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April 2018 | Healthcare Financial Management Association

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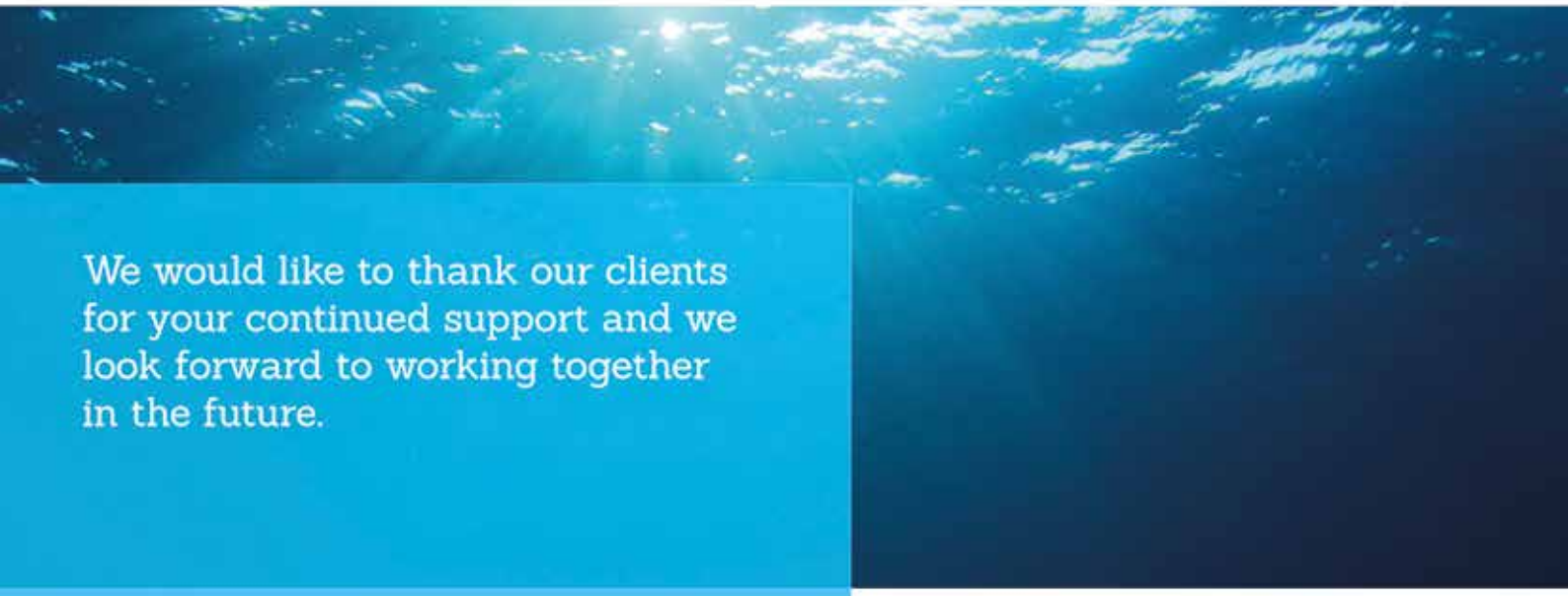

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HFMA Qualifications
Masters-level qualifications in healthcare business and finance

Funding support for HFMA's masters-level qualifications

There are different funding options available to support you to study HFMA's masters-level qualifications in healthcare business and finance. Funding support includes:

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News

Pay deal aims to recruit and retain NHS staff

By Seamus Ward

A deal giving Agenda for Change staff pay rises of between 6.5% and 29% over three years has been agreed between the unions and ministers, who have moved to boost the service's ability to attract and retain staff.

The deal, which is expected to cost £4.2bn, will be funded in full by the Treasury and not from existing NHS finances.

The agreement covers more than a million staff in England and targets the lowest paid. All staff will receive pay rises from 1 April this year. A new minimum basic pay rate of £17,460 will be introduced in the NHS in England – a rise of more than £2,000 that will benefit 100,000 staff.

It is understood that funding will be available for NHS staff in Scotland, Northern Ireland and Wales, where local administrations have responsibility for health service pay.

Starting salaries across all pay bands will increase following a simplification of the bands. This will be achieved by removing pay points at the bottom of current pay bands that overlap with a lower band. One pay point will be removed in 2018/19 and further points in 2019/20.

The standard NHS employment contract will include a new provision for NHS apprentices. The framework says this will help employers make the most of the apprenticeship levy and increase capacity.

To retain staff, the new structure will aim to ensure that on 1 April of each year, all staff will have a higher basic pay than the current expectations of a 1% pay award plus contractual increments.

> **"The deal won't solve every problem in the NHS, but would go a long way towards making health staff feel more valued"**
> **Sara Gorton, Unison**

Staff will also be able to get to the top of their pay band more quickly – up to three years sooner in some cases. A new pay progression framework will be put in place by April 2019. This will ensure staff have the skills and knowledge to perform their role, but also include minimum time periods before progression to the next pay point.

Earlier reports that staff would have to give up a day's leave as part of the deal proved untrue.

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Jeremy Hunt: deal recognises hard work

However, some concessions will be made. Pay progression will not be automatic. And unsocial hours pay enhancements will be reduced.

This will mean payment for band one on Sundays and public holidays (midnight to midnight) will be time plus 97% in 2018/19, falling to time plus 95% in 2019/20 and time plus 94% in 2020/21.

The GMB is the only union advising its members not to accept the deal. Unions will consult members and announce the outcome by 8 June. If agreed, the pay rises will be backdated to April.

Sara Gorton, Unison's head of health, and the lead pay negotiator for the NHS unions, said: 'The agreement means an end at last to the government's self-defeating and unfair 1% pay cap. It won't solve every problem in the NHS, but would go a long way towards making dedicated health staff feel more valued, lift flagging morale, and help turn the tide on employers' staffing problems.'

Health and social care secretary Jeremy Hunt said: 'NHS staff have never worked harder and this deal is recognition of that, alongside some important modernisation of the way their contracts work.'

Danny Mortimer, chief executive of NHS Employers, added: 'This deal will benefit more than a million health staff in England. To support long-term attraction and recruitment, starting salaries for all our non-medical staff groups will also see increases, which will help to make these roles more attractive for people considering a career in the largest employer in Europe.

'It will also ensure that existing staff receive deserved increases to pay, which will assist our work to value and retain these vital colleagues.'

The BMA and NHS Employers also agreed a new general medical services contract for GPs in England in 2018/19. It includes a 1% rise in pay and 3% for expenses.

• *See Grow your own, page 13*

Pay deal: key points

- **The deal is expected to cost £4.2bn.**
- **The gain in earnings over the three years would vary between 6.5% and 29%.**
- **The NHS in England will introduce a new minimum basic salary of £17,460.**
- **The value of the top points on each pay band will increase by 6.5% cumulatively over the period for bands 2 to 8c. This will mean a 3% rise in 2018/19; 1.7% in 2019/20; and 1.67% in 2020/21.**
- **In addition, in 2019/20 a cash lump sum of 1.1% will be given to staff on the top points in bands 2-8c. This will be paid in April 2019 and will not be consolidated.**
- **In each of the three years, the value of the highest pay points in 8d and 9 will be capped at the level of increase in the top point in 8c – a lump sum would also be paid in April 2019, but again capped at the value given to those at the top of 8c.**
- **Re-earnable pay – where those at the top of bands 8c, 8d and 9 have up to 10% of their salary linked to performance – will continue.**

Quality, morale and financial position are top concerns for finance directors

By Seamus Ward

Almost two-thirds of commissioner and provider finance directors believe the quality of patient care had deteriorated in the last year, according to the King's Fund Quarterly monitoring report.

In the previous report – covering the halfway point of the financial year – the fund said 50% of trust finance directors and 59% of CCG finance leads thought care had got worse. But at the end of the third quarter, this had increased to 63% of both provider and commissioner finance chiefs.

Provider finance directors put the decline in their opinion of service quality down to a number of factors, including lack of staff, the decommissioning of services without a suitable alternative and lengthening waiting times.

The survey received responses from 78 provider finance directors and 27 clinical commissioning group chief finance officers (covering 33 CCGs).

Trust finance directors said their biggest concerns were bed occupancy and staff morale, while they remain troubled by delayed transfers of care and A&E. The failure to meet the four-hour A&E waiting time standard continued to be CCG finance leads' main concern, followed by the pressure on general practice.

More than half of directors forecast a 2017/18 year-end deficit, while 82% said meeting their forecast position would depend on significant financial support. And 53% of those expecting to receive sustainability and transformation funding still forecast a deficit at year-end.

More than a third (36%) of CCGs expected to overspend in 2017/18 and 27% said they expected to cancel or delay spending plans to support their year-end position. The fund said there was a threat to the CCG risk reserve – 0.5% of CCGs' allocation that is uncommitted – with 21% of CCGs saying they were relying on the funding being returned to them rather than being used to offset provider deficits.

The King's Fund was concerned about operational performance and the impact of the way headline A&E performance is measured – an average of type 1 or major A&Es, type 2 single specialty A&Es, and type 3 or minor injury units. Combining the figures was increasingly misleading, it said, neither reflecting the deterioration of performance in type 1, nor the excellent performance against the four-hour standard in type 3.

Richard Murray (pictured), the fund's policy director, said: 'With demand for services likely to remain high, it's very unlikely that meeting [waiting time] targets will become more achievable. The waiting time standards should not be abandoned but the NHS needs to ensure the way they are implemented does not leave patients who are not treated within the time limits facing long waits for treatment.'

NHS Providers deputy chief executive Saffron Cordery said it was becoming increasingly difficult to ensure patients receive safe and timely care 'when demand for treatment is growing so quickly, and funding is so tight.

'It is also disappointing to see so many people waiting longer than 18 weeks for planned routine operations. It feels like we are losing the hard-won gains of the last decade. We have reached a watershed moment. We need to see urgent steps towards establishing a long term funding solution for health and social care.'

Providers reject criticisms over subsidiaries

The suggestion that trusts set up wholly owned subsidiaries to avoid VAT or that they are a back door to privatisation are 'inaccurate and misleading', according to NHS Providers.

A report by the providers' body said subsidiary companies were a vital tool for trusts to enable them to respond to a range of challenges. Trusts have been actively establishing wholly owned subsidiaries since 2010 and, for much of that time, they have been uncontroversial, it added.

Trusts have long argued that the VAT system puts them at a disadvantage compared with private organisations carrying out similar activities. While setting up a wholly owned subsidiary would generate VAT savings, the report insisted the motive for creating subsidiaries differentiated the NHS from others. It said there was a difference between setting up a wholly owned subsidiary to make savings that are reinvested in frontline care and using a subsidiary solely or primarily to obtain VAT savings.

NHS Providers also rejected concerns that wholly owned subsidiaries have been set up to employ staff on lower wages. It said that, when transferred, staff retain their employment rights, terms and conditions and pension rights. New staff may be on different terms, but it contended that these contracts often offered flexibility on pay and pensions that attracted staff who would otherwise not consider working in the NHS.

Subsidiaries were not back-door privatisation as they are an alternative to outsourcing services to the private sector and they are 100% owned by NHS organisations, it added.

Saffron Cordery (pictured), NHS Providers deputy chief executive, said: 'It is important that people understand why NHS trusts are turning to wholly owned subsidiaries, and to address some of the misleading and inaccurate arguments that have been made.

'They are set up for many reasons which vary depending on local circumstances and needs. But trust leaders are clear they have become a key tool to deliver the current strategic requirements expected of them. And they have a record of delivering practical benefits for trusts, staff and patients.'

Department to review 6% interim loan interest charge

By Seamus Ward

NHS Improvement chief executive Ian Dalton (pictured) has pledged to review the 6% interest rate for cash support received by trusts in financial special measures.

The 6% rate was introduced as part of the finance reset in 2016 to incentivise struggling trusts to turn around their finances. Trusts in financial special measures that deliver three months of NHS Improvement-agreed targets are charged less than 6% on further loans. Generally, a rate of 1.5% or 3.5% is levied on other trusts.

Overall, since the system of interest-bearing loans for interim cash support was introduced in 2016, trusts have paid £183m in interest to the Department of Health and Social Care.

The 6% rate has attracted criticism for penalising trusts with the greatest financial difficulty. Mr Dalton said he was convinced the system of control totals, sustainability support funds and other support measures implemented since 2016/17 was the right thing to do. But there was support at the centre to look again at the higher interest rate as part of a financial review.

He told a Common Public Accounts Committee hearing on NHS sustainability and transformation: 'We do need to review it. The distressed loans that have been given to some of our largest trusts are in the hundreds of millions of pounds. As part of the look at this that we have committed to, it would be absolutely right to consider the rate of interest and the nature of the financing.

'Effectively, trusts need that financing so that they can pay their staff and pay their bills, so I think there is a legitimate question about their ability to pay the principal, as well as the interest rate on it. I do not think that people enter into those loans without cause. We need to have that conversation that we have all committed to.'

The Department's director general of finance, David Williams, added that the rate was not applied across all trusts that were in financial special measures.

