contracts awarded for community services.

And CCGs and NHS England are not the only commissioners – local authorities also share some of this responsibility.

Community health service reference costs 2017/18

Service area	Unit cost*	Total cost £000
Allied health professionals	68	863,549
Audiology	58	192,355
Community rehabilitation teams	89	111,915
Day care facilities regular attendances	102	28,306
Health visiting and midwifery	65	979,489
Intermediate care	125	887,241
Medical and dental	149	202,559
Nursing	45	2,104,532
Wheelchair services	187	109,601
Total		**5,479,548**

*Unit costs primarily represent cost of care contact, however there are exceptions including audiology, intermediate care and wheelchair services

NHS providers are not the only providers of community services – some estimates suggest that they hold just over half of the total value of contracts awarded for community services

NHS Improvement's consolidated provider accounts for 2018/19 suggest providers' income from community services was £7.3bn, with £6bn of this coming from CCGs and NHS England.

At the same time, a recent allocation publication from NHS England says that in 2017/18, community health services accounted for 9% of total CCG core service spending (which also equates to £7.3bn).

According to Lord Carter's report on productivity in community and mental health services, which was published in 2018, spending on community services totalled £7.8bn, which can be broken down into the following:

- Community trusts (£2.9bn)
- Mental health trusts (£2.2bn)
- Acute hospital trusts (£2.7bn).

NHS reference costs for 2017/18 cover £5.5bn of community health services costs, with nearly 40% of this being the cost of nursing and 16% covering allied health professional costs. A district nursing contact (face-to-face) costs £38 on average.

Payment for community services in the main is covered by local prices and agreements, although some community services may be paid for as part of pathway payment arrangements.

The 2019/20 national tariff publication says that central bodies are testing a new approach to funding of community healthcare, focusing on five areas: children and young people with disabilities; single episodes of care; long-term conditions; frailty; and last year of life. A pilot was due to run until March 2020.

HFMA bitesize

The biting point

By Alison Myles, HFMA director of education

News and views from the HFMA Academy

Training

The HFMA can now boast more than 2,800 hours of online learning with the addition of the new HFMA bitesize courses in healthcare business and finance.

The new HFMA bitesize portfolio – which is due to be unveiled at the HFMA annual conference this month – provides opportunities for NHS staff at all levels to develop a better understanding of key subjects or take steps towards a broader qualification.

The HFMA bitesize approach has been developed in response to demand from the NHS. Increasing numbers of healthcare finance practitioners, clinicians and staff from other disciplines have been signing up to the association's intermediate (level 4) and advanced (level 7) qualifications in healthcare business and finance.

The HFMA bitesize courses will suit those who wish to learn on a topic-by-topic basis with no time constraints. They enable prospective learners to select specific topics where they want to develop their own or their team's knowledge and understanding.

The courses also offer a route through to the established HFMA qualifications at intermediate and advanced levels, if desired. The HFMA's new bitesize courses are available at three levels:

HFMA bitesize short courses, formerly known as HFMA e-learning, typically take three hours to complete. There are 40 courses to choose from, with some tailored specifically for different parts of the UK, and the aim is to give an overview of topic areas such as:

- How NHS providers are paid
- Integrated healthcare
- Budgeting
- Performance management.

Completion of five courses, including an NHS finance overview course, leads to the *Introductory award in healthcare finance.*

HFMA bitesize intermediate courses are a new offering with 21 courses each taking up to six hours to complete. These courses draw on the material used in the association's level 4 intermediate qualifications in healthcare business and finance and are aimed at those who may want a deeper understanding of how healthcare finance and business works. There are courses covering funding and structure and others looking specifically at provider and commissioning roles, as well the issue of integration. Other courses look at management skills such as influencing and negotiation or communication and presentation, while a further set looks at issues connected to governance and risk management.

HFMA bitesize advanced courses are another new arrival, with 18 available courses typically taking up to 10 hours to complete. The courses cover material from the association's masters-level qualifications, covering tools to support decision-making, such as primary sources of comparative data, and the delivery of value in the NHS, which looks at the role of payment systems and importance of measuring outcomes.

