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# Contents

## March 2018

## News



## Comment



## Professional lives



Page 13 **Despite improvements post-Wannacry, the NHS needs to step up its cyber security efforts**

## Features



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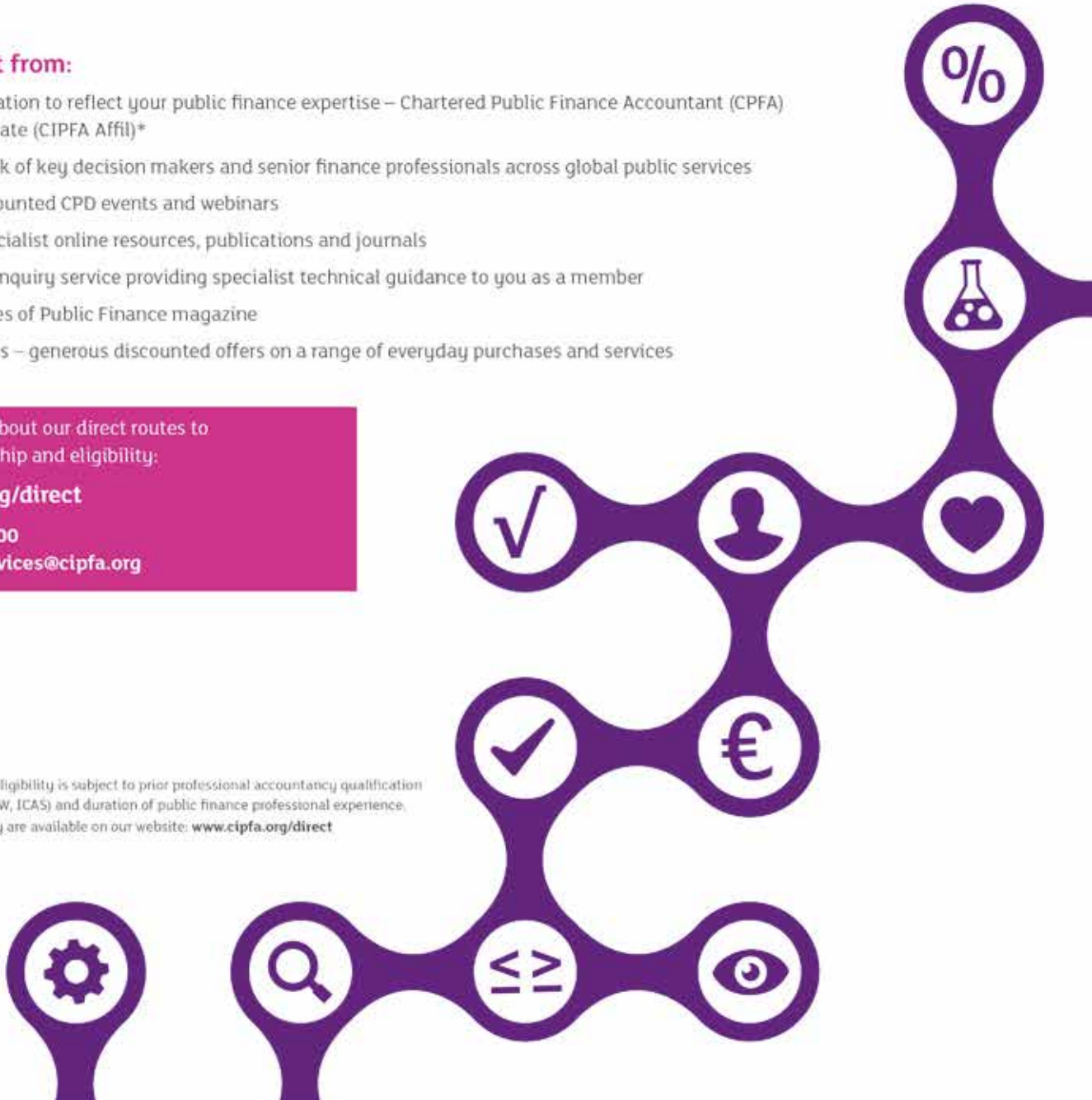


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# News

*Paul Baumann: working hard to mitigate risks*

## Increasing demand pushes trusts further into deficit

**By Seamus Ward**

NHS providers in England could be heading for an aggregate deficit of more than £900m, based on forecasts at the end of quarter three.

Figures published by NHS Improvement showed that providers had forecast a combined year-end deficit of £931m – £435m more than planned for 2017/18.

At month nine, the commissioning sector predicted an overall underspend of £18.5m at year-end. However, NHS England chief financial officer Paul Baumann warned that clinical commissioning groups were facing significant financial risk. They forecast a combined year-end overspend of £291m, but NHS England believed the underlying position amounts to a deficit of between £400m and £500m. NHS England and CCGs were working hard to mitigate the risks, he said.

**Providers had forecast a combined year-end deficit of £931m – £435m more than planned for 2017/18**

CCG expenditure includes a £360m contribution to a system reserve to support wider system deficits. NHS England is also holding a further £200m uncommitted reserve centrally, according to a paper at its February board meeting.

The provider sector posted a year-to-date aggregate deficit of £1.28bn, when uncommitted sustainability and transformation funds are taken into account. NHS Improvement said that this was £365m more than the plan for the end of quarter three – which it described as 'ambitious'. Since quarter two the position has deteriorated by £222m.

Overall, 109 of the 234 providers reported year-to-date adverse variances against plan. This position is expected to improve over the final quarter – 91 trusts are forecasting that they will be overspent against plan by the end of the financial year.

The difficult financial position was the result of a number of factors, including overspends in pay (£701m) and non-pay costs (£292m), driven by operational pressures, and failure to achieve planned efficiency savings, NHS Improvement said.

Over the three-month period, a quarter of a million more patients visited A&E than in the same quarter in 2016/17. The government provided an additional £337m in the November Budget. NHS Improvement said acute providers received £238m of this. An NHS England board paper added that a total of £317m had been made available to NHS providers overall, while primary care received the remaining £20m.

Although providers had achieved significant cost savings – £2.1bn or 3.3% – at quarter three, this was behind plan by £329m (13%). Much of this was attributed to the underdelivery of pay cost savings. However, with trusts failing to achieve some recurrent cost improvements, many were compensating for this with non-recurrent measures.

At Q3 trusts had planned to deliver £2.27bn (92%) in recurrent savings, but delivered just under £1.6bn (74%). Non-recurrent savings increased from £197m (8%) to £546m (26%), potentially leaving trusts with additional savings to find in 2018/19.

NHS Improvement said trusts needed to step up delivery of cost savings, with forecasts indicating that they may fall £392m short of the planned £3.7bn savings at year-end.

The oversight body said trusts must identify detailed schemes to save a further £86m before the end of the financial year to achieve the newly forecast savings of £3.3bn.

NHS Improvement chief executive Ian Dalton paid tribute to providers and their staff for their hard work in the face of rising activity, but said local health systems must plan for increasing demand in the future. He added: 'Some providers appear to have managed the financial pressures better than others. We are working closely with those providers whose financial position has deteriorated seriously to ensure that they grip their problems while delivering the best possible care for their patients.'

• *See news analysis, page 8*

## More work needed on STPs, says HFMA

Sustainability and transformation partnerships (STPs) embody the correct approach to joining up services and improving efficiency, but there is still a lot of work to do to improve collaboration and engagement and achieve financial goals, according to the HFMA.

In its submission to the Commons Health Committee inquiry into STPs, the association said its members broadly agreed that the system-based approach was the right direction of travel.

However, the advent of STPs marked a significant change in working practices – replacing the competition of the internal market with collaboration.

In the latest HFMA *NHS financial temperature check*, finance directors said relationships between commissioners and providers had improved overall, but further work was needed to strengthen ties with GPs, local authorities, ambulance trusts and the voluntary sector. Engagement with the public, patients and staff was mixed and a lack of transparency had led many members of these groups to view STPs as a vehicle for cost-cutting.

The fact that STPs are not statutory bodies creates potential barriers to collaboration. Individual organisations remain accountable for the delivery of services and their financial targets.

The HFMA evidence reiterated finance directors' concerns about STP governance because of this lack of alignment. It also highlighted concerns about STPs' ability to deliver a plan to help close the funding gap by 2021 and finance leads' fears that transformation is being hindered by the operational split between NHS England and NHS Improvement and current operational pressures.

# Government admits significant savings still needed to ensure NHS sustainability

**By Seamus Ward**

The government has acknowledged significant efficiencies will be needed to make the NHS and social care system sustainable for the long term.

Its response to the Lords Select Committee report on NHS and adult social care sustainability reaffirmed government support for the founding principles of the NHS, including ensuring care is free at the point of delivery.

Many of the Lords' recommendations called for sustained and transparent increases in funding, but the government defended its record on investment in health and care. In the face of unprecedented challenges relating to the growing and ageing population and to maintain services free at the point of use, it had committed to a real-terms increase in the NHS budget of £10bn in the 2015 spending review.

It had increased NHS resource spending by £2.8bn between 2017/18 and 2019/20. And in the recent planning guidance, a further £540m had been identified for 2018/19. Capital spending of £3.5bn had been announced for the next five years. Social care spending will also rise by more than £2bn over three years.

Despite the extra investment, the introduction of new models of care and local partnerships,

SHUTTERSTOCK

health minister Lord O'Shaughnessy said efficiency gains were still important.

'As the committee's report makes clear, significant efficiencies will need to be delivered and I do not underestimate the scale of this challenge, even with achievements made by the NHS to date,' he said. 'We will continue to ensure every pound of NHS spend has the greatest possible impact on patient care, building on an unprecedented five consecutive years of productivity improvements in the NHS.'

The government will try to support the health service to deliver these efficiencies, he added. The autumn Budget included £200m of capital to support efficiency programmes that give staff more time to treat patients.

The response also backed the national tariff as a means to drive up productivity, including the adoption of best practice. Responding to a recommendation on giving financial incentives for increased productivity and the uptake of innovation, the government said the tariff, the sustainability and transformation fund and the NHS England 10-point efficiency plan were the main means of delivering this. The tariff helped providers and commissioners deliver the most efficient, cost-effective care to patients.

The Lords recommended greater consistency in the allocation of funding to health and social care, which they said should at least rise in line with GDP. This would reduce volatility in overall funding levels and aid alignment of the services.

The response agreed stability and certainty in funding were desirable, but sidestepped linking annual spending hikes to GDP. Decisions on health and social care funding would be taken at the next spending review, it said. It pointed out that in the Better Care Fund the contribution from the NHS to adult social care must be maintained in line with inflation.

• *See news analysis, page 8 and A fresh approach, page 16*

# CIPs led to patient safety risk

**A trust has apologised after a review concluded that its cost improvement programmes (CIPs) had put the safety of patients at risk.**

**According to the independent review of Liverpool Community Health NHS Trust, commissioned by NHS Improvement, the trust had sufficient contract income to continue with its level of services when established in 2010. But commissioners asked for significant cost savings over the following four years. As well as accepting this unsustainable revenue position, the report said, the trust sought to generate a significant surplus over the same period – apparently in support of its bid to gain foundation status.**

**The review added that the trust had not adequately considered the cumulative impact of these measures. To address cost pressures, it aimed to make cost savings of 15% in one year, but there was no evidence managers or the board saw this as a substantial risk.**

**Cost reductions focused largely on cuts in staff numbers. There was 'a culture based on fiscal delivery rather than patient care, and managers were driven to reduce cost, irrespective of whether it was in the best interest of patients and staff', the review said.**

**Johanna Reilly, the trust's chief operating officer, said: 'On behalf of the trust, I apologise for the failings outlined in this review and I am extremely sorry that patients, families and members of staff suffered as a result.'**

**She added: 'May I reassure people that significant progress has already been made and we will continue to monitor all our processes, clinical and HR practices to help ensure we deliver the highest standards of care.'**

**The trust is scheduled to become part of Mersey Care NHS Foundation Trust on 1 April.**

**NHS Improvement said the CIPs had put patients at risk. Its chief executive, Ian Dalton (pictured), said the report highlighted significant failings in patient care. 'The report has important lessons for our organisation and the whole of the NHS. We will carefully consider its findings and take appropriate action. We expect to respond fully to the review's findings by late March.'**

## NHS England: MH spending growing

Commissioners have increased the proportion of budgets spent on mental healthcare, according to NHS England chief executive Simon Stevens.

He said clinical commissioning group spending had risen from around £9.15bn in 2015/16 to £9.72bn in 2016/17 – up 6.3% – compared with 3.7% overall growth in allocations.

In a letter to the Commons Health Committee, Mr Stevens said 85% of CCGs had increased their mental health expenditure by more than the growth in their overall allocations. The mental health investment standard, introduced in 2015/16, requires each CCG to give mental health services an annual increase that at least equals the growth in their overall allocation.

Spending on specialised mental health services also increased between 2015/16 and 2016/17 from £1.83bn to almost £1.88bn – a rise of 2.6%.

CCG and specialised commissioning mental health spending increased from £10.98bn in 2015/16 to £11.6bn in 2016/17 – growth of 5.7%, compared with an overall rise in CCG and specialised spending of 3.4%.

Figures published separately on the NHS England website suggested total mental health funding would rise to £11.86bn in 2017/18.

The Royal College of Psychiatrists said 86% of CCGs are meeting the standard in 2017/18, rising to 90% in 2018/19. The 2018/19 planning guidance requires, for the first time, every CCG to meet the invesment standard.

# Department moves to cap clinical negligence legal costs

**By Seamus Ward**

The Department of Health and Social Care has asked an expert group to develop a schedule of fixed costs for legal fees in most clinical negligence cases.

Publishing responses to a consultation on fixed legal costs for cases where compensation is up to £25,000, health and social care secretary Jeremy Hunt said the working group would examine improvements in the clinical negligence claims process, including a schedule of costs.

The group's proposals would apply to care given in England and Wales (NHS and private) and it is expected that recommendations will be published in the autumn.

Most clinical negligence litigation settled in the patient's favour lead to compensation of £25,000 or less – 63% of cases, according to Lord Justice Jackson, who has reviewed civil litigation costs for the government and will lead the group.

Last year, a National Audit Office report said in the 10 years to 2016/17 spending on the clinical negligence scheme for trusts had quadrupled to £1.6bn. While the rising number of claims accounted for 45% of the increase, the award of higher damages accounted for 33% and claimant legal costs 21%. The value of claimant legal costs had grown from £77m in 2006/07 to £487m in 2016/17.

With an increase in low- and medium-value claims in 2016/17 (up to £250,000), claimant legal costs outstripped damages awarded in 61% of settled cases, the NAO said.

The initial focus of the group appears to be on claims of up to £25,000, though Lord Justice Jackson has spoken in favour of introducing fixed recoverable costs in cases up to £100,000.

The NHS Confederation has called for lawyers' fees in clinical negligence cases to be fixed. Chief executive Niall Dickson (pictured) said the announcement of the group was a step in the right direction. 'It must surely be fair to cap the amount lawyers charge for their costs, and we welcome the decision to set up a group to work on this. We trust the government will act quickly on its recommendations.'