'Of the 12 trusts currently in financial special measures, eight that have shown at least three months' worth of improvement against plan are now being financed at a lower rate,' said Mr Williams. 'Only four [of those trusts] are still attracting the 6% rate for new borrowing.'

Loans to two trusts that have exited financial special measures have been refinanced at a lower rate 'as part of the incentive to encourage people to sign up to a recovery plan and then deliver it', he added.

By the end of February, trusts had paid £85m in interest (£54m for trusts and £31m for foundation trusts); £74m in 2016/17 (£45m for NHS trusts and £29m for foundations); and £24m in 2015/16 (£15m and £9m, respectively).

According to the Department, the interest paid is not lost to the NHS. 'It is paid to the Department but is channelled back into the NHS through the annual funding provided to the NHS through the NHS England mandate.'

HFMA roundtables to examine NHS future

The HFMA has announced a series of roundtables in the build-up to the 70th anniversary of the foundation of the NHS in July.

The association and others have called for a debate on the future of the NHS, with the 70th anniversary seen as an appropriate point to look at the challenges over the next 30 years. The HFMA is keen to understand these challenges and support members. So it has put together the roundtables – known as the *NHS at 100* programme – as a key element of 2018 HFMA president Alex Gild's theme for the year, *Brighter together.*

The roundtables will explore the areas that are likely to have the biggest impact on the financial future of health and social care. There will be four, which will look at:

- The expected demographic changes and the public health agenda
- The impact of technology, including the effect it will have on self-care
- Society and the role of the state and citizens in health
- How these factors are likely to impact on the finance profession as the NHS reaches 100.

A briefing covering the discussions will be published at the HFMA Convergence conference (5-6 July, see p29).

For further information about the roundtables, see HFMA chief executive Mark Knight's blog at **www.hfma.org.uk/news/blogs**

If you are interested in taking part in the discussion and contributing to the *NHS at 100* briefing, email HFMA head of policy and research **emma.knowles@hfma.org.uk**

Emergency admissions challenge NHS finances

The NHS has not taken control of the management of emergency admissions and this is a serious challenge to its financial position, according to the National Audit Office.

In a report, *Reducing emergency admissions*, the auditors said progress has been made, but the cost of emergency admissions had increased from an estimated £13.4bn to £13.7bn between 2013/14 and 2016/17 – a 2.2% rise – while emergency admissions had increased by 7%. In 2016/17, there were 5.8 million emergency admissions, but NHS England believed 24% of these were avoidable, the report said.

While the pace of the rise in emergency admissions slowed a little in 2016/17, the NAO said there was little evidence this was brought about by initiatives such as the Better Care Fund and the urgent and emergency care programme.

It added that significant challenges remained in efforts to manage emergency admissions. These included increased pressure due to bed closures, the growth in emergency readmissions and gaps in community capacity.

NAO head Amyas Morse said: 'A&Es remain overloaded and a constant point of stress for patients and the NHS. A lot of effort is being made by NHS England. At the centre of this is increased day case treatment but the decision to stop methodical measurement of emergency readmissions a few years ago makes it difficult to understand whether day case interventions achieve enduring results.'

News review

Seamus Ward assesses the past month in healthcare finance

While operational pressures remained high due to the adverse weather, March may have brought some respite from the turmoil of the winter months. But work to hit year-end financial plans will have reached fever pitch. And, in the longer term, there were warnings of costs that could spring from NHS financial instability and pointers to opportunities that could save the service millions of pounds.

The Commons Public Accounts Committee said NHS financial pressures could lead to more work for the Care Quality Commission. A committee report said services could deteriorate in the face of severe financial pressure and the CQC should monitor the impact on its staffing needs. This could come amid funding cuts to the regulator. The committee said the CQC had improved since 2012 – when it first reported on the regulator. It added that the CQC should make inspection reports available to the public sooner and improve its regulation of, and interaction with, GP practices.

There is a clear association between a provider's level of employee engagement and its agency staff spending, according to a report commissioned by NHS England. The report examined links between staff engagement and sickness absence and also engagement and temporary staff spending. It said trusts with higher employee engagement have lower levels of sickness absence and have lower spending on agency and bank staff. NHS leaders should investigate the importance of measures to make staff more highly engaged, it added.

Public Health England also came up with a cost-saving opportunity. Its newly launched target of reducing calories in everyday foods by 20% by 2024 is, of course, about improving the health of the nation. The public health body said the measure could prevent more than 35,000 premature deaths. However, it could save around £9bn in health and social care costs over 25 years too. The public health body said the NHS currently spends £6bn a year treating obesity-related illnesses and these problems keep people out of work, stifling their income and the country's economic productivity. As well as challenging the food industry to reduce calories, it also launched a campaign to get adults to limit calories to 1,600 a day – 400 for breakfast and 600 at both the other main meals.

The full extent of the winter pressures on the NHS is becoming more apparent. The NHS National Emergency Pressures Panel issued an update on the demand faced by health services this winter. The panel said that the number of bed closures as a result of norovirus was up to 143% higher than in the previous winter. And following the worst flu outbreak this decade, an estimated 4,000 beds a week are still being taken up with flu sufferers. The latest winter situation reports (sitreps), published separately by NHS England, showed bed occupancy at just over 95% in the week ending 25 February. The panel warned that further cold snaps in March could trigger a rise in hospital attendances and admissions. Despite the pressure, it added that there were some notable successes, including a fall in the number of bed days lost due to delayed transfers of care, which are now at their lowest in almost three years.

NHS England said there were 45,000 fewer delayed transfer of care cases in January – a decrease of almost 23% on the previous January. It added that 85% of A&E patients were seen

The month in quotes

'The simple truth is that on average we need to eat less. Children and adults routinely eat too many calories and it's why so many are overweight or obese.'
Public Health England chief executive Duncan Selbie sets out the case for eating fewer calories

'Sir David's successor will inherit a mixture of persistent weaknesses and looming challenges. These must be tackled amid commission funding cuts and continued financial pressure across the health and care sectors. Both are a potential threat to the commission's ability to carry out its duties.'
PAC chair Meg Hillier outlines the challenges faced by David Behan's successor as CQC chief executive

'Despite mounting pressure on the NHS, satisfaction in the health service has remained high in recent years. In the last year, however, the tide has started to turn. The drop in satisfaction and rise in dissatisfaction this year suggest that the public are worried about the NHS.'
John Appleby, chief economist and director of research at the Nuffield Trust, says the public is increasingly uneasy about the future of the NHS

'This pressure [norovirus] comes as the NHS is already contending with the worst flu outbreak this decade, which peaked at the start of February. We estimate this has meant up to 4,000 hospital beds a week are still being taken up by sufferers. Patients who contract the virus typically stay in hospital two and a half days longer than others.'
The National Emergency Pressures Panel sums up some of the difficulties faced by the NHS this winter

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Challenging the food industry to reduce calories, Public Health England launched a campaign to get adults to limit calories to 1,600 a day

within four hours in February, compared with 87.5% in February 2017. There were 1.82 million attendances – 4.9% more than the previous February. There were also 6.5% more emergency admissions than in February 2017. Just over 88% of patients in January had been waiting for elective treatment for less than 18 weeks. In January 2017, the figure was 90% – in both months, the service missed the 92% referral to treatment target.

Given the problems faced by the NHS, it's of little surprise that public satisfaction fell by six percentage points in the last year. The British Social Attitudes survey found satisfaction dropped to 57%, while dissatisfaction rose to 29% – the highest level in a decade. There was also a significant drop in satisfaction with GP services, which fell seven percentage points to 65% – the lowest since the survey began in 1983. The King's Fund and Nuffield Trust, which run the survey, said the figures demonstrated the public concern over the funding and staffing of the health service.

The *Getting it right first time* programme has made 17 recommendations to improve the delivery of vascular surgery. A report identifies opportunities to save lives, deliver better outcomes for patients, improve efficiency and reduce unwarranted variations between hospitals.

Figures show a 1.5% increase in the number of full-time equivalent (FTE) staff working in the NHS in England. Between September 2016 and September 2017, the number of FTE staff increased by 17,900 (from 1.2 million), according to NHS Digital. This included a 2.4% rise in the number of doctors in training and a 3.4% increase in consultants. However, there was a small decline in the number of nurses and health visitors (excluding nurses in GP practices). Manager numbers increased by 3.3% (687) over the period, while there was a 7% rise in the number of senior managers (676).

The Department of Health and Social Care announced that prescription charges in England will increase by 20p from 1 April. In a written statement to Parliament, health minister Lord O'Shaughnessy said the charge would rise to £8.80 for each medicine or appliance dispensed. The cost of a prescription pre-payment certificate will be frozen at £29.10 for three months and £104 for an annual certificate.

However, the cost of prescriptions dispensed in the community in England fell slightly in 2017, according to NHS Digital. Its figures showed that the cost decreased from £9.2bn in 2016 to £9.17bn, despite an increase in the number of prescriptions dispensed. The cost figures are based on net ingredient cost (the basic cost before VAT is applied) and is not necessarily the price paid by the NHS.

from the hfma

The HFMA published a number of blogs on its website in March, focusing on changes and developments in the NHS.

Shropshire Community Health NHS Trust finance director Ros Preen (pictured) argued that out-of-hospital care could play a major role in developing new models of care to better meet patients' needs in a more sustainable way. Good out-of-hospital care can help people live independently and reduce demand for urgent and emergency care, she said. She chairs the new HFMA Out-of-Hospital Care Special Interest Group, which aims to facilitate better understanding of, and develop thinking in, this area. Early work will include consideration of the value provided by out-of-hospital care.

Audit committees face an expanding agenda as systems move to more integrated care, according to HFMA Governance and Audit Committee chair Kevin Stringer. Working across NHS boundaries and with local government, with new partnerships and models of care, presents significant governance challenges. While the core role of the audit committee remains the same, the context has changed and the revised version of the HFMA *NHS audit committee handbook* will guide committee and governing body members through the new landscape.

In another blog, HFMA policy and technical manager Debbie Paterson said NHS organisations should not wait for Treasury guidance on new accounting rules for leases – they should begin preparations now. IFRS16 is due to apply to accounting periods starting after January 2019 and implementation will not be straightforward, she added.

News analysis

Headline issues in the spotlight

Solving the integration puzzle

Integrated care is either the solution to fragmented services or, in the guise of accountable care organisations, a mechanism for privatisation. Steve Brown listens in on recent debates

Even after a minor make-over, ditching its original accountable care branding, integrated care has had a big image problem lately. Back in 2014's *Five-year forward view,* it was the widely supported goal for transformation efforts. But in recent months it has faced accusations of being a Trojan horse for privatisation and nothing more than a vehicle for cost-cutting. For health economies across the UK pursuing an integrated care agenda, the change of mood is perplexing and potentially distracting.

A Commons Health and Social Care Committee inquiry into integrated care, covering organisations, partnerships and systems, has provided a platform for some of the debate. But in reality, the inquiry responds to increasing concerns and campaigns that have led to judicial reviews of a proposed accountable care organisation contract.

The challenges have come as a surprise to many. There seemed to be complete agreement about the benefits of more integrated care. Last year's forward view update promised to 'make the biggest national move to integrated care of any major national western country'. It suggested sustainability and transformation partnerships would evolve into accountable care systems, with some of these moving on to become accountable care organisations over time. More recently, NHS England and NHS Improvement have dropped the accountable care terminology in response to some of the concerns, and now talk of developing integrated care systems.

The overriding aim of integrated care is to address fragmentation in service delivery and ensure services are built around patient and population needs. The King's Fund defines integrated care as what happens 'when NHS organisations work together to meet the needs of their local population'. This can involve local authorities and the third sector, and the most ambitious forms of integrated care aim to improve population health by tackling the causes of illness and the wider determinants of health. It identifies three forms of integrated care:

- **Integrated care systems (ICSs)** have evolved from sustainability and transformation partnerships and take the lead in planning and commissioning care for their populations and providing system leadership. They bring together NHS providers, commissioners and local authorities.
- **Integrated care partnerships (ICPs)** are alliances of NHS providers working together to deliver care. These include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved.
- **Accountable care organisations (ACOs)** are established when commissioners award a long-term contract to a single organisation to provide a range of health and care services to a defined population following a competitive procurement. This organisation may subcontract with other providers to deliver the contract.

It is this last format that has provoked recent concern. Two legal challenges have been launched – one questioning the legality of the ACOs under the *Health and Social Care Act 2012*, the other arguing that ACOs will lead to increased privatisation.

Integrated debate

At a breakfast briefing on integrated care at the end of March, King's Fund chief executive Chris Ham challenged this. 'We believe arguments that integrated care and accountable care will lead to increased privatisation are very wide of the mark,' he said. Integrated care systems and partnerships are being led by the NHS in collaboration with other public sector partners. And the two areas that have so far expressed an interest in using the proposed ACO contract – Manchester and Dudley – have both identified NHS trusts as their preferred providers.