The intermediate and advanced courses themselves do not lead to level 4 or level 7 qualifications. But following completion of all the courses that make up a module, a learner would be eligible to complete the relevant qualification module assessment.

The association's bitesize approach does not include the tutor-taught elements of the HFMA qualifications. There is no support for the development of academic skills and learners would not have ready-made access to a network of other students. However, the ability to commit in smaller chunks, to spread the costs and to have complete control over when they study may well suit many learners.

The new HFMA bitesize courses will be launched at the HFMA annual conference this month and will be available for purchase from the HFMA website from the end of February.

Diversity event is a celebration

Future focused finance

Future-Focused Finance (FFF)welcomed more than 100 delegates from NHS organisations across the country to its *Celebrating diversity in NHS finance* event on 7 November, *writes Grace Lovelady.*

The event was held in London's China Town, and decorations from a variety of cultures were displayed across the hall – quite a different setting to what we are all used to in NHS finance!

The concept for this event was based on an idea of doing something completely different, to push boundaries and to celebrate the diversity of the NHS workforce in an informative but fun way.

The challenges the NHS, and finance in particular, face around equality, diversity and inclusion are widely discussed at conferences and events. So FFF didn't want the event to solely focus on the negatives but rather on the positives and celebrate what we're working on together.

Organised as a networking-focused event, delegates were able to make new connections and have discussions with their colleagues in an informal and relaxed environment.

The agenda included speed-networking followed by a live theatre performance, Bollywood dancers, food from around the world, and a speech from transgender activist and *Vogue* columnist Paris Lees.

Thank you all who attended and if you are interested in hearing more about the event, go to **hfma.to/diversity**

Grace Lovelady is FFF programme manager

Diary

January

10 (B) Eastern: introduction to NHS Finance, Fulbourn
14 (F) Annual chair's conference, London
15 (I) Institute: introduction to NHS costing, Manchester
21 (F) Directors' forum and new year lunch, London
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
30 (B) Northern: members' social evening, Newcastle
31 (B) Yorkshire and Humber: conference, Scunthorpe

February

10-11 (N) CEO forum, London
11 (B) KSS: TIAA accounting standards, Gatwick
12 (F) Provider Finance: technical forum
13 (B) Wales: VAT training level 3, Cardiff
14 (B) KSS: intro to NHS finance, Wroxham Heath
27 (I) Institute: costing together (south), London

March

11 (I) Institute: value masterclass, London

April

8 (I) Institute: costing conference, London

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

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

All HFMA activities now CPD accredited

Participation in all HFMA activities now counts as accredited continuing professional development (CPD) after passing assessment by the CPD Standards Office.

Delegates attending national events, branch conferences, webinars or roundtable discussions will be issued with an accredited CPD certificate of attendance for inclusion in their CPD records for their professional body, institute, regulator or employer.

Reading HFMA briefings or *Healthcare Finance*, studying via e-learning or taking part in board game activities will also count as accredited CPD.

Previously, participation in these activities would have been viewed as 'unaccredited hours', but some professional bodies are now insisting that up to 50% of CPD should be made up of accredited activities.

The CPD Standards Office is an independent accreditation body that supports best practice in the provision of CPD.

Events in focus

CEO forum
10-11 February, London

The regular HFMA CEO Forum gives NHS chief executives and accountable officers a chance to hear insights on and to debate burning issues in the healthcare sector. Built on the HFMA's experience and focus on governance and finance, case studies from around the world are presented, as well as best practice from closer to home.

The February event will hear from NHS Employers chief executive Danny Mortimer (pictured) on delivering a people plan, and King's Fund chief executive Richard Murray on current NHS policy. Chris Ham, chair of the Coventry and Warwickshire Health and Care Partnership, will outline the lessons from integrated care systems' experience in implementing the *NHS long-term plan.* Networking is key to the CEO Forum and the February event includes a networking meal – an opportunity to catch up with colleagues in an informal setting and talk freely to develop fresh approaches.

