healthcare finance

December 2018 | Healthcare Financial Management Association

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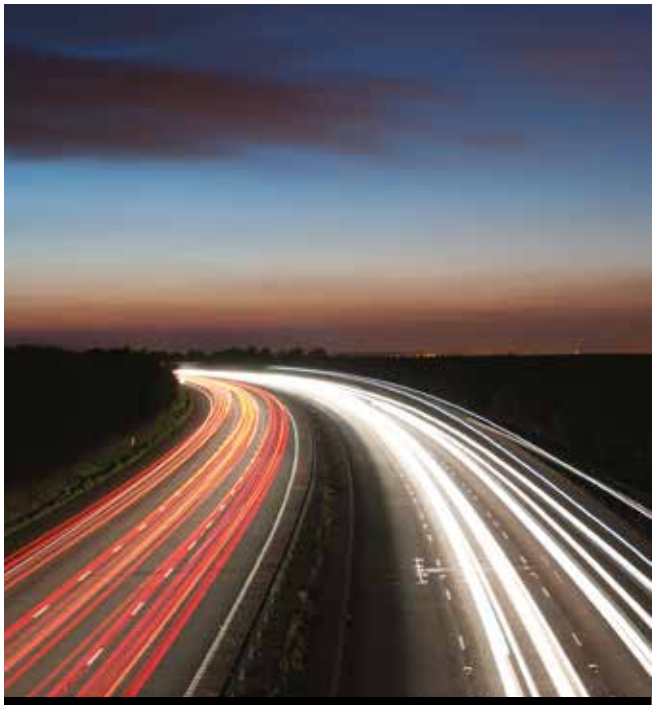

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Turn to the centre pages of the magazine to view the HFMA's *president and chief executive's report – year to 30 June 2018*

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News

Action to recover finances as trust position worsens

By Seamus Ward

Work continues to identify further savings and secure a balanced financial position in 2018/19 for the NHS as a whole, NHS Improvement said, with the provider sector forecasting a year-end deficit of £558m at quarter two.

At Q1, the sector forecast a £519m deficit. NHS Improvement said this was unaffordable and agreed an action plan with NHS England to produce a balanced position at year-end. Commissioners were asked to deliver a £265m underspend to contribute to this. At Q2 the commissioning sector is on track to meet this – and could underspend by £450m at year-end (*see page 4*).

NHS Improvement has worked with providers to confirm the level of improvement that could be made, initially targeting £254m at the end of Q1. Using the provider sustainability fund (PSF) framework, the oversight body offered providers additional bonuses for improving their financial position. A small number of providers took up the opportunity to receive the payments, allowing NHS Improvement to reset the planned forecast deficit to £439m – a reduction of £80m.

However, at Q2 trusts' aggregate position deteriorated. The forecast deficit – calculated after applying the provider sustainability fund – was £119m higher than the reset plan of £439m.

The year-to-date deficit of £1.23bn was £87m more than planned. All overspending at month six was in the acute sector, which had an aggregate deficit of £1.7bn (£257m worse than plan). NHS Improvement said the financial position in nine trusts had deteriorated by more than £5m over the quarter and the trusts' boards must take 'firm action' to achieve their plans.

Much of the deterioration in the financial position was due to increased pay costs as trusts face greater demand. Once the effect of the new Agenda for Change pay deal is stripped out (£410m), overall pay costs were £151m higher than plan in the year to date, largely due to agency and bank spending.

The report said the overspend was driven by volume increases rather than agency rates – the average price per shift was 15% less than at the same point in 2017/18.

The increase in agency and bank spending reflects rising demand – A&E attendances were up by 4% compared with Q2 in 2017/18. The waiting list for diagnostic tests was 5.1% higher than the same period in 2017/18. Emergency admissions at trusts with major A&E departments were up 7% on Q2 last year. As a result of the rise in emergency admissions, providers struggled to deliver planned activity –

"Despite the eye-watering financial deficits, the NHS as a whole remains close to financial balance"
Siva Anandaciva, King's Fund (pictured)

the elective waiting list was 3.9 million patients at the end of September, 7.3% up on last year.

Emergency care income was £218m (3%) higher than plan, but elective income was £116m (2.4%) lower than plan. High-cost drug income was up £76m (3.5%). The Q2 report said this was 'continuing the trend previously identified by which profit-making elective income is crowded out by loss-making non-elective income and zero-margin pass-through drug costs'.

Siva Anandaciva (pictured), the King's Fund's chief analyst, said the report highlighted a tough winter ahead. 'Despite the eye-watering financial deficits reported by many hospitals, the NHS as a whole remains close to financial balance, underlining the need for significant reforms to NHS financial management in the forthcoming NHS long-term plan,' he added.

The new funding will not be enough to address all the pressures facing the service. 'It is vital that sufficient funding is dedicated in the plan for developing new models of care, building on the work currently taking place in integrated care systems up and down the country.'

NHS Providers' chief executive Chris Hopson said trusts must be set realistic operational and financial targets. 'They must be properly funded to break the current cycle of ever-worsening performance. And we still need more urgent action to address workforce shortages,' he said.

Conference call

Alex Gild will bring to a close his year as HFMA president at this month's annual conference (5-7 December), which runs under his theme of *Brighter together*.

With a new long-term plan for the NHS due to be released in December, the central London conference will provide a platform for debate on the current financial issues, the move to integration and other specific challenges such as addressing workforce shortages.

The annual HFMA awards will also be presented during the conference, recognising the achievements of the NHS finance function and best practice across financial management and governance.

HFMA members not attending the conference can follow the action via the *Top stories* news feed at **www.hfma.org.uk** or on the myHFMA app (inset) – a revamped version is being released in time for the conference.

Early pointers emerge to spell out long-term plan

By Seamus Ward

Although the NHS long-term plan for England is expected to be published this month, some of its measures emerged in November, including a move to reduce inappropriate clinical procedures.

NHS England said that, as part of developing the plan, it would seek to reduce activity in 17 clinical interventions. While the main goals were to avoid needless harm to patients and free up clinical time, the restrictions will release resources – potentially £200m a year – to be reinvested in patient care, NHS England said.

The interventions, which are not being banned outright, were split into two groups.

Four interventions in category 1 should no longer be commissioned by clinical commissioning groups, except where an individual funding request (IFR) is made. The procedures are deemed inappropriate in most cases or superseded by a safer alternative. They include injections for lower back pain without sciatica and surgery for snoring.

The 13 interventions in category 2 should only be commissioned or performed when specific clinical criteria are met, including varicose vein surgery, tonsillectomy and removal of benign skin lesions.

Subject to the 2019/20 national tariff consultation, commissioners will be allowed to withhold payment for the category 1 interventions if there is no evidence of an IFR. The NHS standard contract for 2019/20 has been amended to require commissioners and providers to comply with the policy.

NHS England medical director Stephen Powis told the organisation's board meeting on 28 November: 'Though the financial and contractual changes will start from April 2019, our expectation is that commissioners, providers and clinicians will start to implement the clinical criteria from today. We want to ensure that patients have access to the most appropriate interventions as possible and to minimise avoidable harm as rapidly as possible.'

The 17 interventions were provided a total of 335,000 times as inpatient spells and day cases in 2017/18. NHS England intends to reduce these by at least 128,000 by the end of 2019/20.

It will also consider including a new progress indicator on reduction of the activity in the 2019/20 assessment frameworks for CCGs, sustainability and transformation partnerships and integrated care partnerships.

A series of announcements from prime minister Theresa May (pictured) and her ministers gave further insight into the long-term plan. They allocated at least £2bn of extra funding to mental health and £3.5bn to out-of-hospital services and said funding should be shifted to public health – all important elements of the long-term plan.

CREATIVE COMMONS/PAUL MEE

Mrs May said the £3.5bn for primary and community health services in England would be used to establish 24/7 community-based rapid response teams, providing emergency as well as day-to-day care, and dedicated support for care home residents.

The money is part of the £20.5bn rise in revenue allocations promised to the NHS over the next five years.

Mrs May said: 'Many of us might assume that hospital is the safest place to be, but many patients would be much better off being cared for in the community. The longer a patient stays in hospital, the more it costs the NHS and the more pressure is put on its hardworking staff. This needs to change.'

Commissioners report aggregate underspend

The commissioning sector reported a year-to-date underspend of £37.5m six months into the financial year and forecast it would overachieve on planned savings at the year-end.

The Q2 figures, published at the NHS England November board meeting, showed clinical commissioning groups had a year-to-date overspend of £74m, largely driven by overspends on acute contracts. There were 36 CCGs with year-to-date overspends.

Interim chief financial officer Matthew Style (pictured) told the board meeting that, at month six, he expected all but 11 of the 36 CCGs to bring their position into line with their plan at year-end.

However, the year-to-date position was balanced by underspends in direct commissioning (£28.5m) and NHS England central budgets (almost £94m). Central budget underspends were largely due

to vacancies and unexpected income from GP rates rebates. Technical and other adjustments (-£11m) reduced the final year-to-date commissioning sector figure to a £37.5m underspend.

In September, NHS England and NHS Improvement agreed an action plan to recover planned provider year-end deficits of £519m. They wanted the provider sector to reach a balanced position at year-end to give them a springboard going into the five-year funding settlement and implementing the long-term plan.

The report said commissioners were on track to deliver the planned underspend of £265m at year-end – the sector's contribution to getting providers back in overall balance (*see page 3*).

Mr Style said a greater year-end underspend could be delivered. NHS England had conducted its regular deep dive into central budgets half way through the year to see if further funding could be released. Likely underspends in central budgets, together with the management of risk, the conclusion of the Pharmaceutical Price Regulation Scheme deal and the successful procurement of biosimilar medicines would also contribute.

He added: 'We think for month 7 we will be able to release further reserves and contingencies into the reported position. Taking those together with the position on direct commissioning and updated forecasts of performance against the quality premium in our next report, we expect to forecast a year-end underspend of at least £450m.'

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Case study

Optimising outcome, performance and reimbursement improvements through data quality

The Information Department and Clinical Coding Team of a Midlands-based NHS Foundation Trust have taken steps to deal with significant financial pressures and meet targets set through the NHS Cost Improvement Programme. The Trust serves a population of approximately 360,000 people and provides local healthcare through acute and community services.

Results

2017 Realised reimbursement improvement

The Trust's first eight months of using the 3M™ Data Quality Analytics (DQA) module showed significantly improved reimbursement with an average of £47,913 per month. By June 2017 the Clinical Coding Team was fully trained on using DQA, hence the financial increase. July to September was impacted by the period of annual leave within the team, December alone, however, generated improvements of £60,964.

> "I would recommend DQA as a great tool for data analysis because this Trust has successfully used it to:
>
> - demonstrate significant financial results
> - reduce incidence of error and therefore improve quality of the coded clinical data
> - deliver the Cost Improvement Programme (CIP) target
> - target training gaps in the clinical coding team"
>
> **Clinical Coding Manager***

Financial benefit

The Trust has benefited from income improvement in the first eight months of:

£383,309

An average increase per month in appropriate reimbursement of:

£47,913

Increased data accuracy

The 3M DQA module has led to an improvement in data accuracy and quality whilst presenting real-time actionable data in a dashboard available to the Trust's management teams. An alert on the dashboard allows for the review of episodes that exceed an expected length of stay. The drill in episode level data may reveal omitted comorbidities, procedures or even an inaccurate primary diagnosis. Correction of this coding improves data quality and may change the Healthcare Resource Group (HRG) with a consequent financial impact.

Team development

Training gaps have been identified through the 3M DQA module and are addressed with the entire team at weekly meetings, therefore reducing potential future errors.

Complete, accurate clinical coding is essential to the Trust and its revenue is dependent on its coding quality. 3M Health Information Systems worked closely with the Information Department and Clinical Coding Team to optimise data accuracy and therefore income improvement.

Building on the Clinical Coding Team's knowledge and skills acquired through the 3M™ Medicode™ Clinical Encoder, the 3M™ Data Quality Analytics (DQA) Solution was implemented. The DQA module reviews all coded episodes and reports against the National Clinical Coding Standards, alerting the user to potential errors. The Clinical Coding Manager uses the tool to identify gaps in training needs. The amount recognised is directly proportional to the time invested in reviewing the DQA outputs and correcting errors.

*Clinical Coding Manager. Names withheld by request.

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LIAISON

Developing a collaborative bank at a Lead Employer Trust and HEE

7 trusts collaborating

620 doctors registered on the bank across **36** specialties

Liaison has been working with trusts in the North East and North Cumbria to develop Flexishift - a collaborative locum bank to share doctors across the region, reduce reliance on agency locum workers and benefit from reduced rate cost savings.

FlexiShift

NHS Health Education England

Scope and findings

Some seven trusts now form part of the 'Flexishift' collaborative bank in the North East and North Cumbria supported by Liaison's TempRE service. The success of the collaborative bank has been in the delivery of the 'concept'. We spoke with trusts to dispel some of the 'myths' around readiness to join a collaborative bank and the benefits of joining a TempRE bank. These included:

- Trusts do not need to be using the same agency platform to join.
- No need to agree regional rates before creating a collaborative bank.

Liaison's pilot involved:

Driving Productivity, Innovation and Compliance

Education and Training: Provided training to system users and also to all the trusts who formed part of the pilot. Some trusts chose to upload the shifts directly onto the system whilst others used Liaison to do this task for them.

Technology and Support: Joint processes, technology and governance, saving costs to reinvest in care.

Reduced Agency Reliance: Reduction in reliance on agencies, and more familiarity in temporary staff leading to improved staff experience resulting in higher morale and retention.

