healthcare finance

May 2018 | Healthcare Financial Management Association

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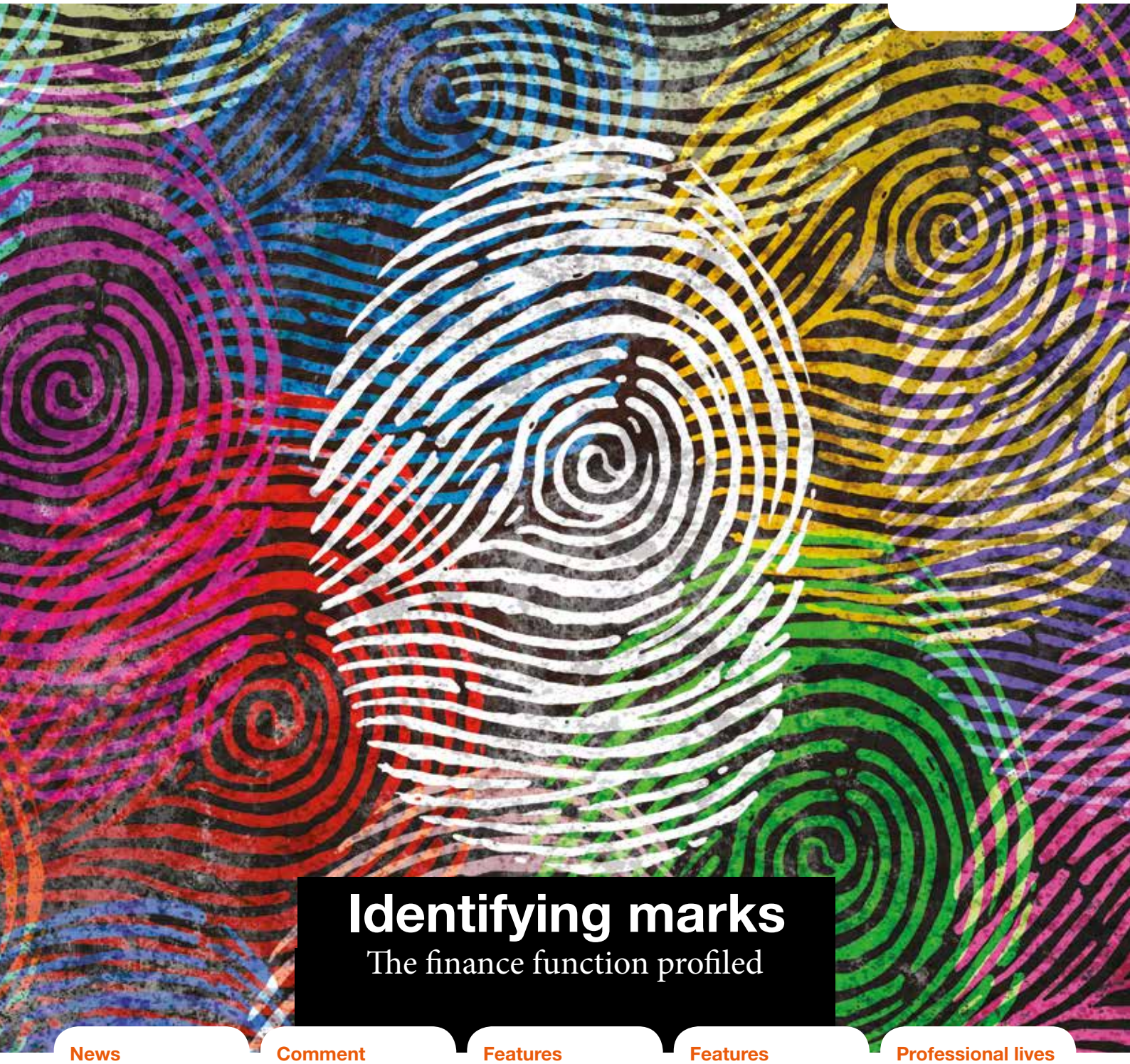

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Contents

May 2018

News

Comment

Professional lives

Features

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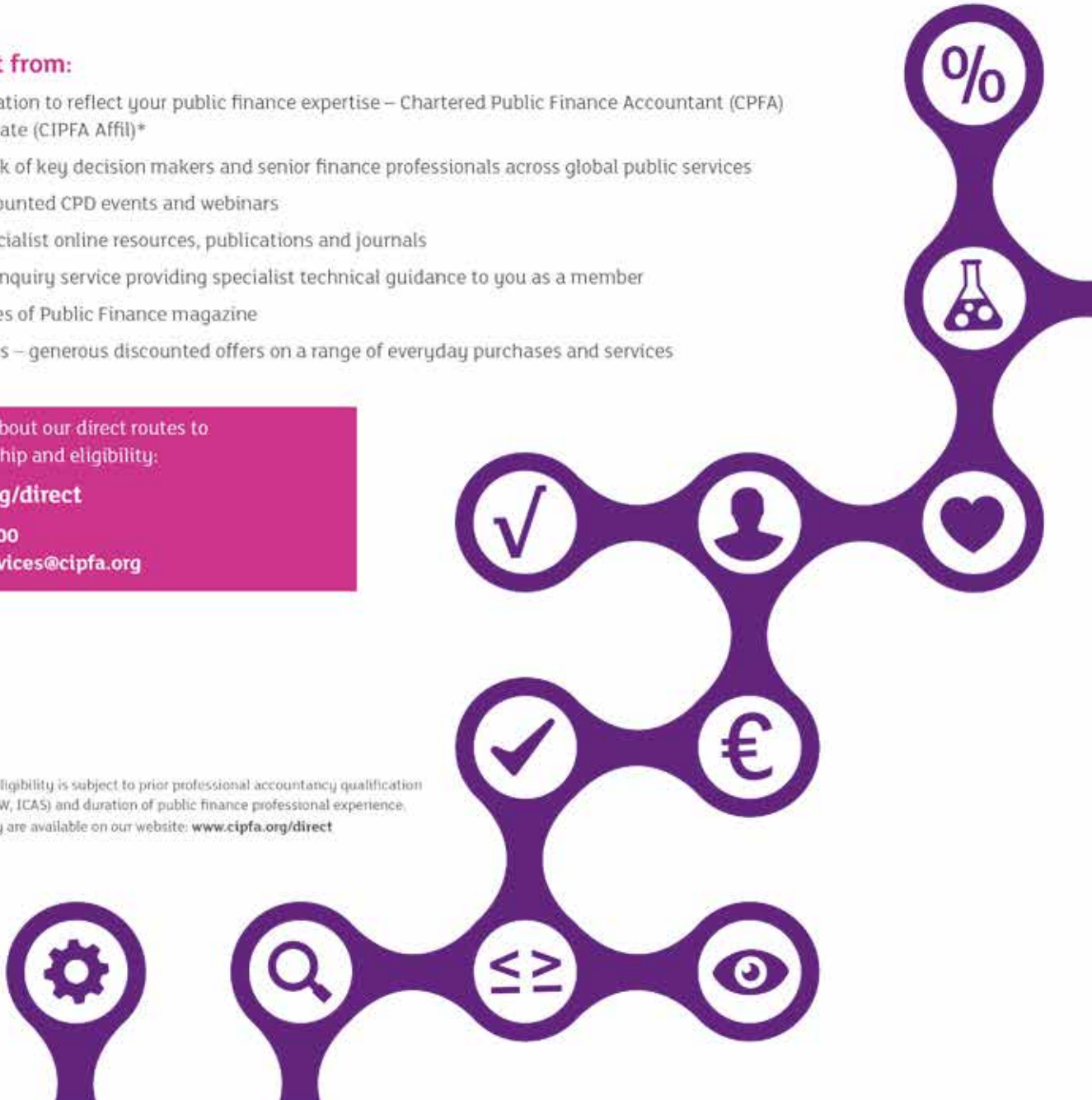

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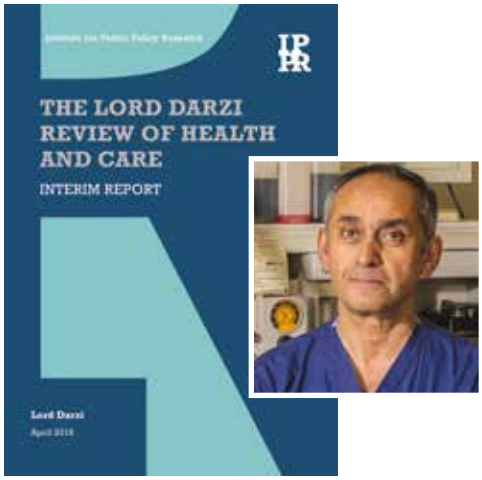
News

NHS to need more efficiencies in optimistic funding scenario



By Seamus Ward

The NHS in England may need to find a further £27bn of efficiency savings by 2030, even if it receives annual budget increases equivalent to its long-term average growth, according to leading clinician and former Labour health minister Lord Darzi.

He is carrying out a review of health and care with the Institute or Public Policy Research and an advisory panel drawn from across the political spectrum, health, social care and industry. In an interim report, Lord Darzi said the NHS has 'endured the most austere decade in its history'.

He continued: 'As a result, we are seeing signs of a system under strain all around us: patients left in corridors; operations cancelled; and deficits on the rise. Simply demanding more for less or promising more money without a plan for better care isn't good enough.'

"Voters may want northern European public services at American tax rates, but this is simply not possible"
Lord Darzi, pictured

The report concluded that demand pressures will rise to £200bn by 2030, without changing the way the health service works. If the NHS is returned to its long-term average annual increase in funding, which the report describes as the most optimistic scenario, the budget would rise to £173bn by 2030. This would leave the service to deliver the balance in efficiency savings (£27bn). The report notes this would be 1.4 times its long-run efficiency trend.

In addition, social care would need a further £10bn, as a bare minimum, to maintain existing service levels, it said.

The review will now look into the funding system and will present the full costs for both health and social care in a final report.

Lord Darzi warned difficult conversations with the public lay ahead. 'Voters may want northern European public services at American tax rates, but this is simply not possible. But it also shows that simply pouring more money into health and care will not be enough. The health and care system will need bold reform – and significant productivity increases – to be fit for the future,' the report said.

The future sustainability of the NHS was debated in the House of Lords at the end of April, following the report of the Lords' Committee on the Long-term Sustainability of the NHS.

Lord Patel, who chaired the committee, welcomed the government's indication that a long-term settlement would be forthcoming (see story below). 'How much and what it will be used for will be the important question.'

He added: 'Lack of any long-term planning for the workforce is the biggest internal threat to the sustainability of the NHS and adult social care. Much of the workforce planning is fragmented. Too much training of our workforce is done through the old model, lacking flexibility and with poor opportunity to upgrade skills.'

Lord Patel, a crossbench peer and obstetrician, said prevention of ill-health was a key component of the *Five-year forward view*, but it had received little attention. 'A service centred on illness is not sustainable,' he added.

The government had enacted one of the Lords' committee's key recommendations – that the Department of Health also be given responsibility for social care to support a more joined-up approach. However, he said less progress has been made in other areas including establishing an Office for Health and Care Sustainability, which would look ahead to the funding needed over the next 15-20 years.

PM promises new NHS plan

The NHS will have a new, strategic and financial plan – possibly before the autumn – after prime minister Theresa May (pictured) said she was convinced of the need for a long-term strategy.

In April, health and social care secretary Jeremy Hunt was reported to have written to fellow Conservative MPs asking for views on funding the NHS. He is said to have promised that he would bring forward funding solutions by the summer, together with a green paper on the future of social care.

And it emerged that a cross-party group of MPs, which includes former ministers, was urging the government to make national insurance a tax dedicated to funding the NHS.

Speaking at the House of Commons Liaison Committee in March, Mrs May said new funding must be complemented by reductions in variations in care quality; more integration between health and social care; and greater accountability for every pound spent.

'We also need to get away from this annual approach to the NHS budget and recognise that for the NHS to plan and manage effectively, we need to get away from those annual top-ups of the budget. We do need to have a sustainable, long-term plan that should build on the work of the *Five-year forward view*, but we should look beyond it to a plan that allows the NHS to realise greater productivity and efficiency gains.'

Mrs May added that she wanted to build a consensus on the plan, which she said should be brought forward quickly – the NHS could not wait until next year's spending review.

King's Fund: rising costs may limit availability of medicine

By Seamus Ward

Patients' access to drugs could be compromised by the rising cost of the medicines bill, according to the King's Fund.

Its report, *The rising cost of medicines to the NHS: what's the story*, said that NHS medicines spending increased by £4.4bn between 2010/11 and 2016/17, an average growth of around 5% a year. During the same period, NHS funding overall grew by an average of 1% overall.

The cost – £17.4bn in 2016/17 – includes generic and branded drugs. In recent years, spending on the latter group has been restricted by the Pharmaceutical Price Regulation Scheme.

The greatest growth in spending was seen in the hospital sector, which now accounts for more than half the total NHS spending on drugs. The King's Fund said hospital medicine costs grew by 12% a year on average since 2010/11.

A lack of robust data means the scale of and reasons for this growth are unclear, it said, but it is likely to have been fuelled by an increase in the number of patients treated and the introduction of expensive new treatments – for example, drugs for cancer and autoimmune conditions.

The fund acknowledged there were some limitations to its figures, as they were based on list prices and not the price paid by the NHS, which could be lower.

In primary care, there has been a rapid increase in the number of prescriptions issued, with more than 1 billion items prescribed in 2016. This is due to a rise in the use of drugs such as statins and anti-depressants, it said.

Spending growth has been much lower than in hospitals due to the success of policy initiatives, such as encouraging the use of cheaper generic drugs, that have led to a reduction of nearly 25% in the average costs per prescription item, the report added.

