healthcare finance

February 2020 | Healthcare Financial Management Association

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Caroline Clarke

Looking to the future with pride

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Trusts highlight concerns over blended approach

Comment
Finance teams must stay objective and be future-focused

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Capital funding: Leeds rising to the HIP challenge

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Value roundtable: the way forward for measuring outcomes

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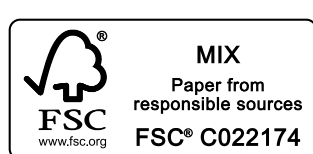

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Clarke begins presidency

Caroline Clarke became the HFMA's president at the association's annual conference in December, succeeding Bill Gregory.

Ms Clarke, group chief executive of the Royal Free London NHS Foundation Trust, has an extensive background in NHS finance, joining the health service in 1991 as a national graduate finance trainee. She received the chains of office from Mr Gregory before announcing her presidential theme – *Taking pride in our future* – which reflects her belief that people from across the NHS workforce are key to delivering more integrated care models.

The association made eight industry awards at the conference, including Finance Director of the Year Karen Geoghegan, and honoured 84 students who gained HFMA intermediate or masters-level qualifications. Edward Gold, head of costing and income at East Suffolk and North Essex NHS Foundation Trust, won the 2019 Tony Whitfield Learner of the Year Award.

• *See Taking pride in our future, page 16*

THEODORE WOOD

News

Trusts raise concerns with blended payment baselines

By Steve Brown

A 1.4% increase to tariff prices and an expansion of the blended payments model to more service areas are the headline messages from the formal consultation on the 2020/21 national tariff.

NHS England and NHS Improvement published their tariff proposals at the end of 2019 and the consultation ran until the third week of January.

The tariff has reduced in importance in recent years as many health economies have reverted to simpler block contracts or introduced caps and collars and other risk-sharing arrangements. However, along with detailed planning guidance, due to be published as *Healthcare Finance* went to press, the cost uplift and efficiency requirement are key details in enabling systems to agree contracts for 2020/21.

The guidance proposes a 2.5% inflation cost uplift, offset by a 1.1% efficiency factor.

Price relativities will be rolled over from the 2019/20 tariff to minimise financial volatility with the tariff set for just one year. The move to new market forces factors – which adjust national prices to take account of unavoidable local costs incurred in different parts of the country – will continue, with 2020/21 the second year of a five-year 'glide path'.

The consultation document also confirmed an expansion of a blended payments approach. Blended payments combine a fixed payment based on agreed activity with one or more of: an outcomes-based element; a risk-sharing element; and a variable payment. Already set as the default mechanism for emergency care and adult mental health services, this will now be extended to outpatients and maternity services, with a pilot scheme also run for adult critical care.

NHS Providers backed the one-year timeframe for the tariff as appropriate given the 'lack of uniformity across payment systems'.

But policy officer Patrick Garratt said: 'Over the long term, providers will require more certainty over their baseline allocations. NHS England and NHS Improvement should work towards setting the tariff for a longer period of time after 2020/21 to support the long-term ambitions of the sector as set out in the long-term plan.'

> **"We are concerned about the potential for double-counting... a trust could face a double penalty on overactivity"**
> **Andrew Monahan, HFMA**

The representative body's response to the consultation also raised issues with the blended payment approach, with trusts concerned about the difficulty in establishing baselines. 'Trusts must be reassured that activity levels will be forecast on previous years' outturns and continuing trends,' the response said. 'Commissioners should not place unrealistic expectations upon providers by setting ambitious forecasts.'

A report from The Strategy Unit at the Midlands and Lancashire Commissioning Support Unit – *Establishing fair benchmark levels for the blended payment system* – suggests that the financial implications of using inappropriate modelling approaches for setting planned activity levels within the blended payment system are not trivial. 'Our analysis showed that a group of providers could see swings of up to £6m in their payments (for emergency admissions alone) depending on the method used,' it said. The report calls for methods to set benchmarks to be set out in detail.

Despite the proposed expansion of blended payments, it is not clear how many systems have adopted the approach in 2019/20 for emergency care or mental health. A formal evaluation of the emergency care system is promised in the consultation paper. However, NHS England and NHS Improvement have suggested that the majority of commissioners and providers have something in place that follows the spirit of the blended payment policy.

The HFMA's response has also raised concerns with the process to agree the fixed payment, specifically for outpatients.

'We are concerned there is the potential for double-counting,' said HFMA policy and research manager Andrew Monahan (pictured). 'If reductions in face-to-face contacts are factored into the fixed payment and also included as an outcome measure, a trust could face a double penalty on any overactivity,' he said.

He added that there were also concerns about the suitability of a blended payment approach for specialised services outpatients.

Carillion costs contained but risks remain

By Seamus Ward

The government has limited the additional costs to the taxpayer for completing two hospitals following the collapse of constructor Carillion, but could have avoided compensation paid to investors, according to the National Audit Office.

A report into the efforts to rescue the two hospitals – Royal Liverpool University Hospital and Midland Metropolitan Hospital – found that the new hospitals will open much later than planned and with higher costs.

Both were being built by Carillion under private finance schemes when the constructor went into liquidation in January 2018.

The Royal Liverpool, which was being built under the private finance initiative, was originally due to open in July 2017, but is now to be completed in 2022. The Midland Metropolitan, which was being built under the PF2 initiative (in which the government took an equity stake), is also due to open in 2022 – just under four years later than planned.

After several failed attempts to rescue the projects, the contracts were terminated in September 2018. The Royal Liverpool was expected to cost £746m to build and run, including maintenance and facilities management costs, as well as construction costs.

New audit code

The final draft of the NAO's new *Code of audit practice* has been presented to Parliament. The code, which sets out statutory requirements for relevant public bodies, including NHS organisations, has a number of changes. It proposes the introduction of a narrative-style commentary on bodies' arrangements for securing value for money, together with a greater focus on supporting financial sustainability, governance and value. Expectations on timely and effective audit reporting have been made clearer. The new code will come into effect in April, subject to Parliamentary approval.

It is now predicted to cost more than £1bn. It is expected the taxpayer will pay £739m of this £1bn – £7m or 1% less than originally planned.

The Midland Met is now expected to cost £988m to build and run – around £300m more than planned. The taxpayer is currently expected to pay £709m of this – an increase of 3% (£23m) on the original plans. However, the NAO believed there was significant risk of further delays and additional costs.

The NAO estimated the private sector's total losses on the projects stands at more than £600m. However, it added that the government paid £42m in compensation to private lenders on the Royal Liverpool scheme soon after the contract was terminated. Although the compensation was based largely on the estimated cost of completing the hospital, the government would have paid nothing once a fuller picture of the actual cost emerged.

The Unite union assistant general secretary Gail Cartmail called the report 'grim reading'.

'Two desperately needed hospitals are going to be years late and in the meantime local communities are left with facilities that are no longer fit for purpose,' she said. 'While the report notes the financial cost of the projects, the human cost of the delays of completing the hospitals has not been recognised.'

Hancock promises permanent pensions solution

The government has promised a permanent fix for the NHS pensions issue that has led some clinicians to turn down additional shifts, leave the pension fund or consider early retirement.

Some senior clinicians face four-, five- or six-figure tax bills, according to the British Medical Association. This is due to rules on tax relief on pension contributions that include a taper on annual allowances for incomes above £110,000. Senior NHS managers have also been affected, though there are no current plans for them to be covered by new proposals.

In December, health and social care secretary Matt Hancock (pictured) said he was targeting a long-term solution. 'We've already agreed a short-term solution for this winter, but we're launching an urgent review of the annual allowance taper so we can fix it permanently and give clinicians the confidence to do their jobs in the knowledge they will be fairly rewarded,' he said.

In January, there were reports that the Treasury is considering increasing the income threshold at which the taper applies to £150,000. But the BMA insisted raising the threshold would not fix the problem.

BMA pensions committee chair Vishal Sharma said: 'The annual allowance is completely unsuitable for defined benefit schemes. Simply raising the threshold income would not remove any of the complexity of the taper, nor the threat of doctors facing a "tax cliff" when their income increases.

'And due to the complexity of the way pension growth is calculated, with a final figure only known at the end of the tax year, even those who earn well below this increased threshold would still likely limit their work to ensure they're not hit with unexpected charges.'

In the short term, NHS England and NHS Improvement have moved to ease clinicians' fear of taking on extra work this winter – clinicians will pay any tax liability using funds from their pension pot and the NHS will be legally bound to cover any resulting shortfall in pension on retirement.

NHS England and NHS Improvement chief financial officer Julian Kelly said the arrangements will incur no extra costs for the employer. Mr Hancock confirmed the commitment will be honoured when the affected clinicians retire.

PCN funding clarity urged

Almost half of primary care networks (PCNs) are confused about the funding available to them and how it is allocated, according to the NHS Confederation.

PCNs have been established under the *NHS long-term plan* and put general practice at the heart of services. They allow more care traditionally carried out in hospitals to be offered in the community, and bring pharmacists and social prescribers directly into patient care.

The confederation surveyed PCN leaders (clinical directors), mostly GPs. As well as 48% of respondents being confused over PCN funding, there were significant concerns over whether draft service specifications – setting requirements of PCNs over the next four years – were adequately funded.

Ruth Rankine, the confederation's development director for primary care networks, said: 'Despite the huge potential, there is overwhelming concern that [PCNs] are far from prepared or resourced to deliver what is being expected of them. In particular, clinical directors told us that they need more time, more support from their local systems, and greater clarity around funding for what is being asked of them.'

However, she added: 'We welcome the positive signs from NHS England and NHS Improvement that they are listening to us, and to clinical directors across the country, and urge them to continue this engagement as a priority.'

Assembly deal boost for NI health and social care

By Seamus Ward

Health and personal social care services in Northern Ireland received an immediate funding boost in the wake of the reformation of the local power-sharing Assembly, which has led to the suspension of strike action by thousands of staff.

Staff on Agenda for Change pay scales took industrial action over December and early January, including strikes – a first for members of the Royal College of Nursing (RCN).

Their main complaints were over the lack of pay parity with colleagues in England and staffing levels. With no executive in place for three years, civil servants at the Department of Health were unable to offer pay rises to meet staff expectations. One offer – which would have added a projected 3.1% to the pay bill – was rejected by health unions in December.

However, with the Assembly reinstated on 11 January, Robin Swann was installed as health minister in the new executive. Some £30m was made available from proposed future allocations to Northern Ireland to restore pay parity this year. Mr Swann quickly met with health unions, who subsequently suspended industrial action while they consulted with members on whether to accept the pay offer.

Later, the UK government agreed an additional £2bn financial package for the executive, which includes £200m to deliver pay parity immediately and over the next two financial years.

As part of the package, further financial support will be provided for a new medical school, while a £245m transformation fund will be shared between health, education and justice services.

The deal to reinstate the Assembly – *New decade, new approach* – includes pledges to create an action plan on local waiting times (which are the longest in the UK) and to implement a series of reforms to transform health and social care.

A joint UK government/ Northern Ireland executive board will oversee service transformation and keep healthcare delivery structures under review.

Mr Swann said: 'Additional funding has now been secured. Pay parity with England can be restored. Our nurses and other great health and social care staff can come off the picket line, can get back to the jobs that they love and do so well.'

The RCN said the minister had committed to producing a costed implementation plan for safe staffing.

Pat Cullen, director of the RCN in Northern Ireland, said: 'This dispute always focused not just on pay, but on ensuring that we have the right numbers of nurses in the right places, to provide the care and treatment required.'

The Northern Ireland Audit Office said a new approach was needed as it found major and high-priority capital projects were failing to meet cost and timescale targets. Cumbersome governance and delivery structures hampered the delivery of value for money, it added.

Mental health a priority in Welsh draft Budget

Health and social care in Wales will receive an increase of more than £400m next year, taking total funding in 2020/21 to £8.7bn, according to the Welsh government's draft budget.

Unveiling the draft Budget in mid-December, finance minister Rebecca Evans said health was a priority and its focus included improving mental healthcare – ring-fenced mental health funding will rise by £13m to £700m.

An additional £421m will be allocated to health and social care, which includes £385m in revenue and £36m in capital funding. Health and care revenue funding will rise to almost £8.4bn, while capital funding will total £374m.

Most of the extra revenue will be allocated to the NHS (£342m) and, as well as funding pay awards and inflationary cost growth, there will be investment in service transformation and new technologies.

Funding for Public Health Wales will increase by £6.8m, with nearly £5m of this supporting the development of a National Health Protection Service, fighting antimicrobial resistance and investing in Improvement Cymru.