The CEO Forum and lunch are free to any NHS organisation that currently has a subscription to one of the HFMA's services, be that a faculty, the Healthcare Costing for Value Institute, the partner programme or e-learning. The majority of NHS organisations are taking at least one of these services.

• To check your eligibility and to book your place, please email josie.baskerville@hfma.org.uk

Pre-accounts planning
29 and 30 January, Leeds and London

The popular annual events return in January, with the programme offered across two locations. The event aims to help those involved in the planning and delivery of the 2019/20 annual accounts process and there will be a mix of plenary and workshop sessions.

The conference offers the opportunity to discuss changes to accounting and reporting requirements and to raise questions or give feedback to colleagues from NHS Improvement, NHS England and the Department of Health and Social Care. Issues that are likely to arise from the 2019/20 accounts preparation and audit process will be raised and debated. Discounts are available for delegates from HFMA partner organisations. The event is CPD accredited with the CPD Standards Office.

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

Election impact

Association view from Mark Knight, HFMA chief executive

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

My HFMA

The HFMA Conference is upon us – you might even be reading this at the event. The conference is held at this time because, years ago, it coincided with key announcements for the following year – planning guidance, the national tariff and so on. One year, the allocations announcement was even broadcast live from Parliament.

As we know, the timing of key announcements has been somewhat 'flexible' in recent years. But we have always held the conference at this time safe in the knowledge that it won't clash with an election – until this year that is. This year, the first December election since 1923 is taking place on the 12th of the month.

The implementation of a strict pre-election policy has had a big impact on our efforts to hear from the new NHS England and NHS Improvement team. So there'll be no chief people, medical or operating officer presentations at the conference, and this extends to chief financial officer Julian Kelly – although he will be attending the conference.

My colleagues have been brilliant and we have radically restructured the programme to maintain the content. We will hear from those senior NHS colleagues on other occasions.

A key feature of the conference is the annual general meeting on Friday morning, at which we say goodbye to our current president Bill Gregory and hello to Caroline Clarke. Bill is the 20th president/chair I've worked with. We've spent a lot of time together and the association has benefited from his judgement and surefootedness throughout the year.

Bill's theme of *Value the opportunity* has resonated with our 13 branches, all of which he has visited. Such was his determination to do this that last month he covered two in a day, with a 200-mile journey in between.

I can't reveal Caroline's theme, but it will strike a chord with members. She is our 70th president and we will be changing our logo for the year to celebrate our 70th anniversary. We will mark this milestone with a special event in July and at our annual conference at the end of the year.

HFMA chief executive Mark Knight

It's important we celebrate our past and look forward to the future. Since our 60th anniversary we've had equal numbers of male and female presidents – before 2010, we'd had one in 60 years! Baby steps? Perhaps, but steps nonetheless, as we develop our agenda going forward.

I've had lots of great comments about the changes we made to the magazine last month. We continue to do our bit with the new events app, which has replaced heaps of photocopying and decommissioned a photocopier from the Bristol HQ. Those of you at the conference will also notice we've stopped giving away the briefcase in favour of a smart tote bag.

As well as dramatically reducing our use of paper, we've streamed some sessions at events – though we recognise the networking advantages of being in the same room. And running virtual events would be like playing top-level football matches behind closed doors – no atmosphere. We also recommend train travel where possible.

If you're at the conference, thank you for your support. Stop at the HFMA stand for a chat and an opportunity to use your free biodegradable cup with our on-stand barista. If you'd like to get involved, talk to one of our team – volunteering with us can be fun and rewarding!

SHUTTERSTOCK

Member news

Three HFMA branches have appointed new chairs. Nicky Lloyd, chief finance officer at Royal Berkshire NHS Foundation Trust, is chair of the **South Central Branch**, succeeding Sam Dukes. Hannah Witty, director of finance at Royal National Orthopaedic Hospital NHS Trust, is now chair of the HFMA **London Branch**, taking over from David Needham. In the **East Midlands**, Beth Fleming, head of strategy planning and partnerships at Derbyshire Community Health Services NHS Foundation Trust, has taken over from Simon Crowther as chair of the branch.