He also welcomed the government's determination to tackle clinical negligence claims more widely. 'We fully accept there must be reasonable compensation for patients harmed through clinical negligence, but this needs to be balanced against society's ability to pay. Money used for this cannot be spent on frontline care.'

The Department of Health and Social Care said NHS Resolution had worked with claimant representatives to develop a schedule of fixed costs in 2011/12. However, the process collapsed after objections to linking costs to the value of a clinical negligence claim and the level of costs allowed for at various stages of the process.

The consultation showed a clear split between lawyers who represented claimants (only 15% agreed costs should be fixed) and those who represented defendants (86% backed fixed recoverable costs).

Alongside the responses, the Department published an analysis of fixed-cost options. It recommended using a matrix derived from average base costs to calculate the fixed recoverable costs in clinical negligence claims.

# New care funding welcomed but more needed

Adult social care funding is to rise by a further £150m in 2018/19, but social care directors believe services will still be short of funds.

Unveiling the local government finance settlement for 2018/19, housing, communities and local government secretary Sajid Javid recognised the need to prioritise spending on services for elderly and vulnerable citizens. In the spring Budget last year, adult social care was allocated an extra £2bn over three years. 'We have seen how this money has enabled councils to increase provider fees, provide for more care packages and reduce delayed transfer of care,' he said.

But in February he announced an additional £150m in support grant, taken from anticipated departmental underspends. 'This will be allocated according to relative needs and we will expect to see councils use it to build on their progress so far in supporting sustainable local care markets.'

Mr Javid also acknowledged that a sustainable solution to adult social care funding was needed and the government would set out its proposals in a green paper in the summer.

Association of Directors of Adult Social Services president Margaret Willcox (pictured) commented: 'All money is welcome and we will make the most of what we get, but considering councils need more than £2bn just to stand still in 2018/19, this is not going to make a great deal of difference.

'It also depends on what they define as relative need. Will it be spent in areas struggling with delayed transfers of care? Or will other factors come into consideration?'

# News review

## Seamus Ward assesses the past month in healthcare finance

**The NHS is often used as a political football. It is often the subject of a march on Parliament. But it's rare the two combine and are used as evidence that universal healthcare systems do not work. However, at the start of February, US president Donald Trump tweeted about a march in support of the NHS, where protestors called for more funding. Mr Trump implied the march demonstrated discontent with the universal care model, which he said was championed by his political opponents, the Democrats.**

Not true, said the focus of many of the marchers' ire – health and social care secretary Jeremy Hunt. In a tweeted reply, Mr Hunt said he was proud of a universal system where patients were treated according to need and not the size of their wallet. NHS England chief executive Simon Stevens said the president had 'got the wrong end of the stick' and invited him to visit a hospital to see how well the system works when he comes to the UK.

Of course, the NHS has problems – during this winter there have been issues of access, with waiting times in A&E rising due to increased demand, and in elective care due to a temporary deferral of non-emergency elective care. In England A&E performance improved marginally in January compared with December and the previous January. NHS England's monthly statistics showed A&E attendances were 5.5% higher than January 2017 and 85.3% were admitted, transferred or discharged within four hours. A year earlier – and coincidentally in December 2017 – the figure was 85.1%. The figures also showed there was a 4.3% rise in the number of elective patients starting treatment in the past 12 months – 88.2% had been waiting 18 weeks or fewer by the end of December, compared with 89.7% in December 2016.

Mirroring this growth in A&E activity, attendances at Northern Ireland emergency departments were 5% higher in December 2017 than a year earlier. Just under 68% of patients were seen within the four-hour target period – this was 2.3 percentage points lower than in December 2016. The biggest increase in attendance was in type 1 A&Es (up 5.7%), which also had the lowest performance (63% treated and discharged or admitted within four hours).

The lack of clarity over arrangements for healthcare after the UK exits from the European Union worries MPs. The Commons Health Committee called on Mr Hunt to provide greater clarity on his department's post-Brexit plans. The Department of Health and Social Care should publish its contingency plans to protect patients, NHS services and the UK life science industry, it said. There was a need to protect the supply of medical products.

Meanwhile, NHS Employers, NHS Providers and the Shelford Group of leading academic medical centres, known collectively as the Cavendish Coalition, warned that fewer healthcare providers are planning to recruit staff from European Union countries. Its survey also said 41% of respondents now feel Brexit will have a negative effect on the workforce compared with 19% just after the vote.

The Department announced that health charges for temporary migrants will double to £400 a year. The surcharge for students and those with visas through the Youth Mobility Scheme will rise from £150 to £200 a year. It is paid by those from outside the European Economic Area who wish to live in the UK for more than six months. The Department said this could raise an extra £220m for the NHS. It estimates that the NHS spends an average of £470 a year treating each surcharge payer. The new charges are due to be introduced later this year.

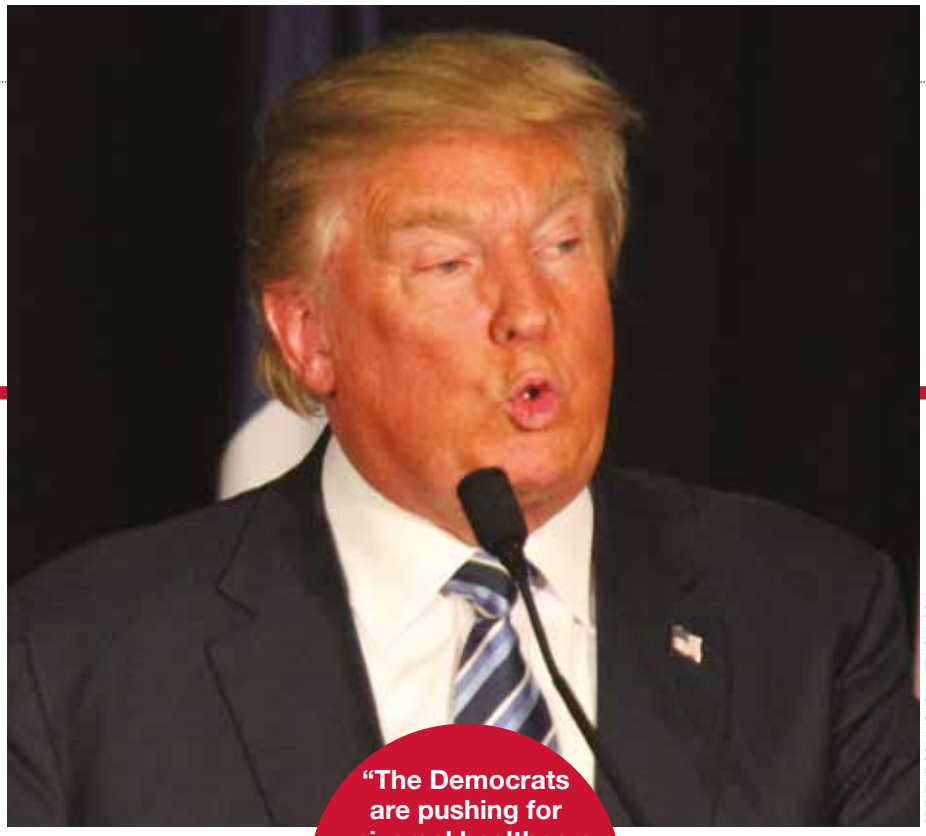
## The month in quotes

'The Democrats are pushing for universal healthcare while thousands of people are marching in the UK because their U system is going broke and not working. Dems want to greatly raise taxes for really bad and non-personal medical care. No thanks!'
**US president Donald Trump brings the NHS into a domestic dispute over universal healthcare…**

**…But health and social care secretary Jeremy Hunt defends the NHS, pointing out deficiencies in the US system**
'I may disagree with claims made on that march but not ONE of them wants to live in a system where 28m people have no cover. NHS may have challenges but I'm proud to be from the country that invented universal coverage – where all get care no matter the size of their bank balance.'

**'A disorderly UK exit could result in an immediate impact on the supply of essential medicines and medical products, both in the UK and the EU27.'**
**Commons Health Committee Sarah Wollaston calls for clarity on the government's Brexit preparations and the position of the remaining 27 nations**

**'When the committee agreed to carry out this inquiry, members expected to investigate different ways groundbreaking and innovative technologies could make dramatic changes to the way the health and social care sector operates. Instead, we've heard how barriers are preventing change.'**
**Scottish Parliament Health and Sport Committee convener Lewis Macdonald asks the government to 'be bold' in backing innovative technology**



CREATIVE COMMONS/MATT JOHNSON

**"The Democrats are pushing for universal healthcare while thousands of people march in the UK because their system is broke"**
**Donald Trump**

Barking, Havering and Redbridge University Hospitals NHS Trust has been placed in special measures for financial reasons. NHS Improvement said this was following a reported rapid and significant deterioration in its finances over the past few months. A financial improvement director has been appointed to help the trust, and the organisation will draw up and deliver a plan to improve its finances, the oversight body added.

Trusts are cautious over the *Getting it right first time* (GIRFT) programme's ambition to save £1.4bn a year by 2020/21, according to NHS Providers. However, providers support the scheme and believe it is an important first step to tackling unwarranted variation. A small survey said that GIRFT should support trusts to deliver productivity improvements and national bodies should set realistic targets for savings together with timescales that reflect wider pressures, including financial and workforce issues.

A £100m fund will be used to implement the recommendations of the Welsh Parliamentary review of health and social care. The review recommended greater integration and an increased role for value-based care. Health secretary Vaughan Gething said the funding, first announced in the Welsh Budget, would not be used to offset pressures that should be managed through increased efficiency. Instead, it would drive forward the report's recommendations and invest in a small number of projects that would have the greatest impact in developing and delivering new models of transformed services.

NHS England estimates it will cost £2.4m to review thousands of items of misdirected clinical correspondence, according to a National Audit Office report. It is believed that at least 374,000 clinical letters, including test results, which were sent to the wrong GP, were then forwarded to Capita. The firm is the current provider of primary care support services but has no contractual responsibility for redirecting clinical correspondence. NHS England has identified more than 1,800 high-priority items, such as test results, and after an initial review sent more than 18,000 letters to the correct GPs for review. No harm to patients has yet been identified. However, GPs are still erroneously sending clinical correspondence to Capita at a rate of 5,000-10,000 items a month. NHS England is planning an information campaign to urge GPs to return correspondence about patients not registered at their practice to the sender to comply with legislation and NHS England information governance.

The Scottish Parliament Health and Sport Committee called on the Scottish government to remove barriers to allow the NHS to use innovative technology in the delivery of care to patients. It said some services should be delivered centrally and the government should adopt a 'once for Scotland' approach in its forthcoming digital care strategy.

## from the hfma

**The NHS could learn a lot from the attempts in New York State to introduce integrated healthcare underpinned by a reformed payment system, according to HFMA chief executive Mark Knight. He has been blogging on a trip to the United States to attend a symposium on the Delivery System Reform Incentive Programme. The programme aims to reform Medicaid, the healthcare system available to those on lower incomes, and reduce its cost.**

The HFMA has produced a briefing on the update to the 2017/19 planning guidance, published at the end of last week. *Refreshing NHS plans for 2018/19: a summary* looks at the key issues in the updated planning guidance for HFMA members. These include: how the additional revenue funding announced in the November Budget is to be allocated; contract and operating plan requirements; and the financial framework. The four-page briefing also looks at integrated care systems (formerly accountable care organisations/systems).

**In a complementary blog, HFMA immediate past president Mark Orchard (left) looks at the planning guidance from the perspective of one of the emerging early integrated care systems. The refreshed guidance may include name changes, but also provides a national solution for binding patches together, he says.**

The association also published its regular briefing on financial reporting, which looks at changes and developments in accounting standards. A further briefing on the year-end is based on issues raised at the recent pre-accounts planning conferences.

# News analysis

## Headline issues in the spotlight

# Bleak outlook

**Quarter three figures reveal the impact that rising demand and staffing pressures have had on providers' financial position. Steve Brown reports**

One of the 'most challenging winter periods that the NHS has had, with demand rising significantly' has had a 'material impact on NHS finances' , according to NHS Improvement's quarter three (Q3) report of the performance of the provider sector in 2017/18.

Providers reported a year-to-date deficit of £1,281m – £365m worse than the plan for this point in the year – and a £222m deterioration compared with the Q2 position. They also projected a year-end deficit of £931m. This is £435m worse than the planned year-end deficit and £308m worse than the Q2 forecast deficit.

Operationally, the regulator praised NHS providers. The 5.6 million people who visited accident and emergency departments over the October to December period represented an increase of a quarter of a million compared with the same period last year. And NHS Improvement confirmed this year as the 'most significant flu season since the winter of 2010/11'.

Despite this record demand for services, providers kept the year-to-date A&E performance steady at a national level compared with the same three quarters last year. While performance remains below the required national standard, NHS Improvement said the NHS appeared to have stopped the year-on-year decline seen during recent years.

The increase in A&E footfall generated 400,000 emergency admissions in December – 5.9% more than in December 2016. And to boost capacity to deal with the increased emergency demand, some trusts reduced planned elective activity, in line with the National Emergency Pressures Panel's recommendation.

Despite this, at Q3 providers reported income £254m above plan, with a £366m overperformance on patient care income and a £112m underperformance on other income. This latter amount includes a £310m shortfall on the £879m planned income from the sustainability and transformation fund (STF) by this point.

Within patient care income, an increase in non-elective and A&E income of £294m above plan was almost exactly matched by shortfalls on non-elective and outpatient income.

Trusts received 70% of an additional £337m winter funding, announced in November's Budget. Although this is included in forecast positions at Q3, NHS Improvement said the forecast income position had not increased by this value. It said this was due to trusts suspending non-urgent elective procedures in January to free up beds and clinical time to support non-elective care over winter.

NHS Improvement acknowledged that 'expenditure tends to exceed income' for higher-than-planned levels of emergency activity, while income typically exceeds expenditure for elective (*see A winter's tale, page 19*).

The Q3 figures appear to back this up. NHS Improvement said the net overspend was almost wholly attributable to the acute sector and was down to overspends on employee costs and non-pay costs of £701m and £292m. Part of the non-pay increase was linked to spending £144m more than planned on healthcare from non-NHS bodies. However, trusts were forecasting non-pay spending to end up just 1% higher than the levels in 2016/17. 'In view of the inflationary pressures evident during 2017/18 [this] represents a significant achievement,' it said.

With trusts employing 1.1 million whole-time equivalents, total pay costs for the first three quarters of the year were £38,923m – £701m over budget. The overspend was driven by medical staff (£460m or 4.9%) and nursing staff (£201m or 1.3%). Acute trusts' overspending on staff increased by £373m in Q3. A significant overspend of £88m was also reported by the mental health sector.

**"It is simply not realistic or reasonable to expect the NHS to go on delivering a comprehensive universal service with inexorably rising demand and demonstrably inadequate funding"**
**Niall Dickson, NHS Confederation**

Trusts expect to end the year £1bn overspent compared with their planned staff budgets. This means forecast staff spending has deteriorated by more than £500m since Q2. However, forecast pay expenditure is only 2.4% higher than in 2016/17. Given that pay inflation was assumed to be 2.1% in the tariff, this represents only a 0.3% real-terms growth, NHS Improvement said.