Ms Evans said: 'This draft Budget delivers on our promises to the people of Wales and invests to protect the future of our planet. Despite a decade of austerity, our plans will see investment in the Welsh NHS reach £37bn since the start of this Assembly term in 2016.'

PROFIMAGES

Chancellor Sajid Javid (pictured) will deliver his Budget on 11 March – a decision that has affected the Scottish Budget process, said finance secretary Derek Mackay, who will present his Budget on 6 February. He said he could not set a date after 11 March as he wanted to offer clarity to public services and give enough time for scrutiny.

News review

Seamus Ward assesses the past two months in healthcare finance

It may seem like a long time ago, but the Conservatives won the general election, sweeping Boris Johnson back into Downing Street with a majority of 80. This will, of course, affect the NHS – with the UK officially leaving the European Union on 31 January under the deal brokered by the prime minister before the election. NHS staff from European Economic Area countries (except the Republic of Ireland), resident before the end of the year, will have to apply for settled or pre-settled status. Those coming in after 1 January 2021 will need the obtain an NHS visa, which will be introduced as part of the government's promised Australian-style immigration system. The smooth operation of both systems will be vital as the NHS gears up recruitment.

NHS revenue funding will remain as planned, and will be enshrined in law. Published in January, the *NHS long-term plan* funding bill commits the government to spending an extra £33.9bn a year in cash terms by 2024. The legislation includes a legal duty on the Treasury and the health and social care secretary to provide this minimum level of revenue funding. While health and social care secretary Matt Hancock (pictured) said the move would give the NHS certainty over funding.

The NHS was at the heart of the government's first Queen's speech, which set out the measures above. It said draft legislation will be produced to accelerate the *NHS long-term plan*, while the government also plans to seek cross-party consensus on proposals for long-term reform of social care. To fulfil a manifesto promise, hospital car parking charges will also be removed for those in greatest need from April. Mr Hancock said people with disabilities, frequent outpatient attendees, parents of children staying overnight in hospital and staff working night shifts would be exempt from the charges. As well as looking at capacity and the potential use of technology, the Department added that it would assess where capital investment could be used to help improve the experience of patients and visitors.

Another manifesto promise – restoring nursing bursaries – was also addressed. The Department of Health and Social Care said that all nursing students on courses from September this year will receive a non-repayable payment of at least £5,000 a year. Additional payments of up to £3,000 will be available for students in regions or specialisms struggling to recruit or to help students cover childcare costs. The move is expected to benefit more than 35,000 students a year and is part of the government's manifesto commitment to increase nurse numbers by 50,000 by 2025.

While much of the government's priorities will be welcomed, those involved in health and social care services will also be looking to the delayed spending review for long-term capital, education and public health allocations. The NHS Confederation said that the government should set a realistic budget in the 2020 spending review to restore investment in training clinicians and improve recruitment and retention. Setting out NHS priorities for the government to focus on, the representative body also called for the pension tapering issue to be addressed (*see news, page 5*). The financial impact on clinicians has led to doctors turning down additional shifts and responsibilities, exacerbating staffing difficulties. And it called for the creation of an emergency capital infrastructure fund and increased funding for social care.

The month in quotes

'This funding bill will empower the NHS and its world-class clinicians to deliver our bold plan for the NHS. They can do so safe in the knowledge that this government is giving them the financial certainty and support to revolutionise prevention, detection and treatment.'

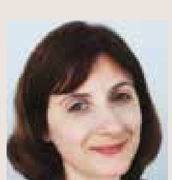
Health secretary Matt Hancock says the *NHS long-term plan* funding bill demonstrates the government's 'iron-clad' commitment to the health service

'Andy's deep knowledge of and commitment to the health service, deriving from many years of public service, is unparalleled. We continually benefit from his insights and wise counsel and I am very pleased to see his contribution recognised.'

Nuffield Trust chief executive Nigel Edwards pays tribute to Andy McKeon, who was appointed a CBE in the new year's honours

'We have more than 100,000 vacancies, the NHS needs significant investment in buildings, equipment and IT, and everywhere it is struggling to meet waiting times. Our members have warned this could be the worst winter on record.'

NHS Confederation chief executive Niall Dickson sets out the scale of the challenge facing the government



'We have seen a worrying increase in the delays for patients between the decision to admit and admission – more than eight times as many patients waited over 12 hours this December compared with December last year.'

Miriam Deakin, NHS Providers director of policy and strategy, says frontline staff are working flat out to meet winter pressures

To fulfil a Tory manifesto promise, hospital car parking charges will also be removed for those in greatest need

One measure not included in the manifesto was also unveiled. The Department said it would allocate £40m to reduce the time staff spend logging into work computer systems. The funding will allow the service to work with suppliers to standardise logins or provide multi-factor logins, such as fingerprint access. Some staff have up to 15 log-ins, the Department said, and had to remember multiple passwords or use the same password, which could compromise security. Trusts will seek to ensure staff have the appropriate access permissions, while there will be a focus on integrating local and national systems. A further £4.5m will be given to local authorities to develop digital adult social care projects – these will help the most vulnerable live independently for longer, as well as improve information sharing between health and social care.

Away from Westminster, the Welsh government said that its integrated care fund (ICF) programme had supported a wide range of new and innovative ways of working that have the potential to influence future patterns of care and support. The ICF's 2018/19 annual report said that it had allocated revenue funding of £59m and £30m of capital funding. Since its establishment in 2014/15 as a means of keeping older people independent and out of hospital or residential care, the fund has grown and some of the new delivery models have been implemented on a larger scale, it said.

SHUTTERSTOCK

Though the winter has been relatively mild so far, there have been outbreaks of flu and norovirus, which have hampered NHS performance. NHS England reported that demand on health systems grew in December. Just 79.8% of A&E patients were admitted, transferred or discharged within four hours, with A&E attendances up 4.8% in the 12 months to December. In November, elective care increased by 2.9% compared with 12 months earlier. The waiting list had increased by 6% compared with November 2018. In Wales, health minister Vaughan Gething said there was pressure across the whole health and care system and, though some operations were being postponed, they were not being cancelled.

Significant numbers continued to access the care they need. The Scottish government provided a further £3.4m to support the NHS as it faces winter pressures. The funding will be drawn from the £815m set aside for the waiting times improvement plan. Winter pressure funding has now reached £13.4m (it was £10m last winter).

Finally, the new year's honours saw awards for many people associated with the NHS. Kevin Parkinson, who was previously chief finance officer and governance director at Morecambe Bay Clinical Commissioning Group, was awarded an MBE for services to the NHS in Lancashire and South Cumbria. David Williams, director general, finance, and chief operating officer at the Department, received an OBE for services to government finances. Nuffield Trust chair Andy McKeon and CIPFA chief executive Rob Whiteman were awarded CBEs for services to healthcare and to public sector financial management, respectively.

from the hfma

It feels like the purpose of the proposed 2020/21 tariff is to support transition, according to Andrew Monahan, HFMA policy and research manager. In a blog on the association's website, he says the consultation on the 2020/21 tariff aims to strike a balance between helping systems introduce new care models and putting too great a burden on providers and commissioners. The extension of blended payments to outpatients fits with the long-term plan ambition to reduce outpatient appointments by a third, but the inclusion of some specialised services outpatients came as a surprise.

Finance staff will have to adapt as the system transforms, and the profession is beginning to map out its future, says *Healthcare Finance* editor Steve Brown. His blog wrapping up events at the HFMA annual conference said debate about the future shape of the finance function – and the skills required – was held against the backdrop of the report, *Designing our future: better decisions, better health.* A panel discussion looked at a range of topics, including the impact of technology, finance's role in carbon reduction, greater system working and meeting the needs of younger finance professionals.

Bermuda Hospitals Board chief financial officer Bill Shields (pictured) – a former NHS finance director – continues his blog series on working on the islands. In his latest blog, he reflects on returning to the UK for the HFMA annual conference and the impact of Brexit on both the NHS and Bermuda.

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Designing our future panel session

Outgoing president Bill Gregory

University Hospitals Birmingham's Clara Day

HFMA AWARDS 2019

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December 2019 | Healthcare Finance supplement

Karen Geoghegan named top director

Leeds Teaching Hospitals' David Berridge

HFMA 2019

Highlights from the conference in December

The general election loomed large over the HFMA annual conference in December – coming as it did just a week before the country went to the polls. A number of senior civil servants were unable to make presentations due to pre-election sensitivity. However, the country's voting intentions and the different offers on the table from the various political parties were still prominent in discussions inside and outside the main conference room.

Jennifer Dixon, chief executive of thinktank The Health Foundation, provided a helpful reminder of the main parties' key promises on health – focusing in on funding for the NHS and all-important social care. However, she also made a more general argument for whichever government emerged to take a longer-term view of the resources needed to deliver services sustainably and to the required standard. She trailed plans by the foundation to establish a centre that would develop careful supply and demand projections for the service going forward.

She added that there did appear to be consensus that staffing now represented the central challenge. This was a theme picked up by Mark Britnell, global chairman and senior partner for KPMG in the UK. Solving the global workforce crisis in healthcare, he said, would mean harnessing technology, devising new models of care and using staff in different ways.

Finance staff will themselves need to adapt to new roles in future as technology also changes the ways their departments operate. A new report from Future-Focused Finance, the HFMA and PwC – launched at the conference – imagines a future where the NHS is seen as the best place to work for finance staff, where diversity helps to drive innovation and where finance staff are widely recognised for their contribution to delivering good patient outcomes.

Introducing the document – *Designing our future: better decisions, better health* – Simon Worthington, director of finance at Leeds Teaching Hospitals NHS Trust and a member of the Finance Leadership Council, said it was an attempt to think about what the function needed to start, stop or do differently. A panel session discussed the need for finance staff to think creatively, and ways to improve staff mobility across different parts of the system.

Bringing the conference back to the election and the Brexit issue that was so fundamental to it, BBC Europe editor Katya Adler reflected on the political landscape during 2019.

However, a stand-out moment for many delegates was the appearance of Jax Kennedy and her amazing assistance dog, Kingston, on the main stage. Kingston, funded from a personal health budget, helps Jax manage her physical disabilities and has transformed her life. Kingston is estimated to have saved the NHS nearly £1m over the last few years and was a major hit with the conference audience.

The conference also hosted the annual HFMA awards, recognising the best in NHS finance and governance. Eight awards were presented, with Karen Geoghegan, chief finance officer at Brighton and Sussex University Hospitals NHS Trust and Western Sussex Hospitals NHS Foundation Trust, named HFMA Finance Director of the Year.

CONFERENCE PHOTOGRAPHY: THEODORE WOOD

Jax Kennedy and Kingston

The Health Foundation's Jennifer Dixon

HFMA qualifications graduates

BBC's Katya Adler

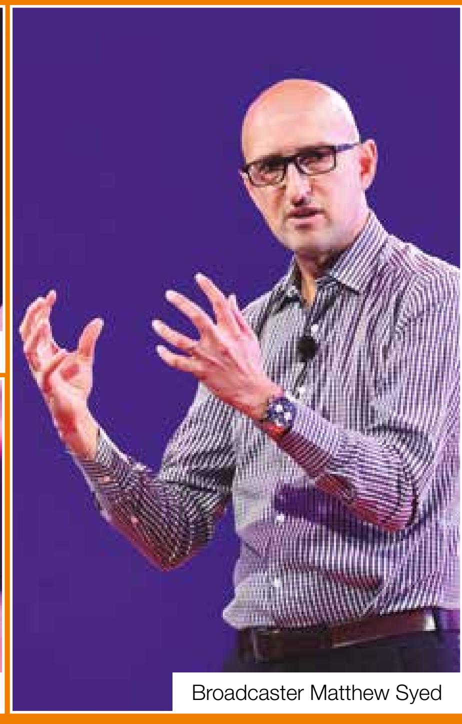
KPMG's Mark Britnell

US HFMA's Michael Allen

HFMA chief executive Mark Knight

Leeds Teaching Hospitals' Simon Worthington

NHS England's Tony Young


Broadcaster Matthew Syed

Comment

February 2020

Back to business

We need to be honest about how much recovery is needed before transformation

Like many people, I'm relieved to have got the election out of the way, so we can at least return to business in the public services. Whatever you think of the result, we now have a government with a working majority that will be able to enact policy in a way that the previous government struggled with.

I was struck by the performance data the NHS released in January. It was pretty grim reading, with less than 80% of patients treated within four hours, rising waiting lists (6% higher than last year, with 4.6 million people waiting for treatment), more patients staying longer in hospital, away from their families and familiar places of care, and pressures across the mental health system showing huge increases in demand.

