healthcare finance

March 2020 | Healthcare Financial Management Association

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System by default

Getting everyone round the table

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Finances off plan as Department looks for overall balance

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Mixed response to planning guidance for 2020/21

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Leading by influence: new skills needed for system working

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Managing editor
Mark Knight
0117 929 4789
mark.knight@hfma.org.uk

Editor
Steve Brown
015394 88630
steve.brown@hfma.org.uk

Associate editor
Seamus Ward
0113 2675855
seamus.ward@hfma.org.uk

Professional lives
Yuliya Kosharevska
0117 938 8440
yuliya.kosharevska@hfma.org.uk

Advertising
Paul Momber
0117 938 8972
paul.momber@hfma.org.uk

Subscriptions and membership
James Fenwick
0117 938 8992
james.fenwick@hfma.org.uk

Production
Wheal Associates
020 8694 9412
kate@whealassociates.com

Printer
Severn Print

HFMA
1 Temple Way,
Bristol BS2 0BU

Executive team
Mark Knight
Chief executive
mark.knight@hfma.org.uk

Emma Knowles
Policy and research director
emma.knowles@hfma.og.uk

Alison Myles
Education director
alison.myles@hfma.org.uk

Ian Turner
Finance director
ian.turner@hfma.org.uk

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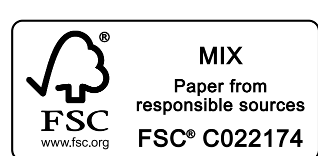

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News

Finances off plan but reserve funding given to Department

By Seamus Ward

As NHS England and NHS Improvement confirmed they will seek to write off historical debt in 2020/21, NHS commissioners and providers forecast an aggregate year-end position for 2019/20 that is £400m off plan.

NHS England and NHS Improvement have planned for a balanced position at year-end.

Meanwhile, Treasury supplementary estimates – which detail in-year adjustments to departmental budgets – show the Department of Health and Social Care has received an additional £420m of reserve funding.

In the supplementary estimates document, the funding is described as 'reserve funding to cover unforeseen in-year pressures'.

Asked about the extra funding and the in-year pressures, the Department said the £420m reserve funding represents a backdated increase to the non-NHS element of its budget.

Non-NHS funding is allocated for running the Department and other arm's length bodies, not including the NHS. It added the funding was backdated to 2019/20 following negotiations to increase non-NHS funding in 2020/21.

The fact that the funding is for the Department's central budget has led some commentators to speculate that it will be used to offset the aggregate deficit in providers and commissioners.

NHS England and NHS Improvement chief financial officer Julian Kelly told the bodies' recent joint board meeting that commissioner and provider year-end forecasts were in line with expectations.

"At the end of the year, in aggregate, the balance of commissioners and providers will be about £400m off plan"
Julian Kelly

'Our current forecast is that at the end of the year, in aggregate, we think the balance of commissioners and providers will be about £400m off plan – bear in mind that that's 0.5% of the total spend.

'The number of organisations forecasting to be off plan is roughly half of what it was at this point last year, which shows progress in delivering the financial trajectories that we agreed, even if there is still more work to do.

'We are working hard with regional teams, systems, providers and commissioners to continue to try to improve that position. We are managing the risk that it poses to the whole NHS mandate, in part through having gone harder this year at our own administration costs and in part because of lower than forecast drugs spend. This is a reflection of the commercial work done in the last two years.'

Mr Kelly also spoke about the 2019/20 capital position. 'Against the allocation the Department has made, we are forecasting to be within £100m or so of that allocation,' he said. 'We continue to work with NHS organisations to make sure funding provided is spent. We are also continuing to work on the process to speed up approvals between systems, ourselves, the Department and the rest of government.'

For 2020/21, operational planning guidance set out a scheme to write off clinical commissioning group historical overspends. Where the overspends are more than 4% of a CCG allocation, a proportion – typically 50% – will be written off. The CCG will then agree a repayment profile for the remaining amount.

NHS England and NHS Improvement are planning to bring forward a scheme to reduce trust historical deficits, probably with a debt for equity swap. According to Mr Kelly, the detail had yet to be finalised, but he added: 'We are in ongoing conversations with the Department and the rest of government about the process of recapitalising and creating a financially sustainable platform for the whole of the NHS.'

• *System default, page 16, and Technical, page 25*

GIRFT report showcases orthopaedic success

The Getting it Right First Time programme in orthopaedics has contributed to improvements worth nearly £700m over the past five years, according to a follow-up report published seven years after the first deep-dive visits to trusts.

Key aims for the programme were improvements in quality and outcomes. But the report said GIRFT had also supported the cumulative release of operational and financial opportunities of £696m over half a decade. These 'savings' represent unnecessary activity avoided, bed days saved by reducing average length of stay and increasing the use of day case surgery. There have also been reductions in emergency readmissions, infection rates and litigation costs.

An estimated £165m was released in 2018/19 alone, with £72.6m from reduced activity. A reduction in litigation costs – valued at £67m over the life of the programme – was claimed to be a conservative estimate.

Average length of stay for elective hip replacements have fallen by 19% since 2013/14.

Other recommendations are also increasingly being put into effect. More trusts are enforcing the ringfencing of beds, many have adopted hot and cold sites and a growing number of implants used now have Orthopaedic Data Evaluation Panel ratings. The use of cemented or hybrid fixations in hip replacements for patients aged 70+ has almost reached the target of 80%.

Professor Tim Briggs (pictured), chair of GIRFT, which now covers 40 specialties, and clinical lead for orthopaedics, said the specialty had a lot to celebrate in tackling unwarranted variation. 'But we know there are still huge opportunities out there,' he said.

Scottish Budget targets greater integration

By Seamus Ward

The NHS Scotland budget will receive major increases in revenue and capital as the local administration seeks to press ahead with the pace and scale of integration and ensure the delivery of person-centred, sustainable care.

The funding rise includes an extra £594m for frontline, territorial boards (*see table*), with NHS and national board capital increasing by £92m to £448m. The overall health and sport budget will rise to more than £15bn for the first time, and more than £9bn will be invested in integration.

The overall 4.2% cash rise in frontline funding includes a £17m pot to ensure no health board is more than 0.8% away from its target allocation. Dedicated funding of £121m will be allocated to improving outcomes. This includes an additional £28m for reform of mental health and child and adolescent mental health services. Mental health reform investment will rise to £89m – in the current year this fund is worth £61m.

The Scottish government has pledged that, over time, more than half of health spending will be in community services. This includes spending on areas such as general medical, dental and ophthalmic services, as well as community mental healthcare. In 2020/21, it plans to continue the move towards this goal, with more than £2.1bn allocated to community health services – up from £1.85bn in 2019/20.

Territorial boards	2018/19 budget £m	2019/20 budget £m	2020/21 budget £m
NHS Ayrshire and Arran	694.9	720.0	762.4
NHS Borders	200.6	207.7	219.8
NHS Dumfries and Galloway	289.1	299.1	316.1
NHS Fife	636.6	661.4	701.5
NHS Forth Valley	506.8	527.0	558.7
NHS Grampian	920.6	957.9	1,013.5
NHS Greater Glasgow and Clyde	2,154.5	2,231.2	2,364.7
NHS Highland	604.3	627.5	666.0
NHS Lanarkshire	1,156.1	1,199.3	1,268.1
NHS Lothian	1,384.3	1,441.5	1,540.1
NHS Orkney	47.7	49.6	52.6
NHS Shetland	48.7	50.6	53.9
NHS Tayside	734.8	762.9	808.5
NHS Western Isles	73.0	75.7	80.0
Total	**9,452.0**	**9,811.4**	**10,405.9**

Much of the focus of its capital spending will be environmental sustainability. The government said NHS Scotland's greenhouse gas emissions will be net zero by 2045. The supply chain will be reviewed to minimise its environmental impact.

The Attend Anywhere programme of virtual clinics will be expanded, improving patient access and reducing emissions. Capital will also be provided to extend elective care capacity and invest in a new £200m hospital in Aberdeen.

National boards such as the Scottish Ambulance Service and Public Health Scotland will receive an additional £86.5m.

Health secretary Jeane Freeman said: 'The Scottish Budget continues to shift the balance towards primary, social and community care and to support our focus on mental health. It ensures we remain on track to deliver more than half of frontline NHS spending in community health services by the end of this Parliament.'

Northern Ireland calls for health and care spending boost

Northern Ireland's health and social care services will require minimum additional funding of £661m in 2020/21 to maintain services and meet the Westminster government's recent funding promise, according to health minister Robin Swann (pictured).

In the build-up to the Northern Ireland Budget, which is expected this month, Mr Swann said £492m would be required to keep services at their current level. A further £169m is needed to meet the commitments in *New decade, new approach*, the agreement that led to the re-establishment of the Stormont Assembly and executive.

The service maintenance funding would include an estimated £170m needed to achieve pay parity. Health unions accepted a deal on pay parity and safe staffing in February.

The *New decade, new approach* money would be used to bear down on waiting lists and to enhance and reform social care – increasing staff numbers and their pay. It would cost £50m to reduce waiting times and meet the agreement's commitment that at the end of September no-one will have been waiting for more than a year.

In the current year, revenue funding stands at around £5.7bn.

The minister said: 'There are deep-seated problems across the health and social care system that will take years to put right. This will require major investment on a sustained basis – along with transformation reforms.'

He insisted that if only the £492m needed to maintain services was received, it meant 'another year of frustration and falling short of public expectations – with gaps in provision and unmet need growing'.

Mr Swann said the latest performance figures for emergency departments (EDs) were 'simply not good enough', though he recognised there was no quick fix to the problem. He has written to trust chief executives asking for a detailed assessment of the situation in their emergency departments.

A clinically led review of transforming urgent and emergency care was ongoing and an initial report was expected shortly. There was an overall drop in attendances at type 1 (major) EDs in December, but only 55% of these patients were treated and discharged, or admitted within four hours (62% in December 2018).

Roles changing in new systems

Changes in commissioning are leading finance staff into different roles, working more closely with colleagues in other teams and across organisational boundaries, the King's Fund has said.

According to *Thinking differently about commissioning*, the skills needed by finance staff are changing. Evolving roles are most marked in clinical commissioning group finance and performance teams, where staff are becoming more of a system than organisational resource.

These staff are working with many different departments in local providers, focusing more on quality improvement, including service development, rather than quality monitoring. In one case, a staff member was embedded in a provider to help develop finance and activity reports for the whole system.

The thinking behind staff recruitment was changing, said the report, with systems prioritised over organisations. System-wide recruitment could strengthen new ways of working. Some roles had been redesigned to suit system working, while others were passed to another part of the system. In some cases, recruitment had been postponed while system needs emerged.

The report said finance and performance issues provided the initial impetus for organisations to work as a system. But tight financial positions had dragged some organisations back to focusing on their own bottom line at the expense of system needs.

Marmot review urges action on wider causes of ill health

By Seamus Ward

A review of health inequalities has called for government action on the wider determinants of health, such as poverty, housing and employment, as well as a greater system focus on population health.

The review was led by Michael Marmot (pictured), 10 years after his landmark report on health equality. The latest report, *Health equity in England: the Marmot review 10 years on*, said increases in life expectancy have stalled since 2010, with the slowdown greatest in more deprived areas. Women have been particularly affected, with female life expectancy declining in the most deprived 10% of neighbourhoods between 2010/11 and 2016-18. Increases in male life expectancy in these areas were negligible.

Though Sir Michael acknowledged the difficulty in establishing the link between cause and effect, he reported that austerity had 'taken its toll' on areas he had examined in the 2010 report. These included rising child poverty, declines in education funding and an increase in homelessness. But he added: 'We can say that austerity has adversely affected the social determinants that impact on health in the short, medium and long term. Austerity will cast a long shadow over the lives of the children born and growing up under its effects.'

It added that a health system designed to reduce health inequalities must focus on place – small areas – and understand the population health and risks, including the wider determinants of health. It must ensure communities at greatest risk of poor health are not excluded. The health system must move away from reactive care for those who are already ill, to supporting good health by improving living conditions.

The report said health and social care integration with a range of other public services in Greater Manchester had enabled the development of 'a truly place-based population health system, appropriate for taking action on health inequalities'.

Jennifer Dixon, chief executive of the Health Foundation, which commissioned the report, said health inequality was worse than 10 years ago, especially for women.

She added: 'There has been a decrease in the proportion of our lives that we can expect to live in good health. And not only has the health gap grown between wealthy and deprived areas, it has also grown between deprived areas. Living in a deprived area of the North East is worse for your health than living in a similarly deprived area in London, to the extent that life expectancy is nearly five years less. Place matters.'

She called for a national, cross-government health inequalities strategy to join up action on the causes of ill health, including poverty, employment, housing and education.

'Areas that need immediate investment include addressing child and in-work poverty, the public health grant to local authorities, and children's services such as Sure Start,' she said.

Mental health trusts issue capital warning

Two-thirds of mental health trusts will not be able to access enough capital funding in 2020/21 to meet their needs, according to a survey from NHS Providers.

Four out of five trusts estimate their capital requirements for the financial year to be between £4m and £20m, though a small number said their needs would be much higher. One trust said it needed £500m to tackle backlog and transformation in the long term.

NHS Providers said that, as well as upgrading the estate and adding capacity, trusts wanted to remove the 350 dormitory wards still in use in the NHS in England. The Care Quality Commission (CQC) has said patient privacy and dignity are not respected in these wards and have no place in 21st century patient care. Two-thirds of trusts estimated they will need between £50m and £150m of capital funding each over the next five to 10 years.

Trusts were concerned the lack of capital was compromising patient safety. Some told NHS Providers they did not have enough capital funding to address CQC concerns about the condition of their estate.

NHS Providers deputy chief executive Saffron Cordery (pictured) said that while recent increases in capital funding were welcome, it was worrying that this was overwhelmingly focused on the acute sector.