Workforce Planning: Greater use of rostering data and analysis to know 'who works where', Increased pool of staff and specialisms to meet demand across sites and bargain with suppliers.

Patient Outcomes: Quality improvement and patient safety.

Payroll Support: Doctors working through Flexishift paid weekly for shifts worked, run by Northumbria Healthcare Foundation Trust.

Achievements to date

December 2017: Started a six-month pilot with five trusts.
These were:

- County Durham & Darlington NHS Trust.
- Gateshead Hospitals NHS Foundation Trust.
- Northumbria Healthcare NHS Foundation Trust.
- North Tees & Hartlepool NHS Foundation Trust.
- South Tees NHS Foundation Trust.

Three months into the pilot and 344 doctors registered on the bank.

August 2018: Mobile TempRE App went live allowing doctors to book shifts on the go.

September 2018: 570 doctors registered on the bank across 34 specialties. An additional mental health trust and another acute trust join the bank.

Next steps

We will be...

...introducing other mental health trusts and other staff groups.

...collaborating with additional trusts from outside the NE area.

...developing the system to allow doctors to add a CV.

> **The new TempRE app has proved to be a great update for our collaborative bank. It's prompted a marked increase in doctors applying for shifts and an uplift in our fill rates.**
>
> **The feedback from our workers tells us it's easy to use and they love the ability to quickly apply for and confirm shifts on the go.**

Linsey Richards, Head of HR at County Durham & Darlington NHS Foundation

To find out more about how a collaborative bank could be a reality for your region, get in touch.

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Subsidiaries face tighter control

NHS providers must now seek NHS Improvement approval before setting up subsidiary companies to run services.

Previously, foundation trusts had the power to set up wholly owned subsidiary companies on their own, while NHS trusts needed permission. But following a consultation, NHS Improvement requires all providers to submit a business case for all proposed subsidiaries or material changes to existing subsidiaries.

The review process – for all subsidiaries, regardless of value – will be in two stages. An initial panel review of about three weeks will determine if transactions are 'material' (lower risk) or 'significant' (higher risk). Significant transactions will then be subject to a detailed review, which could lead to approval, approval with additional oversight or stopping the transaction.

The tighter grip on subsidiaries comes in the face of opposition from NHS Providers. 'We are concerned the level of detail and the steps outlined in the new review process go a long way beyond what is normally expected of trusts and what is required for other transactions and commercial activities,' said its deputy chief executive, Saffron Cordery (pictured).

An HFMA response to the earlier consultation claimed the new companies were no riskier than other transactions covered by existing guidance.

Address workforce or risk long-term plan, NHS told

By Seamus Ward

Extra funding for the NHS in England could go unspent if the forthcoming long-term plan does not adequately address workforce issues, according to three leading health think-tanks.

The King's Fund, Nuffield Trust and Health Foundation said the plan 'risks becoming an unachievable wish list' as staff shortages could lead to longer waiting lists and care quality deteriorating. A joint briefing, *The healthcare workforce in England: make or break?*, predicted vacancies could rise from 100,000 today to almost 250,000 by 2030 – a vacancy rate of one in six. If the NHS continues to lose staff and fails to recruit from abroad, this could rise to 350,000.

Anita Charlesworth (pictured), director of economics at the Health Foundation, said the NHS was already overstretched and services compromised by staff shortages. 'This problem will only get worse over the next decade, putting access and quality of care at risk,' she said.

'Unless government and system leaders take radical action and prioritise the NHS workforce, staff shortages will more than double by 2030. The NHS can't sustain current services, let alone improve, with such a gap between the staff it needs and the people available to provide care.'

The three organisations set out five tests for the long-term plan:

- Address the immediate workforce shortages
- Deliver a sustainable workforce over the next 10 years
- Support new ways of working across the health and social care workforce
- Address inequalities in pay, career progression and recruitment
- Strengthen workforce and health service planning.

A more coherent workforce plan was needed to meet these tests. Workforce planning in the NHS in England was poor and was subject to restrictive immigration policies and inadequate funding for training places. Education and training funding had declined from 5% of health spending in 2006/07 to 3% in 2018/29 – the equivalent of £2bn. Funding was under further threat as the overall Department of Health and Social Care budget, excluding NHS England and capital allocations, will fall by £1bn in real terms in 2019/20, the think-tanks added.

Richard Murray, director of policy at The King's Fund, said: 'The NHS cannot meet increasing demand from patients without the workforce to staff services. Unless the NHS long-term plan is linked to a credible strategy for recruiting and retaining staff, there is a real risk some of the extra funding pledged by the government will go unspent and waiting lists for treatment will continue to grow.'

Nuffield Trust policy director Candace Imison pointed to the NHS's 'woeful' record on workforce planning. 'Unless the NHS long-term plan puts in place urgent and credible measures to shore up the workforce both in the short term and in the longer term, it risks being a major failure,' she said. 'Solving the acute and systemic problems affecting the healthcare workforce will not be easy, but we owe it to patients, staff and taxpayers to start now.'

• *See news analysis, page 10*

Leasing standard implementation put back one year

A new accounting standard covering leasing will no longer be implemented in the NHS from next year but will be deferred until the 2020/21 financial year.

The new International Financial Reporting Standard, IFRS 16 *Leases* replaces international accounting standard IAS17 and comes into force for accounting periods from January 2019.

However, the Financial Reporting Advisory Board has decided to defer its implementation for most NHS bodies.

The new standard ends the distinction between finance leases and operating leases for lessees. Under IAS17, if a lease was judged to be similar to buying the asset, it was a finance lease, reported on the balance sheet. But operating leases were treated in the same way as service contracts, off-balance sheet and only reported as revenue costs.

It is understood the decision to defer was taken because of a failure to agree how to align national accounts budgeting between Treasury and the Office for National Statistics. National definitions of revenue and capital budgets have implications for how the financial architecture in the NHS is designed.

There are concerns that the application of the standard could have implications for the availability of capital resources and affect the decision over how to procure capital assets.

The Treasury plans to use the extra time to review aspects of how the accounting standard is adopted, including the measurement approach for right of use assets.

While the deferment eases pressure on local NHS bodies, significant work is still needed to identify all current leases.

• *See HFMA webinar, held in November:* **http://hfma.to/8k**

News review

Seamus Ward assesses the past month in healthcare finance

While anticipation was building in England in advance of the publication of the NHS long-term plan – with some details emerging (see page 4) – auditors in Scotland and Wales published key reports on the reform and modernisation of local health services.

A report for the auditor general and Accounts Commission in Scotland said NHS boards, integration authorities and councils in Scotland must accelerate and deepen their collaboration to achieve the full benefits of integrated working. The report, *Health and social care integration: update on progress,* said advances had been made, but success would ultimately rely on long-term integrated financial planning and stable and effective leadership.

Meanwhile, the Wales Audit Office warned that, without change, local radiology services were unsustainable, even though they are well managed and are meeting waiting time targets. In a report, *Radiology services in Wales*, the auditors said radiology was under pressure from rising demand, which was increasing by as much as 15% a year. There were recruitment and retention issues in all but one health board, while hospitals were hampered by outdated and insufficient equipment. IT weaknesses limited the efficiency of the service. Despite this, waiting times had improved in the past five years, though some patients waited a long time for their results.

Figures for NHS performance in England showed an increase in activity, including a 0.8% rise in completed elective care in the 12 months to September. However, 86.7% of patients had been waiting fewer than 18 weeks – so the 92% standard was not met. A&E attendances were 3.7% higher in the 12 months to October this year than in the preceding 12 months. In October 2018, 89.1% of patients in A&E were seen within four hours – the figure was 89.9% in October 2017. The British Medical Association said A&Es faced a year-round crisis, with levels of care delivered in summer 2018 worse than in five of the last eight winters.

Emergency departments in Wales also saw a rise in attendances. A greater number of patients in Wales spent more than 12 hours in A&E in October. Official figures show 12-hour waits up 4.1% on September 2018 and 28.9% on October 2017. Performance against the four-hour target also dropped – 80% spent fewer than four hours in A&E in October this year – 0.3 percentage points lower than September 2018 and 3.5 percentage points lower than October 2017.

Pay rises for doctors and dentists next year could be targeted at recruitment and retention. In its remit letter to the Doctors' and Dentists' Pay Review Body, the Department of Health and Social Care asked it to recommend, particularly for junior doctors, how pay funding could address recruitment and retention pressures.

Former transport minister Stephen Hammond (pictured) has been appointed minister of state in the Department of Health and Social Care. He will lead on finance, procurement and operational performance; pay; the NHS England mandate; and transformation and provider policy. His appointment was made after Stephen Barclay moved to become Brexit secretary.

An overhaul of cancer screening services is likely after NHS England launched a review as part of its drive to detect cancers earlier. Professor Sir Mike Richards will lead the review, which will examine the latest innovations, including the potential for artificial intelligence; the integration of cancer research; and how to encourage more eligible people to be screened.

The government must 'make the case' for national tax rises to make adult social care sustainable, according to council leaders. Publishing its response to its own green paper on social care, the Local Government Association said the rises could be in either income tax or national insurance or both. It said over the years, governments had taken a piecemeal approach to social care funding. At the same time, efforts to resolve the funding issue had failed.

Prevention is likely to be a central plank of the NHS long-term plan in England, but Scotland has been warned it lacks public health policies that will prevent ill health. A report from the Scottish Parliament Health and Sport Committee, *Preventative action and public health*, said the health service focused too much on

The month in quotes

'This review provides the opportunity to look at recent advances in technology and innovative approaches to selecting people for screening, ensuring the NHS screening programme can go from strength to strength.'

Professor Sir Mike Richards says the cancer screening programme must match the ambitions of the long-term plan

'Radiology is a vitally important part of our NHS, helping to diagnose, monitor and treat disease and injuries. But it's a service under strain and while it may be coping at the moment, this is unlikely to continue in the longer term.'

Wales auditor general Adrian Crompton warns that issues with radiology services must be tackled

'It is imperative that focus is prioritised on preventing people becoming ill with diseases we know are avoidable. By doing this we can also start reducing health inequality and while the health service can't fix everything, it must play its role in tackling this fundamental issue.'

Scottish Parliament health committee convener Lewis Macdonald

treating existing problems rather than preventing them happening. The report points to examples of good practice – Highland Health Board had significantly reduced hospital admissions due to falls by training staff in care homes, leisure centres and town halls on falls prevention.

Hospital mortality rates in Scotland were more than 11% lower in the period of April to June 2018 compared with January to March 2014. According to new figures, no hospital had a significantly higher standardised mortality ratio (HSMR) in the latter period than the national average. Of the 29 hospitals reported, 13 saw a fall in HSMR of more than 10% compared with the January to March 2014 figures.

Shrewsbury and Telford NHS Trust has been placed in special measures following a recommendation from the Care Quality Commission. NHS Improvement said the trust had been working through its issues, but new support would include additional funding, extra capacity to support the planned improvement programme and strengthened oversight. NHS Improvement added that the trust faced governance, workforce, urgent and maternity care and whistleblowing issues.

NHS England said wearable glucose monitors will become more freely available for people with type 1 diabetes. Prescribing of the device is not uniform, with an estimated 3%-5% of eligible patients having access. If the guidelines are followed, this should rise to at least 20%, NHS England said. The device – which is the size of a £2 coin and worn on the arm – means that patients no longer have to prick their fingers to test their blood glucose. Instead, the device relays their results to a smartphone or e-reader.

from the hfma

The HFMA produced several blogs in November. These included a blog from NHS Future-Focused Finance diversity lead Edward John on targeting full equality and a finance function that embraces and celebrates diversity (see page 14).

HFMA Northern Ireland Branch chair Owen Harkin said local challenges mirror those in the rest of the UK, but there are key differences local finance managers must deal with. These include improving the already integrated health and social care system and transforming care.

HFMA policy and technical manager Debbie Paterson urged estates and finance staff to work more closely.

• www.hfma.org.uk/news/blogs

News analysis

Headline issues in the spotlight

Capital questions

The Budget confirmed the NHS five-year settlement, but left the service nonplussed about what funding would be available to deliver a range of government priorities. Seamus Ward reports

The Budget at the end of October contained few surprises for the NHS. There was confirmation of the five-year settlement of £20.5bn extra in real terms by 2023/24 and welcome provision for NHS pension costs over the same period, although there are some questions over the latter. But one area where an announcement was expected was given little attention by the chancellor – NHS capital spending.

The Budget set out capital spending up to 2020/21, with available capital totalling £5.9bn in the current year, £6.7bn in 2019/20 and £6.8bn the following year. Chancellor Phillip Hammond reiterated that he would consider a new multi-year capital settlement to support transformation – the NHS will have hoped to hear details of this in the Budget, but may now have to wait for next year's spending review for figures to emerge.

The chancellor also had a surprise for the NHS and the wider public sector. The private finance initiative (PFI) and its successor PF2 – where the public sector takes an equity stake, reducing its ongoing payments – will no longer be used for new projects. Private finance schemes have been a source of bad press for successive governments, due to the high costs of annual payments, union opposition and the risks, as recently laid bare by the collapse of Carillion.

Of course, any announcement on capital or other elements of the Budget must be read in the context of the NHS long-term plan, which is due this month. But abandoning PFI and PF2 could leave the NHS with a gap in its capital funding and may serve only to ramp up pressure on the government to announce new funds.

In its response to the Naylor report on NHS capital needs, the government accepted the service would need £10bn to address backlog maintenance and provide the facilities required to support NHS transformation. The £10bn would be provided through public spending, receipts from the sale of surplus estate and roughly a third from other sources, including private finance.