This data was published a year after the *NHS long-term plan*. I'm a pretty optimistic person, and there's plenty in the plan to be cheerful about – a focus on integrated, digital and personalised care, action on inequalities and prevention, some great commitments about some of the biggest killer conditions, and a return to financial balance. What's not to like?

But we've got to be honest about current performance and how much recovery we have to do before we transform. We are going to need both cash and time to clear waiting lists and treat our patients.

HFMA president Caroline Clarke

Getting stuck into value

Finance teams have a key role in moving value to the next level

Value-based healthcare needs to move into the practical delivery phase and finance teams need to be at the heart of this. December's vision paper for NHS finance – *Designing our future: better decisions, better health*, published by the HFMA, Future-Focused Finance and PwC – is littered with references to value being central to finance teams' future role.

It talks about the finance function 'leading the way in developing a system-wide understanding of value' and of adopting business partnering roles 'to focus more closely on value-adding activities'.

It also suggests that the profession needs to recognise the importance of moving to an outcome-driven approach rather than a cost-focused system.

There is wide-ranging acknowledgement that making decisions based on the value delivered – both in terms of outcomes and costs – makes sense. And there are growing examples of value-based approaches delivering real benefits in terms of improved patient pathways, better patient outcomes and savings that help services stay within budget or be reassigned to other patient care.

But value-based healthcare needs to grow its base and become the way of doing business across the whole of the NHS. That's easier said than done, but finance teams have a major role in making it happen.

An HFMA Healthcare Costing for Value Institute roundtable in December (*see page 20*) explored progress in the collection and use of outcome data to inform value-based decision-making. It is clear that the service has made a lot of progress in addressing the cost side of the value equation – with an ongoing programme to get all NHS providers costing at the patient-level.

But there has been far less co-ordination in terms of outcomes. There is no shortage of data collected in the NHS – for outcomes frameworks, clinical audits or to fill various registries – but little finds its way back into

Healthcare Finance editor Steve Brown

PRESIDENT'S PLAYLIST

BOOK *Radical Help, Hilary Cottam* This has some interesting examples of new ways of working, and challenges to historic notions of how the state should provide care. It's an optimistic reinvention of the welfare state, based on how humans work together.

PODCAST *Brexitcast (back after election)* I love hearing political journalists let off steam and get underneath what's really going on. With a 10-year old daughter, I'm also listening to a distressing number of boy bands. Any tips on how to divert away from Lewis Capaldi and Justin Bieber and how to avoid Radio 6 being retuned to Radio 1?

- ***Send your suggestions to president@hfma.org.uk***

"Our job is to ensure we maintain objectivity and clarity, and to grow a focus on the balance sheet"

We also need to be super clear on how we think current concerns on ailing physical infrastructure (across the care system) should be addressed, as well as the well documented crisis in social care. And we need to be much more explicit about how we grow and develop a workforce that is fit for the future and can work in an increasingly digital environment – the NHS has been astonishingly slow to adopt new technologies.

These are all pretty general concerns, but our job as finance professionals is to ensure we maintain objectivity and clarity, and to grow a focus on the balance sheet, the medium to longer term future, as well as the here and now. We must be more future focused.

I note there's been tariff action, with a consultation on blended payments and some further complexities that left me a bit cold. I do worry that the focus on ever more complex pricing mechanisms is in danger of missing the point that systems need to concentrate on reducing system cost and on integrating, rather than passing money around.

Perhaps that's naive, but we have limited bandwidth and our intellectual endeavour needs to be on the big health issues in front of us rather than transactions. For me, as a taxpayer and a patient, those issues are reducing the overall cost of care, increasing quality of care, and reducing unwarranted variation in cost and quality to add value.

Whatever happens, 2020 – international year of the nurse and midwife as well as the HFMA's 70th anniversary – will be a year to remember. The NHS will be high on the government's agenda, and we will have an opportunity to shape the service for future generations. And I think the HFMA and finance professionals have a massive part to play in that. Happy new year everyone.

Contact the president on president@hfma.org.uk

clinicians' hands to inform care decisions or to rethink pathways.

There is an argument for a more centrally co-ordinated approach to the collection of outcomes or to the use of outcome sets that have already been defined and developed. It is true that more of this outcome data needs to reflect the outcomes that patients want – a measure of improved mobility, for example, rather than logging a 'successful' hip replacement.

But NHS bodies cannot afford to sit back and wait for a centrally driven solution.

Getting started – systematically looking at outcomes alongside costs – is the key. Trusts that have made progress urge others to look at the outcome data they already collect – whether clinical outcomes or patient reported outcomes. They are likely to be surprised at what they already have access to.

There will be gaps in the data and metrics that aren't currently collected that they wish were – but there will be enough to start making more informed decisions. And it will help map out how a more comprehensive data set can be pulled together.

You might ask what the finance role is in all of this. Surely outcomes need to be defined by clinicians? That's true, but finance professionals have good skills working with large data sets and good objectivity. And they often have a view of the whole patient pathway in an organisation, as well as contacts with many of the key stakeholders.

"There is no shortage of data collected in the NHS, but little finds its way back into clinicians' hands to inform care decisions or to rethink pathways"

Experience in a number of trusts shows that most clinicians like to engage with value once they are presented with the data on outcomes and costs. But they need help getting there. They need the data presented to them in ways they can understand quickly – and again this is where finance comes in.

Finance directors and boards have another role. Value-based healthcare won't be delivered without an organisation-wide – and ultimately system-wide – approach. This will need senior backing and investment.

That is difficult in the current financial climate. But in reality this is the solution to the current challenges – and not finding the funding will only exacerbate the current problems.

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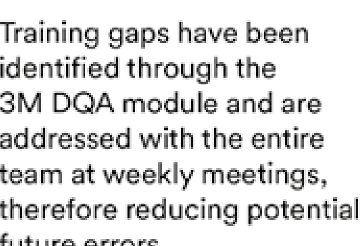

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2 NHSD National Data (England).

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Bright future for Leeds

The Leeds Teaching Hospitals NHS Trust is one of the first six to benefit from the Health Infrastructure Plan and associated funding. Seamus Ward explores what the publicly funded development means for the trust, both clinically and financially

When your chief executive calls on a Saturday afternoon, it's rarely good news. So, when Simon Worthington picked up a call from his chief executive Julian Hartley on a September Saturday last year, he feared the worst. But the chief exec was overjoyed – he had just been told that the trust would be awarded public funding for its planned £600m hospital development. Mr Worthington was, of course, delighted, but his thoughts soon turned to making sure the scheme is a success.

The scheme is one of the first six projects to come forward under the government's Health Infrastructure Plan (HIP) – a five-year rolling capital investment programme that has funding totalling £2.7bn over the first five years. The £1.3bn-turnover Leeds trust has a number of sites, including two major hospitals – Leeds General Infirmary (LGI) and St James University Hospital. Most of the development under the HIP funding will take place at the former site – delivering new adult and children's hospitals – though the project also includes a new pathology unit on the St James' site.

The LGI redevelopment (pictured), known as Hospitals of the future, has become essential because of a number of issues, including under-utilisation at the city centre site. As with many NHS hospitals, the estate has grown as new buildings have been added, piecemeal, over the years. The listed Victorian buildings that formed the original LGI – designed by Sir George Gilbert Scott (who also designed the St Pancras station and hotel) – are no longer suitable for healthcare delivery. The art deco-inspired Brotherton Wing from the 1940s is also no longer fit for purpose. Both will be retained, but repurposed as accommodation for the new Leeds innovation district (see box overleaf).

Mr Worthington says a lot of the estate is not being fully used and when low utilisation rates are coupled with backlog maintenance, the annual cost is high – running to millions of pounds. One of the wings at the LGI sits partly on a bridge over the city's inner ring road, and within 20 years the concrete will no longer be able to support the NHS building – the opportunity must be taken to move the accommodation away from the bridge and increase utilisation.

The new hospitals will also facilitate the consolidation of maternity and neonatal services on a single site at the LGI, although this is subject to a public consultation, currently under way. These services will be housed in the new purpose-built children's hospital.

The current split of maternity and neonatal services between the

LGI and St James' Hospital increases the pressure for workforce and prevents the trust from meeting its priority (and that of its commissioner) – to provide a bigger midwife-led maternity unit and ensure closer alignment with children's services.

Mr Worthington believes the creation of the new children's hospital is an important step for the trust – not just for the potential to improve the quality of care or reduce waste, but also to enhance its reputation.

'Of course, we already have a children's hospital, but it is spread across the site,' he says. 'It's at least as big as some of the more famous children's hospitals across the country. The clinicians want this, and the community want it too.'

The LGI redevelopment has been long planned. 'Since he arrived here about six years' ago, Julian Hartley had been developing the Leeds Way,' Mr Worthington says. 'The new hospitals are a big thing for us and an essential part of the Leeds Way – the development programme is called Building the Leeds Way. All our financial strategy is built around achieving the outcome of getting the new hospitals.'

Above: the atrium at the new-look LGI
Inset: the new pathology unit at St James' Hospital

Financing options

When he became the trust's finance director in 2017, planning work was already under way, but the big question was financing it. Though there was a brief flurry of activity in the early 2010s around using the PF2 model of private finance to build other hospitals, this funding mechanism has since moved off the table. For a while, there was no obvious source of funds for big capital schemes.

Yet trusts still put forward their capital plans – most recently through the sustainability and transformation partnership prioritisation process.

Last April, the trust published an outline business case (OBC) and strategic outline case (SOC), which assumed that funding would be found through a private finance scheme. Both the OBC and SOC are now being rewritten to reflect funding via the HIP.

In the original documents, the trust assumed it would take another four or five years to get through the approval and funding processes before builders broke ground. 'At the time, capital was so constrained and the approvals process difficult and lengthy,' Mr Worthington says.

But the HIP has changed this for the Leeds trust. And, with the emphasis now on getting the hospitals built quickly – but with robust governance – Leeds plans to open the new hospitals in five years. Under the previous proposals, building work would have begun in 2024/25.

The HIP has injected new impetus into the LGI development, but another key feature is public funding and the raising of the Department of Health and Social Care's capital spending envelope. Overall, the trust's five-year plan proposes capital spending of just under £1bn, including the HIP developments. The trust will receive the HIP funding as public dividend capital (PDC), on which a dividend – currently 3.5% – will be paid each year. Mr Worthington says the revenue costs of PDC are due earlier than the unitary charge potentially due under a private finance initiative (PFI). When this is taken into account, the revenue cost of the publicly funded HIP scheme is around £25m a year – but this is still £20m a year less than under PFI.

Mr Worthington says: 'In our finance and sustainability plan we have said we want to deliver a sustainable surplus by becoming the most efficient teaching hospital in England. Our financial strategy is geared to achieving a surplus to pay for the revenue consequences of Building the Leeds Way. A lot of banks were prepared to lend us the money, so the issue was not about access to finance; the issue was about controls on capital spending.'

The arrival of the HIP means the trust will have access to public finance within the government's capital spending limits.

This does not mean the drive to maintain its financial performance will recede. 'Our financial plan was that, over five years, we would generate sufficient surpluses to pay for the revenue consequences of Building the Leeds Way before the new developments open. That's still our plan. There's wiggle room now, because the scale of the surpluses we need is less. But our objective is still to overachieve on our trajectory.'

He adds: 'A £30m surplus is needed – around 0.5% or £6m a year over five years. We are making progress on that.'

The trust made a surplus of £18.9m in 2017/18, followed by £53m in 2018/19, through overachieving on its control totals and with the benefit of provider sustainability fund (PSF) support.

'This year we are aiming for a surplus of £16m because of the changes to the PSF, but our underlying financial position is better than it was last year. Our plan is to have a £1.5m surplus next year – our underlying position will again be better, but we won't have PSF.

'We are looking at our approach to depreciation, which will lead to a significant increase. This will mean our future surpluses aren't as large as we had previously targeted but the "buying power" in terms of capital

Capital roundtable

A recent HFMA roundtable discussed the capital challenges faced by the NHS as it seeks to implement the *NHS long-term plan*. The roundtable discussion – supported by health and care property development company Prime – is detailed in a *Healthcare Finance* supplement. The topics explored include developing system plans to meet the requirements of the strategy, and the health infrastructure plan. The supplement is available to download from the HFMA website at hfma.to/xpp

Innovation hub

The new hospitals at the Leeds General Infirmary will leave the trust with buildings and land – over 5 hectares – that are surplus to requirements. To realise the potential of this site, the trust is working with two of the city's universities and the local council on a scheme that could boost the city's economy by more than £1.5bn.