Saffron Cordery: 'vulnerable patients are at risk'

'We have warned repeatedly of the risks of neglecting investment in NHS mental health facilities,' she said. 'Vulnerable patients are being placed at increased risk because the facilities they need are no longer fit for purpose to deliver the specialist care they deserve.'

News review

Seamus Ward assesses the past month in healthcare finance

In a month of storms and cold weather, NHS staff battled to maintain service levels. Flu and norovirus cases appeared to remain relatively low, but the service did have one virus on its collective mind – the novel coronavirus Covid-19. With its rapid spread from China, across south-east Asia and latterly into Europe, some UK residents returning from affected parts of the world were quarantined – though, at the time of writing, there were only 15 confirmed cases here. The government said the risk to citizens remained low and the country was well-prepared.

MINISTRY OF HOUSING, COMMUNITIES AND LOCAL GOVT

At Westminster, the new Parliament began to move into gear. Aside from the resignation of chancellor Sajid Javid – who was replaced by his deputy, Rishi Sunak (pictured), – just weeks before the 11 March Budget, a familiar face came back into health politics. Former health secretary Jeremy Hunt was confirmed as the new chair of the Commons Health and Social Care committee. Meanwhile, Meg Hillier was re-elected chair of the Commons Public Accounts Committee.

Getting health and social care staffing levels right will be crucial to the delivery of the *NHS long-term plan*, and NHS England and NHS Improvement will outline their strategy in the NHS People Plan, due in March or April. However, the government's announcement of its plans for a new points-based immigration system in February caused consternation. Although the system will make special allowances for the recruitment of NHS staff, there is no provision for social care workers. According to the Health Foundation, 17% of adult social care staff are non-British nationals, while in London the figure is closer to 40%. The King's Fund praised the recognition of the need for overseas workers in the NHS, but added there are more than 120,000 vacancies in social care. Many people were struggling to access the support needed to live independently and avoid long stays in hospital.

The NHS in England needs the biggest rebuilding programme since The Beatles were in their pomp, according to NHS Providers. While recent capital funding announcements are welcome, they fall well short of what is required. In a new report, *Rebuilding our NHS: why it's time to invest*, the providers body said that in a survey of NHS leaders, 97% were worried that their organisation's capital needs would not be met. The last, and only, major national hospital building programme was in the 1960s, which delivered 95 schemes in its first three years. The government has, so far, announced 40 projects – showing more modest ambition than previous initiatives, NHS Providers said.

A two-year delay in breaking ground on a building project can add 36% to the cost, according to health and care property development company Prime. In its report, *Ending change paralysis in NHS estates: how to forge ahead in uncertain times*, the company said a three-year delay can increase costs to 'an incredible, often insurmountable, 49%'. It argued that NHS organisations must create their own momentum to deliver projects sooner, or risk their plans being derailed as costs rise.

The Institute for Public Policy Research (IPPR) urged the government to invest in the primary care estate by allocating £500m a year for a decade to build 1,300 new primary care

The month in quotes

'The NHS is providing world-class care for more patients than ever, and to carry on doing that we need 50,000 more nurses. Boosting the number of nursing apprentices is one important way we can achieve that goal, and as we deliver on our *NHS long-term plan* we want local health service employers to ramp up the opportunities they offer in their areas.'
Ruth May, chief nursing officer for England, calls for more nursing apprenticeships

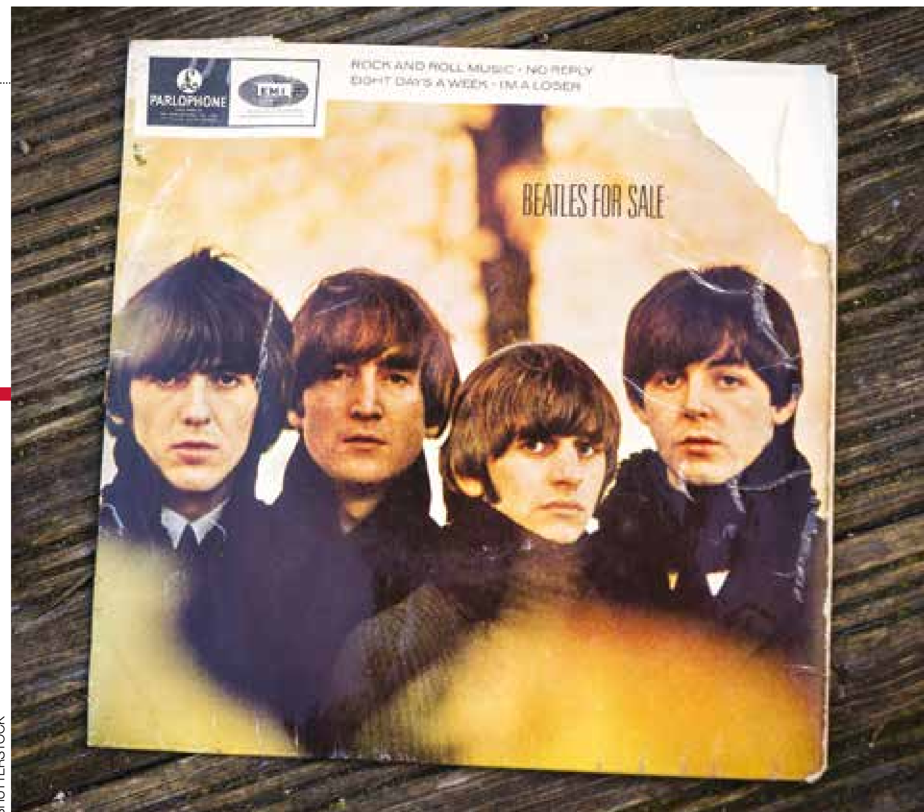
'It's time for the biggest building programme in the NHS since The Beatles. This will support delivery of the long-term plan and provide the opportunity to see tangible improvements to patient safety and staff and patient experience.'
NHS Providers deputy chief executive Saffron Cordery

'While it's positive the government recognises the need for overseas workers to help plug gaps in the NHS workforce, there is a disappointing lack of consideration given to social care. The NHS workforce is only half the story.'

King's Fund director of leadership and organisational development Suzie Bailey

'Over nearly a decade in frontline politics, the NHS has always been my greatest political passion, and I am honoured to have been elected chair of the Health and Social Care Select Committee. I look forward to working with my committee to provide a strong, independent voice that supports health and social care services in a very pressured period.'

Former health secretary Jeremy Hunt on his return to the health arena



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hubs. The IPPR report, *Realising the neighbourhood NHS: delivering a new deal for primary care*, also called for the traditional GP partnership model to be phased out. Rather than being independent contractors, GPs should be salaried. This would allow them to focus on patients, rather than managing a business – improving quality and access to care, and addressing workforce shortages.

"It's time for the biggest building programme in the NHS since The Beatles"
Saffron Cordery, NHS Providers

With some commissioners forecasting an underspend on additional roles funding in 2019/20, NHS England encouraged primary care networks (PCNs) to recruit now to any of the 10 roles included in the scheme from April. Funding for the new roles is included in the new GP contract, agreed between the government and the British Medical Association. There will also be funding for recruitment and retention schemes to deliver 6,000 extra GPs; a renewed focus on improving access; moves to improve vaccination coverage; and an investment and impact fund to reward PCNs that deliver their objectives. The investment fund will be worth £40.5m in 2020/21, rising to £150m in 2021/22, £225m in 2022/23 and £300m in 2023/24.

According to NHS Resolution, a total of 117 trusts achieved all 10 safety actions in the second year of the maternity safety scheme. The scheme was set up at the end of 2017 to incentivise improved maternity safety. Trusts that achieve all 10 actions recover their contribution to the maternity incentive fund (an additional 10% of the Clinical Negligence Scheme for Trusts maternity premium) and share in any unallocated funds. Maternity claims account for 60% of the annual £9bn cost of harm under the CNST. Details of year three of the scheme have also been published.

NHS Employers has not included specific recommendations in its evidence to the Doctors' and Dentists' Pay Review Body (DDRB) for 2020/21. The organisation said junior doctors have a multi-year deal, while any pay increase for specialist and associate specialist (SAS) doctors is likely to be linked to contract reform. Employing bodies have told NHS Employers that they are not in favour of targeting pay at specific specialties or localities.

The NHS invested more than 50% of the apprenticeship levy (£200m) back into apprenticeships in 2019/20, representing a significant improvement on the previous year. NHS England and NHS Improvement urged every trust to aim for 100% in 2020/21. NHS employers were asked recently to review workforce plans to ensure that they make full use of the apprenticeship levy. Chief nursing officer Ruth May insisted that the NHS must increase its nurse apprenticeships if it is to deliver the ambitions of the *NHS long-term plan*. Almost 1,800 nurse apprentices started their courses over the last two years, but the NHS requires thousands more. Boosting apprenticeships is part of the government's plan to increase recruitment and retention.

from the hfma

Collecting patient-relevant outcomes is not just about comparing performance or to inform payments, but also to ensure that patient needs are understood, communication between patient and clinician is enhanced, and to support new models of care. So says GP Sally Lewis, NHS Wales' national clinical director for value-based healthcare, in a blog for the HFMA. Dr Lewis says achieving value is about delivering the outcomes patients want within available resources. Although collecting, analysing and using patient data at scale can be a major undertaking, she believes the benefits mean finance directors will support investment in it.

Value-based healthcare is also the subject of a blog from Healthcare Costing for Value Institute head Catherine Mitchell (pictured). She focuses on a new framework that aims to help clinicians and finance professionals work together to implement value-based healthcare. Clinicians must better understand costing if the NHS is to harness patient-level data to improve services and patient outcomes, she argues. The Engagement Value Outcome framework developed by the institute and Future-Focused Finance aims to help overcome this, bringing together clinicians, operational managers, and finance and informatics staff.

HFMA policy and research manager Lisa Robertson blogs about issues facing non-executive directors and lay members in the annual report and accounts process. Non-execs have a key role in ensuring the annual report and accounts reflect their organisation's position. And, as year-end approaches, it is a good time to ensure they are up to date with the latest guidance, she says.

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News analysis

Headline issues in the spotlight

A question of stability

The funding allocated to stabilise NHS finances has yet to achieve its aim, with some organisations in a worse position, according to the NAO. Seamus Ward examines the detail

Though the NHS in England is treating more patients, it has yet to achieve the transformation of its services or financial regime needed to meet rising demand. That's the opinion of the National Audit Office.

And though it sounds like a familiar tale, the auditors' recent review of operational and financial sustainability lifts the lid on the overall position of the NHS. This includes a stinging criticism of the government and NHS – it said new funding allocated by the government to stabilise NHS organisations has not fully achieved its aims. Indeed, short-term measures have made some parts of the NHS 'seriously financially unstable'.

The NAO published two reports – *NHS financial management and sustainability*, and a *Review of capital expenditure in the NHS* (see box). The former is the NAO's eighth report on NHS sustainability, and it has repeatedly warned about the state of the health service finances.

Its last report in January 2019 took account of the additional £33.9bn in cash terms over five years (3.4% in real terms) announced in the long-term funding settlement for the NHS. The auditor noted that it could not make a conclusion on the adequacy of this funding until other health allocations, such as capital and public health spending, were settled.

However, growth in waiting lists, increases in waiting times and the burden of substantial deficits in parts of the service – offset by surpluses elsewhere – did not add up to a sustainable picture, it said.

The government has still not announced long-term funding of capital, education and public health – these are due to be unveiled in the spending review in the summer.

The most recent sustainability report said trusts reported an aggregate deficit of £827m in 2018/19, not including a favourable technical adjustment of £256m following the collapse of Carillion. The deficit is the equivalent of 1% of trusts' income. Clinical commissioning groups ended the year with a combined deficit of £150m – 0.2% of CCG allocations.

However, with NHS England underspending its budget for central functions and specialised commissioning by £1.066bn (3.6%), overall the NHS recorded a net surplus of £89m.

CCGs failed to achieve financial balance despite a rise in funding and the creation of the £400m Commissioner Sustainability Fund (CSF). CCG overspends did fall compared with the previous year – a £150m deficit compared with £213m in 2017/18, but this included payments totalling £384m from the CSF.

Trusts also received additional support – £2.45bn compared with £1.8bn in 2017/18 – and planned for a £394m aggregate deficit. The final deficit was £433m higher at £827m (£991m in 2017/18). But the system of control totals appeared to largely work for those trusts that

Capital shortfall

As with revenue spending, capital funding has been increased recently, but this too falls short of the levels needed in the NHS, the NAO said.

Its report, *Review of capital expenditure in the NHS*, published alongside the examination of NHS sustainability, set the capital shortfall in stark terms. It said that the health service has requested an average of £1.1bn more capital funding than spending limits allowed over the last three years. While 14% of the estate is older than the NHS itself, backlog maintenance has increased to £6.5bn (including £1.1bn of high-risk backlog maintenance). Funds raised from the sale of surplus assets almost doubled between 2016/17 and 2019/20, though not all has been available to be reinvested in buildings and equipment.

Yet, £4.3bn was transferred from the capital budget to revenue between 2014/15 and 2018/19 – there were good reasons for this, but it slowed the pace of transformation and increased backlog maintenance.

In 2019/20, providers' initial capital spending plans exceeded the budget by £1.7bn and they were asked to reduce their plans by 20%. However, even though the government announced additional capital funding of £1.1bn for 2019/20, the remaining gap between NHS providers' original capital spending plans and their capital budgets in 2019/20 was £600m.

Though there is clearly a demand for capital, the NHS consistently underspends its overall capital budget. Between 2010/11 and 2012/13, the service underspent on capital by an average of £677m (12%) against the capital spending limit. In 2017/18, £360m (6%) was unspent.

The NAO warned that plans to limit capital spending at individually named foundation trusts may make managing the overall capital budget easier to manage, but it could also disincentivise foundations from seeking further efficiencies.