While Professor Ham acknowledged private providers' success in bidding for some NHS service contracts in recent years, he suggested they 'don't have the range of capabilities needed to take on an ACO contract and be able to deliver community services including primary care, some social care and some hospital-based services'.

He noted recent comments from David Hare, chief executive of the NHS Partner Network,

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that independent sector organisations were not expecting to be commissioned to take on ACO contracts in the immediate future – both because of the politics and the exposure to risk.

Also at the briefing, Graham Winyard, a former medical director for the NHS in England and a claimant in one of the ACO judicial reviews, likened the current move towards accountable care organisations to the private finance initiative. He said long-term PFI contracts had been a 'catastrophic' workaround to a chronic shortage of NHS capital in the 1990s. Similarly, he suggested that ACOs – 'non-statutory bodies that can include private sector organisations as partners in long-term contracts' – were the wrong way to tackle the service's current fragmented structure.

He said the lack of open consultation on such a major change had led to 'deep suspicion'. He was an 'enthusiast for a single organisation to take most of the decisions about health and care for a defined population' but this should be based on the former district health authority model responsible for commissioning and providing.

'We would be moving to an NHS where most of the decisions that matter to the public will be taken by non-statutory bodies that can include private and commercial partners whose priority will be profit, not public service,' he said.

Dr Winyard said he took little comfort from the fact that the first two proposed ACOs were being taken forward with NHS partners. 'This policy will roll forward in all sorts of different ways,' he said.

Paul Maubach, chief executive of Dudley and Walsall Clinical Commissioning Groups, is leading the development of the Dudley Multispecialty Community Provider (MCP) that will potentially use the proposed ACO contract. He argued that everyone agreed about the need for more integrated care to meet the changing needs of a population with higher levels of long-term conditions and multiple co-morbidities. 'You can't achieve better continuity and co-ordination or better long-term population management unless you design services around the person and the population, and that is why we want to deliver better integrated care,' he said.

Dudley's wide-ranging partnership has been in place for some time, with multidisciplinary teams delivering 'staggering results', reducing reported levels of social isolation and improving patients' confidence in the management of their conditions. 'We are already delivering better outcomes and better care for our populations, so why do we need to go the step further?' Mr Maubach asked. 'Well, if integrated care is the right thing to do, why wouldn't you want to do it to deliver its maximum potential benefit for our population and staff?

'We see a single integrated care organisation supported by a single population outcome-based contract as really important,' he said.

Improving outcomes was complex requiring multiple factors to be addressed, he added. The MCP's ambitions included improving healthy life expectancy by 1.5 years over five years for the population as a whole – but this demanded the maximum level of integration for its systems and ways of working, he said.

Mr Maubach highlighted general practice as crucial to the success of more integrated care, but it had to be more sustainable. GPs should be leading multidisciplinary integrated teams with the right level of support – the ACO contract offered the opportunity to deliver this. He said a flexible approach would enable GPs to be partially or fully integrated and would place general practice at the heart of the change.

"You can't achieve better continuity and co-ordination or better long-term population management unless you design services around the population"
Paul Maubach, Dudley and Walsall CCGs

Current commissioning approaches worked against integrated care, Mr Maubach added. In diabetic care, for example, GPs work to an outcomes framework, but when patients see diabetologists in acute settings, the hospitals are paid on the basis of activity, not outcomes. He said the lack of alignment was 'nonsense'.

Back at the Health and Social Care Committee, NHS England chief executive Simon Stevens also had to address the privatisation accusation. He stressed that the specific ACO model was unlikely to be adopted by many areas as they pursue different models of integrated care. But he dismissed the privatisation concerns as scare stories, citing similar arguments over the years over the introduction of dedicated commissioners and the establishment of foundation trusts.

The Health and Social Care Committee had itself called for more integrated care in earlier reports, he added. In light of this, it will be interesting to read the committee's conclusions after this inquiry as it has the potential to lead public opinion on the issue.

For the time being, the debate continues. Integrated care – delivered in various different models – remains a clear strategic goal. And the continuing suspicion around the policy does not provide the perfect environment for local health economies to develop their plans and engage with their communities.

Comment

Lean food for thought

Alongside new models of care, we need new ways of working

HFMA president Alex Gild

How can we grow organisational capacity to develop sustainable services and improve safety and quality of care? The NHS faces significant operational, workforce and financial issues and is grappling with a multitude of targets, programmes, constraints, risks and impacts. These are hardly the ideal conditions for developing a focus on improving quality of care for our patients.

Integrating care is a system response to the NHS's challenges. It will help, but is not likely to address fully the capacity and skills needed for healthcare improvement. So, we also need to look for evidenced approaches that assure operational efficiency, reduce waste and drive continuous improvement in safety and quality of patient care. My organisation, Berkshire Healthcare NHS Foundation Trust, and others have been looking for the best way to do this.

We are looking to establish a new way of working – organisation-wide, front line to board – that enables the workforce to deliver quality improvement and aligns improvement effort directly to strategic goals.

On a recent visit organised by Catalysis, hosted by Marianne Griffiths, chief executive at Western Sussex Hospitals NHS Foundation Trust (WSHFT), my colleagues and I joined other interested parties to see the results of a remarkable improvement culture shift at WSHFT. This has involved four years of work that marks just the start of a never-ending journey implementing, embedding and working within a Lean management system (LMS), supported by changed leadership and management behaviours and the development of a continuous improvement culture.

SHUTTERSTOCK

Budget blues

Extra funds may have been a forlorn hope, but the spring statement still feels like a missed opportunity

Healthcare Finance editor Steve Brown

Chancellor Philip Hammond was completely clear ahead of March's new spring statement. Having announced last year that there would in future only be one fiscal event each year – the November Budget – he was not about to announce new tax or spending plans. Nevertheless many experienced health service watchers judged the lack of new funds for the care system to be a missed opportunity.

The Treasury described the point of the new statement as an opportunity to give updates on 'the overall health of the economy' and 'progress made since the autumn Budget 2017'.

Mr Hammond even declared himself to be at his 'most positively Tigger-like' as he insisted there was 'light at the end of the tunnel' after a decade of austerity.

He again defended the government's economic policy during the recession. This has focused on reducing debt because 'we want to see taxpayers' money funding our schools and hospitals, not wasted on debt interest'.

And from autumn 2016, this has been supplemented with a more balanced approach to repairing public finances. He pointed to 'almost £9bn extra' for the NHS and social care system, with £4bn going into the NHS in 2018/19 alone.

Labour's shadow chancellor, perhaps predictably, categorised the lack of additional funding as 'astounding complacency' and accused the government of ignoring public services amid an unprecedented crisis.

But there were many others in and around the health service who did not share the chancellor's optimistic viewpoint, especially

"There is plenty of evidence that proves Lean's applicability to health. The problem is often about sustaining the gains over the long term"

The positive effects of culture development and the high levels of staff engagement in improving care for patients were palpable at WSHFT – as was the contribution of this new way of working to the high performance of the trust.

I know there is some distrust of Lean being purely about removing whole-time equivalent headcount to reduce costs, as has been seen in the banking sector. But that is not what is happening in this case. Process waste is removed and converted into increased value for patients.

I have also heard a 'been there done that' attitude to Lean and seen a tendency for it to be dismissed as a 'fad' in the NHS. But it's hard to counter the core principles, adding value to patients by continuously improving processes and removing waste. And there is plenty of evidence that proves Lean's applicability to health. The problem is often about sustaining the gains over the long term.

Even with successful improvement projects, the impact can fizzle out over time because there is no management system in place to scale up activity or to align the work with trust goals.

However, when an LMS is supported by a flip-change in traditional command and control leadership behaviours, it can be extremely powerful.

New leadership behaviours involve moving to improvement coaching and teaching, and the results can be highly engaging for staff, who are empowered to problem solve at the front line.

Seems ambitious, right? Well, it's happening at WSHFT and we are just starting out at my trust. Both trusts are learning from the model developed by the Wisconsin-based ThedaCare hospital group over 10 years to achieve sustainable improvement.

There are other Lean frameworks that can be applied to healthcare, but what attracts me about this approach is its comprehensive nature.

It enables frontline continuous improvement and provides an LMS that aligns improvement activity to 'true north' strategic goals. These are married with the leadership behaviours and culture change needed to sustain improvement gains for patients.

This new way of working is not the only way forward, but it does offer a strategic long-term antidote to the pressures the NHS faces.

Contact the president on president@hfma.org.uk

given the gloomy deficit predictions unveiled in February's quarter three figures and having seen services under significant stress over the winter.

The NHS Confederation's chief executive, Niall Dickson, said the chancellor still faced two tasks – support the NHS and care services to deal with today's pressures and set out a plan to ensure their long-term sustainability. He added that it was time for political courage, although he detected 'signs within government' that some were beginning to understand the scale of the challenge.

News later in the month of a new NHS pay deal (see page 3) – worth between 6.5% and 29% over three years – provides some cheer for NHS organisations.

The fact that the award will be fully funded by the Treasury – anything else would have put unmanageable further stress on the NHS – will be a relief. However, this won't have any direct impact on the current funding imbalance.

It is hoped that the pay award may have some indirect impact by improving morale among staff – the recent staff survey found that just 31% of staff were happy with their pay, 58% worked additional unpaid hours and 38% had felt unwell due to work-related stress over the past year.

Whether the increase is viewed as sufficient by staff remains to be seen. But anything that helps providers improve retention rates and reduce absence due to sickness is good news – and may help reduce the still-too-high agency staffing bill.

In the meantime, healthcare professionals have to stay focused on meeting current demand and driving efficiency from current budgets, while making as much progress as possible with the development of new models of care.

"Representative bodies need to keep making the case for the right funding to meet demand and support transformation"

Representative bodies need to keep making the case for the right funding to meet demand and support transformation.

And the service must hope that in November's Budget, ahead of the 2019 spending review, the chancellor will set out a path to a better long-term settlement for health and social care.

Thank you to all HFMA corporate partners for their continued support

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Grow your own

Workforce is a key issue for the NHS, but could the apprenticeship levy offer the means and the financial incentive to recruit, train and retain the staff it needs, asks Seamus Ward

The NHS has a workforce problem. Despite overall staff rising in recent years, problems persist in some areas – both geographically and in particular staff roles. There are still 34,000 nursing vacancies, according to NHS Digital, and spending on temporary staff remains high, although there has been some success in attempts to curb it.

With unemployment low, the government's commitment to increasing pay has been welcomed by staff and employers. However, exiting the European Union could have an impact on a valuable source of workers.

One way of counteracting these problems could be for the NHS to recruit and train its own staff using apprenticeship schemes.

The NHS is a well-established training body, particularly in clinical roles. It has used apprenticeships in the past, but the introduction of the apprenticeship levy last year has given an additional financial incentive to get the workers it badly needs.

NHS apprenticeships range from support roles, such as catering, accountancy and general management, through to frontline clinical positions, including a nursing degree apprenticeship.

While there is opportunity, there is also a challenge to scale up the support for taking in more apprentices. NHS employers who wish to become training bodies, rather than outsourcing the off-the-job training to established providers, will have to recruit trainers and assessors and provide accommodation for classes.

Apprenticeships cannot be seen as a silver bullet for all NHS recruitment difficulties – it is understood that when the levy was introduced, around 500,000 of the health service's employees (about 42%) were in roles for which no apprenticeship was available.

The levy amounts to 0.5% of the pay bill of all employers that spend more than £3m a year on salaries. That means many NHS organisations are affected, with some facing paying millions of pounds every year towards the levy. Estimates put the total NHS levy at £200m a year.

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The levy is paid each month, based on the pay bill, and is sent to HM Revenue and Customs through the PAYE process. The funds – plus a 10% government top-up – can then be accessed by levy-paying employers via an online account. The online account allows employers to pay training providers, though funding expires two years after it is deposited.

The levy cannot be used to pay salaries – the funds can only be spent on training and assessing apprentices.

NHS organisations will wish to get maximum value and impact from their levy spending. An HFMA survey earlier this year found that more than half of its sample of 70 NHS organisations expected to spend 25% or less of the funds they had deposited in 2017/18. Only one in eight believed they would use more than half the available funds.

Current provision

At present, there are 19 health-related apprenticeships available in the NHS, with almost 30 in development. Each apprenticeship role has been placed in one of 15 bands and spending per apprenticeship is limited to the maximum for that band.

In the past, apprenticeship funding was related to the age of the apprentice, but this has been abolished in the new system. Spending maxima currently range from £1,500 to £27,000. A level 3 assistant accountant apprenticeship is in funding band 9, with a maximum payment of £9,000, while a level 6 healthcare science practitioner degree apprenticeship attracts the maximum payment of £27,000 as it is in band 15.

It does not always follow that two apprenticeships at the same learning level will be placed in the same funding band. For example, while the assistant accountant and senior healthcare support worker apprenticeships are both at level 3, the former is in funding band 9 (£9,000 maximum spend) and the latter is in band 4 (£3,000 maximum).

Danny Mortimer, chief executive of NHS Employers, says the health service is trying to make the most of the levy. 'The introduction of the apprenticeship levy in April 2017 has enabled the NHS to scale up its approach to embedding apprenticeships into the way that we recruit and develop talent – and significantly so,' he says.

