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November 2018 | Healthcare Financial Management Association

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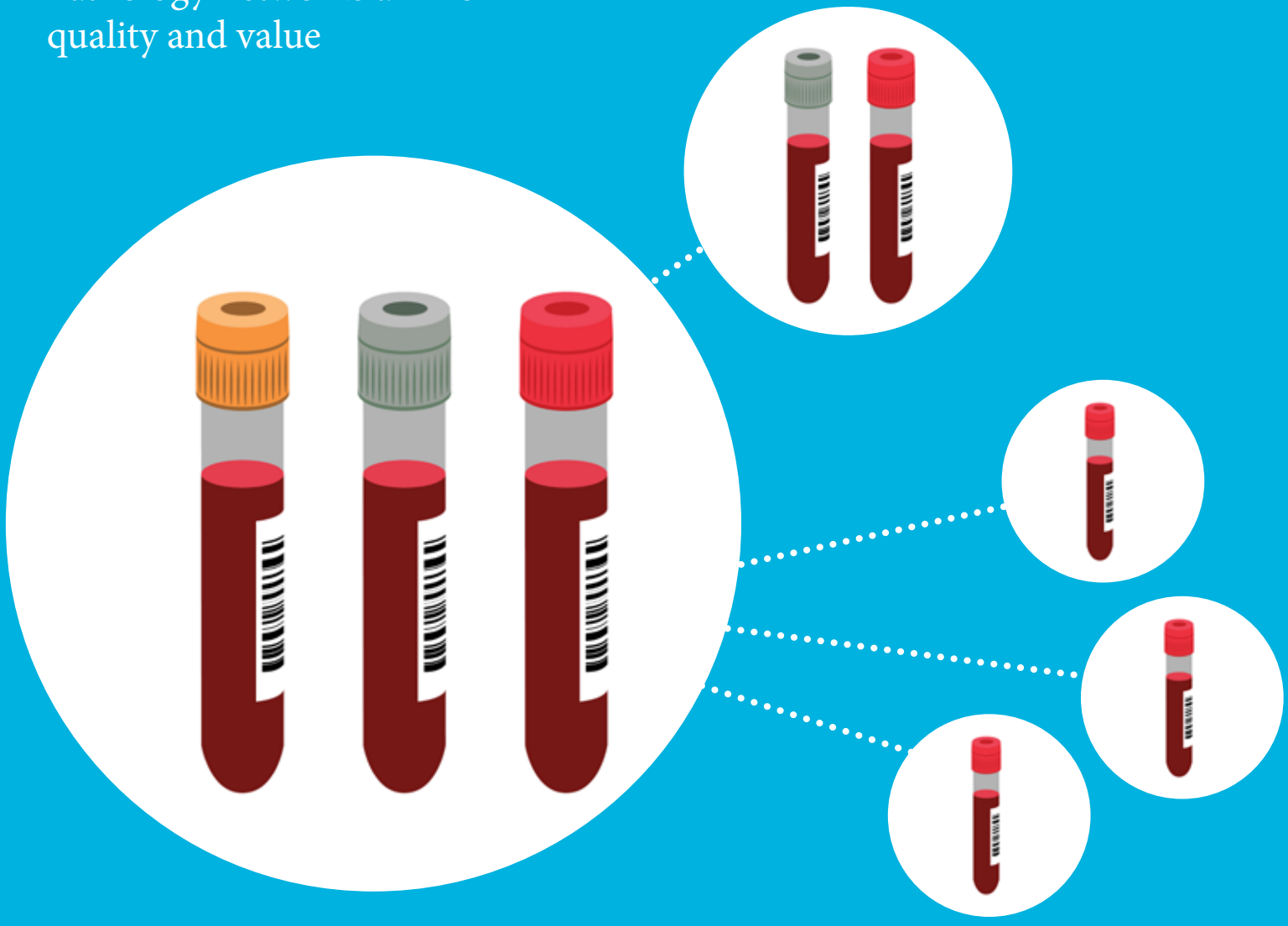
Productivity path

Pathology networks aim for quality and value



HFMA AWARD 2018

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HFMA Awards 2018 short list announced!

Finance Director of the Year

Sponsored by GENMED

- Kathy Roe, Tameside and Glossop Strategic Commissioning Function
- Suzanne Robinson, North Staffordshire Combined Healthcare NHS Trust
- Andrea McGee, Warrington and Halton Hospitals NHS Foundation Trust
- Sandra Easton, Chelsea & Westminster Hospital NHS Foundation Trust

Finance Team of the Year

Sponsored by PA

- Leeds Teaching Hospitals NHS Trust
- Wrightington, Wigan and Leigh NHS Foundation Trust
- University Hospitals of Derby & Burton NHS Foundation Trust
- Chelsea & Westminster Hospital Foundation Trust

Deputy Director of Finance of the Year

Sponsored by Meridian

- Duncan Orme, Nottingham University Hospitals NHS Trust
- Tarryn Lake, Sunderland CCG
- Mike Newton, North Staffordshire Combined Healthcare NHS Trust
- Helen Troalen, The Royal Wolverhampton NHS Trust

Costing Award

- Leeds Teaching Hospitals Costing Team
- Wrightington, Wigan and Leigh NHS Foundation Trust
- Cwm Taf University Health Board
- East Kent Hospitals University NHS Foundation Trust

Governance Award

Sponsored by wardhadaway lawfirm

- Leeds Teaching Hospitals NHS Trust
- Northern Care Alliance NHS Group and MIAA
- Chelsea & Westminster Hospital NHS Foundation Trust
- Berkshire West Integrated Care System with PwC

Innovation Award

Sponsored by prime

- Wrightington, Wigan and Leigh NHS Foundation Trust
- Western Sussex Hospitals NHS Foundation Trust & Coastal West Sussex CCG
- East Lancashire Hospitals NHS Trust
- Devon Partnership NHS Trust

Havelock Award

- NHS Wales Finance Academy
- Leeds Teaching Hospitals NHS Trust
- Betsi Cadwaladr University Health Board
- Wrightington, Wigan and Leigh NHS Foundation Trust

Working with finance – clinician of the year

- David Berridge, Leeds Teaching Hospitals NHS Trust
- Sally Kidsley, Solent NHS Trust
- Dr Phil Wood, Leeds Teaching Hospitals NHS Trust
- Paula Wilkinson, Mid Essex CCG

For more information, please visit hfma.to/awards or contact awards@hfma.org.uk

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

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

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

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

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

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

Production
Wheal Associates
020 8694 9412
kate@whealassociates.com

Printer
BCQ Group

HFMA
1 Temple Way,
Bristol BS2 0BU

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

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

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

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RMS
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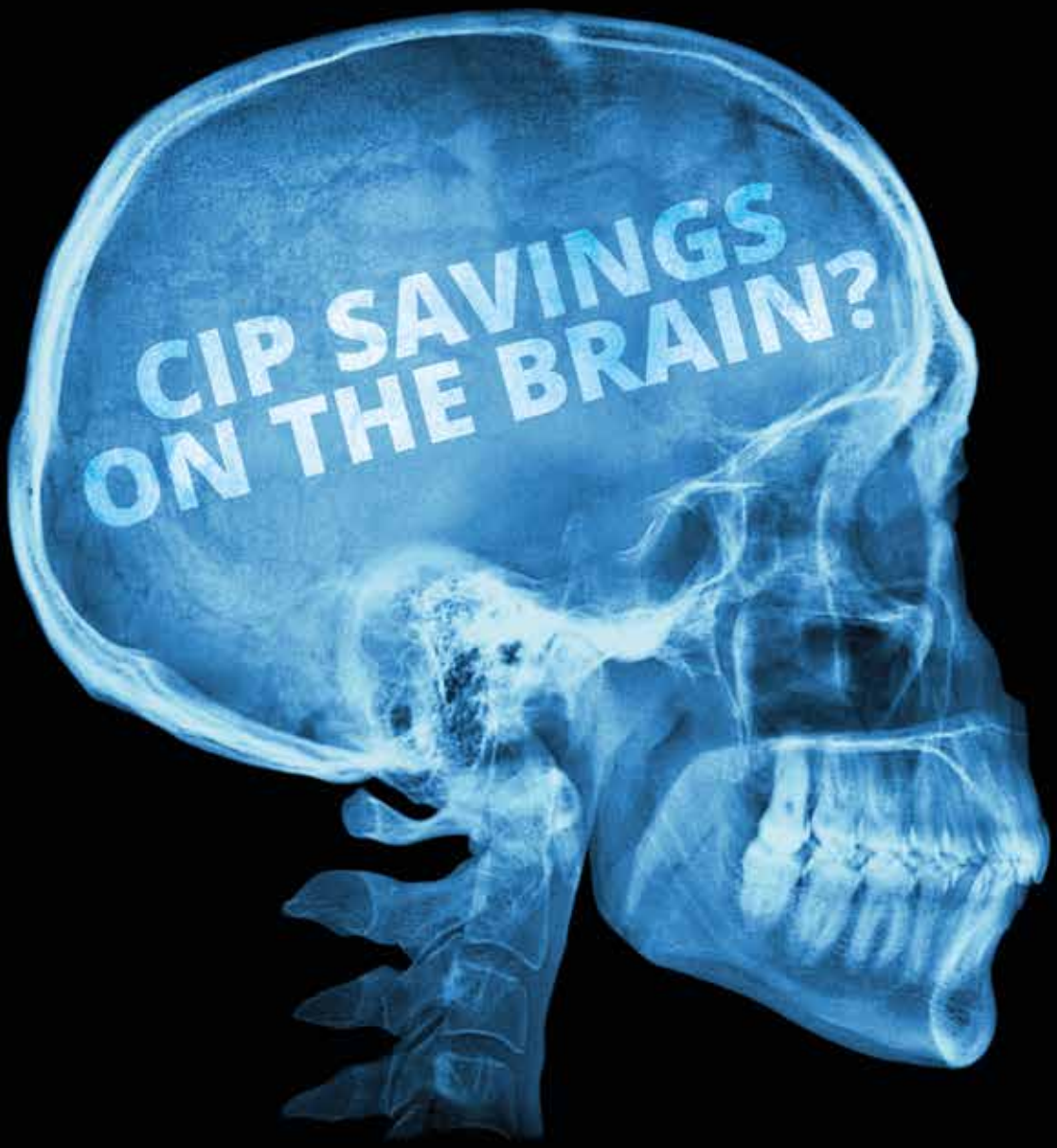

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News

Tougher winter predicted – but NHS plan offers hope

By Seamus Ward

The forthcoming NHS long-term plan offers an opportunity to break the recurring cycle of winter crises, but will come too late to have a positive effect on this winter, NHS Providers has warned.

The provider organisation said in its report, *Steeling ourselves for winter 2018/19*, that this winter is likely to be more difficult for patients, staff and trusts. Though improvements had been made, some of the challenges the service will face are even greater than winter 2017/18.

However, the long-term plan offers an opportunity to ensure that winter pressures do not affect the rest of the year, it said.

'We must escape the current and unsustainable cycle of severe winter pressures, which leaves the service playing catch-up throughout the rest of the year,' said Saffron Cordery (pictured), NHS Providers' director of policy and strategy and deputy chief executive.

'The long-term plan represents an opportunity to do this, but we must be realistic about what resource is needed, and where it is needed, to meet future demand and recover performance.'

Trusts will need adequate time and resources to bring their operational performance back to the levels set in the NHS Constitution, the report said. Immediate and long-term workforce solutions were also needed. And there must be more investment in integration and new models of care – particularly on helping frail elderly patients remain in their own homes or local community rather than in an acute hospital.

"We must be realistic about what resource is needed, and where, to meet future demand and recover performance"
Saffron Cordery, NHS Providers

NHS Providers said the coming winter looked difficult, though some welcome steps had been taken to help the service prepare. The Department of Health and Social Care recently announced additional winter funding for the NHS (£145m in capital funding) and adult social care (£240m).

NHS Providers said these factors, together with significant reductions in delayed transfers of care and the potential for the flu season to be less severe than last winter, could lead to better care this time.

In 2017/18, an extra £337m was allocated in the autumn Budget for winter pressures. But it was difficult for trusts to make the most of the funding, as it came so late in the day. And, with a harsh winter and surging demand for urgent care, provider finances were hit hard. The sector recorded a deficit of just under £1bn at the year end, with two-thirds of acute trusts finishing the year in the red. Much of this was attributable to winter pressures.

This year, the Department received an extra £1.7bn in overall funding, but NHS Providers said none of this had been ring-fenced at a national level for winter pressures.

Ms Cordery said the extra funding for capital projects and social care was welcome. However, the report said the capital schemes must be completed, staffed and operational by 24 December or the full capital costs will be clawed back in 2019/20.

Providers were spending the funding in a variety of ways, such as additional A&E cubicles, walk-in units and medical assessment areas next to A&E. However, they told NHS Providers that earlier notice would have helped the trusts and improved system-wide planning.

Ms Cordery added that there were clear warning signs that pointed to a more difficult winter this year. These included the sustained increase in demand; the continued decline in A&E performance; higher levels of vacancies; and the weaker state of social care.

'All things considered, trusts fear that this coming winter will be more difficult than the last,' she said.

HFMA unveils awards shortlists

The shortlists for the eight HFMA 2018 Awards have been announced by the association, including an all-female line-up for Finance Director of the Year Award. The four shortlisted for the finance director award are:

- Kathy Roe, Tameside and Glossop Strategic Commissioning Function
- Suzanne Robinson, North Staffordshire Combined Healthcare NHS Trust
- Andrea McGee, Warrington and Halton Hospitals NHS FT
- Sandra Easton, Chelsea and Westminster Hospital NHS FT.

The shortlist for Deputy Finance Director of the Year includes: Duncan Orme (Nottingham University Hospitals NHS Trust); Tarryn Lake (Sunderland Clinical Commissioning Group); Mike Newton (North Staffordshire Combined Healthcare NHS Trust); and Helen Troalen (The Royal Wolverhampton NHS Trust).

The Leeds Teaching Hospitals NHS Trust is up for the most awards, with six shortlisted candidates, including two in the Working with Finance – Clinician of the Year Award.

Wrightington, Wigan and Leigh NHS FT has four shortlisted (Innovation, Costing, Havelock Training, and Finance Team) – it has been shortlisted for at least one award for eight years in a row.

Although dominated by candidates from England, the shortlists also include three from Wales. Entries from the NHS Wales Finance Academy and Betsi Cadwaldr University Health Board will face those from Leeds Teaching Hospitals and Wrightington, Wigan and Leigh trusts for the Havelock Training Award. Cwm Taf University Heath Board is also on the shortlist for the Costing Award.

The awards will be presented at the HFMA annual conference on 6 December. To view the full shortlist, see the inside front cover.

‘Radical’ finance reform plans emerge

By Seamus Ward

The financial architecture of the NHS in England will be dramatically reshaped in the long-term plan, with 2019/20 a transitional year, NHS Improvement and NHS England said.

Details of how NHS finance will change next year and in the longer term emerged in the last few weeks in the run-up to the publication of the plan. In a planning letter, NHS Improvement chief executive Ian Dalton and his NHS England counterpart, Simon Stevens, said providers and commissioners will be required to submit one-year operational plans for 2019/20.