To curb costs, policy-makers have tried to regain control over drugs spending – for example, by introducing a budget impact test for new products that will cost more than £20m a year, reforming the Cancer Drugs Fund and restricting prescription of medicines that can be bought over the counter or are deemed low value. However, new cost pressures are emerging, such as the use of biological treatments and the development of effective but expensive products, such as new drugs to treat hepatitis C and prevent HIV, the report added.

The report warns that the health service faces difficult choices as it seeks to balance the competing goals of giving patients access to effective treatments, incentivising pharmaceutical sector innovation and ensuring NHS medicine spending is affordable.

King's Fund senior policy adviser Helen McKenna (pictured) said the NHS had successfully contained medicines spending over the years, but was struggling to balance access, innovation and affordability.

'It is important to tackle inappropriate prescribing and the overuse of medicines, especially antibiotics. However, we are now seeing policy-makers implementing increasingly controversial measures to control the medicines bill.

'With the choices facing policy-makers becoming more difficult, there is a risk of returning to the 1990s, when funding pressures led to widespread concern about the erosion of patients' access to medicines.'

Commissioners forecast £174m underspend

The commissioning sector forecast it would end the 2017/18 financial year with a £174m underspend, despite an overspend in clinical commissioning groups.

Board papers in April showing month 11 figures showed a year-end forecast overspend of £616m for CCGs. At month 9, the CCG forecast overspend stood at £351m. NHS England chief financial officer Paul Baumann (pictured) said the impact of generic drug pricing pressures was responsible for the deterioration in CCG finances. When this pressure was excluded, the underlying CCG position was a £300m-£400m deficit before non-recurrent costs and mitigations.

The increased generic drugs costs can be attributed to a greater number of category M medicines granted price concessions. Category M drugs are generics that are generally readily available – their price is reviewed regularly by the Department of Health and Social Care, based on market information, such as volumes and the prices of products sold. However, sometimes the drugs are not readily available at the price set by the Department and price concessions are granted, increasing the cost to the NHS.

Around 25 concessions are normally in place, but in October last year there were 81 and the cost for that month was more than £57m. This exceeded the total annual cost in 2015/16 and 2016/17, though the cost has fallen since last October, as steps have been taken to tackle the issue.

Mr Baumann said the CCG overspend was offset by underspends of £243m in direct commissioning, £515m in NHS England running and central programme costs and almost £32m in technical and ringfenced adjustments. The figures do not include the risk reserve of £560m.

He noted that most of the mitigations would not be available again in 2018/19, as they were non-recurrent.

A more sustainable solution to CCG overspends was needed. The new commissioner sustainability fund was designed to achieve this.

No national contingency funds will be held in 2018/19, as an extra £650m has been allocated to the provider sustainability fund (formerly the sustainability and transformation fund).

MH investment push welcomed

NHS England's move to require all clinical commissioning groups to meet the mental health investment standard in 2018/19 has been welcomed by the Mental Health Network.

CCGs must meet the standard –which requires clinical commissioning groups to increase investment in mental health services in line with their overall increase in allocation each year – or potentially face sanctions.

In a letter, the commissioning body said 85% of CCGs currently meet the standard, but 'nearly nine in 10 is not enough'. If a CCG is not on track to comply, they will receive a call from NHS England's mental health unit seeking an assurance this will be rectified, it added.

Sean Duggan, chief executive of the Mental Health Network, which is part of the NHS Confederation, said: 'Access to well-funded, high-quality services should not be determined by where you live, which is why we welcome NHS England's move to ensure that all areas receive essential funding for mental health services.'

He added that while the standard was met both nationally and regionally in 2016/17, there was still variation around the country, with around 15% of CCGs not reaching the mental health investment standard.

'We appreciate that decisions around funding are never easy for commissioners, but it is crucial that, as promised, mental health services are given parity to physical health services.'

Dalton: trusts must be realistic about their 2018/19 plans

By Seamus Ward

NHS Improvement chief executive Ian Dalton (pictured) warned that some trusts' plans for 2018/19 were not sufficiently robust and needed further work before final submissions were made on 30 April.

In a letter to trusts, Mr Dalton said activity plans, financial plans and performance trajectories did not align. 'In these cases, there is insufficient read-across between activity plans, financial plans and performance trajectories,' he said. 'And capacity and/or workforce assumptions do not look realistic or deliverable, given the current context.'

He went on: 'Given the high levels of occupancy in the system, and the knock-on impact this has on patient experience, performance and system finances, we need to be absolutely clear what can be realistically delivered and where potential capacity and/or performance gaps exist.'

Mr Dalton insisted that highlighting potential problems in a planned and managed way at the start of the year would allow the NHS to agree collective action to address the issues.

'This is infinitely preferable to submitting a plan where there is no realistic chance of delivery and then watching performance go off plan during the year,' he said.

The plans were due to be submitted after *Healthcare Finance* went to press. The oversight body chief paid tribute to the NHS staff involved in the planning round work. He acknowledged that it has been a difficult task, given the pressure the service was under in the first two months of 2018. And the new money allocated in the November Budget necessitated a speedy adjustment in the national planning framework.

Nevertheless, NHS Improvement expected trusts to build plans that are based on effective demand and capacity planning.

The plans should set out, by month:

- Number of beds/amount of capacity open and available
- Activity levels that will be delivered
- Planned financial position
- Performance levels trusts 'genuinely expect to deliver', highlighting any gaps against national planning requirements.

In response to the letter, NHS Providers chief executive Chris Hopson said NHS Improvement wanted deliverable plans. 'Our conversations with NHS Improvement indicate that it wants realistic 2018/19 plans that reflect what trusts genuinely believe they can deliver. Not what trusts hope they can deliver, what they would like to deliver, or what the planning guidance says they should deliver.'

He added: 'NHS Improvement wants to know now, at the start of the year, where the gaps are – be they money, performance or activity levels – so there can be a sensible debate on how to deal with those gaps. The 2018/19 delivery task looks beyond stretching.

'The letter says it's better to identify the problems now, than pretend they don't exist and fall off plan in year. Trusts tell us they have felt under pressure to submit plans "with the right answer". So how NHS Improvement teams react to the realism that's being asked for, when they get it, will be key.'

NHS Providers rejects subsidiary claims

NHS Providers has rebuffed suggestions that trusts are setting up wholly owned subsidiaries solely to avoid VAT and cut staff pay and pensions.

Following a freedom of information request, Unison said trusts in England are spending millions of pounds to set up the arm's length bodies. It said 15 trusts had spent an aggregate of more than £3.2m. The money was going to consultants, advising on setting up the subsidiaries to which staff are transferred.

At its health conference in Brighton, delegates warned that the subsidiaries were 'back-door privatisation' that would put at risk the pay and conditions of thousands of staff. The union is threatening industrial action against trusts in Yorkshire and Humberside that are considering creating subsidiaries.

NHS Providers' chief executive, Chris Hopson, said that the claims were 'inaccurate and misleading'. He acknowledged that there may be some tax advantages, but guidance prevented trusts from using subsidiaries solely for VAT gains.

He continued: 'They are not private companies, they are wholly owned by the NHS trusts that set them up. They are not outsourcing, they are being set up in many cases to avoid outsourcing to the private sector. They are not being set up solely to avoid tax or cut staff pay.'

The HFMA has published a draft briefing on the financial considerations when establishing subsidiary companies or joint arrangements. The briefing covers a number of areas, including accounting, VAT, ledger arrangements and submissions to Companies House. Members have been asked to comment on the draft document by 14 June.

News review

Seamus Ward assesses the past month in healthcare finance

April brought some respite from the cold weather that hit the UK in March, when the Beast from the East at the beginning of the month and a shorter, though still icy, blast in the middle of the month kept up pressure on hospitals. So, it was not surprising when A&E performance figures for March were among the worst on record.

According to NHS England, in March A&E departments recorded the lowest performance figure against the four-hour waiting time target since the collection began. Figures showed 84.6% of patients were admitted, transferred or discharged within the four-hour target period. In February, this was 85% and in March 2017 the proportion was 90%. However, the cold weather meant A&Es saw more patients – attendances were 1.6% higher compared with March 2017. And attendances in the past 12 months were 2.2% up on the preceding year. However, delayed discharges continued to fall – in February, they were 25% lower than in February 2017.

Of course, weather is not the only cause of demand and the NHS is seeing an increasing number of people whose ill health is due to their lifestyles. NHS Digital said hospital admissions where obesity is a factor increased by 18% in 2016/17 compared with the previous year. In total, there were 617,000 admissions to NHS hospitals where obesity was recorded as either a primary or secondary diagnosis. Of these, 10,705 had obesity recorded as the main cause – 9,929 up on 2015/16. The figures were included in the annual publication *Statistics on obesity, physical activity and diet; England 2018*. Adult obesity prevalence stood at 26% in 2016, a proportion that has been relatively constant since 2010. Child obesity prevalence was 10% in primary school reception year and 20% in year six.

The Department of Health and Social Care and its arm's length bodies were unprepared for the Wannacry cyber attack last May, according to the Commons Public Accounts Committee. The committee's report on the attack said the national NHS bodies had not shared or tested a response plan before the incident and no trust had passed a cyber security inspection. It added that there was much to be done to prepare for another attack and it was a case of when, not if, this would happen.

NHS England has provided a breakdown of the £114bn commissioning budget for 2018/19. *NHS England funding and resource 2018/19* confirms clinical commissioning groups will receive £75.6bn, together with the new £400m commissioner sustainability fund (CSF). The CSF will support all CCGs to return to in-year financial balance. In addition, a further £32.5bn is being spent on direct commissioning, including general practice, while £2.5bn is held for the provider sustainability funds. The remainder will fund a range of transformation programmes, administration costs and other central programmes. NHS England's running costs budget has been set at £508m – a real terms reduction after pay and price inflation.

The NHS in Wales must now comply with nurse staffing levels legislation. The *Nurse staffing levels (Wales) Act* requires health boards and NHS trusts to take steps to calculate and maintain appropriate nurse staffing levels in adult acute medical and surgical inpatient wards. The act also gives them a broader duty to consider how many nurses are necessary to provide care for patients sensitively in all settings.

The month in quotes

'We now have a system to empower and support nurses on the frontline, and nurse leaders to use their professional judgement to understand and plan for the right levels of care.'
Wales health secretary Vaughan Gething describes nurse staffing legislation as a step forward

'At a time when trusts are under tremendous pressure to meet ambitious financial targets, address workforce challenges and meet rising demand, it is disappointing to see the burden and the number of ad-hoc requests from regulators increase again.'
Amber Jabbal, head of policy at NHS Providers, says regulators must consider the impact of their requests for information

'The NHS simply cannot go on like this. Running a health system so close to capacity is highly risky and doing so endangers patient safety, as well as staff wellbeing.'
Nuffield Trust chief executive Nigel Edwards says that despite a huge effort from the NHS, the winter has shown changes are needed

'Government must get a grip on the vulnerabilities of and challenges facing local organisations, as well as the financial implications of Wannacry and future attacks across the NHS. Cyber security investment cannot be properly targeted unless this information is collected and understood.'
Commons Public Accounts Committee chair Meg Hillier with a call to action on cyber security

SHUTTERSTOCK

The cold weather meant A&Es saw more patients – attendances were 1.6% higher compared with March 2017

The Welsh government also approved two new capital schemes at Hywel Dda University Health Board in March. It has given the green light to a £25m development of obstetric and neonatal facilities at Glangwili Hospital in Carmarthen. The development is due for completion by 2020. A £3m scheme to modernise haematology, oncology and palliative care at Withybush Hospital in Haverfordwest was also approved.

NHS Improvement announced that seven trusts will take part in a three-year Lean programme. The oversight body said the scheme would introduce a Lean management system in each of the trusts, building on the earlier partnership between the NHS and the US-based Virginia Mason Institute. The trusts will also build a network to share best practice across the NHS.

Scotland health secretary Shona Robison said the appointment of an interim chair and acting chief executive at NHS Tayside will increase financial scrutiny. The health board was placed in special measures in March over its leadership and the management of its finances. NHS Greater Glasgow and Clyde chair John Brown will also take up the role of interim chair at Tayside, while NHS Grampian chief executive Malcolm Wright will be acting chief executive. Mr Wright will retain his role at NHS Grampian.

More people would be given the right to a personal health budget or integrated personal budget under plans published by NHS England and the Department of Health and Social Care. Currently, people receiving continuing care have a right to a personal health budget, but the bodies said they would like to extend this right to a number of other groups. Where clinically appropriate, the newly eligible group would also have the right to an integrated health and social care budget. People with ongoing social care needs who also regularly access NHS services and people leaving the armed forces who are eligible for ongoing NHS services could be eligible for an integrated budget. A consultation on the proposals closes on 8 June.

NHS Providers warned regulators are not keeping pace with integration of care. Its survey of provider trusts showed just one in five were clear about how providers will be regulated. Respondents said they were unclear how regulators would approach oversight of sustainability and transformation partnerships and integrated care systems. NHS Providers said lack of clarity could lead to duplication of regulatory activity and confusion over which body holds trusts to account for financial performance and care quality locally.

A report on financial difficulties including a severe cash shortfall at Barking, Havering and Redbridge University Hospitals NHS Trust has highlighted issues in the financial governance of the trust. The trust has been reliant on external financial support for several years and had managed cash flow challenges by stretching creditor payments, leading to pressure from suppliers. The trust commissioned Grant Thornton to assess the causes of the cash problem and governance arrangements. Among the contributing factors were non-payment of activity over-performance by commissioners, divisional overspends and over-optimistic assumptions. It said there was insufficient escalation of the issues to the board and inadequate reporting. It recommended improvements to the trust-wide finance report including more detailed analysis of the balance sheet and cash flow with clear, concise explanations of the financial issues and risks. The trust said the report made 'uncomfortable reading' and the approach to financial reporting was being overhauled. 'We have already made significant changes to the way we operate,' it said.