"People have preconceived views about apprenticeships – but they offer on-the-job training at a range of levels and roles"

Liz Faulkner, Worcestershire Health and Care NHS Trust

'In the past 12 months, we have seen a marked increase in the range of apprenticeship standards available for healthcare-specific courses. There are now 19 health and science industry-specific apprenticeships available and 29 more in development. That's more than double what it was when the levy was first introduced.'

He agrees that the new push on apprenticeships could play a role in securing the NHS workforce for the future. 'The NHS has harnessed apprenticeships to enhance and develop the skills of the workforce for many years. The health service continues to be a strong supporter of apprenticeships – not just for entry-level positions, but also across the broader professional workforce. The expansion of apprenticeships is a key part of our long-term supply strategy.'

Liz Faulkner is head of workforce transformation at Worcestershire Health and Care NHS Trust, which was recently named in the top 100 employers for apprentices by the government-backed National Apprenticeship Awards. The trust has around 70 staff on apprenticeship programmes in a range of clinical and support roles.

'We have been trying to change the message about apprenticeships. People have preconceived views about what apprenticeships are and the age of the people who undertake them. Apprenticeships offer an on-the-job training route at a range of levels and roles across the organisation. We offer apprenticeships at levels 2 to 5 to both new and existing staff.'

The number of apprenticeship starts at the Worcestershire trust for 2017/18 is lower than previous years and there are two reasons for this, she says. First, the trust is in the process of setting up as an apprenticeship employer provider – this means it will be able to deliver apprenticeship training to its staff. 'The real driver [for this] is quality – we will be in control of the apprenticeships, with more input into the off-the-job learning that's relevant to the organisation and its values.

'The development of the nursing associate role, which sits between the roles of healthcare support worker and registered nurse, is the second reason for apprenticeship starts being down as we have not been able to include our current cohort of trainee nursing associates in our apprenticeship numbers,' she says.

In October 2017, the government announced expansion plans for the number of nursing associates, which will lead to 5,000 being trained through the apprentice route in 2018 and 7,500 in 2019 across England.

Ms Faulkner says the trust is embracing the role and is in the process of recruiting a second cohort of trainees because it offers a great opportunity for staff to progress their careers.

'The nursing associate role will be an important part of our workforce plans. As with other parts of the NHS, we experience recruitment and retention difficulties regarding our registered nursing workforce. The trust utilises its workforce planning processes to identify gaps in our workforce and try to identify how we can use apprenticeships to develop existing or new staff to meet our workforce requirements.'

Leeds input

In the first eight months after the apprenticeship levy was introduced, Leeds Teaching Hospitals NHS Trust contributed almost £1.8m – the government top-up has brought the total available to spend to £1.96m.

HFMA workforce forum

With workforce a key element of NHS organisations' strategies, the HFMA is holding a conference that will examine the challenges and opportunities to improve workforce efficiency and value. It will look at issues such as the apprenticeship levy and will feature workshops and case study presentations.

The forum – to be held on 20 June – is one of three national events being held in support of HFMA president Alex Gild's theme for the year, *Brighter together.*

The event is free to HFMA members and they are encouraged to bring an HR colleague for £99. For details or to book a place, email clare.macleod@hfma.org.uk

Qualification levels

Apprenticeships in the NHS are available at four levels:

- **Level 2** or **intermediate apprenticeships** are the equivalent of five GCSEs, grade A*-C (grades 4-9 in the new grading structure being introduced in England). These apprenticeships include healthcare science assistant (funding band 7, maximum training spending £5,000).
- **Level 3** or **advanced apprenticeships** are equivalent to two A levels. Examples of a level 3 apprenticeship are dental nursing (band 9, £9,000) and senior healthcare support worker (band 4, £3,000)
- **Levels 4 to 7** or **higher apprenticeships** are equivalent to a foundation degree or above. Examples include apprentice ambulance practitioner (level 4) and nursing associate (level 5) – both funding band 11, £15,000.
- **Levels 6 and 7** equate to a full bachelor's or master's degree and include a nursing degree apprenticeship (level 6, funding band 15, £27,000).

Over the same period, the trust paid training providers just £245,000.

However, it has plans to ramp up its apprenticeships, including those on the higher end of the apprenticeship funding bands. Between April 2017 and January 2018, 464 apprentices started at the Leeds trust – they have been employed in a range of apprentice roles, including intermediate business administration, advanced plumbing and health and fitness assistant. The biggest group was on the intermediate clinical healthcare support worker apprenticeship (229 of the 464).

Before the end of the financial year, it plans to have a further 219 new apprentices, including 71 intermediate clinical healthcare support workers.

The trust will employ its first apprentice nurses (level 6), which is in the highest funding band at £27,000. It plans to recruit 33 nurse degree apprentices to begin work in June, with a further 33 in each of the next two years.

The trust believes the levy will have a significant impact over time. It anticipates that, once qualified, the number of clinical apprentices will offset the need for future spending on bank and agency staff.

Building on its base of healthcare support worker and business administration apprenticeships, Worcestershire Health and Care NHS Trust is also looking to widen the scope of the apprenticeships it offers. A cohort of housekeeping staff are undertaking a level 2 hospitality apprenticeship, while it is also looking at delivering leadership and management apprenticeships (at levels 3-5).

During 2018/19, the trust is committed to achieving the public sector apprenticeship target of 2.3% of its workforce – equal to approximately 90 apprenticeship starters.

The trust's apprenticeship levy amounts to around £450,000 a year. 'We haven't committed much apprenticeship spending at the moment, but we have built into our apprenticeship plans how we will be using more in the future,' says Ms Faulkner. 'The price cap on the nursing associate apprenticeship, for example, is £15,000 over two years per apprentice and the nursing degree apprenticeship is £27,000 over three to four years. You can see how we will quickly allocate more of the apprenticeship funds to support the training and development of our staff.

'We will need to carefully manage our apprenticeship spending to maximise the benefits. I think we will get value from the levy. It's still relatively early days, but hopefully we are moving in the right direction.'

Mr Mortimer acknowledges that employers face barriers in making the most of the levy they pay. 'While employers across the NHS are expanding their apprenticeship programmes, they are facing some specific, significant challenges unique to the health sector,' he says.

'Unfortunately, these challenges are preventing the most effective use of the levy and hampering the ability of employers to scale up their apprenticeship offers.'

Mr Mortimer continues: 'To help ease the impact of these challenges, and to make best use of the £200m contribution the sector makes to the levy, we at NHS Employers have three suggestions.

'The first is for the government to allow the use of the levy to support backfill for apprenticeships that require significant supernumerary time as part of their training. The second is to extend the time within which employers must have used their levy. Finally, employers should be enabled to access levy funds to create infrastructure to boost the scale-up of placement capacity and supervisory support.'

Although the Worcestershire trust is in the process of becoming an apprenticeship employer training provider, some apprenticeships, particularly when specialist knowledge is not available or numbers are small, would not be delivered in-house, Ms Faulkner says. Accountancy falls into this category. The trust has trained level 2 accountancy apprentices for the last two years.

Accountancy issues

However, Ms Faulkner highlights potential issues with accountancy apprenticeships where there is no mandatory qualification. Apprenticeships have been governed by frameworks, but these are being phased out and are expected to be replaced by new standards by 2020.

While the existing accountancy apprenticeship frameworks (at level 2 and 3) included links to AAT qualifications, the new level 3 standard does not include a mandatory qualification.

This creates two issues, says Ms Faulkner. First, an apprentice might reasonably expect to receive a recognised qualification at the end of the programme, but it remains to be seen whether employers will give equal weight to candidates who have completed a level 3 apprenticeship compared with, say, those with an AAT level 3 diploma. Second, since the standard does not include qualifications such as AAT and City & Guilds diplomas, the apprenticeship levy cannot be used to fund these qualifications.

Apprenticeships do not offer a complete solution to workforce issues. NHS organisations will be mindful of the challenges of ensuring they get best value from the levy – and meeting the requirements of their workforce strategy. But apprenticeships and the levy not only offer the opportunity but also the financial incentive for the NHS to address some of its workforce issues.

"There are now 19 health and science industry-specific apprenticeships available and 29 in development. That's more than double what it was when the levy was introduced"

Danny Mortimer, NHS Employers

This year will mark a key milestone in the transformation of NHS costing as NHS Improvement looks to encourage up to half of all mental health providers to implement revised costing standards and submit their first costs at the patient level. Steve Brown reports

MENTAL HEALTH moves centre stage

Costing of mental health services has been in the shadow of its counterpart in acute providers ever since the NHS first took an interest in understanding how it spent its funds. This can in part be explained by poorer data, particularly for non-admitted care, and the lack of a reference cost-based national tariff for mental health services.

However, the push to transform costing across all NHS services makes a big stride forward this year as NHS Improvement hopes to get close to half of all mental health providers making a submission of cost data at the patient level.

Nobody expects perfect cost data to emerge from this exercise. But, if successful, it will mark a major milestone in mental health providers' journey to understand their cost base better and provide a foundation for exploring opportunities for improvement.

At the start of April, NHS Improvement will launch version 2 of its *Healthcare costing standards: mental health* and hopes that around 25 mental health providers will volunteer to use the standards to calculate patient-level costs for their services and then submit them to the oversight body later in the year.

In return, these early implementers would get access to a portal of cost data based on all the submissions, which would enable them to start benchmarking costs and pathways. Early implementing acute trusts already have access to such a portal.

This would be a major achievement. NHS Improvement's Costing Transformation Programme (CTP) aims to get all providers in the English NHS compiling and submitting patient-level cost data by the summer of 2021 (submitting data for the 2020/21 financial year).

Acute providers will lead the way. Some 60 acute providers last year voluntarily submitted patient-level cost data, compiled according to the new standards – final versions of which were published earlier this year. And the NHS Improvement board recently agreed to make patient-level costing mandatory for acute providers from the 2018/19 return in the summer of 2019.

While no decision has yet been taken to broaden this mandatory requirement to mental health, ambulance and community services, consultations for mental health and ambulance take place later this year.

Mental health providers are in general following a trajectory just one year behind acute providers. However, they are starting from a lower base in terms of historical investment in costing systems and support.

'There is a lot of enthusiasm among mental health trust costing practitioners to really improve the costing data their trusts can use to inform decision-making,' says Fiona Boyle, NHS Improvement's costing manager, responsible for the mental health and community costing standards. 'We want to give them as much support as we can to help them realise this ambition.'

The updated standards are fundamental to this support. Ms Boyle believes they do not represent a major rewrite on last year's initial mental health draft standards, but build on the basics and add applicable detail for the sector. However, they are likely to be the first standards used by a large group of mental health trusts.

Last year, three mental health road map partners submitted patient cost data using the first version of the standards. This year, NHS Improvement hopes to get a significant part of the sector involved.

The oversight body believes it makes sense to take part in the transformation programme as soon as possible. It is likely that the sector will be required to adopt the standards in future and experience from the acute sector suggests that improving costing is an iterative process – so the sooner trusts start, the quicker their data will improve and the more useful it will be.

The standards should not come as a surprise to anyone who has been keeping track of the development of standards for acute services (and ambulance and community, for that matter). The aim is to have a consistent methodology, regardless of setting. As a result, the standards have the same format – they even use the convention of referring to 'patients' in all versions, not the more frequently used 'service user' preferred in mental health settings.

As with all the sector-specific standard sets, the mental health standards come in sections, covering: information requirements; cost processes; cost methods; and (currently acute only) costing approaches.

The differences come in the details and examples. The information requirements for mental health, for example, rely on trusts complying with the recently mandated mental health services data set (MHSDS).

"There is a lot of enthusiasm among mental health trust costing practitioners to really improve the costing data their trusts can use to inform decision-making"
Fiona Boyle, NHS Improvement

Common processes

The processes described in the standards are similarly common to all sectors. These cover the creation of a costing ledger with a predefined structure from organisations' own general ledgers. This common starting point then allows these costs to be mapped first to resources and then to activities before finally being attached to unique patient spell, attendance or contact.

With many of the defined resources and activities common to all sectors, the mental health versions of the standards simply add in resources that are specific to the delivery of mental health services.

For example, mental health-specific resources might include a music therapist or a psychiatric nurse. Examples of unique activities would be ward care on either a psychiatric intensive care ward or in an eating disorder inpatient unit.

Standards for costing methods cover high-volume or high-value services or departments. While some of these are common to all sectors, mental health-specific standards focus on issues such as costing of group sessions, home leave, escorting and specialling.

Ms Boyle says the deliberate aim is to make the standards as similar as possible across all the sectors, while still reflecting the different activities undertaken in those sectors. 'This is particularly important for integrated trusts,' she says.

'We are trying to give consistency so that costing practitioners have a single suite of information they can refer to. And they can do this through the same costing system, and from the general ledger to the same costing ledger, all the way through. The consistency also brings benefits for pathway reporting.'