It is important to note that the chancellor's Budget announcement does not rule out other forms of private finance. The government's response to the Naylor report was highly complimentary about the impact of local improvement finance trust (LIFT) schemes, used to fund new health centres and GP surgeries.

NHS Improvement chief executive Ian Dalton addressed the issue of PFI and PF2 at a November Commons Health Committee hearing on the impact of the Budget on the NHS.

'The issue is how the non-use of PFI and PF2 during the next period, and the £3bn that was meant to come from that, is to be replaced,' he said. 'The importance that the NHS attaches to that is: if it is not coming through PFI, we need to see it replaced as part of the settlement.'

He added that the total PFI unitary charge – taken from revenue budgets – was £1.9bn last year across 50 NHS organisations. A small number of trusts had very high PFI costs that made it more difficult for them to balance their books. NHS Improvement would look closely at their private finance deals.

Rather than renegotiating PFI contracts to lower interest rates – as has happened in some cases – Mr Dalton is more concerned with ensuring existing contracts are managed well and value for money is delivered, particularly from facilities management deals bundled into PFI contracts.

A new centre of best practice in the Department of Health and Social Care, which will focus on improving the management of existing PFIs, was announced in the Budget.

Mr Dalton accepted that there was a need to address capital spending over the coming years. About 3.1% of total health spending in England is on capital, but this does not compare well internationally – the OECD average is 5.6% and spending in England is less than in Sweden, France and Germany.

He said that the NHS has 'depressed' capital spending over the past five years to balance the books. And though it was important to 'open the taps on capital' to address some of the maintenance backlog, there were other issues with a claim for capital spending.

'One of the things that needs to change when we see what is in the spending review is the building of new facilities both in hospital and, frankly, in the community,' said Mr Dalton.

Although the cost of addressing overall

Budget measures

- **NHS spending in England will rise to £20.5bn more a year in real terms by 2023/24, an average real growth rate of 3.4%.**
- **The chancellor reiterated that the government will consider proposals for a multi-year capital settlement to support transformation. PFI and PF2 will no longer be used to finance new capital development.**
- **It will also consider a multi-year funding plan for clinical training places.**
- **Budgets for capital, clinical training and public health will be confirmed in the spending review next year.**
- **Funding for mental healthcare will grow as a share of the overall NHS budget over the next five years. At least £2bn has been earmarked to develop mental health services and Mr Hammond revealed that up to £250m a year by 2023/24 will be invested in a number of areas, including crisis services and mental health support in A&E.**
- **£10m in capital funding will be made available for air ambulance services.**

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backlog maintenance had increased from £5.5bn to £6bn in 2017/18, he said it was more appropriate to look at maintenance that had been categorised as significant or high – those in greatest need of action. The cost of these categories had increased from £1.37bn in 2013/14 to almost £3.1bn in 2017/18.

He acknowledged that failure to address the highest priority maintenance backlog adversely affected patient care and staff morale. 'If a lift breaks down, for instance, because it needs replacing, and that lift is meant to take a patient to theatre, the physical act of getting the patient from the ward to the theatre becomes more difficult. The number of patients who can be treated becomes more difficult.'

More and newer equipment, such as MRI and CT scanners, will be needed to serve a significant rise in demand for diagnostic tests, for example, due to the push for earlier diagnosis of cancer.

However, Mr Dalton said the rise in demand for diagnostics would require additional staff as well as more machines. 'The reality is that we have a need for a significant capital injection through the spending review,' he said. 'Obviously, we do not know, over the next five years and preferably beyond, what the capital settlement for the NHS is.'

Capital investment produces gains in the long term, he said, and this was true whether it was addressing a high-priority maintenance backlog or building facilities in the community or new hospitals.

In written evidence to the inquiry, NHS Providers also urged the government to boost capital funding. 'The government needs to ensure that, overall, sufficient funding is made available for capital, particularly because of the limits of land sales and alternative funding sources,' it said.

"One of the things that needs to change when we see what is in the spending review is the building of new facilities both in hospital and, frankly, in the community"
Ian Dalton, NHS Improvement

While capital will be important, the hearing demonstrated other pressures on the wider health budget, with the government continuing its practice of only uplifting NHS spending (allocations to NHS England) in real terms while reducing the Department's remaining budget.

MPs also noted the issues facing social care funding and how it increased demand in the health service.

Anita Charlesworth, Nuffield Trust director of research and economics, told the health committee there was an issue with the £1.25bn pension funding. It was unclear whether the funding for pensions will be added to the overall Department central budget or if it will be taken from the funding already set out.

However, in a later hearing, health secretary Matt Hancock confirmed the Treasury would fully cover the cost of the pension provision.

MPs were concerned about training budgets. NHS Improvement and Health Education England (HEE) will be working more closely, but Mr Dalton did not yet know HEE's budget for the next financial year. Ms Charlesworth said HEE needed to be told its funding before the beginning of 2019/20, while public health grants are expected to be announced this month. While announcing the education and training body's funding before the beginning of 2019/20 is not impossible, time is running out, she added.

Mr Hancock told the committee that it was 'not our intention' to transfer funds out of the Department's central budget to other areas of spending. The planning assumption for the HEE budget was there would be no cuts, he said.

Could the extra money needed for clinical training come from the increased NHS spending, MPs asked. Mr Dalton said it would not be in NHS Improvement's interests to take money from the NHS budget to fund these areas, though he accepted they needed more funding.

'The NHS is going to need the 3.4%, and that was the basis upon which the settlement was agreed. However, we also need – just as with capital, social care and public health – an adequate settlement for Health Education England,' he said.

The five-year settlement for the NHS will not silence the voices calling for more money for health services. The government has said public health will be a key part of the long-term plan, so it will be pressed to find money for it.

The NHS will need more staff as the population ages and there could be a gap in capital funding needed to modernise and repair NHS facilities. The health service will be hoping more money is made available, so it can deliver all the government's priorities.

• *See 'Knowing the limit: understanding how CDEL constrains capital spending', page 35*

Comment

December 2018

Brighter together

Finance staff, working together, have a major role in delivering the plan

HFMA president Alex Gild

What a year 2018 has been for the NHS. The HFMA joined the fabulous 70th birthday celebrations in July, with fascinating insights into how the NHS may look towards its centenary in our *NHS at 100* publication.

In the present, this was also the year when government heeded the collective and loudening voices of the public, patients and the NHS. They shared huge concern for the NHS's immediate future, under the pressures of demand, workforce and the significant deterioration of finances over the past three years.

The revenue settlement announced in the summer is imminently due for translation into a set of plans that underpin a 10-year strategic vision for the NHS.

December is going to be a critically important month. We anticipate the publication of the plan, supported by wide and expert stakeholder engagement in its design, and detailed planning guidance for 2019/20. The aim is to help kick-start the NHS into a recovery of performance, improvement and long-term transformation to the benefit of the patients we serve.

We know the near term will remain hugely challenging, but we should be optimistic for this, our NHS plan.

NHS Improvement chief executive Ian Dalton is due to join us at our annual conference in the first week of December. I hope we will hear from him the positive intent baked into a fundamentally realistic plan for our NHS. One we can all get behind, enabled by a positive cultural shift in the newly integrated support and improvement offer to the

Search for coherence

The long-term plan needs to pull numerous different strands into a coherent whole

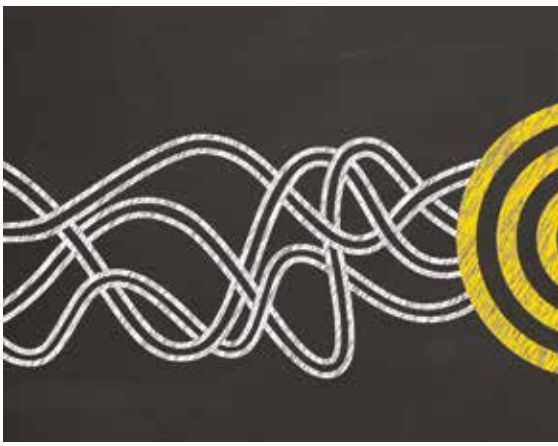
Healthcare Finance editor Steve Brown

We stand on the verge of the promised long-term plan. Informed by 17 working groups covering everything from prevention and personal responsibility, through clinical priorities such as cancer, to the nuts and bolts of funding and the financial architecture – we can expect plenty of detail. The trick will be making it coherent with all the components aligned with the overall achievement of better, more integrated and sustainable services.

We have already seen high-level commitments emerging. At least £2bn of the overall £20bn real-terms increase by 2023/24 will go to mental health, while primary and community care can expect a £3.5bn boost.

Both sectors have been told they can expect to receive an increased share of overall funding. And there have also been good words about shifting the balance of funding between treatment and prevention.

Few would argue with these commitments. Mental health has for a long time been the last in line for funding and low in the list of priorities. The mental health investment standard has attempted to stop further decline by ensuring mental health services get their fair share of local funding increases.



But there has been no account taken of previous underfunding and very little recognition of the increasing demand being met by core and new services.

Mental health providers also continue to point out that they are not seeing their own income rising in line with overall growth, as spending by commissioners on other aspects of mental health also counts against the standard.

As an overarching commitment, giving mental health a greater share of spending

"We know the near term will remain hugely challenging, but we should be optimistic for this, our NHS plan"

NHS from NHS England and NHS Improvement.

Looking back on my year as president, it has been a delight to attend the branches, where the strength of the HFMA is considerably shown in our local networks.

It is remarkable that a good number of branches saw their highest ever turnout for their annual conferences this year – notably, Northern Ireland and Wales.

My theme of *Brighter together* reflects on the similarities and respected differences of the NHS (and care) systems across our four UK nations, and how the HFMA enables learning and networking across them all.

If it were not for the volunteers on branch committees, we would not have the brilliant HFMA we have. So I want to thank each and every one of those volunteers for the work they do for their colleagues in supporting this great and proud NHS finance profession.

The HFMA is a family, and this is one of our core strengths. Future-Focused Finance is part of this family of support to the NHS finance profession. I have been impressed with the leadership, energy and focus of colleagues in FFF in bringing the value maker and equality and diversity agenda front and centre to support people working in NHS finance. Together we are developing new ways to better nurture and develop talent, whoever we are and wherever we work.

HFMA qualifications will provide an important framework for our professional development and I look forward to celebrating our next round of graduates at conference.

There is no time like now to step forward and be a part of the journey in taking our great NHS forward. Finance people are central to its future.

It has been a sincere honour and privilege to serve you and the HFMA as president, thank you for your support. Let's keep doing what we do best for the NHS and patients, working together with others, bringing on our skills and expertise, our people, teams and new talent for the future.

Our NHS. Your HFMA. We are brighter together.

Contact the president on president@hfma.org.uk

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makes sense. But it mustn't be at the expense of other services that have an impact on mental health. Cuts in community services can mean people with mental health conditions don't get identified and supported earlier – leading to potentially increased activity for both acute and mental health services further along the pathway.

The commitment to mental health is important. Better mental health services will deliver better services to patients but also take pressure off other services. So it needs to be the overall outcomes that we measure success by – not whether we have hit a new investment target.

We need a holistic approach to funding that recognises the interwoven nature of key services. Social care, for example, is also vital to how the NHS can regain its performance levels and develop truly sustainable models of care.

And even where funding is increased, NHS bodies won't be able to make efficient use of it unless the right staff are available. A workforce plan needs to have both a short-term and a long-term focus, focusing on training, recruitment and retention. Skimping now will be a false economy. Pathways need to be rethought to make appropriate use of the right clinicians, with staff trained for new roles where this makes sense.

And then the financial levers need to support all of this – delivering funding that covers the efficient costs of healthcare delivery with the right incentives to improve outcomes that matter to patients.

This is a huge agenda and the refinement of approach is unlikely to stop with the publication of the long-term plan. It is made all the more difficult by a five-year settlement that, while generous compared with other spending departments, is widely held to fall short of what is really needed.

"The long-term plan's component parts need to be pulling in the same direction and not at odds with each other"

What is most important is that the plan is coherent. Its component parts need to be pulling in the same direction and not at odds with each other. A healthcare delivery plan without an underpinning prevention strategy will be flawed. The plan will also struggle if there is not a similar ambitious vision for social care.

It won't solve all the problems and it won't be deliverable overnight. It needs to be ambitious but grounded in reality – working within the confines of the NHS settlement and (hopefully) a similar deal for social care.

If it can achieve this, it is an opportunity to set the NHS firmly in the right direction for the next generation.

The senior management of the NHS finance function does not reflect the make-up of finance teams by gender or ethnicity. Finance leaders want that to change and have launched two programmes to address this imbalance. Seamus Ward reports

financial equals

It is no secret that while women and people from a black and minority ethnic (BAME) background make up significant proportions of the NHS finance workforce, they are not well represented in the most senior jobs. This could be due to a number of factors – bias (conscious or unconscious); the self-perpetuating cycle of a shortage of role models; lack of confidence or opportunity. Regardless of how it has happened, the NHS finance function is determined to address inequality, starting with race and gender, with two schemes launched recently in England.

NHS Future-Focused Finance (FFF) and NHS Improvement are developing programmes to tackle discrimination in the finance function. They aim to be complementary, with FFF – in partnership with other organisations including the HFMA – delivering much of the support on the ground.

The evidence that there are problems with equality were reinforced in the last two NHS finance function censuses in 2015 and 2017. While women outnumbered their male colleagues in every grade up to and including band 8b, men dominated the higher grades. In 2015, 26% of finance directors were women. This rose to 28% in 2017, but was still low compared with the overall make-up, where women accounted for 61% of the finance workforce. Two-thirds of women working in NHS finance were at band 6 and below, compared with 46% of men.