These will then be aggregated by sustainability and transformation partnerships and submitted alongside their new five-year strategic plans next summer. Integrated care systems (ICSs) will also be required to submit agreed five-year strategic plans.

The letter said the new strategic plans will allow the bodies to consider the outputs of the long-term plan and the 2019 spending review capital settlement. Five-year commissioner allocations will be published in December.

Proposals for a one-year national tariff were also published, which committed to a move to a blended approach to payment in urgent and emergency care from 2019/20.

Simon Stevens (left) and Ian Dalton

With break-even being the norm for all NHS organisations in the medium term, over time individual control totals would not be needed, allowing provider and commissioner sustainability funds to be phased out. The funds would be added to the baseline and initially targeted at urgent and emergency care (UEC).

Both the marginal rate emergency tariff and the emergency readmissions rule will be removed – the national bodies said this would be on a cost neutral basis. The market forces factor will be revised, with a four-year transition to ensure it does not destabilise local health economies.

Speaking at the NHS Providers annual conference in October, Mr Dalton said these ‘radical’ changes could not be achieved overnight, but the transition would begin in 2019/20. Control totals will be retained next year, but rebased to make the figures more realistic at trust level.

‘From 1 April, I’d like to see the provider sustainability fund, which is £2.45bn, to be very significantly reduced, potentially by a 10-digit figure, with the funds released going directly into the UEC tariff price, which we know has been significantly underfunded. We also want to get rid of the illogical marginal rate, which means admissions are being paid at less than their cost, as well as 30-day readmissions fines. This sits in a context of wanting to move away from payment by results, towards blended payment mechanisms for urgent care which will enable trusts to more appropriately resource this high-growth area of service.’

The HFMA backed the one-year tariff for 2019/20, but believed tariffs should be set for two years or longer thereafter. It added that HFMA members tended to support blended payments for UEC as removing MRET and the readmission rule streamlined the payment system. The blended approach reimbursed the true variable nature of costs and acknowledged there was a cost when patients were readmitted.

• *See The right blend, page 13, plus Comment, page 10*

Swift changes needed to boost Scotland finances

Urgent action must be taken in Scotland to implement long-term, fundamental change as the local NHS is financially unsustainable in its present form, Audit Scotland said.

In its annual review of the health service, the auditors said the NHS faced mounting workforce challenges, rising drugs costs and a significant maintenance backlog. Though at £13bn, health spending accounted for 42% of the total Scottish budget, the 2017/18 health budget was a 0.2% real-terms decrease on the previous year. Health boards struggled to deliver ‘unprecedented’ savings of £449m and relied on non-recurrent savings.

Performance deteriorated in 2017/18 – no board achieved all eight national targets and performance against these targets declined, with more people waiting longer for outpatient and inpatient care.

Audit Scotland welcomed recent announcements by the Scottish government of a medium-term financial framework for health and social care and measures to put health boards on a better financial footing (*see Flexible future, page 8*). However, it said a robust and transparent financial management system must be implemented to manage and monitor boards’ new year-end flexibilities. Audit Scotland will carry out further work to examine how the new approach will work in practice.

It said capital funding should be prioritised through a national capital investment strategy, while the government should continue to develop comprehensive workforce planning.

Caroline Gardner (pictured), auditor general for Scotland, said the problems of declining performance and increasing demand would be solved by changing how healthcare is accessed and delivered. But progress is too slow.

‘Decisive action is needed now to deliver the fundamental change that will secure the future of this vital and valued service,’ she said. ‘Alongside longer term financial planning, this must include effective leadership and much more engagement with communities about new forms of care and the difference they make. This will help to build support among the public and politicians for the changes required.’

Health secretary Jeane Freeman said the government was acting on the recommendations. It intends to invest £850m over the next three years to reduce waiting times.

Call for £3bn boost to grants

Public health grant must be boosted by £3.2bn a year by 2024/25 to reverse the impact of government cuts, the Health Foundation said.

Local authorities receive the grant to deliver public health services, such as drugs and alcohol services. The foundation said the grant had been reduced in real terms by £700m between 2014/15 and 2019/20.

Taking our health for granted: plugging the public health funding gap said the areas of greatest deprivation or need have not been protected from the cuts, risking greater health inequalities.

It recommended, as a minimum, that the government should reverse the real-terms cuts and invest an extra £1.3bn in the most deprived areas in 2019/20. A further £1.9bn should be allocated in phased budget increases over the following four years, adjusted for inflation.

A formula to be developed by the Advisory Committee on Resource Allocation should target the extra funds where most needed, the foundation added. 'At a time of ongoing wider cuts to public services that directly impact on people's health, and with the NHS under intense pressure, the cuts to the public health grant are short-sighted and irresponsible,' said Jo Bibby, the foundation's director of health. 'The long-term consequences of eroding people's health are likely to prove far more costly than short-term savings made.'

Financial balance expected by 2021/22, PAC told

By Seamus Ward

The Department of Health and Social Care expects individual NHS organisations and systems to be in financial balance within two to three years of the new five-year funding settlement.

The Department's permanent secretary Chris Wormald (pictured) told the Commons Public Accounts Committee (PAC) the NHS must meet its clinical and access objectives, regardless of the financial position, though overall financial balance across the service was required.

The provider sector entered 2018/19 with an underlying deficit of £4.3bn. This ignores the provider sustainability fund, which is non-recurrent. Assuming the fund is deployed in full in the provider sector, the underlying deficit falls to £1.85bn. Providers were planning for a deficit this year, but actions by trusts and commissioners in the first six months of the financial year may eliminate this planned deficit. Commissioners agreed a balanced plan overall.

Sir Chris told the PAC inquiry into the Department's 2017/18 accounts and NHS financial sustainability: 'One of the reasons we wanted a five-year financial settlement was to create a longer-term flightpath where it was conceivable to put those [deficits] right. I would probably guess two to three years.'

The Department's director general, finance, David Williams added that the Department would agree the time period with NHS Improvement and NHS England when it signed off the long-term plan. 'One of the financial tests the government has set is that we should return to that more specific set of financial balances during the duration of the long-term plan. It absolutely won't be year one,' he said.

The Department and NHS Improvement were considering two short-term incentive schemes to encourage trusts to produce a balanced position. Trusts planning a surplus that commit in advance to an improved position against their existing control total would receive a 'bonus' from the provider sustainability fund, Mr Williams said. The national bodies were also considering allowing trusts to account for the profits of asset disposals as revenue, but it is not clear how the incentive schemes would work.

Mr Williams also confirmed that only one trust was being charged the higher 6% interest rate on new loans.

He added that a capital to revenue switch was planned at national level again this year. However, he expected that with the new money in the five-year settlement coming in from 2019/20, there would be no further switches.

In 2017/18, £1bn was moved from capital to revenue at national level and the Department planned to move £500m in this financial year.

The Department's senior figures were also questioned extensively about the preparations for exiting the European Union in the event that no deal is agreed. Sir Chris said the Department had spent money stockpiling medical consumables such as syringes, surgical gloves and dressings.

Though commercial confidentiality prevented him from revealing the full amount spent, he confirmed that spending 'in the low tens of millions' had been authorised to create the stockpile and purchase warehousing space. Guidance was issued to trusts in October, asking them to think through the Brexit consequences of the supplies they receive, Sir Chris added.

More savings available from supplies cost tool

A price comparison tool has helped trusts in England save £288m in 2017/18 on the most commonly bought supplies but even greater savings can be achieved, NHS Improvement said.

The oversight body said trusts used the comparison tool to get the best prices on high-volume items such as syringes, disposable gloves, toilet roll and shoe covers.

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Some trusts had aggregated orders to make savings by buying in bulk. For example, 227 trusts joined up to buy couch rolls from a single supplier – saving £824,000 in total – while 184 grouped their toilet roll order to save £106,000.

NHS Improvement said the price comparison tool allowed trusts to see the most expensive and cheapest prices for more than a million products. It also set a benchmark for each product. But it highlighted scope for greater savings. It said trusts could save £3.7m a year if they all paid the minimum price for radiology syringes – prices vary between £324 and £553 per pack of 50.

Health minister Stephen Barclay said: 'As part of putting an extra £20bn a year into the NHS, it's more important than ever that we ensure money is effectively spent and harness new technology to identify where high prices are being paid and challenge this.

'Just as retail customers use price comparison sites, we're using similar principles in the NHS to identify where trusts are paying more than others and using comparative data to drive down procurement costs.'

News review

Seamus Ward assesses the past month in healthcare finance

Though some commentators are saying the traditional winter spike in demand for urgent care is now a year-round problem, governments across the UK continue to find additional pots of funding just as the winter months appear on the horizon. In September, the health departments in Scotland and England allocated £10m and £145m, respectively, to improve capacity. In October, the Welsh government handed critical care services a £5m boost to help relieve pressure in the winter months by strengthening and redesigning services. The funding is part of a previously announced £15m for critical care services in Wales.

The Department of Health and Social Care in England promised an extra £240m to council adult social care departments. It said the funding would help the NHS by reducing delayed transfers of care and increasing the number of care and reablement packages available in the community.

However, social care directors said the government must shift its focus from reducing delayed discharge to fully funding community services. They told an Association of Directors of Adult Social Services (ADASS) survey that the efforts to reduce delayed discharge had led to side effects that had adversely affected the long-term health and wellbeing of those being cared for. Council social services would overspend in 2018/19 and 89% of adult social care directors had limited or no confidence that their budget would be enough to fulfil their statutory duties by the end of 2019/20. Almost 80% of respondents told the ADASS that there had been an increase in the number of hospital admissions that could have been avoided if enough primary, community and social care capacity was available.

The Care Quality Commission said there should be a five-year funding settlement for social care, mirroring the funding for the NHS. The CQC said the five-year NHS funding is welcome, but risks being undermined without a similar long-term funding solution for social care. A report, *The state of healthcare and adult social care in England 2017/18*, said both sectors needed funding security for them to plan collectively for the long-term. It added that the quality of care has been maintained – and in some cases improved – since last year despite challenges of demand and funding.

The calls for greater funding certainty for social care were made against a backdrop of ever-increasing demand for healthcare, which is in turn affecting NHS operational performance. NHS England figures showed the proportion of A&E patients seen within the four-hour target period continued to fall in September in parallel with a sustained rise in activity. The monthly report said 88.9% of patients were seen within four hours – lower than the 89.7% recorded in September 2017. Though delayed transfers of care are falling, elective waiting lists are growing. At the end of August, 87.2% of patients had been waiting fewer than 18 weeks, but in August 2017 the figure was 89.4%.

In Wales, average A&E attendances fell in September, but the proportion of patients spending fewer than four hours increased slightly. Attendances dropped by 1.1% compared with August 2018 and were 0.9% lower than September 2017, according to the Welsh government. However, over the 12-month period to September 2018, A&E attendances were up 2.4%. A performance report

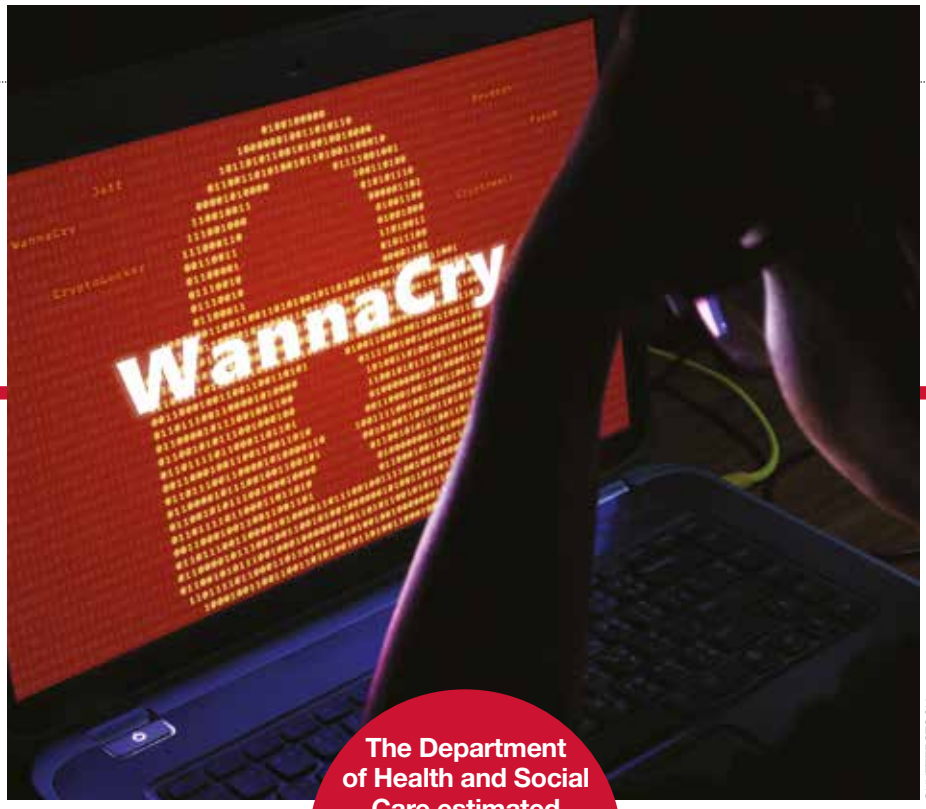
The month in quotes

'Too often, social care finds itself moving resources to meet delayed transfers of care targets and this is having very real unintended consequences on emergency admissions and waits for people in need of community care.'
ADASS president Glen Garrod calls for local care teams to have a greater say in how winter funding is spent

'The challenge for Parliament, national and local leaders and providers is to change the way services are funded, the way they work together and how and where people are cared for and supported.'
Greater health and social care integration is needed to improve care, says Ian Trenholm, Care Quality Commission chief executive

'This decision reflects the determination and hard work of all staff at the trust over the past two years to deliver major improvements in their financial performance. While there remains more to do, everyone at the trust should be congratulated for their contribution to reach this landmark.'
NHS Improvement deputy chief executive and executive director of regulation Stephen Hay announces Maidstone and Tunbridge Wells NHS Trust is now out of financial special measures

'Adalimumab is the NHS's biggest spend on a single drug and, as the NHS develops the long-term plan, we want more clinicians to switch to use the best-value biologics, which will free up hundreds of millions of pounds to reinvest back into patient care.'
NHS England chief executive Simon Stevens sees savings in biosimilar versions of costly drugs



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The Department of Health and Social Care estimated financial cost of last year's Wannacry cyber attack on the NHS in England was £92m

said 80.3% of patients spent fewer than four hours in A&E in September 2018 – 0.3 percentage points more than August 2018, but 4.2 percentage points lower than September 2017. The number of patients spending more than 12 hours in A&E increased compared with August.

Away from operational performance, the NHS was urged to take advantage of potential efficiencies. The patent on the health service's most expensive drug ended in October and NHS England told hospitals to be ready to find savings when cheaper alternatives become available. NHS England chief executive Simon Stevens said adalimumab (Humira), which costs the NHS £400m a year, is prescribed to more than 46,000 patients to treat conditions such as rheumatoid arthritis, inflammatory bowel disease and psoriasis. He said doctors should consider biosimilar alternatives after the patent expired on 16 October. NHS England guidance says most patients should be started on the best value medicine within three months of the launch of a biosimilar – these are expected to be available from December and could help save at least £150m a year by 2021.