Not all mental health providers currently have a patient-level information and costing system (PLICS) capable of supporting the new costing approach. But this isn't necessarily a barrier to rapid progress. One of the acute early implementers last year implemented a new system alongside using the standards for the first time.

And Ms Boyle says some of the mental health trusts that have

Implementation support

NHS Improvement's new Costing Standards Implementation Platform will offer an interactive training forum for costing practitioners.

All early implementers for acute, mental health and ambulance sectors will have access to this new online system. It offers versatile training methods and support, including:

- **'Whiteboard animation' examples of the costing process**
- **Training modules**
- **Discussion forums**
- **Productive tasks that actually contribute to the costing process**
- **Access to direct query assistance with NHS Improvement costing managers.**

Some of the units are shared across all sectors; others are sector-specific and examples are tailored to sectors.

A *Cost ledger auto-mapping* application has also been produced in response to feedback from last year's implementation programme.

The algorithm is designed to reduce the time it takes for an organisation to set up its general ledger to cost ledger mappings.

Early tests indicate that it will map between 50% and 90% of an organisation's general ledger to the standardised cost ledger – depending on how standardised a trust's general ledger expense codes are.

According to NHS Improvement, the costing practitioners who have tested these resources have welcomed them.

The new support platform

volunteered to take part this year are also still in the process of procuring and implementing a new system.

In any case, she says, that work does not have to wait for the introduction of a new system. 'A lot of the work that needs to be done is preparation,' she adds. ' [This involves] getting an understanding of where the organisation has the required data and where it can meet the standards, allowing for planning work where the gaps lie. They may comply with more areas than they think.'

When the standards arrive, she recommends all costing practitioners read through the two information requirement and six costing processes standards – a new standard on assurance has been added this year.

Ms Boyle accepts that some of the prescribed processes will be significantly different from existing practice. However, she says that practitioners should not worry if they don't understand everything immediately. Help is at hand. For a start, two gap analysis tools (one for information and the other covering the standards) will give practitioners

Road map experience

New data streams and costing practices cannot be established overnight, so getting started as soon as possible is the advice from one of NHS Improvement's mental health road map partners.

West London Mental Health NHS Trust (pictured) delivers mental health services and some community services. Its mental health services include high-secure units (Broadmoor) as well as services in low- and medium-secure environments. In total, it delivers services from 27 sites and employs around 3,000 staff.

The trust signed up to be one of NHS Improvement's Costing Transformation Programme road map partners, an early adopter and user of the developing mental health costing standards.

Last year, it made its first patient-level cost submission of 2016/17 data along with two other organisations.

'We had a costing system [Civica's Costmaster] that we knew could do it,' says Pamela Farrow, the trust's head of costing. 'We had been using it at a very high level, doing our reference costs on a top-down basis and producing high-level service line reports. We just needed a push to start doing more patient-level costing.'

The process laid out in NHS Improvement's costing standards involved a completely different approach – mapping costs in the general ledger to the costing ledger and resources and then allocating these resources to activities before sharing these activity costs between patients based on the activities they have received.

The mapping exercise has not been straightforward – Ms Farrow says it has introduced a disconnect between budget-holder statements and cost reports – but she can understand why a consistent approach across all bodies makes sense.

It also highlighted description codes for teams recorded in its Rio electronic patient record that did not match ledger descriptions, and cases where there were

costs in the ledger but no matching activity.

In general, Ms Farrow says, the standards they were working with last year (version 1 for mental health) were still not very mental health sector-specific, having been developed from the acute standards. But this month's revised standards address many of these concerns.

The first attempt to cost at the patient level exposed inevitable gaps in data. 'We didn't have pharmacy data by patient so we continued to use our old method – allocating to teams and sharing with patients treated by those teams,' says Ms Farrow. 'But the process also highlighted reporting differences across the trust. We found that for some wards, all therapy sessions – art, physio or occupational – are recorded, while for others they aren't. This made comparison between the wards difficult.'

The trust was keen to make the costs produced as accurate as possible, although Ms Farrow says it is not an overnight fix.

'We now know what we'd like to see recorded on the wards. And the system is there for staff to record the activity. But we need to get the balance right between adding administrative tasks on to frontline carers' workload and getting the information we need to produce more accurate costs.'

Being able to recognise acuity of patients has been another challenge. It is important to be able to count the duration of each meeting and which member of staff was attending. Again with its Rio system capable of recording at this level of detail, the challenge is in normalising this in routine staff practice and being able to sell the benefits of doing this to those staff members.

With just 1.5 whole-time equivalents meeting continuing reference cost requirements and leading the costing transformation work, the trust faces a demanding challenge with costing.

Ms Farrow is realistic about the trust's ability to increase costing resources in such a difficult financial context, despite board level buy-in for the programme.

That means accepting that moving to patient-level costing is a multi-year project. If a trust finds data is not being adequately recorded, it will be almost certainly not be fixed until the following year's costing exercise. Even with a first year under its belt, Ms Farrow estimates it will be another 18 months before the revised costing approach is bedded in for the trust.

So the message is: the sooner you get started, the sooner you will get better cost data to inform decision-making.

and organisations an idea of what they need to prioritise.

This year both acute and mental health practitioners will also have a new support implementation platform to help them (see page 17), delivering tutorials, providing discussion forums, setting tasks and suggesting reading materials.

Early implementers that access the gap analyses through the online platform will also be able to get help completing them, if there are areas they are struggling with.

Ms Boyle accepts that mental health trusts face a steeper curve in implementing patient-level costing than their acute colleagues. She identifies three key challenges. 'Data quality is a key issue,' she says. Traditionally, a lot of detail about patient interactions in the mental health sector hasn't been recorded. A trust may run a group music therapy session, but the actual patients attending may not be formally recorded in an activity system.

'Looking at activity systems, a trust may know that a patient was visited in the community, but not know exactly which practitioners were involved or how long the session lasted.'

Boards need to recognise the broader benefits of understanding their cost base accurately – as well as the potential for any future payment approaches to be based on more accurate data

Playing catch-up

The fact that the MHSDS is now mandated should help to standardise the collection of required data. However, some of the specific fields needed for costing do not have the mandated status. The reality of the situation is that the sector has not been able to switch on the new data set requirements overnight and is working towards full compliance.

For a number of trusts, this has been an area that has suffered as a result of underinvestment in systems and staff. And the current financial climate makes it even more difficult for some to catch up on that investment in the short-term.

Resources available to support costing have been another issue. While NHS Improvement has made it clear the NHS overall needs to increase the resources available to support the CTP, this is even more the case in mental trusts.

Ms Boyle says many trusts have just one costing practitioner, and this has not always been a full-time post – some mental health trusts have only funded a position to cover the specific task of submitting reference costs.

'We are asking the senior level of organisations to consider if this is enough to do PLICS,' she says.

There are significant benefits to be had from patient-level costing data – increased business intelligence, benchmarking and improved decision-making. But realising these benefits may need some organisations to increase the resources being used.

'Costing practitioners are a key part of this,' explains Ms Boyle. 'But it is also about the information system and the staff helping to build data feeds and the support needed to ensure the data gets out into the organisation and is used.'

This leads into the third issue – ensuring boards understand the importance of good costing.

'The message needs to come from the top so it is understood by management and clinical teams,' says Ms Boyle. 'Where this is the case, it has been shown to benefit the programme all the way through.'

This buy-in from the top of the organisation is a fundamental foundation for making a success of patient-level costing.

The case is arguably harder to make within the mental health sector. All providers stand to benefit from a deeper understanding of their costs – helping them to identify and understand the cost implications of different pathway options and variations in practice, for example.

However, for many acute trusts, deep dives into patient cost data have highlighted long-running coding errors. Fixing them has often improved income with an activity-based tariff system. Given mental health's current reliance on block contracts, the same potential benefit doesn't exist in this sector.

However, Ms Boyle says the major benefits remain in place and boards need to recognise the broader benefits of understanding their cost base accurately – as well as the potential for any future payment approaches to be based on more accurate data.

She adds that some mental health trusts are still endeavouring to undertake a service line reporting-type analysis and actual patient cost data will improve these approaches.

There is significant interest from system leaders in establishing patient-level costing across the NHS. Better costing could inform existing and future national prices for services – or better inform capitation budgets. They are seen as important to underpin national efficiency programmes such as *Getting it right first time* and the Model Hospital. However, the prime benefit is in improving local decision-making.

Armed with patient-level costs, trusts will be able to better understand the financial impact of pathway variation and eliminate the variation where it is unwarranted. Comparing overall costs and the make-up of those costs across all providers will enable organisations to spot opportunities for improvement and investment decisions will be better informed.

Mental health trusts stand to gain from these benefits as much as providers.

In fact, after work in recent years to understand existing service provision and develop more standard packages of care as part of moves towards contracting on the basis of mental health clusters, patient-level costs could mark a step change in management information.

The clear message from NHS Improvement to mental health trusts is to get involved and start the journey now.

Costing conference

The HFMA Healthcare Costing for Value Institute's annual costing conference will provide an opportunity to hear NHS Improvement explain how its Costing Transformation Programme fits in with the oversight body's overall strategy. The same plenary session will also look at how costing data is already supporting the *Getting it right first time* initiative and how the move to patient-level cost data will be able to drive value-based healthcare.

Other plenary sessions and workshops will support costing practitioners to improve costing processes and demonstrate how some trusts are forging ahead in using the data to explore service variations. The conference is being held in London on 18 April.

• See page 29 or www.hfma.org.uk/education-events

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Working together

A sustainability and transformation partnership is bringing finance teams together across the patch to support a drive to improve efficiency at the system level. Steve Brown reports

New models of integrated care can only be delivered by whole systems. Similarly delivering services within current budgets and maintaining the sustainability of those services demands a system approach – otherwise a saving in one organisation could lead to higher costs elsewhere. Pressure to work as systems is increasing and one sustainability and transformation partnership (STP) has started to think about practical ways to take a broader view to the efficiency challenge.

'We simply haven't met in the past to look at efficiency collectively,' says Suzanne Robinson, director of finance, performance and digital at North Staffordshire Combined Healthcare NHS Trust and recently appointed *Together we're better* finance director of Staffordshire and Stoke-on-Trent's Sustainability and Transformation Partnership.

'Traditionally there has been a challenge with the development of efficiency plans – whether they are commissioners' quality innovation productivity and prevention (QIPP) plans or providers' cost improvement programmes (CIPs) – which are often pulling in different directions. So what we're trying to do is to strengthen the links between clinical commissioning groups, providers, NHS England and NHS Improvement and move to co-production or joint ownership of these plans.'

From this month, this will see a new STP efficiency group established to take a more rounded view of the productivity challenge facing all organisations in the health economy individually and collectively. Chaired by Ms Robinson, the group will involve deputy finance directors and senior finance managers, and report back to the STP's overarching finance director forum.

'There has been a tendency for us all to look at what we can do individually in our organisations, and we're often very successful at that,' says Ms Robinson. However, this approach can sometimes lead to unintended consequences. So a saving in one organisation can lead to a cost pressure within another. 'What we're looking for is an approach where we are working collaboratively to incentivise transformation and, where there is a saving for the system as a whole, we don't overlook this based on the impact on individual organisations.'

However, the scale of the current challenge means that tackling efficiency in silos is no longer an option. 'We've been discussing within our leadership forums ways in which we can mitigate those financial pressures that individual organisations face, where it's clear there is a bigger benefit for the system and for the longer term sustainability of our economy,' says Ms Robinson. 'We're clear that this group shouldn't replace the work within existing organisations, particularly the importance of transformation schemes being clinically led; but there is a role for finance professionals and we do have a valuable contribution.'

There are clear tensions between a regulatory system that remains focused on individual organisational performance and calls to operate as whole health economies. But system working is the clear focus.

"We're trying to strengthen the links between clinical commissioning groups, providers, NHS England and NHS Improvement"

Suzanne Robinson

STPs' role

February's refreshed planning guidance for 2018/19 made it clear STPs should take 'an increasingly prominent role in planning and managing system-wide efforts to improve services'. This should involve ensuring key, credible assumptions on finance and activity are used in both provider and commissioner plans. Where these assumptions do not enable all the concerned organisations to meet their control totals, 'the STP will need to agree additional cost containment measures and highlight any implications'.

STPs were also told to lead efforts to 'identify system-wide efficiency opportunities such as reducing avoidable demand and unwarranted variation, or sharing clinical support and back office functions'.

The future direction of travel is also clear. The existing 10 integrated care systems (the eight original shadow accountable care systems and the two devolved health and care systems) have been told to focus on delivery of system control totals (currently a simple sum of organisation control totals). For 2018/19, these systems will only receive their share of the additional £650m put into the newly named provider sustainability fund (PSF) if the system control total is met. But from 2019/20,

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a full system-based approach will see their payments from the whole PSF and the parallel commissioner sustainability fund (CSF) tied to achievement of the system control total.

So it is clear organisations will have to take a much bigger interest in the ability of all parts of a system to deliver efficiencies that enable them to deliver against individual and system control totals. It is something local leaders in Staffordshire and Stoke-on-Trent are bought into.