'We have some fantastic heritage assets for the city, but they are no longer fit for purpose in terms of modern healthcare delivery. We want to regenerate these great buildings and secure their future in the city,' says James Goodyear, director of strategy.

The trust plans that the iconic Gilbert Scott (pictured) and Brotherton buildings, together with the old medical school and Clarendon Wing, will become part of a health innovation hub where universities, the NHS and industry collaborate to solve healthcare challenges. The aim is to support innovation, improve health outcomes and lower cost, and contribute to the city economy.

'We are at the start of the journey, but our initial economic analysis suggests that we could see economic benefits in the region of £1.6bn,' says Mr Goodyear. 'It sits well with the Northern Powerhouse agenda. The government has been supportive,

and we've had significant interest from the business community and our staff.'

The trust is a key national player in NHS hospital-based research and the Leeds city region is already a thriving centre for health technology companies. 'There are about 400 companies in the city region – from large firms such as Johnson & Johnson to medium and small companies,' Mr Goodyear says. 'Also, 22% of digital health jobs in the UK are in Leeds, including at NHS Digital, EMIS and TPP.'

Working in partnership with the universities and the city council is key to the success of the scheme. 'Each of us brings something different to the partnership – be it academic strength, the ability to translate ideas into clinical practice or planning expertise. That partnership is fundamental to what we're trying to achieve.'

spend remains the same. This is partly in response to the issues there were about spending retained surpluses when the NHS was looking at capital spending controls earlier in the year.'

Hitting the £30m efficiencies needed means the trust must refocus on waste reduction – Leeds has rejected the notion of cost improvement in favour of waste reduction – targeting 2.7% a year. Mr Worthington says this will move the trust's reference costs from 103 to 94. 'There's a lot of good work going into making sure that happens,' he says.

Project risks

There are risks related to large, public sector schemes. These can include financial difficulties in a private sector partner, seen recently in the NHS and other parts of the public sector with the collapse of Carillion, and in Scotland building defects in hospitals and schools. Mr Worthington, the project's senior responsible officer, says new procurement arrangements must be developed as it's a few years since such a large publicly funded scheme was tendered in the English NHS. There is also the risk that expertise – ranging from project advisers to builders – could be in short supply with so many schemes coming forward at the same time.

With the trust having so many sites, the HIP development will not address all of the capital needs at Leeds. As mentioned earlier, the HIP funding will support part of an estates strategy totalling around £940m over five years, including plans to relocate the ophthalmology unit.

'We are looking for cost improvement or waste reduction in the context of the Leeds Improvement Method and we are making clear to people that if we achieve all that we are planning to achieve, we will be able to sort out our capital issues,' Mr Worthington says. 'People will be significantly motivated. We are already doing this – we've said if we can achieve our financial plan, we will invest back £7m a year in medical equipment. We have done this. Putting in a clear level of investment is important, and you get better results if you engage with clinicians. Improvement is at the core of what we are.'

Mr Worthington's mention of the Leeds Improvement Method (LIM) – the trust's approach to continuous improvement – is timely, as it will play a central role in much of the next phase of development as the trust finalises plans for the new hospitals. Based on learning from the Virginia Mason Institute in Seattle, the LIM seeks to promote greater efficiency and improve patient experience and outcomes by harnessing the ideas and enthusiasm of its staff.

Mr Worthington says the overall plan is for no significant increase in bed numbers in the new hospitals, though there will be a little more capacity in critical care. However, the LIM will support changes to bring services together, so patients do not have to move around the hospital to receive care. Outpatients will be redesigned, bearing in mind the *NHS long-term plan* ambition of reducing follow-up appointments by a third. Fewer waiting areas will be required in outpatients, but there will be a greater need for video calling and other digital technologies.

A small Kaizen promotion office (KPO) is supporting work to ensure the new hospitals' workspaces suit clinician and patient needs. The emphasis will be on engaging staff to develop and make the changes themselves, according to Rachel Bickerdike, KPO specialist. One method used is a rapid process improvement workshop, where, over the course of a week, around seven or eight staff work with the KPO to make their services better, more effective and with enhanced patient experience.

Staff engagement through the workshops has already proved effective, according to Natasha Bissett, KPO facilitator. They have increased capacity in cardiac care and ensured ophthalmic outpatient clinics start on time, for example, with little to no extra cost. The continuous improvement philosophy of Kaizen will ensure the new hospitals have a strong, patient-centred culture that focuses on efficiency.

'It makes for a more engaging place to work,' says Ms Bickerdike. 'People want to be there and feel they have control over their workplace and their ideas are valued.'

Mr Worthington adds: 'It builds confidence in our staff to meet the change challenge we face to make the new hospitals work.'

The building of two major hospitals in Leeds is a major undertaking for the trust and – in the wider context of the HIP as a whole – the NHS. Not only must the developments meet the needs of local people, but they must be delivered at pace. While PDC funding means the complexities of private finance are not in play, there are other pressures, including the need to generate year-on-year surpluses. But the Leeds trust is hoping its thorough approach, including early and ongoing staff engagement, will help it achieve its plans and deliver modern and efficient facilities geared to patients' needs.

Taking pride in our future

New HFMA president Caroline Clarke believes the real story in the NHS is one of improvement in the face of unprecedented pressure. Staff remain key to success, but she insists the service should be proud of what it has done and optimistic about what it can achieve going forward

Caroline Clarke became group chief executive of the Royal Free London NHS Foundation Trust in February last year, capping an NHS finance career that has spanned nearly three decades. But as she takes on the role of the health finance profession's leader, as HFMA president for 2020, she still sees finance as her 'tribe'.

And it's a tribe that she wants to take a bigger role in meeting the challenges facing the NHS – challenges that remain significant despite increased funding to support the *NHS long-term plan*.

'The finance community can help with improving operational performance because it understands data and that measuring performance does matter,' she says. 'Colleagues look to us for objectivity and facts and to help make decisions.

'You need to be able to quantify as well as narrate your way through a situation. Finance professionals have all sorts of professional capabilities and we should be using these skills in other parts of the service.'

This call for finance to take on a broader role forms part of Ms Clarke's theme for her year in office – *Taking pride in our future* – a theme that reflects her view that people (clinical and non-clinical) are the key to meeting the service's goals of developing more integrated care models.

She recognises that the current context for the NHS is tough, with the service facing extreme challenges. Demand continues to rise and there remain significant staffing shortages – along with the money to pay for

THEODORE WOOD

them. Staff in all functions are hard pressed and the mood music – with record underperformance on performance targets – is gloomy. But despite this, Ms Clarke believes the real story is about improvement in the face of unprecedented pressure and believes the service should be optimistic about its future. 'Because of the short-term pressures, it can be hard to market the NHS as a fantastic career – and it *is* a fantastic career. We should be really proud of what we do in the NHS and develop a sense of optimism about the future. That way, we might be able to shift some of the workforce issues.'

The Royal Free London provides a good example of the wider NHS position. On the face of it, the trust has some major challenges. Last year the Care Quality Commission downgraded its overall assessment of the trust from good to requires improvement. It is struggling with A&E performance, with just 79.5% of all patients seen within four hours in the third quarter of this year, compared with a target of 95%.

In 2018/19, it was not in a position to agree a control total. This meant it did not receive sustainability funding and reported a deficit of £67m. This year, it is on course to hit a £30m deficit control total. But strip out the sustainability funding and non-recurrent savings and it is still carrying an underlying deficit of more than £70m. It also remains reliant on loans to maintain positive cash balances – with cumulative borrowing of £170m repayable over the next few years.

Despite this, the trust is doing lots of the right things. Strategic partners with the Institute of Health Improvement, it has introduced a systematic approach to reviewing patient pathways to reduce unwarranted clinical variation. Twenty clinical pathway groups (CPG) were set up last year and there are plans to expand this to 60. Increasing numbers of its staff are trained in improvement science and there have been real benefits for patients – reducing the length of stay for hip and knee replacements, for example, and major improvements on continuity of carer for maternity services.

Importantly, this is being done at scale and embedded as a new way of working. Significant reductions in demand as patients are treated in more appropriate settings, and with more efficient processes, mean that overall costs to the system will reduce.

Digital role model

The trust – which is effectively testing a group model on behalf of the wider NHS (*Track record, page 18*) – also opened the new £200m Chase Farm Hospital on budget and on time. This provides one of the country's most digitally advanced hospitals. And the trust has embraced the wider digital revolution too, with an electronic patient record in two of its flagship hospitals. This underpins the CPG programme, providing decision support for clinicians.

On finance, there are also positives. The trust's reference costs have been consistently below the national average. And that underlying deficit – as large as it is, fuelled by a tariff set below providers' actual costs for years – has reduced by some £50m in just a couple of years.

'The story internally is one of improvement,' says Ms Clarke. 'We are absolutely on the right track and in the current context, we have to describe the journey around relative improvements as well as binary targets.

"Finance professionals have all sorts of professional capabilities and we should be using these skills in other parts of the service"
Caroline Clarke

Leaders across the NHS have a major role in getting this improvement message across. Staff are working extremely hard and their efforts need to be recognised and celebrated, even though the pressures on the service remain significant, she believes.

There are roles for the centre too. Increased long-term funding for social care, merged health and social care budgets and better policies on long-term financing are the key requests from Ms Clarke. But locally, the focus has to be on supporting and developing staff and being clear that their efforts are making a real difference.

Her theme – *Taking pride in our future* – is focused completely in this area. In December, Future-Focused Finance, the HFMA and consultancy PwC published *Designing our future,* which starts to set out a vision for the NHS finance function. This report (*see Healthcare Finance, December 2019*) is at the heart of a wide consultation exercise that is now under way with finance staff, with a view to publishing a final report later this year.

It explores the impact of new technology as the function embraces cloud computing, blockchain, artificial intelligence (AI) and robotic process automation, and it looks at how roles will need to change to support the transforming NHS. As fewer people are needed for transactional processing, more finance staff will be free to move into business partnering roles – critical for delivering the value agenda.

'We are going to make a career in NHS finance the best there is, and we're going to do it together, and when we look back, we're going to

Track record

An economics graduate from the London School of Economics, new HFMA president Caroline Clarke joined the NHS on the national finance training scheme in 1991. Her NHS career to date is bookended by the Royal Free London NHS Trust. In an early placement on the training scheme at Hampstead Health Authority, she was involved with work to establish the hospital as a freestanding NHS trust. She was to return to the organisation (by now a foundation trust) as finance director some 20 years later.

She got an early insight into the role of HFMA leader in her first substantive job at Kensington, Chelsea and Westminster Health Authority. She worked under finance director Keith Ford, who himself spent a year as HFMA national chairman during her time at the authority. Naming Mr Ford as a major influence, she was impressed with his ability to influence policymakers and his readiness to take informed risks, with a credibility that was based on delivering in his day job.

Deputy and assistant finance director roles at Camden and Islington Health Authority and the Royal Brompton Hospital NHS Trust were followed by a first director-level position at the new City and Hackney Primary Care Trust. Ms Clarke continued to pursue her career in north and east London with a first provider finance director position at Homerton hospital in 2003, taking it to foundation trust status the following year.

After five successful years at the trust, Ms Clarke took a break from the NHS, moving to KPMG to help build the health practice. But just two years later, she was back in the fold, at the North Central London Commissioning Agency. The move to the private sector had taught her a lot, she says, but 'didn't fit entirely with who I am'.

Then, in 2011, she returned to the Royal Free – now a foundation trust – as finance director, subsequently adding the role of deputy chief executive. The trust expanded in 2014 through a merger with Barnet and Chase Farm Hospitals NHS Trust. The Royal Free London group was then established in 2017, with North Middlesex University Hospital NHS Trust as a first clinical partner – followed in 2018 by West Hertfordshire Hospitals NHS Trust.

Ms Clarke was appointed group chief executive at the beginning of 2019.

She has been a long-time supporter of the HFMA – a former London branch chair and a key figure in Future-Focused Finance, where she led the programme's Best Possible Value workstream. She was named HFMA Finance Director of the Year in 2012.

A self-proclaimed extrovert, she says she is a team player who likes people. She claims City and Hackney PCT chief executive Laura Sharp taught her that good management was not about control and power, but about getting the best from other people.

Ms Clarke loves working in the system she lives in – something that has always been important for her – and enjoys the breadth of opportunities and the complexity of issues that her role offers. She is also big on work-life balance. As a mum with a 10-year old daughter, she says she has a 'real moral obligation' to get that right.

She is also open about living with multiple sclerosis (she is a trustee of charity Overcoming MS). 'My condition is very stable. I have had to think about how I manage it in a way that enables me to do my job effectively. Like many long-term conditions there are things you can do to control it – I practice mindfulness to manage stress, I exercise and I manage my diet.