Trusts have been urged to apply for funding to expand their use of LED lighting. NHS Improvement said the government has made £46m available for trusts through the NHS Energy Efficiency Fund. It said LED lighting would save money and provide patients, staff and visitors with a better experience.

Changes to staffing patterns could help avoid workforce shortages and spiralling costs at smaller hospitals, according to a Nuffield Trust report. The report said a number of measures, including improving A&E triage and encouraging clinicians to pool their capacity in A&E, could ensure the viability of smaller hospitals. The study, commissioned by NHS England, said there was no single change that could ensure viability, but a number of measures could be helpful. As well as staff changes, it said giving a financial premium to ambulance and other services in remote areas could be considered.

The Department of Health and Social Care estimated the financial cost of last year's Wannacry cyber attack on the NHS in England was £92m. The figure includes £19m in lost output and IT costs of £0.5m during the attack and £72m in IT costs in the aftermath. The figures are included in an update on actions taken by the Department of Health and Social Care and its arm's length bodies since February to boost cyber resilience in health and social care.

Maidstone and Tunbridge Wells NHS Trust is no longer in financial special measures. NHS Improvement said the trust had increased its board-level stability, scrutiny and grip of its financial position. The oversight body said this had been a result of the appointment of a new chair and chief executive. The trust has reduced its underlying deficit by £15m and is delivering against its control total for 2018/19. It has also delivered year-on-year increases in its productivity and efficiency, NHS Improvement said.

from the hfma

A newly announced financial framework and greater flexibilities will support the move to new models of care in Scotland, according to HFMA Scotland chair Derek Lindsay. In a blog for the HFMA website, he said finance professionals know health and social care faces a big transformation challenge over the next five years and beyond – and that they will play a key role in overcoming the challenge.

Crucially, NHS boards will be able to balance their books over three years rather than the current one year, and outstanding brokerage over the past five years will not be recovered. And there will be a rebalancing of spending between hospital and out-of-hospital services (*see Flexible future, page 8*). While the framework spells out the challenge and shows where some of the savings will be found, multi-year budgets would further enhance flexibility, he adds.

In another blog, HFMA head of policy and research Emma Knowles reports on an HFMA US event in October, looking at intelligence, innovation and patient experience of care. It was an opportunity to look up from the immediate focus of finance staff, she says, and think about the patient experience and how finance staff, technology and other innovations can help improve it.

In the latest of his series of blogs, Bill Shields (pictured), Bermuda Hospitals Board chief financial officer, reflects on the board's new clinical affiliation agreement with John Hopkins Medical in the US. The affiliate agreement is crucial to the health board and has given him an insight into how a non-NHS provider has tackled similar challenges to those in the UK.

www.hfma.org.uk/blogs

News analysis

Headline issues in the spotlight

Flexible future

A new strategic framework for Scotland will shape health and care finances to facilitate the move of services out of hospital. Seamus Ward reports

A new five-year financial plan for health and social care in Scotland and new flexibilities will aim to reset health boards' finances and give them headroom to bring more services out of hospital and into the community.

The *Medium-term health and social care financial framework*, published in October, sets out the challenges facing health and care services in Scotland. These are substantial, with a 'do nothing' gap between costs and funding standing at £1.8bn by 2023/24.

Measures announced alongside the new framework will allow Scottish health boards to balance their books over three years rather than one. They also give boards the flexibility to overspend or underspend their annual budgets by 1% from 2019/20, allowing them to invest in developing new services with payback over the medium term. And brokerage given to health boards over the past five years will be written off.

The framework, which covers 2019/20 to 2023/24, aims to support reform of the health and social care system in Scotland to help close the £1.8bn gap. This includes shifting care out of hospitals and into primary, community and social care settings. To facilitate this, it includes an aspiration that frontline hospital spending be reduced to less than half of total spending from the current 51%.

It also recognises that shifting care will require investment in primary, community and social care provision. Approximately half of the savings released from moving care out of hospital will be redirected into these services by integration authority strategic commissioning plans.

Primary care funding will increase to 11% of the frontline NHS budget by 2021/22 and half of the growth will go directly to GP services.

The report expects further savings to be made (see box below). Even so, this would not completely close the financial gap – the framework acknowledges a residual £159m would remain across the health and social care system in 2023/24. It anticipates that as assumptions on reforms savings are updated, the gap will be addressed.

Christine McLaughlin, Scottish government director of health finance, corporate governance and value, urged finance staff to throw themselves into supporting the framework.

'It's really important that the finance community takes a leading role in ensuring that health and social care services are sustainable over the long term,' she said.

'We need to be planning for the future and making sure that all of our efforts to invest and reform are focused on delivering better health, better care and better value.

'So that's what the medium-term financial framework is all about. It's a joint effort by the Scottish government, NHS boards, integration authorities and COSLA [local government leaders] to set out the challenges and opportunities ahead.

'It also looks at the types of approach to address key priorities such as shifting the balance of care towards community health services.'

HFMA Scotland Branch chair Derek Lindsay said the framework addresses many of the issues the association has been raising, including the need for a clear view of future demand pressures on the local NHS.

The HFMA submission in August 2017 to the Scottish Parliament Health and Sport Committee inquiry on the draft budget for 2018/19 said it would be helpful to have an assessment of the impact of demographic changes and technological advances to support the scrutiny of the budget.

The new financial framework provides an analysis of pay, price, demographic and non-demographic cost pressures. These exceed 5% a year. Mr Lindsay said this was consistent with the report in May 2018 from the Institute for Fiscal Studies and the Health Foundation, which said that UK spending on healthcare would need to increase in real terms by an average of 3.3%

Bridging the gap

The framework concluded that the gap between health and social care funding would be £1.8bn by 2023/24 if nothing is done. However, this could be reduced to £159m by the end of the period.

Health is the largest budget in the Scottish government's total spending – accounting for £12.9bn of the total £30bn in 2016/17. Social care spending was £3bn and frontline expenditure on health and social care – the sum considered by the framework – was almost £15bn. Under the 'do nothing' scenario, the frontline funding requirement would rise to £20.6bn by 2023/24.

The framework said its assessment of future funding requirements allows for the Scottish government twin approach of investment and reform; the increasing levels of demand; and its recognition that the status quo is not an option.

The framework assumed funding rising to £18.8bn by 2023/24 – the do nothing gap is £1.8bn (£20.6bn minus £18.8bn). It then sets out potential efficiencies and savings.

A 1% efficiency requirement in health and social care would save a total of £1.1bn, while shifting the balance of care would produce efficiencies of £155m (after £154m or 50% is reinvested in community services).

Regional working would save £193m, ill-health prevention through public health programmes £158m and the *Once for Scotland* efficiency scheme £39m.

This means efficiencies and savings promise to deliver around £1.64bn, which would leave a gap of £159m.

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a year over the next 15 years to maintain NHS provision at current levels.

The framework assumes receipt of the full consequential from the UK government announcement of an extra £20bn for health in England. 'The use of the additional funding is not specified within the financial framework, although policy commitments include increasing primary care expenditure by £500m a year,' Mr Lindsay said.

Announcements were expected at the end of October on improving compliance with waiting times targets, together with the funding to make this happen.

The financial framework does not identify the level of future year general allocation uplifts to boards, Mr Lindsay added.

'The HFMA has called for multi-year budgets as they would aid the development of longer term plans and support effective decision-making,' he said. 'However, it is not yet known if the draft budget, to be announced in December, will cover more than one year.'

Ms McLaughlin said that, through the framework, the Cabinet secretary for health and sport, Jeane Freeman, had offered NHS boards a new deal. 'In recognition of NHS boards' efforts to deliver reform, this will see a new three-year financial planning and performance framework,' Ms McLaughlin said.

'This will provide greater flexibility for boards in managing their finances and will require boards to deliver a break-even position over a three-year period, rather than annually, as is the case currently.'

In each year, boards will have 1% flexibility on their annual resource budget to allow underspending or overspending in any one year.

As well as greater financial flexibility, boards will also plan over a longer period.

Mr Lindsay said the greater financial freedom would be welcomed. 'I think that all boards would welcome the greater financial flexibility to balance budgets over a three-year period, which is already in place in the NHS in Wales. This is limited to 1% flexibility. However, it will allow plans to be developed that see initial investment and a medium-term payback.'

The Scottish government clearly wants a reset of the boards' financial positions as they go into the new three-year planning cycle, deciding to write off loans that they have received over the past five years.

Ms McLaughlin said: 'The cabinet secretary also decided to give clear ground to move forward on that three-year planning cycle, and therefore the Scottish government will not seek to recover NHS territorial boards' outstanding brokerage – the expenditure incurred by territorial boards over the past five years which has been above their budget.'

She explained that this year, she expected four boards will require additional funding and that this will amount to around £68m. This makes up around 0.5% of the overall health budget and will take the overall cumulative balance of brokerage that will not be recovered to around £150m.

'By not seeking to recover this amount, boards will be able to focus their attention on delivering the measures set out in the health and social care delivery plan and the financial framework, and to do so in a safe and appropriate way – making sure they maintain a strong focus on patient care and the delivery of the services that are safe, effective and person-centred,' she continued.

Although writing off the loans to boards will undoubtedly help them as they plan to return to financial balance, the underlying issues that caused them to need brokerage in the first place could remain.

'We recognise that the financial challenges facing a number of boards in some cases are an indicator of underlying issues, structural or systemic, that require more than a single year solution,' Ms McLaughlin said.

'We are working closely with those boards to identify what financial recovery and sustainability means at an organisational level and to help them pull together a deliverable plan to respond to those challenges.'

She added that boards cannot deliver these plans without collaborating with the wider health and care system.

'We are clear that these plans will require a system-wide, multi-agency response that is led by clinicians and which puts local communities at their heart,' she said.

'We also understand that we may need to provide support and additional resource to make sure this work does not detract from the "day job" of providing high-quality, compassionate healthcare. This is one example of what is meant by the twin approach of investment and reform set out in the financial framework.'

The financial framework does not completely bridge the £1.8bn gap, though the Scottish government is confident it will do so. In the meantime, finance staff have been handed a key role in getting NHS Scotland to the best position possible, providing a solid financial base for improvements in services to patients.

"We recognise that the financial challenges facing a number of boards in some cases are an indicator of underlying issues, structural or systemic, that require more than a single year solution"
Christine McLaughlin, Scottish government

Comment

November 2018

Positive signs

The financial infrastructure review has produced some early wins

It looks increasingly as though we can be optimistic that we are going to see helpful changes to the financial infrastructure and funding flows. These changes should enable more effective allocation, planning and spending of resources in the NHS.

The first indication comes with changes to the funding of urgent and emergency care. The costs of delivering these services will now be better reflected in 2019/20 tariff prices after the announcement that a proportion of the £2.45bn Provider Sustainability Fund (PSF) will be rechannelled into these specific tariffs (*see page 13*).

By taking this step, NHS Improvement and NHS England have recognised it is time to better reflect the reality of where costs are falling in a system. In doing so, they will also dilute the sometimes perverse effects of the PSF central fund. Instead, fairer funding will make systems more accountable for their costs.

The proposed move to blended payments mechanisms, starting the move away from purely episodic tariffs, also starts to create the conditions and behaviours that will help the service work towards system payment mechanisms.

Although blended payment becomes the new default approach for urgent and emergency care, systems are being encouraged to move faster towards population-based payment models where they want to.

Collaboratively agreeing local aims and outcomes for a new payment mechanism has to come first in any design, and there are real opportunities for commissioner and provider partners to take stock of how best to allocate their own system pound.

In many cases, efficient cost recovery with appropriate demand (cost) risk and gain share, linked to prevention and patient

HFMA president Alex Gild

Twin track approach

The future may be about system payment, but individual tariff prices will remain

Healthcare Finance editor Steve Brown

There has been a relatively positive reaction to the announcement by NHS Improvement and NHS England of a new default payment system for urgent and emergency care (UEC). From 2019, the marginal rate emergency tariff is no more – disappearing along with the 30-day readmission penalty. In its place comes a 'new' blended payment system, including a fixed amount linked to expected activity and a volume related element.

I say 'new' but it looks quite familiar. In terms of mechanism, it works in a similar fashion to the existing marginal rate tariff – but, importantly, should allow the agreement of more realistic levels of activity in baselines. Topping up urgent and emergency care tariffs with funds from the Provider Sustainability Fund will also help to address the underfunding of emergency care tariffs.

But the new blended payment approach also looks rather like proposals for new UEC tariffs as long ago as 2014. That was when NHS England and Monitor first started

talking about a three-part tariff for these crucial services to recognise their 'always on' nature (*Healthcare Finance, June 2014, page 14*). They followed this up with formal guidance over a year later, with the idea that the three-part approach – with elements for core funding, volume and performance – could become a local payment mechanism rather than the main default approach.

It is perhaps surprising that it has taken four years for this approach to be promoted to the mainstream, albeit with the performance

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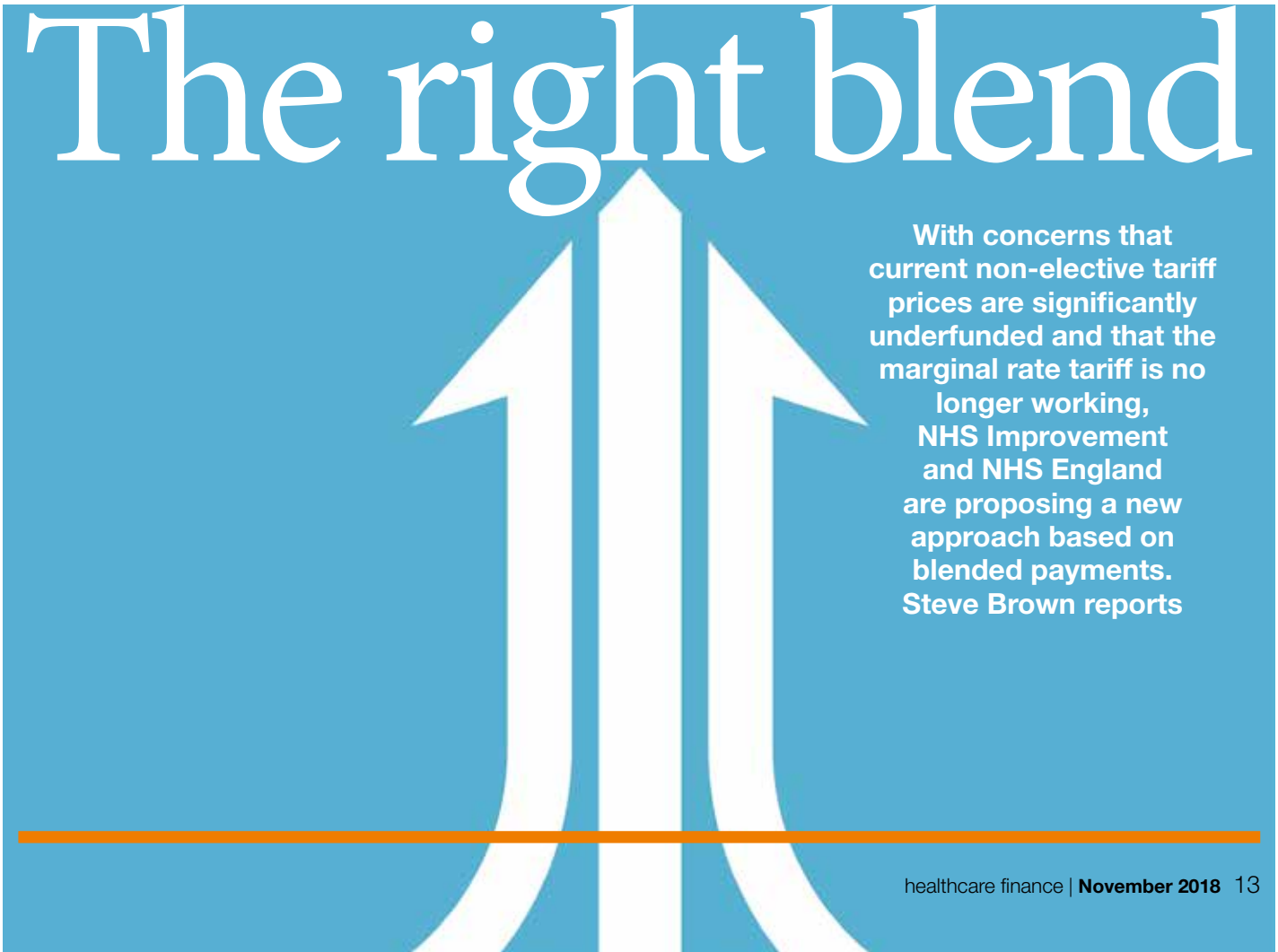
The right blend

With concerns that current non-elective tariff prices are significantly underfunded and that the marginal rate tariff is no longer working, NHS Improvement and NHS England are proposing a new approach based on blended payments. Steve Brown reports



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There are two ways to look at the recently announced plans for a blended payment approach for urgent and emergency care (UEC). Either it looks strikingly similar to the marginal rate emergency tariff it is proposed to replace (with some different numbers and baselines). Or it is a statement of intent showing how tariffs for all services will develop, merging the best features of block contracting and activity-based payment.