'The traditional win-lose approaches to efficiency – run faster, do more with the same/less – have proved to be unsustainable and unproductive, especially within systems where resource is diminishing relative to the demand coming through the system,' says Alistair Mulvey, chief finance officer of the six Staffordshire and Stoke-on-Trent CCGs. 'Increasingly there is an awareness that marginal gains, while needing to be maintained, must be supplemented with material pathway and service delivery change. Without these stepped changes, then the resource utilisation will continue to be imbalanced.'

He believes that if a systems-wide approach is not adopted – with clinically led change programmes – the future will be about the 'management of decline', which would be neither sustainable nor in patients' interests. 'The answer lies in systems-based, authentic, open and honest engagement around efficiency improvements and management of these changes with the focus on patients being paramount,' he says.

Staffordshire challenge

Staffordshire and Stoke-on-Trent's challenge is arguably bigger than most. It was one of just a handful of STPs identified as 'needing most improvement' in last summer's baseline STP progress dashboard. It was also one of the 14 STPs put into the capped expenditure process. And some of its five providers are running significant deficits.

The STP's sustainability and transformation plan predicted a gap of £286m in health funding by 2020/21 if no changes were made to current care models and demand continued to rise. This increased to £542m when social care was factored in. Continuing pressures across the healthcare sector have done little to suggest that the forecast gap is closing.

"The answer lies in open and honest engagement around efficiency improvements with the focus on patients being paramount"
Alistair Mulvey

To address this, the STP has been looking at a number of workstreams including: focused prevention; enhanced primary and community care; effective and efficient planned care; simplified urgent and emergency care; mental health; and maternity and children. It is looking at these issues with two distinct timeframes in mind: over one to five years (affordable care) and over three to 10 years (transforming care).

The sustainability and transformation plan acknowledges that the economy has been living beyond its financial means for a number of years, yet it continues to exhibit health inequalities across the system (between Stoke-on-Trent and parts of Staffordshire for example) and underperforms when compared with other areas on some key outcomes.

It has high levels of avoidable admissions, high cost of urgent and emergency care, duplication of planned care services and too much estate. STP director Simon Whitehouse says that quality of care is the driving force. 'We've not got the luxury of funding any double running,' he says – the health economy can't invest in community and general practice while at the same time funding acute services to keep meeting the current levels of demand.

It has to find ways to change the model of care within the existing financial envelope. 'We are currently spending more than we should and we are not delivering the outcomes we want or turning back the dials on health inequalities in the right direction across the board. We need to do better for the local population that we serve, but also have to recognise that housing, education and employment opportunities have a much bigger impact on some of these areas. So we have to work on those aspects as well with our partners,' he says. Even if there was additional funding available, the health economy would still need to change its service model.

All service changes are being clinically led and a new community model involving multidisciplinary teams working in 23 localities within three geographical alliance footprints is central to transformation plans.

The new efficiency group aims to support this broader work, challenging the workstreams on efficiency opportunities by providing detailed examples of where the STP is a financial outlier, where variation is unwarranted or where opportunity exists.

Mr Whitehouse believes that dealing with any duplication and variation 'in a way that makes most sense for our clinicians and for our patients is essential'. 'There is a valid challenge from the public – before you start talking to us about cutting services and reducing clinical staff, can you tell me that you've done everything you can to ensure you are as efficient as possible,' he says. 'We need to be able to say we've gone as far as we can with utilities, estates, staff and rotas and use of agency.' And he adds that this means exploring whether greater efficiency can be achieved working as systems rather than in isolation.

'Organisations have been hardwired to look after themselves and it is no surprise that they've done this very well,' he says. 'But does every organisation need its own payroll or can we get a better deal if we are all on the same payroll?' He stresses that bigger isn't always better, but the options need to at least be explored and the current arrangements challenged.

Getting the organisations in the system to work through these issues, rather than imposing

Convergence 2.0

Last year's Convergence event brought together the HFMA's annual commissioning and provider conferences to focus on moves towards accountable care. A year later, the terminology has changed, with 'integrated care' being the new preferred description. But the agenda is still very much about finding the best ways for organisations to work together to deliver services that meet the needs of individuals and populations. This involves establishing new models of care, supported by new governance arrangements and underpinned by new payment systems that are aligned with overarching system goals. Convergence 2.0 will provide practitioners with an update on progress across the country, as well as drilling down into the detail of some of the areas making the most progress with integration.
• More details page 29 or online at HFMA.to/converge2

decisions from the STP, is seen as the best way to ensure different stakeholders own the decisions.

A set of principles to support the co-production of efficiency plans has already been drafted by the STP organisations with a view to adopting these into contracts. The overarching aim is to focus on getting 'value from the overall health pound', says Ms Robinson.

Mr Mulvey says that systems can help meet patient demand in better ways. 'For example, with nursing homes, we find that the number of patients admitted into acute settings continues to cause pressure,' says Mr Mulvey. But this demand curve can be bent downwards by working with primary care to ensure a single GP looks after a cohort of patients in a home (rather than multiple GPs with several patients each). This can then be supported with greater access to community services such as IV antibiotics or advice lines and support from pharmacy technicians.

'This can lead to patients increasingly being cared for in their nursing homes rather than conveyed to hospital multiple times,' Mr Mulvey adds. The outcome is better for the patients and delivers better overall value. The scheme is currently being piloted in 28 homes across the north of the county with early results demonstrating a 15% reduction in A&E attendances from the homes involved.

Other organisations in the STP agree with a collective approach. University Hospitals of North Midlands NHS Trust was placed into financial special measures a year ago. Chief finance and performance officer Helen Ashley says that since then the trust has focused on its own internal efficiencies. 'But given the scale of the financial challenge that the trust and commissioners face, it's clear that by working with colleagues across the economy there are far more opportunities to generate efficiencies – something that we have not historically focused on,' she says. 'At the end of the day there is only one pot of money and, therefore, we all have a duty to work collectively to ensure best use is made of the limited resource that we have.'

This approach to efficiency should also help sidestep some of the existing barriers to improvement. 'For example, in very simple terms, consider if we wanted to change a service and it means the commissioner pays £1m less to a provider,' says Ms Robinson.

'If that provider can only release the £0.5m of variable costs and is left with £0.5m fixed costs, on the basis that the system is £0.5m better off overall, we can agree a mechanism to cover these costs for a period of time. We are looking to remove those disincentives [for the provider] and to allow for transformation to take place and costs to be removed.'

Wider engagement

The sub-director level involvement in the group is important. 'We are deliberately trying to cast the net further and engage more of the finance community,' Ms Robinson explains. 'Sometimes the STP is visible at the very senior level in organisations, but as you drop down, there is less involvement. We're keen for all our staff (and specifically in finance) to see the STP as a collective whole, not a few individuals. We want everyone to be aware of what the STP is about and for everybody's day-to-day work to be about delivering this plan.'

The group will use NHS England's 10-point efficiency plan as the focus for its discussions. There are already issues that the group wants to explore – such as how different bodies contract for different IM&T services. 'There may well be an opportunity to rationalise those arrangements across the system,' says Ms Robinson.

With the engagement CQUIN now worth 1% of contract value, as a result of the refreshed planning guidance, the group will also explore ways in which specific criteria could be used to trigger payment and encourage further joint working. And it is aiming to develop a better understanding of what efficiency schemes are actually delivering, with the intention of ruling out double-counting of organisational efficiencies as improvements secured by the STP.

Another area the group will look at involves contract breaches. 'In the system we have created, it is very easy to send letters to each other when you breach contractual targets or data requirements,' she says. 'But does this always add value and would we be better using the time and energy to agree an outcome or an efficiency scheme and then work collectively to achieve that? We are just looking for better ways to work together.' She adds that the group may also examine the potential to combine forces and purchase things together where that makes sense – for example, IT service contracts or corporate services procurement.

Both NHS Improvement and NHS England will be represented on the group and Ms Robinson says the involvement of both regulators has already started to add value to their discussions.

The group's terms of reference state it will develop 'creative and forward thinking ideas that push the boundaries of possibilities with the aim of making the STP a leading light in terms of innovation, progress and delivery'. It will also lead the health economy's thinking on moves to different payment systems – such as population health budgets – to better incentivise and support new models of care.

There are some significant challenges in Staffordshire and Stoke-on-Trent. But all health economies are facing similar issues. All health economies need to understand what efficiencies can be realised at the system level and many may see Staffordshire and Stoke-on-Trent's efficiency group as a possible vehicle to help explore this area.

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counter measures

The new NHS counter-fraud agency's finance director wants greater engagement with finance staff, says Seamus Ward

Several things are known about fraud against the NHS: it is under-reported; the understanding of fraud and associated financial risk is patchy across the service; and there is a lack of benchmarks at local level. To help address this, the Department of Health and Social Care has set up the NHS Counter-fraud Authority (NHSCFA) to gather intelligence on fraud, build the understanding of risk and develop innovative and proportionate ways of tackling fraud against the NHS.

Set up last November, the NHSCFA initially grabbed headlines through its estimate that the NHS lost £1.25bn a year to fraud. It has since been working in the background, implementing its strategy and developing standards for commissioners and providers.

These standards were published in February and include a quality assurance programme with a self-assessment tool. The NHSCFA can visit an NHS organisation to assess its counter-fraud arrangements, while clinical commissioning groups also have a role in ensuring their providers' arrangements are satisfactory.

Healthcare Finance spoke to **Matthew Jordan-Boyd**, NHSCFA director of finance and corporate governance, about the role of the authority, the importance of counter-fraud arrangements in good governance, the levels of fraud and the assurance regime for local counter-fraud arrangements.

How is the work of the CFA different from NHS Protect – is it a rebadging or a change in approach?

The NHSCFA is a new special health authority and was created to focus purely on fraud, bribery and corruption across the NHS. The new structure and approach is designed to focus on filling the gaps in knowledge to improve understanding of fraud within the system in support of the Department of Health and Social Care anti-fraud strategy with a view to identify cross system solutions that reduce the financial loss to the system that fraud creates.

What's the local counter-fraud structure – has it changed?

No, the local counter-fraud structure has not changed. Each NHS body is directed by the secretary of state to take such action as is reasonably necessary for the purpose of preventing, detecting or investigating fraud. Each NHS organisation is still required to have access to an accredited local counter-fraud specialist to undertake local counter-fraud work.

The interaction between the local counter-fraud specialists and the NHSCFA differs, however, from the previous central approaches, as NHSCFA does not provide the support function for investigative work that was previously delivered by NHS Protect.

NHSCFA provides a quality control process for counter-fraud investigative work and provides the gateway process for NHS

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organisations to submit case files to the Crown Prosecution Service.

Due to this change in approach we have identified as a priority in 2018/19 the need to develop stronger links with the finance directors and chief finance officers to identify the best ways in which tools and information can be shared to ensure counter-fraud work is delivered effectively at a local level.

As part of their corporate governance role, what should boards be doing to counter fraud in their organisations?

The NHSCFA has developed and published its counter-fraud standards for providers and commissioners and has set out the approach to strategic leadership of counter-fraud. I would hope that boards and audit committees have familiarised themselves with those requirements to ensure internal assurance of delivery. However, the audit committee has a crucial role in holding the organisation independently to account in the application of the standards and in ensuring fraud, bribery and corruption are prevented or, if not prevented, properly investigated. The published counter-fraud standards can be found at www.cfa.nhs.uk.

Should the finance director/CFO lead on this?

Yes, I believe the finance director/CFO is key to driving the counter-fraud message at a strategic level. In the NHSCFA counter-fraud standards, organisations are required to have a member of the executive board responsible for overseeing and providing strategic management and support for all counter-fraud, bribery and corruption work within the organisation.

What is the level of NHS fraud?

The NHSCFA estimates the overall losses to fraud in the NHS to be £1.25bn [a year]. This estimate is based on our knowledge of fraud in the system to date and is reviewed annually.

What areas are most at risk?
Our strategic intelligence work identifies the key areas that we believe need to be addressed, although fraud is an ever changing issue and we must all be vigilant to ensure we identify new approaches by criminals as they emerge (see box for more).

Is there a level that NHS fraud could be realistically brought down to?
We know that the fraud threats change as criminals look at different methodologies to defraud systems. NHSCFA, working with finance directors/CFOs, wants to bring the overall level of fraud down and will target those areas in which we can make the most impact across the system. In 2017/18 we have targeted optical fraud and EHIC (European Health Insurance Card), and in 2018/19 we will be targeting procurement and commissioning fraud and [fraudulent] pharmaceutical contractors.

Are there areas of anti-fraud activity on which CFA will focus/NHS bodies should focus?
As previously stated, the landscape of fraud is ever changing. However, areas of known NHS fraud include but are not limited to:
- Dental, pharmaceutical and optical contractor fraud
- GP fraud
- Payroll and identity fraud
- Access to care, procurement and commissioning fraud
- National tariff and performance data manipulation fraud.