Temporary staff costs remain a challenge. Of the total £701m overspend on staff, £556m relates to overspent temporary staff budgets – made up of an overspend of £664m on bank staff and a £108m underspend on agency. This suggests providers are at least being successful in increasing the use of their own staff banks rather than the more expensive agencies.

## Agency staff

NHS Improvement also pointed out that trusts' spending on agency staff was £441m (20%) down on the same period last year. And despite the big overspend on bank staff, overall temporary staff costs were down £110m (2.7%) on the same period in 2016/17. The oversight body said there were clear signs that the controls on agency spending introduced over the past two years were facilitating a greater level of workforce planning and improving value for money.

Vacancies are a big factor in trusts' need to source temporary staff and NHS Improvement is monitoring vacancy rates closely.

Medical vacancies have reduced steadily over the year, while nursing vacancies increased from Q1 to Q2 before falling in Q3. Overall for all staff, a 9% vacancy rate in Q1 (more than 102,000 WTE vacancies) has fallen to 8.4%

NHS trusts employ more than 313,000 WTE substantive nursing staff, leaving more than 35,000 vacancies. Some 90%-95% of these vacancies are currently filled by a combination of bank and agency staff.

Providers do not expect to see the annual costs

**"If trusts are asked to deliver the impossible, it's not surprising there's slippage against plan during the year"**
**Saffron Cordery, NHS Providers**

associated with blocked capacity fall significantly (with year-to-date costs just £5m down). This is despite an extra £1bn government funding for social care, some of which was to be used to reduce the volume of delayed transfers of care and free up hospital beds.

However, NHS Improvement said activity recorded over the past three months suggests progress is being made. 'This is vitally important,' it said, 'as the delivery of financial plans depends on achieving a number of key assumptions around risk management, agreed activity levels and the availability of beds.'

Cost improvement programmes (CIPs) have reduced total operating costs by £2.14bn (3.3%) – although this is £329m (13%) behind plan.

Pay cost savings are the biggest contributor to this shortfall, at £313m. Trusts expect this pay CIP gap to widen to £428m by the year end.

The oversight body also raised concerns about the continuing reliance on non-recurrent CIPs to compensate at least partly for underperformance on recurrent CIPs. While 92% of savings at this point in the year were planned to be recurrent, the actual level was just 74%.

Current forecasts suggest providers will miss their full-year savings target of £3.7bn by £392m. Even to achieve the current forecast saving outturn, trusts need to identify schemes to deliver a further £86m. There is still significant work to be done, with just 65% of the revised forecast efficiencies achieved in the first nine months.

However, trusts were at a similar point last year, offering evidence that trusts can increase delivery in the final quarter.

## Rising efficiencies

While providers remain off-target on efficiencies, their combined savings in the first three quarters are nearly £100m up on the same period last year – a 4.7% increase.

NHS Improvement has made an early calculation of the productivity of the provider sector – putting it at 1.8%. This is equivalent to productivity in 2016/17 and means the sector continues to outperform the wider economy.

The difference between efficiency savings achieved in CIPs (3.3%) and the calculated productivity is explained by the number of one-off savings initiatives in CIPs and because providers are funding investments in quality through efficiencies – these investments are not measured in cost-weighted activity.

The worsening financial position provoked further calls for a more realistic view on the level of savings services can be expected to deliver and greater recognition of levels of rising demand (see box).

With providers still facing a 4% efficiency requirement for next year, even with additional funds announced in the Budget and planning guidance (*see A fresh approach, page 16*), there seems no let-up on the efficiency ask. But there are signs of greater recognition of the unrelenting demand on all services.

Announcing the Q3 report, NHS Improvement chief executive Ian Dalton praised NHS staff for their continued hard work and acknowledged there is more hard work ahead.

'It would be unrealistic to assume the demand which has been building for a number of years is going to reverse,' he said. 'Local health systems need to work together to plan for capacity in future years that can meet the increasing levels of demand that we will continue to see.'

## Q3 reaction

**Commentators came together to call for greater reality in what the NHS should be expected to deliver within existing resources.**

**Saffron Cordery**, NHS Providers' director of policy and strategy, described a service 'pushed to the limit' and 'working at full stretch'. 'Increases in demand for treatment continue to significantly outstrip increases in NHS funding; trust savings targets remain too ambitious; and there are serious ongoing workforce shortages,' she said, adding that demand was outstripping funding in the mental health, community and ambulance sectors as well as in acute care.

She said NHS trusts were generating significant productivity gains but savings targets continued to be overambitious. 'If trusts are asked to deliver the impossible, it's not surprising there's slippage against plan during the year,' she said, calling again for a plan to address long-term funding.

King's Fund director of policy **Richard Murray** said the deterioration of the forecast deficit to £931m was 'alarming'. He also questioned the financial targets. 'While NHS Improvement is right to point to increases in demand for services as the reason for the financial difficulties, these are not pressures that have sprung up in the last few months, and they show no sign of abating,' he said.

'This underlines yet again that after the biggest funding squeeze in NHS history, the service does not have enough money or staff to do everything being asked of it.'

**Niall Dickson**, chief executive of the NHS Confederation, said the year-to-date deficit was 'just the latest evidence' of severe underfunding in health and care. 'It is simply not realistic or reasonable to expect the NHS to go on delivering a comprehensive universal service with inexorably rising demand and demonstrably inadequate funding,' he said. 'We have lurched from Budget to Budget with one futile bail out after another. It is now time for the political class to wake up and tackle the long-term funding of both health and social care.'

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# Comment

March 2018

## Workforce – what's the plan?

**Serious thinking is needed for sustaining this critical NHS resource**

HFMA president Alex Gild

**When my board reviews** our assurance framework – a document identifying key risks to the trust's strategic objectives – we all agree that workforce is our most significant risk to sustaining safe, high-quality mental health and community services in Berkshire. And this has been the case for some time.

That's saying something isn't it? It's saying our principal risk is not just about the money.

I don't think my trust is hugely different in this perspective to others. Increasingly the focus for the NHS is on workforce sustainability risk – and arguably it should be, more so than funding.

We have to ask ourselves a question in the NHS, as local system partners or in our own organisations, wherever we decide to prioritise service funding. Can we employ and retain the extra people needed to deliver those new or expanded services to meet demand and provide safe care?

As we face up to the challenging NHS funding outlook over the next few years, the reality is that we must also factor in a medium-term view of workforce availability. The risk to sustaining services is driven by issues such as comparative pay perspectives, the prohibitive cost of living and housing, filling clinical training intakes, Brexit uncertainty, increasing demand pressure on services and a continuous negative media focus putting people off joining the NHS.

These are just some of the significant inhibitors to

## Pace check

**New models of care are the priority, but development of revised payment systems should speed up**

Healthcare Finance editor Steve Brown

**The payment system in England is** broken and needs replacing. Few people would argue with this. But what will replace it and how close is the NHS to having that replacement ready?

Some areas would already say the national tariff – or payment by results, its original title – has already run its course and has in any case only reached as far as the acute sector. Activity-based contracts in some areas have given way to block arrangements with loose agreements about risk-sharing for activity overruns.

The future is likely to be about capitation-based budgets supporting place-based contracts that drive integrated care within accountable care systems (ACSs) or, to give them their new name, integrated care systems (ICSs). But the view that 'payment by results is all bad' may be too simplistic.

Matthew Style made exactly this point at the HFMA annual conference in December. The NHS England director of strategic finance warned against accountable care systems adopting simple block contracts and argued that there were benefits within payment by results that should not be lost.

**"It is time for some serious team creative thinking. What can we in finance do to help address these problems?"**

attracting and retaining staff. And, unless we do something about it, this workforce risk could threaten delivery of the NHS's forward view intentions.

While the 'macro' work gets in motion concerning national and regional workforce planning, locally we and our local partners are the ones with the potential answers or ideas. So it is time for some serious team creative thinking. What can we in finance do to help address these problems?

We need to support improvement in the accuracy and reliability of workforce plans, and our understanding of the consequent financial impact. If the majority of NHS expenditure is in our pay bill, we collectively need to get the baseline right and project with a much greater dose of reality.

A clearer, more explicit view of future workforce gaps at organisation and local system level in the medium to long term would help signal the changes needed in service models and workforce to sustain safe high quality care to patients.

We have resources tied up in historic pay budgets that will often not be spent as planned. There are high vacancy factors in some services because we can't recruit. And the use of agency staff in some service models has implications for quality.

Multidisciplinary teams often hold the key to changing service models to address projected people and skills deficits. But unrealistic or inaccurate near term workforce planning potentially hinders their ability to do this.

Draft workforce plan submissions are due early this month. These plans need to be clear about the challenge, but also signal how things will change.

In the here and now, there is the matter of how we protect, develop and sustain our existing workforce – retention really is mission-critical. One approach is lean management and associated culture change. I'll talk more about that next month. Until then keep thinking about people, because that is what our brilliant NHS is made of.

*Contact the president on president@hfma.org.uk*

The tariff has certainly led to improvements in coding and costing – which are valuable in their own right, not just because they lead to more 'accurate' payment. It has helped to reinforce good pathways through best practice tariffs and established a legitimate link between activity and costs. And it has, in some areas, helped to engage clinicians in service line management and cost improvement.

The tariff also potentially has a role going forward even if it isn't used as the main system of payment. It provides a mechanism for payment between systems where no formal contract exists – from one ICS to another, for example. And it may well provide the best initial mechanism for calculating baseline contract prices for the new capitation-budgets.

Throw out the tariff and you may be left with crudely rolling forward existing contract values and fixing capitation budgets at historic cost levels that take no account of procedure-specific service developments or efficiencies.

People often point at the UK nations outside of England. They don't have a tariff and, some argue, are therefore better placed to move services between acute, community and mental health – and perhaps even social care – as a result. There is some substance to this – and many say it is only political dogma that keeps England clinging on to the remnants of its market system.

However, it is interesting to note that the recent independent Welsh review of health and social care recommended introducing a 'more creative set of financial incentives (revenue, capital and transformation funding) such as pay for performance, pay for quality (including productivity).' It also wanted users to be empowered to choose services from different NHS providers, which implies some form of tariff or payment system for cross-health board flows.

The reality is that the future of healthcare payment is likely to involve a number of approaches. There is already good work going on to develop capitation-budgets with outcome-based incentives and risk-sharing arrangements. But it is relatively low profile.

The new models of care need to come first, which can then be underpinned by new payment approaches. However, more could be done in parallel. The service would benefit from understanding more about these emerging approaches and the relative value

**"The service would benefit from understanding more about these emerging approaches"**

between adopting an already tried approach and starting from scratch in each locality.

It would also help to have a steer from the system leaders – with NHS England, NHS Improvement and NHS Digital all having roles in currency development, pricing and cost data collection. They have not been completely silent – last year's *Whole population handbook* was helpful. But this is an area where the service could and should be making more progress and faster.

New work by consultancy PwC and the HFMA is hoping to contribute to this debate by examining how current funding flows, including the national tariff, could be changed. Finance managers are often best placed to understand what is and isn't working in the current system and what would support the development of new care models. And a survey as part of this work will offer them the chance to have their say. (See www.hfma.org.uk for more details.)

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Our NHS, your HFMA

**Brighter Together**

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# Free one day programmes for HFMA members*

## Finding fresh solutions to your challenges

Alex Gild's presidential focus this year is one of collaboration and partnership, supporting innovation and bright ideas. Forming alliances across teams, organisations, and health and care systems to improve patient services. As part of his theme, HFMA will be supporting members nationally with a series of sessions providing an opportunity to work with colleagues and explore fresh solutions to the challenges in **procurement**, **workforce** and **estates**.

### When

**Procurement**, 24 May
**Workforce**, 20 June
**Estates**, TBC November

### Where

110 Rochester Row, London

For more information and to book **HFMA.to/BT**

*Open to all but HFMA full individual members will be able to attend for free

# Securing access

SHUTTERSTOCK

**Last year's Wannacry attack has renewed the NHS focus on cyber security, but despite improvements the service will need to remain vigilant, reports Seamus Ward**

On 12 May 2017, many NHS managers' nightmares became real. They had always said it was a case of when not if the health service would be the subject of a cyber attack and sadly that prediction proved correct. While there are questions over the service's vulnerability pre-attack, the immediate response was good and over the past 10 months there have been efforts to increase investment and raise awareness of the dangers. But how well prepared is the NHS for the next attack?

While the world of cyber attacks can be a difficult one to understand, it is clear by the (some would say confusing) number of reports, standards and initiatives introduced since last May that Whitehall wants the NHS to act quickly to secure its data.

Cyber security is an issue of governance, with oversight from the national regulators, but it is also a financial issue, with the government recognising the need for investment while also warning that it could fine those organisations that are not up to standard.

Some IT experts believe the NHS got lucky with Wannacry – it hit on a Friday, minimising the number of operations and outpatient appointments affected, while a UK-based IT researcher was able to identify and use a kill-switch quickly, limiting the impact of the virus.

Even so, in England 603 primary care and other organisations, including 595 of the 7,454 GP practices, were affected. There are no reports of harm to patients, though operations and appointments were postponed, five trusts diverted patients away from their emergency departments and some experienced issues with their diagnostic imaging machines. More than 1,200 diagnostic machines with vulnerable operating systems were affected directly by Wannacry, with others disconnected to prevent the infection spreading.

In the immediate aftermath of the attack, the health service's vulnerability was blamed on a lack of funding and outdated operating systems that had not been patched – received a software fix. This particularly focused on Windows XP. However, the attack was not made against old, unsupported software but against unpatched devices – most of those affected were running an unpatched Windows 7 operating system, according to William Smart, chief information officer for the health and social care system in England.

At the time of the attack, around 4.7% of NHS devices used Windows XP, but this fell to 1.8% in January 2018. With support for Windows 7 operating system due to end in 2020, the Department of Health and Social Care has urged organisations to review their systems and take action.

NHS Digital had introduced a system, known as CareCert, to alert trusts and the wider NHS to threats and help them respond. But none of the 80 trusts affected by Wannacry had implemented a Microsoft patch to address the vulnerability exploited by the virus, despite an alert issued by CareCert more than two weeks before the attack. Even without the patch, Mr Smart says stronger security within the N3 network (the NHS broadband network) would have mitigated against infection.

NHS Digital has introduced a further system, CareCert Collect, which requires trusts

and commissioning support units (on behalf of clinical commissioning groups) to report on action taken to mitigate high-severity CareCert alerts – for example, by implementing security patches or updating anti-virus software.

The government has formally accepted the national data guardian's 10 data security standards. These aim to ensure confidential personal information is handled securely and organisations proactively prevent breaches – for example, by ensuring technology is up to date. Mr Smart says adherence to the 10 data security standards would have significantly mitigated the impact of Wannacry.

## Extra funding

There is also additional funding. The board responsible for the £4bn *Personalised health and care 2020* technology programme reprioritised £21m in capital for 32 major trauma centres and ambulance trusts to upgrade firewalls and network infrastructure and support transition from outdated hardware and operating systems. This will minimise the risk to medical devices, such as MRI scanners, and improve anti-virus protection.