The proposals were published by NHS Improvement and NHS England for a short engagement exercise in October ahead of the formal consultation on firm proposals in the new year. The changes to emergency care payment are the stand-out feature.

The attempt to do something different was broadly welcomed by the service. There is wide recognition that the current system of paying for non-elective admissions in particular is not working. This uses a marginal rate emergency tariff (MRET) that pays 100% of tariff for activity in a baseline that in many cases reflects historical activity levels that fly in the face of recent demand increases. Providers are then paid a 70% marginal rate for activity above this level.

Many have also argued that the full tariff rate doesn't cover costs, as a result of overall underfunding and flawed costing processes in the reference costs on which tariffs are based. The targeting of sustainability funds on providers of emergency care has sought to address some of these concerns.

A number of areas have even moved away from the whole payment by results approach, preferring instead a return to block contracts to improve certainty for both commissioners and providers.

NHS Improvement chief executive Ian Dalton underlined the need for change at NHS Providers' conference in October, when he announced wider plans to change the NHS financial architecture – including a phased end to control totals and the Provider Sustainability Fund.

'From 1 April, I'd like to see the PSF, which is £2.45bn, to be significantly reduced, potentially by a 10-digit figure, with the funds released going into the UEC tariff price, which we know has been significantly underfunded,' he said. He went on to describe the current marginal rate as 'illogical', with admissions paid at less than their cost.

The new proposals would see MRET abolished, along with the 30-day readmission rule, in favour of a blended payment approach that is better suited to the new world of integrated care systems, sustainability and transformation partnerships and collaboration.

'We wanted something that takes the best parts of an episodic spell-based system and block arrangements,' says Gareth Harper, pricing development lead for NHS Improvement, 'providing greater certainty while still reacting to activity.'

Two options

Two options are put forward to deliver a blend of fixed and variable payments. Under option A, the fixed element would be based on agreed forecast levels of activity paid at 100% of the tariff price. Under/over-performance of activity against this level would then be deducted or added to the payment using a rate of just 20% of the tariff price.

In option B, the fixed element would be based on 80% of expected revenue, with the 20% variable element then paid for all activity, not just activity in excess of plan.

To some, option A looks rather like the current MRET mechanism, albeit with a much lower marginal rate. The crucial differences are in the activity level used to inform the fixed element and the additional resources channelled into UEC tariffs from the PSF.

When MRET was introduced in 2010/11, there were already concerns that using a baseline set on 2008/09 activity levels failed to recognise that emergency demand had already grown beyond these levels. Ten years later, these levels of activity are a distant memory in many areas.

More recent tariff guidance has introduced greater levels of flexibility in acknowledging demand increases in the baseline, but the

official tariff guidance for 2017/19 still references 2008/09 activity. The reality is that different areas use different approaches to set activity levels in the baseline and this can create the potential for misplaced incentives, with providers paying the price for failed demand management programmes.

Basing the fixed element on agreed activity at 80% of tariff price arguably moves the NHS into slightly different territory. The guidance underlines that both approaches would lead to the same price being paid for the same levels of activity. It is the flow of payment that could differ.

The idea is that the fixed element would pay for capacity, corresponding to fixed and semi-fixed costs – 80% has been chosen as a proxy for this, informed by patient-level costs, but this could change. 'A provider that has invested in emergency services – for example, providing 24-hour consultant cover – could argue for a higher fixed rate,' says Chris Skilbeck, head of pricing engagement at NHS Improvement, underlining that the proposed new approach is not intended to inhibit health economies already working on local payment approaches.

Either option would mean the end of the existing MRET and the 30-day readmission rule – although the guidance says this would happen on a 'financially neutral basis between providers and commissioners'.

'Whatever is currently paid as MRET and episodic prices plus any extra money [from the transfer from PSF] will continue to be the amount commissioners spend on emergency care,' says Mr Harper.

He admits the detail has not been finalised and is keen to hear ideas from finance practitioners. The proposed financial neutrality is not intended to inhibit the change of money flows to support service change – re-providing services in the community, for example – but seems to offer protection against arbitrary changes in where financial risks sit.

This is possibly the hardest proposal to understand. Mr Harper admits NHS Improvement may define better what it means by 'financially neutral', particularly in terms of specifying the comparative baseline.

Another significant change will make it even more difficult to understand how any changes in financial flows have come about. The market forces factor – used to adjust tariff prices to allow for the unavoidable cost differences that arise from delivering healthcare in different geographical areas – has been revised. This includes an update to the calculation method and the data on which it is based.

Given that the last update was 10 years ago and PCT boundaries were still being used within the formula, Mr Harper says it was 'untenable to leave it as it is'. NHS Improvement has published all the work behind the updates. But many providers will have been concerned by seeing their MFF reduce. One trust finance manager said a 25% reduction in its MFF, from 4% to 3%, was its clear biggest concern about the tariff plans.

"From 1 April, I'd like to see the PSF, which is £2.45bn, to be significantly reduced, potentially by a 10-digit figure"
Ian Dalton, NHS Improvement

However, straight comparisons may be misleading. The range of variability between highest and lowest MFF has reduced. Next year, the MFF 'top-ups' will amount to a smaller total – with about £120m rechannelled back into the core tariff price. So trusts need to see the changes in the round – rather than focus on their change in MFF.

This won't be straightforward given that there are a number of forces acting on what commissioners will pay and providers receive under the new tariff proposals:

- New reference costs (2016/17) will change the relativities between different HRG prices
- At least £1bn of PSF funds will be added to emergency tariff prices overall
- The updated MFF will change actual tariff prices in different areas, with London losing out due to wage differences narrowing
- The blended payment approach, depending on the financial neutrality clause, could change flows between commissioners and providers.

Direction of travel

Although the proposed changes will have a financial impact, in many ways they are symbolic of where the NHS is heading in terms of payment approaches. 'Looking at the two options for emergency care, if the activity is the same, then the financial outcome is the same,' says Mr Skilbeck. 'But we are interested in whether the service sees these as two genuinely different propositions – could they lead to different behavioural responses and better outcomes?'

The new approach is currently being proposed for non-elective admissions, accident and emergency attendances and possibly ambulatory care. The inclusion of ambulatory care is seen as particularly important, although current data quality and completeness is far from ideal. But there are more ambitious plans. 'This is probably a first step in a longer term move towards bringing in all services,' says Mr Harper.

How the continued development of the tariff fits into broader plans for system-level payments remains unclear. On the one hand, there are systems moving away from using tariff towards system-level capitation payments, while there are also new detailed level tariffs being proposed for services such as smoking cessation and IVF.

Mr Harper insists the approaches are compatible. He argues that moving to capitation-based payment with gain/loss sharing mechanisms depends on the maturity of different systems. But even if this is the direction of travel, there is still a role for tariff – and 70% of NHS bodies say they are currently using tariff to some degree. 'A detailed and high-level approach can both be required,' he says. 'Even if contracts aren't based on episodic payments, it is crucial we have the currencies and reference prices and ways to build these contracts.'

Other proposals

Outpatient attendances Non-mandatory prices will be set for non-face-to-face follow-ups for specialties with national prices. Non-mandatory prices would also be set for non-consultant-led first and follow-up attendances. A single price for all outpatient attendances in a specialty will be piloted.

Procurement Feedback is sought on proposals to reduce tariff prices by around 0.35% so the £250m overheads of the new Supply Chain Co-ordination Ltd (SCCL) can be funded centrally. The aim is to encourage greater use of the new Supply Chain function, which currently recovers its overheads through a mark-up on prices.

Maternity All maternity pathway prices will become non-mandatory as some services are the responsibility of public health services and fall outside the scope of national prices. The number of payment levels for delivery will increase from two to six or 36 – 36 reflecting the different HRGs, six grouping these together. Both would mean tariff prices more closely matched the costs of different birth scenarios.

Mental health A blended payment approach will be mandated consisting of a fixed element based on forecast activity, a variable element and an element linked to locally agreed quality and outcomes measures.

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Confirmed speakers for this year's conference include:

- **Elizabeth O'Mahony**, Chief Financial Officer, NHS Improvement
- **Ian Dalton CBE**, Chief Executive, NHS Improvement
- **Matthew Swindells**, National Director of Operations and Information, NHS England
- **Claire Murdoch**, CEO, Central & North West London NHS FT and National Mental Health Director for NHS England
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"Keeping payment mechanisms simple while systems mature should be a precondition to improving system alignment"

pathway integration activity across systems, feels like a good place to start. The point is, there is not a one-size-fits-all solution. Keeping new payment mechanisms simple while systems mature should in my view be a precondition to improving system alignment on allocation of resources.

More good news: as a result of the central diversion of PSF into the emergency tariff, control totals are to be rebased and will, it is hoped, be more realistic for 2019/20 in terms of stretch. We can understand why control totals need to exist another year to avoid instability and maintain aggregate control during transition into the five-year funding settlement. However, it is good to get indications that the control total regime will be reviewed beyond 2019/20 to enable partners to plan more effectively within their systems, without the polarising effect of control totals and perverse incentives on individual organisations.

CQUIN is also, happily, coming up for review. For providers, this reduces the transactional burden and distraction, with providers needing to earn large components of CQUIN as core revenue funding.

Commissioners were also frustrated at the lack of leverage the mechanism really had for innovation and outcomes. If designed well, new payment mechanisms can incentivise innovation and outcomes for patients.

So, we should appreciate the positive early signs from NHS Improvement and NHS England on what is already changing to support transformation of the NHS.

Our HFMA policy team, committees and finance leaders have been considering the change constraining issues of capital funding, unrepayable provider balance sheet debt and the effects of control totals in driving a singular view of financial performance via a revenue target. This control total view has been to the detriment of balance sheet health and scrutiny.

Excellent improvement recommendations can be found in an association briefing, published in October (*see page 25*). We hope this will feed into the continuing financial architecture workstream of the NHS plan. The HFMA is at its best when we speak as a profession making practical suggestions for improving the way things work.

The financial architecture review for the NHS plan is a critical enabler and the HFMA will continue to apply the influence of our association on your behalf.

Contact the president on president@hfma.org.uk

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element dropped – although that is included in the proposal for mental health services. And there are indications that this approach is the future for other services including elective.

Others might be thinking 'why now?'. Aren't we moving towards a system of system-based payment, with budgets set on the basis of capitation and gain/loss mechanisms to share risk across different providers and commissioners?

While clearly, the blended payment approach proposed in October's tariff engagement document continues to support contracting between commissioners and acute providers, some believe it moves the NHS in the right direction. It arguably weakens the link between payment and activity for acute providers and, as Alex Gild says above, 'starts to create the conditions and behaviours that will help the service work towards system payment mechanisms'.

It also perhaps underlines the fact that the centre continues to see a role for the tariff even as the NHS moves into a world of capitation-based payments and population health.

There are many possible reasons for this. First, it will take time to develop new payment approaches and the service needs to modernise its existing tariff in the meantime. Second, even with system-based payment approaches in place, local bodies will need prices and currencies to inform contract values and budgets (*see 'The right blend', page 13*). And third, our system leaders see the future as needing both a high-level and a very detailed approach. For example, there are proposals to develop prices for services such as IVF and smoking cessation.

"The centre continues to see a role for the tariff even as the NHS moves into a world of capitation-based payments and population health"

There is understood to be a lot of excitement about how greater support in hospital for smoking cessation can have major benefits in terms of population health and future demand for services.

And specific tariffs – or at least a clear idea of the cost of an enhanced service – are seen as the right way to encourage providers to develop services.

So, while the broadbrush approach to paying for services in future might be all about system payments and capitation, don't expect to see individual tariff prices disappearing anytime soon.

the new path

NHS Improvement wants trusts to form pathology networks across England by 2021 to maintain standards and increase productivity and efficiency. Seamus Ward reports on progress

The government's recent announcements that the NHS long-term plan will include a renewed focus on detecting cancer earlier was widely welcomed. But the extra activity brought about by, for example, lowering the screening age for bowel cancer to 50, will be supported by a range of specialists and also increases in a swathe of diagnostic tests. Trusts and NHS Improvement will be mindful of such step changes as they implement reforms of pathology services that aim to make them more efficient and maintain or improve services to patients.

The reforms go back to the first report by Lord Carter a decade ago – which was confined to pathology – and his more recent report on the performance and productivity of acute trusts. In 2008, he concluded that trusts should consolidate pathology services. Trusts that responded by forming partnerships with neighbouring trusts were the most efficient in the NHS, according to analysis for the more recent report.

Last year, NHS Improvement wrote to trusts, setting out plans to bring together 122 individual pathology units in English hospitals into 29 pathology networks by 2021. It claimed this would save at least £200m a year on total running costs of £2.2bn. The networks would be formed on a hub-and-spoke basis, with hubs performing 'cold' pathology, where results are not needed within one to two hours, as well as some specialist tests and urgent 'hot' pathology for its host trust.

Single networks for the whole of England are being developed for specialist tests for highly complex services, such as paediatric pathology, and those services at risk, including electron microscopy.

The spokes – or essential service laboratories (ESLs) – should provide tests essential for the acute management of patients – including those in A&E, intensive care and theatres – as well as tests that are operationally urgent, for example diagnostic tests to support discharge.