What is the cost of counter-fraud activity?
NHSCFA spends in excess of £10m annually targeting and developing system-wide solutions to fraud, bribery and corruption within the NHS. However, each individual NHS organisation is responsible for the procurement and delivery of its own local service and will fund this directly as this requirement will be based on their local assessment of counter-fraud risk.

What do the CFA's quality assurance programme self-assessments and on-site assessments tell us about the robustness of counter-fraud activity in the NHS?
Few organisations meet all the standards when assessed. However, we have seen improvement in both providers' and commissioners' efforts to develop a strong counter-fraud culture within their own organisations. NHSCFA is working with strategic partners in order to develop its role in assisting organisations to identify fraud locally, and try to increase engagement with directors of finance and other finance professionals.

Self-assessments should be signed off by a board member – should this be the finance director or the full board?
Self-reviews are required to be signed off by the finance director, but best practice would be for audit committees to be fully engaged and boards sighted.

What is a commissioner's role in ensuring providers have anti-fraud measures in place?
NHSCFA counter-fraud standards require co-ordinating commissioners to hold providers to account where the provider is not complying with standards. Where commissioners are not complying with standards, NHS England will hold them to account.

"Where commissioners are not complying with standards, NHS England will hold them to account"
Matthew Jordan-Boyd, NHSCFA

How will commissioners review providers' arrangements?
Commissioners have a responsibility to review the self-review tool returns annually and seek further information for any areas of concern regarding counter-fraud compliance.

Will all commissioners have to review a provider's anti-fraud arrangements or will it be performed by a lead commissioner?
Co-ordinating commissioners have been identified and they will review the self-review tool of providers under their co-ordination. They can liaise with the NHSCFA while undertaking this where required.

Level of fraud

The NHSCFA says fraud is under-reported and this can be due to suspicious activity being missed or a misconception that reporting fraud casts the organisation in a bad light. There are inconsistencies in local counter-fraud activity, it adds – in how it is reported and recorded and how fraud is identified and investigated, as well as the process used to apply sanctions.

Breakdown of estimated losses in key areas of NHS spending (£m)

Confidence level	Almost certain	Highly likely[1]	Probable[2]	Realistic probability[3]	Total
Help with health costs (patient fraud)	216.7	60.9	120		397.6
Payroll and identity fraud			90.6		90.6
Optical contractor fraud			48		48
Dental contractor fraud		73.2	20.6	26.9	120.7
Pharmaceutical contractor fraud			100		100
General practice fraud				81	81
Fraudulent access to NHS care in England				35	35
EHIC			2.6	16.1	18.7
NHS student bursary scheme			12.9		12.9
NHS pensions		1.4	1.1		2.5
National tariff and performance data manipulation				90	90
Procurement and commissioning fraud			165	87	252
Fraud against NHS Litigation Authority administered funds				2.55	2.55
Total	**216.7**	**135.5**	**560.8**	**338.5**	**1,251**

[1] High confidence – eg where there is good quality information or corroborating evidence from a range of different sources
[2] Moderate confidence – where the information is open to a number of interpretations or is credible or plausible but lack corroboration
[3] Low confidence – where information is scant, or fragmentary, or where sources are of dubious reliability

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Revenue recognition standard: NHS bodies will have to review contracts

Technical update

The Department of Health and Social Care (DHSC) expects the introduction of financial reporting standard IFRS 15 – *Revenue from contracts with customers* – to result in very little change to existing practices, *writes Debbie Paterson*. But NHS finance managers will need to pay it some attention first.

In general, the standard, which applies to accounting periods starting on or after 1 January 2018, is more prescriptive than existing guidance on how revenue is profiled. As the standard's name implies, if, when and how much revenue is recognised by an organisation depends on the terms of its contracts. Some commercial organisations are reviewing and rewriting their contracts in anticipation of the standard, which means it is important that those writing and/or signing contracts have an understanding of the accounting implications of those arrangements.

While intra-NHS arrangements use the centrally written NHS standard contract, these include locally drafted schedules. NHS bodies need to be clear on how the new standard might affect current income recognition.

The new standard sets out a logical five-step approach for recognising income. The core principle is that an entity should recognise revenue when it transfers goods and/or services to customers and the amount recognised should reflect the amount to which the entity expects to be entitled to in exchange for those goods and/or services. The five steps include the following:

1. Identify contracts with customers. For NHS bodies, this will include all NHS contracts and contracts with third parties.
2. Identify all the separate performance obligations in the contract. This is what has to be done to earn the income – the provision of goods or services – and may take place at a point in time or over time. There may be more than one performance obligation in a contract but they must be separate – one way to think about separability is whether the service would have to be redone if the service provider were changed. For NHS bodies, long-term contracts, contracts for pathways of care and research and development contracts are expected to be the least straightforward. For example:
   - In a maternity pathway, the patient simultaneously receives and consumes antenatal care. The revenue relating to antenatal care is likely to be recognised over the length of the pregnancy. However, any revenue relating to the delivery of the baby is likely to be recognised on the date of delivery. As the antenatal care and delivery do not have to be performed by the same NHS provider, they are separate performance obligations.
   - A pre-operative assessment may be done at one NHS body, but the surgery may be performed elsewhere. If the assessment needed to be redone if the patient moved to a different NHS provider for surgery, then it is not a separate obligation
   - Research and development contracts may require the NHS body to deliver a report at the end of the process. If the report is not delivered, even though the research has been done, then payment is not due under the terms of the contract. Other research contracts might include staged deliverables so income would be recognised as they are met
3. Determine the transaction price – this is likely to be the price set out in the contract, but it could be different if the contract includes a variable element.
4. Allocate the transaction price to the performance obligations in the contract – this can be more complex where a price has to be allocated to different performance obligations.
5. Recognise revenue when (or as) performance obligations are satisfied.

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To implement the standard, all contracts in place on 1 April 2018 should have been reviewed against the new requirements. The impact will be greatest for contracts that are in operation across the year-end as it will be important to recognise revenue in the appropriate financial year. It will also be important to consider revenue recognition when discussing contracting arrangements for new models of care.

Debbie Paterson is an HFMA technical editor

Technical review

The past month's key technical developments

Technical roundup

The Department of Health and Social Care added an update on the **quarter 4 agreement of balances** exercise to its web pages in March. While there was a reduction in the value of mismatches between initial submission and resubmission at month nine, the Department said the value of mismatches at resubmission was higher than in previous years. The level of mismatches is above the materiality level and this may be partially due to sustainability and transformation fund balances, the Department said. But it added that improvements made during this financial year must be maintained and continue into the year-end exercise.

A number of new documents on **continuing healthcare and NHS-funded nursing care** have been published by the Department of Health and Social Care. These include a new national framework, which will be implemented from 1 October, and supporting documents, such as a checklist, a decision support tool and a fast track pathway tool, all for continuing healthcare (CHC). The Department said the revised framework did not change the eligibility criteria for continuing healthcare. However, it clarifies several policy areas. For example, it says most CHC assessments should take place outside of acute hospital settings and clarifies that the main purpose of three- and 12-month reviews is to review the appropriateness of the care package, rather than reassess eligibility. It also introduces new principles for clinical commissioning groups on the local resolution process when individuals request a review of an eligibility decision.

The HFMA published a briefing on the application of financial reporting standard IFRS 16 on **accounting for leases**. The HFMA document sets out the basic requirements of the new accounting standard and the decisions that must be made when applying it for the first time. It also reflects on the decisions expected to be mandated by the Treasury and the issues NHS bodies may need to consider. The briefing is an update of one published last November and will be revised as HFMA members discuss the application of the standard and as further government guidance is issued. NHS bodies are being encouraged to start preparing for the changes immediately (see 'Don't play the waiting game on leasing changes' at www.hfma.org.uk/news/blogs)

Changes to the Care Quality Commission's inspection and rating process came into force in March. Acute providers will now additionally be assessed for their **use of resources**. Following consultation, the care regulator confirmed this assessment will be considered as a sixth key question alongside the existing quality-related questions that aim to assess whether services are safe, effective, caring, responsive to people's needs and well-led. The new use of resources rating – outstanding, good, requires improvement or inadequate – will be published alongside the ratings for the five key quality questions. The quality ratings will continue to be combined into a single rating on quality, and this will be further combined with the use of resources assessment to give an overall rating.

A new briefing from the HFMA – *Understanding the financial position* – sets out the importance of reviewing all an organisation's key financial statements to properly understand financial health. It looks at NHS bodies' financial targets, including control totals, and looks at the different financial statements and warning signs that governing body members should be alert to. These warnings signs include rising levels of receivables or payables. However governing body members should also understand movements in levels of provisions and maintain a careful eye on cash balances.

NICE offers system view on emergency care

NICE update

NICE's guideline NG94 offers best practice advice on the organisation and delivery of emergency and acute medical care for over-16s in the community and in hospital, *writes Nicola Bodey*.

Demand in the NHS is increasing across the whole urgent and emergency care system. Hospitals are finding it increasingly challenging to maintain the flow of patients from admission to discharge, and readmissions to hospital are also increasing.

A number of recommendations are made, though they do not include detail about how they should be implemented (how many staff are needed or the exact content of an intervention). The most cost-effective solution is likely to vary depending on local systems.

One recommendation is to provide specialist and advanced paramedic practitioners who have extended training in assessing and treating people with medical emergencies.

Higher banded advanced paramedic practitioners would result in additional staff costs for ambulance trusts. Staff undergoing additional training may need to be released to attend courses, and extra staff time could be needed to backfill rotas. There may also be increased training and education costs.

However, using advanced paramedics may result in fewer attendances at emergency departments and fewer admissions and avoid more costly call-outs for an ambulance.

A further recommendation is to provide access to physiotherapy and occupational therapy seven days a week for people admitted to hospital with a medical emergency. The costs of expandng therapy services should be offset by savings from reduced length of stay and fewer delays to discharge.

Diary

April

18 I Healthcare Costing for Value: costing conference, London
26 B North West: quiz, Manchester

May

10 F Commissioning Finance: prescribing forum
10 B South West/South Central: developing talent conference, Bristol
16 F Provider Finance: directors' forum, London
16 F Mental Health Finance: directors' forum
17 F Chair, Non-executive Director and Lay Member: forum
24 N Brighter together: procurement forum, London

June

7 B West Midlands: branch conference, Sutton Coldfield
8 B West Midlands: NHS finance – the next generation, Sutton Coldfield
14 B Eastern: positive psychology to improve wellbeing and resilience, Newmarket
19 B South Central: introduction to NHS finance, Newbury
20 N Brighter together: workforce forum, London
21 B London: annual conference, Rochester Row
26 B Northern Ireland: report writing for finance, Newtownabbey
28/29 B North West: annual conference, Blackpool

July

5-6 N Convergence 2.0, East Midlands Conference Centre
25 B Kent, Surrey and Sussex: introduction to finance, Crawley

September

13/14 B South Central: annual conference, Reading
19 B Eastern: student conference, Cambridge
19 N CIPFA/HFMA health and social care finance conference
20 F Provider technical forum, preparing for IFRS16
20/21 B South West: annual conference, Bristol
25 N CEO forum
27/28 B Wales: annual conference, Hensol
27 N Mental health finance conference

October

10 F Chair, Non-executive and Lay Member: forum
16 F Operating game for new non-executives

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

key B Branch N National F Faculty I Institute

Increased nurse-led support in the community for people at increased risk of hospital admission or readmission could prevent admissions and readmissions and give better outcomes for patients.

There is considerable overlap between the guideline and other policy initiatives, such a NHS England seven-day services clinical standards. Commissioning for urgent and emergency care needs align with NHS England programmes on the *Five-year forward view* and urgent and emergency care programme.

Costs and associated savings are likely to arise in different sectors of the health and social care system. Commissioners may need to consider local funding changes to reflect this and support providers.

Nicola Bodey is senior business analyst at NICE

Events in focus

Convergence 2.0
5-6 July, Nottingham

Health policy is pointed firmly in the direction of greater collaboration between NHS bodies and with external agencies, including social services. Health and social care organisations in Scotland and Wales are taking steps towards greater integration. Services in Northern Ireland are already integrated. Meanwhile, in England the establishment of sustainability and transformation partnerships and integrated care systems (ICSs) are further blurring lines between commissioners and providers, already distorted by new care models first set out in the *NHS five-year forward view*.

This national conference will bring together commissioners and providers to share learning and best practice. Speakers include Jim Mackey, until recently NHS Improvement chief executive, who will deliver the keynote speech on his time at the oversight body and progress on development of the Northumbria ICS. Elizabeth O'Mahony (pictured), NHS Improvement chief financial officer, will look at how integration and wider societal changes will have an impact on the NHS finance function. And Claire Murdoch, NHS England mental health director and chief executive of Central and North West London NHS Foundation Trust, will offer her perspective on how national bodies can shift control to citizens.