'I hope that is a good message for other people with long-term conditions. I had a wake-up call, but the overall message is that we all need to look after ourselves, and each other, in order to achieve our potential.'

Inset: Caroline Clarke winning the 2012 HFMA Director of the Year award (top) and at Homerton hospital in 2004

be proud of what we've done,' she told December's HFMA annual conference. Mapping out what the future could look like within finance teams will be essential if finance teams are to be in the best possible condition to add value. 'We have people working for us now who will be finance directors in 30 years' time,' she says. 'We need to think about what the world will look like for them and how we get people ready for that.

'Finance staff need to be on top of the idea of using multiple sources of data and being really clear about what data is telling us,' she continues. 'They need to be guiding decision making in organisations – right there at the table and often leading it.'

"We are going to make a career in NHS finance the best there is, and we're going to do it together, and we're going to be proud of what we've done"
Caroline Clarke

She takes issue with the portrayal of finance only as a support function. 'There is a whole raft of people, who because they've gone into a technical profession, don't see themselves as leaders. But we are leaders. You only need to look around at the HFMA annual conference to see the capability in the room. We have something really special in the finance community.'

But she adds that finance will need to embrace changes in its own operation, which will involve adopting technology for transactional processing and sharing services where that makes sense. Letting go of transactional responsibilities will free up time to provide more analysis and understanding of what is happening in the business.

'So we need to make ourselves invaluable – and we do this by being a bit broader,' she says. 'There is definitely room for centres of excellence and people being experts at tax or the capitation formula or whatever. But for business partners and the vast majority of finance managers, you have to have a broader outlook, be able to use multiple data sets and think about data science and technology. And you will need to have a new set of skills – even if we don't yet know what all those skills will be!'

Ms Clarke wants finance to be fully engaged in helping the NHS meet its wider people challenge too. 'In the next 10 years, the NHS will potentially need 250,000 new members of staff if we do nothing,' she says, suggesting that the solution will lie in innovative thinking as much as straightforward recruitment.

Attracting staff

Attracting new staff and retaining existing workers is clearly the 'number one priority' and 'the most important part of the long-term plan'. Technology will provide part of the solution. For example, a recent study involving researchers from Google Health and Imperial College London showed that an AI model was as good as the current two-doctor system of reading mammograms and better than using a single doctor to spot cancer. With an estimated shortage of more than 1,000 radiologists across the UK, this could help increase capacity by a different route.

Ms Clarke believes that finance staff have a big part to play in asking hard questions about why things are done in a particular way, or sometimes why things are done at all. And she is clear that the more diverse the finance function becomes, the better able it will be to meet this challenge.

'The function needs to reflect the population,' she says. 'The business case for diversity is really strong. When you have cognitive diversity, which comes from having people around the table who don't look the same or haven't grown up in the same way, you get better solutions. I am completely sold on that.'

The challenge is making this happen. Future-Focused Finance is leading work to improve diversity in senior finance leadership roles. The last finance staff census, due to be updated shortly, revealed that women account for 61% of the finance function, but just 28% of finance directors. And 18% of the finance workforce are from a black, Asian and minority ethnic (BAME) background, while only 4% of director level positions are held by BAME employees.

'We need to use the diversity of our populations to bring diversity of thought and approach to our problems,' says Ms Clarke. 'If we continue to look at things in the old ways, we will miss the new solutions.' There is no one single solution. Instead, improving diversity will take lots of small steps – more targeted recruitment and more work getting people ready for senior roles, for example. And in many cases it will be something that organisations have to do for themselves.

'A lot of this has to be done locally as it is about local culture,' she says, but adds that the centre's role could be to showcase departments that have made themselves more inclusive.

Ms Clarke's year as president also coincides with the HFMA's 70th anniversary – a birthday she is keen to point out the association shares with NATO, Stevie Wonder and Snoopy. However, she is determinedly looking forward with her presidential theme. She wants finance staff to fulfil their potential, broaden their role and take pride in their contribution to delivering high-quality, sustainable healthcare. That has to be something worth celebrating.

The right OUTCOMES

HFMA ROUND TABLE

Understanding the value of services means understanding the outcomes that are important to patients. An HFMA Healthcare Costing for Value Institute roundtable in December explored progress in measurement and the use of outcomes to inform decision-making. Steve Brown reports

There is increasing support for value-based healthcare. There has been a lot of work in the NHS on improving data on costing – one half of the value equation. But the other key factor in assessing the value of any decision or intervention is the outcome. And there has been far less done to put outcomes alongside cost data or to make sure the outcomes monitored are the ones that are most important for patients.

'You can't address the value equation until you've decided what outcomes you are trying to deliver,' Sally Lewis told a roundtable organised by the HFMA's Healthcare Costing for Value Institute in December.

The roundtable, supported by Johnson & Johnson Medical Devices Companies, was convened to discuss where different organisations are in terms of their collection and use of outcome measures. It also aimed to identify challenges to the wider use of outcome measures and to understand the specific role finance practitioners should play in moving this agenda forward.

Dr Lewis, GP and national clinical director for value-based healthcare for NHS Wales, and chair for the roundtable, said that outcome measures came in different guises. 'We are talking about clinical outcomes that you might find in national clinical audits and registries,' she said. 'But we also need to think about patient-reported outcome measures (PROMs) and experience measures (PREMs) – for example, have we reduced patients' pain, can they now perform their daily activities or are they sleeping better?'

There is growing recognition that, while the NHS collects a mass of clinical data, many of the measures focus on processes or outputs, not outcomes.

And, where there are outcome measures, they don't necessarily reflect the outcomes that patients most want to achieve.

Collection question

The roundtable kicked off by discussing why health services should be collecting patient-defined outcomes at all. For some, it was about the NHS catching up with other areas of people's lives and meeting public expectation.

'Other industries and services are modernising their policy and practice in ways that cut with the grain of wider changes in society and public expectations,' said James McGowan, specialty registrar in public health medicine at Public Health England. 'As people become more empowered to make their own decisions in respect of using services, including health services, the NHS has a principled and practical need to respond to this.'

Pictured: Sally Lewis and Simon Kenny

Simon Kenny, paediatric surgeon and clinical lead for the national Getting it Right First Time programme, and former clinical director at Alder Hey Children's Hospital NHS Foundation Trust, said that outcome data could inform both the immediate care being provided, while also supporting broader decisions about interventions that deliver the best outcomes for patients.

'Big data can help us do that, but it will only happen if we've got the outcomes embedded,' he said. Talking specifically about PROMs, he added that it was a key way to 'measure outcomes that are important to patients'.

Glyn Jones, finance director at Aneurin Bevan University Health Board, agreed, suggesting that outcomes also provided a common language to improve engagement between clinicians and finance staff on deciding how resources should be used. PROMs also helped

clinicians have more meaningful discussions with patients about the right next steps in their care. A 'successful' surgical intervention, for example, might not address psychological or social issues affecting a patient and a PROM can help to inform patient-clinician discussions.

Duncan Orme, operational director of finance at Nottingham University Hospitals NHS Trust, stressed the importance of understanding patients' own views of healthcare interactions. 'Work by the Royal College of Physicians found that 20% of pensioners who attend an outpatient appointment reported feeling worse afterwards because of the stress involved in getting there,' he said. 'When you add this into the climate impact – with nearly 5% of road traffic in England being NHS-related – then arguments start to build up for doing something differently with how we work with patients, starting with allowing patients to report their own outcomes.'

PROMs data is essential to realise these social and economic benefits.

Bill Gregory, chief finance officer and deputy chief executive of Lancashire Care NHS Foundation Trust, and immediate past president of the HFMA, underlined this key role for PROMs. 'It is only when you are in an outpatients department as a patient that you see it with their eyes,' he said. 'Only the patient travels through the whole pathway and they see the disjoins – and if you don't ask the patient, you won't find out about them.'

The reason to collect outcome data also changes depending on what you want to do with the data. Chris Graham, chief executive officer of Picker, which specialises in undertaking surveys of patient experience, suggested there are 'many different whys'.

'These are often in opposition to each other and there may not be a single approach that meets every need,' he said. 'If you want to have person-centred care, you need to recognise that what matters to individual patients differs – so one-size-fits-all won't work.

'You might need something different for clinical practice, something for local service improvement work and then something different again for national collections.'

Acknowledging these different uses for outcome data, Clara Day, nephrology consultant and associate medical director for finance at University Hospitals Birmingham NHS Foundation Trust, stressed that it was important to be clear about the reasons for collecting PROMs data in advance.

'If you want the patient to fill something in, they need to know why they are doing it,' she said. 'Is it to help inform their care now or to support population health? Both are fine, but you need to be clear and get the balance right. [As a clinician] it can also be frustrating if a patient reports on something and you receive a report six months later showing how a patient had a bad time, but you didn't know about it at a point when you could have done something about it.'

Dr Lewis underlined the importance of embedding the measurement in direct patient care. 'A PROM is essentially a structured communication from the patient,' she said. 'They are telling us what they need, not just the result of a treatment.'

What to collect

The roundtable next turned its attention to the question of what to collect. It started by discussing the data already collected in the NHS. Jenny Lewis is the analytics and content lead for the National Clinical Improvement Programme, which is developing a secure online portal to enable (initially) surgeons to view outcome data and to

Pictured, top to bottom: Glyn Jones, Duncan Orme, Bill Gregory and Clara Day

support consultant appraisal. The NCIP, which runs as part of the GIRFT programme, has to date been implemented across eight surgical specialties and is being initially rolled out to five trusts to pilot its use.

This programme has been set up to use data that already exists, either in the national hospital episode statistics data set or from audit or registry data. Dr (Jenny) Lewis said that existing data should be the starting point for outcomes.

'There is a vast amount of data collected and pitifully small amounts of it that actually gets out into the hands of clinicians,' she said. While there were issues that needed to be addressed in terms of using or sharing some of the data, there was certainly no shortage of it. 'It is amazing what you can get out of it if you throw the right analytical resource at it,' she said, adding that analytical expertise was an area of major underinvestment across the NHS.

Picking up the issue of data quantity, Dr McGowan called for data collection to be rationalised. He emphasised the importance of clinical leadership in this process, but said there also needed to be greater focus on building the evidence base to support high-quality measurement in the NHS.

'Many measures and indicators are used in healthcare,' he said. 'But too small a proportion of them are patient-based or patient-focused and an even smaller proportion are supported by evidence. Addressing this imbalance should be a priority for clinical leaders, researchers and policymakers.'

HFMA ROUND TABLE

So, make better use of existing data an agreed starting point. But there was also recognition that this may need to be supplemented with PROMs to get a more rounded view.

NHS Wales' Dr (Sally) Lewis asked the participants how agreement could be gained among clinicians about what to collect. 'For example, if respiratory physicians have a view on what PROMs should be used in asthma, how do we get them to a real consensus?'

Mr Gregory said there was a precedent with the work on costing and tariff development. There was wide-ranging input from clinicians into the development of the HRG4 currency, which was the first healthcare resource group currency designed to be used for payment purposes.

Dr (Jenny) Lewis agreed that clinical ownership was important and that the NCIP had used a similar approach of involving the royal colleges and professional bodies to get endorsement for the metrics it uses. 'Once you've got that endorsement, there is a degree of ownership, which is helpful,' she said.

However, she warned that it didn't necessarily last, as clinicians out in the field often had different ideas. And getting a patient perspective was a continuing challenge. 'There has been little patient involvement in our contact with the professional bodies,' she said.

HFMA ROUND TABLE

Su Rollason, chief finance officer of University Hospitals Coventry and Warwickshire NHS Trust, suggested that outcome standards from the International Consortium for Health Outcomes Management (ICHOM) provided a good place to start.

These outcome sets – including clinical outcomes and PROMS – have built-in clinical input, having been pulled together by teams of clinicians, and are being adopted by increasing numbers of health bodies across the globe, opening up the potential for benchmarking.

The trust has done pioneering work on collecting prostate cancer outcomes – looking particularly at the outcomes delivered using robotic surgery.

'We went to ICHOM because we needed clinically recognised outcomes that gave us the patient perspective,' said Ms Rollason. However, having decided what outcomes they wanted to collect, the next job was to work out what data they already had.

'We were amazed at the amount of data we capture and submit,' she said. 'However, it is completely siloed, isolated and in most cases not used for any other purposes.'

Offering another 'off-the-shelf' solution, Professor Kenny also highlighted the work undertaken as part of the COMET initiative, started in Liverpool, to develop core outcome sets to support clinical studies, audits and research.