Another £25m of capital funding has been allocated in 2017/18 for organisations that have self-certified they are not compliant against high-severity CareCert alerts.

A further reprioritisation process is looking at NHS IT budgets to identify additional funding between 2018/19 and 2020/21 – so far £150m has been found for investment in local and national systems to improve monitoring, resilience and response. However, the Department says local organisations must commit capital and revenue funding to maintain and refresh their own IT estates and ensure they are using operating systems that are supported with updates or patches.

On-site cyber assessments have identified that most NHS trusts need capital investment in areas such as upgrading firewalls, improving network resilience and segmentation – separating vulnerable systems from the main network – to minimise the risk to medical equipment.

The government also plans to introduce fines of up to £17m for organisations that provide critical services – including some NHS bodies – but do not meet the European Union cyber security standards. The directive, known as the Network and Information Systems (NIS) standards, will apply to all providers, including health boards in Scotland and Wales. The Department of Culture, Media and Sport, which is overseeing implementation of the NIS, told *Healthcare Finance* that NHS bodies would only be fined as a last resort.

Gary Colman, head of IT audit and assurance at the West Midlands Ambulance Service NHS Foundation Trust, says NHS organisations have increased their focus on cyber security since the attack. A dedicated unit at the ambulance trust provides information security and assurance services to NHS organisations and other public and private sector bodies.

He says if trusts are taking reasonable steps to improve their cyber security, the likelihood of facing a financial penalty is low. Support and a more proactive approach by NHS Digital – flagging up threats and suggesting fixes – is a step in the right direction, he adds.

'The level of patching operations has improved. But IT isn't something that just happens – you have to think about the security and governance aspect of it.'

In his February report on lessons learned from Wannacry, Mr Smart, the health and care CIO in England, outlines a number of actions to improve cyber security. These include considering data security as part of segmentation under the single oversight framework and as part of decision-making on special measures under the standard NHS Improvement framework. NHS Improvement could introduce these measures this summer.

He adds that, by 31 March 2019, all health and social care organisations that provide NHS care through the NHS Standard Contract must provide NHS Digital with details of their position against the Data Security Protection Toolkit. This will help audit compliance against the 10 security standards and the Care Quality Commission well-led assessment.

Position statements are expected to include an action plan setting out how organisations will address any shortfalls in their compliance and plans for the General Data Protection

## Minimising the threat

University Hospitals of Morecambe Bay NHS Foundation Trust had taken serious action on cyber security, with a weekly threat assessment and protocols to patch its networked devices regularly, but it was still hit by the Wannacry attack.

The trust is connected to a shared network across the North West and, once the virus was in the network, it moved quickly to infect machines at the trust. Nevertheless, only 0.5% of the trust's PCs (including those the trust supports in local general practices) were affected. This was because the patch that closed the vulnerability exploited by Wannacry was applied to most PCs as part of its regular patching policy, explains trust chief information officer Andy Wicks.

Servers for some critical clinical systems, such as pathology, were affected in the attack on Friday 12 May, but were back up and running by the Monday morning.

To minimise the impact on patient care, pre-Wannacry these systems were not patched immediately unless a review of the weekly NHS Digital's weekly CareCert bulletin raised a high-severity alarm, Mr Wicks says. Vulnerabilities classed as medium risk (including that used by Wannacry) and low risk were patched on an ad hoc basis, when time could be negotiated with users.

The trust has changed this policy and, while continuing its weekly threat assessment, all servers are now patched every month. This includes critical systems, which are patched out-of-hours to minimise disruption. Working with senior operational leaders, the IT team has also reviewed its list of priority systems, ensuring vital systems are fixed first in the case of an attack. It has also developed a tool that flags up where patches have not been applied.

'I think we are well prepared, and I can say that with confidence because of how our regular patching led to a low PC infection rate. We understand why some servers were affected and we have taken steps to address that.'

He adds that NHS organisations must keep up to date with operating systems, which would be most cost-effective through a national licence agreement with Microsoft.

'In the absence of a national agreement, it is important trusts prioritise the necessary funding to access the latest operating systems from Microsoft, which are more secure and less vulnerable.'

**"The level of patching operations has improved. But IT isn't something that just happens – you have to think about the security and governance aspect of it"**

**Gary Colman, West Midlands Ambulance Service NHS Foundation Trust**

Regulation (GDPR) to be implemented in May. This European legislation aims to protect personal information, with hefty fines for non-compliance.

The CQC is making unannounced inspections solely on cyber issues and NHS Improvement will take regulatory action as required. As a minimum, by the end of June all NHS organisations should develop action plans to comply with the government-backed Cyber Essentials Plus standard, which includes security controls, by June 2021.

NHS Digital has completed 200 on-site assessments of trusts and all have failed. 'There are reasons for that – it's not a case of the trusts have done nothing around cyber security,' deputy chief executive Rob Shaw told a recent Commons Public Accounts Committee hearing. 'The amount of effort it takes from NHS providers in such a complex estate to reach the Cyber Essentials Plus standard is quite a high bar. I always think it's better to have information about your vulnerabilities so you can do something about them rather than hope you'll be okay when you do get an attack.'

Mr Colman says attacks borne by malicious links in emails remain a threat. 'Staff awareness is still low. You could spend thousands on security, but if one user clicks on the wrong attachment you could be in difficulty.' Progress has been made. NHS Digital says there were two similar attacks in the weeks following Wannacry, but no health organisation was affected due to the mitigating action that had taken place.

Even so, Mr Shaw told the committee: 'We will never mitigate against all cyber attacks. We've got to be honest about that. I cannot understate the complexity of some NHS estates and the complexity of patching different parts of it, because you can patch one part of it that can have an impact on something else.'

## Weighing up the risks

A patch could mean a key element of a clinical system stops working as effectively. The question then is over the risk of not patching, including potential remedial action, versus the need for the clinical system. 'We have to accept some things will get through that will cause cyber attacks on the NHS and social care. How we respond to those becomes crucial,' he said.

Peter Sheppard, head of cyber assurance at business assurance services provider TIAA, agrees that clinical applications in medical devices pose a problem for trusts, particularly when they are internet enabled. Generally, there is no requirement for the vendors to update software to prevent cyber attacks.

Mr Sheppard says the standard procurement terms and conditions must be changed to include updates and patches. 'We aren't seeing a huge amount of assurance, but we're not talking about science fiction here. You can envisage the scenario where a medical device connected to the internet is used to leverage another attack or cause someone harm. NHS organisations are starting to wake up to that.

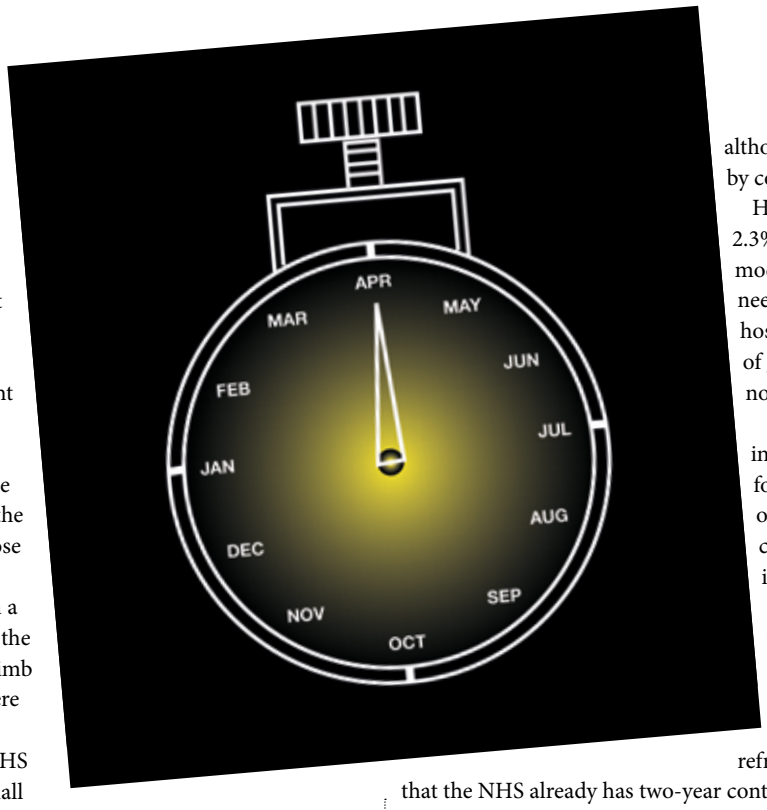
'The chief executive of the National Cyber Security Centre has warned we are facing a category one event – Wannacry was a category two. A category one will affect or put at risk patient safety.'

It has recently been revealed that there is a vulnerability in the chips used in many computers, and that would-be hackers with little technical knowledge can buy off-the-shelf software to attack organisations or individuals.

In the past experts said it was a case of when, not if, the NHS would suffer a widespread attack. It's still the case, but keeping up with cyber threats is like a game of whack-a-mole – knock down one and another pops up.

# a fresh approach

**Refreshed planning guidance in February unveiled how extra funds will be allocated, set expectations for what can be delivered and described the next steps towards system working. Steve Brown reports**




The publication of refreshed planning guidance for 2018/19 was welcomed across the NHS. This was not only because local health economies have been waiting since November's Budget for details about how additional funds will be shared out. It was also because the guidance brought with it some extra good news – a further increase in the resources available to local bodies and some pragmatic decisions about what the service can deliver, even with those increased funds.

But while there may have been a small sigh of relief, it stills leaves the NHS with a huge mountain to climb – as numerous commentators were quick to point out.

'At least this is realistic,' says NHS Confederation chief executive Niall Dickson. 'To have expected the NHS to deliver more than has been achieved this year would have been to raise expectations and place further burdens on frontline care. It will be an immense task just to stabilise the service in the coming financial year.'

Saffron Cordery, director of policy and strategy and deputy chief executive of NHS Providers, adds: 'Holding performance and meeting the required financial task is at the top end of what can be expected.'

The realism that both commentators refer to is a rolling forward of access targets by a year. In aggregate, providers will need to be seeing 90% of A&E attenders within four hours by September 2018, with a majority then achieving 95% by March 2019 and a complete return to the 95% performance standard during 2019. On elective surgery, health economies should target a reduction in the number of patients waiting over 52 weeks and the number of patients on an incomplete pathway should be no higher in March 2019 than in March 2018.

NHS England's board paper said that allocations for 2018/19 allowed for a non-elective increase of 2.3% and 1.1% in A&E attendances – although growth patterns would vary by commissioner and provider.

However, hidden in the overall 2.3% figure was a trend of more modest growth for admissions needing an overnight stay in hospital and much higher levels of growth involving zero-day non-elective spells.

CCGs will also be given incentives to moderate demand for emergency care, with £210m of their quality premium funding contingent on managing growth in line with the agreed plan.

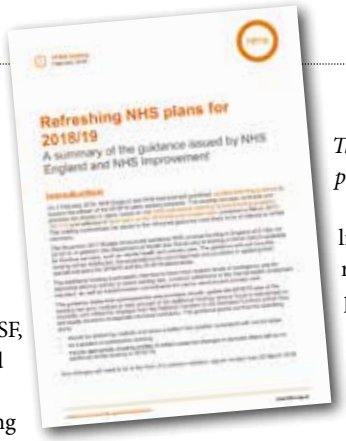
For electives, the assumption is that outpatient attendances will increase by 4.9% and elective admissions by 3.6%.

Perhaps the key trigger for refreshed planning guidance – given that the NHS already has two-year contracts in place based on two-year planning guidance issued in September 2016 – was the additional £1.6bn announced in November's Budget for 2018/19.

In unveiling how this will be distributed, *Refreshing NHS plans for 2018/19* – published jointly by NHS England and NHS Improvement – also adds an additional £540m into the mix, made available by the Department of Health and Social Care.

That means an increase of £2.14bn compared with the 2015 spending review figure for 2018/19. Total growth compared with 2017/18 (not taking account of the non-recurrent additional funding for 2017/18 announced in the Budget) now amounts to £4.6bn, equivalent to 4.2% cash or 2.4% in real terms.

The extra £2.14bn breaks down into an additional £603m for clinical commissioning groups, with a further £400m creating a commissioner sustainability fund (CSF). Specialised services receive an additional £354m and the provider sustainability fund (PSF, a rebrand of the former sustainability and transformation fund) gets a further £650m on top of its existing £1.8bn (see table).




*The HFMA has published a summary of the planning guidance at www.hfma.org.uk*

In fact, NHS England says the resources available to CCGs will increase by £1.4bn – enabling them to fund 'realistic levels of emergency activity in plans, the additional elective activity necessary to tackle waiting lists, universal adherence to the mental health investment standard and transformation commitments for cancer services and primary care'.

On top of the £603m increase in allocations and the new £400m CSF, NHS England has removed the requirement for CCGs to underspend 0.5% of their allocations to create a system reserve. This increases the resources available to spend by a further £370m. (While not increasing overall funds, the requirement to spend a further 0.5% of allocations on non-recurrent items of expenditure has also been removed.)

The £603m is being distributed on the basis of simple fair shares, in proportion to CCGs' target allocations, which have been updated to reflect the latest population estimates.

Speaking to the NHS England board a week after the guidance was published, chief financial officer Paul Baumann said it would not have been appropriate to assign the money in a more differential way on this occasion, as all CCGs were facing current pressures. However, one CCG – South Worcestershire – has also received an additional £1.1m to ensure that it joins all other CCGs in being no more than 5% below its updated target allocation.

As part of a commitment to protect planned investment in mental health, cancer and primary care, CCGs will all be required to meet the mental health investment standard (where mental health funding grows faster than a CCG's overall funding growth). With the centre clearly taking this issue seriously, CCG auditors will be asked to validate the achievement of this standard

The £400m CSF mirrors the financial framework for providers and provides a targeted fund to support CCGs that would otherwise be unable to live within their means in 2018/19. All CCGs are being given control totals and any that have been set a deficit control total will be eligible for the CSF. The idea is that CSF allocations will be set at a level to enable the CCG to achieve in-year balance and will be conditional on delivery of the control total.

According to Mr Baumann, there are about 50 CCGs implementing recovery plans to eliminate structural deficits. The new fund would be used in cases where 'even with stringent measures to close the gap', it would take longer than one year to do so.

'Rather than leave them to rack up ever bigger accumulated deficits – some of which are now reaching proportions that mean they have little chance of repaying them over any reasonable period – we are proposing to provide non-recurrent funding equivalent to their in-year deficit in 2018/19,' Mr Baumann told the board meeting.

While there were obvious rewards for the CCGs concerned, the whole system would benefit. 'The amount of national resource consumed by the most challenged CCGs will be minimised and over time there will be more money for routine allocations and drawdown of historical surpluses for CCGs that have them.'