'We have modelled the ESLs to be as efficient as possible while retaining the high level of service we see across the NHS,' says David Wells, head of pathology services consolidation at NHS Improvement.

'We have also been modelling highly specialist work in supra or national networks, so the NHS is not introducing new capacity in a system where there is existing capacity across specialist trusts.'

Mr Wells insists NHS Improvement has a few non-negotiable rules. The first rule is that pathology providers must work together in a defined local network. Also, variations from the hub and spoke model must be backed by a sound business case and must not adversely affect the patient pathway.

In September, NHS Improvement published a 12-month progress report, *NHS Improvement pathology networking in England: the state of the nation*, which highlighted high levels of engagement in the formation of networks. It said trusts reported £33.6m of pathology cost improvements, with a further £30m identified in trust plans for 2018/19.

Savings underestimate

Mr Wells says the savings generated so far are those declared by trusts in their cost improvement programmes (CIPs) – delivered through the first steps trusts have taken to consolidate work, perform it at scale and bundle their procurement of pathology supplies. But he believes the real savings figure is much higher. 'The reduction in operating costs of £33m is an underestimate of what's being driven out of the costs of pathology services in England. This is from working towards networking – they've not made big changes yet,' he says.

'Trusts have been modest about their savings. Our data collections are becoming more consistent and we are confident that £33m is an underestimate – that's why we believe our figure of £200m in savings by 2020/21 is possibly a conservative estimate.'

Reaction to the network model has been mixed. The Royal College of Pathology has been worried about jobs and the loss of key skills, which could disrupt these vital services.

Alan Sumner, head of public affairs at Roche Diagnostics UK, which has partnerships with some trusts, says: 'We welcome any plans that will enable patients to receive quicker, more advanced and reliable screening

test results that will deliver better value and high-quality care.

'The core of a sustainable pathology system lies in appreciating the true value of in vitro diagnostics. Innovative in-vitro diagnostic tests are an essential part of the NHS. Their use reduces healthcare problems, hospitalisation rates and health costs, as well as facilitating more informed clinical decision-making. They bring sustainable financial benefit to healthcare, improving the quality and saving patients' lives.'

Following the Carter reports, pathology provision is a complex picture – much of it is provided in-house by trusts, but some trusts have partnership agreements with neighbouring NHS providers; some trusts or groups of trusts have set up wholly owned subsidiaries; and in other areas pathology is wholly or partly provided by private sector labs.

The state of the nation report sets out how each of the 29 networks could be arranged, with a hub and ESL spokes, but also recognising that other models have been established. For example, the North East network includes two hubs, five ESLs and two public outsourced providers (see box overleaf). Lancashire and South Cumbria Pathology Partnership has one hub and three ESLs. A network labelled Midlands and East 8, providing services in Essex, has an ESL and two private outsourced providers.

Mr Wells says NHS Improvement is agnostic about the exact model adopted by each network. A network could have more than one hub or an ESL could retain some cold pathology tests, for example, if the network can prove it is efficient and the right choice for the local patients and system.

'It could be a wide geographical area where some general practices are some distance from the hub,' he says. 'If the changes are presenting a challenge to your local system, come up with your alternatives and come and talk to us if you want to do something different.'

However, he points out that there is an issue of scale – hubs should provide the greatest value because they will perform tests at volume.

Local disagreements alone cannot be the basis of decisions over hub and spoke arrangements, he adds. If, for example, two trusts can't agree and insist both should have pathology hubs, this would not be supported

Black Country collaboration

The new Black Country Pathology Service (BCPS) – a network that is currently made up of four trusts – went live on 1 October and aims to save £52m over 10 years.

The network is hosted by The Royal Wolverhampton NHS Trust, which is also the pathology hub, under a partnership agreement underpinned by service level agreements between the partners. On 1 October, around 500 staff, including consultants and pathology staff, moved under TUPE rules to The Royal Wolverhampton.

The four trusts in BCPS – Sandwell and West Birmingham Hospitals NHS Trust, The Dudley Group NHS Foundation Trust, The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust – had been working on the collaboration for 18 months before being placed in a network by NHS Improvement.

Each trust has two representatives on the strategic board running BCPS, which is independently chaired.

The trusts hope Shrewsbury and Telford Hospital NHS Trust will join the network – in the NHS Improvement model, the trust would provide a spoke or ESL service, though details have yet to be decided.

'We have opened constructive discussions with Shrewsbury and Telford Hospitals to get it to join us,' says Kevin Stringer (pictured), chief financial officer of The Royal Wolverhampton trust.

'We were not being exclusive or difficult when we decided to go ahead without it in October – it's just the four other trusts had got so far along with the partnership model we decided to complete the transaction and then see how Shrewsbury and Telford wanted to join the network. We kept them up to speed with our progress.

'I think all four trusts have worked hard together to finally have a collaborative partnership. Everyone involved should be congratulated in making it happen as it means high-quality services for patients and staff at lower cost through economies of scale and technology.'

The NHS Improvement state of the nation report said trusts across the country made savings in 2017/18 through collaboration and cost improvement programmes implemented in advance of establishing networks.

This is true in the Black Country. Mr Stringer says each of the four trusts has made savings in staffing or through renegotiating managed equipment services (MES) contracts. MES is often used for specialist laboratory equipment and he adds that the network will have to issue a new tender for MES to ensure all the labs have the same equipment where appropriate.

The new network is backed by the Black Country Sustainability and Transformation Partnership, which has been awarded £9m in capital funding for IT development and the building of extra physical capacity.

The host trust has signed a commercial contract for the development and implementation of a new laboratory information management system (LIMS) that will have common pathology ordering and results reporting across the Black Country for all hospitals and GPs.

'It's critical to have a system in pathology that ensures ordering of tests and reporting of results are done in the same way across the Black Country in one system,' Mr Stringer says.

An extension is being built to the pathology lab at the Wolverhampton trust's New Cross site – the network's hub – to accommodate the additional staff and activity.

However, the delay in completion of the new Midland Metropolitan Hospital (Sandwell and West Birmingham Hospitals or SWB NHS Trust) following the collapse of Carillion will affect the level of savings achieved in the short term. This is due to the requirement for an extra ESL at SWB's City site due to the delay in the completion date of the new hospital.

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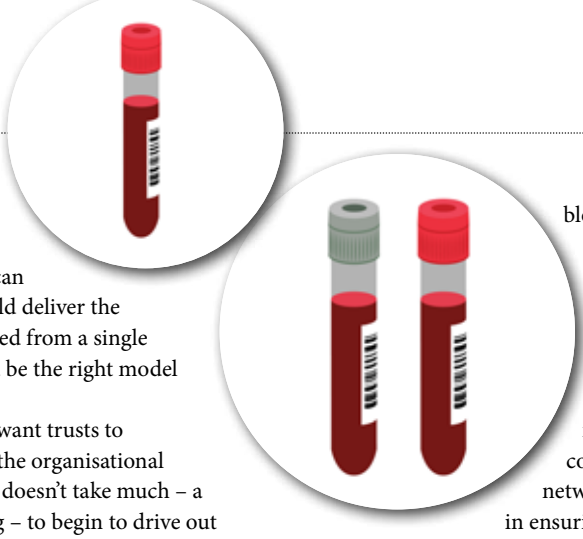


by NHS Improvement without strong evidence to back the arrangement. However, if they can demonstrate that two hubs would deliver the same benefits to patients expected from a single hub, at the same cost, this could be the right model for that network.

NHS Improvement does not want trusts to get caught up in decisions over the organisational form their network will take. 'It doesn't take much – a memorandum of understanding – to begin to drive out large savings without getting involved in the complexities of what the ownership model should be,' Mr Wells says. 'Form should follow function – trusts should act immediately. Though we are insisting trusts will network, we are relaxed about organisational form.'

All options are on the table, from alliance contracting to outsourcing. 'Some footprints are going to struggle to find the investment they need to provide the quality and scale of services and outsourcing could be the answer,' says Mr Wells.

'We are looking for high-quality lab services that are fully staffed and continue to provide our high standards. We have workforce shortages in some areas and they might need to take a partner.'

Developing market

He acknowledges that trusts can see outsourcing as a loss of control, adding that a market for pathology services could develop as providers – public and private – seek to expand. As a result, the number of networks could shrink.

A market could also develop for GP direct access pathology. 'We have high-quality lab services, with most ISO1589 accredited. The quality of the service is largely a given and, though we wouldn't want to rest on our laurels, the choice comes down to cost.

'Normally, clinical commissioning groups commission blood tests for primary care from their closest provider. But where we are seeing networks form, commissioners are being a lot smarter and are going to alternative providers. Again, our rule is that it should not affect the patient pathway – don't let there be circumstances where a patient has two blood tests where previously it would have been one.'

"CCGs commission blood tests from their closest provider. But where networks form, commissioners are being a lot smarter and are going to alternative providers"
David Wells, NHS Improvement

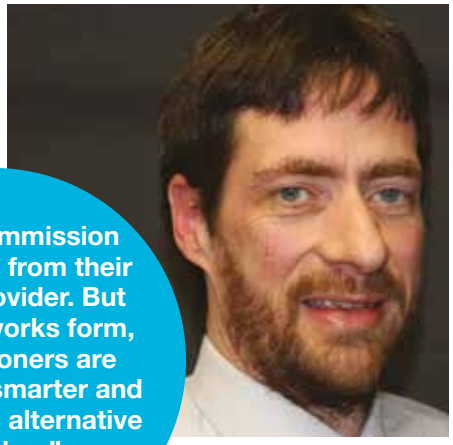
The Royal College of Pathology has called for investment to ensure samples can be transferred in a safe and timely fashion. Crucially, the lab IT systems must be compatible and this could require additional investment.

Interoperability – making sure laboratory information management systems (LIMS) can communicate with each other across individual networks and throughout the NHS in England – is vital in ensuring the networks are efficient and work in patients' interests. Mr Wells says: 'With networking there should be compatible IT systems, so it doesn't matter where you request or process the sample – as long as the GP and secondary care clinician can see the results.'

NHS Improvement is working with NHS Digital and NHS England to define the level of interoperability needed and sources of funding.

He adds that pathology networks should act as a stepping stone, supporting the evolving NHS as set out in the long-term plan. NHS Improvement wants change at pace that also allows for the transformation of care in other parts of the service.

'I don't think we are being particularly ambitious with regards to what's possible, and we want to see that ambition lifted,' Mr Wells says. 'Building on the networks will be a key theme of the long-term plan – to ensure we can deliver earlier diagnosis, provide high-quality diagnostic and support tools to primary care and speed up interventions on the right pathway for patients.'



NHS Improvement wants trusts to speed up their move to networks – not only to reap the benefits in terms of services and efficiencies, but also to be ready to implement the long-term plan.

Network north

In the North East of England, the NHS has already taken steps to modernise its pathology services. In 2014, three trusts – Gateshead Health, City Hospitals Sunderland and South Tyneside NHS foundation trusts – brought together their pathology services into a single site in Gateshead. This facility could become part of a wider network that will serve nine trusts.

The Gateshead site is largely automated. It carries out 80% of the 'cold' pathology tests – where results are not needed immediately – for the three trusts. Each of the trusts have 'hot' pathology labs, which perform urgent tests. The hub allows for thousands of tests to be carried out each day, more efficiently and accurately, the service says. It can also offer state-of-the-art technology and new tests.

However, things could be about to change. Ruth James, pathology programme director for the North East and North Cumbria, says the collaboration will be included in the new North Cumbria and North East Pathology Network, but the final form of the network has yet to be decided.

'Within the region, work is in progress to develop a local model for pathology services across the North East and North Cumbria,' she says. 'The financial impact of any new service model will be calculated once any changes to the current service configuration are agreed.

'There is a need to invest in IT to support interoperability between the labs. The impact of any new service model on transport will be calculated when the configuration of services is agreed.'

HFMA ROUND TABLE

Delivering for systems

An HFMA roundtable in September brought together clinicians and finance professionals to talk about how value could be delivered across health systems. Steve Brown listened in

When prime minister Theresa May announced a new funding deal for the NHS and called for the development of a 10-year plan in England, she said it should be a plan in which 'every penny is well spent'. 'It must be a plan that tackles waste, reduces bureaucracy and eliminates unacceptable variation, with all these efficiency savings reinvested back into patient care,' she added. In essence, she was calling for a plan that delivers value – getting the best outcomes for the least cost.

There is a growing consensus that value-based healthcare is the best way to ensure health services meet the growing demands of the populations they serve while remaining sustainable over the long term.

Typically, the pursuit of value has been at the level of individual organisations. But increasingly there is a recognition that value can only be delivered at the level of whole systems.

For example, a hospital might optimise its treatment pathway such that admitted patients receive the best possible care in that setting. But real value might only be delivered if the patients had not been admitted in the first place – instead, being identified earlier and given support in a community setting.

In September, the HFMA Healthcare Costing for Value Institute organised a roundtable of clinicians and finance professionals to talk about progress in delivering value across systems. The roundtable, sponsored by biopharmaceutical company AbbVie and its *Decisions with value* programme, explored how different health

Participants

- Lucy Billington, assistant director of finance, Lancashire Teaching Hospitals NHS FT
- Lee Bond, chief financial officer, Hull and East Yorkshire Hospitals NHST
- Mark Bowling, head of business intelligence and value, Aneurin Bevan University Health Board
- Alan Brace, director of finance, health and social services, Welsh government
- Matthew Cripps, director of sustainable healthcare, NHS England
- Colin Dingwall, CTP director, NHS Improvement
- Sandra Easton, finance director, Chelsea and Westminster Hospital NHS FT
- Catherine Monaghan, clinical director, North Tees and Hartlepool NHS FT
- Stuart Murdoch, consultant, Leeds Teaching Hospitals NHST
- Chris Randall, assistant director of finance, Barking, Havering and Redbridge University Hospitals NHST
- Phil Schwab, director of government affairs, AbbVie
- Craig Wakeham, GP and chief clinical information officer, Dorset CCG

Mark Bowling

Chris Randall

economies were progressing on their own value journeys and the obstacles that needed to be removed to speed up current progress.

Contracting arrangements

Delegates reported that commissioners and providers in some areas were working more collaboratively than they had done in the past. In some cases this had been facilitated by different contractual arrangements. In other areas, contracting issues were blocking progress with delivering value across systems.

Lee Bond, chief financial officer at Hull and East Yorkshire Hospitals NHS Trust, said Hull's local health economy was only just starting to get into value-based healthcare, but a decision to move away from the activity-based payment by results system had led to a more productive relationship with commissioners.

'Arguing on contracts was a waste of time,' he said. 'Now we look at how much money is in the system and agree what the system can afford, and where possible bring services back into the NHS. That's led to a much better working relationship. We've not had a conversation about counting and coding in over 18 months and we've managed to make changes in a number of clinical areas, including some outpatient areas and around working with GPs.'

Aside from commissioner-provider relationships, Mr Bond said suppliers were starting to talk about different contracting arrangements for goods. 'One pharmaceutical supplier wanted us to use an expensive dressing it claimed would significantly reduce surgical site infections and therefore reduce the number of occupied bed days within the hospital for these patients – and was prepared to guarantee this reduction. This is a completely different value proposition and one we need to be more open to. But, other than the obvious clinical input, we need to understand how we can evaluate these new types of deal.'