But Lee Outhwaite, director of finance and contracting at Chesterfield Royal Hospital NHS Foundation Trust, raised concerns about the scope of PROMs. 'What does a PROM actually tell us?' he asked. 'If it is for a patient in end-stage renal failure receiving a new kidney, they are likely to be quite pleased with the outcome. But if someone has multiple comorbidities and is socially isolated, what you find out from an episodic treatment might have little to do with the intervention.'

Mr Outhwaite said the service needs to start measuring broader health and wellbeing metrics for the local population. 'That will help us see the impact of upstream interventions around social exclusion and isolation,' he said.

There was a lot of discussion around the benefits of standardising outcome measures rather than allowing different organisations to do their own thing. Using bespoke outcome measures in a single organisation may help with direct care locally, but if multiple organisations collect the same outcome measure, it opens up the potential to compare and identify best practice and opportunities to improve.

Professor Kenny went further: not only did organisations need to collect the same outcome measures – ask the same question – but the data needed to be widely accessible. 'The days of the standalone outcomes database are dying,' he said. 'Data needs to sit centrally and be available to the public, commissioners, providers and clinicians,' he said. Such a system should be built on solid foundations, so the NHS number and the GMC number would

Pictured, top to bottom: Chris Graham, Jenny Lewis and Lee Outhwaite

"Google may not be doing this in a way we would want in the NHS but they have lots of experience to learn from"
Chris Graham, Picker (left)

be key to any future development. Professor Kenny suggested the NCIP offered this.

Mr Graham said the NHS was still a long way off a comprehensive, single system to collect and analyse outcomes. 'To build a future-proof system of measurement, you'd need a mechanism to aggregate lots of different types of data and structure it around patients so that patients become the organising point in the data set and the data follows them,' he said. 'That's really important because most current mechanisms are focused on single services, illnesses or conditions and don't take account of individual patient complexity and wider determinants of health. You need as much data in one place as possible.'

Tech sector

There were lots of obstacles to developing such an approach, including public confidence, information governance and consent. But to move forward, the NHS needed to harness the expertise from other sectors and especially technology companies. 'The likes of Google may not be doing this in a way we would want in the NHS but they have lots of experience to learn from,' said Mr Graham.

Neil Davis, director of commercial and strategic capabilities at Johnson & Johnson Medical Devices Companies, said there was a rich volume of data, but to gain value from it, digital systems were needed to support its use.

'We need systems that allow for better data analysis, segmentation and best practice sharing to drive better outcomes for patients and bring more value across the NHS. This provides a real opportunity and an important role for industry to use our resources to innovate and create the artificial intelligence (AI) capability for the health sector,' he said.

Johnson & Johnson, for example, already works in partnership with Google on AI and use of data. 'The nature of our organisation means we're embedded in hospitals and theatres, not just across the country, but

globally. So we're in a very strong position to use the insights we gain from this to successfully partner with the NHS to bring a meaningful solution to this opportunity,' he added. 'Of course, with any new approach, regulation and protecting patient data is fundamental and something we would support developing in collaboration with regulators and authorities.'

Mr Jones felt a more organic approach to measuring and collecting outcomes was more realistic. 'How do you design a big theoretical model that involves everyone and gets their buy-in and then collects a consistent set of outcomes?' he asked. 'My perspective is that you should start at the ground level – at the front line – and build on this involving different people and different groups.'

This has been the approach at Aneurin Bevan University Health Board, which began its value-based journey five years ago. 'We started at a simple level by just trying it in one or two areas, such as Parkinson's disease,' he said. 'We were manually collecting outcomes and working with clinicians to see how we could better design services.' The health board knew that, to collect and use outcomes at scale, it needed an IT system, and the 'start small' approach encouraged clinical buy-in and demonstrated positive results.

One of the next areas it is considering is working with social care – aiming to collect a wider set of care outcomes.

Mr Jones said adopting a big bang approach – or waiting for a service-wide system – would have likely meant the organisation making little or no progress. 'The answer is probably somewhere in between: some bottom up work along with a top down approach that enables collection and use of outcomes at a system level, enabling it to be used with individual patients, along a range of care pathways and to inform decisions at a population level.'

Perhaps the real challenge is implementing PROMs and outcome measurement at scale. Mr Orme described Nottinghamshire's view of 'at scale' which had focused within the county boundaries.

'Our key challenge was the need to engage with primary care,' he said. 'The project required their data to understand complex comorbidities, when examining outcomes for patients with type two diabetes.'

Developing trust and offering win-win arrangements with primary care were essential in gaining access to the insights from other providers' data sets.

Mr Gregory said the service should explore existing events where people interact with health services – such as repeat prescriptions. 'Is that an opportunity to ask simple questions?' he asked, recognising that these questions couldn't be too detailed or intrusive. And he said that supporting people to become more activated in terms of their wellbeing and condition would also provide a better foundation for greater collection of PROMs data.

Digital solutions are likely to play a major role. Professor Kenny referenced a patient portal being developed at Alder Hey as part of its global digital exemplar programme. While this would provide opportunities to deliver routine communications to patients, it also opens up the potential for collecting clinical outcomes. Dr (Sally) Lewis said the portal's two-way communication would also put the patient in charge of governance, untying some of the knots the health service has found itself embroiled in over information governance and consent. The NHS app was also mentioned as a possible way of collecting outcome data.

Pictured: Su Rollason and Neil Davis

Two principles of design should be adopted for any system of outcomes collection, according to Mr Graham. 'First, you have to minimise the burden of administration,' he said. 'Otherwise it will be unbearable on the system – and that suggests a digital approach. Second, measure as rarely as possible and use as often as you can. At the moment, the system tends to measure frequently and then not use the information as much as we should. We need a total reversal of this situation.'

Mr Jones said clinician and patient buy-in were also essential to ramping up outcome collection. 'You need to work with patients to convince them that this is not just an Amazon after-sales survey but an important part of their care – allowing them to take control of how their care is delivered,' he said. And he said that once buy-in was in place, organisations needed to make it convenient for patients to complete the essential information – via a smart app while waiting to go into a clinic, for example.

Dr Day again underlined the importance of clinical buy-in in any scale-up. 'We have a national renal PREM and we've started collecting some PROM data as well,' she said. 'It can be looked at as a curiosity, as something that is interesting. But it should be used to improve and guide care at an individual and unit level, not simply to compare between patients or units.' Patient outcome data must be used to drive transformation.

At Aneurin Bevan, the health board's investment in an outcomes reporting system is helping it to scale up – although Mr Jones warned that this alone would not solve all issues. There was still a need to ensure that different systems could talk to each other. By solving this, it is possible to develop single dashboards for clinicians, enabling them to easily access all the relevant data to discuss the patient's care and inform decision-making.

The roundtable also discussed how data from outcome measures could be turned into useful information to inform decision-making. Dr (Jenny) Lewis said there was a role for digital design agencies to feed back information in a way that directly supports the decision to be taken. 'In the NHS, we have a tendency to build a dashboard for one purpose and then use it for 10 other things,' she said. This doesn't work and can discredit the data and put people off using it.

Mr Graham agreed that visualisation was important, with boards wanting information in a totally different format to the frontline. While boards want detailed reports and benchmark data, clinicians often prefer narrative feedback and infographics that engage them more.

This brought the roundtable to its final question of the day. What is the role of finance teams in mainstreaming the collection and use of patient-defined outcome data in the NHS? Ms Rollason said finance professionals' training meant they were well suited to support the roll-out of outcomes.

"Many measures are used in healthcare but too small a proportion are patient-focused and an even smaller proportion are supported by evidence"

James McGowan (left)

'Finance people have experience with very large data sets,' she said. 'They are objective in looking at data and they have a privileged view over the whole pathway in an organisation and already engage with many of the key stakeholders.'

Mr Orme said the finance function also had a role in ensuring future payment systems supported the collection of robust data. The payment by results (PBR) system had led to a major increase in coding and data quality, even though there are now plans to move towards population-based payment approaches.

'While the finance profession has recognised what was wrong with PBR, it has provided an enormously valuable data set and we mustn't throw the baby out with the bathwater,' he said.

'There is real value to developing the contract data into an outcome-focused data set, and finance professionals are in a unique position to help develop our understanding of outcomes and value.'

Finance leaders will also have a major influence on the development of the outcomes agenda as they have a leading role in investment decisions. Will they support investment in outcomes? Mr Gregory said some would be in the vanguard and the HFMA Healthcare Costing for Value Institute had a role in encouraging others to follow them rather than wait to see benefits emerging. However, he added that the focus needed to shift towards system value and system outcomes, rather than the narrower focus on individual organisational value.

HFMA ROUND TABLE

Overall the roundtable agreed that more needed to be done to demonstrate the value of collecting and using outcomes to improve pathways. They called for more case studies to be shared and suggested more peer-reviewed evidence would help demonstrate this as good value for citizens, patients and clinicians.

Thank you to all HFMA corporate partners for their continued support

For more information about becoming a corporate partner, please contact Paul Momber **E paul.momber@hfma.org.uk T 0117 938 8972**

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Events, people and support for finance practitioners

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Group accounting manual firms up expectations in run-up to year-end

Technical

It's the time of year that guidance is issued thick and fast as we run up to the year-end. This year, the Department of Health and Social Care's Christmas present of the updated *Group accounting manual* was late and arrived in time for Hogmanay instead, *writes Debbie Paterson*.

SHUTTERSTOCK

There are seven FAQs – the usual update on discounts and the injury cost recovery rate, as well as some tidying up of terminology and reflecting the updates to the Treasury's *Financial reporting manual* (FReM).

The more substantial changes are:

- An update to the public dividend capital (PDC) dividend policy that removes terminology relating to grant accounting that is no longer relevant. It also adds instruction on what should happen when a provider demises or is involved in a merger or acquisition
- Guidance on how transfers of property from NHS Property Services to NHS providers should be accounted for
- An initial indication of the accounting treatment for the element of the employers' pension contribution that is being paid for by NHS England. The FAQ makes it clear that NHS bodies will be required to account for the full employer contribution of 20.68%, with an offsetting entry to reflect the funding for the part of the contribution being paid by NHS England. Further guidance on how this will work in practice, including how the amounts being paid by NHS England will be calculated, will be provided before the year-end.

The NHS foundation trust *Annual reporting manual 2019/20* has also been published. There are very few amendments this year, so they were not subject to consultation. Most of the changes reflect changes to other guidance:

- The *UK corporate governance code* means changes to the disclosure of key issues and risks in the performance report and disclosure of policies on diversity and inclusion in the staff report
- UK auditing standards have required changes to the wording used in relation to 'going concern'
- Guidance issued by the Tax Centre of Excellence in relation to highly paid off-payroll workers
- The new name of the *NHS oversight framework* has required changes to references to framework disclosures
- To reflect the FReM, disclosures around information to auditors has now been moved to the statement of accounting officer's responsibility.

Further changes – not related to other guidance – have been made. These help foundation trusts to explain the single total figure of remuneration table; require a link to be included to the gender pay gap report; and require disclosure on the FT's compliance with guidance on managing conflicts of interest in the NHS.

The NHS Business Services Authority has also issued its *Greenbury guidance*. There are few changes – the deadline for submissions for information is 28 February; there is now a reference to the General Data Protection Regulation (GDPR); there has been a change to the method used to calculate cash equivalent transfer values (CETVs) to remove the adjustment for guaranteed minimum pension; and a change in the inflation rate to 2.4% (3.0% last year).

The December pensions newsletter makes it clear that the NHS Business Services Authority will not be able to provide revised calculations once final pay figures are known.

Finally, the *Agreement of balances guidance* has been issued for 2019/20. It has been revised to make it easier to read and to ensure that it is internally consistent. It is worth noting that the word 'variance' has been replaced with 'mismatch' to better reflect differences highlighted by the agreement of balances exercise.

The guidance has been substantially amended to reflect the changes made to NHS England's structure – notably, paragraph 7.1 and Appendices 1 and 3 of the NHS England appendices. Other changes reflect the revised approach to the Provider Sustainability Fund, Financial Recovery Fund and the marginal rate emergency tariff.