NHS Providers deputy chief executive Saffron Cordery said reform of bidding, prioritisation, allocation and approval processes was needed. 'The NAO has reached many of the same conclusions as us, including the increasing risk of harm to patients as a result of growing backlog maintenance; trusts' assessment that their need for capital funding is greater than the funding available; and that the system for accessing funding does not necessarily ensure it is made available where the need is greatest or most urgent,' she said.

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accepted them. In 2017/18, 71% of trusts that accepted their financial targets reported their year-end positions to be at or better than plan. This increased to 75% in 2018/19.

As part of *NHS long-term plan* goals, the provider sector is due to return to financial balance overall in 2020/21, with no trust reporting a deficit by 2023/24.

While the trust sector is moving towards financial balance, the NAO was concerned about the level of one-off savings needed to get to the final position in 2018/19. The proportion of non-recurrent savings increased from 26% in 2017/18 to 31%. In the same period, the proportion of trusts in deficits grew.

The NAO also argued that the provision of sustainability funding had increased the variation in financial performance between trusts (£102m surplus to £180m deficit), as payments were contingent on achieving control totals. In 2018/19, less than 40% of payments from the provider sustainability fund (PSF) helped trusts eliminate or reduce deficits.

NHS England and NHS Improvement have recognised the PSF was not helping those most in need and have reduced the size of the fund to £1.25bn in 2019/20.

This enabled them to make £1bn available for urgent and emergency care and £1bn for the financial recovery fund (FRF). The latter is exclusively for trusts in deficit and in 2020/21 will be the sole source of sustainability funding. The NAO said this should help reduce variation in financial performance.

Underlying deficits continued to be an issue, indicated by the level of loans given to individual organisations. Trusts in financial difficulty owed the Department of Health and Social Care £10.9bn at year-end. Almost two-thirds (64%) of sustainability and transformation partnerships and integrated care systems (ICSs) were in aggregate deficit. With all areas due to become ICSs by April 2021, NHS England and NHS Improvement hope measures outlined in the planning guidance for 2020/21, such as writing down debts incurred before 2019/20 and more timely payment of sustainability funds, will improve cashflow and reduce the need for interim financial support (*see System default, page 16*). However, while the NAO believes the FRF will help reduce the need for interim support, it said loans will still be needed.

"The Department continues to provide trusts with short-term loans just to meet day-to-day costs, with little hope they will be repaid. This is not a sustainable way to run public bodies"
Gareth Davies, NAO

The report added that the current use of loans was 'not an acceptable or sustainable approach to the financial management of major public bodies and the Department is reviewing options to address this.'

Gareth Davies, head of the NAO, said bodies at the centre had to adopt a longer term outlook. 'The short-term fixes that were introduced to manage the NHS' finances are not sustainable. The Department of Health and Social Care continues to provide some trusts with short-term loans just to meet their day-to-day costs, with little hope they will be repaid. This is not a sustainable way to run public bodies.

'To bring about lasting stability, the Department and NHS England and NHS Improvement need to move away from short-term financial fixes and provide longer term solutions.'

The financial difficulties were set against a backdrop of rising demand. In 2018/19, the NHS treated more patients – more than 700,000 additional patients were treated within four hours in A&E – but continued to miss performance targets.

In A&E, there was a slight drop in performance against the four-hour target, with 88.1% being seen within four hours (88.3% in 2017/18). Only six of the 16 acute access standards were met in 2018/19. The number of patients on waiting lists for non-urgent treatment also continued to rise, from 3.85 million in 2017/18 to 4.23 million in 2018/19.

For Nuffield Trust senior policy analyst Sally Gainsbury, the report was a reminder of the fragile state of NHS finances.

'The report raises serious questions about whether this new money will make a difference in the context of yawning staffing gaps, hospital trusts being forced to rely on one-off savings, short-term loans or emergency funds to balance the books, and the lack of a long-term financial settlement for social care,' she said.

'What's more, this report makes clear the folly of missing out crucial areas of health spending, such as medical training, capital spending and public health from the plans to invest billions in the NHS. As the NAO implies, without clarity and a sustainable plan for these areas, the NHS is unlikely to succeed in delivering its own long-term plan.'

Financial improvement is pivotal for the NHS. Would the Treasury release more taxpayer money without the service achieving – or coming close to achieving – overall and individual organisation financial balance?

Sustainability hinges on financial assistance in the form of the FRF and writing off historical debt, as outlined in the 2020/21 planning guidance. But measures such as service transformation and demand management will be as vital to stem the causes of financial distress.

Comment

March 2020

Mixed response

Reaction to the planning guidance for 2020/21 will depend on local context

HFMA president Caroline Clarke

The operational guidance arrived at the end of January, setting out operational and financial requirements for the year ahead, and the notion of 'system by default'.

I've been testing reactions to the guidance. It's fair to say that they are mixed, and that context is everything.

If you're in a more developed, financially stable system, you'll be thinking about how the guidance can genuinely help improve system performance. If you are in a financially challenged economy, you'll be wondering how on earth you can make the whole thing stack up. And if you're in a hospital, you may be wondering about how you run at 92% capacity, while welcoming the increased investment into community, primary care and mental health services.

And everyone is probably wondering what on earth is going on with social care funding.

There's promise of a detailed people plan in the spring. If you want to hear more, do sign up for our webinar with Julian Kelly and Prerana Issar on 10 March at hfma.to/4bh.

Personally, I'm pleased to see more emphasis on population health, and sustainability, although whether we are being tough enough as a sector in either area remains to be seen.

As finance professionals, we have a head start in measuring. And we should

Switching over to systems

System working will require real behavioural change backed by boards

Healthcare Finance editor Steve Brown

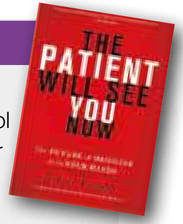
It will take more than words to change the focus away from individual organisations in the English NHS. So simply saying that we are moving to a 'system by default' model does not make it so.

Institutionally focused lines of regulation remain firmly in place – and will remain so without legislative change – and there is a clear tension between this and the ambitions to move to system oversight.

That said, the operational planning guidance makes the direction of travel very clear. There is no change to the April 2021 deadline for all systems to become integrated care systems. And NHS England and NHS Improvement have made it abundantly clear that organisations need to be working together to deliver system goals. Individual organisation plans and decisions must be system coherent.

The operational guidance comes with welcome steps to support the move to systems. Clinical commissioning groups with historic overspends – some of which will be related to allocations that have been consistently under target, despite recent progress on pace of change – will have debt written off or brought down to levels where repayment is more feasible.

PRESIDENT'S PLAYLIST



BOOK *The patient will see you now, Eric Topol* This describes a world turned upside down by technology, where the patient is genuinely empowered to take control of their own health. It describes the technological and social changes occurring under our noses, singling out the smartphone as the modern-day equivalent of Gutenberg's printing press in upending paternalistic medicine and democratising healthcare.

MUSIC *Food, Kelis* We managed to get some tickets to see Kelis at the Camden Roundhouse in March and I am super excited.

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

"We have a head start in measuring. And we should have carbon measurement firmly in our sights"

definitely have carbon measurement firmly in our sights. If your organisation doesn't produce regular carbon statements, why not start? After all, if we don't reduce our carbon usage, we are, as they say, toast…

Meanwhile the latest data on workforce equality standards has been published and it's a mixed picture. There's a bit of progress overall, but way too much variation, and too many of our colleagues and staff still experience bullying and harassment. And it's much worse if you aren't white.

That's not OK. It never was OK and it isn't OK for the future. We've got a long way to go, and I hope we can get the finance profession to really lead the way.

We point to some of the actions that we need to take in the document *NHS finance: designing our future* – see hfma.to/3xe.

If we want the NHS finance function to be a career destination of choice for young people, we need to step up and take pride in our work and our diversity.

We'll explore more on these themes at a series of events in 2020 (4 June and 8 October) with key policymakers.

In other news… the spread of the Covid-19 coronavirus globally continues to attract comparisons with the 1918 flu pandemic. We still don't know what the course of the disease will eventually be.

However, the response of the NHS has been brilliant in comparison with many other countries that simply don't have the same basic infrastructure as us.

For all the short-term operational and financial pressures, our ability to track patients, contain the virus and repatriate people has been globally admired. It may not be enough, but it made me proud of our *national* health service and our ability to respond as a single system. That is something to keep hold of when the chips are down.

Contact the president on president@hfma.org.uk

The guidance acknowledges that these debts have become a barrier to system transformation. It is certainly easier to see organisations being more motivated to work together if they can focus on what can be done collectively in the future, rather than first having to address financial deficits from previous years.

You can read more about the key components of the planning guidance, and reaction to it, in our cover story this month (*System default, page16*).

Similarly, we are promised a solution for provider historic debt – although a final approach had not been agreed in time for the planning guidance.

Some argue that the proposals make little practical difference for providers – swapping interest payments for public dividend capital dividends. But the restructuring of debt that has no chance of being repaid could help local bodies to look ahead rather than over their shoulders.

Again, this provides a better foundation for collaborative work. Read about what a change from loans to PDC would mean in accounting terms in this month's technical section (*Technical, page25*).

Addressing the causes of these historic debts will also be important alongside providing a new starting position.

Some of that will be about relative funding – getting closer to target funding levels. And some of it will need extra funding in absolute terms – where providers are dealing with unsustainable growth in demand with insufficient cash or where the lack of capital resources leaves providers operating with ineffective or inefficient estates.

Sustainability funding will now be concentrated on providers and commissioners in deficit. And with 50% of the Financial Recovery Fund linked to system performance, the calls for collective working are backed up with a financial incentive.

If you want to maximise the amount of money coming into the local health economy, which will have a knock-on impact for all local NHS bodies, organisations need to focus on more than their own financial performance.

Moving to system working will require organisations to work in new ways and this will also put different demands on finance professionals.

Some finance directors are already taking on specific system roles (*see The art of influence, page 13*) but collective working places new demands on all finance directors. Finance teams will also have to work differently.

"If you want to maximise the amount of money coming into the local health economy, organisations need to focus on more than their own financial performance"

The King's Fund's recent report – *Thinking differently about commissioning* – highlights how this is already the case in some CCG areas, with the adoption of system-wide processes for monitoring spending, activity and performance and even the preparation of single system finance reports.

Joint working and embedded staff members are likely to be characteristics of this new way of working.

Signing up to some warm words about collective working won't be enough. It will require genuine behavioural change, backed up by clear commitment from boards and finance teams.

This involves more than simply flicking a system switch, but turning on a new mindset is the right first step.

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Support from the HFMA ahead of the year-end

As the end of the financial year approaches, the HFMA has produced a suite of CPD accredited materials to support members and finance staff involved in producing the annual report and accounts.

- **Year-end reminders for finance teams**
- **The external audit: best practice in working well together**
- **Going concern – assessment and reporting requirements in difficult times**
- **Financial reporting watching brief 2019/20 and beyond**

The HFMA has also produced materials to support non-executive directors and lay members - please flag these with your audit committee.

Visit hfma.to/yearend to find out more

The art of influence

Finance leaders are increasingly having to think more broadly about system performance alongside their organisation's. One provider finance director, who has taken on an additional system role, says the key skill in the new position is the ability to exert influence. Steve Brown reports

The move to system working presents big challenges for NHS bodies in England to work together to make best use of resources across a broader footprint. It also brings new challenges for finance professionals as they step into system finance roles that, under current structures, rely on influencing skills to ensure system goals are delivered.

Su Rollason has spent 15 years at the University Hospitals Coventry and Warwickshire NHS Trust (UHCW), becoming director of finance and strategy in 2015 and then chief finance officer at the start of 2018.

However, last October, she expanded her remit by also taking on the system finance lead role for the Coventry and Warwickshire Health and Care Partnership, the recently adopted name for the area's sustainability and transformation partnership.

Both are major roles. UHCW is an acute and tertiary provider that on its own delivers services for more than a million patients from two main sites with income of £700m. The system role – with system allocations totalling close to £1.4bn in 2018/19 – means supporting an ambitious five-year plan, while delivering scaleable savings that mean the whole system stays within its financial envelope.

The system role needs different skill sets than the trust role – or at least better developed influencing abilities. 'It is really all around influencing,' says Ms Rollason. 'I don't have control over any of the organisations in the system. I can't tell a finance director or chief executive not to do something because it isn't system coherent. I have to influence them to make that decision for themselves. The lack of direct control is the big difference.'

And there are a lot of people to influence – four providers, three clinical commissioning groups and two local authorities make up the partnership. And influencing these organisations means regular discussions with chairs, chief executives, accountable officers and all the finance directors, particularly as monthly finance figures come in.

These discussions centre on the need to think system-wide and beyond the immediate impact on any individual organisation, while recognising the organisationally focused lines of accountability that still exist. 'The volume of discussions is itself challenging,' she says. 'But it is also a huge opportunity personally to exert influence and make a difference.'

The strategic system plan, an early draft of which appeared in partnership board papers last year, builds on the initial STP plan published in 2016. Over the past four years, moves to a population health management approach have been underpinned by place-based and asset-based joint strategic needs assessments.

Good progress has been made on urgent and emergency care, with about 6,000 more patients on average seen across the system within four hours each month compared with 2016. And in mental health, there has been increased access to psychological therapies.

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Health and wellbeing have also improved, with a reduction in smoking prevalence among adults across Coventry and a reduction in the under-75 mortality rate from cancer.

The new plan will look to push on with these priorities, with service development focused on four areas: Coventry, Rugby, North Warwickshire and South Warwickshire. With A&E attendances and emergency admissions to hospital rising nationally, the Coventry and Warwickshire system will target a 50% reduction in the growth of such activity.

"The non-executives need to be brought on this journey, as well as the chief executives and accountable officers"
Su Rollason (pictured)

But Ms Rollason says this won't translate – at least not immediately – into stripping out provider capacity. 'It is about stopping the high levels of growth that commissioners have had to pay for and taking that to a level that is within their allocations,' she says.