He added that it was not obvious how deals such as this could be taken forward with the new operating model for procurement, based around category towers providing a central purchasing function. 'It is not clear how trusts will have these types of conversation directly with suppliers in the new world,' he said.

Chelsea and Westminster Hospital NHS Foundation Trust has a lot of the foundations in place for delivering value, including a robust costing system – enabling it to identify the financial impact of changing services or outcomes – and a clinical director responsible for this year's cost improvement programme (renamed as a quality improvement programme).

'This feels quite advanced,' said finance director Sandra Easton, 'but we are struggling to have a quality conversation across the system. Instead, it is a contracting conversation and that is a big barrier to change.'

Outpatients were a good example, she said, with about 50% of first referrals in some specialties resulting in discharge back to GPs.

'We know as a system we need to redefine those pathways, take what we can out of hospitals and take what we can through to telemedicine,' she said. 'But we are struggling to have those conversations because the first thing that happens is that people want to talk about how to contract for it. We need to define what we are going to do and then work out how we contract for it.'

She said the system had just agreed some rules

HFMA ROUND TABLE

Expanded roles

Much of the current focus in the NHS is on stopping inappropriate referrals between primary and secondary care, but in fact practitioners on both sides should be working together to better manage patients. GP Craig Wakeham, chief clinical information officer at Dorset Clinical Commissioning Group, told the roundtable that the challenge was to upskill the non-medical workforce and use medical staff to support these news ways of working.

'In the future, the integrated nursing team will do most of what I used to do as a GP and do it better,' he said. Roles already include supporting diabetes and COPD patients, working with specialist nurses not instead of them.

As with the hospital at home programme in North Tees, he said more value could at times be added by a consultant supporting multidisciplinary teams rather than seeing all patients personally.

'You often achieve the best return by doing a little for a lot of people, rather than a lot for few people,' he said. 'We should be looking to expand shared learning and collaborative working, not deskill each other.'

Non-medical staff could also take a lead role in conversations with patients about their treatment preferences. 'Medics are sometimes protectionist of their current volumes of work and often other skillsets can deliver that part of the pathway, such as supported self-care,' said NHS England's Matthew Cripps. Nurses, health coaches, pharmacists and physiotherapists are well placed to take this role and reduce the burden on doctors, he said.

Dr Wakeham said medics could help to empower them to do this. There has been a drive towards consultant-delivered care in recent years, but he said the NHS needed to rediscover consultant-led care.

> **"Arguing on contracts was a waste of time. Now we look at how much money is in the system and agree what the system can afford"**
>
> **Lee Bond, Hull and East Yorkshire Hospitals NHS Trust**


Catherine Monaghan


Colin Dingwall


Lee Bond

of engagement, including setting out how risks and gains will be shared.

North Tees and Hartlepool NHS Foundation Trust has set up a hospital-at-home service for chronic obstructive pulmonary disease (COPD) patients. The service aims to keep people at home or, if patients are admitted, to discharge them as early as possible.

'Within two hours of receiving a referral, seven days a week, 8am-8pm, the team of healthcare assistants, physios and nurses will do a home visit with a full assessment,' said Catherine Monaghan, the trust's clinical director for out-of-hospital care and consultant in charge of the service.

The service adds value in a number of ways. First, about half of these patients would previously have been admitted, so there is an immediate reduction of pressure on beds. Patients seen in A&E would most likely have been seen by a non-respiratory specialist and subject to a comprehensive set of tests. Now only tests that are absolutely necessary are undertaken. The service also identifies people who don't have COPD but are on expensive inhalers they don't need, or are making frequent visits to A&E, when different support would be more appropriate.

There has not been a single clinical incident in two and a half years, and the service has also found lung and laryngeal cancers in patients. 'We save about 100 bed days a month,' said Dr Monaghan. That is not enough to close beds, but it is enough to not have to open extra beds in the winter, when COPD demand rises.

However, she agreed there was a disconnect with the contracting position. Commissioners weren't convinced it was saving them as much as they would like and yet reducing admissions lost the trust money under the tariff system, providing a financial disincentive to running the new model.

'If you ask clinicians, they will always say they need more resource,' said Dr Monaghan. 'But this needs to be reconsidered because it won't happen. We can't appoint more clinicians because there aren't any qualified and ready to apply – so we have to do something different. This model works using highly skilled nurses and allied health professionals under the banner of one consultant. I couldn't have 200 beds under my name in hospital but I can in the community.'

> **"You often achieve the best return by doing a little for a lot of people, rather than a lot for few people"**
> **Craig Wakeham, Dorset CCG**

Lucy Billington, assistant director of finance at Lancashire Teaching Hospitals NHS Foundation Trust, added a note of caution around changing contracting and funding arrangements without understanding how stranded costs will be managed. The trust is part of the system-wide 'Our health, our care' programme, which is taking forward clinically led work to develop new models of care across out-of-hospital, planned and urgent care. The system is developing a new provider-vendor model, pooling budgets across current services to deliver more joined-up care overall – services for frail elderly is one of the first areas being explored.

'In the trust, we are starting to think about the predictive forecasting we can undertake as patients come through the acute hospital door, but we also need to think about what more we can do to keep people out of acute care,' she said.

'But in making changes, we have to bear in mind that we are a huge infrastructure and if we move everything out, the hospital still has to cover its costs and remain sustainable.'

Shared decision-making

The Leeds Teaching Hospitals NHS Trust has recently adopted aligned incentive contracts in place of tariff-based arrangements. This provides the trust with an agreed level of income for expected activity, with payments only changing with dramatic, unexpected changes in activity.

HFMA ROUND TABLE

Consultant in critical care Stuart Murdoch said this is 'beginning to take shape and make discussions easier'. However, he added that more fundamental changes were needed in what the NHS sought to deliver.

'How often do we talk to patients about the outcomes they want?' he said. 'We work on the basis that the patient wants to see a consultant or that they want lots of tests. Sometimes it might be that all they want is reassurance.'

Dr Murdoch said the failure to talk to patients about their desired outcomes early in the pathway was particularly evident in intensive care, where clinicians were often taking difficult decisions for patients with no clear idea of their preferences.

Consultants were hardwired to intervene to help patients, he added. A culture change was needed, with consultants more comfortable with recommending no treatment where the outcomes linked to treatment weren't good.

Matthew Cripps, director of sustainable healthcare at NHS England and former director of the NHS RightCare programme, said the NHS was in fact driven by supply. He said the RightCare work was built on the premise that optimising quality and outcomes delivers sustainable healthcare. He suggested this was demonstrated for pathways but not yet 'on the bottom line at a health economy level.'

'The reason for this is that it is a supply driven system, not demand driven,' he said. 'Archie Cochrane's thinking [Cochrane is the father of evidence-based medicine] shows that if we engage with patients at a sub-optimal point in the pathway, then it's human nature for clinicians to do the best they can at that point – and that includes using the equipment that's available to them, in that part of the pathway.'

The key to changing this, he said, was shared decision-making and understanding the


Craig Wakeham


Matthew Cripps


Sandra Easton

personal preferences and outcomes that were important to patients. For example, clinicians often recommended treatments without understanding a patient's preferred outcomes. They didn't set out the different options, risks and evidenced outcomes associated with different treatment paths – physiotherapy, for example, as an alternative to surgical intervention.

He suggested that clinicians were all keen to do their best for patients, but that shared decision-making, in its purest sense, isn't yet culturally recognised as the thing to do.

Outcome focus

Alan Brace, finance director for the Welsh government health and social services group, and roundtable chair, said better understanding of outcomes was crucial to value-based healthcare. He reinforced earlier comments about how contracting and competition could inhibit transformation, suggesting integrated boards with a population health focus and the lack of internal market in Wales provided a good foundation for system working. NHS Wales has committed to embedding a value-based approach across its health services as part of its *A healthier Wales* strategy.

'But our problem is outcomes. We don't have a common approach to outcome measurement or improvement. We often talk about outputs rather than outcomes and the outcomes we measure tend to be clinical outcomes rather than functional outcomes that matter to patients.

'So, we measure how well a surgeon puts a knee in, not what difference it made for the patient. And then research tells us that a lot of knee surgery shouldn't be done in the first place. Or in diabetes, we measure blood sugar levels, but we ignore amputation rates that give you a very different picture and a very different view of resources used over time.'

He added that there was no internationally accepted system for measuring outcomes, which had led NHS Wales to working with the International Consortium for Health Outcomes Measurement. While there are criticisms that these outcome sets are still too clinical, Mr Brace said they were more rounded than many approaches. And they offered an approach that was consistent with a growing number of health systems around the world.

The most recent Commonwealth Fund report on international health systems had placed the UK 10th out of 11 on outcomes, he said, while ranking the UK first on care processes – underlining how the UK needed to change its focus from simple efficiency to effectiveness.

'Understanding outcomes that meet the needs of the Welsh population – that is what

Understanding the costs

Costing data is fundamental to value-based decision making, helping clinical teams to understand the cost implications of existing and revised patient pathways. To support the delivery of value across systems, the NHS needs to be able to look at whole pathway costs, not just hospital costs. Although NHS Improvement is already supporting work to understand costs across systems, its current main focus is introducing a consistent approach to patient-level costing across acute, community, mental health and ambulance service providers.

Colin Dingwall is director of NHS Improvement's Costing Transformation Programme. 'The aim is to get to where every system consists of providers that can explain how much resource is consumed by each bit of activity,' he said, 'because that is the information, when plugged into the outcome data, that will generate the value equation we are all looking for.'

This first step was challenging, given the volume of data and range of different approaches in operation across different providers before the programme began. But it was important to get the building blocks in place. That process is reasonably well advanced with acute providers, and data has started to be fed back to the service via a dedicated portal. Other sectors are following their own transition paths.

However, Mr Dingwall said that in early summer, a pilot project kicked off in the Nottinghamshire Integrated Care System (ICS) to explore how a system view of costs and activity could be pulled together. 'This is being led by clinicians with pathways they wanted to work on,' Mr Dingwall said. The aim is to develop a solution that could be rolled out across other ICSs.

NHS Wales has made progress with patient-level costing, though some boards are more advanced than others. However, Aneurin Bevan University Health Board has used a different approach to costing to support its value work – time-driven activity-based costing (TDABC). While there is a US-view that this is the only useful costing approach to support value work, the board's head of business intelligence and value Mark Bowling said patient-level costing and TDABC complemented each other well.

TDABC involves mapping a pathway and then working out the practitioner time consumed by each step. It builds up a rich picture of costs consumed, helping users to understand how a different allocation of resources might impact on outcomes. But, it takes more time as a technique. Mr Bowling said it would, therefore, be impractical to use across the board's £1bn of expenditure.

'In places, TDABC has delivered more rounded and accurate analysis than previously achieved. Elsewhere we employ a hybrid, where TDABC does the bits that patient-level costing doesn't reach, helping to plug the gaps in a pathway,' he said.


Lucy Billington


Phil Schwab


Stuart Murdoch

HFMA ROUND TABLE

should drive my allocation of our £7.3bn budget in Wales,' he said. He added that Sweden was ranked second in terms of outcomes, but was poor on care processes. 'It is easier to improve process than to improve outcomes and I think the market in England is a technically efficient system focused on volume at low cost.

'That needs to be flipped into a system that allocates scarce resources to a service that itself has scarce staffing resources to drive best outcomes to meet people's needs.'

Mr Brace highlighted work at Hamburg's Martini-Klinik, a specialist prostate cancer centre, as an example of where the NHS needed to get to. With a database of long-term outcomes stretching back 25 years and a focus on outcomes that matter to patients, the clinic has produced impressive results.

While its five-year survival rate is on a par with the rest of Germany, it significantly outperforms other providers in terms of incontinence and erectile dysfunction rates.

There was a need to share how health economies were engaging with their communities to understand the outcomes that were important to them, he said..

Chris Randall is assistant director of finance at Barking, Havering and Redbridge University Hospitals NHS Trust. However, he previously worked in the Cambridge health economy, which attempted to put together an outcome-based contract for the provision of community care and elderly emergency care in 2014.

Alan Brace

"We measure how well a surgeon puts a knee in, not what difference it made for the patient. And then research tells us that a lot of knee surgery shouldn't be done in the first place"

Alan Brace, Welsh government

'My reflection is that you need to focus down a bit,' he said. 'We started with 215 outcome measures and, by the end of the process, we'd got it down to 75.'

Mr Randall suggested that this was still an unmanageable number of outcomes to be included in the contract. Instead there needed to be a focus on the key outcomes that the commissioner wanted.

And he added that the scale of the task was such that changing to an outcome focus could not be done across every patient stream at the same time.

The roundtable concluded that the first step in transforming services was understanding what needed to be delivered. That meant getting to grips with the treatment preferences and outcomes that matter to patients.

New models of delivery, contractual arrangements and different roles for practitioners should then be developed to best deliver these outcomes.

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HFMA calls for greater balance sheet focus and capital regime changes

Technical

Current attention on financial sustainability – at organisational and system level – and the importance of capital investment to transformation mean that the HFMA's new briefing on the NHS capital system is a timely contribution to an essential debate, *writes Debbie Paterson.*

NHS capital – a system in distress highlights the twin problems of a lack of focus on balance sheet metrics as a financial management tool and the difficulty of accessing capital finance. It sets out what a healthy balance sheet should look like and identifies the following qualities to look for:

- Sufficient cash balances to finance short-term working capital needs
- Historic and in-year surpluses that have allowed the build-up of cash balances to finance the capital programme
- Debt (where it exists) is being used to finance capital investment rather than servicing working capital needs
- An unqualified value-for-money conclusion from the auditors with no emphasis of matter in the audit report.

Few NHS provider bodies will have all of these qualities, given the sustained period of austerity and continuing rising demand. Getting back into financial shape will take time and resource and is a problem too big to be solved in one briefing.

However, in the short term, NHS bodies can improve their financial reporting to include balance sheet metrics as well as the all-important revenue/control total metrics. The HFMA will continue to look at best practice in financial reporting over the next few months.

Many NHS bodies are frustrated by the current system for financing capital and are looking to find alternatives to borrowing from the Department of Health and Social Care (DHSC). The paper sets out the reasons why the current system works as it does and highlights the fact that all capital expenditure in the NHS needs to stay within the DHSC's capital departmental expenditure level (CDEL).

SHUTTERSTOCK

While other sources of finance may seem attractive, they do not increase the overall amount that can be spent in any one year. The paper, therefore, considers how the resource available could be best allocated across the sector and identifies the key characteristics of any capital financing regime:

- Open and transparent
- Fair and equitable
- Based on clear criteria
- Co-operative rather than combative
- Timely
- Able to provide long-term certainty
- Streamlined.

In 2017/18, the DHSC reported an underspend of £360m against the CDEL, of which £267m related to NHS provider bodies – most of which was not forecast until the end of the year. This is not carried forward to the next year, but is lost to the NHS.

A better system of allocation with the characteristics set out above may have allowed the available capital resource to be spent in year, but it is not all down to the system of allocation. Some NHS bodies are able to finance part of their capital expenditure internally without additional funds from the centre – 77% of the capital expenditure in 2017/18 was financed internally. However, this all counts against the CDEL. So, to manage the national position, the DHSC needs accurate forecasts of capital expenditure throughout the year, especially at the year-end.