Kent, Surrey and Sussex Branch has two new committee members – Sally Flint and Richard Boyce. Lorraine Clegg is now deputy chair.

The **System Finance Special Interest Group** has appointed Nigel Foster deputy chair. Mr Foster has been an active member of the group since it was launched.

The **East Midlands Branch** hosted its annual conference in partnership with Future-Focused Finance and the Skills Development Network. The November event was attended by 150 delegates – the highest number for the branch's annual conference on record. At the dinner, the branch held its annual awards ceremony. The winners were:

- Student of the Year – Jasmine Whatling, Lincolnshire Community Services NHST
- Team of the Year – Nottinghamshire Healthcare NHS FT and East Midlands Ambulance Service NHST
- Unsung Hero – Kendre Chiles, University Hospitals of Derby and Burton NHS FT
- Outstanding Leadership – Matthew White, Leicestershire Partnership NHST
- Innovation of the Year – University Hospitals of Leicester NHST
- Chairman's Award– Imtiaz Girach, Leicestershire Partnership NHST.

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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

Branch focus

My HFMA **North West Branch**

Over the past year, the North West Branch has been rapidly increasing its member numbers and is likely to have one of the biggest memberships by the end of the year.

The North West Branch has also been working hard to support students across the patch and correct the misconception that HFMA membership is only for senior finance professionals.

It recently held a successful event with the Finance Skills Development Network and the SDN North West Student Forum.

Attendees were able to find out more about the career journeys of finance directors from the region, including Kathy Roe, HFMA Finance Director of the Year 2018. The event also included a 'speed dating' session with finance directors that allowed students to ask informal questions and receive advice on studying for their qualifications.

'It was interesting to see that none of the directors of finance at the event had gone through a traditional career path – some of us hadn't gone to university at all, some had, some had qualified very late in life, one earlier,' says branch chair Ian Boyle (pictured).

Mr Boyle also spoke at the event, alongside Ms Roe, Mid Cheshire Hospitals NHS Trust director of finance Russell Favager, and St Helens and Knowsley Teaching Hospitals NHS Trust assistant director of finance Dave Miles.

'The local directors of finance we had at the event were very enthusiastic, inspirational people and the event received great feedback. It was very useful for the students to find out the career options available to them,' says Sara Braidwood, co-ordinator and students lead for the Finance Skills Development Network in the region, who led on the delivery of the event.

'Students are the future of NHS finance – it's important we engage with them and encourage them to look at other people's careers and how they got there,' she adds.

The branch also plans to start a research committee – 'another opportunity for students to make a positive impact', says Mr Boyle. To find out more about the branch or to express an interest in the research committee, please visit **www.hfma.org.uk/our-networks/branches/north-west** or email **hazel.mclellan@hfma.org.uk**

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Appointments

Coventry and Warwickshire Partnership NHS Trust has appointed **Clare Hollingworth** (pictured) director of finance and resources. She was previously chief finance officer in the joint management team for Warwickshire North, and Coventry and Rugby clinical commissioning groups. Ms Hollingworth has over 25 years' experience in the NHS in a range of roles, including contracting, business planning, and performance management. She takes over from interim Neil Muholland.

Glyn Howells is now director of operational finance at North Bristol NHS Trust. He has more than 18 years' experience in senior NHS finance positions, most recently as interim chief finance officer for Bristol, North Somerset and South Gloucestershire Clinical Commissioning Groups. Mr Howells has also worked in the private and public sectors.

London North West Healthcare NHS Trust has named **Bimal Patel** (pictured) as its acting chief finance officer. He was director of finance at the organisation. Mr Patel first joined the trust in 2016 as deputy director of finance. He has over 10 years' senior NHS finance experience.

Simon Lazarus has become interim chief financial officer at University Hospitals of Leicester NHS Trust. He takes over from Paul Traynor, who, after five years leading the finance function at Leicester (and 29 years in NHS finance), has been named chief financial officer at The Open University.