## STF rebranding

The provider sector was forecasting a £623m deficit at Q2 after taking account of use of the existing £1.8bn sustainability and transformation fund (STF). So, to meet the pledge agreed at the NHS England board in November – to 'deal with current levels of unfunded care (deficits) that need funding going into next year' – the STF has been increased to £2.45bn in 2018/19 and rebranded as the PSF. This also creates the headroom to remove the 0.5% system reserve requirement on CCGs, which in 2017/18 will still be needed to offset the provider overspend.

Together, the increase to the PSF and the new CSF mean an additional £1.05bn is being made available to support the costs of care currently being provided. With these funds, NHS England is clear that 'the CCG sector is expected to achieve budget balance in 2018/19', and NHS Improvement has specified that the trust sector will do the same.

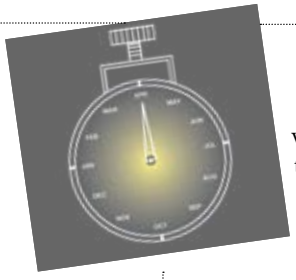
As in the current year, 30% of the PSF will be linked to A&E performance – with providers having to achieve 90% on the four-hour wait target or beat their performance in the equivalent quarter of 2017/18, whichever is better. The remaining 70% is linked to the control total. Providers accepting their control totals will continue to be exempt from a number of agreed contractual performance sanctions, except those relating to mixed-sex accommodation, cancelled operations, healthcare-associated infections and the duty of candour.

On capital, the planning document highlights the extra £354m of public capital in 2018/19, announced in the autumn Budget. However, it added: 'STPs and providers should not assume any capital resource above the level in the current 2018/19 operating plans unless NHS

## NHS England: How the £2.14bn breaks down

| | 2017/18* allocation pre-Budget £m | 2018/19* allocation pre-Budget £m | Previously planned growth £m | 2018/19 additional allocation £m | 2018/19 final allocation | Total growth | Revised growth % |
|---|---|---|---|---|---|---|---|
| **CCGs** | 73,450 | 74,996 | 1,546 | 603 | 75,599 | 2,149 | 2.9 |
| **CSF** | 0 | 0 | 0 | 400 | 400 | 400 | n/a |
| **General practice** | 7,815 | 8,127 | 312 | 0 | 8,127 | 312 | 4.0 |
| **Specialised services** | 16,602 | 17,339 | 737 | 354 | 17,693 | 1,092 | 6.6 |
| **PSF** | 1,800 | 1,800 | 0 | 650 | 2,450 | 650 | 36.1 |
| **Other direct** | 6,684 | 6,653 | -32 | 71 | 6,724 | 39 | 0.6 |
| **Other NHS England** | 2,949 | 2,886 | -63 | 61 | 2,947 | -2 | -0.1 |
| **Total** | 109,300 | 111,800 | 2,500 | 2,140 | 113,940 | 4,640 | 4.2 |

* as at October 2017



England or NHS Improvement have given written confirmation of additional resource.'

Approval of additional STP capital will be contingent on a 'compelling estates and capital plan'. Plans will need to demonstrate value for money and savings to the STP over a reasonable payback period. STPs will also have to demonstrate they are maximising opportunities for self-funding using their own capital and receipts from land disposals and are 'fully considering the use of private finance'.

## Local payment reform

The tariff – set for two years starting from 2017/18 – remains in place, although local systems are encouraged to consider local payment reform. There is a particular push for payment systems to support advice and guidance services. Local tariffs should also be introduced for emergency ambulatory care to replace current A&E and non-elective tariffs for appropriate conditions (see *Healthcare Finance,* September 2017, page 23).

The allocations allow for a 1% headline pay settlement and so do not reflect any increased pressure that would arise from the government's commitment to raise the current pay ceiling.

Growth on specialised services has increased from the previously planned 4.4% to 6.6%. The additional £354m in part reflects an updated review of new drugs likely to receive NICE approval. However, it is recognised that staying within budget will still require a substantial programme of planned efficiencies and 'the consideration of affordability constraints'.

The planned 2018/19 allocation for general practice has been maintained but not increased further, as these commitments were seen as sufficient to cover expected cost uplifts and extended access targets set out in the *General practice forward view*.

The joint planning document puts a focus on system working, calling for more system-wide estates reviews and for efficiency opportunities to be looked for across organisational boundaries – for example, by reducing avoidable demand and sharing clinical support and back office functions. STPs are also expected to strengthen governance arrangements and improve engagement with communities and other partners.

It also introduces integrated care systems (ICSs) as the new name for devolved health and care systems and accountable care systems. The recent associations of the accountable care description with accountable care organisations in the US have made the term toxic and the relabelling provides an opportunity to market the new ICSs. They are described as being 'where health and care organisations voluntarily come together to provide services for a defined population'.

There is a clear attempt to put clear water between the systems approach and any suggestion of encouraging greater private sector involvement in the health service providing whole packages of care to populations. The eight shadow ACSs – plus the two devolved health and care systems, Manchester and Surrey Heartlands – have been asked to prepare a single system operation plan narrative that encompasses CCGs and NHS providers, rather than provide individual organisation plan narratives.

This narrative should align key assumptions on income, expenditure, activity and workforce between commissioners and providers. Having a credible plan to deliver a system control total will be a condition of becoming operational. And this will be overseen by a new oversight approach by NHS England and NHS Improvement, focusing on the assurance of system plans rather than organisation-level plans.

Within ICSs, individual organisations will be able to vary their individual control totals, with agreement from the oversight bodies, as long as the system control total is met. Systems will be encouraged to adopt a system-based approach to the PSF and CSF, under which no payment is made unless the system as a whole has delivered against its system control total. If the system achieves its target but individual organisations do not, the system will still receive its sustainability funding, but NHS England and NHS Improvement will have a role in how the funds will be shared.

In return for adopting this system-wide approach, a system would enjoy a 'more autonomous regulatory relationship' with regulators. If an organisation within an ICS is subject to intervention, the system leaders could have a key role in agreeing what remedial action to take.

King's Fund director of policy Richard Murray believes this could be an important new lever. 'This holds out the possibility that where intervention is needed, ICS leads will decide what to do and the national bodies will then carry out their instructions,' he says. 'We must see how this new offer plays out, but it could be a game-changer in terms of ICS powers and the relationship with the centre.'

This system incentive structure will be mandatory for ICSs by 2019/20. In the meantime, systems may opt for an interim approach where only the additional funding put into the PSF (£650m in aggregate) is linked to system financial performance.

NHS Providers' Ms Cordery says it was helpful to get further guidance on how system working is expected to develop. 'But we would like to see a more formal and extensive engagement and consultation process on the national policy direction, along with more clarity on support for local systems which, for good reason, are finding this transition difficult,' she said. 'We also need realism on how fast the required transformation will occur, given how much less we are investing in change compared to the assumptions made when the *Five-year forward view* was created.'

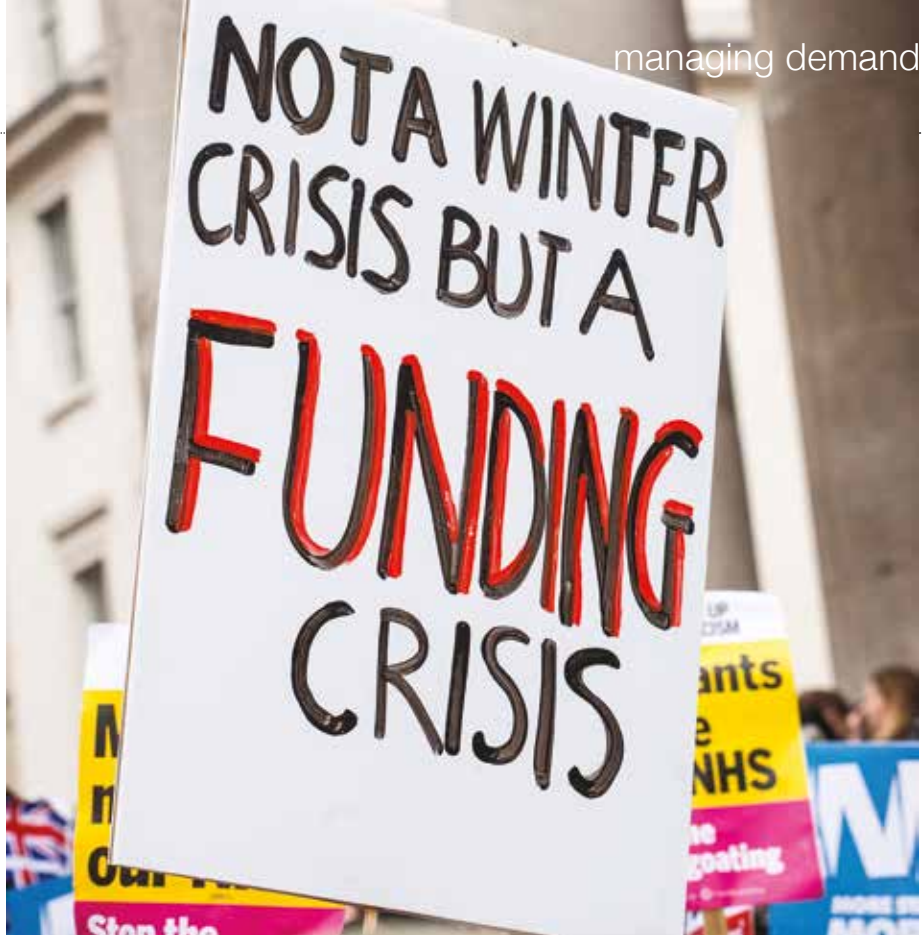
**"We need realism on how fast the transformation will occur, given how much less we are investing in change compared to the assumptions in the *Five-year forward view*"**
**Saffron Cordery, NHS Providers**

Draft organisational operating plans need to be submitted by 8 March, with board-approved plans following on 30 April.

There appears to be a lot of support for the general approach. Commentators remain supportive of the push towards more integrated care and system working. And the steps towards real system incentives and system regulation are seen as good moves forward. However, there remains concern that, even with the increase in funding, there is still the underlying problem of overall resourcing for the health service.

Commissioners still face 3% efficiency targets and providers more than 4% – both in line with the current year, when it is recognised that services have been stretched to the maximum.

Ms Cordery says the extra money in the Budget has simply 'turned an impossible task into an extremely difficult one'. Mr Dickson describes the guidance as providing a 'set of temporary solutions'. And both bodies are united in continuing to underline the need for a new long-term funding settlement for health and social care.




SHUTTERSTOCK

**Patients have been the sole focus for acute providers during the increased pressures this winter. But what will the financial impact be? Steve Brown reports**

# A winter's tale

Winter brings major pressures for the NHS each year, but few would deny that this year's pressures have been even more severe than usual. Ubiquitous images of patients waiting in ambulances or crowded corridors have been backed up by statistics confirming plummeting access standards, increased demand and acute hospitals working well beyond recommended capacity levels.

Official figures show December and January A&E attendances up 3.7% and 5.5% respectively on the same months a year ago. NHS Improvement's Q3 performance report said there were almost 400,000 emergency admissions via A&E in December – 5.9% more than in December 2016. And the rate of flu-confirmed hospital admissions was around three times higher than last year.

The crisis played out under full media scrutiny. And the television images have had an impact, throwing NHS funding firmly into the public and media spotlight – even provoking protest marches calling for increased funding. It arguably helped to prompt the Department of Health to find extra resources to those in November's Budget for the coming 2018/19 financial year (*see Fresh approach? page 16*)

While the service's ability to cope with winter pressures is undeniably influenced by the level of funding available, it is also true that the winter pressures themselves exacerbate the current financial position.

A tweet from NHS Providers in mid-January said the cancellation of operations that month – an officially sanctioned response to the rising non-emergency activity – would have a big impact on the end-of-year deficit, which has already increased from the forecast £623m at the halfway point in the year to £931m in the latest forecast. NHS Providers chief executive Chris Hopson had already written to health and social care secretary Jeremy Hunt raising trusts' concerns about the 'financial impact of the extra costs they have incurred and the elective income they are likely to lose'.

## Changing income

NHS Improvement's Q3 report recognised that changes in the make-up of providers' income could have a major impact on their financial position. In general, providers income from elective work is down, while non-elective activity and income is up. However, expenditure tends to exceed income for higher-than-planned levels of emergency activity, the report said, while income would typically exceed expenditure for elective work.

So what exactly are the financial impacts on the NHS of this winter's hike in demand and the service's response to it?

NHS Providers has made a lot of the loss of elective income. In theory, this is absolutely right. Under tariff (or payment by results, to give it its old name), elective activity cancelled as a result of the NHS National Emergency Pressures Panel's recommendation would lead to a loss of income associated with that work.

However, there are a number of caveats. Many trusts already plan for minimal levels of elective activity during January – so cancelling operations at this time of year has smaller impact in these bodies. However it should be said that elective income is down for the year to date overall, largely as a result of increased emergency demand through the year. Additional non-elective activity – which is filling beds and displacing the elective workload – does come with its own income. However, for areas operating under full tariff rules, this non-elective income would come in at a marginal rate of just 70%, where the activity is above planned levels.

And even in areas where the income for additional non-elective activity is higher than

the loss of income for elective, additional costs of dealing with the spike in emergencies can far outstrip the net increase in income. In some further areas, payment by results has been set aside in favour of risk share contracts, which means income won't always flex with activity.

## UHCW planning

University Hospitals Coventry and Warwickshire NHS Trust (UHCW) chief executive Andy Hardy says his trust didn't stand down much more elective activity than it usually would in this period. 'Our non-elective to elective mix is about 60:40 over the whole year, but from mid-December to end of January we have a working assumption that we will mostly do urgent cases, cancer and day cases because our beds are just full,' he says. 'So we don't think we cancelled much more than we normally would.'

The trust did attempt to keep a day surgery programme running. However, pressure for beds on some nights did lead to day-case beds being used for emergencies.

January's board papers show that contract income for the first nine months was already under plan by £1.4m. But Mr Hardy says that, having planned for limited elective work in January, the trust has not seen a huge drop in profiled income for that month. In fact, the higher level of non-elective activity may generate more income than planned.

However, this will be at the marginal rate of 70%. And while in absolute terms this may amount to more income than planned for January, Mr Hardy says it will not have covered costs. 'The challenge at 70% is that when you are having to staff up for extra beds overnight – for example, those day surgery beds – that's all at agency or premium rates. Costs are well above this 70% rate.'

On top of the agency premium for staff at short notice, Mr Hardy says there has been a clear increase in patient acuity, so length of stay goes up. This ties up beds, putting pressure on the trust's ability to admit patients as quickly as it would like, increasing bed occupancy and putting further pressure on any planned elective activity.

This increased activity piles pressure all the way back to the front door, with A&E having to cope with more attendances, fewer free beds to admit to and major staff pressures. As well as costs being higher, increased activity and pressure can also cost the trust in other ways. At month nine, UHCW's sustainability and transformation fund (STF) income had already slipped by £2.5m against a plan of £9.5m due to the failure to meet the A&E four-hour target.

Elsewhere in the country, a CCG finance director acknowledges that in his patch there is no direct reinvestment of the 30% retained from marginal rate activity back into demand management. 'However, we have diverted GPs from some of our other services into the GP streaming service at the local hospital,' he says.