Frailty pathway

The frailty pathway will be another focus, with the establishment of an acute frailty service and development of the out-of-hospital model. Part of this will look to address community providers' workforce problems. 'We want to see if, as a system, we can use our total resource in a different way and build a more flexible workforce,' says Ms Rollason. This could involve joint appointments with staff working across different providers and settings.

One of the system's key service improvement schemes will involve the musculoskeletal (MSK) services. This was identified as a system priority in a 2018 clinical strategy that aimed to reduce unwarranted variation across the system. Data has also shown the system's commissioners spend more than comparable commissioners on MSK elective activity. New MSK hubs will provide a first point of contact, primarily with a physiotherapist rather than a consultant, giving faster access to treatment and making better use of consultants' time.

Moving beyond a simple organisational focus presents different challenges in terms of how you view issues – whether from the point of view of the place or system or from a commissioning or provision perspective.

Each area has a different mix of deprivation and challenges in terms of the age and needs of the population. Their financial positions also vary as a starting point for system working.

'There are different dynamics across the system,' says Ms Rollason. 'It becomes even more complicated if you start to think about the moves to a single or strategic commissioner and provider.' This also presents significant opportunities, she adds, and the ability to transform services on a greater scale.

There are other dynamics at play too. South Warwickshire NHS Foundation Trust and George Eliot Hospital NHS Trust work together as a part of a foundation group with Wye Valley NHS Trust – which is outside the Coventry and Warwickshire system. The group shares a single chief executive.

System finances are arguably the single biggest issue that needs to be addressed in moving to an integrated care system – the national timetable suggests this needs to be in place in just over a year. The system is forecasting a circa £34m deficit for the current year, £50m off its £16.5m surplus control total. Stripping out current contributions from the Provider Sustainability Fund and non-recurrent funds, the system has an underlying deficit of around £100m to address.

Delivering the strategic system plan, including reducing growth in activity and remodelling patient pathways, will be key to closing these financial gaps.

In practical terms, Ms Rollason has to split her time between system and organisational work. Notionally, she spends two days a week on system activities, though in practice she has to work flexibly across both roles – largely dictated by the availability of other senior officers across the system.

She says she relies on her deputy at UHCW, Antony Hobbs, who has stepped up to fill some of her duties, but there has been no formal backfilling. One new finance officer supports system work and works with a virtual team across all organisations, with each organisation nominating a finance contact to provide information and figures as needed.

Ms Rollason acknowledges that the clear move to a 'system by default' approach, as laid out in the planning guidance, supports the attempts locally to work more collectively. However, she points out: 'You still have to remember that these are all statutory autonomous organisations and we can't underestimate the challenge of bringing them all together.

'It is becoming better as accountability is aligned at the system level by the regulators NHS England and NHS Improvement. But this doesn't change overnight – especially not for governing bodies and boards. The non-executives need to be brought on this journey, as well as the chief executives and accountable officers – they were all appointed to specific boards but we are now asking them to think about the system as well.'

A key change for 2020/21 is a move to aligned contracts across the whole system. While these are already operating in some places, other areas have retained contracts based largely on the national tariff. The switch aims to acknowledge providers' clear role in managing demand alongside commissioners. 'It's about more than just the money,' says Ms Rollason. 'This is about the performance objectives, the capacity providers are putting on to deal with demand, and what transformation programmes we are jointly signing up to. It is about putting it all together.'

She points to a huge focus on the financial challenge facing the whole system by the chief executives and chairs of each organisation. Finance directors from across the system meet fortnightly and there is greatly enhanced transparency about each organisation's financial position. 'We held a joint financial development session recently with all finance directors and their deputies. We went through the system financial position in detail, with a specific session on the barriers that mean we don't operate as a system at times.'

Financial MoU

This 'all part of the same team' approach is underpinned by a locally developed financial memorandum of understanding, which supplements the new financial management agreement required to accompany contracts. This memorandum sets out the values and parameters that all organisations are signed up to. Ms Rollason says she is lucky to have the support of finance director colleagues around the system. 'Without this backing, there is no way I could do this role,' she says.

She recognises the need to be objective and transparent in all her actions, which she believes is reflected in how she is trusted. But she has to walk a line. 'I do have a system role, but I still have to represent my organisation. If anything, there's a danger I overcompensate – something I have to think about daily.'

Increasing numbers of finance professionals must find such a balance as the move towards integrated care systems continues.

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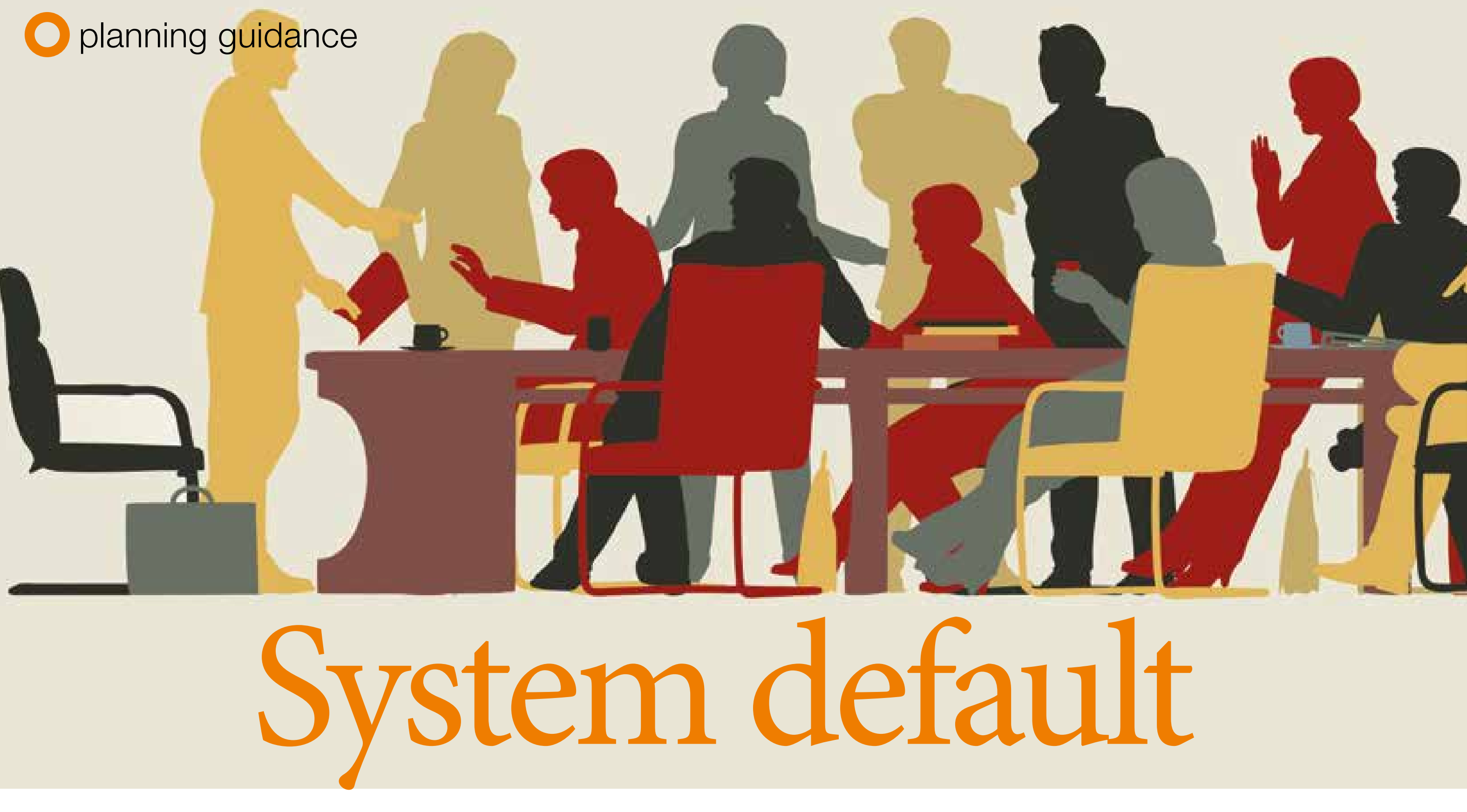

System default

NHS England and NHS Improvement want system working to underpin local services – quickly – so they have turned to financial levers. Seamus Ward reports

The NHS has been moving to system working for a number of years, with some areas moving faster than others. But with the 2021 deadline for setting up integrated care systems (ICSs) looming, NHS England and NHS Improvement have acted to speed up the process and introduce the concept of system by default.

The introduction of system by default is eye-catching – naming the process will make it 'more real', while reinforcing the direction of travel.

However, this is more than a call to arms. The planning guidance for 2020/21 seeks to give integration a boost by making system working a part of the financial landscape. Not only will system financial performance be a key factor in organisations' ability to access the Financial Recovery Fund (FRF), but systems could also play a role in setting financial trajectories and distributing some of the FRF.

The King's Fund's senior policy adviser, Anna Charles, says the planning guidance is designed to deliver the *NHS long-term plan*. 'I don't think there's anything particularly surprising in the planning guidance in terms of the overall direction of travel. It supports the ambitions of the long-term plan,' she says.

'It's positive in terms of ICSs and integration. For those areas that are already working in this way, it reflects the way local organisations are starting to work together.

However, the changes in the planning guidance will not be enough

Underlying deficits

While much of the focus has been on reducing and eradicating in-year deficits over the past few years, there has been a feeling that, while this work is vital, there is an elephant in the room – historical debts.

Providers are expected to recover historical deficits. Deficits from previous years can also lead to cash shortages for providers, meaning they have to borrow from the Department of Health and Social Care to meet ongoing costs.

The scale of these underlying debts was highlighted last month in the National Audit Office report *NHS financial management and sustainability*, which said that, by March 2019, providers had built up £10.9bn of debt in the form of interim support loans from the Department. Interim support, available to providers to help them meet their liabilities, had grown from £2.25bn in 2015/16 to £5bn in 2016/17 and £8bn in 2017/18. Normal course of business loans – financing arrangements based on trusts' ability to service the debt – remained steady at around £3bn a year.

The loan profile and interest payments were such that there was little prospect of the interim support loans being repaid. The NAO said 17 trusts had loans that exceeded 20% of their 2018/19 turnover. Indeed, some simply refinance loans by taking out a further loan from the Department.

Swapping debt for public dividend capital (PDC) – one option reportedly under discussion – has a number of advantages. First, it makes the balance sheet look better, moving the loan to the bottom half and the provider would no longer have to pay back the principle of the loan. Of course, adding PDC could mean a trust will pay more PDC dividend, potentially swapping loan interest payments, which could vary between 1.5%, 3.5% or 6%, for PDC dividend at 3.5%.

However, some observers have speculated the Department could reduce the PDC dividend rate. Some providers have net negative assets, which complicates the picture (*see page 25*).

NHS England and NHS Improvement are currently considering ways of restructuring the loans taken before 2019/20, with chief financial officer Julian Kelly (pictured) telling the bodies' joint board meeting in January this could happen via a debt for equity swap – hinting at issuing public dividend capital – though details had yet to be finalised.

A finance director at a trust with a significant historical debt said the move

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Back office

The guidance reiterates the importance of efficiency and productivity programmes created under the Releasing Time for Care banner – such as Getting it Right First Time and RightCare – and other national priorities, including the new pathology and imaging networks and e-rostering. However, it also outlines a number of requirements for finance back office and payroll.

Here again, the mantra of system by default can be seen. The guidance says all contracts for finance software, IT systems and financial services should be reviewed to ensure they align with other regional providers. This should guarantee interoperability, standardisation of services, and better use of technology. Transactional processes should also be reviewed to find opportunities for automation.

However, decisions on finance systems and contracts must not be taken in isolation by trusts – and they should not make decisions that prevent system collaboration.

A similar approach should be taken to payroll. As a minimum, where contracts are up for renewal in the next 12 months, or where payroll provision is not in contract, plans should be developed to collaborate on a system-wide basis. At every opportunity, NHS bodies should review payroll contracts and arrangements to increase collaboration, and improve workforce and service resilience. The aim is to increase quality, reduce costs and eliminate risks. Organisations must not make decisions that hamper regional or national collaboration and, when reviewing existing service arrangements, should seek to maximise collaborative opportunities to achieve economies of scale, the guidance adds.

on their own to turbocharge the efforts that are already being made.'

NHS England and NHS Improvement hope that this will not be the case and that systems will press ahead quickly while also stabilising the financial position.

Five financial tests

To deliver this, organisations and systems must meet five financial tests in 2020/21. Each must:

- Meet its trajectory for 2020/21 and the following three years
- Achieve cash-releasing productivity growth of at least 1.1% each year
- Reduce the growth in demand for care via integration and prevention
- Reduce unwarranted variation in performance
- Make better use of capital investment and existing assets.

Perhaps the biggest changes outlined in the planning guidance relate to the rules on FRF. As previously stated by NHS England and NHS Improvement, the FRF will be the only source of financial support for providers and CCGs unable to live within their means in 2020/21.

was positive. He assumed the I&E impact of paying more PDC dividend would be neutralised at national level – perhaps by changing the level of the dividend. Swapping the debt for equity would improve liquidity ratios and potentially allow future surpluses to be invested in capital schemes.

The planning guidance did bring forward a scheme to write off clinical commissioning groups' historical debt. There is recent precedence for this in the NHS.

Brokerage owed by Scottish territorial health boards, totalling around £150m, were written off by the Scottish government at the end of 2018/19.

The level of CCG underlying debt is unclear, but the guidance says typically 50% of CCG historical debts will be written off if they are more than 4% of a CCG's allocation. A repayment profile of the balance will then be agreed with NHS England and NHS Improvement.