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from the hfma

Costing has moved forward a great deal in the last few years, but there is still work to be done if the NHS is to realise costing's full potential. So says Catherine Mitchell, head of the HFMA Healthcare Costing for Value Institute. In a blog on the association website, she says that costing can be associated in many minds with crudely imposed budget cuts. But good cost data can prevent crude, top-down cuts – allowing cost improvement programmes to target waste and highlight areas for improvement.

Another new blog looks at accountants' ethical responsibilities. Introducing a briefing on these duties for finance staff and other stakeholders, HFMA research manager Lisa Robertson says ethical responsibility is at the heart of an accountant's role. Pressures can mount, particularly in a tough economic climate and as integration brings in new complexities and conflicts. The briefing examines NHS finance staff responsibilities and explores potential ethical dilemmas.

Trusts are increasingly interested in setting up wholly owned subsidiaries to deliver services such as estates and pharmacy. There is some controversy around subsidiaries, but, that aside, there are also many practical and accounting issues to consider when setting them up. HFMA policy and technical manager Debbie Paterson sets many of these out in a blog. The association has published a draft briefing considering some of the issues, including governance and general ledger and IT requirements, and has called for comments.

• To view any of the HFMA's blogs, go to www.hfma.org.uk/news/blogs

News analysis

Headline issues in the spotlight

Paying it forward

The proposed pay deal for Agenda for Change staff in England has not been welcomed by all. Seamus Ward reports

The announcement in March that the government and union leaders had agreed a proposed pay deal for Agenda for Change staff in England came with much fanfare. The pay ceiling placed on around 1 million NHS staff since 2010 had been lifted, and most unions, employers and ministers highlighted the potential increases in earnings of between 6.5% and 29% over the next three years. But, with unions currently consulting their members on a deal costing £4.2bn, not everyone is happy.

That said, 13 of the 14 NHS unions with members on Agenda for Change contracts have recommended the new pay framework to their members. Only the GMB has rejected it, declaring it a 'jam tomorrow' pay offer.

Around half of Agenda for Change staff are at the top of their pay bands, according to the framework, and they would receive pay rises totalling 6.5% over the next three years (backdated to April 2018). This would include a 3% increase in 2018/19; 1.7% in 2019/20; and 1.67% in 2020/21.

In 2019/20, staff at the top pay point in bands 2-8c will receive an additional unconsolidated lump sum of 1.1%. Those at the top of higher pay bands will receive a lump sum equal to the value given to those in 8c (around £800).

The GMB said the proposed 6.5% rise amounted to a pay cut – the Office for Budget Responsibility forecasts one measure of inflation (the retail price index or RPI) will increase by more than 9% over three years.

It should be noted that there is some debate about measuring inflation, with the unions preferring RPI and the Department of Health and Social Care favouring the consumer price index (CPI), which could be closer to 6% over the three-year period.

Kevin Brandstatter, the GMB national officer, claimed the drop in earnings was on top of eight years of pay caps that has cost paramedics, midwives and nurses thousands of pounds. He said: 'This deal won't allow them to claw any of that cash back – in fact, for longer serving, most loyal NHS workers the 6.5% increase over three years actually means a real-terms pay cut. It does nothing to address the recruitment and retention crisis that is driving workers from our NHS and has left 100,000 positions unfilled.'

While there is consternation in some quarters about the level of pay rises for those at the top of their band, the headline increases in pay of up to 29% has also caused much indignation, particularly on social media.

The issue is how the rises have been calculated and shown in the framework document. A table in the individual pay journeys section shows the potential earnings gain for each pay point over the three-year period. However, the earning gains include pay progression, even though these would not be automatic under the proposals (more about this later).

As a result, a person in band 6 on pay point 24 would see their earnings rise by 14.02% over the three years to 2020/21 – pay journeys published on the NHS Employers' website show their salary would rise from £29,626 to £33,779.

However, under the current system, it would rise to £33,723, assuming they received all three annual incremental pay awards and assuming a continuation of the 1% pay cap. Critics said there was little difference in this.

That's not to say all gains would be this low. A band 7 on pay point 26 (the pay point due to see gains of 29%) would see their income rise from £31,696 to £40,894 in the proposed system. In the current system, their pay would rise to £36,655 over three years (see table).

As noted above, there will be changes to pay progression (annual increments). Since 2013, pay progression has not been automatic, but subject to criteria set by each employer and linked to annual appraisals. Anecdotally, issues with recruitment and retention have led, de facto, to progression being automatic.

However, though the framework insists automatic progression would end, it is expected staff will progress through the pay-step points – employers would be required to budget based on this expectation. Progression would be linked to the satisfactory completion of the appraisal process and mandatory training. Local standards must be met and there should be no formal disciplinary action live on the staff member's record. The deal would introduce minimum time periods staff must remain at a pay point.

The pay-off would be faster progression through the bands compared with the current system, particularly for the lower paid. This would be achieved by reducing the number of pay points in each band.

Given the current economic climate and ongoing uncertainty, is this the best deal that could have been achieved? Is the new minimum basic pay of £17,460 in 2018/19 (rising to £18,005 by 2020/21), benefiting 100,000 staff, not a huge step forward?

Unison thinks the deal would make the

Proposed deal compared with current system

Current pay point	2017/18 salary (£)	Proposed 2020/21 salary (£)	Increase in proposed deal (%)	Increase in current deal (%)
24	29,626	33,779	14	13.8
26 (band 7)	31,696	40,894	29	15.6
34 (top of band 7)	41,787	44,503	6.5	3

SHUTTERSTOCK

NHS pay system 'fairer and better' for current and future staff. It pointed out there would be no fundamental changes to unsocial hours payments and no change to leave entitlement. Just before the deal was announced, there were reports that the government had insisted staff should lose one day of annual leave in return for the pay rises.

'We think this offers a better alternative for members – and more certainty – than waiting around for the pay review body to make recommendations each year,' said Sara Gorton, Unison's head of health.

The deal would benefit the NHS, chiefly in terms of recruitment and retention, said Phillippa Hentsch, head of analysis at NHS Providers. 'Our most recent workforce report, *There for us*, showed that pay restraint had begun to bite in terms of recruitment and keeping staff within the NHS,' she said.

'More than one in three (38%) of trust leaders cited pay and reward when asked about the biggest challenges to attracting and keeping staff. Alongside this, as seen in the latest NHS staff survey, only 31% of staff said that they were satisfied with their pay.

'Although pay is only one part of efforts to make the NHS a great place to work, lifting the pay cap will send an important signal to a workforce that remains overstretched.'

She added: 'It is important to remember that there are other factors that will play a part in the wider strategy to improve staff retention. Work-life balance is still the fastest growing reason behind staff choosing to leave.'

Ms Hentsch said there could be potential savings from reduced recruitment costs and lower agency spending, with more staff staying in or joining the NHS workforce.

An NHS Employers' spokesperson said: 'Higher starting salaries in all pay bands will help recruitment and career progression. Increases at the bottom of the pay structure will future-proof the NHS against increases in the statutory living wage and help the NHS maintain a market advantage at that level.

'The reform of the pay structure has been a longstanding shared objective with the NHS trade unions. The new simplified structure better reflects the needs of the service now, rather than the existing structure, which has largely been in place and unchanged since 2003.'

One of the key benefits to employers is that the deal is fully funded by the Treasury rather than existing NHS budgets.

Ms Hentsch said: 'Given the financial pressures facing NHS trusts, it is imperative that they are not left to foot the bill. We have since had assurances that community-based and local authority contracted Agenda for Change staff will also receive the benefits of this deal. Clearly, further detail is still required about how the £4.2bn cost attached is made up, and whether this has implications on national insurance and pension costs.'

She added that providers will be watching closely for the next pay rise for doctors and dentists. 'The doctors' pay review body is currently preparing a report and a recommendation on doctors' pay,' she said. 'Should the review body recommend an increase above 1%, we are clear that this must also be fully funded by the Treasury rather than it being a further cost to be absorbed by trusts. We now need to see quick progress towards a settlement for doctors.'

Providers will also be waiting to see how the funding to cover the pay rises is allocated in the current financial year – should the deal be accepted by the union members.

If it is accepted, the new pay rates will begin in October and be backdated to the beginning of the financial year.

A recent NHS Improvement circular on planning for 2018/19 told trusts not to attempt to reflect the impact of the potential deal (over the assumed 1% rise), when putting together financial planning submissions due on 30 April.

It said: 'Any additional cost arising from an agreed pay award that is higher than this planning assumption will be fully funded and therefore will have a nil impact on their financial position.'

Ms Hentsch insists the funding should be paid directly. 'We have strongly argued that the pay award in 2018/19 should be transferred directly to employers. We understand the Department of Health and Social Care, NHS Improvement and NHS England have agreed to this, but agreement for how the funding will be allocated in future years is yet to reached.'

NHS pay has never been simple and, although the proposed deal will simplify some elements of the system, it may be a few years in operation before it is well understood by employers and staff.

"Although pay is only one part of efforts to make the NHS a great place to work, lifting the pay cap will send an important signal to a workforce that remains overstretched"

Phillippa Hentsch (right), NHS Providers

Comment

May 2018

Unlocking potential of all

We need to do more than make progress on equality and diversity

HFMA president Alex Gild

Wake-up call anyone? I'm not talking about a friendly call rousing you from holiday slumber. I'm talking about a realisation that rattles your own personal, often too comfortable consciousness.

As board disability sponsor, I was at a recent trust equality champions meeting, hearing feedback from our first cohort of black, Asian and minority ethnic (BAME) staff who had joined a new trust programme, 'Making it right'.

The pilot aims to address staff survey feedback about perceptions of unfairness in career progression. It provides targeted personal development support to enable BAME staff to build their voice, skills and confidence to break through in their career and worklife. No one should feel stuck, but people sometimes are.

My wake-up call came as we heard feedback from a member of my team on the 'Making it right' programme. She was smiling as she confidently presented to a room of many people because, like others recently completing the programme, she had just been promoted.

The shock for me was that this person had been at the same grade for nearly 20 years and had been unable to break through until now. There was no bitterness from her, she just gave a factual account of being 'stuck' at work for far, far too long.

Another area of focus in my trust is people coming to work with high levels of stress and anxiety. This relates in particular to disabled staff, those with long-term conditions or mental health illness and those caring for someone with a disability.

Again, we heard powerful personal stories from two clinicians, both living with long-term mental health conditions. They have found strength for themselves, and others, in feeling able to be

Finding the sweet spot

A long-term settlement must balance legitimate pressure to improve with realistic budgets

Healthcare Finance editor Steve Brown

The last month or so has seen some significant strides forward in terms of addressing the sustained NHS funding shortfall. The government has previously met demands for more funding– from lobby groups, commentators and the public – with claims that funds have already been increased (both in the spending review settlement and additionally in last November's Budget). So it was a major breakthrough to see the prime minister personally promise to bring forward a long-term funding plan for the NHS.

Theresa May's actual comments, at the very end of March, were made to the Commons Liaison Committee. She said that a long-term plan that built on the *Five-year forward view* would be supported by a multi-year funding settlement. She added that the NHS could not afford to wait until next Easter and the next spending review, and suggested that an answer was needed in this the service's 70th anniversary year, with any solution 'also 'properly joined' with social care.

The service has breathed a collective sigh of relief. Demand has continued to rise in general, as a result of a growing and ageing population. But the impact has been particularly noticeable over this past winter. In the face of this demand, access targets have been slipping. And while the service has delivered significant levels of efficiency – with productivity outperforming the wider economy – finances have continued to deteriorate.

Subsequently, a cross-party group of MPs has called for a 'second Beveridge moment' by using national insurance contributions to fund the NHS. There have also been reports of health secretary Jeremy Hunt writing to Conservative MPs for their views on how to fund the NHS.

But the source of funds is really of secondary importance. Clearly, it is a practical issue that needs to be resolved, but whether funds come from taxation or national insurance is a matter of presentation not substance for most members of the public. The recent British Social Attitudes survey suggested that more than six in 10 voters are willing to pay more tax to increase

FFF will be hosting two safe house discussions in July 2018 on understanding the barriers to career progression facing female employees and employees from a BAME background. FFF is currently setting up a new diversity delivery group to shape its ongoing work programme.
• For further information or to register an interest in joining the new delivery group, contact **futurefocusedfinance@nhs.net**

"We need to keep our eyes open and fully understand who our colleagues are"

open about who they are and the positive contribution they can bring to their work, and by being better understood and supported by colleagues.

As a trust, we have been making positive progress on equality and diversity, but progress is not enough. I hope we are starting to build a culture in our NHS, where it's safe to bring your whole self to work. But we need to keep our eyes open, address our unconscious bias and fully understand who our colleagues are and what contribution they can make. If this can happen for every individual, then we can truly say we are making progress. And progress will be measured in improved quality of care to patients.

So, our shared equality and diversity agenda should be about defining action to improve inclusion and unlock everyone's potential, whoever we are, whatever characteristic we have.

This is not just a frontline clinical or patient-related issue; it's societal and affects everyone. Our support services, including finance teams, can do more to raise awareness of the unconscious bias we all carry, and create the conditions where positive action can be taken.

Understanding staff survey data is critical to targeting the right action. And team planning needs to be shaped to explicitly address local equality issues. These are just as important as delivering on your finance objectives, because you can't deliver the technical objectives as well as you might without bringing everyone's talents to the fore.

I leave you with this call to action. It sounds easy to do, but it's not, and takes conscious practice. Open your eyes and challenge your thinking on how you judge others. Seek to better understand and know the people you are working with and model the leadership needed at every level to unlock and unblock people's talent and contribution.

Think specifically about the band 7 and 8 posts as these are the jobs that enable people to progress to senior positions. Ask yourself why you may be appointing someone over another, and properly reflect on your unconscious bias.

Take the opportunity to listen to people's personal stories and engage in new conversations. I have been reverse-mentored (by an LGBT clinician) and would recommend this process as a way to learn deeply from others' experiences of working in our NHS.