Debbie Paterson is HFMA policy and technical manager

Technical review

The past two months' key technical developments

For the latest technical guidance download the myHFMA app from the Apple store or Google Play

Technical

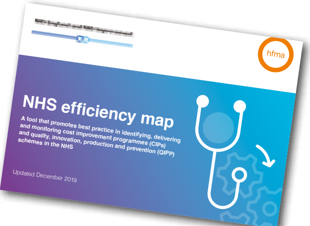
Getting it Right First Time (GIRFT) has launched a series of questionnaires in support of its work on **paediatric critical care**. This includes a questionnaire on finance, which seeks to gain an understanding of how the service is commissioned and funded; the information gathered in providers; and the data reported outside the organisation. GIRFT said it expected a senior member of the finance team would be best placed to provide the information, though it may also require input from contracting teams. hfma.to/68t

A new HFMA briefing looks at the accounting and valuation issues related to **property, plant and equipment**. The guide covers the initial measurement of purchased assets as well as when subsequent expenditure can be capitalised. It goes on to explore depreciation, including component depreciation, and looks at the revaluation model for measuring asset value in the NHS after initial recognition. A simple table summarises the valuation basis used depending on the asset type and reason it is being held. The guide goes on to cover the role of the auditor, impairment and disposal of property and equipment. hfma.to/r75

The existing **reference costs grouper**, as used in 2019 (relating to the financial year 2018/19), is being retained for use with the 2020 collection. The decision follows a review by NHS England, NHS Improvement and NHS Digital of the options for developing the grouper. It was decided that the existing grouper continues to meet the requirements of stakeholders and has the added benefit of being immediately accessible. A January costing newsletter also reminded providers that the deadline for the voluntary education and training cost collection had been extended to 17 February. hfma.to/qit

North Staffordshire Combined Healthcare NHS Trust implemented a **patient-level information and costing system (PLICS)** for its mental health services in 2014/15. Now a new briefing from the HFMA Healthcare Costing for Value Institute describes how the trust has worked hard to turn the large amounts of data generated by the system into information that is useful for clinical and operational services. The trust has developed an information dashboard in-house and clinical teams are starting to use this to identify opportunities for improvement. It has also started to map service user pathways and link these to patient outcomes. The briefing is available to all institute partner organisations. hfma.to/qj6

NHS Improvement has published a guide on good **governance for audit and assurance** for providers and commissioners. The guide looks at best practice in appointing and managing external audit contracts, as well as external audit findings and reporting. It sets out expectations for good governance over audit and assurance and seeks to help NHS bodies understand their responsibilities. hfma.to/86m



The HFMA updated its **efficiency map** in December. The map – developed by the HFMA in partnership with NHS England and NHS Improvement – promotes best practice in identifying, delivering and monitoring cost improvement programmes and quality, innovation, productivity and prevention schemes. It links to a range of tools and guidance and is split into three sections: enablers for efficiency; service efficiency; and system efficiency. The map supports the delivery of efficiency in the 10 priority areas identified in the *NHS long-term plan*. A new case study explores how one sustainability and transformation partnership is embracing the use of costing data to drive its efficiency programme. hfma.to/c4z

Commissioning for quality and innovation guidance has been published for 2020/21 by NHS England, covering both the clinical commissioning group and prescribed specialised services schemes. Selected indicators are aligned to four key areas: prevention of ill health; mental health; patient safety; and best practice pathways. Applicable indicators depend on the type of provider and payment rules continue to promote simplicity, with lower and upper adoption goals for each intervention chosen to ensure CQUIN funding is fully earnable. hfma.to/ovn

CDF approval for breast cancer treatment

During December and January, NICE published a further seven technology appraisals, one medical technology and two guidelines, *writes Gary Shield*.

The guidelines – *Acute kidney injury: prevention, detection and management* (NG148) and *Indoor air quality at home* (NG149) – are supported by resource impact statements that detail why implementing the guidelines are not expected to lead to a significant resource impact.

All seven technology appraisals had positive recommendations, with *Palbociclib with fulvestrant for treating hormone receptor-positive, HER2-negative, advanced breast cancer* (TA619) being recommended for use with the Cancer Drugs Fund (CDF). It is estimated that up to 3,300 women per year will be eligible for this treatment, which is for those who have already had endocrine therapy.

Palbociclib joins two other NICE-approved drugs – ribociclib and abemaciclib – at this stage of treatment. Taken once-daily in pill form, palbociclib is a type of drug called a cyclin-dependent kinase 4 and 6 (CDK4/6) inhibitor. These work by inhibiting proteins in cancer cells, thereby preventing the cells from dividing and growing.

Implementing the medical technology guidance *GammaCore for cluster headache* (MTG46) is not expected to lead to a significant resource impact.

Gary Shield is resource impact assessment manager at NICE

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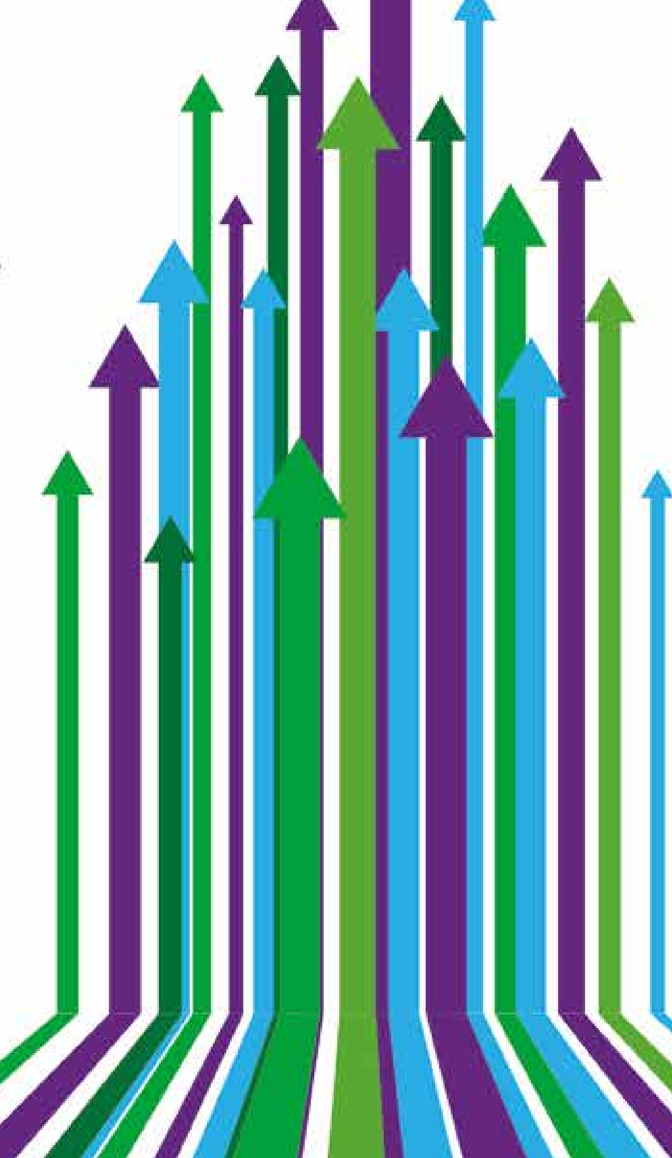


Diploma shows clinical appeal

News and views from the HFMA Academy

When Toby Garrood signed up to study for the HFMA *Advanced higher diploma in healthcare business and finance* last September, little did he know that he was passing a significant landmark for the association, *writes Steve Brown.* Dr Garrood (pictured) was, in fact, the HFMA Academy's 500th learner to start one of its programmes.

As a clinician, he is also one of an increasing number of frontline staff keen to improve their grasp of NHS finance. In fact, across all the academy's programmes – covering both the HFMA's intermediate and advanced healthcare business and finance qualifications and the diploma in advanced primary care management, delivered on behalf of the National Association for Primary Care – about one in six learners has a clinical background.

Dr Garrood is a consultant rheumatologist and clinical director for specialist ambulatory services at Guy's and St Thomas' NHS Foundation Trust. So, what attracted him to supplement his already extensive clinical training with a business oriented programme?

'I'm a clinical director at Guy's, so it is really to fill the gaps around finance,' he says. 'As doctors we don't get any formal training in finance and we may find ourselves in senior management positions without specific expertise in these areas.'

Dr Garrood completed his first module – *Managing the healthcare business* – in January and has now started on the second of three modules that make up this diploma.

This term he will be studying *Making finance work in the NHS* – before moving on to *Creating and delivering value in UK healthcare.*

However, he hopes to move beyond this and, upon successful completion of the diploma, wants to sign up for the MBA in healthcare finance, delivered by the HFMA Academy's partner, BPP University.

'The content has been surprisingly enjoyable,' he says, admitting that he had expected it to be drier. 'It is very well written and it is good relevant content. I wouldn't have time to learn things that aren't relevant – I couldn't just be learning for the sake of learning – but this is all very pertinent to my job.'

He singles out coverage of forecasting, accounts and ratio analysis as being useful. 'It was all really interesting, but the content on the accounting side was particularly helpful,' he says.

Dr Garrood says he would recommend the programme for other clinicians going into management or leadership positions. 'The NHS is not great at providing this kind of support for clinicians, but it is definitely what they should be doing,' he adds.

He also highlights the value of the tutor-led sessions run by Paul Dillon-Robinson, who spent 17 years in the NHS and nine as director of internal audit at the House of Commons. 'The tutorials were brilliant,' he says. 'They kept it all moving and interesting.'

Dr Garrood admits that the level 7 modules are a lot of work – each one taking up to 200 hours according to guidance. 'It is a significant commitment and you do need to be prepared for it,' he says. 'I have done a PhD in the past, so I knew what to expect from a postgraduate degree, but people need to believe it when they are told it is a significant amount of work. And experience with writing is definitely helpful.'

Value maker conference announced

Bookings are now open for NHS Future-Focused Finance's fourth Value Maker Annual Conference (VMAC) in London on 24 September. VMAC 2020 will bring together finance professionals from across the country to: share best practice from their organisations; network and build on their professional connections; and celebrate the success of the network, which is currently made up of over 1,450 people – and growing.

The network has grown dramatically over the past 12 months, with increased engagement across the regions. Value makers have been the driving force behind some of the biggest achievements FFF has made. In particular, the number of NHS organisations reaching at least level one on the Towards Excellence accreditation programme is now in excess of 100.

The much sought-after value maker awards (pictured) will also be taking place again this year at the conference and details will be shared soon. The event is open to all NHS colleagues: those already a part of the value maker network and those who aren't yet but are interested in learning more.

If you would like to hear more about the network and how it can benefit you, join FFF at this free networking-based event. Bookings can be made at **hfma.to/ytj**

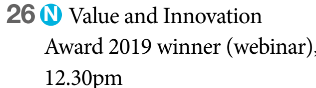
Diary

January

29 N Pre-accounts planning, Leeds
30 N Pre-accounts planning, London
30 B Northern: social evening
31 B Yorkshire and Humber: branch conference, Scunthorpe

February

6 F Integration summit, London
10-11 N CEO forum, London
11 B Kent Surrey and Sussex: accounting standards, Gatwick
12 F Provider Finance: technical forum
13 B Wales: VAT training level 3, Cardiff
14 B Kent Surrey and Sussex: introduction to NHS finance, Wroxham Heath
20 N Clinical coding transformation at North Bristol NHS Trust (webinar), 12 noon



26 N Value and Innovation Award 2019 winner (webinar), 12.30pm
27 I Institute: costing together (south), London

March

4 I Institute: the next step – how to use PLICS to benefit your trust (webinar), 11am
5 N Driving workforce savings – staff bank best practice (webinar), 11am
11 I Institute: value masterclass, London

April

8 I Institute: costing conference, London
24 B North West: golf event

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

key: B Branch N National F Faculty I Institute

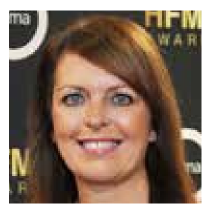
HFMA webinars

Three new webinars will be available to HFMA members over the coming month, focusing on clinical coding, patient-level costing (PLICS) and finance business partnering:

- At North Bristol NHS Trust, **Clinical coding transformation** (20 February, 12 noon) will look at how the trust significantly improved its coding in three pilot specialties in 2018/19. It will also examine the trust's standardisation of its improvement methodology and look in detail at improvements in neurology coding.
- Costing practitioners, as well as those focusing on improving internal PLICS reporting and the use of data, will find **The next step – how to use PLICS to benefit your trust** useful. The webinar (4 March, 11am) will examine how to move from generating annual PLICS data to reporting quarterly and monthly.
- A third webinar, **Exploring the role of the NHS finance business partner**, was held on 23 January and is available on demand via **www.brighttalk.com** (search for HFMA), together with a range of previously held webinars.

Events in focus

Integration forum
6 February, London



With the new government throwing its weight behind the *NHS long-term plan*, health and social care organisations throughout England will be carrying on with their efforts to implement its ambitions on integrated care. A year on from the publication of the plan, the HFMA's fifth annual integration summit will focus on the implementation of integrated care systems (ICSs) and the progress made towards national coverage (due by April 2021).