It appears the proportion to be written off will be linked to historical underfunding – where CCGs have been given allocations that are less than their target funding calculated with the funding formula.

The write-off may be applied retrospectively, but if any CCG overspends its allocation in the two years following the write off, the historical liability could be reinstated.

CCGs with historical deficits of less than 4%, and have achieved or close to recurrent in-year balance, have been set a trajectory to underspend their 2020/21 allocation to help repay their historical overspends.

Vale of York, which had a significant underlying deficit at the end of 2018/19, told *Healthcare Finance* it was currently working out how it would be affected by the planning guidance. 'We have yet to submit our draft 2020/21 operational plan, but we will be working with our regulators to understand the implications of this new policy,' a spokesperson says.

A chief finance officer, whose CCG will not qualify for the write off, says the planning guidance must strike a balance between carrot and stick. They continue: 'I'm all for writing off pointless debt that will never ever be repaid to change the focus of contract negotiations to a more positive strategic discussion.

'But is it fair that systems that are a bit more ahead of the curve, and have used every tool they can to cashflow themselves through some really difficult problems, are then not able to qualify for the support on offer when the underlying problems still exist? As usual, timing is everything here – there are always winners and losers in every planning proposition.'

Cashflow will be improved by phasing payments each quarter (25% per quarter) and making the payments as soon as possible during the quarter rather than, under current arrangements, after the quarter ends.

More timely payments of FRF, combined with interest-bearing loans being written off (*see Underlying deficits, page 16*), should ease cashflow and mean trusts require less short-term financial support.

In a recent report on NHS financial sustainability, the National Audit Office notes that the FRF arrangements will reduce the levels of loans required, but it said some level of interim support will still be needed.

Individual organisations must hit their financial performance target – now known as financial trajectories rather than control totals – but this will only give them access to 50% of their FRF allocation. Receipt of the remaining 50% will depend on their local system achieving its financial trajectory – calculated as the sum of individual organisation trajectories.

The centre's reasoning for this is that it will stop commissioners and providers passing financial pressures between each other. Systems will be allowed to link a higher proportion of FRF allocations to system performance should they wish.

Systems and individual organisations that fail to hit their trajectories will still be able to access some of their FRF allocation as a taper will be introduced. It will mean that £1 of FRF will be lost for every £1 of system or organisation underperformance against trajectory.

There are several possible scenarios. If a system meets its trajectory, organisation FRF lost through the tapering process will be available to the system to distribute, together with its system FRF. But if a system fails to hit its trajectory, it will not receive the tapered organisation FRF.

If all system FRF is lost after tapering, system FRF will not be available to individual organisations, even if they have hit their trajectories.

In an extreme case, if both organisation and system FRF is lost after tapering, no FRF will be available.

Siva Anandaciva, chief analyst at the King's Fund, says the English NHS has come a long way towards system working. However, he wonders what system by default will feel like on the ground, particularly when the statutory duties of organisations clash with, currently, non-statutory system goals.

'In our last survey of finance directors, most people said system and organisation were important,' he says. 'However, about a third said their organisation was more important when push came to shove. A small minority said the system was more important.'

"One issue for finance directors will be the visibility of other organisations' cost improvement plans"
Siva Anandaciva, King's Fund

Mixed messages

Mr Anandaciva is concerned that boards are getting mixed messages on finance, while for some advanced areas the planning guidance will feel a few steps behind what they have already achieved.

He believes the plan to make 50% of FRF income dependent on system financial performance is 'absolutely consistent with the direction of travel'.

But he adds: 'One issue for finance directors will be the visibility of other organisations' cost improvement plans. If you don't have open-book arrangements setting out what their cost improvement plans look like, it's fair to say it's a downside of system working in this financial framework.'

The finances of an organisation in a system may look healthy, but they could deteriorate over a financial year. At this point, the attitude of other

Key financial commitments

The 2020/21 planning guidance includes a number of spending commitments alongside the promise to write off large portions of historical CCG debt. These are:

Mental health investment standard The guidance sets out several broad areas where mental health spending must rise. Continuing the requirement to increase spending on mental healthcare, the guidance insists each CCG's spending must rise by – at a minimum – its overall programme allocation growth plus an increment to reflect the additional funding included in CCG allocations.

This new investment must ensure that activity commitments in strategic plans are delivered and are consistent with the *Mental health implementation plan*. CCGs must increase their spending in mental health providers and on children and young people's mental health services if they are to deliver the service expansion planned for 2020/21.

CCG governing bodies must confirm they have achieved the investment standard in 2019/20. This is also subject to external verification. But if auditors find

that the standard has not been met, the commissioner must recover the shortfall and plan to increase spending in 2020/21. System partners will assess CCG mental health investment plans to ensure they are credible. Where this is not the case, systems must agree action, and if the standard is not delivered, escalated to NHS England to consider regulatory action.

Primary medical and community health services funding guarantee In line with the long-term plan to increase spending in these areas by £4.5bn by 2023/24, systems and commissioners should plan to spend their primary care medical (GP) allocations in full to increase the number of GPs. They must also increase overall core spending on primary, community and continuing healthcare so that they deliver system spending targets, including providing £1.50 per registered patient to primary care networks (PCNs).

Systems will be asked to support PCNs plan for the employment of an additional 26,000 staff, by helping them develop indicative plans, support recruitment and ensure PCNs are included in wider workforce planning. A breakdown of PCN additional roles for 2020/21 will include maximum allotted sums from the Additional Roles Reimbursement Scheme.

Better Care Fund Although planning requirements for the fund have yet to be published, the overall CCG minimum contribution to the fund will grow by 5.3% in cash terms. The total contribution will be £4.084bn. As this is a real-terms increase, it is expected that more social care packages than in 2019/20 will be funded. CCG minimum contributions to the fund have been published and commissioners should work with local authorities to plan and agree health and social care capacity assumptions.

local organisations – whether they wish to generate additional savings to meet the system shortfall, for example – will be pivotal.

'I don't think there's enough to convince organisations to take on local financial pressures just yet,' says Mr Anandaciva. 'We've been to meetings with foundation trust governors and they understandably find it difficult to get their heads around this. They can see the benefits of system working to improve patient care, but they don't understand why this means their organisation should be tied to another organisation's finances.'

Local government concern

Back at the King's Fund, Dr Charles says there is concern in local government. With more CCGs merging in April, the coterminous nature of CCGs with local authorities is vanishing in some areas.

'Some see a risk of resources moving away from their area,' he says. 'They are asking: why would their local organisations be judged on the finances of an organisation with a massive financial problem three boroughs away?'

System working was always going to be a major culture shift for a service where the foundations over the last 30 years have been built on competition. In recent years, NHS England and NHS Improvement have been nudging organisations to work together. In 2020/21 not only is this expected, it is also required.

Summary of NHS operational planning and contracting guidance 2020/21

The HFMA has produced a summary of the operational planning guidance. Download it at ***hfma.org.uk/publications***

Capital and IFRS 16

With the availability of capital funding dependant on the outcome of the spending review later this year, the NHS has been asked to plan for 2020/21 based on known funding sources and schemes. These include the sustainability and transformation partnership capital programmes and the Health Infrastructure Plan.

Emergency capital finance requests should be identified, and it is vital all currently funded plans are based on realistic forecasts – this will help NHS England and NHS Improvement see how much is available for emergency funding and other programmes. Organisational and system plans should be consistent.

The adoption of IFRS 16 in 2020/21 will mean all leases will come on balance sheet – apart from short-term and low-value leases. Leases taken out after 1 April this year will score to national capital budgets and the guidance anticipates that national capital limits in 2020/21 will be increased to account for the impact of the new standard.

The planning guidance outlines two schemes to help with capital development. The first offers more support for business cases, with a training package made available across the NHS. A portion of a scheme's funding will be granted earlier – before full business case approval – if the national bodies are convinced of the benefits of doing so.

In the second scheme, the business case approval process will be streamlined. Alternative bid documentation will be used in place of a strategic outline case, where organisations have traditionally bid for capital through a competitive process. This will save six to 12 months, although its implementation is subject to the completion of a current pilot.

Also, the arrangement where the Department of Health and Social Care, NHS England and NHS Improvement triage cases that need additional support or, on the other hand, can be fast-tracked, will be formalised. The planning guidance adds that a single investment committee – made up of the Department, NHS England and NHS Improvement – will be created to consider major schemes, reducing the number of central approval layers.

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Patient progress

When the Costing Transformation Programme was launched five years ago, it set out a daunting agenda to get all English providers calculating costs at the patient level. The new national cost collection – built from submitted patient-level costs from all acute providers – marks the first significant output from this programme. Steve Brown reports

SHUTTERSTOCK

The Costing Transformation Programme reached a significant milestone with February's publication of the national cost collection, according to NHS England and NHS Improvement. For the first time, the cost schedule for acute providers (covering the financial year 2018/19) has been built solely from patient-level costs for admitted patient care, outpatients and accident and emergency.

There remain major challenges ahead as mental health, ambulance and community services face extremely demanding deadlines if they are to join the patient-level cost fold.

And there are outstanding issues with the acute sector too, with continuing concerns about the complexity of the costing process, the time taken to publish the data and the balance for costing practitioners between time spent compiling cost data and actually using it to inform improvement work.

But first, that milestone. Jack Hardman, head of costing at NHS England and NHS Improvement, says the move to patient-level costing is a journey. It has taken five years to get here – former provider regulator Monitor announced plans for a new approach to costing using patient-level information and costing systems (PLICS) at the end of 2014.

Start of the process

While the two national bodies are keen to show what has been achieved, the publication of acute costs based on a patient-level submission really marks year one in the use of patient-level cost data, not the end of the process.

If you look just at the national publication, it may be difficult to spot what has changed. The newly named national cost collection looks very like the reference cost publications from previous years. There is still a schedule of costs, setting out national average costs for a range of currencies: including healthcare resource groups (acute activity), outpatient attendances, mental health clusters, attendances and contacts. There is also a national cost collection index to replace the previous reference cost index – providing a comparison of costs at the aggregate level for each provider (100 = average costs, 90 means costs 10% below average, 110 means costs 10% above average).

However, the process to arrive at these average costs is very different for the acute sector. Instead of a top-down approach allocating costs to individual HRGs, and trusts

then submitting their average cost for each group, with the new approach providers submit costs for individual patients. The averaging calculation is then conducted centrally.

The crucial difference is that the average costs are now underpinned by huge detail. Previously, a higher than average cost for an HRG might leave a trust scratching its head as to the cause. Now it should be able to pinpoint the reasons. Are the higher than average costs due to greater complexity or patient age within the relevant HRG? Are they distorted by small numbers of high-cost outliers? Or are the costs being driven by theatre, ward care or pathology costs, for example?

Changes in approach

While the publication may look familiar, there are small differences. The schedule of reference costs no longer separately identifies the costs of excess bed days beyond HRG-specific trim points, for example. After all, the patient-specific costs submitted by providers will inherently reflect their length of stay. Data relating to an activity count below eight has also been suppressed, in line with NHS Digital's data disclosure protocol.

At a more general level, however, is the patient-level derived version of the average costs more robust than in previous years? Mr Hardman believes this is likely to be the case. The past five years have seen a new detailed costing methodology developed and rolled out across trusts, which should mean providers are now costing in a more consistent way.

In reality, Mr Hardman says, the improvement will have been gradual. The new standards have been out for a number of years and trusts have been moving towards a bottom-up approach to costing over that period – rather than switching it on overnight.

Last year may have been the first time all acute trusts were mandated to submit data, adhering to the new standards, but the change started well before. Many acute trusts had even taken part in voluntary submissions to test the new approach and the centre's ability to cope with the significantly increased amount of data.

The data will also have been improved by factors beyond the new guidance – which is still bedding in and faces ongoing calls for simplification. 'We've benefited from the work that costing practitioners are doing at their own organisations,' says Mr Hardman.

'Rather than doing the submission at the aggregate reference costs level, people can see their individual patient costs. This allows trusts to look at their own internal outliers and fix any obvious errors in cost apportionment before they submit. Practitioners are more aware of any errors.'

Headline figures

The costs collected for 2018/19 cover £69bn and represent 61% of the total NHS expenditure of £113bn. Acute costs accounted for £54.1bn of this amount, with mental health next at £7.5bn.

Within the acute data, non-elective inpatient activity cost nearly £18bn, with elective and day cases costing £5.4bn and £4.5bn respectively. Outpatient attendances cost a further £9.6bn. The NHS undertook just over 23,000 major hip procedures (with a complications and comorbidities score of 0 or 1) at an average cost of £6,040. This was about 1.3% cheaper than in the previous year even allowing for the extra costs of excess bed days (which were separately reported in 2017/18).There was a similar small rise in cost of the most straightforward day-case cataract operations on a slightly smaller volume of activity.

But these changes (and other more dramatic swings) could be a result of several factors – changes of age or complexity within the HRG; changes in clinical practice; changes in costing practice; or efficiency.

In mental health, 62% of total costs were costed against care clusters with an average cost per cluster day of £19 (total cost of cluster period divided by the days spent in the cluster). Care contacts in community services cost £46 for nurses, £67 for health visitors and midwives, and £73 for allied health professionals.

Just over two-thirds of ambulance costs were incurred against the 'see, treat and convey' currency, with each such episode costing £257 on average.

Analysis of the first mandated acute PLICS data by NHS Digital shows 52% of admitted patient care related to females and 43% to males, with the gender unknown or unspecified in 6% of cases.

There are increases in costs and activity for women aged 15 to 49, representing maternity-related admissions.

Analysis of the PLICS data by deprivation (using the indices of multiple deprivation) shows that A&E attendances and admitted patient care episodes increase with deprivation.

However, there was little difference in the total cost and count of outpatient appointments across the deprivation categories.