Be the change, don't be a bystander. We are brighter together.

Contact the president at president@hfma.org.uk

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funding for the health service – which tax pot was not an issue.

The real question is how much funding the service needs. The government has been more tight-lipped about this, other than to dismiss newspaper suggestions of a £4bn-a-year funding boost as premature speculation.

Ms May told the Liaison Committee that the new plan should allow the NHS to realise greater productivity and efficiency gains.

This is the crux of the issue. No-one would disagree that there are inefficiencies within the NHS, relating both to support services and clinical variation. Programmes such as *Getting it right first time* and tools such as the Model Hospital and patient-level costing (see page 25) give the service a fighting chance of addressing some of these.

And new models of care and integrated care systems are starting to show that they can bend the demand curve and meet patient's needs more proactively and cost-effectively (see page 21). But these improvements won't be turned on overnight.

In fact, if funding is insufficient to meet current demand, it will simply postpone some of the improvements that the NHS could realistically make.

"Legitimate pressure on the service to reduce costs must be balanced with realistic funding"

Unrealistic control totals would restrict clinicians', support staff's and managers' vision to the here and now. It would be a case of getting through to the next milestone, not planning for a sustainable future. There would be no headroom to enable clinicians and finance managers, for example, to work together to understand variation and find ways to address it.

There is clearly a sweet spot of NHS funding that the government needs to find. On the one side, this needs to put legitimate pressure on the service to reduce costs and improve productivity. But this must be balanced with realistic funding that enables the service to both meet current demand and develop services that will be sustainable into the future.

The NHS and partner organisations have enhanced services to care homes at six vanguard sites, but what has the impact been? Seamus Ward reports

Demand management is a particular focus for the NHS post *Five-year forward view*. The enhancement of community and primary care services, together with the integration of health and social care, provide the policy backdrop for tackling demand, but can groups of people be given greater support to avoid hospital admission?

Older people, particularly in care homes, where the residents are frail and often have a number of complex physical and mental needs, are among the most frequent users of healthcare. NHS England says one in seven people aged over 85 now live in care homes and there is evidence their needs are not being properly assessed or addressed, leading to unnecessary unplanned, avoidable admissions to hospital.

To help tackle this, the NHS in England set up its *Enhanced health in care homes* (EHCH) vanguard to look at ways of reducing the demand.

Six areas were selected to take part in the EHCH programme, which, along with the other elements of the three-year vanguard programme, was completed at the end of March. As well as testing the impact of various interventions, the sites have helped develop a framework that describes the EHCH model and how it can be commissioned.

The framework comprises seven fundamental elements:

- Enhanced primary care support
- Multidisciplinary team support
- Reablement and rehabilitation
- High-quality end-of-life and dementia care
- Joined-up commissioning
- Workforce development
- Better use of data and technology.

The six sites built on already established local engagement with care homes. South London's Sutton Homes of Care vanguard, for example, developed a range of initiatives. These included: multidisciplinary teams to improve the outcomes for patients with complex conditions, with a view to identifying potential health issues early; training packages for care home staff; and a tool for identifying the early signs of dementia.

The Sutton vanguard also developed the 'red bag' scheme – a simple idea, now adopted by many areas – to ease the transfer into and out of hospital. The bag contains information about the resident's health and includes standard information about health problems and medication they are taking. When they go home, the resident takes their discharge summary in the bag, so care home workers have the details on discharge.

Airedale collaboration

The biggest EHCH vanguard in terms of footprint was in West Yorkshire and East Lancashire. Known as Airedale and partners, the collaboration involved three trusts including Airedale NHS Foundation Trust, local CCGs – covering Airedale, Wharfedale and Craven, Bradford and East Lancashire – as well as community and mental health providers, social care and voluntary organisations.

Rachel Binks, a nurse consultant in digital and acute care at Airedale NHS Foundation Trust, and clinical lead for the vanguard, says much of the initial work was based on its successful telemedicine service.

As well as introducing other ideas to improve services to care home residents, the vanguard tested the application of 24-hour video-based care and assessment.

The trust established its telemedicine service in 2007 and offers video consultations in prisons (more than 1,000 consultations across the UK each year) and supports 25,000 care home residents.

Initially, the telemedicine service was based solely around patients with long-term conditions, such as diabetes and heart failure, in their own homes. However, in 2011 the service expanded into care homes as this is economically more viable. Instead of a single installation of equipment for one patient, in care homes a single installation could serve 50 or more residents.

'We were struggling to get a critical mass of clients to provide enough funding to keep our telemedicine hub staffed 24 hours a day. So we went into a joint venture in 2013 with Involve VC to provide the expertise on installation, IT support and managing relationships with the care homes, while we provide the clinical service.'

Overall, the trust is contracted by 26 CCGs to offer telemedicine in around 600 care homes across the country. Around half of the homes were directly involved in the EHCH vanguard. When the vanguard started, around 120 care homes were involved, but that doubled in the first year to around 250, before rising nationally to around 300.

Ms Binks says that if a resident or care home staff have any concerns, they can call the telemedicine hub 24 hours a day. A nurse or paramedic assesses the situation and takes appropriate action – this could range from answering a question, requesting a local GP or community nurse visit the resident, or even calling an ambulance.

But the telemedicine element of the vanguard looked beyond the video assessments – also providing remote training and virtual supervision to care home staff. This reduced demands on GPs and community staff – for example, by supervising care home staff to give fluids or paracetamol.

Ms Binks says: 'This might offset some of the pressure falling on GPs or hospitals. We want to enhance the knowledge and abilities of care home staff and make sure we are not thinking differently about residents just because they are in a care home – we should avoid the need to admit them to hospital, just as we would if they lived in their own house.'

A&E impact

An assessment by the Yorkshire Health Economics Consortium, published in March, found reductions in A&E activity (-0.3%), 111 calls (-4%) and inpatient emergency (-3%) in care homes with telemedicine compared with the period before installation. There was a 2% increase in the use of GP out-of-hours services.

By comparison, in a small control group of homes without telemedicine, 111 activity rose 36%; A&E 30%; inpatient emergency activity 7%; and out-of-hours GP activity by 56%.

However, the York team urged caution on these findings – it said there were issues over statistical significance, given the sample size of some of

North East approach

Local efforts to improve services to care homes and prevent unnecessary hospital admissions are in their 10th year, according to Lesley Bainbridge (pictured), lead nurse, frailty and integration at Newcastle Gateshead Clinical Commissioning Group.

The CCG was one of the six EHCH vanguards over the past three years, but its work in this area stretches back a further seven. Its model is based on evidence – rigorous analysis, testing and piloting – and the use of comprehensive geriatric assessments to develop needs-based care plans for individual residents.

Even so, she says: 'Being part of the vanguard programme has taken us to another level, ending up with fewer people going into hospital and developing a few things that we wouldn't have done ourselves.'

The CCG has a GP practice linked to each care home, together with a lead GP. Eight nurse specialists work closely with the GPs and there is a rapid response nursing team that operates 24/7. It also has a virtual ward – every Wednesday, the nurse specialists, an old age psychiatrist and community geriatrician carry out a virtual ward round, ensuring care is meeting the residents' needs.

The results have been positive. In November last year, the national EHCH dashboard showed Newcastle Gateshead had reduced emergency admissions from care homes by 3.2%, compared with the pre-vanguard period. In all six vanguards there was a 1.6% reduction and a rise of 6.7% in non-vanguard care homes.

And, in quarter three for 2017/18, the CCG vanguard showed:

- An 8.8% decrease in 999 calls leading to transport to hospital with an overall decrease in 999 calls
- A 3% decrease in A&E attendances
- A 34.7% decrease in non-elective admissions for care home residents with a urine infection
- A 16.6% decrease in non-elective admissions for care home residents with a chest infection
- A 26% decrease in oral nutritional supplement prescribing (15,000 fewer prescriptions)
- £41,000 less spent on low-dose antipsychotic medication
- 11% more dying in their place of choice.

Ms Bainbridge says it's difficult to say which initiative led to the reduction in hospital admissions. 'It was due to the whole package we put together. We realised that care home staff did not have access to the same level of training as NHS staff, so we invested in some clinical educators. Hydration is one of the things they have focused on, as it is important in avoiding hospital admission due to urinary infections.'

Local care home residents tend to be older (averaging 84-85) and live an average of just under two years in local care homes – elsewhere it can average seven years. Ms Bainbridge explains that this means local residents' needs are more complex. It is vital to understand local differences when putting together a care model, she adds.

And, as the model develops under the sustainability and transformation partnership, the CCG is hoping to add the same focus on the over-80s still living in their own homes. 'All the things we have done can be done for people in their own homes and I think we would expect the same findings.'

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The Airedale trust provides telemedicine services to around 600 care homes nationally

the comparator groups, for example. It warned that the results can only be seen as indicative.

Ms Binks says the impact of the vanguard varied, depending on the attitudes of care home staff and local GPs, levels of frailty of residents and the previous degree of support and engagement from community services.

But she believes telemedicine in care homes can make a big difference, working alongside other support schemes. In East Lancashire, for example, there has been a huge focus on telemedicine as part of the vanguard, together with enhancing community services to care homes, and there have been reductions in A&E attendances, ambulance calls, hospital admissions and GP visits.

'We have learnt that if the local support to care homes is really good, we can make it fantastic, as we can enhance existing services rather than replacing them. But clinical engagement and support from GPs, community teams and the care home staff are hugely important as we need the GPs and community teams to be going into the homes to talk to the residents about what they want in their plan of care.'

The Airedale vanguard is working closely with colleagues in the nearby Wakefield vanguard on telemedicine, providing the service to a small number of care homes.

"Clinical engagement and support from GPs, community teams and care home staff are hugely important as we need to be going into the homes to talk to the residents"
Rachel Binks, Airedale NHS FT

Multidisciplinary effort

The Wakefield vanguard, known as Connecting Care, is itself focused on developing a multidisciplinary team (MDT) to look at physical and mental health of individuals.

The team included colleagues seconded from local acute and mental health trusts. They reviewed care plans for individuals and co-ordinated with a community geriatrician to see if a comprehensive geriatric assessment was needed.

'It is very much person centred,' says Connecting Care senior project manager Lesley Carver. 'Ultimately, the question we wanted to ask ourselves was: "Would I want my mum and dad in that care home?". We wanted to be able to say: "Yes, we would".'

The MDT includes a general nurse, mental health nurse and physiotherapist, while a GP care home lead works with the 26 practices aligned with the vanguard care homes. Wherever possible, the GP ensures one-to-one mapping of GP practices to care homes. They also provide a regular, scheduled visit to each home to support medicines reviews, end-of-life planning and dialogue with carers and families.

Wakefield Clinical Commissioning Group, which led the vanguard, says: 'When a resident moves into a care home, a holistic approach to assessment is undertaken as part of care planning. This should recognise frailty and include an assessment of functional needs and both physical and mental health.

'Assessment and care planning is an iterative process, which includes reviews at the six-month time period. When a resident moves between a care home and hospital, a prompt and efficient transfer of clinical care is supported.'

Ms Carver believes the MDTs have been important in building a rapport with care home managers.

'They see the team coming in on a regular basis and staff feel confident to bring up any issues they might have,' she says. 'It also encourages them to train – we may have some training around dementia and end-of-life issues. This provides a better quality of life for residents, helps minimise the falls and upskills the staff as well.'

She adds that there have been some encouraging signs. In June 2017, a year-long evaluation found a 13% reduction in emergency admissions in the Wakefield vanguard care homes, compared with a control group of residents in the care homes not in the pilot. In addition, A&E attendances were down by 6% and ambulance call-outs down 5%. There was a reduction in bed days by 28%.

'Long-term conditions and falls management have improved in care homes,' says Ms Carver. 'We've seen improvement in end-of-life care, with people able to die where they choose, proactive care management

and care planning. We are starting to see a lot of benefits.'

The savings in 2016/17 were about £1.65m, with costs of £959,000, resulting in £688,000 of net savings. The vanguard received £550,000 from NHS England in 2016/17 and £405,000 in 2017/18.

Funding has been important for the EHCH vanguards. The Airedale and partners vanguard received £1.5m in the first year, then £500,000 in the second. In the third year, a further £500,000 was available if the CCGs signed up to the EHCH framework – only the East Lancashire CCG was in a position to do so.

'The funding made a big difference in getting the technology and the framework embedded,' Airedale's Ms Binks says.

Telemedicine focus

With the vanguard – and the separate funding – now ended, the localities are looking to focus the use of telemedicine on where it will make the biggest impact. Ms Binks says that some homes did not use the technology effectively, while others did not need to use it as frequently – for example, if they were well managed with good community support and staffed by registered nurses.

In Wakefield, Ms Carver says: 'The vanguard will help lay the groundwork for the STP and integrated care system. Though the funding finished on 31 March, it becomes business as usual for us.'

To this end, the CCG has set aside just over £900,000 to fund the services in 2018/19 and has selected a further eight care homes to continue the trial of the Airedale telemedicine system from the end of this month.

Using GPs and other clinicians, often as part of MDTs, to reduce the transfer of care home residents to hospital is not unique to the EHCH vanguard areas. A pilot in Barking and Dagenham, Havering and Redbridge CCGs that gave GP support to four nursing homes led to a 36% reduction in emergency admissions to hospital. A study of the Health 1000 pilot by the Nuffield Trust found that the largest reductions in admissions were during the last three months of life.

The scheme offers nursing homes access to GPs between 8am and 8pm, seven days a week, together with training and advice and support from a geriatrician. Staff told researchers that they felt more supported and able to get advice quickly, when previously they would have sent a resident to A&E.

The report estimates that the monetary value of the reduction in emergency admissions could lead to savings of £1,000 per patient per year, although this would not necessarily translate to direct savings for commissioners or providers.