The paper identifies possible changes that may go some way to resolving current difficulties:

- Consider the revenue and capital problems as a single issue. Basic double-entry bookkeeping dictates the income and expenditure position is linked with the balance sheet. NHS bodies in deficit cannot build up reserves to finance investment.
- Consider a financial reset that removes the historic deficits that some NHS bodies are managing. Any financial reset would have to recognise that some NHS bodies do not have historic deficits and should not be penalised.
- Develop a longer term system of capital. allocation that allows NHS bodies to plan their capital programmes from the start of the year rather than having to wait for approval during each year.
- Determine a fair and transparent basis for allocation – there will never be enough resource, so there needs to be a mechanism for determining where it is allocated
- Simplify and streamline the current system.

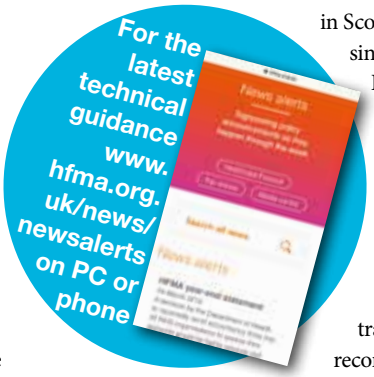
Debbie Paterson is the HFMA's policy and technical manager

Technical review

The past month's key technical developments

Technical

Patient-level cost collection file specification guidance for mental health services has been published by NHS Improvement. The guidance sets out the required data fields and format required by NHS Digital for the PLICS submission. A file on the data checks in the NHS Improvement data validation tool was also published. http://hfma.to/85



While every health and care system is different, there are some common essential ingredients needed to develop good **system-wide finance and governance** arrangements, according to an HFMA briefing. *How do you align resource plans across the system?* is the first in a series of four briefings focusing on system finance and governance issues and how to achieve strong strategic system planning. As sustainability and transformation partnerships are not statutory bodies, finance leaders told the HFMA that good relationships and a willingness to work together across a system were essential. http://hfma.to/86

The cost of backlog maintenance in the NHS in England increased to almost £6bn in 2017/18, according to NHS Digital. In 2016/17, it was £5.5bn. Publishing **estates return information** collection (ERIC) data for the year, NHS Digital said the total cost of running the NHS estate was £8.8bn in 2017/18 – £0.2bn higher than the previous financial year. However, the total cost of cleaning and inpatient food remained the same at £1bn and £0.6bn, respectively. Meanwhile, backlog maintenance in Scottish NHS buildings has fallen by around a quarter since 2011, according to health secretary Jeane Freeman. Publishing the results of the latest annual survey of **NHS Scotland assets and facilities**, she said the proportion of building classified as being in good condition had increased from 58% in 2014 to 72% in 2017. http://hfma.to/87

HM Revenue and Customs has produced an information pack to help stakeholders make the transition to **digital VAT returns** and VAT business record-keeping. Under the Making Tax Digital (MTD) programme, most businesses with a taxable turnover above the VAT threshold will be required to keep digital VAT business records and submit VAT returns via MTD-compatible software. HMRC has also announced that there will be a six-month delay in the requirement for NHS trusts to make VAT returns via the new MTD online system. http://hfma.to/88

NHS Improvement has amended its **medical agency price caps** to be in line with the recently approved pay rise for medical staff. NHS Improvement asked providers to ensure the amended caps are reflected in reporting from 8 October. http://hfma.to/89

New tools published by NHS Improvement will help English trusts, sustainability and transformation partnerships and integrated care systems forecast their finances, activity and workforce. The new **long-term financial model** will support organisations undertaking material transactions that require NHS Improvement assessment, including foundation trust applications, mergers and acquisitions and new care models. NHS Improvement said the new long-term financial model replaces the model in use since 2004. http://hfma.to/8a

Dialysis patients given greater choice

Technical: NICE

In October, NICE recommended four new technologies for use in the NHS, as well publishing guidelines on renal replacement therapy and decision-making and mental capacity, *writes Gary Shield*.

Recommendations in the guideline on renal replacement therapy mean people being treated with dialysis after kidney failure are to be offered a choice over where and what type of treatment they have. Patients, in discussion with their clinician, should choose the type of dialysis that is right for them and where they can have their treatment.

Three types of dialysis are offered on the NHS depending on local arrangements and suitability for the patient. Once a decision is taken, the patient, in consultation with their clinician, will decide whether treatment takes place at home or in hospital. This will also depend on local arrangements.

The independent NICE committee agreed clinicians should consider offering haemodiafiltration (HDF) in the first instance to patients who opt for treatment in hospital. This may lead to a rise in the number of patients using HDF rather than haemodialysis (HD). The associated resource impact tools model various scenarios to look at the potential costs of implementing the guideline.

On the technologies front, *TA542 Cabozantinib for untreated advanced renal cell carcinoma* recommends cabozantinib for adults with untreated advanced renal cell carcinoma that is intermediate or poor risk, as defined in the International Metastatic Renal Cell Carcinoma Database Consortium criteria.

TA544 Dabrafenib with trametinib for adjuvant treatment of resected BRAF V600 mutation-positive melanoma recommends dabrafenib with trametinib as an option for adults with this type of cancer.

More than 1,700 and 600 people respectively are estimated to be eligible for each of these technologies.

Gary Shield is resource impact assessment manager at NICE

NHS in numbers

A closer look at the data behind NHS finance

Allocations

Technical

The NHS rightly prides itself on its goal of providing equal access to healthcare based on need. While this is a laudable principle, it is not straightforward to put into practice. However, the first step is to divide its overall budget fairly, so that local health economies can put in place local services to meet the needs of their specific local populations.

All four UK nations do this by using a weighted capitation-based resource allocation formula to set budgets for health boards (Scotland and Wales), local commissioning groups (Northern Ireland, where budgets also cover social care) and clinical commissioning groups (England). The principles are similar, with each area set a target allocation that represents its fair share of resources.

In England, the starting point is the GP registered population. This is then adjusted for age, additional need (taking account of health status, morbidity and deprivation) and for unavoidable differences in the cost of providing services due to geographical location (using a market forces factor, MFF).

Weighted populations are calculated for different activities (covering hospital and community services and prescribing) and combined based on the share of each component in national spending, creating an overall weighted population for each commissioner. Each CCG then receives the same amount per weighted head of population.

CCGs are moved slowly towards this target allocation informed by a pace of change policy. By giving more growth to CCGs that are furthest away from target, the aim is – over time – to bring all groups to their fair share of resources.

In England, about 90% of Department of Health and Social Care funding is channelled through NHS England, with just over 60% of this overall funding going into CCG allocations. In 2017/18, core CCG allocations (covering hospital and community health services and prescribing spend) amounted to £74.2bn. NHS England also identified place-based budgets for each area. These included the budgets for specialised services and general practice relating to each CCG's population, but funded by NHS England.

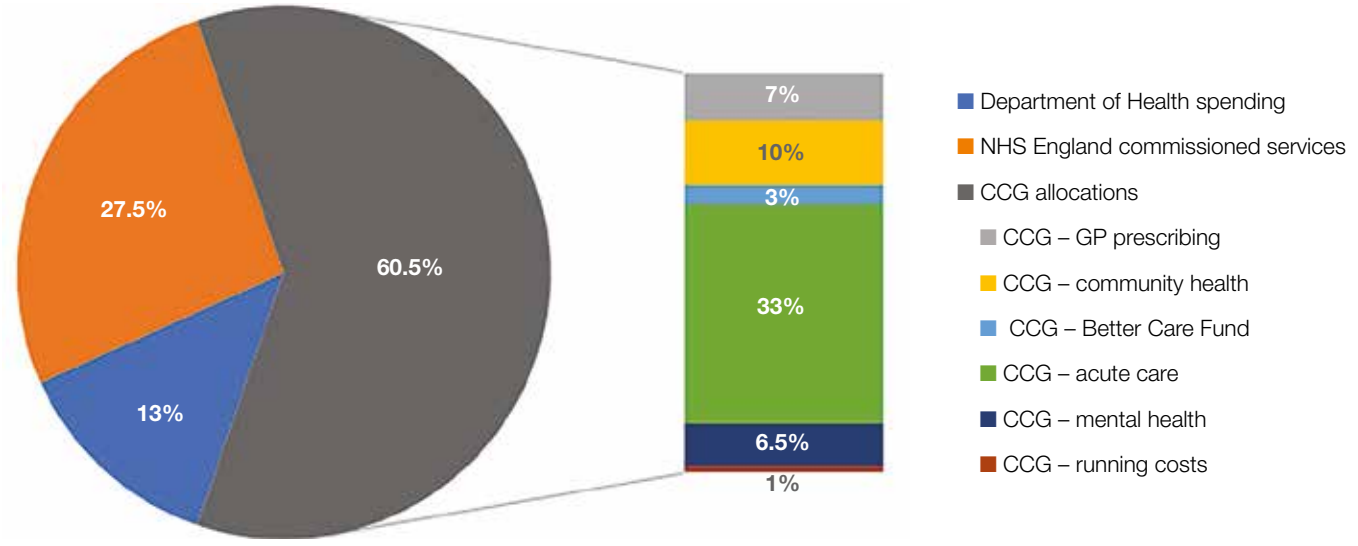
Allocations were set ahead of 2016/17, providing three fixed years of funding and two indicative. Revised CCG allocations and targets were published for the current year to reflect the addition of £600m to local commissioning budgets as a result of last November's Budget boost for health.

After a concerted effort since 2016, no CCG is more than 5% below its target allocation. There are just 16 CCGs with allocations more than 5% above target. Within these there are four that are over target by more than 10%, including one West London CCG that started the year 30% over target. Reducing an over-target position is necessarily a slow process as significant cuts in funding are likely to destabilise local services. And over-target CCGs maintain that local pressures are not always recognised by the formula.

New allocations covering five years from 2019/20 are due to be announced in mid-December following the operational planning guidance and alongside near final tariff prices and control totals for next year. With a revised MFF planned for use in the proposed national tariff for 2019/20, allocations will also be influenced by the updated data and tweaked calculation method.

The impact of the new MFF on tariff prices is being phased in across four years. But it is not clear if a parallel transition will be used for CCG allocations as CCGs are already on a transition towards being at target. Any decisions around this are likely to be part of wider discussions on the continued pace of change.

How funds are allocated



Source: (data) NHS England Fair shares; a guide to allocations, www.england.nhs.uk, based on 2016/17
Note: figures do not add up to 100% due to rounding

Primary colours

Alison Myles, HFMA director of education
News and views from the HFMA Academy

Training

HFMA members may be fully aware of the masters-level and first-year undergraduate-level qualifications now offered by the HFMA Academy for those interested in a further qualification in healthcare business and finance (*see September and October 2018 issues of Healthcare Finance, page 28*).

But how many also know that the association is also a major partner in a leading qualification aimed primarily at primary care and GP practice managers?

The *Diploma in advanced primary care management* was launched just over a year ago in October 2017 to cater for a demand from practitioners for developing the skills and competencies for managing primary care at scale. The demand is understandable, given the priority that's being given to expanding primary care generally, and looking at different models for organising primary care resources in super-practices, federations and as part of new care model arrangements within integrated care systems.

The diploma is offered by the National Association of Primary Care in association with the HFMA and law firm Capsticks – but it is being delivered through the HFMA Academy.

Following on from the pilot intake in October 2017, there have been three further intakes. This means more than 160 students in total have started the course – with the first students having just submitted their final assessment last month. There are lots of practice managers in the student body, but also some general practitioners, managers from a broader primary care setting and those with a specific focus on transformation and integration.

The network of students with a specific focus on primary care is one of the major attractions of the qualification. Comments from a current student, GP practice business manager Kay Keane, underline this point. 'I've met so many other brilliant NHS managers, those who are established in practices and those who wish to develop their skills, and those who currently work in other areas of primary care such as dentistry,' she says.

'This diploma has been a real leveller, we have all come together as novices and all helped each other in areas where we aren't sure. For me, that community and those friendships have been priceless and I know I have new friends to call on from across the NHS because of this course.'

The diploma consists of three modules all delivered through online tutored learning sets, workplace assignments and one national learning event and takes an estimated 600 hours to complete.

The three modules cover:

- Personal effectiveness and leadership
- NHS policy, law and governance
- Healthcare business and finance.

The whole course is delivered through the HFMA Academy and the leadership and finance modules were developed by the HFMA, with Capsticks leading on the law module.

Candidates successfully completing the diploma are eligible to take the HFMA healthcare business and finance advanced higher diploma, which itself opens up the possibility of entering a new MBA programme in healthcare finance, developed by BPP university.

Advanced diploma results

The HFMA Academy has published the results of May assessments for students studying for its advanced and advanced higher diplomas in healthcare business and finance (including students studying a single module for a certificate level award).

Of 56 submissions, 49 were successful in achieving the required standards. Of these, one received a distinction (the first awarded since the 2017 launch of the masters-level qualification) and 11 were awarded merits. Submissions covered four modules: *How finance works in the NHS* (core); *Managing the healthcare business*; *Tools to support decision making*; and *Creating and delivering value in healthcare*.

For seven students, the completed modules marked the completion of the advanced higher diploma.

FFF to celebrate diversity

Future focused finance

NHS Future-Focused Finance is to launch its *Diversity and inclusion* work programme, recently signed off by the Finance Leadership Council, at an event on 7 November in Birmingham.

A key objective of the programme, led by Edward John, director of operational finance at Frimley Health NHS Foundation Trust, is to remove the disparity between band grades across the whole finance function. It focuses on helping all finance colleagues to achieve their potential. And it aims to ensure that finance leaders today and in the future represent the diverse workforce within NHS finance and the local population they serve.

At the event, delegates will hear from policy leaders and champions of diversity from within the NHS and commercial sector, plus staff stories and, most importantly, patient experiences.

TV presenter and author of *Diversify: six degrees of integration* June Sarpong (pictured) is the keynote speaker. Attendees will also hear from Anne Hurst, diversity and inclusion specialist at PwC, who will share insights into how NHS finance might learn from the commercial sector.

The event is free to attend and will act as a platform for delegates to network and discuss the challenges facing them and their organisations. The event aims to encourage you and your teams to make a change in your organisation.

• To book a place or find out more, email futurefocusedfinance@nhs.net

Diary

November

7 I Institute: costing together (North)
8 B West Midlands: AGM, Birmingham
8-9 B East Midlands: annual conference, Loughborough
13 N Brighter together: estates forum, London, Rochester Row
14 F Chair, Non-executive and Lay Member: audit committee conference 2018, London, Rochester Row
15 F Commissioning Finance: forum, London, Rochester Row
16 B Northern: annual conference, Durham
17 B South Central: Brighter together theme event
20 B Eastern: interview skills workshop, Newmarket
20 B South Central: positive psychology workshop, Reading
22 F Mental Health Finance: site visit, Nottinghamshire Healthcare NHS FT
23 B Northern Ireland: annual conference, Belfast
27 I Institute: technical update, Leeds
27 B West Midlands: collegial conversations workshop, Birmingham

December

5-7 N HFMA annual conference, London
14 B Northern Ireland: Christmas cracker and AGM, Belfast

January 2019

15 F Chair, Non-executive and Lay Member: annual chairs' conference, London
16 I Institute: introduction to costing (North)
17 B West Midlands: Clue HQ escape room social, Birmingham
29 B Eastern: introduction to NHS finance, Fulbourn
30 N Pre-accounts planning, London
31 N Pre-accounts planning, London
31 B Yorkshire and Humber: annual conference, Broughton

February

11-12 N Chief executive forum and dinner
27 I Institute: value masterclass

June

21 B Northern: Keep stepping, Durham

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

key: B Branch N National F Faculty I Institute

HFMA webinars

Information is key to making the most of costing – if the data is inaccurate or unable to withstand challenge it can affect clinicians' confidence and potentially hamper trusts' ability to identify improvement opportunities and make good decisions. Collaboration between costing and informatics professionals is one way to improve data quality.