COSTS BY DEPARTMENT

	2018/19 £bn
Day case	4.5
Elective inpatient	5.4
Non-elective inpatient	17.9
Core admitted patient care	**27.8**
Other acute services	11.2
Outpatient attendances	9.6
Outpatient procedures	2.0
Accident and emergency	3.4
All acute services	**54.1**
Mental health	7.5
Community health services	5.4
Ambulances	2.0
Total	**69**

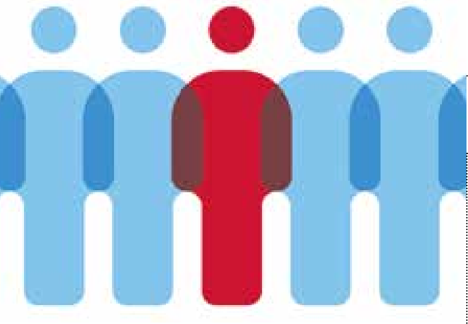
The schedule and national cost index provide some interesting insights into the cost of NHS activity (*see Headline figures*). But in reality, the added value should come from the ability to go beyond the averages and identify the causes of variations in costs.

Enter the acute PLICS portal (*see Portal power*), released a week or so after the average cost figures were published. According to Mr Hardman, the portal 'puts the power of the data into users' hands' whether that is a costing practitioner, finance business partner or frontline clinician. It does not provide access all the way down to individual patient level, but it does enable data to be analysed by treatment function code, point of delivery and HRG. Users can compare their own trust's performance with all providers or their own selection of peer organisations.

Within this, they can check they are benchmarking with an organisation doing a comparable volume of activity. Then they have the option to drill down to look at the component costs behind these organisational averages – ward costs, nursing costs or medical costs, for example. Using a key metrics screen, users could compare average length of stay across their chosen peers. More metrics will be added during the summer.

Some of the way in which data is displayed will remind users of the Model Hospital interface and there are longer term plans to link the two systems, enabling Model Hospital users to continue their analysis of improvement opportunities by accessing the PLICS-derived cost data.

'It is a tool to inform and ask questions,' says Mr Hardman, with the portal giving providers a key benefit – the ability to benchmark detailed costs – as a reward for the significant



effort required in the submission process.

The work involved remains a key sticking point. Last year, the HFMA raised a number of costing practitioner concerns in a report to NHS England and NHS Improvement. While the association and the costing community remain supportive of the move to collect costs at the patient level, practitioners feel that the methodology and standards are unnecessarily complex. Providers are required to identify costs across a massive number of different resources and activities, creating a large matrix of costs for each patient – even though resource costs are then collected at a summarised level.

Providers said there was too much focus on collecting small costs – many of them immaterial in accounting terms. According to one practitioner, although there were around 260 resource IDs (covering all sectors), just 26 of them accounted for 80% of the cost quantum, and 40 covered 90%. There were also concerns about the requirement to map the whole general ledger to a cost ledger as a first step – seen as 'overly bureaucratic, overly prescriptive and of questionable value'.

Ledger mapping

NHS Improvement has been listening and it is understood that a new option for this year's collection is being introduced – although formal notification had not been issued as *Healthcare Finance* went to press.

As a minimum level of compliance, providers would be allowed to map their general ledger directly to the smaller group of collection resources – with the number of collection resources being extended slightly compared with last year.

The second – preferred – level of compliance would continue to involve full mapping of the general ledger to the standardised cost ledger and subsequently to the full list of allocation resources, before grouping these to the collection resources for submission.

The new *Approved costing guidance* for the 2020 collection reduces the maximum possible number of resources for an acute trust (including patient facing and type 1 and type 2 support costs) to closer to 200, while also slightly increasing the collection resources.

Some practitioners feel the cost ledger should be set aside, with the standards simply providing clear definitions for the prescribed resources. While this would involve a manual mapping exercise, costing practitioners say it would be more accurate. And if the resource definitions were left unchanged between years, the bulk of the mapping work would be one-off.

However, there are also plans to require trusts to generate new PLICS feed types – including new extracts for adult critical care and high-cost drugs.

These will be introduced as part of a live collection – albeit with certain fields 'required' rather than 'mandatory', according to a February cost update.

Practitioners spoken to by *Healthcare Finance* were worried about the destabilising effect of these changes and the further burden on already hard-pressed costing teams.

This was especially the case given that software suppliers had also raised concerns about the plan.

There are further concerns about the late publication of the national cost data. Reference costs data was typically published at the end of November or early December. Publishing the national cost data two months later reduces costing practitioners' window to make use of the data before becoming preoccupied again in April with the subsequent year's submission.

NHS England and NHS Improvement acknowledge the data needs to be out earlier.

Mr Hardman points out that there have been mitigating circumstances. This has been the first year of the mandated acute submission, which has involved joint working with NHS Digital for the actual collection.

'It has been a huge learning curve. We have streamlined the process since last summer and we believe our partners have done the same,' he says. The goal is to return to a December publication, although this could be challenging over the next couple of years as mental health trusts, ambulance services and then community services also come on board.

However, Mr Hardman insists: 'Everyone wants to make this quicker.' This will need to be the case. Currently, commercial benchmarking services deliver data – albeit often just based on a software supplier's clients – around October.

Mr Hardman is also aware of the growing interest in being able to access the data outside the provider community. In a world of system working and open book accounting – a commitment to which is supposed to be included in new system agreements – it would seem appropriate to allow commissioners to have access.

And there are wide-ranging third-party organisations – the HFMA, thinktanks, royal colleges and economic research bodies among them – that would be keen to use the data as the foundation for research and study. This would arguably help to raise awareness of the data and promote its wider use. However, Mr Hardman says that information governance issues need to be addressed before this could even be thought about.

The national cost collection data does mark a key milestone on the journey to patient-level costing. There is continuing excitement about the potential applications for this detail – supporting the delivery of value alongside outcome data and enhancing the accuracy of improvement tools such as the Model Hospital and Getting it Right First Time. Progress is being made, but there continues to be a long way to go.

Portal power

The acute PLICS portal is accessible by acute providers. Many data submissions in the NHS are one way – with trusts required to submit returns but seeing no benefits from the submission.

The PLICS portal aims to change this – giving trusts the ability to analyse and compare their own costs against those of all providers or selected peers. If done in a timely way, this could replace the need for trusts to buy in additional benchmarking services to inform improvement.

Having selected peers for comparison, which can take account of the quality of a provider's costing submission as measured using the costing assessment tool (CAT), users can then explore their potential opportunities to reduce costs. An overall opportunity for the trust is broken down by treatment function code and healthcare resource group.

A new reporting functionality shows a breakdown for a selected HRG of the costs by collection activities and collection resources. So, if a trust is higher cost than its peers, it should be able to see if higher costs are driven by ward care or theatre costs. Equally, looking at resources, are the higher costs driven by consultant, nursing or device and implant costs?

The portal also provides comparisons across eight key metrics, including average inpatient length of stay and emergency department minutes and average pathology. More metrics will be added in a portal release this summer.

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Understanding the implications of a debt for equity swap for NHS providers

Technical

There has been a lot of talk recently about the possibility that the Department of Health and Social Care will replace provider revenue support loans with public dividend capital (PDC) – which is the equivalent of a debt for equity swap in the commercial world, *writes Debbie Paterson*.

So what might this mean for the 117 provider bodies that have current or non-current revenue support loans as at 31 March 2019?

First, it may well reduce some of the administrative burden that comes with applying for revenue support loans to manage working capital. In most cases, these loans can only be repaid when another loan is received, so that there is a constant application and re-application process taking place.

Second, it will have an impact on the revenue costs resulting from borrowing. Loans issued by the Department currently attract interest of either 1.5% if providers are delivering control totals or 3.5% if not. There was also a 6% rate, but this is no longer being issued.

On the face of it, because provider bodies have to pay a 3.5% PDC dividend to the Department each year, this looks like a bad deal for those provider bodies borrowing at 1.5%.

However, this may not necessarily be the case. The calculation of the PDC dividend is not a straightforward 3.5% of PDC. Instead, it is 3.5% of the average relevant net assets of the provider body and any of its subsidiaries for the year.

The definition of relevant net assets, according to the 2019/20 *Group accounting manual*, is shown in the table.

To calculate the average, the opening balances are added to the closing balances and then the total is divided by two.

The complicating factor is that the calculation of the net cash balances in Government Banking Service accounts is on the basis of the average daily cleared balances. It is therefore impossible to calculate the impact of the debt for equity swap without detailed information about daily cash balances.

SHUTTERSTOCK

Based on our calculations using the 2018/19 provider accounts information, 30 provider bodies had negative net assets at the end of March 2019. None of these entities paid a PDC dividend in 2018/19.

If their current and non-current revenue support loans are all turned into PDC and effectively move from liabilities in the top half of the balance sheet to taxpayers' equity in the bottom half, only two bodies would still have negative net assets at the end of March 2019.

On the face of it, the other 28 bodies would pay a PDC dividend. However, in 2018/19, those 30 bodies paid £78,404 of interest on revenue support, so that would no longer be paid.

RELEVANT NET ASSETS	
Total assets employed	X
Less: net book value of donated assets and grant funded assets	(X)
Less: charitable funds (before consolidation adjustments)	(X)
Less: net cash balances in GBS accounts (excluding cash balances relating to a short term working capital facility	(X)
Less: outstanding PDC dividend prepayments	(X)
Plus: outstanding PDC dividend payables	X
Total relevant net assets	**X**

In terms of accounting, section 3.3 of the international financial reporting standard on financial instruments (IFRS 9) requires financial liabilities to be removed from the statement of financial position when, and only when, they are extinguished. This means the obligation is discharged or cancelled or expires.

In the case of revenue support loans, the Department will have to cancel the obligation to repay or issue PDC to the same value that can be used to discharge the liability.

IFRS 9 says that the difference between the carrying amount of the financial liability extinguished and the consideration paid should be recognised in the statement of comprehensive income. It is unlikely that there will be any difference in the case of these loans.

As a final thought, it will be interesting to see what impact this transaction, if it happens, will have on the going concern assessments of NHS provider bodies.

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

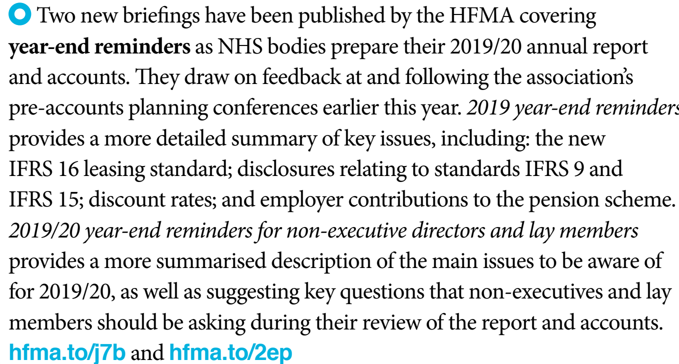
Technical

NHS Resolution has updated the safety actions for year three of its **maternity incentive scheme**. A number of small changes or additions have been made to the actions first released in December last year. On safety action 2 (submission of data to maternity services data set), the data quality and completeness assessment will consider data for April and May 2020, not March and April as previously indicated. The guidance provides the conditions for the scheme, full details of the 10 safety actions and a range of commonly asked questions and answers. In year two of the scheme, 117 trusts achieved all 10 actions, enabling them to recover their contributions to the maternity incentive fund and share unallocated funds. **hfma.to/pve**

Health Education England is introducing a national standardised student data collection tool from April to aid the calculation of tariffs for **student placements**. The tool will cover degree courses, excluding doctors and healthcare scientists, and the data used to calculate the non-medical education and training (NMET) tariff (also known as the placement tariff). The data, which is also used to estimate current and future capacity, has been collected in different ways – and at different times – from employers and education providers. But this will change from April with the introduction of a standardised electronic collection. **hfma.to/y51**

A booklet clarifying guidance on **coding for hospital dentistry** has been issued by Getting it Right First Time (GIRFT), the British Orthodontic Society and the Royal College of Surgeons. The guidance is based on GIRFT deep-dive visits to trusts, as well as conversations with clinical coding teams, and has been developed to improve the quality of data and reduce unwarranted variation. It is aimed at clinical coders, clinicians and other health professionals in secondary care trusts. **hfma.to/pw3**

A new case study-based briefing sets out Gloucestershire Health and Care NHS Foundation Trust's experience piloting the new **Engagement Value Outcome framework** – developed by the HFMA Healthcare Costing for Value Institute and Future-Focused Finance. The framework – which is known as EVO – aims to support the engagement of multidisciplinary teams in the understanding and use of patient-level information and costs and its relationship to value. The briefing covers pilots on allied health professionals, the diabetes service and wound care. Further case studies from the programme across other pilot trusts will be published soon. **hfma.to/yez**



Two new briefings have been published by the HFMA covering **year-end reminders** as NHS bodies prepare their 2019/20 annual report and accounts. They draw on feedback at and following the association's pre-accounts planning conferences earlier this year. *2019 year-end reminders* provides a more detailed summary of key issues, including: the new IFRS 16 leasing standard; disclosures relating to standards IFRS 9 and IFRS 15; discount rates; and employer contributions to the pension scheme. *2019/20 year-end reminders for non-executive directors and lay members* provides a more summarised description of the main issues to be aware of for 2019/20, as well as suggesting key questions that non-executives and lay members should be asking during their review of the report and accounts. **hfma.to/j7b** and **hfma.to/2ep**

NHS Improvement revised its national cost collection publication and its **patient-level costs** PLICS portal shortly after its initial release in February. The corrections included uploading (3 February) a reissued data file, including unadjusted data – the initial upload had included market forces factor (MFF)-adjusted data. There were also corrections (18 February) to the scaled MFF figures within the national cost collection index and to cost data for A&E. Portal users were also reminded that the breakdown of collection and activity data can only be accessed once a single healthcare resource group has been selected in the potential cost opportunities tab. **hfma.to/9hd**

Type 1 diabetes treatment approved

Technical: NICE

NICE has published three technology appraisals with positive recommendations in recent weeks, alongside three guidelines. The guidelines – *Supporting adult carers* (NG150), *Colorectal cancer* (NG151) and *Leg ulcer infection: antimicrobial prescribing* (NG152) – are supported by resource impact statements detailing why implementing the guidelines is not expected to lead to a significant resource impact.