**Andy Hardy and Sue Jacques: costs of extra non-elective activity outstrip income**

'And between us and the council, we made sure the hospital was empty in the run-up to Christmas, with significant investment in the out-of-hospital system around domiciliary care, GP resilience and community services. So, the investment is there – it just hasn't been badged in this way.' He adds that the money retained from the marginal rate policy is not as large as it might be, with best practice tariffs for some work meaning activity is not counted.

## Durham pressure

County Durham and Darlington NHS Foundation Trust chief executive Sue Jacques says the trust's hospitals saw significantly more activity than in previous years. Even traditionally quiet days, such as Christmas Eve, were noticeably busy this year.

She estimates this year's winter pressures have cost the trust £2m in lost income and lost efficiency. Increased activity and pressure in Q3 had already led to the trust marginally missing its A&E four-hour target, costing it £1.16m in STF funding.

Again the trust says the winter pressure-related additional costs are not predominantly down to the national recommendation to suspend elective work. 'We planned to do very little elective in the week between Christmas and new year and then the first week of 2018,' says Ms Jacques. 'But because we had a lot more emergency patients in than planned, we were making finer judgements – not blanket bans – right through to the end of January.'

As with UHCW, County Durham and Darlington was forced to use some day-case space as emergency spillover. 'We have the benefit of an elective site in Bishop Auckland, so we can keep a lot running through there,' says Ms Jacques. But she says the spike in emergency activity has still hit the trust financially.

'There are two types of inefficiency,' she says. 'We have surgeons who are not doing as much elective activity as they would otherwise, so they are not bringing in the income. Then we have patients spread around the hospital and more of them than medical teams would plan to cope with even in our winter plans. The logistics of getting patients reviewed, sorted and discharged means it is more complicated and time-consuming and that means length of stay goes up and efficiency goes down. We have simply been running too hot – well above the 85% recognised level.'

## Chesterfield action

Chesterfield Royal Hospital NHS Foundation Trust cancelled much of its elective programme in January (other than cancer and urgent cases). Finance director Lee Outhwaite says the trust has lost elective income. 'But this is highly likely to be offset by the higher non-elective income, despite the 70% marginal rate, due to the volume of non-elective cases involved.'

A January board paper reveals that by the end of December, the trust had seen underperformance on day case and elective activity, particularly within surgery. However, this amounted to an adverse variance of just £375,000 and non-elective had over-performed to the tune of £3.8m.

**"With patients spread around a hospital, getting patients sorted and discharged is more time-consuming, length of stay goes up and efficiency goes down"**

**Sue Jacques, County Durham and Darlington NHS FT**

This increased non-elective income comes at a higher cost. The board paper said the non-elective over-performance was driven by price rather than volume and predominantly within general medicine. This backs many trusts' assessment that acuity and patient frailty – particularly for patients with flu and other viral infections – have been higher this year. This manifests itself as higher length of stay and raised staff costs, for example, for increased levels of one-to-one support.

Mr Outhwaite agrees that temporary nursing staff have driven the additional costs of unscheduled care. 'To augment the other nursing staff, we have moved back to ward-based roles as per our escalation plan during winter,' he says. Extra bed capacity was opened up and some additional medical consultant capacity brought in.

One of the challenges facing all acute trusts is how to deploy staff. Cancelling an orthopaedic elective programme might create bed capacity for emergency patients. But not all the medical staff freed up can be reassigned to support increased emergency activity – or at least not to maximum efficiency.

'We've tried to schedule more outpatients to avoid stranded costs on the elective pathway,' says Mr Outhwaite.

**"We've tried to schedule more outpatients to avoid stranded costs on the elective pathway"**

**Lee Outhwaite, Chesterfield Royal Hospital NHS FT**

But equally a trust might go the other way and cancel outpatient sessions to release consultant staff to support the unscheduled workload. At UHCW, Mr Hardy says delaying clinic start times was seen as the best solution – releasing consultants to wards ahead of their normal outpatient duties.

Ms Jacques acknowledges that it is not straightforward to switch staff onto different roles – despite staff in general 'going out of their way to help in any way they can'.

'For example, with an orthopaedic consultant and their junior team, there is some trauma coming in anyway, but outside that, they can pitch in to review general and medical patients – something we do daily at the trust,' she says.

'This is clearly not as optimal as having a consultant from the right specialty. So they can help out with the general busy-ness and check that patients are being reviewed, but they can't work out the medical plan for a respiratory patient, for example.'

Some commentators have suggested asking consultants to switch supporting professional activities during periods of high non-elective demand to patient-facing activities could help. However, with many staff already going well beyond contracted hours to help out, this is not necessarily a solution.

The recommended suspension of elective care was lifted at the end of January, with the National Emergency Pressures Panel believing bed capacity was increasing and the flu position was stabilising. But there are still pressures and challenges ahead and thoughts are turning towards how a well prepared NHS could be even better prepared next year.

Some trusts are already exploring whether there are other parts of their hospitals that could be turned into emergency ward areas.

But there is recognition that the long-term solution in parallel with adequate funding is to develop a more integrated response across acute, community, primary and social care to keeping patients out of hospital and enabling faster discharge where possible.

# capital ideas

**While the government has provided additional capital funding to support transformation, STPs will also have to recycle receipts from property sales and look to the private sector. Seamus Ward reports**

The NHS in England has been selling off its surplus land and buildings for decades, largely in a piecemeal fashion. But the continuing bite of austerity, the Carter efficiency and productivity review and moves to remodel care pathways have given it fresh impetus. And, after years of nudging the service to sell surplus estate, the Department of Health and Social Care will now incentivise disposals.

The health service is one of the largest landowners in the UK. The Carter review says reducing unwarranted variation in estates use could save the NHS £1bn a year. By April 2020, all trusts should have a maximum of 2.5% unoccupied or under-used space, it said.

As well as reducing revenue costs, selling off surplus property can release capital to reinvest in the buildings and equipment the NHS will need as it moves care out of hospitals and into community settings.

Last year, a Department review of the NHS estate, led by Sir Robert Naylor, looked at under-used or unoccupied property, concluding that the NHS could dispose of this surplus estate and gain up to £2.7bn in capital receipts – perhaps more if sold with the benefit of planning permission.

Responding to the report last month, the government set out its capital funding strategy. It agreed with many of the Naylor recommendations, though it believes the NHS could receive £3.3bn from disposals over the next five years.

The Naylor report estimated £10bn will be needed over the next five years to meet new capital needs and catch up with the maintenance backlog. If disposals raise £3.3bn, the balance of almost £7bn will be made up of £3.9bn announced in last year's Budgets plus private capital.

The £3.5bn capital funding over five years announced in November's Budget, plus more than £400m in the spring Budget last year, will be allocated to a number of programmes. These include £2.6bn to support sustainability and transformation partnership (STP) estates transformation plans; £700m for critical maintenance and to help trust turnaround plans; and £200m to support efficiency programmes.

With public funding already on the table, the spotlight has been thrown onto sale of unneeded property. The government is planning changes in the NHS capital framework to incentivise both the disposal of surplus assets and the use of receipts to support local service transformation. At the same time, NHS property owners are being urged to examine the possibility of redeveloping surplus estate to provide accommodation for staff.

STPs will have a major role to play. They should produce and agree a prioritised capital investment plan. The government says that STPs will only be allowed to access capital if estates transformation is given high priority at executive level; if they can demonstrate they are pursuing all the value for money opportunities they can to generate capital funds; and if they are reducing running costs by improving estates utilisation and tacking backlog maintenance.

STPs will have to develop plans to dispose of surplus land and have clear plans for reinvesting the receipts before they can access the £3.9bn of available public capital. STPs will have to agree local targets for disposals. The government says it wishes to maximise the surplus land disposal over the next two years and if sufficient progress is not made it will consider changing capital charges or other mechanisms. STPs will be required to submit revised estate plans, including disposals, during 2018/19 and before receiving central funding.

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Though receipts from the sale of provider land or estate are generally retained by the trust, Naylor called for this policy to be clarified. The government response makes clear that NHS organisations will be allowed to retain capital receipts from land sales as long as the funds are reinvested into the NHS estate for local priorities and STP strategies.

King's Fund chief analyst Siva Anandaciva welcomes the additional funding in the last Budget. But he doubts whether the NHS will see the full £10bn promised this Parliament, and whether all parts of the country will benefit from the funding.

'There is no doubt the Treasury retains a strong desire for the NHS to sell land it no longer needs or uses to provide savings for the taxpayer,' he says. 'But that desire has been there since at least the 2015 Comprehensive Spending Review and yet we have not seen significant increases in the sale of land – showing just how difficult it is to get NHS land sales completed quickly in a way that delivers real value for the taxpayer. If a large chunk of the NHS's future capital funding depends on significant land sales, there are real doubts on whether we will actually see this funding materialise in the life of this Parliament.'

He questions whether the emphasis on selling land limits the NHS's ability to pursue more creative land leasing options that might deliver better return in the long run.

Nuffield Trust senior fellow Helen Buckingham says there may be issues associated with selling surplus NHS estate. 'If you go out to the market with the aim of selling £3bn of property, there is a risk you could depress property prices. The NHS needs to think carefully about how its assets are disposed of to get the best value. Part of doing that is thinking about the balance between maximising value and maximising public support for what you want to do. One thing that's hinted at in the Naylor review, and more strongly in the government response, is using some of the estate for housing for NHS staff.'

She suggests NHS bodies may get best value by retaining land or property, and redeveloping it in partnership with other public sector organisations as well as the private sector.

The government has declined to implement the Naylor recommendation that receipts from disposals be matched with an equivalent amount of public funding. This may be because some areas will benefit more from retaining receipts than others. The report said London STPs could realise 57% (more than £1bn) of the risk-adjusted potential receipts in the acute sector.

Ms Buckingham says the new Strategic Property Board, which will oversee delivery of the Naylor recommendations, could be important in joining up the work of national bodies. And she believes the potential disparity in capital receipts could be one of the first things the board will examine. 'It seems unfair that due to an accident of history either you don't have assets to sell or you have assets that will not generate receipts of the level you need.'

Mr Anandaciva insists there must be a clear strategy on how funding will be distributed. 'On the one hand you might allow areas that can sell surplus land to use that as their primary means of raising capital. This would allow parts of the country without that option to have greater calls on public or private funding. But it will be more complicated than that as all these sources of funding come with different risks and different likelihoods of materialising – all it would take is for a few private deals or land sales to fall through before the clamour for public funding swamps the available amounts the Treasury has set aside over the next five years.'

## Bridging arrangements

The government says trusts often postpone sales until they need the funds. To speed up the delivery of capital schemes, the government will introduce new bridging arrangements, allowing trusts to 'bank' receipts with the Department, and then draw them back, with interest, when needed to fund agreed STP priorities.

While this could create a useful pool of funds that the Department can then distribute to capital schemes that are ready to go – much like a bank uses customer savings to lend to others – experts question the government's belief that trusts hold back sales. The property market blows hot and cold, making it difficult for trusts to predict whether their surplus land or buildings will sell at a time of their choosing for the amount they expect, they say. And, holding onto a property without marking it for sale risks falling foul of accounting rules that would force a revaluation – potentially reducing the paper 'profit'.

**"If a large chunk of the NHS's capital funding depends on land sales, there are real doubts we will see this materialise in the life of this Parliament"**
**Siva Anandaciva**

The government says it will scrap rules that require trusts to pay half the profits from the sale of former primary care trust estate to the Department. It acknowledges this discouraged disposal – the change applies to all sales requiring these overage payments since 1 April 2017.

The third strand of funding – private finance – could prove problematic. Though it did not reach an overall value-for-money conclusion, a recent National Audit Office report on the private finance initiative (PFI) and PF2 found no evidence that privately financed buildings led to greater operational efficiency. There were benefits – being off-balance sheet in government accounts, potentially higher maintenance standards and bringing capital investment when funding is limited – but the NAO said some costs were higher and the deals reduced trusts' flexibility on the use of buildings.

However, ministers believe private funding, through LIFT (Local Investment Finance Trust), PF2 and other public-private partnerships, has a role to play in providing an alternative source of capital. It points in particular to the part played by LIFT schemes in building primary care facilities – over the last 14 years, LIFT has raised £2.5bn for capital investment, secured with £100m of public sector investment.

Though some commentators doubt whether significant amounts of private funding will be found, Ms Buckingham sees a role for private finance. 'Whether the £10bn figure for capital need is accurate or not, it's clear the requirement will be in excess of what the government can provide,' she says.

'The big challenge for the NHS is not access to private finance, but being able to service the revenue costs whatever form the finance takes.'

She warns the Treasury must increase the capital departmental expenditure limit (CDEL) in line with the amount of private finance attracted by the NHS or it risks restraining the available capital.

The health service needs capital funding to transform services and, although the government has allocated some funding, there are questions over how the service will find the full amount required.

## HFMA estates focus

**As part of Alex Gild's *Brighter together* presidential theme this year, the HFMA will be holding three free events for members, including one on estates. The focus is on building partnerships across teams and members will be able to bring along an estates colleague for £99. See page 29.**

**HFMA e-learning**
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# Reach for the top

**With MBAs firmly on the NHS agenda, the HFMA has established a pathway to a master of business administration qualification. Seamus Ward reports**

For years, gaining an MBA has been seen as a requirement for those seeking to get the top jobs in the commercial sector. In the NHS, while some clinicians and managers, including finance professionals, have taken the qualification, it has not been seen as an absolute necessity.

However, in November 2016 health and social care secretary Jeremy Hunt announced plans to bolster health service management skills by introducing a specialist NHS MBA. With interest in MBAs rising, the HFMA's master's-level diplomas are gaining momentum and provide a clear pathway to BPP University's recently validated MBA programme in healthcare finance.

The first HFMA students are soon to finish their higher diploma and many will be applying to complete the final part of their MBA with BPP University.

So what are the benefits of taking an MBA? The Association of MBAs – an international organisation that aims to raise the profile of postgraduate management education and the quality of MBAs – says more MBA graduates are working in the public sector. Its 2013 survey found that more than twice as many people with MBAs were working in the UK public sector than 10 years earlier – 9% of graduates from its accredited schools worked in healthcare.

It adds that there are many benefits from gaining an MBA, including higher salaries, improved career prospects and a better network of peers.

More recently, the Advent Group, an independent media agency and specialist in the higher education sector, cautioned against unrealistic expectations (especially in terms of salaries), although it believes that the future remains bright for MBA graduates.

Its 2016 survey of 2,000 prospective, current and past MBA students from countries around the world found that 45% of students believed the degree would lead to a higher salary, while 29% of graduates said they are able to increase their earnings as a result of the degree.

MBAs scored highly when it came to preparing people for their careers. Graduates said their MBA gave them greater practical skills and knowhow, specialised skills for their chosen sector and better interpersonal skills. And only 6% of specialist MBA graduates were unemployed, it added.

**"The MBA has, without question, given me a breadth of knowledge, experience and networks – all critical to the modern NHS"**
**Jane Tomkinson, Liverpool Heart and Chest Hospital NHS FT**


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A number of finance professionals in the NHS have taken MBAs and then either moved into top finance jobs or into general management as chief executive.