Nuffield Trust senior research analyst Chris Sherlaw-Johnson says: 'It is encouraging to have found a service that appears to show real benefits for nursing home residents and staff. This research shows how primary care may be able to take the burden off local hospitals as well as offering better quality of care in a more comfortable environment.'

But he adds: 'We don't know about the sustainability of these findings in the longer term and organisations wanting to replicate the service in their own area must note that success relies on building and maintaining effective relationships between staff and GPs.'

This appears to be one of the major learning points from the vanguards too – initiatives such as telemedicine or assigning a GP or multidisciplinary team to individual care homes can make a difference. But the key to success is the engagement and support of all local clinicians and care home staff.

Distinguishing features

Ever asked yourself how many finance staff there are in the NHS and where they all work? Or wondered about the balance between the more junior and senior roles? The latest NHS finance function census should provide all the answers. Steve Brown reports

The English NHS finance function is made up of highly qualified, experienced and motivated people, who work long hours in the face of significant pressures, despite not always feeling valued. However, the relatively low number of women working in the most senior roles continues to be out of step with the overall gender mix of the function.

This picture is drawn from the latest finance staff census and staff attitudes survey. The biennial census, with the latest representing the position in the summer of 2017, is the result of a long-standing collaboration between the HFMA, Future-Focused Finance and the NHS Skills Development Network.

The staff attitudes survey is a parallel piece of work undertaken by the HFMA, in particular to help understand finance staff's career paths to date and in future. The results of both pieces of work have been published in a briefing – *The NHS finance function in 2017: England.*

There have been no major reorganisations since the last census was undertaken in 2015. However, the NHS has faced significant challenges in this period, with financial settlements well below the long-run average. There have also been conflicting pressures on back-office costs, including those incurred by NHS finance functions.

While finance teams have a key role in the delivery of financial control totals, they have also faced increased pressure to support the delivery of new models of care as part of broader NHS transformation plans.

Lord Carter's 2016 report on acute hospital productivity increased the pressure to improve efficiency and also triggered the compilation of wide-ranging data (for initiatives such as NHS Improvement's Model Hospital and *Getting it right first time*). And the roll-out of NHS Improvement's Costing Transformation Programme has also gathered pace, creating a need to invest in the costing process itself and support an increased use of patient-level cost data to inform improvement.

All of this has combined to increase the demands on finance teams.

However, the Carter report also put a specific focus on reducing back-office costs, including those of the finance function.

Against this backdrop, the census shows that finance function headcount in England has stayed relatively static – with the latest headcount of

Table 1: Change in NHS finance staff headcount between 2015 and 2017

Organisation type (number of organisations)	2017 staff in post headcount	2015 staff in post headcount	Change in headcount	% change in headcount
Providers				
Acute - NHS trusts (52)	3,571	3,446	125	4%
Acute – FTs (101)	6,239	6,000	239	4%
All acute (153)	**9,810**	**9,446**	**364**	**4%**
Mental health – NHS trusts (11)	363	465	-102	-22%
Mental health – FTs (41)	1,698	1,732	-34	-2%
All mental health (52)	**2,061**	**2,197**	**-136**	**-6%**
Ambulance – NHS trusts (5)	146	153	-7	-5%
Ambulance – FTs (5)	135	151	-16	-11%
All ambulance (10)	**281**	**304**	**-23**	**-8%**
Community trusts – NHS trusts (11)	234	403	-169	-42%
Community trusts – FTs (6)	185	116	69	59%
All community (17)	**419**	**519**	**-100**	**-19%**
Total providers (232)	**12,571**	**12,466**	**105**	**1%**
Non-provider				
NHS England National (1)	127	88	39	44%
NHS England regional offices (5)	86	72	14	19%
NHS England – area teams (16)	251	255	-4	-2%
CCGs (207)	1,931	1,704	227	13%
CSUs (6)	560	736	-176	-24%
Specialised commissioning (10)	52	82	-30	-37%
Total non-provider (245)	**3,007**	**2,937**	**70**	**2%**
Total core NHS organisations (477)	**15,578**	**15,403**	**175**	**1%**
Total non-core NHS organisations	**865**	**808**	**57**	**7%**
Grand total	**16,443**	**16,211**	**232**	**1%**

16,443 representing a small increase of 232 – or just under 1.5% – compared with 2015. This is based on 510 organisations, including a core NHS of 232 NHS providers and 245 commissioning bodies.

Looking specifically at these core NHS organisations, an overall increase of 175 staff masked increases and decreases within the different types of organisations. For example, there are an extra 364 staff (up 4%) working in acute providers compared with 2015, while both mental health providers and dedicated community providers saw a fall in numbers (-6% and -19% respectively).

Similarly, a 227 increase in clinical commissioning group staff, representing a 13% increase, needs to be seen alongside a 24% reduction in finance staff working in commissioning support units and a 37% reduction in specialised commissioning staff.

Overall, provider staff account for 76% of NHS finance staff, while 18% work in commissioning and commissioning support. Of the 12,571 staff working in providers, 8,257 (66%) work in foundation trusts and 9,810 (78%) work in the acute sector. Of the 3,007 non-provider staff in the core NHS, 1,931, 64% work in CCGs (see table 1).

Looking at the number changes a different way, the average size of an acute provider finance team has increased by three staff to 64. There have been bigger increases in average acute trust teams (increased by six) compared with foundation trusts (increased by two).

Team size and turnover

However, team size is very dependent on turnover. Acute providers with a turnover of more than £500m now have an average team size of 108, compared with 32 in a trust of £100m-£200m. The average size of a mental health provider team is 40, with average teams ranging from 24 to 60 depending on turnover (although there are no mental health trusts with a turnover above £500m).

The average CCG team is just nine staff, up one since 2015 – although there are two fewer CCGs this time around. However, a number of CCGs share chief finance officers and finance teams and there have been some mergers since the census was conducted.

The national small increase in staff headcount was mirrored in three of the four NHS regions. Numbers rose in the North (up 2.9% to 5,471), London (up 1.5% to 2,884) and South (up 3.5% to 3,632) and reduced in the Midlands and East (down 2% to 4,456). London had the greatest proportion of agency staff, but all regions place some reliance on agency to cover vacancies.

The census does not give a complete picture of the use of outsourcing in NHS financial services. However, just 19% of provider trusts

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reported this time that they outsource none of their activities, compared with 25% in 2015 – suggesting an increase in the use of outsourcing. There has also been an increase in the proportion of staff identified as financial management (55%), which is consistent with a function that is outsourcing its more transactional services.

The census also provides a detailed breakdown of the finance function by Agenda for Change (AFC) pay band. Some 42% of the function are band 7 or above (including finance directors and senior managers not on Agenda for Change rates). A further 25% are at bands 5 and 6, the remainder at bands 1 to 4.

The census report highlights London as having the largest proportion of senior staff, with some 49% paid at grade 7 up to very senior manager level (up from 47%) and only 21% in bands 1-4.

There were 427 finance directors across the 477 organisations in the core NHS, the mismatch in numbers reflecting some shared arrangements and different structures in some commissioning organisations.

There were 151 chief finance officers across 207 CCGs, but more 'directors' than organisations in provider bodies – reflecting some instances of executive chief finance officer posts alongside director of finance roles.

Women directors

The census also revealed a small increase in the number of finance director positions occupied by women – now accounting for 28% of all director posts compared with 26% in 2015. However, the proportion remains low compared with the make-up of the overall NHS finance workforce, where women account for 61% of all staff. Women outnumber men in every band up to and including band 8b. From band 8c upwards, this position is reversed.

A second collection of ethnicity data continues to show that the function is 70% white British (compared with 72% in 2015).

The mix looks completely different in London, where just 34% of staff identify as white British. However, ethnicity was not disclosed for one in four staff in London compared with just over one in 10 across the whole country.

The function is also highly qualified, with some 7,082 staff (45%) holding a CCAB qualification or equivalent (32%) or studying for one (13%). Within this professionally qualified cohort, the CIMA qualification is the single biggest choice – representing 47% of qualified or studying staff. Another 12% of the function are qualified with or studying for AAT. It also boasts significant amounts of experience (see box).

'At the overall level, the figures show only a small increase in numbers from 2015,' says Emma Knowles, HFMA head of policy and research. 'But the demands on finance staff have increased significantly in the last two years – and continue to increase.

'Roughly the same number of finance staff are overseeing a bigger budget and are supporting the achievement of major efficiency demands to meet challenging control totals. They also have a major role in supporting the transformation of the NHS and the development of new models of care.'

Given these extra demands, she added that it was encouraging to see job satisfaction was only down a fraction compared with 2015. However, she said the fact that many senior staff in particular were having to work additional hours (up to an extra 20 hours per week) was not sustainable.

'Frontline staff have been under significant pressure in the face of unrelenting demand. But these pressures are also felt in support services and we need to ensure that services are funded and managed in a way that is fair to all staff and sustainable for the future.'

Experience, satisfaction, motivation

The HFMA's finance staff attitudes survey reinforces the census finding that the function is highly qualified. But it also suggests that the function also possesses significant amounts of experience.

There were more than 600 responses to the survey, with the majority having an accountancy qualification or studying for one, and more than one in four had spent more than 10 years with their current organisation.

Over 40% had been with their current organisation for at least five years.

One in three of the sample had spent their entire careers in the NHS. Nearly two-thirds of the rest had spent time in the private sector.

Job satisfaction is skewed towards the higher end of the scale, with a mean of 6.6 out of 10 (6.7 in 2015). Concerns raised tended to focus on: worsening NHS finances; increased workload and falling pay in real terms; and job insecurity.

Job satisfaction increases with seniority, although comments suggest many are under great pressure. Some 70% of respondents work more than their contracted hours at least once a week, with 22% reporting that they always work in excess of contracted hours.

More than one in three of the most senior staff (band 8d and above) said they always work additional hours – although this is a slight decrease on the findings in 2015.

These levels of additional hours were reported to be more than 20 hours a week in some cases.

Three quarters of respondents said they were happy with the level of career development they were given – however, just 40% of 134 deputy or assistant finance directors wanted to become a finance director.

Most finance staff (80%) felt valued by their line manager, with half this number feeling valued by clinicians. One in four felt valued by other organisations across their local system but only a very few felt valued by the public (7%) or the government (10%).

Finance staff, however, remain motivated to work in the NHS, with 67% citing public sector values and 56% driven by the opportunities to improve patient care.

There were roughly even numbers of staff who believed the finance function was the right size or too small, with just a small remainder of 10% thinking it was currently too big. However nearly 60% thought that it would be smaller by 2020/21.

Table 2: Average staffing levels

Organisation type	Staff in post, 2017	Average staff in post, 2017	Average staff in post, 2015
FTs	8,257	54	53
NHS trusts	4,314	55	50
CCGs	1,931	9	8
Core NHS	15,578	33	32

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one population one budget

Eight integrated care systems are leading the way in taking collective responsibility for resources and population health. Steve Brown speaks to two of these systems about their progress to date

Frimley Health and Care's integrated care system is a good example of what NHS England had in mind when it talked about an 'evolved version of a sustainability and transformation partnership (STP)' in last year's *Next steps on the five-year forward view* document. But in fact, Frimley's integration journey started long before that.

Frimley Health NHS Foundation Trust was born out of the acquisition by the former Frimley Park NHS Foundation Trust of the Heatherwood and Wexham Park Hospitals NHS Foundation Trust. And as long ago as 2015, one of the ICS's clinical commissioning groups (Surrey Heath) was already planning a programme of health and social care integration for older people with long-term conditions and complex needs.

But the creation of the STP, and its selection last year as one of eight shadow accountable care systems (now rebadged as ICSs), has increased the momentum even further. Final confirmation of Frimley's operational status as an ICS could happen in May, although this requires all involved organisations to sign up to a system control total – which itself is dependent on NHS Improvement issuing final rules on how this will operate.

However, there are already signs of improvement from a more integrated approach in terms of getting a grip on demand. And there are some very visible signs of the increased collaboration that has brought the system this far.

These include last summer's appointment of Nigel Foster as director of finance and information management and technology at Frimley Health. He was previously chief finance officer for the three local East Berkshire CCGs (now formally merged into one CCG as of April) and retains this role – thought to be the only example of a shared provider/CCG director of finance role in the country.

The goals for the system could be lifted from any number of STP plans around England. It wants its population to have the 'best possible health and wellbeing' and to keep them 'healthy and in their homes for longer'.

Like other STPs, it has identified a 'do nothing' gap – the system deficit it would face by 2020/21 if service models remained unchanged and demand and activity continue on trend. In Frimley's case, this upfront calculation in

2016 amounted to £236m across health and social care. To address this, the ICS is bringing together statutory bodies including local authorities, three principal providers and three CCGs (Surrey Heath, North East Hampshire and Farnham and the new East Berkshire), with an initial focus on seven transformation initiatives.

Some might point at the providers' relatively stable financial position as the foundation for its good progress to date and some early success. NHS Improvement's Q3 figures showed all three of the main providers forecasting a surplus for 2017/18, with surpluses in two of those cases being more than plan.

Mr Foster acknowledges that 'solid finances clearly help', but says Frimley Health's underlying position is much more challenging. In 2017/18, the trust was still benefiting from £15m of non-recurrent support related to its earlier acquisition. This income stream has now significantly reduced.

But a good financial base is only part of it. 'The thing that makes all the difference is the level of trust and the quality of the relationships we have across the system,' he says. 'If you don't have that, you won't progress as far or as fast.'

"The thing that makes all the difference is the level of trust and the quality of the relationships we have across the system"
Nigel Foster, Frimley Health

Common cause

Relationships across Frimley weren't always good – the system exhibited relatively adversarial relationships in the past. But the need to find a system solution for Heatherwood and Wexham Park marked a change in approach.

'Previously, there had been no great rationale for lots of conversations between CCGs across the patch,' Mr Foster says. 'But this gave us a common cause and reason to come together to develop a standardised approach to commissioning and contracting from the acute trust.'