Technology appraisal TA622 recommends sotagliflozin with insulin as an option for treating type 1 diabetes. It is suitable for adults with a body mass index (BMI) of at least 27 kg/m^2, when insulin alone does not provide adequate glycaemic control despite optimal insulin therapy, under certain conditions.

Sotagliflozin is not yet available in the NHS, but the company anticipates it will be available to the NHS in England and Wales within 12 months of the guidance publication. So, the period of time the NHS has to comply with these recommendations has been extended (see the section on implementation within the guidance). Implementing this guidance is not expected to have a significant resource impact.

TA623 recommends patiromer as an option for treating hyperkalaemia in adults, but only in certain circumstances. The potential resource impact of implementing this guidance should be assessed locally as the list price of one of the other treatment options, sodium zirconium cyclosilicate, has a discount that is commercial in confidence.

Finally, TA624 recommends peginterferon beta-1a as an option for treating relapsing–remitting multiple sclerosis in adults. Implementing this guidance is not expected to have a significant impact on resources.

Gary Shield is a resource impact assessment manager at NICE

NHS in numbers

A closer look at the data behind NHS finance

Further information
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Smoking habits **hfma.to/ewl**
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Lifestyle factors

Technical

A new review led by Michael Marmot – *Health equity in England: the Marmot review 10 years on* – reports that life expectancy has stalled since 2010, with growing differences between the most and least deprived areas.

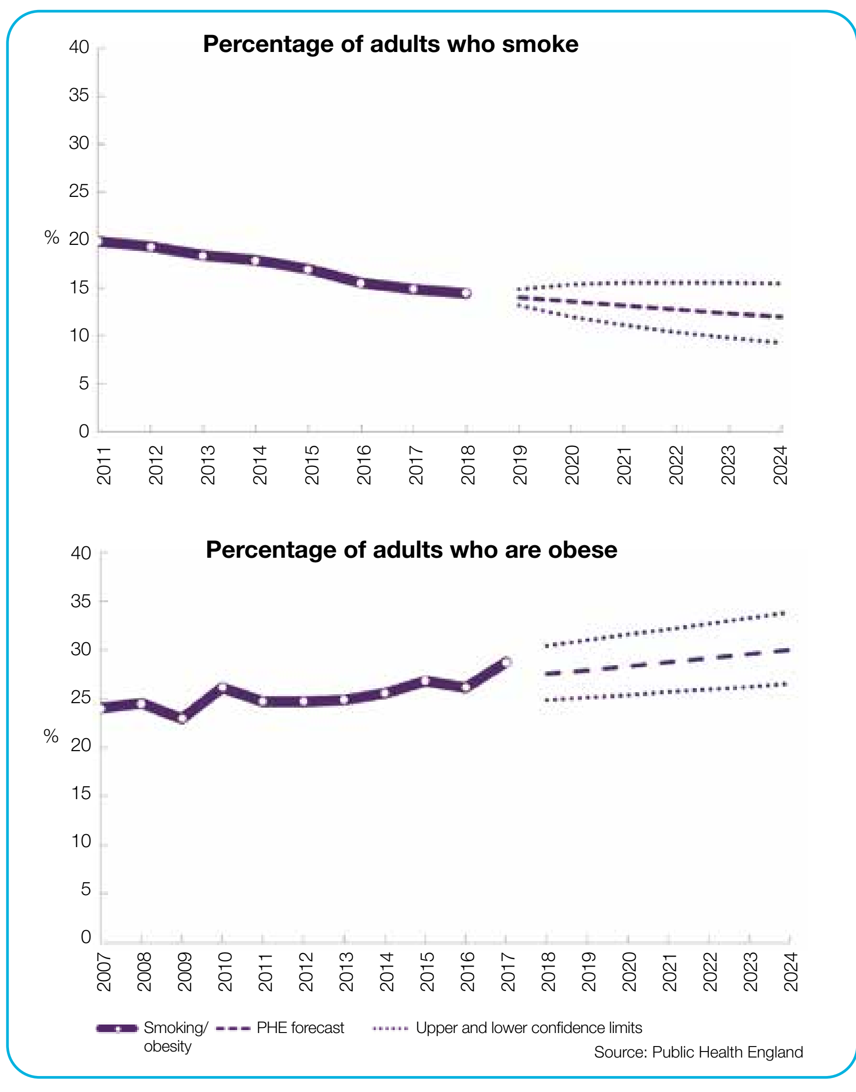
Healthy life expectancy has declined for women over the same time period and the percentage of life spent in ill health has increased for men and women.

The *Health profile for England: 2019* also shows a small increase in the age-standardised morbidity rate since 1990, although the previous year's data, using a slightly different methodology, had shown a slight decrease.

The profile backs up the Marmot figures on healthy life expectancy, although the changes are very small.

Smoking and obesity are among the leading risk factors for morbidity, associated with cardiovascular disease, musculoskeletal conditions, respiratory diseases, diabetes and most cancers.

The prevalence of smoking has continued to decline over the past seven years to 14.4% of adults (18+) in 2018. A time series analysis suggests that if this continues, it will fall to between 8.5% and 11.7% by 2023. Office for National Statistics figures show rates are higher in the other UK nations, with rates of 15.5% in Northern Ireland, 15.9% in Wales and 16.3% in Scotland. The overall UK rate is 14.7%.



OECD figures show UK smoking rates are below the OECD average. Figures in the OECD's *Health at a glance 2019* publication are not directly comparable to ONS figures – they use a different survey source and define adults as 15+. It puts the UK smoking rate for 2017 at 17.2%, compared with an OECD average of 18%. Rates range from 25% in Greece, Turkey, Hungary and France to below 10% in Mexico and Iceland.

The *NHS long-term plan* says that, while rates have fallen, smoking still accounts for more years of life lost than any modifiable risk factor. Around 6.1 million people in England still smoke. Smokers see their GP over a third more often than non-smokers, and smoking is linked to nearly half a million hospital admissions each year, costing more than £900m. Add in the cost of primary and ambulatory care services and the cost rises to £2.4bn, according to pressure group Ash's 2019 costs of tobacco ready reckoner.

The cost of smoking-related social care is nearly £900m and the total cost to society each year is estimated to be £12.5bn, when you add in lost productivity. Smoking cessation services are commissioned by local authorities. But the long-term plan says all patients admitted to hospital will be offered NHS-funded tobacco treatment services by 2023/24.

NHS Digital statistics show that in 2017/18, 10,660 hospital admissions were directly attributable to obesity (primary diagnosis) and there were 711,000 admissions where obesity was a factor (primary or secondary diagnosis).

The latter is a rise of 15% on 2016/17, although some of this may be due to better recording. For admissions where obesity was a factor, there were many different primary diagnoses. Less than a quarter of these related to the top 10 diagnosis types – although the most common related to joint issues and maternity issues.

Alcohol misuse is the biggest risk factor attributable to early mortality, ill-health and disability for people aged 15 to 49 (and the fifth biggest for all ages). According to NHS Digital statistics (2019), some 21% of adults (16+) drink more than 14 units per week.

There were 338,000 hospital admissions in 2017/18, where the main reason for admission was alcohol – 15% up on 2007/08 and 2.1% of all hospital admissions. Blackpool had the highest rate (1,100 per 100,000 people) and Wokingham the lowest (390).

Tutorial value

News and views from the HFMA Academy

The more that students engage in the academy live sessions, the more they will get out of them and the better chances they will have of successfully achieving the qualification. That's the view of Paul Dillon-Robinson (pictured), a tutor on the *Managing the healthcare business* module of the HFMA's advanced qualifications in healthcare business and finance, *writes Steve Brown.*

He believes the online tutorials are a key element in helping students on the masters-level course to get the most out of the material. There are 12 formal sessions in total – one for each topic covered in each of the 10 weeks of study, an introductory session and a tutorial to support students in preparing their final assessment.

'My key role is to help them think more broadly than just what they are reading in the study material,' he says. 'I try to illustrate it, drawing on my own experience and encourage them to think about it in the context of their own experience and roles.'

Mr Dillon-Robinson's experience is extensive. He spent 17 years working in NHS internal audit, including eight running South Coast Audit (now TIAA). He also had a prominent role nationally in promoting good governance and effective audit committees and was chair of the HFMA's Corporate Governance and Audit Committee. After leaving the NHS, he moved to the House of Commons, where he spent nine years as director of internal audit and risk.

Now a consultant, he balances his role as an HFMA tutor – and soon-to-be skills coach on the association's level four accountancy apprenticeship – with non-executive roles at the Queen Victoria Hospital NHS Foundation Trust, where he chairs the finance and performance committee, and at the Rural Payments Agency.

With his own MBA achieved through the Open University, Mr Dillon-Robinson recognises the motivation to return to study and enhance career prospects.

'For finance people taking the advanced diplomas, it can be about seeing the wider management issues, while clinicians are often looking to get more comfortable with the business and financial aspects that can help them in broader management roles.

'It is great when you are there for a lightbulb moment – a clinician suddenly "understanding risk management" and realising how they can engage more effectively back at their trust,' he says. 'The focus of the qualification is often not on the how something is done, but why – and that can be an interesting challenge for many of the students from various backgrounds.'

Mr Dillon-Robinson acknowledges that the return to study can be challenging at first. People need to work out their own balance between work, home and study and get a feel for what needs to be read in detail and where a summary understanding is sufficient. Each student will be different and he likes to talk to each student individually up front to understand their motivations and learning styles.

'The academy live sessions are designed as tutorials not just a teach-in,' he says. 'I want people engaged, thinking through the practical issues of, for example, embedding a whistleblowing policy that will actually work. It is great when the students develop their own virtual networks to support each other.'

Mr Dillon-Robinson has written modules for the HFMA qualifications. All the modules are regularly reviewed and rewritten, where necessary, to take account of both student and tutor feedback. 'We are refining all the time and that's also the case for the tutorials where we try to use different examples than those used in the study material to illustrate key aspects of the topic. It's a challenge for me and the learners.'

Feedback suggests the tutorials are popular with many of the students – an opportunity to test what they've learnt, ask questions and think about issues from different angles. 'It's about getting the most out of the material and I'm convinced there is a huge correlation between engagement in the sessions and ultimate success in completing the relevant module,' he says.

• For more about HFMA qualifications visit www.hfma.org.uk/education/hfma-qualifications

FFF seeks views on future vision

Following the release of the *Designing our future* report, which was developed in conjunction with the HFMA and PwC, FFF is working with NHS England and NHS Improvement to co-create a new vision, plan and way of working for the NHS finance community.

Over the next six months, FFF wants to gather the views, insight and passion of all finance staff to help develop a vision of how we can improve what we do at an individual, team, trust, system and national level.

'If we can truly involve all 16,000-plus finance professionals in co-designing our future, we will be far better placed to meet the challenges we face as a society and the pressures on the NHS,' says NHS England and NHS Improvement chief financial officer Julian Kelly.

As part of the exercise, FFF will be holding a number of regional events for staff across all regions to have their say. The dates for the regional events are as follows:

- London – 16 March
- Leeds – 19 March
- Durham – 20 March
- Newmarket – 23 March
- Crawley – 27 March
- Taunton – 31 March
- Manchester – 2 April
- Birmingham – 3 April

Alongside the regional events, an online forum will be launched on 12 March to ensure that every member of the NHS finance community has an opportunity to participate in the national conversation.

By using online technology and expert qualitative analytics, all feedback received will be turned into a practical plan of action, which will be launched in September.

Further details and how to book the regional events and pre-register for the online forum can be found on the FFF website at **www.futurefocusedfinance.nhs.uk**

Diary

March

3 Ⓝ Year-end issues (webinar), 12:30pm

4 Ⓘ Institute: the next step – how to use PLICS to benefit your trust (webinar), 11am

5 Ⓝ Driving workforce savings – staff bank best practice (webinar), 11am

10 Ⓝ NHS finance priorities for the year ahead – Julian Kelly and Prerana Issar (webinar), 10:30am

11 Ⓘ Institute: value masterclass, London

17 Ⓝ Primary care networks (webinar), 1pm

27 Ⓝ The future of payment systems (webinar), Gary Andrews, 12pm

April

8 Ⓘ Institute: costing conference, London

24 Ⓑ North West: golf event

May

5 Ⓕ Provider Finance: forum, implementing NHS strategy, London

7 Ⓑ South West and South Central: developing talent conference

14 Ⓕ Chair, Non-executive Director and Lay Member: forum, the role of non-executive leadership in system working, London

June

3 Ⓕ Chair, Non-executive Director and Lay Member: forum and board game, London

4 Ⓝ Taking pride in our future: forum, London

July

2-3 Ⓝ HFMA summer conference, Hilton Birmingham Metropole

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

Ⓑ Branch Ⓝ National Ⓕ Faculty Ⓘ Institute

HFMA Hub

The *NHS long-term plan* stipulates that every organisation in England will need to be part of an integrated care system by 2021. The transition to system-wide working presents enormous opportunities and challenges for health and social care leaders as they work towards a unified system that is patient focused.

The HFMA's longstanding partner programme and faculty offering has evolved into the HFMA Hub to mirror current system working across the NHS.

HFMA faculties will continue as networks within the hub and will retain their identify and the strong communities each area has built.

In addition to their networks, hub partner organisations will have the added benefit of access to the rest of the programme and the opportunity to engage with other organisations and other colleagues, sectors and networks both nationally and in their local health economies. This should support an increased focus on system-level working.