Jane Tomkinson, chief executive of Liverpool Heart and Chest Hospital NHS Foundation Trust, says she decided to study for an MBA primarily for development.

'I qualified as an accountant back in 1989 and have had no formal study since then. I saw it as a key qualification to respond effectively to the changing nature of the NHS and to strengthen and broaden my career options in the future.'

She took the MBA at the University of Keele. 'It was the broader private sector option with no specific health elements. However,

it was partnered with a university in the Netherlands, which was great for expanding my thinking and partnership working.'

She says the qualification has made a big impact on her career. 'The MBA has, without question, given me a breadth of knowledge, experience and networks. These are all critical to the modern NHS, its leadership and transformation.

'Following completion of the MBA I took on my first foundation trust finance director role, with system finance director roles to follow. In 2013, I was appointed as chief executive and am certain the MBA was a crucial element in this. I have encouraged former and existing colleagues to undertake an MBA,' she adds.

Andy Hardy is chief executive of University Hospitals Coventry and Warwickshire NHS Trust and a former president of the HFMA. Prior to becoming the trust's chief executive in 2010, he was the trust's chief finance officer for six years. He completed an executive MBA at the University of Birmingham prior to taking this first finance director appointment and says it was a pivotal moment in his career.

'It undoubtedly helped,' he says. 'I think mostly this was because it encouraged me to think more widely and come at things from a different angle. At that point, I had no particular plans to pursue a career outside finance – that wasn't why I took the MBA. But I do think that is when I started to think more broadly than finance – which is where I've ended up pursuing my career.'

## This year's cohort

The first cohort of HFMA learners is likely to start on the final part of their master's degree this summer.

There will also be intakes into the HFMA master's level certificate, diploma and higher diploma programmes in May and September.

NHS England and NHS Improvement bursaries are available for these HFMA qualifications and will provide up to 50% of the funding to learners who meet the criteria. Many are already benefiting from the bursaries.

It is also possible to apply for a government career development loan, which provides a reduced-interest loan of up to £10,000.

Students awarded the diploma and higher diploma gain the equivalent of 120 credits at master's level and can seek admission to the final part of the MBA programme (60 credits) through BPP University.

HFMA education director Alison Myles says the MBA programme aims to support a new generation of staff. 'The HFMA comes into its own for people focused on a career in the health service, particularly those in NHS finance, but also those in clinical, operational and other healthcare-related roles,' she says. 'This is especially important, not only because of the financial pressures facing the NHS at the moment but also because of the increased need for greater clinical-financial engagement.

'The HFMA qualifications aim to deepen the practical skills and knowledge of NHS staff as they proceed through our certificate, diploma and higher diploma in healthcare business finance, right up to the final part of the MBA with BPP University. Together with BPP, we are looking forward to seeing our first cohort of MBA students successfully graduate in 2019.'

MBAs remain a valued qualification in industry and, since receiving a ringing endorsement from the top echelons of the Department of Health and Social Care, they are also set to become increasingly important to development and career progression within the health service.

## MBA aspiration

Not only was Tracy Parker the first winner of the HFMA Tony Whitfield Award for student of the year, but she could also become one of the first learners to successfully achieve an MBA in healthcare finance.

'I am a qualified accountant and I always had in mind that, once qualified, at some stage I would take an MBA,' she says. 'I have done a fair bit of research into courses offered at local universities and at places like London Business School, but they are quite expensive. When the HFMA qualifications came along, I saw it as an opportunity to get value for money, and it's a course that's relevant to the industry I am working in.'

She is currently working on the three-module higher diploma and has completed two – *Creating and delivering value in healthcare* and *Managing the healthcare business*. She passed both with a merit, and is currently on her third, *Personal effectiveness and leadership*. If successful, she will have achieved 120 credits at master's level and will be eligible to apply to BPP University to complete the final part of the MBA.

She is hoping to begin the MBA in October. Part self-funded, she has also received a bursary from NHS England and NHS Improvement. The HFMA branches in England and the devolved nations also provide bursaries for local students.

'It is hard work and requires a lot of self-discipline, but you get out what you put in, to some extent,' she says, adding that she has built strong networks with her fellow students.

The support of the course tutors has been a key aspect of her experience of the HFMA master's degree programme. 'My tutors have given me great support and went above and beyond.'

Being nominated by a tutor (Paul Assinder) and being named the first HFMA student of the year – receiving her award from former HFMA president Tony Whitfield (pictured) – was a massive confidence boost, she says. And she believes the course has already helped her along her career path – she recently moved to become an assistant director of contracting at East Riding of Yorkshire Clinical Commissioning Group.

'I want to continue the learning. It's an opportunity to get a top job in the future. I have a lot of learning to do, and experience to get under my belt, but the course has given me such confidence.

'A year ago, I would not have been able to say out loud that my ambition was to get to finance director level.'

## HFMA qualifications

The association's master's-level qualifications are module-based:

- **Certificate** Completion of a single module (20 credits)
- **Diploma** Three modules (60 credits, usually includes *How finance works in the NHS* module)
- **Higher diploma** (For diploma holders or qualified accountants with two years' experience), three modules (60 credits, 120 credits cumulative)
- **MBA** (Higher diploma holders can apply), run by BPP University (60 credits, 180 cumulative)

hfma
# professional lives
Events, people and support for finance practitioners



# Pre-accounts: pay attention to detail ahead of future accounting changes

Technical update

As has been said before, 2017/18 is a year of little change in terms of preparing the annual report and accounts. And most of the required guidance has already been issued. Even so, *writes Debbie Paterson*, this year's HFMA pre-accounts planning conferences still provided timely reminders of key issues that should be consider in meeting end of year requirements and deadlines.

It is certainly a year to get the detail right, ahead of two busy years that will see the implementation of three new accounting standards. And although IFRSs 9, 15 and 16 are not applicable in 2017/19, their expected impact does need to be disclosed in this year's accounts because they are standards that have been issued but not yet adopted.

Some analysis of the expected impact will therefore be necessary before this financial year-end.

For NHS trusts, 2017/18 is the first year that they will be responsible for making their own submissions to NHS Improvement – so an allowance for this needs to be built into the year-end timetable. NHS Improvement has produced a detailed schedule of what needs to be sent where and in what format.

All of the regulators encountered problems last year when the summarisation schedules that they were using were not the same as the ones auditors submitted to the National Audit Office. The message here is to remember to send your auditors the final, final version – particularly where late changes have been made to the accounts.

The sustainability and transformation fund (STF) process will be the same as last year, although some of the details about the calculation are still to be resolved. The final STF apportionment cannot be calculated until the draft results are submitted, so it is vital that those draft results are as accurate as possible.

A change to one NHS body's position can affect many others as the STF apportionment is recalculated. The closeness of some NHS bodies' financial position to their control totals adds an extra risk – a small change in an estimate or balance can have a much larger impact if it has an impact on the achievement of a control total.

Disclosures around significant judgements and estimates may well be the focus of auditors' attention. This is partly because of the closeness to meeting control totals and the resulting impact on STF income, but also because this is an area that the Financial Reporting Council has identified could be done better in all financial statements.

The financial position of NHS bodies raises the profile of management's consideration of going concern and, in particular, the disclosures around significant risks to that position.

Agreement of balances remains a key risk for the overall group consolidation and, although the process is as smooth as it has ever been, there is always room for improvement. The message here is: please read and follow the guidance.

One completely new transaction for 2017/18 is the apprenticeship levy. This is to be accounted for as a tax as it is incurred. The use of the levy also needs to be reflected in the accounts and that will be different depending on whether the NHS body is a provider of training or not.

For clinical commissioning groups, the guidance on completion of note 45, on purchase of non-NHS healthcare, is being amended. The information in this note is disclosed in both NHS England and the Department of Health and Social Care's accounts and is the subject of lots of external scrutiny.

In the staff report, the off-payroll disclosures have been amended as a result of the changes to the IR35 rules (see HFMA September 2017 briefing, *Off payroll: reform of the intermediaries (IR35) legislation* at www.hfma.org.uk).

In addition, the threshold for reporting has been increased to those engagements costing more than £245 per day.

**Debbie Paterson is an HFMA technical editor**

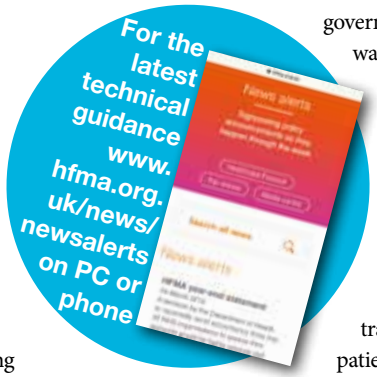
SHUTTERSTOCK

# Technical review

## The past month's key technical developments

**Technical roundup**

The HFMA has updated its briefing *Reporting on environmental sustainability* to cover changes and latest guidance for 2017/18. It identifies the sources that require NHS bodies to **report their environmental impact** and their progress on climate change targets. In particular, it looks at requirements and guidance in the NHS standard contract, the Department of Health and Social Care's *Group accounting manual* and NHS Improvement's *Annual reporting manual* for foundation trusts. It also looks at where the Department's environmental reporting duties arise.




A change in rules last October mean it is now mandatory to collect payment upfront from any chargeable patient that is not in need of urgent or emergency care. New guidance from NHS Improvement and NHS England – *Improving systems for cost recovery for overseas visitors* – explains how changed risk-share arrangements now operate and how they should be accounted for and the actions expected of providers and commissioners. Although initial guidance was published in 2015, the new **visitor cost recovery** guidance reflects subsequent changes. In particular new regulations now require providers to make and collect an initial estimate of the whole cost of the care or treatment before the care begins. Chargeable visitors from non-European Economic Area countries should be charged 150% of tariff prices.

The HFMA has published an updated version of its ***Audit committee handbook***. Last published in 2014, the new edition takes account of key changes in the NHS in recent years. In particular, a new chapter covers the implications of partnership working at scale. The handbook explores the most common new arrangements – alliances of providers working together, clinical commissioning group committees in common and shared back office arrangements – and looks at how the audit committee should approach them and their associated risk. It also looks at the broader governance implications of system working. The new guide was due to be published towards the end of February.


NHS Improvement confirmed that it will not be collecting **education and training costs** this year and has published a transitional method for 2017/18 for netting off education and training income from both patient-level costs and reference costs. The guidance should be used by acute early implementers of the new patient-level costing approach being implemented as part of the Costing Transformation Programme (CTP). Education and training costing standards are due to be published in March for use in a pilot collection. February also saw NHS Improvement announce that submitting patient-level costs for acute activity would be mandatory from the 2018/19 costing year – although trusts will be given time to achieve full compliance. New costing standards for the 2018 collection (for 2017/18) were published in the month for acute (final) and ambulance (draft) providers. Mental health and community standards will be published in the spring.

Clinical commissioning groups that have been set a deficit control total will be eligible for allocations from the new £400m **commissioner sustainability fund** (CSF) – with the value set to bring the CCG back to in-year financial balance. According to details issued alongside the refreshed planning guidance, control totals have been set with an expectation that an overspending CCG will reduce its rate of expenditure by at least 1% of allocation. Those with longstanding cumulative deficits will have to make faster improvements. Where a CCG's risk-adjusted forecast outturn for 2017/18 deteriorates after month 9, the control total may be adjusted to recoup some or all of the further deterioration.

## Myeloma treatment gets cancer fund go-ahead

**NICE update**

NICE has recommended ixazomib (with lenalidomide and dexamethasone) for use within the Cancer Drugs Fund (CDF) as an option for treating multiple myeloma in adults who have already had two or three lines of therapy, *writes Nicola Bodey*.

Myeloma, also known as multiple myeloma, is a cancer arising from plasma cells, a type of white blood cell that is made in the bone marrow.

Unlike many cancers, myeloma does not exist as a lump or tumour. Most of the symptoms and complications related to myeloma are caused by the build-up of the abnormal plasma cells in the bone marrow and the presence of the paraprotein (an antibody) in the blood and/or in the urine.

Myeloma is a relapsing-remitting cancer. This means there are periods when the myeloma is causing symptoms and/or complications and needs to be treated, followed by periods of remission or plateau where the myeloma does not cause symptoms and does not require treatment. Many people require more than one line of treatment.

Ixazomib (with lenalidomide and dexamethasone) will be available to the NHS in line with the managed access agreement (MAA) with NHS England.

As part of this, NHS England and Takeda have a commercial access agreement that makes ixazomib available to the NHS at a reduced cost. The financial terms of the agreement are commercial in confidence.

The resource impact of ixazomib will be covered by the CDF budget. The guidance will be reviewed when the final analysis of the Tourmaline-MM1 trial is available.

The access agreement will continue until this data is available. The aim of the review

# Diary

## March

2 (B) Northern Ireland: final accounts workshop, Templepatrick
13 (F) Chair, Non-executive Director and Lay Member: operating game for new NEDs, chairs and lay members
14 (I) Healthcare Costing for Value: introduction to NHS costing, regional networking and training event (North)
14 (B) Kent Surrey and Sussex: accounting standards update, Gatwick
16 (B) London: student conference, Rochester Row
22 (F) Provider Finance: preparing for the use of resources assessment, London
22 (I) Healthcare Costing for Value: clinical forum, London
22 (B) London: quiz, Lewisham

## 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: annual conference, Sutton Coldfield
19 (B) South Central: introduction to NHS finance, Newbury
20 (N) Brighter together: workforce forum, London
21 (B) London: annual conference, Rochester Row
28/29 (B) North West: annual conference, Blackpool

## July

5-6 (N) Convergence 2.0, East Midlands Conference Centre

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

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

is to decide whether or not the drug can be recommended for routine use.

Further information can be found in NHS England's *Appraisal and funding of cancer drugs from July 2016 (including the new Cancer Drugs Fund).*

It is estimated that between 400 and 800 people will be treated with ixazomib (with lenalidomide and dexamethasone) within the CDF during the course of the MAA period.

This technology is commissioned by NHS England. Providers are NHS hospital trusts.

**Nicola Bodey is a NICE senior business analyst**

# Events in focus

## Brighter together events
### 24 May, 20 June, November

HFMA 2018 president Alex Gild's theme for this year, *Our NHS, your HFMA, brighter together,* is one of collaboration and partnership, supporting innovation and bright ideas. Mr Gild (pictured) wants to reflect on and support the formation of strong alliances across teams, organisations, and health and care systems to improve patient services. As part of his theme, the HFMA will be supporting members nationally with a series of sessions. They will provide an opportunity to work with colleagues and explore fresh solutions to the challenges in procurement, workforce and estates.


The free one-day events for full HFMA members and colleagues are due to take place in London. First up is procurement (24 May), then workforce (20 June) and estates (date in November to be confirmed). HFMA full individual members will be able to attend for free and bring along a colleague from procurement, human resources or estates for £99. At the procurement event, for example, finance leaders and senior procurement professionals will look, together, at the latest developments in procurement savings programmes. They will also share best practice in how to make savings in the procurement of everything from day-to-day supplies to the most expensive pieces of medical equipment.