This also meant there was an established footprint to work from when STPs came along, with a logic based on a common primary flow of patients into the acute provider Frimley Health. 'We've spent a lot of time developing relationships, perhaps especially with local authorities – they've been in the room from the outset with representatives on the ICS board and on the finance reference group,' says Mr Foster.

An integrated care system does not mean everything is decided together – or that there is one single model in all parts of the economy. 'Surrey Heath, for example, is continuing to work on integration and

Integrated focus on demand

Berkshire West is another first-wave integrated care system that is building on a history of integration. Local organisations started working in 2014 as the Berkshire West 10, including the four local CCGs (now merged into one), Berkshire Healthcare NHS Foundation Trust, Royal Berkshire NHS Foundation Trust, the ambulance service and three unitary authorities. The other key partner has been general practice, with GPs now organised into four alliances based on the old CCG boundaries.

However, the move to work as an ICS means the remit has broadened beyond the BW10's focus on frail elderly, mental health, children and the Better Care Fund. The system is pursuing a number of new care models. These include a more proactive way of supporting high intensity users – based on work from Blackpool and Fylde (*see Unlocking variation, Healthcare Finance April 2017*) – and work on musculoskeletal (MSK) services, outpatients and respiratory care.

Rebecca Clegg (pictured, facing page), acting chief finance officer for the newly merged Berkshire West CCG says the lack of financial headroom in the system means that progress is slower than participants would like. But it is also the reason why reform is so essential.

'With outpatients we want to understand what we can stop doing, what we can deliver using different technology and what would be better delivered in primary care or the community,' she says. 'Then we can understand the residual activity that still needs to happen as it does currently.'

The reality is that the make-up and potential solutions for outpatients are different specialty by specialty. And so the system is now pursuing multiple projects.

However, Ms Clegg says the system is not trying to recreate the wheel. Lots of other areas are pursuing changes to outpatients, and Berkshire West is keeping a close eye on the MSK work in mid-Nottinghamshire (*see New payment model, Healthcare Finance July 2017*). The current focus is on putting the right enablers in place to support the delivery of benefits in both outcomes and finances.

The payment approach to date has involved a block contract for community and mental health services (delivered by Berkshire Healthcare NHS FT) and a tariff-based contract for acute services (Royal Berkshire NHS FT), albeit capped and then using a marginal rate.

The ICS has set out a clear aspiration to put a single capitated budget and financial plan in place and to have contracts based on cost, not price.

Ms Clegg says for 2018/19 this still involves each organisation having its own contract, but is optimistic the system can make this happen in the not-too-distant future. A relatively simple system – with a single health commissioner, a single acute provider and a single mental health and community provider (alongside GP alliances) arguably makes this more straightforward than in systems with more complex patient and financial flows.

Alex Gild (pictured, facing page), chief financial officer at Berkshire Healthcare NHS Foundation Trust and the current HFMA president, says there is still commitment across the system to move to a single capitated or population-based budget. But momentum has reduced in the current regulatory environment, where the risk-

doing so very successfully – it is not in competition with what we are trying to do,' says Mr Foster.

There is also clarity about what is best done together and what individual organisations just need to get on with. 'Most of the things an acute trust has to do, it can just get on and deliver – debating them on a system level doesn't add any value,' he adds.

But for issues such as pathway redesign and ensuring organisations remain viable within transformed models of care, a system approach makes perfect sense.

Decision-making hubs

One key initiative is the development of integrated care decision-making hubs, building on existing work in local CCGs and North East Hampshire and Farnham's *Happy, healthy, at home* vanguard. This has seen community multidisciplinary teams managing people with a high risk of hospital admission and the creation of multidisciplinary assessment and rehabilitiation centres and hospital in-reach services.

The ICS has also taken a system approach to clinical variation, pursuing its headline opportunity areas identified by the RightCare programme. For example, Frimley is implementing a new neurology service across its whole system, providing proactive and reactive support to patients to enable them to live as independently as possible.

There are some positive signs that all its initiatives are bending the demand curve on hospital services. Recent figures suggest that there have been reductions in A&E attendances, non-emergency admissions and GP referrals across most of its commissioners. Some of these are significant – a 10% reduction in GP referrals from Surrey Heath, for example, and a 4% reduction in A&E attendances in the former Windsor, Ascot and Maidenhead patch. And the system believes that it can continue to control this demand in 2018/19.

Funding flows need to underpin these new models as current payment systems will not always support revised pathways. For example, more proactive community support may reduce hospital admissions. But reducing the hospital's payment using tariff (activity x price) would not recognise any fixed costs the hospital could not eliminate.

'We all recognise that not all the payment by results costs can be taken

benefits balance of moving more rapidly to an 'all costs' system risk share is not yet compelling. A system control total, encouraging partners to plan and act in the best interests of system resources is a step in the right direction. The next step is moving away from payment by results.

'We need to stabilise financial flows in a system control total environment and PBR doesn't support that,' he says. 'So the discussion is around moving to a fixed sum of funds for acute services. That is not necessarily a block contract as there could be slightly different risk arrangements, but it breaks the link with PBR, shifting mindsets to cost rather than price within the system.

'That will allow us the headspace to start looking at system costs and to understand better where there are interdependencies within pathways between partners and experiment with risk and gain share more clearly to incentivise system pathway improvements and cost reduction.'

Mr Gild stresses this is not a risk transfer to the acute provider. 'The intentions are still very clearly to deliver a system control total together, jointly supporting organisation pressures and system delivery in an open and transparent way.'

And moving to cost-based contracts is something the system hopes to make fast progress with. 'We only have payment by results as a proxy for costs at the moment,' says Ms Clegg. 'There is patient-level cost information at the Royal Berkshire but not yet in Berkshire Healthcare. But we are hoping to use the data we have to inform contracts.'

She says that crude block contracts are not appealing to either commissioners or providers. They do transfer risk to providers, but only future risk. By starting with the previous year's contract value, the commissioner in effect carries the risk of earlier care not having been delivered as cost effectively as possible.

The CCG's allocation is currently £25m below its fair share of funding – at 4.5% under target. Pace of change at the moment is modest given limited funding growth. The area hopes the government's promise of a long-term settlement for the NHS might also mean a faster pace-of-change policy on allocations.

But the system is not planning on this basis. 'What we want to do is to ensure that growth in demand is lower than our increase in allocation,' says Ms Clegg. 'If we can cap demand, that is where the gold is.'

out, and conversations are about what represents a genuine cost saving and what are reasonable challenges in terms of efficiency improvement,' says Mr Foster.

However, he says the system has 'moved away from thinking about spending a lot of time devising a new complex payment system', suggesting this would be 'almost a distraction from the main challenge.'

'So we will continue to turn the tariff handle,' he says, 'as that is the best point of reference everyone has for pricing activity and services across the system.' This will provide a starting point for conversations about what is affordable and what is needed – and all within the context of meeting its newly set system control total.

Convergence 2.0

Berkshire West chief finance officer Rebecca Clegg and Frimley Health NHS Foundation Trust director of finance Nigel Foster are taking part in a session on moving integrated care systems from theory to practice at this year's HFMA Convergence conference on 5-6 July. The event brings together the HFMA's annual provider and commissioning conferences to again focus on the integration and collaboration agenda. Mark Orchard, immediate past president of the HFMA and finance director of Poole Hospital NHS Foundation Trust, will provide an update on progress in Dorset. The conference will also highlight ongoing work in Nottinghamshire and Staffordshire, with a keynote address from Northumbria Healthcare NHS Foundation Trust chief executive and former NHS Improvement chief executive Jim Mackey.

• **See page 29 for more details**

Frimley, like many other ICSs and STPs, does talk about moving towards 'one budget', although this is currently more figurative – getting best value out of the £1.7bn spent on health and care – than literal.

Mr Foster acknowledges there are different views on how this might move forward. 'My view is we need to explore the idea of one budget – but it is not the main thing,' he says. 'The priority is keeping trust and relationships going. There are already enough ways to move money around the system between organisations – and we don't even need a system control total for that.'

However, he acknowledges that in more financially challenged systems, more formal funding flows may be important.

rising interest

NHS Improvement has again underlined the importance of improving costing, insisting patient-level cost data has a major role in the transformation of the health service and in the move to integrated care systems (ICSs). And it has repeated that there are growing numbers of would-be users of new patient-cost data waiting for the programme to deliver more detailed, granular data.

Speaking to the HFMA Costing for Value Institute's annual costing conference in April, NHS Improvement director of strategy Ben Dyson described the move to patient-level costing as 'vital to the future of the NHS'. He made no apologies for the 'grand' language, insisting it really was seen in these terms by the oversight body.

'There are continuing constraints on NHS funding and continuing challenges of an ageing population and increasing numbers of people living longer with increasing numbers of complex health conditions,' he said.

'So it is more vital than ever that we understand the relationship between the needs of different patient groups, the activities and care we deliver and the outcomes and how that all relates to the cost base. This triangulation is right at the heart of the Costing Transformation Programme (CTP). Without patient-level costings, we can't build up that rich picture in individual organisations and across health economies.'

He said patient-level costing could play a major role in the move to greater system working through integrated care systems. This required organisations to come together to make decisions about the resources they are using across the system and the outcomes they are achieving. 'ICSs really can't do this if they haven't got really good cost data in organisations and across sectoral boundaries,' he said, adding that patient cost data combined with outcomes data could be the glue that unifies organisations in systems.

NHS Improvement believes improved costing is vital to the future of the NHS and there is growing interest from a number of different stakeholders in establishing this new detailed dataset

Colin Dingwall, CTP programme director, told the conference that the rollout of the programme was about half way through – with a first mandatory submission of patient-level cost data from all types of organisation in England in 2021. (Acute trusts will face their first mandatory submission in 2019 and NHS Improvement will consider making it mandatory for community, mental health and ambulance services.)

Some 67 providers last year took part in a voluntary submission, mostly from the acute sector. And Mr Dingwall said there were others who 'fell at the last hurdle'. Some 140 providers have signed up for the same again this year, including more than 100 acutes, half of the country's mental health trusts, most of the ambulance trusts and a small number of community providers.

In fact, there will be five collections – including collections for acute, mental health, community and ambulance services, and a pilot collection for education and training. NHS Improvement will attempt to reconcile the outputs of the acute collection with the reference costs collection.

'And if we can persuade users of reference costs data that this is a credible source for that reference cost data, we'll move to a single PLICS-based collection next year,' said Mr Dingwall. 'We can't guarantee this, but it is our aspiration to reduce some of the burden on [costing practitioners].'

Mission statement

Mr Dingwall suggested NHS Improvement was determined to get data back out to trusts quicker this year to enable them to make earlier decisions about resubmissions. And there are plans to further develop the online data portal and create a series of case studies on how costing data can be put to use in understanding and identifying variation and driving improvement.

He added that while the acute standards were nominally in their final format, NHS

Improvement still wanted to hear about aspects that could be improved.

He also announced two pilot programmes that are being taken forward as part of the wider CTP. First, NHS Improvement is working with NHS Digital and NHS England on how cost and outcome data could be linked across the system. 'We are aware there is a range of different outcome sources and we want to give this a push,' he said.

In the second pilot, the oversight body is working closely with the Nottinghamshire ICS to 'develop a model for costing that links costs across different care settings'. Many think this is the ultimate benefit of patient-level costing – enabling the costs and interactions across whole patient journeys to be seen alongside outcome data. This would provide much greater information around the impacts of moving services into community settings or providing more proactive care.

'If we can do something like this and address some of the information governance challenges as well, we could add a huge amount of value,' said Mr Dingwall.

He said that within three to five years the NHS could have a 'single standard benchmarkable cost dataset' and be able to provide a population view of care, including costs, linked across care settings. Linking costs data to outcomes would help organisations and systems to focus on the delivery of value. Decision-making would be supported by better data and tariffs and pricing would also be based on better source data.

Mr Dyson (above) and Mr Dingwall (right) referred to the growing interest in patient-level cost data from other initiatives looking to support improvement, sharing of best practice and elimination of unwarranted variation. Currently, reference cost data underpins the *Getting it right first time* (GIRFT), NHS RightCare and Model Hospital initiatives (see box). The better accuracy and consistency of patient cost data based on a detailed national methodology – combined with the ability to drill down into the make-up of costs at individual patient and aggregate level – is expected to enhance the value of these centrally led programmes.

GIRFT agenda

Consultant physician Martin Allen is the respiratory lead for GIRFT, and he confirmed the programme has high hopes for new patient-level cost data. The programme uses peer review against national standards and benchmarks to identify unwarranted variation within provider organisations. It started with orthopaedic surgery in 2012, but now covers more than 30 workstreams.

Dr Allen said there was substantial clinical variation across the service, even where national guidelines – for example, from the National Institute for Health and Care Excellence – set out the most clinically and cost-effective approaches. Patient-level cost data would help clinicians to understand the financial implications of unwarranted variation – helping to identify more opportunities for improvement and making the case for change more convincing. He said the goal had to be to 'spread this across the whole care pathway'.

He cited an example from the orthopaedics work of clinicians using uncemented hip joints costing £5,300 each rather than a £650 cemented implant, despite there being no difference in the outcomes for the over 65s. Change in practice would deliver the same outcomes and save an estimated £4.4m. With reductions in costs of loan equipment, length of stay, readmissions and infection rates, he said the programme had already pulled out about £50m of orthopaedic spend in its work to date – and there had been parallel improvements in the costs of litigation.

Dr Allen said the peer review approach – clinicians talking to clinicians – marked the GIRFT work out from other improvement initiatives. But in general he said that engagement was key and that in many cases all you needed to do was show a clinician variation. There was also agreement from all the speakers that language was important.

'Understandably if you talk about making savings, people can get defensive,' said Mr Dyson. 'But if you talk about using resources in a different way to create better outcomes for patients, people think in a different way.' And he added that finance teams had a big role to play in this translation exercise.