Paul Corlass (pictured) is now interim senior finance lead at NHS England and NHS Improvement for Yorkshire and Humber. Over the past 10 years, Mr Corlass, a member of the national talent pool for aspiring finance directors, has held senior finance roles, mainly in the provider sector. He has taken the opportunity to cover a maternity leave for a year to gain regulator experience working on significant capital investment cases across the region.

New HFMA London Branch chair **Hannah Witty** (pictured) is to take over as chief finance officer at Central and North West London NHS Foundation Trust in February. Ms Witty is currently director of finance at the Royal National Orthopaedic Hospital NHS Trust. Before joining the NHS, she was acting director of finance at the UK Home Office. She has also worked in the Ministry of Justice and National Audit Office. The move follows **Hardev Virdee**'s appointment as group chief finance officer at Barts Health NHS Trust.

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

"This opportunity came along to have a seat at a senior level in an organisation going through a significant change. It's a chance to help set the landscape for the service going forward"
Sandra Easton, NHS England and NHS Improvement

Easton takes top-level NHS management role

On the move

Sandra Easton has taken a senior position at NHS England and NHS Improvement, but though her job title is director of operational finance and performance, her role is much more wide-ranging.

'Operational finance is about in-year financial reporting and management of the whole system,' she says, 'both providers and commissioners. The performance analysis team sit under me and does the key reporting of operational performance. Then, there's the cash and capital team, which looks after cash and capital requests for the provider sector.

'I also have the strategic planning team, co-ordinating long-term plan planning and operational planning across the whole sector.

'The last bit of my portfolio is the oversight and assessment team, which develops the oversight framework for both clinical commissioning groups and providers as well as supporting CCG mergers.'

Ms Easton reports to NHS England and NHS Improvement chief financial officer Julian Kelly. Though there is much to do as a result of the merger of the organisations, she has three main objectives she believes will help the system.

'The first thing I want to do, from an oversight and assessment point of view and an operational finance point of view, is ask how we start to make things feel different. How do we move to a more supportive and values-based approach? How do we start to get more autonomy back into the system where sustainability and transformation partnerships are performing well? What support do we need to provide to STPs that are struggling? How do we make it feel different from what's happened in the past, for both commissioners and providers and bringing both sectors along together?

'The second thing is planning. We have just had the long-term plan submissions from STPs. We need to publish the outputs from those plans as quickly as possible so we can be really clear about how we will use this starting point to ensure operational plans link smoothly.'

Ms Easton's third priority is capital. 'How do we get on top of the issue, recognising that we don't have a multi-year settlement yet? We have to be more proactive, while managing CDEL across the system and being more transparent.'

Operationalising the health infrastructure plan (HIP) will be key to this. 'We must look at how we get the skills into the system to be more effective in the management of capital. How do we streamline the business case processes so it doesn't take excessively long to approve a new hospital, while still ensuring that we get sufficient assurance that we are building the right thing for the right price?'

"How do we get on top of capital? We have to be more proactive, while managing CDEL across the system and being more transparent"

Better forecasting, both for capital and operational finance, is key. Mr Kelly has called for the NHS to ramp up its forecasting skills on a number of occasions. 'There will be a big focus on forecasting, which is needed this financial year to get assurance that the system will deliver what it is telling us,' Ms Easton says.

She remains committed to her work on diversity and inclusion, jointly leading the London-based Going Beyond programme. 'I am really passionate about staff development and diversity and before I accepted this job I wanted to be clear that I could continue doing that.'

Ms Easton spent just over four years at Chelsea and Westminster, and she admits it was hard to leave. 'It was the best job I've ever had, I absolutely loved working there – the people, the culture, everything about it was amazing. But this opportunity came along to have a seat at a senior level in an organisation going through a significant change. It's a chance to help set the landscape for the service going forward.'

Though sad to have left, she is proud of the staff there. Deputy director of finance Virginia Massaro is now acting chief financial officer, and several other staff have stepped into roles with greater responsibility to fill the gaps. 'I take pride in that – it's succession planning in operation.'

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