• For further information or to book a place, email emily.bowers@hfma.org.uk

Costing conference 2018: Shaping the future
18 April, London

Costing is increasingly playing a central role in supporting decision-making in the NHS. In England, NHS Improvement is pushing ahead with its Costing Transformation Programme and has mandated acute trusts to collect and submit costs at the patient level from 2018/19. Mandation of patient-level costing for mental health, community and ambulance services is expected to follow. In Wales, costing is well established, and many are actively using costing information to inform strategic and clinical practice. Its implementation and use could well be extended across the region. The HFMA Costing for Value Institute's annual costing conference is a valuable event for costing professionals as well as finance staff and clinicians with an interest in costing. Together with policy updates, there will be interactive workshops, case studies and a chance to network with colleagues. Institute member organisations receive two free places for the event.

• For details, email charlie.dolan@hfma.org.uk

A bit of Bully

Association view from Mark Knight, HFMA chief executive

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

CREATIVE COMMONS/HUMOR BLOG

My HFMA

The passing of Jim Bowen last month reminded me of the night he saved our 2004 spring conference in Blackpool. When we were informed our after-dinner speaker had missed the plane, we thought we'd lost our evening's entertainment, but Jim stepped up to the oche. He changed course from the golf club, where he'd been heading, to perform at our dinner.

I've sat through dozens of comedians over the years and there is no doubt he was the funniest – I thought I'd have to go to hospital, I laughed so much. He judged the audience perfectly and, for those like me whose formative years were spent watching *Bullseye*, it was an absolute treat.

The reason for sharing that story is not only to recognise an unlikely contribution to our efforts, but also to remind ourselves of the multi-faceted nature of the association. One role of our network is to provide opportunities to spend time together. Building informal relationships is important in developing support networks and experience. Sharing together at events is all part of the process of learning new skills.

I know that many branches are currently working away to organise their annual conferences. It's worth taking a look at what your branch is doing over the coming months.

As usual, the HFMA is busy creating new opportunities for you to learn and share. We have launched our annual conference booking for December and are close to agreeing our first motivational speaker – look out for that announcement soon.

We have commitment from the main statutory organisations and are working hard to plan the rest of the programme. We're focusing on short interactive sessions for the event, as well as our rich variety of workshops.

We are also going to be enhancing our graduation celebration on the Wednesday night, as many more students receive their certificates. Please join us to celebrate their achievements.

Well before this is our Convergence 2.0 event in July, with a clear focus on getting different organisations together. Once again, the event combines the provider and commissioning faculties' annual conferences and will focus on how organisations are looking to work as systems to deliver more integrated care. Please book your place, we are selling fast.

HFMA chief executive Mark Knight

As part of our president Alex Gild's *Brighter together* theme, we are now in the final throes of developing our *NHS at 100* roundtables. These are taking place soon and will focus on the important issues for society to consider over the next 30 years. What, for example, will be the role of the state and the citizen in healthcare? And how will technology impact on its delivery?

We are hoping to publish our thoughts on these issues in the week of the 70th NHS celebration, launching them at the convergence event. We believe it will be a good contribution to an essential debate.

So, as usual, there's plenty going on and there is much for members to get involved with.

The footnote to the Jim Bowen story is that later in 2004, flushed with success, we booked another comedian to be our after-dinner speaker for the annual conference – who turned out to be one of the worst we've ever had!

So, it doesn't always go alright on the night – but that's ultimately part of the fun.

Member news

The West Midlands Research and Development Committee has published a research paper on delayed transfers of care (DToCs) – when a patient is ready to leave acute or non-acute care but still occupies a bed. It explains why DToCs happen and what can be done to tackle the problem. Read it at **http://hfma.to/5r**

To celebrate International Women's Day, HFMA's coaching and mentoring team asked senior women leaders to share their stories about female role models who supported their career development. To read about Pam Dyson, Kim Li, Sue Lorimer, Louise Shepherd or Jane Tomkinson, go to **hfma.to/iwd** or the **@HFMA_UK** Twitter account.

As the UK struggled with the snow in March, many NHS staff fought their way to work. But spare a thought for snowed-in

NHS Lothian deputy finance director Craig Marriott, whose team made it in and sent him this picture of them holding the message: 'Nae bother to us #NHShardcore Snow... what snow?'. Mr Marriott said: 'The Beast from the East stopped some NHS Lothian staff getting to work, me included. But I was delighted to see so many of the finance team battle in, and show good humour at the same time! A special thanks to those who also assisted in co-ordinating the army effort to transport staff.'

Stuart Wayment continues to fundraise for Southampton cancer charity Planets – this year by joining the Brietling Wing Walk team on top of a biplane. Support him at **www.justgiving.com/fundraising/stuart-wayment2**

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Member benefits

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

Branch focus

My HFMA **North West**

In April 2016, a £6bn budget was formally devolved to the 37 NHS organisations and local authorities that formed the Greater Manchester Health and Social Care Partnership. To an extent, devolution built on a history of local authorities working together. The move is often seen as a forerunner of the sustainability and transformation partnerships.

Greater Manchester sits in the HFMA's second biggest branch in terms of members – North West. 'Everybody's watching to see what happens in Greater Manchester,' says Kim McNaught (pictured), North West branch vice chair and associate director of finance, financial improvement, at Southport and Ormskirk NHS Trust.

It isn't straightforward to get everybody working together when there are so many stakeholders involved, she says. Upfront investment and the £450m in NHS transformation funding have been key to the devolution's success.

The area that the branch covers is also large, encompassing Lancashire, Cumbria, Merseyside and Cheshire. To ensure inclusiveness, the branch often holds the same event twice in different locations and has breakfast and evening sessions to minimise the time out of the office.

According to Mrs McNaught, despite the wide area the branch covers, the member community is close-knit. This has allowed formal and informal learning and sharing of best practice around the Manchester devolution and other developments.

Delegates at the North West Branch annual conference in Blackpool on 28-29 June will have the opportunity to hear a further update on the changes within Manchester, along with a range of other topics, including resilience, diversity and motivation.

The branch has an active student body and works closely with the local Finance Skills Development network. 'We've always had a student member on the committee and we rely on their input because they bring a different perspective,' says Ms McNaught, who was a student representative when she first joined the HFMA.

The branch has organised recent networking events for students to encourage them to make the most of their membership and to understand better the importance of the HFMA's support network in their professional development.

• **Visit** http://hfma.to/5w

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Appointments

Davina Ross has been named assistant director of finance at Devon Partnership NHS Trust. Ms Ross was previously head of finance at the organisation. She takes over from **Lynne Blandford**, who is now head of financial strategy (South) at NHS England, leading financial strategy and planning for region.

The Welsh Ambulance Services NHS Trust has appointed executive director of finance and deputy chief executive **Patsy Roseblade** (pictured) interim chief executive. Ms Roseblade joined the organisation in 2012 and has 18 years' senior NHS finance experience.

Chris Turley (pictured), previously deputy director of finance at the organisation, has been appointed interim director of finance, ICT and health informatics. The move follows the appointment of **Tracy Myhill**, former chief executive at the trust, as chief executive at Abertawe Bro Morgannwg University Health Board.

Ben Travis (pictured) has been appointed chief executive of Lewisham and Greenwich NHS Trust, after seven years at Oxleas NHS Foundation Trust. He spent four years as director of finance at Oxleas before being appointed acting chief executive and then substantive chief executive in June 2016. Mr Travis worked for Heineken and Deloitte before joining the NHS. In his new role, he will succeed Tim Higginson, who is retiring after 10 years at the South London trust.

Obituary: Helen Vinters

In February, Helen Vinters, a committed HFMA member, passed away after a short illness. Mrs Vinters, who had worked in NHS finance in the Midlands for over 30 years, was much loved and highly regarded by all who worked with her. Helen had worked for providers and in a range of roles in the regional health authority, strategic health authority and NHS England. Earlier in her career, she was deputy unit accountant at Selly Oak Hospital. For the past 21 years, she job-shared with Andrea Nash, most recently leading on capital and direct commissioning at the Midlands and East Regional Team of NHS England. She will be greatly missed.

If you'd like to make a donation in her memory, please contact any of the regional finance team at St Chads Birmingham. Her colleague Helen Dempsey has also set up a PayPal account for donations at helen.dempsey1@nhs.net. The chosen charities for donations are the cardiothoracic critical care unit at University Hospital South Manchester, and Cats Protection.

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

> " Working together on a larger footprint and seeing things from a system-wide perspective, with our providers, makes more sense"
> **Mark Baker, Central Sussex Commissioning Alliance**

Baker takes Sussex alliance challenge

On the move

In his new role as strategic director of finance for the Central Sussex Commissioning Alliance, Mark Baker aims to address the financial and commissioning challenges facing the local health economy.

The alliance was initially made up of four clinical commissioning groups – Brighton and Hove; Crawley; High Weald Lewes Havens; and Horsham and Mid Sussex – and they will be joined by East Surrey on 1 April.

All the CCGs have signed up to a memorandum of understanding to work together, with a single management team, staff and resources, to a common strategy.

Mr Baker says the commissioners have teamed up to turn around local service and funding issues. 'Of the four CCGs currently part of the alliance, two are in legal directions and are facing particular financial difficulties. There is a recognition that trying to solve the financial difficulties and commissioning issues on your own is not going to work.

'Working together on a larger footprint and seeing things from a system-wide perspective, with our providers, makes more sense. It's a recognition of the state of play and what we need to do to be successful in transforming the healthcare system and solving some of the financial challenges we face.'

That financial challenge currently stands at an in-year deficit of around £50m for the four CCGs in 2017/18. Once East Surrey is added, the deficit rises to £75m on an overall budget of around £1.3bn. 'It's a significant amount and the central Sussex patch faces one of the biggest financial challenges in the country. We are going into 2018/19 with a similar budget gap.'

The Sussex system is struggling to meet demand with its allocation of funding, Mr Baker says. The ageing population contributes to the financial problem, together with acuity and the system's inability to transform services quickly to meet patients' needs.

While each CCG is currently working to their individual control total, Mr Baker says the alliance is hoping to be given some flexibility to begin managing finances across the five commissioners. It will need the approval of the governing bodies and regulators to do so.

He is new to the patch, having previously been chief finance officer at North West Surrey Clinical Commissioning Group. His early career was spent in local government and he was finance director of Sussex Police immediately prior to joining North West Surrey.

He is also new to managing across a number of organisations. 'It's a challenge because we are trying to do two things – manage the collective financial strategy across all the organisations, while still doing the day-to-day work of financial returns, statutory accounts and budget planning for each CCG,' he adds.

'The key immediate issues are stabilising the financial position, getting to a level where there is grip around the finances, and also to be challenging but realistic. Then, over three to five years the objective is to manage across the commissioners, working with providers, to get back to a financially stable position. At the same time, we are developing one finance team across the five CCGs to support this.'

While there are significant financial and organisational challenges, he jumped at the chance to lead the alliance's finance function.

'I wanted the challenge of a bigger role; of doing something over a much larger footprint and having the scope to do that with a much bigger finance team. Working across the CCGs allows me more influence on the whole system. There's a sense of commitment and wanting to do this across the CCGs. I spoke to all the CCG chairs before I applied for the job and their commitment to working together was strong.'

Diversity barriers examined

Future Focused Finance

The Future-Focused Finance team is looking into the barriers preventing women and black, Asian and minority ethnic (BAME) finance colleagues from making the progress they might wish in their careers.

Initial examination of the 2017 HFMA/FSD census suggests little change in the diversity of the NHS finance function. While 61% of the workforce is female, only 28% of finance directors are women. BAME representation across the whole finance workforce is relatively high at 18%, but BAME colleagues hold only 4% of the most senior posts.

FFF has already undertaken a range of diversity-related activities, including the publication of a narrative (available on its website) explaining why diversity is important in ensuring the NHS: builds organisational resilience; attracts, retains and engages the best talent; and enhances patient care.

FFF wants to identify the barriers and what, if anything, NHS organisations are doing to address the issues. It plans to hold facilitated 'safe house' discussions, where women and people from BAME backgrounds can describe their workplace experiences, to allow FFF to develop a clear understanding of the key issues.

FFF diversity lead Edward John, director of operational finance at Frimley Health NHS FT, said: 'Statistics show that female and BAME representation at senior levels in NHS finance is disproportionately low, indicating we have a group of people who are not being given equal opportunity.

'This represents a real waste of potentially high-calibre talent. We want to create an environment where hardworking staff from all backgrounds can thrive.'

To be involved in the discussions, contact futurefocusedfinance@nhs.net

Book your place now
Visit: **hfma.to/converge2**
Email: **converge@hfma.org.uk**

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5–6 July 2018

Convergence 2.0

East Midlands Conference Centre, Nottingham

Early booker rates end on Friday 27 April

The Convergence Conference returns 5-6 July, bringing providers and commissioners together to facilitate networking and shared learning. Since the creation of STPs and with the movement towards accountable care, roles of providers and commissioners are becoming increasingly blurred.

We're looking forward to hearing from…

Jim Mackey, Chief Executive, Northumbria ACO

Elizabeth O'Mahony, Chief Financial Officer, NHS Improvement

Anita Charlesworth CBE, Director of Research and Economics, The Health Foundation

Anthony Bennett, 'miracle man' patient speaker

Kriss Akabusi, motivational speaker and Olympian

….and many more

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