The event will be useful for those with an interest in integrated finance and governance, particularly those from health and local authorities working in integrated systems. The programme, chaired by Kathy Roe (pictured), finance director at Tameside and Glossop Clinical Commissioning Group and Tameside Metropolitan Borough Council, will hear from Jacquie White, director of system development for primary care and system transformation, NHS England and NHS Improvement. There will also be speakers from local government and ICSs.

If you are affiliated with a HFMA partner organisation, you can attend this event for free. Limited free places are also available for members of the Local Government Association.

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

Save the date: the HFMA annual summer conference (2-3 July) will focus on ICSs and the transition to system-wide working in the NHS, how the aims of the long-term plan can be delivered and how finance teams can work together across organisational boundaries.

Mental Health Finance Faculty technical forum/Provider Finance Faculty technical forum
12 February, London

Each year, the HFMA mental health and provider finance faculties run technical events, each focusing on a single topic. This year, the events will be held on the same day, with the mental health faculty hosting the morning session. This will look at digitisation and will include an update from NHS X director for technology and data strategy Kathy Hall.

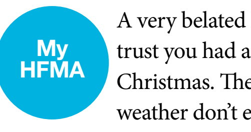
Delegates are welcome to attend both sessions – the Provider Finance Faculty's afternoon forum will examine system finance management. There will be updates from national bodies, and speakers include John McLoughlin, senior finance lead for financial accounting and services at NHS England and NHS Improvement (pictured).

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

New opportunities

Association view from Mark Knight, HFMA chief executive

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



A very belated happy new year. I trust you had a good break over Christmas. The short days and cold weather don't entice us back to work but, for many of us, it is the belief we are doing something worthwhile that motivates us.

For the HFMA, the work continues. Thank you to all who attended the annual conference in December. Apart from a pretty shockingly bad dinner, for which I apologise, I felt the event was one of the best we had run, with a variety of interesting and stimulating speakers present.

For the association, it was a piece of crisis management four weeks out, when the general election date was set for the week after our flagship event. Several NHS leaders scheduled to speak had to withdraw because of pre-election sensitivities. But HFMA staff were able to turn a potential disaster into a triumph. And many of our colleagues from NHS England and NHS Improvement, who were unable to address the conference, will be delivering webinars on the HFMA platform in the coming weeks.

For those who like to plan early, the early booker rate for our 70th anniversary conference in December will be out soon.

The new year means a new president and we are excited to have Caroline Clarke at the helm for 2020. Her theme, *Taking pride in the future,* is a powerful rallying call in the association's 70th year of existence. She wants NHS finance to take pride in what it does well and play a key role in securing the future success of the NHS.

Those of you who have met Caroline will have been struck by her energy and charisma. We look forward to helping her deliver her objectives. There is a different dimension in having a CEO as president and it's great to have someone from London – the first since 2000.

The association used the annual conference to launch our HFMA bitesize portfolio of courses, with three levels to meet the learning needs of a wide range of NHS staff. We are exploring how we can make these courses much more accessible across all four UK nations. The product will be available to purchase from early March and we will be sending out further details shortly.

HFMA chief executive Mark Knight

In April, we launch our new hub concept. Most of the face-to-face networking at HFMA in England takes place via our faculties, which have been astonishingly successful. But we must move with the times. The HFMA's longstanding partner programme and faculty offering will evolve into the HFMA hub partner programme to mirror moves towards system working. Partnership with the hub will allow organisations and systems to come together, network with peers, share expertise, and influence policy and decision-making. The aim is to support wider finance teams working across organisational boundaries for integrated service delivery.

The HFMA faculties will continue as networks and keep their strong identities. But there will be more focus on integration and picking up new methods of delivery. Hub partners can select the events and familiar benefits from their faculties. But they will also be encouraged to access the broader hub programme. You'll hear more from us in the coming months and weeks, so look out for further details on the hub.

2020 has got off to a flying start already for the association. Perhaps this is the year you will get more closely involved with the HFMA!

SHUTTERSTOCK

Member news

Sussex Community NHS Foundation Trust's finance team has donated a £100 voucher to Brighton Food Bank. The team won the Training Award at the **Kent, Surrey and Sussex Branch** awards and received the voucher to recognise the achievement. The Brighton charity supports families and individuals going through times of crisis. **hfma.to/foodbank**

Meanwhile, Sheila Stenson, chair of the Kent, Surrey and Sussex Branch, and committee member Stuart Wayment visited St Catherine's Hospice to hand over £1,300 that the branch raised during its annual conference.

The **Northern Branch** celebrated the best in local NHS finance at its recent annual conference. The winners were:

- Large Team – financial management team, Northumbria Healthcare NHS FT (pictured)
- Accountant – Lis Dunning
- Student – Arran Scott and Georgia Carter (joint winners)
- Apprentice – Lewis Chater, Aiden Watson, Connor Buckley and James Davison (joint winners)
- Accounting Technician – Josh Lowes

- Small Team – financial management community team, Co Durham and Darlington NHS FT
- Unsung Hero – Ritchie Barron
- Chair's Award – Moya Mearman, Lynne Hodgson, Samantha Hebdon, Louise Ferguson and Anne Dinsley
- Graeme Smart Award – Lynne Hartley

Hundreds of HFMA members took part in an end-of-year quiz that asked members to match dogs with their NHS finance-related owners. Tameside and Glossop Integrated Care NHS Foundation Trust's Michelle Hurst was randomly selected from a small number of entries that got all the pairings correct. She won an HFMA goodie bag.

Member benefits

Membership benefits include a subscription to *Healthcare Finance* and full access to the HFMA news alert service. Our membership rate is £65, with reductions for more junior staff and retired members. For more information, go to www.hfma.org.uk or email membership@hfma.org.uk

Network focus

Environmental Sustainability Special Interest Group

As one of the biggest employers in the world, the NHS plays a key role in the environmental sustainability agenda. From reducing single use plastic in canteens and in clinical practice to redesigning processes to reduce carbon emissions, the scope for improvement and culture change is vast (*see Healthcare Finance, December 2019*).

By building on the work of the NHS Sustainable Development Unit and taking the advice of other experts in the field, the HFMA Environmental Sustainability Special Interest Group (SIG) aims to support its commitment to embed significant and effective sustainability strategies into all aspects of the NHS. The group facilitates the sharing of best practice and urges the NHS finance function to take steps to reduce the negative environmental impact of NHS activity as a whole.

'We want to develop the capabilities of the NHS finance function in terms of how to plan for, manage, analyse and report on the sustainability issues of the NHS,' says Pam Dyson (pictured), a longstanding member of the group. 'Everything that happens in the NHS involves a financial demand on the public purse as well as an impact on the global environment. Both need constant professional focus and to be expertly managed.'

Environmental sustainability is everyone's business, and this is why the group is keen to reach a wide audience across the NHS. To achieve this, the SIG shares case studies and information to illustrate the impact of NHS activity on environmental sustainability. It helps to identify resources available to NHS finance staff to address the environmental sustainability agenda at a professional and personal level.

'There are a lot of good case studies to show what NHS organisations have already done to enable sustainability in their local communities and to address the wide variety of issues identified in the UN Sustainable Development Goals (SDGs) – from waste management to improving procurement processes or reducing the impact of NHS-related travel. But there is still a huge amount left to be done,' says Mrs Dyson.

'As an NHS finance function, we're very capable of addressing "big issues". Environmental sustainability and the survival of the planet needs everyone's attention now. It's the biggest problem we have ever faced, and we only have one shot at it,' adds Mrs Dyson.

• To get involved, please visit hfma.to/environmentSIG

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Appointments

Steve Wilson (pictured) is now treasurer at Greater Manchester Combined Authority. He was previously executive lead, finance and investment at Greater Manchester Health and Social Care Partnership. Mr Wilson started his NHS finance career as a finance trainee on the NHS financial management training scheme in 1996.

University Hospitals Birmingham NHS Foundation Trust has named **Claire Finn** director of operational finance. Previously, she was head of productivity and financial improvement at the trust. Ms Finn has over 15 years' experience in NHS finance.

Mark Axcell (pictured) has been appointed chief executive at Black Country Partnership NHS Foundation Trust, in addition to his position of chief executive at Dudley and Walsall Mental Health Partnership NHS Trust. Mr Axcell has over 25 years' experience in the NHS, most of it in finance. He is also a trustee at A Child of Mine, a charity supporting grieving families.

Chelsea and Westminster Hospital NHS Foundation Trust has appointed **Virginia Massaro** acting chief financial officer. Ms Massaro joined the trust in 2010 as head of financial planning before progressing to assistant director of finance and deputy director of finance, having worked in finance teams across NHS organisations in North West London. She takes over from **Sandra Easton**, who is now director of operational finance and performance at NHS England and NHS Improvement.

Peter Holt (pictured), former finance director of Health Education England for London and the South East, is now chief finance officer at GambleAware, a charity committed to minimising gambling-related harm. Mr Holt has 12 years' experience in public finance.

Peter Munday has been named lay member for governance and audit for Cheshire Clinical Commissioning Group, to be formed by the merger of Eastern Cheshire, South Cheshire, Vale Royal and West Cheshire clinical commissioning groups on 1 April. Mr Munday has held the same post at Eastern Cheshire CCG. He previously worked in finance for Salford Royal and Mersey Care trusts.

Frankie Morris has been named acting chief finance officer at Liverpool Heart and Chest Hospital NHS Foundation Trust. She has been deputy chief finance officer at the organisation. Ms Morris joined the NHS in 2006 and has held senior positions in organisations in the North West.

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

"There are lots of opportunities to go at – and if we make the right changes, we will be up there with the very best"
Claire Wilson, Wirral University Teaching Hospital NHS Foundation Trust

Wilson makes chief finance move to Wirral

Claire Wilson has been appointed chief financial officer at Wirral University Teaching Hospital NHS Foundation Trust. She joins from the Liverpool Heart and Chest Hospital NHS Foundation Trust, where she has been chief financial officer since 2016. Previously, she has worked in a clinical commissioning group and at regional and national level.

'The move was a natural next step from a personal perspective,' she says. 'Wirral is a teaching hospital with a broad range of services and a busy emergency department. The trust has been on a journey of improvement for the last 18 months and has built strong foundations to improve quality and governance.

'Like many others, the trust is facing considerable financial challenges, but there are opportunities for improvement and a strong commitment to tackle them,' she adds. 'It is an exciting time to join the team, the foundations are there, and we can build on this now to focus on wider system sustainability.'

The trust is focusing on a number of developments, including acting as a global digital exemplar and delivering an £18m upgrade to its urgent treatment centre, and it is moving forward on population health.

Meeting the new management team – appointed following some instability at the trust – confirmed her feeling that Wirral was the right choice. 'The board of directors has a clear and ambitious vision for the hospital, including a determination to address the financial challenges faced by the trust and the wider Wirral system,' she says. 'As a finance director, that was a strong draw for me.'

In 2018/19, the trust ended the financial year with a deficit of £31m, which was £6m more than planned. Provider sustainability funding was not available to the trust in 2018/19, as it did not agree to its control total.

'Geographically, Wirral has the right ingredients to make integrated care work – a single CCG, a community trust, acute trust, mental health services and a single local authority. We are at the start of the journey, but there's a will to work together across the system and there's a great opportunity to develop a successful integrated care system.'

Ms Wilson continues: 'There are some big financial challenges across the health economy, but the partners in health and care are now working together around the shared financial challenge. That's a positive and one of my objectives for the coming year is to build on that.'

"Geographically, Wirral has the right ingredients to make integrated care work – a single CCG, a community trust, acute trust, mental health services and a single local authority"

She is optimistic that this will deliver better care for patients. 'Looking at the benchmarking, Model Hospital and RightCare data, there are lots of opportunities to go at – and if we make the right changes, we will be up there with the very best.'

A strong finance team that is supported to reach its potential will play a vital role in facilitating these improvements. To this end, Ms Wilson will focus on developing her team.

'This year, I want to look at how we are supporting and engaging with staff at every level in the hospital. We need to find the best ways to make the financial challenge meaningful to the people who are delivering care every day and to support them to help us to turn this around.'

She wants to ensure that finance staff have the skills, capability and capacity to provide this support to frontline carers. This will mean developing business partnership arrangements for the next phase of the journey. She praises the recent report, *Exploring the role of the NHS finance business partner*, published by the HFMA, Future-Focused Finance and ACCA.

She is keen to use the support offered by the HFMA to develop her team. 'The HFMA is a strong community for finance colleagues in tough times, offering insights into best practice.'

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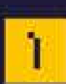

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