Events in focus

Implementing NHS strategy: update for provider trusts

5 May, London

This one-day event, part of the HFMA Provider Network*, offers a high-level briefing for senior finance staff in provider organisations. Delegates will hear updates on funding and efficiency in relation to the long-term plan. They will also gain insight into the role of NHSX and debate expectations for, and concerns about, the NHS capital budget. Key features of the programme include:

- NHS capital, including budgets; the impact of capital on trust productivity; and concerns for the future of capital
- The key principles of the Getting it Right First Time (GIRFT) programme and the importance of early intervention in crisis and acute mental health
- An update on the latest government spending review, a look at the implementation of the *NHS long-term plan* and the provider sector financial position
- The NHSX goals for 2020 and its digital transformation plans for the NHS.

Speakers include Simon Currie, NHS England and NHS Improvement director of financial planning and delivery; Health Foundation senior economist Ben Gershlick; and Ian Davidson (pictured), GIRFT national clinical lead for crisis and acute mental health.

* The event sits with the Provider Network but is free to attend for any current members of the HFMA partner programme or any members of the HFMA faculties.

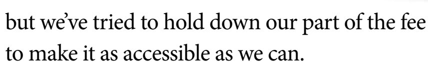
- **To book a place, email** josie.baskerville@hfma.org.uk

HFMA annual conference

9-11 December, London

The HFMA has just opened booking for this year's annual conference – one of the highlights of the NHS finance year. Not only a first-rate networking event, it also provides an opportunity to hear the latest policy developments from the centre and new ideas from around the UK and the rest of the world. The conference will take its lead from 2020 HFMA president Caroline Clarke (pictured), whose theme, *Taking pride in our future*, will inform discussions. The focus is likely to be on some of the biggest developments of the year – including ongoing integration, such as the development of integrated care systems, due to be established across England by April 2021. The outcome of this year's spending review is also likely to be a hot topic. Delegates can also expect sessions on best practice in the health service, while the best of NHS finance will be celebrated at the association's annual awards ceremony.

- **For further details and early booker rates, see** www.hfma.org.uk/events



Cause for celebration

Association view from Mark Knight, HFMA chief executive

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

My HFMA As many of you will have noted, this year marks the 70th anniversary of the association. We don't have great detail about the formation of the association, but its foundation occurred following initial meetings in late 1949. Since then, the HFMA has been there for virtually all of the NHS's history, from the introduction of prescription charges in 1952, through the creation of district general hospitals in the 1960s and the *Griffiths Report* in 1983, all the way to the most recent *NHS long-term plan*.

For those interested, you can read more about the association's history in our booklet published for our 60th anniversary (**hfma.to/history**).

Who would have realised the impact the creation of the NHS would have? It has become a national institution, a shrine to British values, with finance tucked in the middle helping to move money round the system and enabling the service to stay within its voted financial envelope. It is a history worth celebrating. But an anniversary should also be an opportunity to think about where the service is going too.

Caroline Clarke, the association's president for our 70th year, has set a theme for her time in office of *Taking pride in our future*. This clearly focuses on the future and how the finance function can ensure it helps build the service of tomorrow that meets the needs of patients and taxpayers. We will be holding a celebratory dinner in July, and the end of our anniversary year will be at the annual conference.

Those attending our main annual event this year will notice the new owners of the facility are investing a lot of money in refurbishment. As a result, there will be a slightly different feel to this year's conference, with the whole of the front of the hotel effectively closed. However, this means we can use other parts of the facility for our conference activities and my team are spending lots of time working on ensuring this works well.

The early booker offer for annual conference is now available, giving you until the end of April to save 10% on the prices. We have been faced with some higher than average hotel price rises, but we've tried to hold down our part of the fee to make it as accessible as we can.

HFMA chief executive Mark Knight

The other development is a new 'twin ticket' for delegates happy to share a bedroom. By purchasing a twin ticket, subject to availability, organisations can save £400 (or £200 per delegate). We must know the individuals' names and be assured they are happy to share.
We are starting to think about the conference programme and if you have suggestions – especially sessions that would support the *Taking pride in our future* theme – please get in touch at **chiefexec@hfma.org.uk**.

We value all of the feedback we receive and are working hard to put together a line-up worth getting on the train for. I was proud of the superb programme for the 2019 event, which then had to be rewritten following the announcement of the general election and the withdrawal of key speakers. We can be confident those circumstances will not arise again this year.

We will strive to recreate the vibrancy of 2019 programme – there was a real buzz about the conference, which lots of people commented on.

Remember, it's our 70th anniversary, so please book early and let's all take pride in our future – together!

Member news

Yorkshire and Humber Branch hosted its annual conference in January over two days. The event featured prominent speakers, including cancer survivor Greig Trout, comedian Cally Beaton, executive coach and performance psychologist Steve Bull and more. During the conference, the branch also presented its annual awards. The winners of the six awards were:

- **Lifetime Achievement**: Mark Johnson, Leeds Teaching Hospitals NHST (pictured below with branch president Cathy Kennedy)
- **Close Partnering and Collaboration** (sponsored by Sellick Partnership): Calderdale and Huddersfield NHS FT
- **Innovation** (sponsored by Lifecycle): York Teaching Hospital NHS FT
- **Finance Student of the Year** (sponsored by First Intuition): Thomas Mitchell, Leeds Teaching Hospitals NHST
- **Finance Team of the Year** (sponsored by IQVIA): Humber Teaching NHS FT
- **Finance Professional of the Year** (sponsored by Seymour John): Iain Omand, Humber Teaching NHS FT

The HFMA is now on Instagram **@HFMA_UK**. This is the latest addition to the HFMA social media suite, giving NHS professionals across the country a chance to share what is happening in their organisations with **#myHFMAstory**. The best posts will be shared with the wider community, allowing people to exchange best practice and informal news from their region. The HFMA also recently released a monthly podcast. Tune in to **HFMAtalk** on your podcast player or visit **hfma.to/HFMATalk** to hear the latest episode.

Member benefits

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

Branch focus

West Midlands

The West Midlands Branch is developing a three- to five-year strategy that will allow one of the HFMA's biggest and most successful branches to improve its member support. It wants members to drive the strategy, which will be launched at the branch annual general meeting in November.

The process of crafting the strategy began with a session facilitated by consultant and experienced NHS finance director Paul Miller, where it was agreed that members should be at its heart. Key themes for consultation in developing the strategy include: providing more support for members; looking at how the branch helps to hold the finance system in the region together; and how the branch can further support system innovation and integration, as well as clinicians and managers.

'The challenges NHS finance professionals in the West Midlands face are similar to those in other places across the country. They include the move to greater collaboration and integrated care systems, and delivering the asks from the long-term plan with limited resources,' says Rob Pickup (pictured), director of finance at Dudley and Walsall Mental Health NHS Trust and chair of the branch.

'We are focusing on how we can support people through that process, rather than supporting the process itself, which is what the national HFMA structure does.'

Mr Pickup was appointed branch chair at its annual general meeting last November. He has been part of the committee since 2005, taking various positions, including vice chair, treasurer and secretary.

'The two main points of focus of our new strategy will be how we support our members and how we help provide the glue that holds the system together,' adds Mr Pickup.

Alongside its events, the branch holds regular meetings for directors and deputy directors of finance in the region, enabling them to network and share experiences. There is also an active student community.

The branch hopes the new strategy will better help it bridge the gap and provide more support for people in between these job levels. There will be a session on the strategy at the West Midlands annual conference in June, or join the conversation via Twitter @HFMAWestMids or by emailing fleur.sylvester@hfma.org.uk

Eastern kate.tolworthy@hfma.org.uk
East Midlands joanne.kinsey1@nhs.net
Kent, Surrey and Sussex elizabeth.taylor29@nhs.net
London amy.morgan@hfma.org.uk
Northern Ireland kim.ferguson@northerntrust.hscni.net
Northern catherine.grant2@nhs.net
North West sara.braidwood@hfma.org.uk
Scotland fleur.sylvester@hfma.org.uk
South West amy.morgan@hfma.org.uk
South Central georgia.purnell@hfma.org.uk
Wales charlie.dolan@hfma.org.uk
West Midlands jessica.balfour@hfma.org.uk
Yorkshire and Humber khushnu.mehta@hdft.nhs.uk

Appointments

HFMA trustee **Sanjay Agrawal** (pictured) has been appointed national specialty adviser, tobacco dependency, at NHS England and NHS Improvement. Dr Agrawal continues as a consultant respiratory intensivist at University Hospitals of Leicester NHS Trust.

Sarah Stansfield (pictured) is now director of outcome-based contracting at Nene Clinical Commissioning Group and Corby Clinical Commissioning Group. She was executive director of finance at Gloucestershire Hospitals NHS Foundation Trust, where she is succeeded by **Karen Johnson**. Ms Johnson joined the NHS in 2010, after working in local government. She was previously director of finance at Great Western Hospitals NHS Foundation Trust.

Tracey Cotterill has been appointed on an interim basis as director of finance at Great Western Hospitals NHS Foundation Trust. She has spent the past 10 months as an interim director of finance at Kingston Hospitals NHS Trust. **Yarlini Roberts** has taken over Ms Cotterill's position on a secondment from The NHS South West London Alliance, where she was finance director.

Royal Papworth Hospital NHS Foundation Trust has named **Tim Glenn** chief finance and commercial officer, taking over from **Roy Clarke**. Mr Glenn is currently finance director at Cambridge University Hospitals NHS Foundation Trust. He has been with the trust for nine years, initially as divisional head of finance.

Jazz Thind (pictured) has joined Imperial College Healthcare NHS Trust on secondment as interim chief financial officer. Ms Thind joins the trust from Oxleas NHS Foundation Trust, where she has been finance director since 2016. She replaces **Richard Alexander**, who remains with the trust until April, leading a portfolio of north west London system-wide programmes to increase value from support functions. He is also continuing his work with Future-Focused Finance.

Imperial College Healthcare NHS Trust has appointed two new deputy chief financial officers. **Sam Bullen** is moving from his role as associate director of strategic finance at the trust to become deputy chief financial officer (strategic and commercial). In addition, **Desireé Irving-Brown** will join the trust as deputy chief financial officer (operational finance) from Kingston Hospital NHS Foundation Trust, where she is currently deputy director of finance. The two new deputy directors of finance will replace **Janice Stephens**, who is leaving the trust, and **Paul Doyle**, who is moving teams to become a deputy director of transformation.

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

"I know there are questions about the cost of PFI, but Royal Derby Hospital will still be here, serving local people, long after I retire"
Scott Jarvis

Jarvis opts for early retirement from NHS

On the move

The end of this month will see an NHS plan come to fruition as Scott Jarvis retires from University Hospitals of Derby and Burton NHS Foundation Trust. It will be a double retirement in the family, with his wife Jane also leaving the trust. She has spent 33 years there, working exclusively in payroll.

'We decided to go together,' says Mr Jarvis, the trust's director of operational finance. 'We always had a long-term plan to retire early, but it took us ages to get around to making the decision to call it a day.

'I have been in a senior position for a long time and I will miss the people. Together with contacts through the HFMA, these are people who I consider my family and I don't want to lose touch.'

How have his colleagues reacted to his early retirement? 'The first reaction was, "You've always been here; you can't leave us". NHS finance is tough and it's getting tougher, and I feel a loyalty to everyone I'm leaving behind.

'But no-one's irreplaceable and I am in a fortunate position where I can retire early – so why not?

'They've been really supportive and told me to enjoy it. I think they would be annoyed if I sat on the sofa all day, but we plan to do some travelling and make full use of our National Trust and English Heritage memberships. I want to spend more time outdoors.'

Mr Jarvis joined the NHS in 1987 after graduating from the University of Essex with a degree in mathematics, statistics and economics. He was unsure of his next step, but as a native of Nottingham he wanted to return to the area.

'A lot of my mates went into proper accounting firms, but I didn't want to be an auditor. So I wrote to the health and local authorities, and Southern Derbyshire Health Authority was the first to reply. I had a meeting with the deputy treasurer on a Thursday and started the next Monday on the basis that they wanted a trainee and I'd give it a go.'

Mr Jarvis wanted a job where he could gain a qualification – and he duly qualified with CIMA in 1991. It also offered variety, with the health boards managing the planning of care, as well as all types of provision. He took secondments to the family health services authority – where he helped develop GP fundholding – and Derby City General Hospital, where he has remained for more than 20 years.

He has seen significant policy changes, including the advent of the internal market, the formation of trusts, the private finance initiative and the introduction of payment by results. Derby City has merged with the Derbyshire Royal Infirmary and, more recently, Burton Hospitals. Mr Jarvis has been deputy finance director for about 15 of the past 20 years.

"I missed a meeting, and when I came back I was told I had been elected East Midlands Branch treasurer in my absence"

The building of the new Royal Derby Hospital under PFI was a standout event. 'It took 10 years of my career – five years planning, five years building it,' he says.

'But even now it makes me proud to have been involved in building it. I know there are questions about the cost of PFI, but the hospital will still be here, serving local people, long after I retire.'

An HFMA member for almost 30 years – a clue to his years of support can be seen in his membership number, EMD6 – Mr Jarvis has been East Midlands Branch treasurer since 2011. 'I missed a meeting, and when I came back I was told I had been elected treasurer in my absence.'

Mr Jarvis has been nominated for the HFMA Deputy Finance Director of the Year Award and was given a Key Contributor Award in 2015.

As retirement beckons, he will stand down from the branch committee, but he is proud of the local HFMA networks he has helped establish, including for senior finance staff, as well as student and costing forums.

'You can find out how the STPs are doing, or what providers or commissioners do, in a safe environment where no-one takes sides,' he says.

HFMA apprenticeships

Register now

Your organisation can now enrol staff onto HFMA apprenticeships, funded directly through the levy. The HFMA is now offering an **assistant accountant Level 3 apprenticeship** and an **accounting technician Level 4 apprenticeship**.

For more information and to register visit **hfma.to/apprenticeships**

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