Model Hospital

NHS Improvement's Model Hospital programme is keenly awaiting the creation of a rich national database of detailed patient-level costs. The Model Hospital was born out of the Carter review of productivity as a way of bringing together comparative data on productivity, quality and responsiveness from across NHS providers. Providers can use it to compare their own performance in a number of areas to the national average or the performance of a group of selectable peers.

Data comes from multiple sources including bespoke and regular national returns, the electronic staff record, providers' annual accounts and, currently, reference costs. In particular the reference costs enable the calculation of a productivity metric – the cost per weighted activity unit (the cost for a unit of clinical activity).

However, replacing reference costs with patient-level costs is expected to enhance the value of the model hospital tool in a number of ways. First it should improve the accuracy and comparability of costs, courtesy of a standardised national costing methodology.

And the level of detail that can be examined will also be enhanced. For example, patient-level cost data enables clinicians or managers to look at the range of costs for different patients and how different cost components such as theatres contribute to the overall cost.

The Model Hospital is arranged in five different 'lenses' – board-level oversight, clinical service lines, operational, people, and patient services. And each lens includes a number of compartments giving access to analysis of detailed metrics. For example, the operational lens includes compartments on theatres, pathology, procurement, corporate services and estates.

The clinical service lines lens includes a number of different specialties, all of which include some headline metrics such as overall spend, the specialty's spend as a proportion of all spend, clinical output (WAUs) and cost per WAU as well as more detailed metrics such as theatre utilisation.

But many of the specialties also pull in the metrics used in the GIRFT initiative.

In a recent NHS Improvement webinar, Professor Tim Briggs, GIRFT programme chair, said that by December 2019, the Model Hospital would give access to between 6,500 and 10,000 quality metrics for every trust in England across 35 specialties.

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Trusts told what to expect from new use of resources assessment

Technical update

NHS Improvement began undertaking new use of resources (UoR) assessments in October last year. But at the start of March, for non-specialist acute trusts, these new assessments are being considered as a sixth key question alongside the Care Quality Commission's own existing quality ratings (for safe, caring, effective, responsive and well-led), *writes Debbie Paterson.*

Like CQC's five quality questions, use of resources will be given a rating of outstanding, good, requires improvement or inadequate. This means that after the combined assessment, affected trusts will receive a:

- Rating for each of the CQC five key questions
- Combined rating for the CQC's five questions
- Rating for UoR
- Combined rating for all six questions.

All of the ratings are determined by the CQC, but the UoR assessment is undertaken by NHS Improvement, which concludes its assessment by recommending a rating to the CQC.

The UoR assessment is retrospective, while the well-led assessment is forward-looking and focuses on governance.

The new UoR rating was the topic of March's HFMA Provider Finance faculty forum, with NHS Improvement and the CQC presenting alongside NHS bodies that have been through the process. Assessed bodies reflected on a positive process and there was a consensus that getting the UoR rating is not the prize – what matters is how the data is used and the feedback.

All acute trusts need to be familiar with the CQC and NHS Improvement's assessment framework. It should be used by providers as they prepare for their NHS Improvement visit and, more generally, as a management tool to get operational engagement with the model hospital and the UoR process. A brief guide for non-specialist acute trusts is also helpful pre-visit.

The assessment visit lasts one day and follows a fixed agenda that NHS Improvement sends through in advance with suggestions for who should attend – all board members/senior managers as a minimum. Feedback is that this is an intensive day.

Providers are given the opportunity to present at the start of the visit – and are told to 'focus on what you are proud of'. They should also be aware of where things aren't so good as these will be picked up later in the day.

All of the data used is already available – most of it in the Model Hospital database – and the focus is on unwarranted variations. Ahead of the visit, NHS Improvement asks for a short data return, although providers may produce more extensive submissions.

NHS bodies will be challenged to produce evidence to support any assertions they make – and data quality is not acceptable as a reason for variation. The oversight bodies stress the importance of NHS bodies understanding their data and are keen to underline the cost per weighted activity unit (WAU) as a key metric.

The assessment covers five areas – clinical services, people, clinical support services, corporate services (procurement, estates and facilities) and finance. The areas taking the most time are clinical support and corporate services. The finance questions are straightforward – is the provider operating within its control total – then the focus shifts to what is driving this.

NHS Improvement will feed back on areas of good practice and those in need of improvement. It will not give an indicative rating as this is for the CQC to determine. The final report will include a detailed report and action plan.

Links to the SOF

The use of resources assessment is not a replacement for the finance score calculated for NHS providers as part of NHS Improvement's single oversight framework. Confusingly, one of the themes in the SOF is 'finance and use of resources' and the finance score (name changed from the finance and use of resources score) is calculated monthly. This score continues to provide a 1 (best) to 4 rating based on five metrics: capital service capacity; liquidity; income and expenditure margin; distance from financial plan; and agency spend. The UoR report and rating will be used alongside the finance score to inform the oversight body on a provider's support needs.

How the published rating could look

	Combined rating	**Requires improvement**
Quality: Requires improvement	Safe	Requires improvement
	Effective	Good
	Caring	Good
	Responsive	Requires improvement
	Well-led	Good
Resources: Good	Use of resources	Good

Technical review

The past month's key technical developments

Technical roundup

The HFMA has responded to a consultation on amendments to the **Charities Statement of Recommended Practice**. The changes reflect the latest version of FRS 102. The association largely supported amendments likely to affect NHS charities – the requirement to include comparatives in the accounts for all disclosures; changes on investment properties; and a new requirement to disclose movements in net debt as a note to the cashflow statement. However, it noted that including prior period comparatives for all disclosures can make accounts difficult to read and does not align with the clear and concise disclosure initiatives. http://hfma.to/65

NHS Improvement has updated its guidance on the **statutory breakeven duty** for NHS trusts. The duty, which does not apply to foundations, was last updated in 2013. The new document replaces that guidance, though NHS Improvement said there are no changes of substance to the operation of the breakeven duty. The changes update terminology and context, it added, including explaining the link between control totals and the breakeven duty. http://hfma.to/6a

The HFMA and NHS Improvement **NHS efficiency map** has been updated and redesigned. The new-look map includes new links to tools and suggested reading matter and is organised in three sections: enablers for efficiency; provider efficiency; and system efficiency. Some 67 studies, tools and reports have been added, bringing the total to nearly 180. The provider efficiency section also includes a new improvement area giving ideas to improve patient flow. http://hfma.to/66

NHS England and NHS Improvement have published five case studies on the experiences of clinical commissioning groups and trusts that have developed, or are developing, an **outcomes-based payment approach for improving access to psychological therapies** (IAPT) services. The 2017/19 national tariff included local pricing rule 8, which required commissioners and providers to introduce an outcomes-based approach for IAPT from April 2018. The national bodies said the case studies would provide clarity and further support to the NHS. Some commissioners and providers had concerns that previously developed approaches – or those being developed – would fall foul of rule 8. http://hfma.to/69

A new briefing from the HFMA provides a practical guide to **conflicts of interest** in the NHS. It is a subject the association has tackled before, most recently in 2015, but the new guide has been updated to recognise the move to greater system working and commissioning of new models of care. *A short practical guide to conflicts of interest in the NHS* in particular reflects NHS England guidance on managing conflicts of interest – across the NHS and specifically for clinical commissioning groups – published in 2017. http://hfma.to/6d

Ethical standards: roles and responsibilities of the NHS accountant is a new briefing from the HFMA that reminds finance staff, governing bodies, clinicians and others of the ethical roles and responsibilities of the NHS accountant. The guide – introduced in a blog by HFMA research manager Lisa Robertson (http://hfma.to/67) – explores the ethical dilemmas facing NHS finance staff; summarises the ethical requirements; and sets out what NHS finance staff can do to ensure standards are met. http://hfma.to/68

Patient-level costing cost collection file specifications have been issued by NHS Improvement. The templates are aimed at software suppliers and costing practitioners participating in 2017/18 **patient-level cost collections**. The documents include a data validation tool that assesses the quality of files before submission to NHS Digital – minimising the chance of submission failure and the need to resubmit. The latest costing newsletter has also been published and includes information on the latest standards, webinars and the costing assurance programme. http://hfma.

Tocilizumab for treating giant cell arteritis

NICE update

NICE has produced a guideline (*TA518*) that recommends tocilizumab as an option for treating giant cell arteritis in adults, *writes Nicola Bodey*.

Tocilizumab, used with a tapering course of glucocorticoids (and when used alone after glucocorticoids), is recommended for treating giant cell arteritis in adults, only if:

- They have relapsing or refractory disease
- They have not already had tocilizumab
- It is stopped after one year of uninterrupted treatment at most
- The company provides it with the discount agreed in the patient access scheme.

Giant cell arteritis (sometimes called temporal arteritis) is a condition causing inflammation in the walls of medium and large arteries, usually in the head and neck. This causes the arteries to narrow, which restricts blood flow.

The standard treatment is a high dose of glucocorticoids, gradually reduced over time. High doses of glucocorticoids may cause a number of problems, including skin problems, weight gain, diabetes and osteoporosis.

The annual incidence of adults with giant cell arteritis is around 9,600 in England. Some 4,100 adults (43%) are estimated to have relapsing or refractory disease and will be eligible for treatment with tocilizumab. From 2019/20 once peak uptake of 10% is reached (in line with an NHS England clinical commissioning policy), 410 adults are expected to be treated with tocilizumab.

A resource impact template has been produced to support implementation of the guideline – allowing organisations to estimate the local cost. Tocilizumab has a patient access scheme, agreed between the Department of Health and Social Care and Roche, which makes it available with a commercial-in-confidence discount to the list

Diary

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
24 B Eastern: health sector insights 2.0, Cambridge
24 B London: VAT focus group level 3, Mayfair

June

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

July

5 B London: VAT focus group level 1, Rochester Row
5-6 N Convergence 2.0, East Midlands Conference Centre
11 B Kent, Surrey & Sussex: keep stepping, Crawley
25 B Kent, Surrey and Sussex: introduction to finance, Crawley

September

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

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

key B Branch N National F Faculty I Institute

price. Tocilizumab will be delivered at home, with the cost of training for administering subcutaneous injections being covered under the homecare programme. It is therefore assumed that VAT is not applicable to the costs of tocilizumab.

Benefits include more people being expected to stay in remission and receive lower cumulative doses of glucocorticoids compared with people having glucocorticoids alone. There may be a reduction in adverse events, the number of appointments required, and the use of concomitant medications.

Nicola Bodey is senior business analyst at NICE

Events in focus

Convergence 2.0
5-6 July, Nottingham

The second HFMA Convergence conference brings together commissioners and providers. Against the backdrop of greater collaboration between organisations in the NHS and other sectors such as social care and volunteers, former NHS Improvement chief executive Jim Mackey (pictured) will give his views on integrated care. Now returned to his previous role as chief executive of Northumbria Healthcare NHS Foundation Trust, Mr Mackey will reflect on his time at the oversight body and how Northumbria's integration fits with the national agenda.

Nottinghamshire is also a frontrunner in integrated care, and local leaders, including sustainability and transformation partnership (STP) chair David Pearson, will set out their vision. Mr Pearson will deliver a plenary session on unified healthcare, while colleagues will hold workshops on how the partnership has embedded out-of-hospital care and mental healthcare in the work of the STP and emerging integrated care system (see Network focus, p31).

The conference will also look at the future of the NHS. The service turns 70 during the event and many organisations, the HFMA included, have called for a new long-term plan to see the service to its 100th anniversary. Issues likely to be faced over the next few years, such as workforce, technological advancements and citizen empowerment, will be debated. The development of integrated care systems and integration with local authorities will take centre stage on day two.

• Day tickets are now available. For details or to book a place, email emily.bowers@hfma.org.uk

Annual conference 2018 – Brighter together
5-7 December, London

The HFMA is now taking bookings for the centrepiece in the NHS finance calendar – the association's annual conference. The conference offers the opportunity to hear the latest thinking on developments in healthcare finance from home and abroad. Taking HFMA 2018 president Alex Gild's theme, *Brighter together*, the event will include workshops and a chance to network with colleagues. Places that are booked before 30 June will be charged at a discounted rate – the names of delegates can be confirmed at a later date if preferred.

• For further information or to book, email josie.baskerville@hfma.org.uk

Plans and pay promises

Association view from Mark Knight, HFMA chief executive

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

My HFMA

I'm delighted the message finally seems to have got through to those in power that we need a long-term, sustainable settlement for the NHS and, hopefully, the social care system.

The third series of the BBC's wonderful *Hospital* programme – this time at Nottingham University Hospitals NHS Trust – has provided a timely reminder of why this is essential. It is wrong on so many levels to have so many medically fit people with nowhere in the social care system to go.

We need a holistic plan that integrates care around patients' needs. And we also need to factor in, to a much greater degree, the social determinants of health, such as poor housing, poverty and lack of opportunity.

The devil will be in the detail, but it is a major step forward to have politicians talking seriously about this. It was in this spirit that HFMA presidents Mark Orchard and Alex Gild have so actively championed our 'NHS at 100' project, speculating what the health and care system will need in 30 years. A roundtable will be taking place in May, with a report to follow in July.

Another welcome development is the pay award. Although it barely gives health workers an increase relative to inflation, based on the CPI index, it does break the cycle of increases of 1% or below. Workforce is a major issue, whether the service is dealing with 'normal' shortages in supply or the added complications of Brexit.

The pay settlement will no doubt be a key focus of our workforce forum on 20 June, one of our free national events for members. Of equal interest is how the increased pay awards will be funded and how the money will flow through to where it is needed. We are told it is new money, but we'll tracking this in the coming months.