Data on ethnic mix changed little between 2015 and 2017, with 70% of the NHS finance workforce in England saying they were white British. Some 86% of finance directors were white British. Nationally, 11% of organisations did not disclose their employees' ethnicity.

Edward John, FFF diversity programme lead, says the large accounting and consultancy firms were leading the field when it came to action on diversity, but the NHS faced being left behind. He says no-one knows why NHS finance lags behind – the big firms have looked into their recruitment, performance management and talent identification

and development. But the other side of the coin is how the people in protected groups feel.

FFF organised two safe-house discussions for NHS finance staff below director level in the summer – one for women, the other for BAME groups. Common themes emerged, Mr John says. 'There was a lack of identifiable and relatable role models and the groups said we need to hear from these individuals. They didn't seem visible to many people in the groups.'

FFF diversity programme lead Edward John (left) and Chelsea and Westminster Hospital CFO Sandra Easton

For women, striking a good work-life balance was one of the biggest issues. Employers often paid no more than lip service to helping balance childcare or other carer duties with their career. 'But when it comes down to it, it doesn't really happen,' says Mr John. 'There's always something stopping it happening.'

Other experiences of discrimination were perhaps more subtle, he says. 'Some said that if they, as a woman, walk into a meeting they are expected to take notes. For me, that was shocking to hear and, though it's good for it to come out, we must challenge these behaviours.'

The BAME group spoke of a lack of confidence to apply for jobs and a feeling that senior posts were 'a closed shop'. Again, there was a lack of role models. Mr John adds: 'Unconscious bias and even conscious bias came up as a significant barrier.'

London scheme

In addition to the FFF work, a scheme that started life in London will now be rolled out across the country with the backing of NHS Improvement chief financial officer Elizabeth O'Mahony. The *Going beyond* scheme will sit alongside the FFF work and the regional talent management programme.

It began when NHS Improvement London region director of finance Jeff Buggle asked Sandra Easton, chief financial officer at Chelsea and Westminster Hospital NHS Foundation Trust, and Hardev Virdee, Central and North West London NHS Foundation Trust chief finance officer, to examine the diversity problem in the capital's finance function. Initially, it is focusing on gender and ethnicity.

Going beyond is working with the HFMA London Branch to implement the programme in the capital and will cover providers, commissioners and regulators.

In London, women make up 50% or more of finance staff up to and including band 8a. In some lower bands, the difference is stark – in band 3, they account for around 75% of staff and two-thirds of band 4s. But in more senior roles, the picture is turned on its head. While women make up just over half of band 8a staff, from band 8b the proportion declines, with more men in the most senior roles – only one in six finance directors in the capital are women.

The picture for BAME finance staff is similar – they make up between 15% and 20% of bands 1 to 8a, but this declines to 13% of 8bs and around 4% of directors.

Anonymous quotes collected by Ms Easton and Mr Virdee for a recent meeting of national finance directors showed the depth of the problem. One acute finance director, for example, believed a woman could not do his job. A woman spoke of a verbal offer not materialising once the potential employer discovered she had a child. A deputy finance director felt an event for finance directors looked like an exclusive club with no-one who looked like them. Recruitment consultants advised people they would not 'fit in' with a board because of their backgrounds.

'We could have put pages and pages of quotes like these in our presentation,' Mr Virdee says. 'But the people affected are more interested in knowing what's going to change, rather than looking back – what's going to change to make it easier for their career and people around them? We've got to recognise there's a problem and now is an opportune time to resolve it.'

Ms Easton believes recruitment consultants must be asked to improve their approach. 'People who are gatekeepers, like recruitment consultants, are failing to give equity of access so we must get it out to them that this is not acceptable.'

FFF has almost completed drawing up a diversity code of conduct for recruitment consultants and hopes to roll this out soon. *Going beyond* is deliberately targeted at senior posts – at 8b and above – and FFF will support this work, as well as looking to encourage greater diversity across all grades. Mr Virdee says FFF will play a key role in rolling out *Going beyond*. 'FFF is well equipped to make that happen.'

They will also work with professional accountancy bodies, accountancy firms and other groups such as the HFMA. The idea is for *Going beyond* to expand the cohort of women and ethnic minority staff at senior levels. With more role models in place, and capitalising on the fact that decision-makers tend to appoint staff that look like them, the effect should trickle down to the lower grades. It will then move on to other inequalities.

Edward John says the biggest difference between the NHS finance function and the big accounting firms is that the latter generally have diversity indicators built into their performance management. 'We're pushing for that to change and will look for some mandatory processes.'

The Rooney rule in American Football, for example, states that at least one shortlisted candidate for senior football management jobs, including head coach, must have a BAME background. It has led to a significant

Diversity metrics

The HFMA and FFF have developed a range of diversity metrics and have issued individual reports to all NHS organisations that completed the 2017 NHS finance census.

The reports show an analysis of the organisation's finance staff by gender and ethnicity, compared with the national and regional picture. The metrics are as follows:

- **Percentage of females in the finance function**
- **Percentage of females at band 7 and above**
- **Percentage of flexible working patterns supported**
- **Percentage of finance staff from a BAME background**
- **NHS finance by gender and band**
- **Percentage of females at band 8d and above**
- **Percentage of finance staff working part-time**
- **Percentage of finance staff from a BAME background at band 7 and above.**

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increase in the number of black coaches since its introduction in 2003. Mr John adds: 'We are not saying we should do that, but it's something that should be on the table and up for discussion.' He says FFF will support the provision of training and education to break down barriers.

Going beyond will conduct a national annual census and aims to see a 10% year-on-year improvement nationally across all grades until the finance function reflects the population on gender and ethnicity.

At regional level, it will target a 10% year-on-year increase in finance directors on both counts until reflective of both gender and ethnicity. And at organisation level, *Going beyond* hopes for a 10% year-on-year improvement at bands 8b and above.

Ms Easton and Mr Virdee recognise that organisations and regions will start from different places. However, they argue it's important for all organisations to push ahead with the work. 'At regional level, the 10% year-on-year improvement could be one post. I think that makes it achievable,' Ms Easton says.

There will be a number of initiatives to help finance departments, including shadowing and restructuring of leadership programmes to reflect greater diversity. Sponsorship – where a senior member of staff actively promotes a protégé, introducing them to a wider network – and mentoring will be important in *Going beyond* and FFF's programme.

Positive feedback

The national finance directors have shown enthusiasm about the scheme and a number have already stepped forward, wanting to be involved or to become sponsors. 'Sponsorship is much more of a commitment than mentoring,' Ms Easton says. 'It's so valuable as there is a one-to-one relationship, whereas a mentor might have two or three mentees. They will get to know the people they sponsor and, when the time is right, put that person forward when finance director jobs come up.'

There will also be a focus on ensuring women and those from a BAME background who are capable of stepping up have the required soft skills. This could mean experience of chairing a meeting, influencing non-executives or making a presentation on complex issues.

These skills are not taught to finance professionals, Mr Virdee says. 'We feel we have hundreds of finance directors in the privileged position of being able to deliver that [training] using their experience and knowledge.'

FFF also aims to include diversity indicators in its accreditation and aspiring leader programmes (*see Diversity metrics, page 15*).

'We must ensure we are in there, making sure the selection process is fair. It's about getting the right person for the job – it isn't about positive discrimination, it's about ensuring we are using all the talent that's available to us,' Mr John says.

FFF programme director David Ellcock says the diversity workstream is a vital element of the Future-Focused Finance workstreams. 'The Financial Leadership Council's strategic aims cannot be achieved if we don't have diversity underpinning everything we do. But we need organisations and individuals to support what we are trying to achieve.

'We want to ensure that organisations that want to be seen as good finance organisations take diversity seriously. Diversity will sit front and centre in the accreditation process,' says Mr Ellcock.

The workforce and leadership theme will help build networks and ensure that there is no closed shop when it comes to recruitment, Mr Ellcock adds. The FFF future leaders work programme will be key to bringing forward women and BAME finance directors and it has already helped talented finance professionals from these groups get their first finance director jobs.

The engagement and development theme team is working with the Skills Development Network to ensure equity of access to staff development tools. Diversity issues will also be a part of the FFF work with PwC on how the finance function will look in the future.

The NHS finance function is determined to take steps to ensure, over time, that its senior leadership better reflects the make-up of its workforce in terms of gender and ethnicity. This is just the start and the agenda will move on to other elements of diversity. While some performance management levers will play a part, and organisations will start from different points, finance leaders hope the function will embrace the diversity agenda because it is the right thing to do.

Derbyshire diversity

Derbyshire Healthcare NHS Trust is working to ensure it is inclusive and diverse.

Claire Wright (pictured), the trust's deputy chief executive and director of finance, says it is important to offer staff a positive work environment – perhaps aiding recruitment and retention – and ensuring that all patients and staff feel comfortable to be themselves.

She acknowledges that the trust's workforce race equality standard (WRES) data is not as good as it wants it to be and its black and minority ethnic network is supporting the trust to deliver on an improvement action plan.

She is a reverse mentee – a programme where senior staff are mentored by more junior staff with a different ethnicity. The initiative disrupts the traditional power hierarchies and mentors and mentees speak openly about challenging issues in a safe environment. 'The BAME member of staff is the expert and they are the person I am learning from,' she says. 'When I meet with my mentor, Bal, I always come away energised and inspired.'

At present, the reverse mentoring pilot is confined to executive board members, but the trust plans to roll it out across the trust following evaluation of the pilot with the University of Nottingham.

The trust has also set up an LGBT+ network earlier this year and Ms Wright says the trust is proving its commitment to improving LGBT+ inclusion in many ways. 'We chose to use the + in the network name because it recognises that we don't all fit into simple boxes,' she says.

'The UK has come a long way, but there is still a way to go to eliminate LGBT+ discrimination and to be fully inclusive of sexual and gender diversity.

'At the trust, we are doing lots of things. For example, as part of the induction for all new staff we set the tone at day one by emphasising the fundamental importance to us of equality, diversity and inclusion in our trust.'

She adds: 'We openly promote our LGBT+ support not just to our colleagues but also to individuals and families who receive our services. I believe that everyone can make a positive difference – whether they are part of the LGBT+ community themselves or whether they are allies, we all play a part.'

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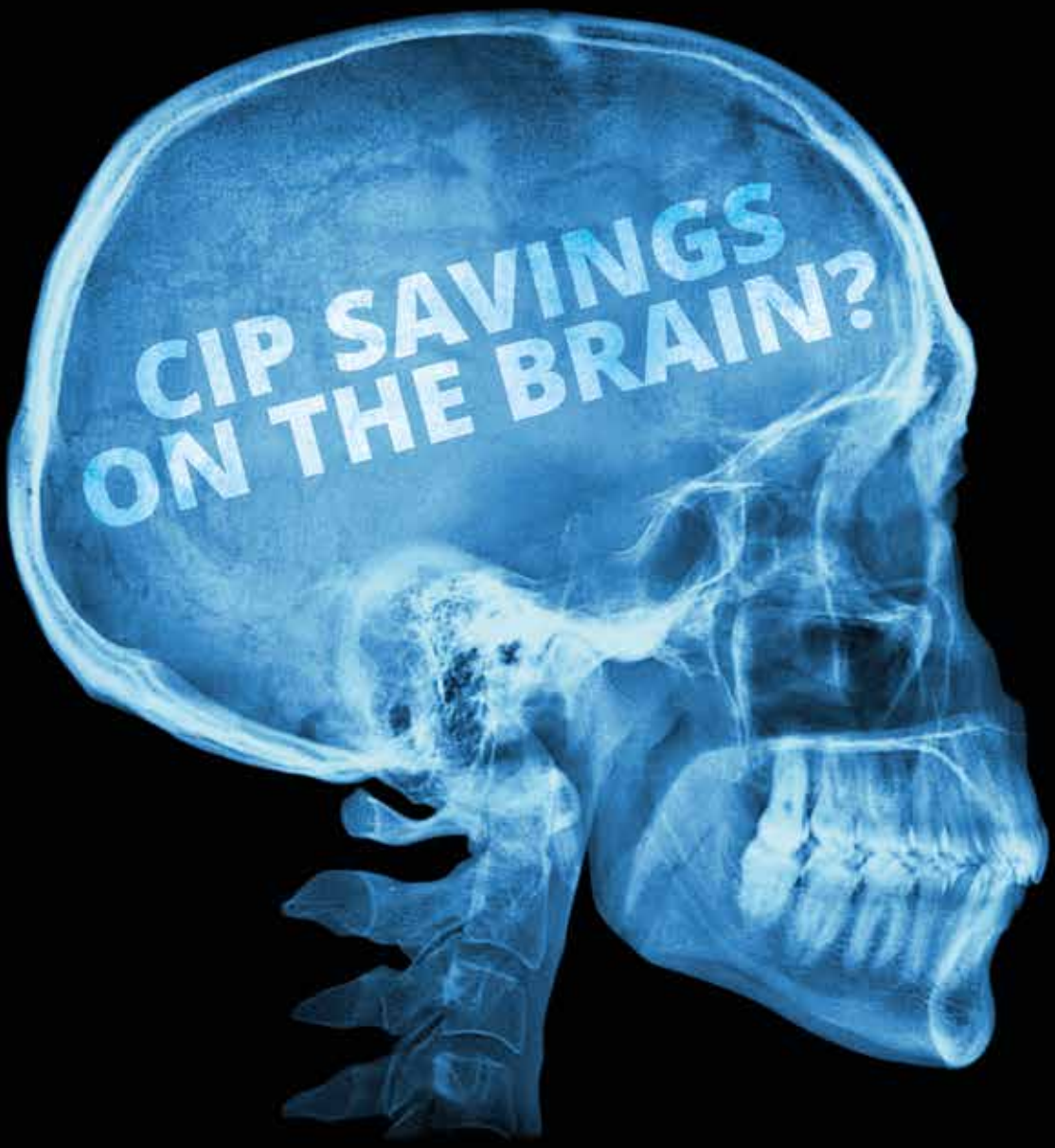

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With huge numbers of invoices travelling between NHS bodies, could a different approach to dealing with non-contracted activity improve efficiency in transactional processes? Steve Brown explores

Traffic control

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There are around 600,000 transactions between NHS providers and commissioners. More than half of them involve invoices of less than £1,000 and collectively represent just 0.1% of a total £70bn spend. Reducing the volume of low value invoices could streamline provider-commissioner interactions and lead to significant cost savings.