An upcoming HFMA webinar (12 December) will look at how East Lancashire Hospitals NHS Trust brought together its **informatics and costing** teams to develop a 'single version of the truth'.

Hosted by the HFMA Healthcare Costing for Value Institute, the webinar is open to institute members. The trust is an integrated acute, community and mental health provider, so the content will be suitable for costing and informatics professionals working in these sectors.

Also, look out for details of a webinar on **IFRS 16 *Leases***, which the association is due to hold in November.

• **Further details from** www.hfma.org.uk/education-events

Events in focus

Annual conference 2018 – Brighter together

5-7 December, London

With further details of the five-year funding plan and long-term strategy for the NHS in England due to be published soon, the future shape of services and its financial architecture are sure to be hot topics at this year's HFMA annual conference.

The annual conference is the culmination of HFMA 2018 president Alex Gild's theme for the year – *Brighter together,* encouraging collaboration between NHS staff and with other stakeholders to improve patient services.

As ever, this year's conference will also include workshops and a chance to network with colleagues.

Speakers include former Liberal Democrat health minister Norman Lamb, as well as Elizabeth O'Mahony (pictured) and Ian Dalton – respectively NHS Improvement chief financial officer and chief executive, and Jon Rouse, the chief officer of Greater Manchester Health and Social Care Partnership.

The 2018 HFMA Awards – one of the highlights of the annual conference – celebrating excellence in NHS finance, will also be presented during the gala dinner on 6 December.

• **For further details or to book a place, email** josie.baskerville@hfma.org.uk

Pre-accounts planning

30 January, Birmingham; 31 January, London

The HFMA is to hold two of its popular pre-accounts planning events at the end of January to help members in the run-up to the annual accounts planning season.

The one-day conferences are designed to help in the planning and delivery of the 2018/19 annual accounts. Plenary and workshop sessions will provide opportunities for feedback, discussion and networking. NHS England, NHS Improvement and Department of Health and Social Care representatives will be available to answer questions or discuss changes to accounting and reporting requirements.

Delegates will hear about and discuss issues that are likely to come up during the preparation of the 2018/19 accounts and the audit process, as well as lessons from the 2017/18 accounts.

• **For further details or to book a place, email** josie.baskerville@hfma.org.uk

System insiders

SHUTTERSTOCK

Association view from Mark Knight, HFMA chief executive

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

My HFMA

As we hit November, the countdown to this year's annual conference has really started, and we are developing a fantastic experience. Unfortunately, the timing means we are probably not going to hear from the (by then) newly appointed chief finance officer for the new joint executive team at NHS Improvement and NHS England.

Nonetheless we have a packed agenda and the opportunity to hear about crucial developments for the NHS – the 10-year plan, proposals to move away from the current control total system and payment reform, to name just a few.

On the Wednesday of conference, we celebrate with those who have achieved success in our diplomas. I'm indebted to all those involved in the delivery of the qualification and within the awarding body. In three years, from a barely formed concept, we have delivered a practical, well-regarded programme designed to meet the needs of the ever-changing health service.

Tickets are still available for the main event and we welcome as many members as the venue will take. The annual awards dinner on the Thursday night is another highlight and this year has a healthy crop of nominations (*see page 3 and inside front cover*). Our awards continue to provide a great opportunity to celebrate the work of finance teams.

The finance function is at the heart of the system. I often represent the HFMA at meetings with many different professions and pressure groups. While they make good contributions, they do so from a standpoint of looking into the system. The HFMA comments from the point of view of being part of the system.

Finance professionals play a crucial role in the delivery of high-quality health services – a contribution not always appreciated by others. Proper budgeting means the money is in the right place to deliver services all year round.

Costing data is increasingly being seen as a tool for identifying opportunities to improve clinical services, address variation and deliver value. The audit function plays a vital safeguarding role in ensuring money is spent well, making the best use of taxpayer funds. And, at an executive level, finance directors provide valuable input to boards. What you do as a function is important, and that means what we say on your behalf is important too.


HFMA chief executive Mark Knight

At events, while I may not always say popular things, I do get listened to because I represent an important and powerful community – you.

At a recent roundtable – I can't reveal details as it was a Chatham House meeting – there was a distinct chill in the air when I finished speaking. Reality had hit a cosy conversation as we talked about the 'F' word. I make no apologies for this. We must continue to articulate the realities of where we are as an NHS. And we have influence!

We are listened to because we are a credible, professional function. Since the demise of strategic health authorities, we have set up regional finance director, and sometimes deputy director, groups. This underlines our status as part of the system.

It is a major plus for us and it is down to your hard work in delivering excellent services time and time again across all UK health services.

Member news

At their annual conferences, Wales Branch and Kent, Surrey and Sussex Branch handed out several awards to members, in recognition of achievements over the past year. The Wales Branch winners (pictured) were:

- Training and skills development award – Betsi Cadwaladr University Health Board. Highly commended – Timothy Kelland
- Student award – Ffion Geary
- Excellence in finance/ performance improvement award – Welsh Ambulance Services NHS Trust.

Kent, Surrey and Sussex Branch winners included:

- Finance team of the year – contracting and income team, East Kent Hospitals NHS Foundation Trust.
- Outstanding contribution – Margaret Moulds
- Student of the year – Alex Dimond

At the Kent, Surrey and Sussex Branch annual general meeting, Spencer Prosser stepped down as chair after eight years. The branch thanked him for his leadership and passion for the HFMA during that time. The new chair is Sheila Stenson, executive director of finance at Kent and Medway NHS and Social Care Partnership Trust. She has been deputy chair since 2017.

HFMA policy and research manager Sarah Day has trekked 60 miles along the Western Front in France and Belgium, as part of her fundraising campaign for the Royal British Legion, commemorating the centenary of the end of WW1. Ms Day aims to raise over £1,500. 'It was an emotional experience,' she said. 'Our blisters seemed insignificant. The funds that the trek raised will go towards supporting today's veterans and their families.'

Branch focus

My HFMA

Northern Ireland

Northern Ireland has an integrated health and care system, with a health and social care (HSC) board and five trusts. The HSC is facing a similar range of pressures as elsewhere in the UK. As in the other nations, transformation is a hot topic, with an ambitious plan to transform health and social care by 2026 to enable people to stay well for longer and to receive more treatment in a community setting.

There has been significant progress in recent months with the transformation agenda. Initiatives have been taken forward within a comprehensive accountability framework underpinned by partnership working.

Since January 2017 there has not been an executive body governing Northern Ireland, as the two main political parties are in dispute. This presents challenges to health and social care leaders as they can't make major changes to services without authorisation from the executive (*see The long view, Healthcare Finance, October 2018*). In these times, the role of the HFMA Northern Ireland Branch is even more important, providing a forum for the healthcare finance community to come together.

The branch organises at least four events a year that give its members not only continuing professional development but a chance to talk to colleagues facing similar issues.

The branch has members from all HSC bodies. 'We're a settled community and support each other,' says branch chair Owen Harkin (pictured). 'We're an effective branch. Everyone is passionate about what we do – it is a truly great network to be a part of.'

Despite having an integrated health and care system, integration is still high on the local agenda – continuing to work across professional boundaries to improve patient and client flows in all sectors. 'We've only made significant progress towards formalising a more integrated way of working in recent years. Multidisciplinary planning, delivery and monitoring are key to ensuring more collaborative and effective working across the system,' adds Mr Harkin.

The branch's annual conference takes place on 23 November. As well as local health and care figures, Steve Wilson, executive lead, finance and investment at Greater Manchester Health and Social Care Partnership, will share best practice from Manchester's transformation and integration experience.

• **To find out more visit** hfma.to/ni

branch contacts

Eastern kate.tolworthy@hfma.org.uk
East Midlands joanne.kinsey1@nhs.net
Kent, Surrey and Sussex stuartwayment@nhs.net
London katie.fenlon@hfma.org.uk
Northern Ireland kim.ferguson@northerntrust.hscni.net
Northern catherine.grant2@nhs.net
North West hazel.mclellan@hfma.org.uk
Scotland alasdair.pinkerton@nhs.net
South West laura.ffrench@hfma.org.uk
South Central katie.fenlon@hfma.org.uk
Wales georgia.purnell@hfma.org.uk
West Midlands fleur.sylvester@hfma.org.uk
Yorkshire and Humber laura.hill@hdft.nhs.uk

Appointments

Leeds Teaching Hospitals NHS Trust has appointed **Jonny Gamble** (pictured) associate director of finance. He was previously deputy director of finance at Kettering General Hospital NHS Foundation Trust. He takes over from **Neil Atkinson**, who is now director of finance at North Tees and Hartlepool NHS Foundation Trust.

Having served as chief finance officer at the Royal Free London NHS Foundation Trust for seven years, **Caroline Clarke** (pictured) is now group deputy chief executive at the organisation. Ms Clarke is an HFMA trustee and is in line to be the organisation's president for 2019/20. She has over 25 years of experience working for the NHS and also spent two years working as an associate partner at KPMG.

Kate Anderson is now interim director of corporate governance at Lewisham and Greenwich NHS Trust, having been associate director of finance at the organisation. Ms Anderson is the chair of the HFMA London Branch. She joined the NHS in 2015 after working at KPMG for 14 years.

Suzanne Robinson (pictured) will be taking over from Martin Roe as director of finance at Pennine Care NHS Foundation Trust. Ms Robinson moves from finance director of both North Staffordshire Combined Healthcare NHS Trust and Staffordshire and Stoke-on-Trent Sustainability and Transformation Partnership. She is also the newly appointed chair of the HFMA Mental Health Finance Faculty.

Jackie Bilcliff has been named acting director of finance and informatics at Gateshead Health NHS Foundation Trust. She joined the trust as deputy finance director in 2014 and was most recently operational director of finance. She takes over from **John Maddison**, deputy chief executive and director of finance, who is currently acting CEO there.

CIPFA has appointed **Bob Alexander** (pictured) associate director of health and integration, though he will continue as executive chair of Sussex and East Surrey Sustainability and Transformation Partnership. Mr Alexander was executive director of resources and deputy chief executive at NHS Improvement. He is joined at CIPFA by new health and social care policy manager **Eleanor Roy**, who previously worked at the National Assembly for Wales.

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

"The challenge is to balance the local focus with the scale you need to be financially and clinically sustainable"
Paul Brown, North West London Collaboration of Clinical Commissioning Groups

Brown returns to the NHS after 16-year break

On the move

Paul Brown is excited to be returning to the NHS after 16 years away working for a consultancy firm. And he is convinced he can help transform the care given to patients.

Mr Brown has been appointed chief finance officer of the North West London Collaboration of Clinical Commissioning Groups – eight CCGs spanning inner and outer London. He takes up the post this month and succeeds Neil Ferrelly, who is retiring.

Returning to the NHS reflects Mr Brown's lifelong belief in the value of a career in the health service. 'In consultancy, I got to see everything in terms of geography, as I worked in every part of the UK, and in terms of the system – I worked with commissioners, providers and regulators,' he says. 'I learned a lot. But I was advising. A big driver for me was to get back to doing, to shape and be responsible for the delivery of change and making it happen.

'Finance people are in a powerful and important position in terms of constraining or allowing resources. I want to allow resources to be invested to make care the best it can be.'

Mr Brown first joined the NHS in 1985, as a regional finance trainee – qualifying with CIPFA – and spent the next 17 years in the service, principally in the South East of England.

This included a short spell as acting finance director at Hastings and Rother NHS Trust, then as finance director at Thanet Healthcare NHS Trust and East Kent Hospitals NHS Trust.

In 2002, he moved to the private sector with accountancy and consultancy firm Bentley Jennison, which, through a series of mergers, became RSM. He joined consultancy firm Carnall Farrar in 2017.

'I left the NHS always intending to come back. I joined the NHS as a life choice as much as a career choice. I was quite young when I became a finance director – I was first appointed at 28, so I had already been an FD for 10 years by the time I was in my late thirties, so I wanted to add some private sector experience to my CV and then return to the NHS. Now is that time.'

"A big driver for me was to get back to doing, to shape and be responsible for the delivery of change and making it happen"

What experience will he bring to the NHS from the consultancy sector? 'One of my key learning points is to look at time as a cost. So I will be looking to concentrate my and the team's time, ensuring focused outcomes and lots of short interventions.'

He believes the key challenge of his new job relates to the sheer size of the collaborative. The local system has a change programme in place, *Shaping a healthier future,* which has been through public challenges and a judicial review.

'There's a strategic blueprint to bring about significant change – building up primary and community care and, alongside that, resizing the acute sector. It's exciting to be implementing the strategy, but the challenge is to balance the local focus with the scale you need to be financially and clinically sustainable.'

A joined-up financial strategy that empowers people to deliver the change programme locally and ensures accountability will also be important, Mr Brown adds.

Moving to an integrated care system (ICS) will be a key part of this, he says. 'For everything we want to happen, the ICS will be vital – we want commissioners and providers operating in a coherent and collaborative way.'

Obituary: Bill Jones

Bill Jones, chief finance officer of Dartford, Gravesham and Swanley Clinical Commissioning Group and Swale Clinical Commissioning Group, has sadly passed away. The CCGs issued this obituary:

It is with the heaviest of hearts that we announce the sad loss of our dearest friend and outstanding chief finance officer, Bill Jones. Bill passed away on 24 September surrounded by his close family. Bill was a longstanding, dedicated finance director, highly regarded across the whole of Kent and Medway. He will be hugely missed not

only by his team and staff at Dartford, Gravesham and Swanley CCG and Swale CCG, but by his wider NHS family, including colleagues at NHS England, provider trusts and other CCGs.

Bill had been poorly for some time with a rare medical condition, AL amyloidosis, which affected his heart. He went through a lengthy chemotherapy, but throughout was determined to keep working. More recently his health deteriorated after a fall.

Bill worked at finance director level in the NHS for over 25 years. He started his career with the NHS in 1993 with the Kent Ambulance Service, later moving on to Shepway Primary Care Trust. He joined Eastern and Coastal Kent Primary Care Trust following reorganisation in 2006 and became finance director for performance and contracting when the three Kent and Medway PCTs merged in 2011.

Bill took up his post as chief finance officer of Dartford, Gravesham and Swanley, Swale and Medway CCGs in August 2012.

Bill was a very proud family man who lived life to the full and we had many laughs with him. He leaves wife Lorna and twins Natasha and Matt. Our thoughts and prayers are with them at this sad time.

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