**• For details, email clare.macleod@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, for example, NHS Improvement is pushing ahead with its Costing Transformation Programme and has recently mandated acute trusts to collect and submit costs at the patient level from 2018/19. In Wales, costing is well established in some areas and could well be extended across the country as it moves to value-based care. 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**

# Spelling out value

**Association view from Mark Knight, HFMA chief executive**

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

My HFMA

HFMA vice-president Bill Gregory (pictured) and I recently attended a conference in New York, organised as an update on the state's Design System Reform Incentive Payment programme (DSRIP). This is the main mechanism used by the state health department to restructure its Medicaid health system (the government insurance system for those on limited income).

It aims to introduce integrated healthcare underpinned by a reformed payment system. A small number of states pursue similar programmes – read more about the approach in my blog, *Learning from the DSRIP nation,* on the HFMA website or in our recently launched app.

The emphasis at the conference was on the 'why' and not so much the 'how' or the 'what'. This was summed up in a TED Talk by Simon Sinek in 2009, where he talks about businesses underpinned by clearly defined values. He uses Apple as an example. On the face of it, the company makes a dull product – a phone. But through clever marketing, it has drawn us in with its passion for technology. It is the greater sense of mission that attracts the consumer and provides real value. It also draws in many young people keen to work for the organisation.

When it comes to values-driven people, I can't find a better example (in accountancy anyway) of our own membership. Many of you would not dream of leaving the service – and that's not because of the allure of the pension scheme or the attraction of the working conditions. For many accountants in the NHS, it's the satisfaction they get from working in their organisations, the extraordinary feeling from the idea that you're making a real difference.

So it's no surprise that, by extension, your professional association has the values of the NHS at its heart. When I joined the HFMA, I knew this. And while I had previously known the association was well supported, I quickly came to understand just how fundamental members were to its success and its work programme.

Volunteers were and are the bedrock of the HFMA. And there is a group of key supporters whose passion, particularly at branch level, simply drives the organisation along.

HFMA chief executive Mark Knight

Recently the board asked the staff of HFMA to consider what values exemplified the association. They came up with four suggestions:-

**H: High quality** – we aim for excellence, continuous improvement, innovation and professionalism in all our work

**F: Fair** – we strive to do the right thing and to be open, honest and independent

**M: Member-focused** – we aspire to put members at the heart of everything we do

**A: Accessible** – we aim to be friendly, caring, supportive and collaborative

I'd like to thank the staff group, led by head of policy and research Emma Knowles, for developing this easy-to-remember list of values. But what do you think? Would you add to or modify this set of suggested values?

I'm proud to lead an organisation that means something to so many people and which has some important values at its heart. It's at times like we've been through recently that these become important touch points as we look to deliver more with less.

Please get in touch with your views at chiefexec@hfma.org.uk

## Member news

Mark Collis, deputy director of finance at Salisbury NHS Foundation Trust, has taken over from Yvette Bacon as the South Central Branch treasurer.

The London Branch held a networking event based on new HFMA president Alex Gild's theme, *Our NHS, your HFMA, brighter together,* in January. The event enabled senior finance professionals to discuss the achievements of STPs, particularly in London, and the future of the NHS. The next branch event is its annual student conference on 16 March, at which finance students will hear how they can have an impact on their organisation and identify potential career paths. To book a place at this free event email isabel.morley@nhs.net

NHS Lothian's finance department has been working over the past two years to raise money for local charities. Its social committee has organised some successful events, including bowling and quiz nights, bake-offs and Christmas jumper days (pictured). The department has raised more than £2,000 for Team Jak, which provides respite facilities for young cancer patients, and £1,000 for children's hospice CHAS Rachel House in Fife. Not only have the events raised funds for good causes, but they have also reunited staff recently relocated to new offices.

HFMA office administrator Lizzy Coghill and her friend Emily Merry are tackling the Tough Mudder obstacle course in support of the Alzheimer's Society and Macmillan. You can donate for their causes at https://www.justgiving.com/crowdfunding/emilyandlizzy

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## Member benefits

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

## Network focus

My HFMA

### Healthcare Costing for Value Institute

Telling patient stories through practical case studies is the quickest way to convince clinicians to trust cost information and engage them in the value agenda, according to John Graham (pictured), chair of the HFMA Healthcare Costing for Value Institute Council.

Since the launch of the institute in 2015, Mr Graham and the Institute team have been working to bring this value agenda forward in more NHS organisations and to involve clinicians and finance staff in the process. The value equation (outcomes divided by cost) allows organisations to explore variations in practice and whether a service is providing genuine value to the patient. Clinicians have a key role in this – they are needed to establish the desired outcomes and understand the reasons for variations in practice.

'Resources are tight and there is a danger that if we don't engage with the clinical community, we will just get accountants who say that something is cheaper or it's the most efficient and effective way. But this won't lead to change,' says Mr Graham. A lot of clinicians are enthusiastic about value and see it as their responsibility to engage with the agenda, he adds.

To further support clinicians in their costing and value journey, the institute is hosting its first clinical forum on 22 March in partnership with the Faculty of Medical Leadership and Management.

The event will focus on how clinicians can advance value-based healthcare, both in their clinical roles and by working collaboratively with their finance colleagues.

The institute also provides training and development for members of the costing community and this year's costing conference in April will highlight what is needed to support the implementation of NHS Improvement's Costing Transformation Programme.

One of the institute's flagship events is the annual international symposium, which shares examples of the practical application of value-based healthcare from around the world. 'It's interesting to see what colleagues are doing elsewhere, but sometimes we downplay what we've achieved here,' says Mr Graham. 'When you step back and think about what we are doing, we are actually not too far back – and in some ways, we are actually leaders in the sector.'

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**West Midlands** rosie.gregory@hfma.org.uk
**Yorkshire and Humber** laura.hill@hdft.nhs.uk

# Appointments

**David French**, chief financial officer at the University Hospital Southampton NHS Foundation Trust, has been appointed interim chief executive, following the departure of **Fiona Dalton**. He will also remain director of finance. Mr French first joined the NHS in 2010 and has extensive experience in the pharmaceutical industry. He also serves as a non-executive director for Hampshire-based social housing provider Sentinel Housing Association.

After 34 years working in the NHS in England and Wales, 16 of which he has spent as a director of finance, **Paul Miller** (pictured) has semi-retired. His latest position was as director of strategy in Poole Hospital NHS Foundation Trust. Mr Miller will continue as an HFMA executive coach and will do other work to support the development of NHS staff.

**Chris Harrop** (pictured) has been appointed programme lead at Mersey Internal Audit Agency's advisory service team. Mr Harrop has been chief executive at The Walton Centre NHS Foundation Trust for the past four years, having spent 10 years as a director of finance at the organisation. Mr Harrop is also an HFMA executive coach and supports the HFMA Academy. **Hayley Citrine**, who was previously director of nursing and operations at the trust, has been named as the new chief executive of The Walton Centre trust.

NHS Highland has appointed **David Garden** interim director of finance following the departure of **Nick Kenton**. Mr Garden has been head of financial planning at the organisation for the past nine years and has more than 27 years of experience in the NHS.

**Craig Carter** is now director of finance at Bury and Rochdale Care Organisation, which is part of the newly formed Northern Care Alliance NHS Group. The organisation brings together Salford Royal NHS Foundation Trust and The Pennine Acute Hospitals NHS Trust. Previously, Mr Carter was deputy chief finance officer at Chorley, South Ribble and Greater Preston Clinical Commissioning Group.

Liverpool Women's NHS Foundation Trust has appointed **Jenny Hannon** (pictured) director of finance. Ms Hannon first joined the organisation in 2012 and, after a short spell with NHS England, returned to the trust in 2014 as deputy director of finance. In October last year, she became interim director of strategy and planning. In her new position, Ms Hannon is taking over from **Vanessa Harris**, who has retired.

**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

"You get a closed picture working in just one area – it's better if you understand how the whole organisation's finances work"
**Hugh Groves, Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group**

# Groves to retire

**On the move**

Respected South West finance director Hugh Groves is to retire this month after 38 years in the health service. Currently chief finance officer at Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group, Mr Groves has a long association with finance staff development in the South West – something that gives him great pride.

'I was particularly pleased we re-established the training scheme in the South West in conjunction with the HFMA,' he says.

Although he chaired the group that pushed forward with the training scheme, he is keen for credit to be shared. 'The whole programme is testament to the commitment of all the finance leaders in the South West. We have robust networks and a strong branch.'

Closely associated with the local HFMA branch – he was secretary to the research committee in the 1990s – Mr Groves received an HFMA Honorary Fellowship in December.

While he sees the award as a great honour, he adds that qualifying as an accountant was another career highlight. 'We shouldn't underestimate that. I was privileged to go through the graduate training programme, I felt well supported and it gave me time to study as well as gain work experience.'

Moving on to managing people was another milestone. 'It's a big step and we are still not necessarily good at preparing people for this key part of their development,' he adds.

Other highlights include setting up the finance function at Yeovil and taking the unit through to trust status in 1991; working with clinicians – for example, to develop a day case unit at Taunton's Musgrove Park Hospital; helping set up East Devon Primary Care Trust in 2001; and the Devon Partnership NHS Trust finance team winning the HFMA Financial Management Award in 2007 in recognition of its financial turnaround.

Mr Groves joined the NHS finance graduate training scheme in 1980 looking for a career that would offer something different from the corporate world. Though he was attracted to the public sector, he adds: 'The reality was that times were tough and to get onto a graduate training scheme was difficult.'

He has worked in the South West his whole career, starting with the training scheme in Bristol. He spent eight years in the city's NHS, including the South West Regional Health Authority, as principal accountant, a post he says gave him a solid grounding in financial and management accounts. While he understands why many finance professionals are attracted to management accounts (with its close links with clinicians), he believes NHS finance professionals need to know both sides of the business. 'You get a closed picture working in just one area – it's better if you understand how the whole organisation's finances work.'

Mr Groves has worked for providers as well as commissioners. He joined NEW Devon CCG from Devon Partnership NHS Trust, where he was director of finance and deputy chief executive. Before that, he was director of finance and commissioning at East Devon PCT.

He moved between the sectors partly in response to opportunities, but also because he believes it is important to gain a rounded perspective of NHS finance.

'I always stuck to the view that I am employed by the NHS,' says Mr Groves. 'You do your best for your organisation, but hopefully not at the expense of what might be more beneficial across the whole community. I must also pay tribute to the great teams of finance staff and individuals who have supported me – they have been brilliant and a credit to the NHS.'

On retirement he plans to take a break, though he will continue to work with a small charity. He is philosophical about retirement. 'I will miss the people and working alongside clinicians and others to develop the services they want to deliver. I am sure the HFMA branch and finance staff network will continue going from strength to strength.'

## FLC changes announced

**Future focused finance**

Bob Alexander's time with Future-Focused Finance ends on 31 March, having taken up his new role as chief executive of Sussex and East Surrey Sustainability and Transformation Partnership.

David Ellcock, Future-Focused Finance programme director, paid tribute to Mr Alexander's work with FFF and the Finance Leadership Council (FLC).

'Bob has received many accolades from colleagues in NHS finance since announcing that he was to move on from his current role. Everyone involved with FFF would wish to be associated with those accolades and to acknowledge that our programme would not be in its current healthy state without Bob's formidable input since its very first days.'

Mr Ellcock also confirmed that Elizabeth O'Mahony will not only be taking on Mr Alexander's chief financial officer role at NHS Improvement, but will also be joining the FLC as the regulator's representative on FFF's governing body.

In another change of personnel on the FLC, Bill Gregory (pictured), chief finance officer at Lancashire Care NHS Foundation Trust, will take on the role of HFMA representative. Mr Gregory, an HFMA vice-president, will fill the vacancy left by Shahana Khan's departure in late 2017.

Mr Ellcock said: 'We are delighted to welcome Elizabeth and Bill to the FLC and look forward to working with them both to deliver our strategy for 2018/19 and beyond.

'We are especially pleased that two senior individuals with excellent track records will be helping to shape our future work.'

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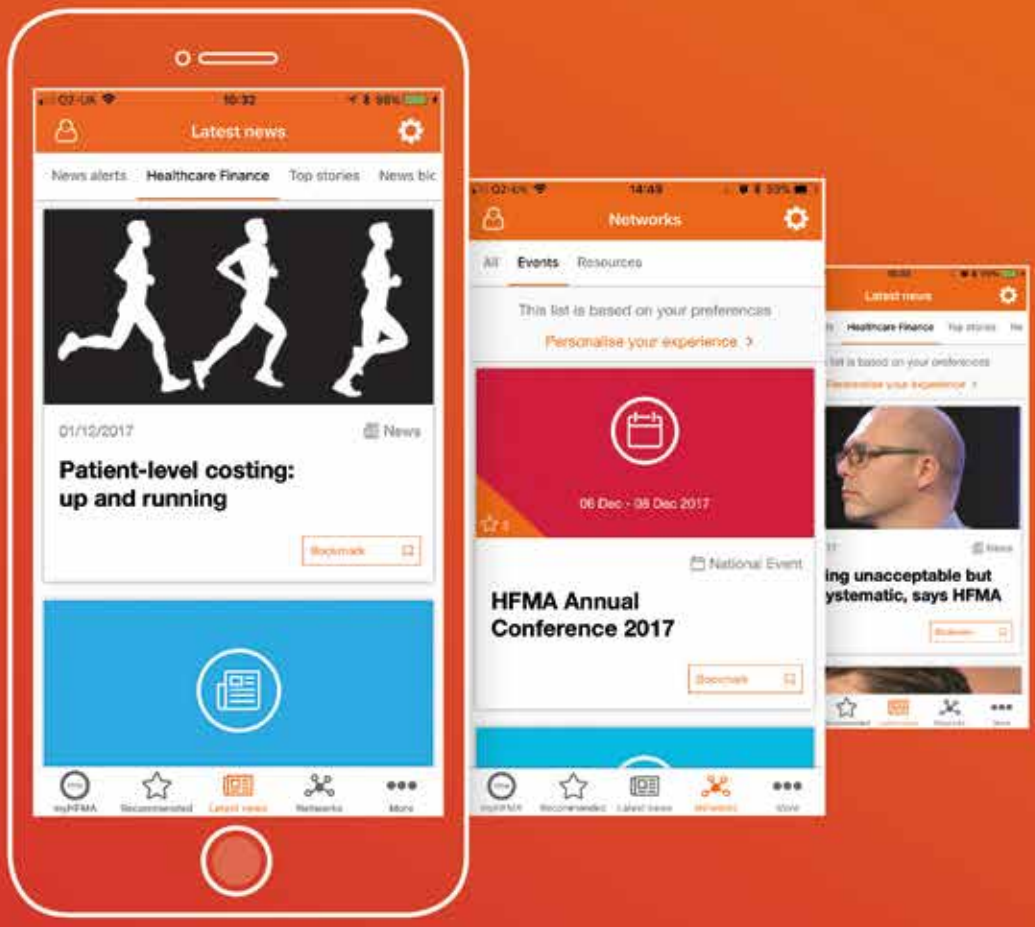


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