That is exactly what NHS England and Future-Focused Finance, through its *Efficiency and value* workstream, are currently exploring.

'We've gathered data to show that the majority of this low value activity involves non-contracted activity or out-of-area treatment,' says John McLoughlin, senior finance lead for financial accounting and services at NHS England. Typically, this might be payment for someone attending a walk-in centre or A&E department while on holiday or out-of-town on business.

In fact, around 76,000 invoices in 2017/18 – 13% of the total provider to commissioner invoice traffic – were for less than £100 and collectively accounted for just £3.9m. This suggests that some providers are invoicing commissioners for single-patient events. It would be easy for this to get out of hand.

Working with rough numbers, 200 providers sending just one invoice each month to each of 200 commissioners would result in 480,000 invoices. So, the fact that there are just 300,000 invoices for less than £1,000 indicates that there is already some consolidating going on with providers including multiple patients on each invoice.

Without this consolidation, the situation might be even worse, but Mr McLoughlin is convinced there must be a better way to deal with these low value transactions.

He says that one possibility would be to look at the net impact of low-value payments. For example, Sheffield CCG might currently receive an invoice from a Cornish trust for a Sheffield patient who received treatment while on holiday. But the commissioner would also not be billed for a visitor to the city who received treatment in a local hospital. At the moment, this would involve potentially low value invoices being sent in both directions.

What would be the net impact if Sheffield CCG was charged for all patients treated in its city (below a certain cost threshold) regardless of where the patient is registered? It would pick up the additional bill for out-of-area patients treated locally, but avoid the costs of local patients treated elsewhere.

Mr McLoughlin suggests that in a lot of cases the net impact would be close to zero.

In any case, on average, there are only small sums involved. The 300,000 invoices below £1,000 only move £73m between commissioners and providers – around £350,000 on average per trust or per CCG. From the provider perspective it doesn't matter which CCG pays – as long as out-of-area activity is allowed for in local contracts. It would, however, change CCG expenditure.

'But it is not a significant amount per commissioner. And by the time you net it all off, you are probably talking about a £150,000 cost at one extreme to a £150,000 credit at the other with many of them at nil,' says Mr McLoughlin.

He adds that the service could even go further and think about applying the same approach – with the host CCG charged for all local activity – for invoices up to £10,000. He says this ties in with the threshold above which providers need to seek CCG permission before undertaking planned treatment as non-contracted activity (set out in NHS England's *Who pays?* guidance).

'So we've been challenging this to take it a little further. Could we say that below £10,000 is immaterial? We could be dealing with that through the locality where the treatment is done and then tweak allocations with some form of tourism factor so that high tourism areas get slightly more in their allocations to treat the patients coming in, with others getting slightly less.' He suggests the adjustments would be small, probably ranging from +£2m to -£2m.

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He says the counter arguments are that this does not support the idea that money should follow the patient and that the approach could be open to gaming, with people being encouraged to go out of area for treatment to avoid hitting local budgets.

Mr McLoughlin accepts this is a fair challenge, but believes the potential benefits outweigh these issues and suggests the current system also has the potential for gaming around challenges over responsibility for patients involved in non-contracted activity.

Alternative approach

An alternative approach, that has also been explored, would involve providers sending a monthly invoice for non-contracted activity to someone centrally, together with a breakdown of the commissioners that different payments relate to. The providers could be paid and the costs for different CCGs could then be consolidated and applied to each commissioner.

This has obvious attractions for providers – which would potentially be paid more quickly – but commissioners are less convinced, with concerns about how this would impact on their ability to challenge whether costs are appropriate.

Reducing the number of transactions by any mechanism would have an instant pay-off. Under the NHS England contract with NHS Shared Business Services (NHS SBS) for the provision of the integrated single financial environment and finance and accounting service for commissioners, each transaction costs £3.50. This amounts to total transaction costs for commissioners of £2m per year based on 570,000 transactions.

NHS England figures suggest that providers in fact face higher transaction costs of £9.62 per transaction – or £5.5m in total. Completely avoiding the need for the 300,000 invoices with a value under £1,000 could save more than £1m for commissioners and potentially close to £3m for providers.

"Everyone buys into the concept – the figures are quite compelling. We now need to move to how we can actually deliver this and by when"

Adrian Snarr, NHS England

And these savings take no account of commissioner and provider staff costs, with staff currently managing the non-contracted activity process being freed up to take on more value-added tasks than debt collecting.

Adrian Snarr, NHS England director of financial control and senior responsible officer for the FFF *Efficiency and value* workstream, says the ideas have been presented at various FFF events. 'Everyone buys into the concept – the figures are quite compelling,' he says. 'But we now need to move to how we can actually deliver this and by when.'

He adds that linking the work to the imminent long-term plan, including further development of system working and proposed changes to the current payment system, will be key. In particular, he says that the establishment of systems built on good local relationships should demand a better way of dealing with local non-contracted activity.

Mr Snarr adds that the current focus is firmly on a whole system-level solution – with a relaunched FFF working group bringing together key stakeholders including shared services providers, commissioning support units and NHS Improvement's efficiency team. He believes that this has a better chance of rapidly achieving improved efficiency than encouraging local providers and commissioners all to make changes to local payment rules for non-contracted activity.

Once transactions have been minimised, a second step in NHS England's efficiency drive is to get as many of the remaining transactions as possible covered by electronic invoices. Under the NHS England/NHS SBS contract, the £3.50 transaction cost falls to £2.50 if an e-invoice is submitted for payment.

In total, CCGs process some 3 million invoices each year, when you add in invoices from independent providers and other goods and service suppliers. CCGs currently receive just 27% of all invoices electronically. Extending this to 100% and assuming the same £1 per transaction saving would generate hard savings of £2.2m.

Take this a step further to include all the invoices processed by commissioners and providers within the NHS and the service could be looking at savings closer to the £20m mark (and £1 per transaction is well below the level of savings often quoted for adopting e-invoicing).

Even just converting a higher proportion of the 600,000 intra-NHS transactions to e-invoices would be worthwhile. According to NHS England figures, more than 40% of providers issue all their NHS invoices on paper. And within the 35% of e-invoicers there is scope to increase the volume of invoices sent

NHS provider to commissioner transactions 2017/18

Value range £	Number 000s	Amount £000	Quantity %	Amount %	Cumulative volume %	Cumulative value %
0-100	76.1	3,900	13.2%	0.0%	13.2%	0.0%
100-1k	223.7	69,400	38.8%	0.1%	51.9%	0.1%
1k-10k	154.4	439,500	26.7%	0.6%	78.7%	0.7%
10k-100k	76.8	1,981,800	13.3%	2.7%	92.0%	3.3%
100k-1,000k	32.5	9,356,800	5.6%	12.5%	97.6%	15.9%
1,000k-10,000k	11.8	33,422,200	2.0%	44.7%	99.7%	60.6%
>10,000k	1.9	29,483,400	0.3%	39.4%	100.0%	100.0%
Total	**577.2**	**70,430,773**	**100%**	**100%**		

electronically. (The balance is made up of NHS SBS clients, whose invoices are within the NHS SBS system and effectively 100% electronic).

NHS England believes improving this position should be straightforward. There are a range of e-invoicing system providers that meet the PEPPOL compliance requirement – the adopted standard for NHS procurement. Any of these would enable providers to submit e-invoices to CCGs and NHS England.

NHS SBS entered a deal with e-invoicing system provider Tradeshift in 2014 giving all commissioners an account to receive invoices. Providers can use this system to send invoices to commissioners without being charged per invoice.

Stephen Sutcliffe, finance director of NHS SBS, says there has been an increase in the adoption of e-invoicing by trusts. NHS England figures suggest a nearly 10 percentage point increase in the number of providers sending at least some e-invoices to commissioners between March and December 2017. But this has plateaued more recently.

Mr Sutcliffe says this is often down to culture or a suspicion that the process will be more costly or arduous than claimed. 'But it is relatively easy to do,' he says. 'And the pay back is really quick – easily within a year.'

Providers benefit from increased visibility. They can't submit an invoice unless all the required fields are present. They get notification that the invoice has been received and can then monitor progress through the payment process. No more calls to check an invoice has been received or to ask when payment will be made.

Invoices can hit commissioners as soon as they are sent – rather than the more typical five to nine days it can take to get from provider to commissioner system via post.

Electronic invoices

NHS SBS has also set its sights on getting suppliers to send electronic invoices for goods procured by the 75 trusts that use its finance and accounting service. This is a big job given these trusts deal with some 200,000 suppliers (nearer to 500,000 if you allow for subsidiaries) generating some 8 million invoices.

Currently NHS SBS receives about 1.2 million of these invoices electronically from some 11,000 registered suppliers, including most of the NHS' biggest suppliers. Again Mr Sutcliffe says it is the same sell as for trusts – suppliers get increased transparency and potentially quicker payment.

However, he adds that NHS SBS has also been piloting a broader e-commerce platform called The Edge4Health, which is being developed in partnership with Virtualstock.

A drain on time

Northampton General Hospital NHS Trust submitted some 3,262 invoices in 2017/18 to other NHS bodies. Just under half of these invoices (1,576) were for £1,000 or less and represented just 0.18% of total NHS income.

In total, non-contracted activity accounted for 71% of the overall 3,262 NHS invoices, but just 1% of NHS income. And looking again at just the invoices up to £1,000, non-contracted activity accounted for 87% by number and 90% by value.

Derek Stewart, associate director of finance for financial services at the trust, admits that issuing and managing of non-contracted activity invoices is 'a significant drain on our time' given it brings in a relatively small proportion of income – and impacts both on the small invoicing team and (for queries) the income team.

'We have done the analysis on our 2017/18 income and it shows that

73% of the number of invoices are for less than £5,000, while 73% of the value relates to less than 1% of the number. 'An alternative solution would make sense,' he says, adding that it should help improve cashflow as well as freeing up staff for more value-adding activity.

One of NHS England's proposed solutions to reduce the number of invoices and transactions between NHS bodies is to make non-contracted activity the responsibility of local commissioners. 'If this approach was taken, it would need to be differentiated within local contracts' he says. Otherwise there would be the danger that increases in activity fell foul of local capping arrangements, leaving providers bearing the cost of activity they have no control over.

Northampton has recently taken a step towards full e-invoicing by integrating its previously stand-alone accounts receivable system into its existing ledger. This now means that invoices can be emailed direct from the ledger system, although the system is not a PEPPOL-compliant system – and so doesn't deliver the full benefits of e-invoicing. Mr Stewart says the trust is keen to learn more about the Tradeshift system or other alternatives.

Suppliers are able to create and upload catalogues to the system for free but then pay a subscription to enable trade with NHS trusts registered to the platform. About 350 supplier catalogues are now on the system as part of the trial with NHS South of England Procurement Services at Portsmouth Hospitals NHS Trust.

Direct deals between trusts and suppliers should reduce over coming years as the new central procurement model aims to increase the use of NHS Supply Chain from 40% of spend on consumables and equipment to 80%. However Mr Sutcliffe says it is not clear how quickly this will happen and even if it does there would still be a need to trade efficiently with non-Supply Chain suppliers.

The main focus of the current transformation agenda is on redesigning models of care – integrating services across systems and delivering more services within the community. But back office functions also need to play their part as well as finding ways to provide greater support to the broader transformation programme. Reducing the time and money that is currently tied up in supporting the process around low value transactions would appear to support both of these goals.

Keeping our members at our **core**

President and Chief Executive's Report – year to 30 June 2018

During this, the first year of our new three-year strategy to 30 June 2020, we have made great strides towards achieving the objectives we set for ourselves over the three years.

As well as maintaining the quality of the more traditional activities in the year to 30 June 2018, we have also started to deliver on some of the new activities we identified in our strategy. One of these is the continuing digitalisation of our member offering which took a great leap forward with the launch of our members' app in December 2017. Another, which is arguably the most ambitious development we have ever undertaken, was the first full year of running the HFMA Academy and the HFMA Awarding Organisation which deliver the HFMA Diploma and Higher Diploma in healthcare and business finance and the formalising of arrangements with BPP University meaning our students can complete a third year of study to achieve an MBA in business and healthcare management.

Having our own HFMA qualifications and running them through our HFMA Academy and awarding them through our HFMA Awarding Organisation has been a long-term desire. We are delighted that following the launch of the HFMA Diploma and Higher Diploma in Healthcare and Business Finance last year, the first full year of running these qualifications has been an unqualified success with 78 students enrolled on modules at 30 June 2018.

The HFMA Academy has also developed, launched and now runs a Higher Diploma in Practice Management for the National Association of Primary Care. At the end of June 2018 there were 105 students enrolled on this qualification.