We are now in a new financial year, with plans for much closer working between NHS England and NHS Improvement. At the time of writing it's not clear exactly what this will look like. As an association, we have historically followed the statutory structures with the format of our branches. This was last changed in 2006 with the advent of 10 more regionally focused SHAs. However, in the light of proposed changes, we may have to take a look again at how we are organised and tailor our offering to suit. But I'm not expecting much change, and we don't have to worry about our devolved nation branches.

HFMA chief executive Mark Knight

Another way we are responding to the changes in the system is a move towards various faculties working together. This is most evident in our Convergence 2.0 conference in July. After a long absence, we are going back to a university campus to lend an academic feel to proceedings. However, unlike my own alma mater in the 1980s, students these days reside in the equivalent of hotel luxury, which we are able to take advantage of. If you've got the chance to come along, this event makes an informative alternative to December's annual conference.

As we move forward through this year, you may want to reflect on whether you could become more actively involved in HFMA. We have all sorts of interesting volunteer roles offering a real opportunity to shape your association.

I'm available to chat to any member who's interested in getting involved. So what are you waiting for?

Member news

Marcus Thorman, chief financial officer at The Royal Marsden NHS Foundation Trust, ran the London Marathon in just over 3.5 hours in support of JDRF, a charity that supports research into type 1 diabetes, and The Royal Marsden Cancer Charity. You can still sponsor him at **https://lnkd.in/dr2WkZj**

Nominations are open for three HFMA branch awards:
- West Midlands will host its awards ceremony afer its annual conference on 7 June. The deadline for nominations is 4 May, see **http://hfma.to/62**
- London is accepting awards nominations until 18 May and will announce the winners on 21 June. See **http://hfma.to/64**
- South West is accepting nominations until 1 August and will host its awards ceremony on 20 September in Bristol. Find out more about the five categories at **http://hfma.to/63**

HFMA membership manager Flo Greenland has moved to Canada, so James Fenwick has been appointed as the new membership executive. Joanne Hitchen is the new Commissioning Finance Faculty executive, following Jonathan Richards' appointment as HFMA events manager.

Joe Burton, one of three apprentices employed by the HFMA in 2016, is the first to secure a job after completing his IT systems course. He is now an IT analyst for a private company.

Recently qualified? Make sure your record is up to date and you are on the right level of membership – use the MyHFMA app, email **membership@hfma.org.uk**, or call James Fenwick on 0117 938 8992.

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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

Provider and Commissioning Finance

'Leaders in NHS and local government organisations must be focused on their own organisation responsibilities, but also work together to deliver joint outcomes for the population,' says David Pearson (pictured), corporate director adult social care, health and public protection at Nottinghamshire County Council and lead officer for Nottinghamshire Sustainability and Transformation Partnership.

Organisations must work in partnership to serve the population well, he says. 'When I became a director of social services 13 years ago, I could afford to spend 80% of my time looking at social services and 20% of my time working in partnership to make the system work better. Now, leaders need to spend about half their time making sure the system is successful.'

Partnership work has been a focus for Mid Nottinghamshire and South Nottinghamshire for years. It was one of the NHS vanguard sites and a pilot for integrated personal commissioning. The Prism (profiling risk, integrated care, self-management) programme is one example of its partnership projects. The project uses integrated community teams to identify the top 2% of the population with the highest risk of hospital admissions. These multidisciplinary teams have managed to better support patients and reduce emergency admissions.

'While partnership work doesn't solve all financial challenges, it can make a significant difference toward both outcomes and value for money,' says Mr Pearson.

The importance of partnerships is reflected in the bringing together of the HFMA Provider Finance and Commissioning Finance Faculties annual conferences for the second year. The event will take place in Nottingham on 5 and 6 July.

Mr Pearson and his colleagues will take part in a panel discussion at the conference. They will share the ingredients of their success, the challenges they've faced and their plans for the future.

Mr Pearson has a rule of thumb for transformation: to make a change that will save money, you need to invest an average of 10% of the final savings. 'We often underestimate and don't provide for the capacity and capabilities to make change. This goes back to investing in the skills and capabilities to do it,' he says.

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Yorkshire and Humber laura.hill@hdft.nhs.uk

Appointments

Queen Victoria Hospital NHS Foundation Trust has appointed **Michelle Miles** director of finance and performance. She was previously deputy director of finance at Croydon Health Services NHS Trust. Ms Miles has worked in the NHS for 20 years, having started her career as a band 3 management accountant. She has a strong community background, having worked in community and primary care trusts. Ms Miles succeeds acting director **Jason McIntyre**.

Usman Niazi has been appointed interim director of finance at Lewisham and Greenwich NHS Trust. Mr Niazi was previously deputy director of finance at the organisation. He succeeds **John Hennessey** (pictured), who has been in the position since 2006. Mr Hennessey is now interim director of finance at Norfolk and Norwich University Hospitals NHS Foundation Trust, where he takes over from **James Norman**.

Whittington NHS Trust has appointed **Kevin Curnow** operational director of finance. Mr Curnow's previous position was acting director of finance at Hertfordshire Community NHS Trust.

Andy Robinson has retired from the NHS after 27 years in the service. His most recent position was system lead director of finance at Devon Sustainability and Transformation Partnership. This role will be covered on an interim basis by **John Dowell** alongside his role as a chief finance officer at Northern, Eastern and Western Devon and South Devon and Torbay clinical commissioning groups.

Another participant in the Aspiring Finance Leaders Talent Pool programme, **Neil Atkinson** (pictured), has moved to his first substantive role as a director of finance. Mr Atkinson, recently associate director of finance at Leeds Teaching Hospitals NHS Trust, is now director of finance at North Tees and Hartlepool NHS Foundation Trust.

Bridgewater Community Healthcare NHS Foundation Trust has appointed **Sue Hill** director of finance. Ms Hill was previously deputy director of finance at St Helens and Knowsley Teaching Hospitals NHS Trust. She joined the NHS in 2012 after a career in the private sector and succeeds Gareth Davies, who has moved to a position at Network Rail.

Paul Briddock (pictured) is now director of finance for NHS England (North Midlands). He has worked in NHS finance for nearly 25 years, including 15 as finance director at Sheffield Children's NHS Foundation Trust and then Chesterfield Royal Hospital NHS Foundation Trust. Recently, he was director of policy and technical at the HFMA.

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

"Having the opportunity to meet other board members enabled me to understand the importance of developing cross-board relationships and to pay attention to the differing needs of non-executive directors"
Angela Hibbard, Devon Healthcare NHS Trust

Hibbard steps up to FD

On the move

Angela Hibbard has no doubt the support from the NHS finance leaders national talent pool has been a key element in her appointment to her first director of finance role.

Newly appointed as director of finance at Northern Devon Healthcare NHS Trust, she says: 'I would highly recommend this development programme to anyone who is aspiring to be a director of finance. It will open up your personal networks, open up your eyes to the role, give you exposure to opportunities around you and most importantly build your confidence in your readiness to do the job.

'Perhaps the most important aspect for me was the focus on a more targeted personal development plan to help me reach my goal. Having the HFMA and Future-Focused Finance attached to this programme helped me approach directors of finance within my local system, but outside my own organisation, for support in my development.

'The response I had was incredible, enabling me to identify specific areas I needed to tackle and more importantly how I would bridge the gap in my own experiences.'

The new network led to her shadowing a director of finance in an acute trust through a number of internal meetings. This included private board meetings, giving her access to the chief executive and other board members.

'I was also able to secure time with our frontline mental health services to expand my knowledge of areas I had not had much exposure to. These specific areas of development enabled me to see the reality of being a director of finance in today's NHS and helped me to determine whether it was right for me at this time.

'Ultimately I took myself out of my comfort zone and found actually it didn't feel that uncomfortable after all. This then led me to have a belief in myself and my ability to perform at this level, which pushed me forward to apply for the role [at Northern Devon].'

Ms Hibbard joined the NHS in 2003, working first in acute trusts, NHS England and latterly was deputy chief finance officer at Northern, Eastern and Western Devon Clinical Commissioning Group.

Going for the top finance job was daunting, but she said she felt well prepared by the talent pool. 'The rigorous selection criteria not only tested my ability to perform to a high level in an interview setting but also validated my position as being an aspiring director of finance.

'Having that acceptance from a panel of highly experienced existing directors of finance was a significant boost to my confidence.'

Meeting other finance staff with similar career goals was inspiring, she adds. 'The atmosphere was highly charged and full of ideas, which the next generation of leaders could bring to the table. I left the first masterclass feeling motivated to make a step change in my career.'

Ms Hibbard says the masterclasses held as part of the programme gave her a valuable insight into the selection process that directors of finance go through. This made the eventual process less daunting and enabled her to tailor her interview preparation to ensure she made the greatest impact.

'Equally, having the opportunity to meet other board members enabled me to understand the importance of developing those cross-board relationships and to pay particular attention to the differing needs of the non-executive directors,' she adds.

Taking part in the programme also offered the opportunity to join the national NHS England finance working group. This group includes clinical commissioning group chief finance officers and senior NHS England finance leaders.

'Having the opportunity to liaise at this level and understand the national picture helped me to appreciate the political knowledge you need to develop when managing relationships outside your own organisation,' says Ms Hibbard.

FFF increases clinical engagement

Future focused finance

As pressure mounts on the NHS, improving financial and clinical engagement remains a top priority for Future-Focused Finance. Almost every decision a clinician makes about patient care has financial implications and the FFF FACE (Finance and Clinical Educator) network believes that all doctors should understand at least the basics of NHS finance.

On 12 June, the FACE network will be running a *Finance 4 clinicians* day in Bristol, where it will be training 80 junior doctors in the basics of NHS finance and

the importance of working collaboratively.

FFF senior responsible officer for its *Close partnering* workstream, AK Maheswaran (left), will lead the day. AK, a doctor who has been working with Health Education England East Midlands on the finance element of its medical leadership and management programme, will be joined in Bristol by a range of speakers, including the HFMA 2017 Clinician of the Year, Paul Buss.

FFF will run a series of events throughout the year and across the deaneries to train as many clinicians as possible. It has also created resources on the basics of NHS finance at **www.finance4clinicians.co.uk** and will add to this in the coming months.

Educating clinicians on the mechanics of NHS finance will allow them to work with their finance colleagues to improve patient care. FFF aims to have in every NHS organisation at least one educator, who is best placed to champion clinical engagement and financial training.

If you are interested in becoming 'the FACE of finance' in your organisation, email **futurefocusedfinance@nhs.net**

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5–6 July 2018
Convergence 2.0

East Midlands Conference Centre, Nottingham

Day delegate passes are now available

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

AVAILABLE
Day delegate passes
NOW

We're looking forward to hearing from...

Jim Mackey, Northumbria ACO

Elizabeth O'Mahony, Chief Financial Officer at NHS Improvement

Anita Charlesworth CBE, Director of Research and Economics at the Health Foundation

Anthony Bennett, ('Miracle Man') Patient Speaker

Kriss Akabusi, Motivational speaker and Olympian

....and many more

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

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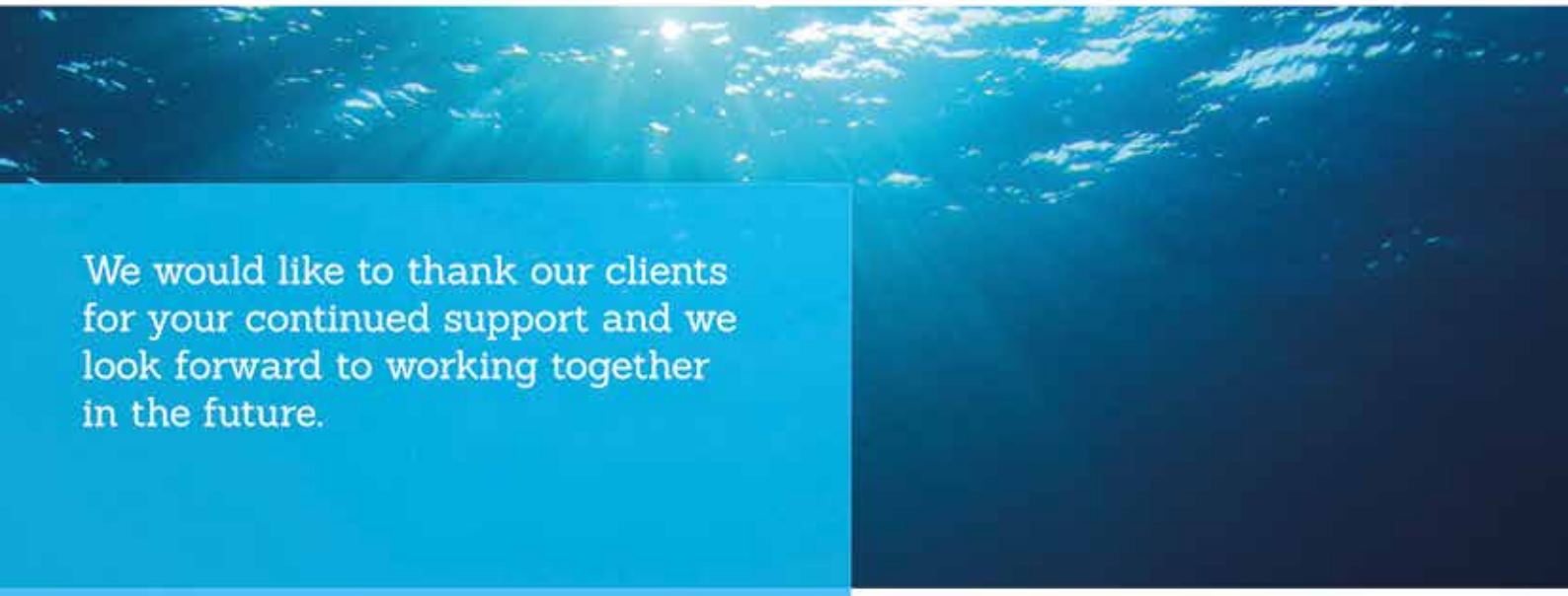

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