The strategy over recent years has been to build reserves to ensure the association is financially sustainable and able to navigate any unforeseen issues. With reserves at £4,418k it was agreed that the strategy for 2018-20 recognises the importance of continuing to invest all the association's resources into supporting the membership and financially, the focus will be on maintaining the current levels of reserves rather than building them further.

As a result, the financial target over the three years to 30 June 2020 is to break-even. For the year to 30 June 2018 the result was a small deficit of £37k, after £94k of one-off exceptional reorganisation costs a small surplus of £57k was achieved.

Although the development of the HFMA Academy and HFMA Awarding Organisation have been a major focus of the year, our other activities also continue to go from strength to strength. Our conference facility, 110 Rochester Row, continues to be busy and provides a focal point in the centre of London and continues to contribute financially with a surplus in the year to 30 June 2018 of £217k.

We continue to work closely with the private sector and would like to thank our friends on the corporate partner programme – all 20 of them – who provide us with valuable resources without which we would not be able to run our central infrastructure. We would also like to thank all of our commercial supporters whether they are national or local businesses.

Our reason for existence is to support our members so HFMA is delighted to be able to say that at the end of 30 June 2018 we have reached a record 14,342 members.

We recognise that our members continue to be under huge pressure at work as they help manage a health system which is itself under significant pressure. Over the past year the HFMA has been able to support members and others in the NHS through:

- providing 133,710 hours of CPD during the year
- 163 local and national events
- 44 briefings and publications

We are also very proud of the fact that we ask attendees and users of all our activities to give feedback which over the last year was an amazing 96% good or excellent.

During 2017/18 we continued to host and be recognised as prime partner for Future Focused Finance (FFF) and committed £100k of our resources to support the initiative. The HFMA is proud to be at the heart of FFF.

As an association the HFMA is blessed to not only have a very professional and dedicated team of staff but also a magnificent group of volunteers. These individuals work so hard in their free time whether they be committee or branch members or Chairs or as Trustees. We are truly blessed to have such busy people in the NHS working so hard to make the HFMA the success it is.

Mark Orchard was the President for the first half of the year. His theme *Everyone Counts* was articulated very effectively and struck a nerve across the service but particularly with the branches. We would like to thank Mark for the energy, positivity and commitment he brought to the role over the year.

The theme for the second half of the year, launched at the annual conference in December 2017, is *Our NHS, your HFMA, Brighter Together*. Which focuses on the importance of working across boundaries both within the NHS and the wider public sector (geographically and organisationally) and also the private sector, with the common aim of improving patient care and experience.

Thank you for reading this annual review. If it inspires you to take part, please do not hesitate to contact us.

Alex Gild
President

Mark Knight
Chief Executive

Keeping our members at our **core**

Total number of HFMA members: 14,342

Learning and development

96%
good/excellent
feedback on all events

163
local and national events held across the UK

7,806
delegates
attended national and regional events

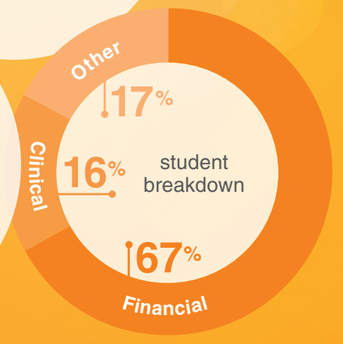
133,710
CPD hours provided

HFMA Qualifications

We completed our first full year of running the HFMA Academy and HFMA Awarding Organisation

94
students studying HFMA qualifications

12
students successfully completed their diploma or higher diploma



Aspiring finance leaders

- 9 successful candidates from the programme obtained a CFO/DOF role
- Welcomed 23 future leaders to the programme

Commercial

- Supported by 20 corporate partners
- 110 Rochester Row, our conference centre in Victoria, continues to be a successful investment for HFMA

Annual conference

- HFMA president 2017/18 Alex Gild launched his theme 'Our NHS, your HFMA, Brighter Together'
- Olympic athletes, **Alistair and Jonny Brownlee** closed the annual conference 2017

The policy and technical team:

Produced:
44
publications

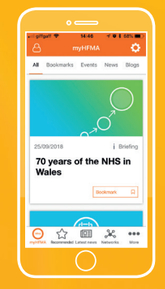
Responded to:
7
consultation papers

Increasing our digital presence

We launched the

myHFMA member app

all our content is now available through the app



Branches

The **Eastern** branch provided 1,147 hours continuing professional development (CPD) in total for 2017/18. 92 delegates attended the annual conference and 27 attended the student conference.

In November 2017, 116 delegates attended the **East Midlands** branch annual conference and gave the event 100% good or excellent feedback.

162 delegates attended the **Kent**, **Surrey** and **Sussex** annual conference in 2017, providing 1,701 CPD hours with 99% good/ excellent feedback.

London branches student conference welcomed 59 delegates. The branch also received 100% good/ excellent feedback from the 76 delegates who attended the annual conference.

The **Northern Ireland** branch annual conference was a resounding success with 171 delegates who rated the event 100% good/ excellent. In total the branch provided 2,962 hours of CPD throughout the year.

190 delegates attended the **Northern** branch annual conference and received 1,330 hours of CPD.

The **North West** Branch continued to strengthen its links with key supporters as well as developing new relationships with EY and CIPFA. The Annual Branch Conference in June 2018 was well attended from across the region and it was the fifth year of the HFMA North West Awards with the highest number of entries ever received.

98 delegates attended the **Scotland** annual conference in October 2017.

South Central annual conference was attended by 136 delegates, which provided 1,564 hours of CPD.

4,175 CPD hours were provided throughout the year by the **South West** branch in 2017/18. 2,750 of them were provided to the 220 delegates who attended the annual conference in 2017.

The **Wales** branch annual conference continues to grow year on year with 225 delegates from across the nation.

Three research projects were produced by the **West Midlands** Research and Development Committee covering the STP process, new models of care and delayed transfers of care. The branch also held a hugely successful annual conference, attended by 320 delegates.

The **Yorkshire and Humber** branch annual conference took place in January 2018 and attracted 160 delegates and received 100% good/ excellent feedback.

Policy and Technical

During 2017/18, the HFMA's policy and technical team produced 44 publications and submitted seven responses to consultation documents issued by stakeholders. The continued support from, and expertise of, our committees, which contribute to the thought leadership of the association, allow us to produce a wide range of publications.

We continued to communicate the concerns of NHS finance directors through our *NHS financial temperature check* surveys. We produced a range of briefings on technical matters aimed at supporting members as they go about their work. The topics covered included accounting for the apprenticeship levy, leases, ethics and conflicts of interest. During 2017/18 we updated the *NHS audit committee handbook* and produced briefings for members working in Scotland, Wales and Northern Ireland. We also published a briefing to mark the 70th birthday of the NHS which considered what the next 30 years might bring.

The reach and depth of HFMA networks provides us with invaluable expertise and knowledge, adding value to our collaboration with a wide range of partners. For example, we published a report with PwC *Making the money work in the heath and care system*, continued to update our *NHS efficiency map* with NHS Improvement and carried out a review of the challenges facing general practice with Future-Focused Finance.

Our policy and technical outputs continue to be well received by members, with 92% rating them as either very high or high quality.

Our networks

The Provider Finance Faculty and the Commissioning Finance Faculty came together for the first time to host a joint summer conference in July 2017. The Convergence conference was well attended by delegates from both sectors and was so successful that Convergence 2 was held in summer 2018. The Provider Finance Faculty also facilitated the sharing of best practice on the topic of making sustainability and transformation partnership (STP) finance a reality at its September technical forum. The Faculty joined up with the Healthcare Costing for Value Institute for the October Directors' Forum to give members the opportunity to attend the International Symposium. The March Technical Forum provided a platform to discuss and learn from experienced trusts about NHS Improvement's use of resources assessments. The May Directors' Forum focused on funding and launched the joint report from HFMA and PwC *Making money work in the health and care system* and included a speech from former Secretary of State, Rt Hon Alan Milburn.

The Commissioning Finance Faculty continued the continuing theme of collaborative working from the Convergence conference in July through to the HFMA/CIPFA annual health and social care conference in September. Delegates discussed the challenges facing health and social care and how both sectors are increasingly becoming aligned through shared budgets, integrated personal commissioning and social prescribing. November's Faculty Forum looked at the future of primary care and the impact on commissioning. The Commissioning Technical Issues Group also met at the HFMA annual Conference to discuss integrated care systems, NHS Property Services, local STP progress and various topics in the faculty's work programme.

The highlight of the Mental Health Faculty's year was its Routes to Success annual conference held in November 2017, which included a keynote address from Professor Tim Kendall and an interesting collection of case studies. One from Tees, Esk & Wear Valleys NHS Foundation Trust chief executive officer, Colin Martin, reflecting on his move from finance director to chief executive and the trust's work on new models of care in tertiary mental health. There was also a case study from Dorset Healthcare University NHS Foundation Trust on a service-user designed patient pathway. The Faculty coordinated sessions at forums and conferences, reflecting progress with the *Five-year forward view*. The Faculty has sought to develop and influence on mental health's role within the integrated care agenda as well as exploring links with social care and the prevention plan.

The Chair, Non-executive Director and Lay Member Faculty offers a rich and unique network for information sharing and education. Discussion points during 2017/18 included: transformational leadership; new care models; diversity; engagement and integration. Members reflected on their experiences of workforce challenges, counter fraud, mental health and social care reform. In January we are also pleased to welcome Peter Wyman, Professor Tony Young and Baroness Dido Harding to our annual chair's conference, which also featured sessions on diversity in leadership and integrated care governance.

The Healthcare Costing for Value Institute continues to provide a wide range of networking and training opportunities for the improvement of patient-level costing, the use of patient-level data as powerful intelligence and the application of value-based healthcare in practice.

Flagship events included the annual costing conference which supports NHS staff to improve their costing, and the International symposium which presents examples of value-based healthcare from across the globe. The Institute's first clinical forum 'Harnessing the power of clinical and financial collaboration to drive value' took place in March 2018, aimed at all clinical staff with an interest in quality improvement, the effective use of resources and the practical implementation of value-based healthcare.

The community services PLICS toolkit supported trusts to turn patient-level costing data into operational intelligence, and a costing briefing for clinicians provided a high-level overview of what PLICS is and how it can support clinicians to improve patient care. A number of case studies described how NHS organisations are overcoming challenges and achieving success in costing and value.

The Institute delivered the NHS Improvement Costing Regional Forum and National Sector Forum programmes from September 2017 to March 2018 and also delivered the Future-Focused Finance Best Possible Value Toolkit project between June 2017 and March 2018.

The Institute introduced a new form of membership for organisations to become Associates of the Institute, made available to arms-length bodies and relevant membership organisations. The Institute also re-established an independent costing group to share best practice, support the Institute programme and provide a cross-sector industry representation for NHS costing.

HFMA Qualifications
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qualification.enquiry@hfma.org.uk

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Stubbing it out

SHUTTERSTOCK

There is a growing consensus that the NHS should provide smoking cessation services in hospital. Seamus Ward looks at how the services could be developed and funded

If you see an adult smoker, you are probably looking at someone who has tried to quit at least once. These attempts may have been prompted by health concerns; the advice of clinicians and loved ones; or even the nudge of the ever-increasing cost or the striking pictures on cigarette packets of the effects of smoking. Whatever the reason, many will have tried to give up without help and support.

Although smoking is the single biggest preventable cause of all cancers, accounts for 16% of all deaths, and treatment for current smokers costs £1.6bn a year in secondary care, NHS support for quitters is uneven. It is believed that around 95% of smokers try to give up without support – only about 1% of them succeed – because they are unaware of the support available or it is not offered during routine contacts with the NHS. About 50% of quitters succeed if they are given behavioural support and pharmacotherapy via a stop smoking service.

The inconsistent nature of NHS support may be partly due to the commissioning of smoking cessation services moving from the NHS to local authorities in 2013. Currently, on admission, hospitals check whether a patient smokes or not and collect the data, but they generally do not provide treatment such as pharmacotherapy – a range of drugs and nicotine replacement therapies that have been shown to double rates of smoking cessation.

To receive treatment to help them quit, patients are referred to smoking cessation services commissioned by local authorities. These can be provided by the NHS – community trusts, for example – local authorities and voluntary sector and commercial organisations.

The services are funded by the public health grant and councils have considerable flexibility in how to use it. However, the grant has been cut since 2015.

Overall, local authority smoking cessation budgets fell from £128m in 2013/14 to £89m in 2017/18, according to the Royal College of Physicians (RCP). It says all smokers could access specialist help when the NHS handed over control of the services to local authorities in 2013/14. But in 2017, this specialist offer was only available in 61% of local authorities.

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"If you have a heart attack, we don't say, "Would you like us to treat you for a heart attack?". We just treat you. So why should smoking be any different?"
Sanjay Agrawal

Hospital admissions attributable to smoking have been creeping up steadily. The Office for National Statistics says these admissions rose by 9% between 2006/07 and 2016/17. Yet smoking prevalence has fallen – from around 20% of adults in England in 2011 to just under 15% in 2017. Attempts to give up by attending specialist services have also declined since 2011/12.

Hospitals have some incentives to refer patients to stop smoking services – between 2017 and 2019 there is a tobacco-related CQUIN. To receive it, hospitals must identify smokers, deliver brief advice and refer patients for treatment. Other incentives include elements of best practice tariffs for specific conditions. And smoking cessation referrals have been included in GP quality and outcome framework (QOF) schemes. However, some areas have no smoking cessation services or have eligibility rules – prioritising, for example, smokers who are pregnant.

There is evidence that helping smokers to quit is not a priority in hospital. A British Thoracic Society survey in 2016 spoke to 15,000 hospital patients – 73% had been asked if they smoked. Of those who were asked, less than a third were asked if they would like to give up and 27% were given a referral.

Proactive role

Clearly, the system is not working, and many doctors, royal colleges and senior NHS leaders feel it is now time for hospitals to play a proactive role in helping their patients give up smoking for good.

A new tariff is central to these ambitions. NHS Improvement and NHS England announced in their recent tariff proposal document that they are working on advice and guidance for smoking cessation services in hospital.

The introduction of bedside intervention on smoking – and a tariff to support it – was advocated in a recent report from the Royal College of Physicians. The HFMA contributed to the report, *Hiding in plain sight*, which said the current opt-in system, where hospital patients are referred to stop smoking services, is not working.

'The problem is that smokers access the NHS with a health-related tobacco problem, but they don't get treatment at the point of care,' says Sanjay Agrawal, a consultant respiratory intensivist who contributed to the RCP report. 'Lots of local government services have disappeared entirely or have been cut back. Essentially, patients are not treated in hospital and they find it difficult to access local government-commissioned services. In local government it can be seen as a "nice to have", but not absolutely necessary.'

He believes – as the report outlines – that NHS trusts should offer stop smoking services to their patients, complementing existing local authority-commissioned services. Treatment should be given on an opt-out basis, rather than the current opt-in.

'If you have a heart attack, we don't say, "Would you like us to treat you for a heart attack?". We just treat you. So why should this be any different? People think it's a lifestyle choice to smoke when it's an addiction,' he adds.

There is evidence of the value of supporting the introduction of a hospital-based stop smoking service. In Ottawa, Canada, a study identified and recruited smokers when they were admitted to hospital. They were given bedside counselling by a specialist nurse to help them quit, together with appropriate nicotine replacement therapy. Staff were given training in smoking cessation and, upon discharge, patients received follow-up phone calls and outpatient appointments.

The reported one-year quit rate of patients receiving the hospital-based support was 28.5%, compared with around 18% for those who just received a leaflet on stopping smoking.

There were significant reductions in all-cause readmissions (down 12%), smoking-related readmissions (9%), all-cause A&E visits (3%) and GP appointments (1% reduction) in the intervention group. The model has now been adopted in more than 350 primary and secondary care sites across Canada.

The RCP report estimates that a similar hospital-based service in the NHS would cost £24m, but produce savings of £85m within a year, based on a patient take-up rate of 27%. In the longer term, even with a more conservative take-up rate of 13.5%, the lifetime cost saving was estimated at £129m.

Dr Agrawal says the NHS could base its service on the Ottawa model, which has also caught the eye of health secretary Matt Hancock. In a speech launching his overall vision for a public health-led NHS, Mr Hancock said he 'liked the look of' the Ottawa model. 'I want to see bedside interventions in our hospitals so smokers who are patients are offered medication, behavioural support and follow-up checks when they go home,' he added.

At least one part of the NHS is already using the Ottawa model (see box overleaf).

A tariff to encourage the development of hospital smoking cessation services is being developed with support from senior members of the NHS England board.

Though yet to be finalised, this could mean a non-mandatory tariff with estimated costs in the first year. Following a familiar model, it is likely that a number of pilot sites would return cost data from the first year, with wider take-up of the tariff in the subsequent years, including mental health trusts, outpatients and possibly primary care.

Local authority services would remain – Dr Agrawal insists that

Disease focus

Hospital-based intervention to help smokers quit should not be directed solely on patients who are admitted for smoking-related reasons, consultant Sanjay Agrawal says.

'For every single doctor and specialty, it doesn't matter where you work in the hospital, you will see smoking influencing the disease outcomes in every patient. Intervention will produce recurrent savings and avoid costs in secondary care.'

Smoking has wide-ranging effects on the body. The Royal College of Physicians (RCP) has come up with around 100 diseases or conditions associated with smoking, including back pain, rheumatism and still birth. The list is wider than that used by Public Health England in the past, which is around 30 years old and was originally developed by the US surgeon general.

The RCP report estimates that the financial burden on the NHS in England caused by smoking is £890m a year or around £1bn for the UK as a whole. This is based on a basket of 52 diseases and calculated using coding data.

Smoking prevalence among inpatients is 25%, compared with around 15% in the general population. In England almost 78,000 deaths in 2016 were attributable to smoking.

A Managed Surgical Facility from KARL STORZ

Medical device manufacturers need to look at new end to end solutions to support the productivity and financial challenges facing NHS hospitals. One hospital Foundation Trust in the East of England recognised the value of working with KARL STORZ on a surgical solution, freeing up valuable funds to facilitate theatre refurbishment leading to reduced equipment down time and improved clinical outcomes, staff and patient experiences.

Trust Challenges

- No spare capital to fund the refurbishment of aging and unsupported surgical operating theatres and minimally invasive instruments and telescopes.
- Stretching the Trust's cash further while maintaining good clinical outcomes.

Need

- Future-proof their operating theatres.
- Attract clinical staff.
- Improve operating theatre staff working environment.
- Save money whilst maintaining or improving surgical outcomes.
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the objective is not to replace these but to complement them.

A tariff, rather than new CQUIN or QOF payments, is needed to encourage hospitals to develop the new service. Dr Agrawal argues that most CQUINs do not lead to culture change.

'This is for a variety of reasons,' he continues. 'It's too easy to tick the box and say you've met your CQUIN, but long-term culture change and quality improvement is built on investment and transformation.'

The QOF scheme is not dissimilar, he adds. 'GPs are rewarded for recording smoking status and offering support through a referral, but that's meaningless. We should be initiating treatment in primary care and measuring and rewarding actual uptake of treatment, not a poor surrogate. This is why we have suggested a mandatory tariff and rewarding treatment uptake. The great thing about the proposed tariff is that it will be an enabler for hospitals to do it.'

He acknowledges a tariff alone will not ensure hospitals develop their own bedside stop smoking service. NHS England will have to work out how best to mainstream the service.

Dr Agrawal says data is key and figures on the number of smokers attending hospital should be routinely gathered, just as the prevalence of C difficile or MRSA is collected and reported.

'If we are going to improve the treatment of tobacco addiction, we need to look at how we collect data. Smoking status is collected in hospital as part of routine coding and this is potentially a brilliant source of information. We need hospitals to use that information to drive improvement and actual treatment, but currently prevalence data is not being used by the NHS.'

The British Thoracic Society survey found that only 6% of NHS institutions completely enforce smoke-free grounds

Smoke-free estates

Moving to truly smoke-free estates will also help, he says. In England, there is no legislation outlawing smoking on hospital grounds, though the NHS as a whole and individual hospitals express a desire to be smoke free.

The British Thoracic Society survey found that only 6% of NHS institutions completely enforce smoke-free grounds. There is legislation in Scotland to enforce smoke-free estates: Nothern Ireland will go smoke-free from March; and Wales has consulted on such a move.

There is a new focus on hospital-based smoking cessation services and a tariff is in the pipeline. It is consistent with the likely emphasis on ill-health prevention in the long-term plan for England and, it appears, hospital smoking cessation will be strongly backed by the centre. It has a number of benefits. As Dr Agrawal concludes: 'We have got to reduce demand by focusing on prevention of ill health. By introducing this service we can reduce demand – that's why it's important for hospitals. It will save lives and money with immediate benefit.'

Addiction CURE

A hospital smoking cessation service based on the Ottawa model has been up and running at Wythenshawe Hospital for a little over two months.

The programme, known as CURE, sets out to provide a tobacco addiction service in hospital, bringing it into core NHS activity, according to Matt Evison (pictured), CURE's clinical lead and a consultant in respiratory medicine at Manchester University NHS Foundation Trust. The service is scheduled to be rolled out across Greater Manchester in 2019.

The idea is to make treatment of tobacco addiction part of medical teams' everyday practice. 'Every clinician is responsible, and we aim to train the entire workforce to know about tobacco addiction and treatment. All non-clinical staff will be given brief training in a mandatory training module.'

The service has four steps, with each related to the CURE acronym – conversation, understanding, replacement therapy and evidence. The initial conversation helps clinicians gain an understanding of the level of a patient's addiction, says Mr Evison. 'We use the admission documents lodged in the electronic patient record to identify smokers, which triggers protocols and pathways leading quickly to replacement therapy.'

The service is delivered by frontline staff from the moment patients walk through the hospital doors. A team of six specialist nurses sees every smoker who is admitted to the hospital and develop an evidence-based treatment plan. The specialist team will follow up in face-to-face sessions with the patient at two, four and 12 weeks before handing them back to primary care.

The programme was launched at Wythenshawe on 1 October – the hospital was the obvious choice as it is the regional cardiothoracic centre. Though Dr Evison admits it will take a little time for it to be fully implemented – staff training, for example, will take time – he is confident that it will make a difference.

It uses an opt-out model. 'Every smoker is referred to the specialist team and offered an appointment. This is the point where they could opt out, but all will have received a brief intervention from the admission team and offered nicotine-replacement therapy immediately.'

Dr Evison says the experience in Canada and the evidence it produced have helped bring the service from concept to implementation. 'It means we have won the argument over evidence. But we did need the support of the executive team – this is a big culture change for the whole hospital and the pharmacy has to be ready for the upsurge in demand for the medication.'

In Greater Manchester, he estimates the scheme could save 3,000 lives, 30,000 bed days and £10m in avoided demand in the first year. 'In general terms, the prevention steps being talked about mean benefits years into the future, but this is a solution for the problems now.'

The scheme took 18 months to two years from first concept to launch and received more than £2m in transformation funding from the devolved health budget controlled by the Greater Manchester Health and Social Care Partnership.

Mr Evison says: 'The initial pump-priming helped to get the service off the ground, but commissioners need to make this a commissioned service. A dedicated tariff for tobacco addiction treatment will help as it will show that it's the right thing to do.'

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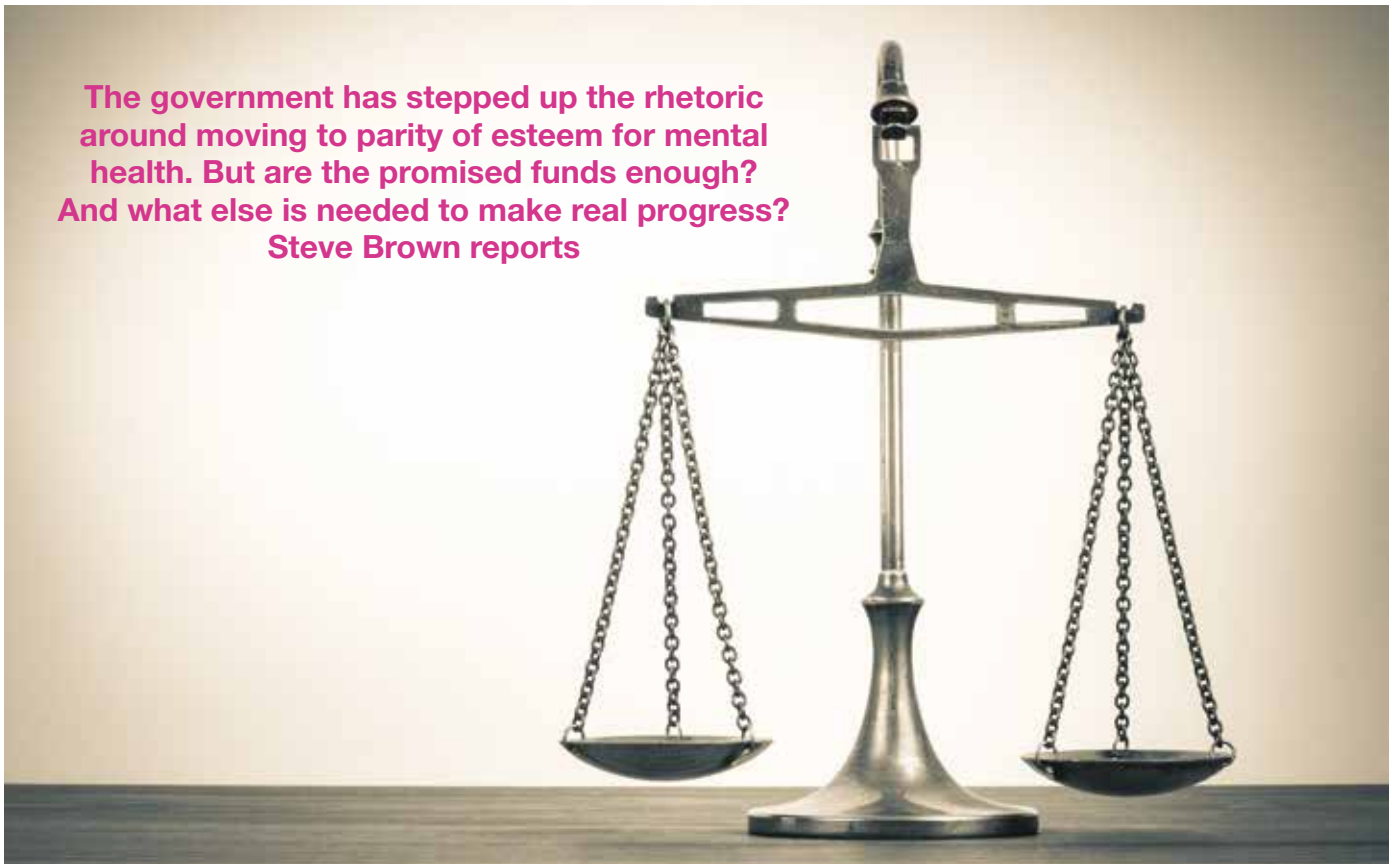
Equity investment

The government has stepped up the rhetoric around moving to parity of esteem for mental health. But are the promised funds enough? And what else is needed to make real progress? Steve Brown reports



SHUTTERSTOCK

The government's commitment to increase spending on mental health services as a proportion of the overall NHS budget has been widely welcomed. However, with significant challenges and pressures, mental health provider trusts are keen to see how this extra funding translates into practice before getting too excited.

The government has previously committed to deliver parity of esteem between physical and mental health. It subsequently backed this up with a mental health investment standard (MHIS) that aims to ensure that clinical commissioning groups increase spending each year on mental health at least in line with their increase in total funding.

The new commitments go beyond this. When prime minister Theresa May announced in June that NHS funding would increase by £20.5bn in real terms by 2023/24, she was clear that better access to mental health services would be one of the key priorities alongside cancer, prevention and restoring performance standards. This was reinforced in chancellor Phillip Hammond's Budget with his commitment, within the overall increase, to boost mental health spending by more than £2bn a year by 2023/24 and for it to grow as a share of the overall NHS budget.

Mixed reception

There was immediate praise for the rhetoric around prioritising mental health spending, which was seen as a 'welcome step on the journey towards true parity of esteem'.

However, there were also plenty of commentators keen to stress that the extra funding would not solve all the mental health service's problems. Richard Murray, director of policy at The King's Fund warned that 'years of underfunding have taken their toll' and that services needed 'more than money to meet demand'. In particular, he highlighted a chronic shortage of mental health staff as a major obstacle. But there has also been a little confusion about what the government's funding promise really adds up to – £2bn, at 10% of the overall £20bn, looks very close to being simply mental health's proportional share of the funding increase. (Take current spending and multiply it by the average 3.4% per year increase and you'll get growth very close to £2bn).

National mental health director and chief executive of Central and North West London NHS Foundation Trust Claire Murdoch has used Twitter to point out that the Budget reference was to an increase of 'at least £2bn'.

Wendy Burn, president of the Royal College of Psychiatrists suggests that mental health services need closer to £2.5bn if mental health is to achieve a higher proportional spend. And a report from the Institute for Public Policy Research, just ahead of the Budget, called for funding to increase from £12bn in 2017/18 to £16.1bn in 2023/24 and £23.9bn in 2030/31 to

achieve real parity of esteem. On average this equates to increases over the next five years of 5%, compared with the 3.4% being applied to the overall NHS budget.

Unsurprisingly, the government's new funding promise came with new spending commitments – £250m for new crisis services, for example. Amber Jabbal, head of policy at NHS Providers, while welcoming the recognition given to specific mental health pressures by the government, is concerned that core services should not lose out. 'Targeting limited funding in this way risks leaving investment in the wider mental health services stretched thinly,' she says. 'Given previous commitments on mental health funding, it is particularly important to ensure that this time any additional money reaches the frontline and is deployed to strengthen core services.'

Finance directors have also been quick to welcome the commitment made to mental health. They too underline that more than £2bn will be needed to make further progress towards parity of esteem, but insist that the increases need to realise their intended purpose – and not be a retrospective exercise in justifying that spending meets targets.

'The mental health investment standard is to ensure that mental health investment keeps pace with the general level of increase for all services,' says Paul Stefanoski, director of finance and business at West London NHS Trust. 'In effect, an increase of £2bn merely delivers this commitment.'

He accepts the reality that the £2bn announced in the Budget is unlikely to be wholly in addition to the mental health investment standard, but suggests it does need to be somewhere in between.

Investment standard

There has been some dispute in recent years about whether the MHIS is being achieved. In some areas, trusts argue that their contract income has not increased in line with their commissioners' overall growth. But commissioners say overall mental health spending has increased by the required amount – including (sometimes unplanned) increases in spending on continuing healthcare, drugs and non-NHS services.

And in some areas spending on *Five-year forward view* targets has been at the expense of core mental health services – either in terms of actual cuts or in failing to recognise demand growth for core services.

Mr Stefanoski says the investment standard was supposed to support trusts in achieving the goals of the *Five-year forward view* and if providers don't receive this, it will inevitably impact on their ability to hit those goals.

"We want to see investment in mental health as part of the whole solution for the health system"

Suzanne Robinson, North Staffordshire Combined Healthcare NHST

A recent HFMA survey of its Mental Health Finance Faculty provider members shows that nearly 90% have no (19%) or low (69%) confidence of receiving anticipated funding under the MHIS this year. There is more confidence that commissioners will achieve the target in terms of spending, but providers just don't see it being passed on to them (a further survey is being undertaken of commissioners).

Faculty chair and finance director of North Staffordshire Combined Healthcare NHS Trust Suzanne Robinson acknowledges the competing pressures facing commissioners, but says it should not be a competition between spending on different areas or sectors.

'We want to see investment in mental health as part of the whole solution for the health system,' she says. 'For example, investment in crisis services, if done in the right way, can reduce acute attendances and admissions. So you might make targeted investment to ensure patients receive the right care in the right place and don't incur unintended costs elsewhere in the system.'

Ms Robinson says the long-term plan has to support more of this holistic approach to investment rather than looking at meeting investment targets in separate sectors.

Rob Pickup, interim director of finance, performance and information management and technology at Dudley and Walsall Mental Health Partnership NHS Trust, also wants investment to be seen in the round. 'We are seeing a lot of core services suffering because of other pressures,' he says. 'Because some community services have been stopped, we are not seeing people identified and supported in the community at the points they need it.

'And that leads to growth in numbers and higher acuity coming through into the mental health system.'

Mr Pickup adds that the trust has seen an increase in the level of specialling it has to provide as a result of this higher acuity. He suggests the widespread retendering of drug and alcohol services may have contributed to a reduction in the service provided. And broader cuts to community groups have exacerbated loneliness – another key contributor to worsening mental health – and removed another opportunity to identify people in need of support earlier in the pathway.

New 'must-do's

There is a danger that funding is poured into one area only for cuts further upstream to increase demand for services and cancel out the benefit of the investment.

Mr Pickup acknowledges that some of the 'must-dos' attached to the new funding – such as increasing the number of crisis cafes – will support existing plans to reduce out-of-area placements. But he says there also needs to be recognition that different service models in different areas will demand different solutions.

'For one organisation, reducing out-of-area placements may not be about extra local beds. Its answer might be to reach people before they require beds,' he says. 'Some areas may not have assertive outreach teams anymore, which can really help with readmissions and patients with frequent admissions. In other areas, it will be about increasing inpatient capacity.'

He also warns that significant staff shortages in key areas – psychological wellbeing practitioners to deliver IAPT (improving access to psychological therapy) services, for example – will affect the pace at which the mental health sector can increase service levels.

The most important thing about the long-term plan, he suggests, is that it needs to deliver a joined-up strategy. It needs to align with the existing *Five-year forward view* and be built around a comprehensive staff strategy. It will still take time before new staff can be trained, so thought needs to be given to how other professional staff can be trained up to deliver new models of care.

'So it may be that we need money for transformation up front and then growth once we have extra staff available and new models proven so we can start to expand services to meet demand,' he says.

It is arguable that mental health has been easier to ignore in recent years because mental health providers don't exhibit the financial

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deficits that are increasingly common across acute providers. But they face many of the same demand pressures for core services without increases in funding. Many are reliant on sustainability funding and other non-recurrent sources to achieve control totals. And rather than deficits, the pressures play out in terms of gaps in services.

Ms Robinson says the lack of an engineered payment system has contributed. 'We've fallen behind acute providers in terms of the information and data we capture and present,' she says. 'And we don't have the same level of understanding of our demand, activity and capacity. We need to step this up, if just to show the increase in activity that services are delivering for the same funding.'

However, she says finance practitioners in providers and commissioners are unconvinced about the proposals for a blended payment approach for mental health from 2019. While links between funding and activity levels might be welcome, there are concerns about the time it might take to properly understand and agree baseline activity levels. Instead, many think the service should be concentrating on new payment systems to support integrated care and population health approaches.

Sean Duggan, chief executive of the

"We want to see investment in mental health as part of the whole solution for the health system"

Rob Pickup, Dudley and Walsall Mental Health Partnership NHST

Mental Health Network, part of the NHS Confederation, underlines that mental health practitioners are looking for a package of different measures in and alongside the 10-year plan. More funding for mental health services is certainly needed – £2bn won't deliver parity of esteem – but this is only one component.

A long-term social services settlement is also vitally important for people with mental health problems, and the long-term plan also needs to set out how it will increase funding for associated areas such as learning disabilities, autism and long-term physical conditions.

He says there has been good progress in areas such as perinatal mental healthcare and the roll out of IAPT, although more needs to be done, and major strides forward are needed with services for children and young people. Services should also take more advantage of digital opportunities.

'Two reports [Institute of Fiscal Studies and Institute for Public Policy Research] confirm that £2bn will only keep the ship afloat,' he says. 'It won't do much in terms of the large-scale journey to parity of esteem.'

However, he says it is 'quite clear' that the new funding is 'over and above the existing promises for the *Five-year forward view* commitments'.

The chancellor's Budget statement was really just the trailer for the coming long-term plan. All eyes are now on this key report to see if the detail matches up to the rhetoric.

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Events, people and support for finance practitioners

Knowing the limit: understanding how CDEL constrains capital spending

Technical

There is broad agreement the NHS needs increased capital investment to help it transform services and develop new, sustainable models of care. Pension investment or borrowing from local government have both been suggested as opportunities to expand capital investment. However, under current government capital controls, neither would actually increase capital resources, *writes Steve Brown*.

The problem comes in the form of the Department of Health and Social Care's capital departmental expenditure limit (CDEL).

Performance against CDEL should not really be a consideration for NHS bodies as it is applicable to, and managed by, the Department. However, all spending on capital across the whole NHS has to be contained within this limit no matter how it is funded – with perhaps one exception. It is therefore important that everyone has a basic understanding of how their decisions impact on the group's financial performance.

So, funds spent by NHS providers from internally generated resources (such as built-up surpluses and the charge for depreciation) count towards the limit. The same goes for centrally allocated capital funds (in the form of public dividend capital) and capital borrowing – whether from the Department's Independent Trust Financing Facility or a private bank.

Without a rule change, borrowing from a pension fund or local government would similarly be captured and therefore not increase the overall funds available for investment.

The one exception has been private finance initiative funding, which benefited from dual accounting arrangements. PFI deals are effectively treated as capital investments at provider level, with assets appearing on the balance sheet and unitary charges split between financing and facilities management costs. But at the national level, most of this 'capital spending' is stripped out, with asset costs not hitting the CDEL. Only those rare PFI deals that are 'on-balance sheet' under the European System of National and Regional Accounts (ESA 10) would count against CDEL.

However, PFI (or PF2) has been dormant for a while and was finally taken off the public sector options list (in its current form at least) in October's Budget.

Nor is the full CDEL available for local investment. The CDEL budget was set at £5.6bn in 2017/18 and of the actual spending of £5.2bn, NHS providers accounted for just £3bn. The biggest other component was research and development, which has been counted as capital expenditure since 2016.

Given the desperate need for capital resources in general (see HFMA briefing *NHS capital – a system in distress?*), which have been further depleted in recent years by capital to revenue transfers, the shortfall against the overall limit is not ideal. Although a small underspend is expected given the CDEL is a hard limit that cannot be exceeded, there were concerns about the size of the underspend – with providers contributing the bulk of it at £267m.

Underspends can easily arise as building projects can be delayed even after resources have been allocated. However, NHS Improvement said this forecast underspend emerged only at the very end of the year, preventing it being used as emergency capital funding during the year. It is currently reviewing the capital regime along with the Department.

To ensure the CDEL is not breached, the Department has a number of controls and mechanisms. NHS trusts are given capital resource limits and they, along with financially distressed foundation trusts cannot enter into capital schemes with an investment value of more than £15m without submitting a business case to NHS Improvement even when they have the resources available to do so. They also need approval for any loans to finance capital expenditure.

Foundation trusts were set up to have more freedom and do not have any capital spending limits. In theory, they can incur capital expenditure as long as they have the resources to do so. However, with more than 100 providers in deficit at the end of 2017/18 (mostly acutes), the surpluses that can create the cash for investment are less common. And depreciation is not enough to cover all required capital expenditure.

Any borrowing would similarly be subject to a business case and only approved where there is available headroom within the CDEL. And there are two metrics within the single oversight framework use of resources assessment (capital service capacity and liquidity) that providers need to keep in mind when considering borrowing for or spending on capital.

Assets sales can extend the usable amount of CDEL. When an asset is sold any profit is recorded as income in the statement of comprehensive income. This may contribute to a surplus in year, which could contribute to resources to support capital investment. For NHS trusts and foundation trusts in financial distress a business case is also required for sales where disposal proceeds are more than £15m. Where there is a plan to reinvest the disposal proceeds, the business case will have to cover that too. Foundation trusts do not need to follow this process unless they are in financial distress.

At the national level, the net book value of the asset which has been sold is a benefit that increases the capital spending possible before hitting the CDEL limit.

Technical review

The past month's key technical developments

Technical

NHS Improvement issued the **accounts and reporting timetable** for 2018/19 in November following work with the Department of Health and Social Care and NHS England. As in 2017/18, there will be a key data return at months 9 and 12, with the month 12 key data used to inform the calculation of indicative Provider Sustainability Fund allocations. A change this year to the agreement of balances process will see a provider-to-provider mismatch report issued two to three working days before the Department's wider mismatch report. This is intended to give providers extra time to start looking at provider mismatches before the wider report is available. http://hfma.to/8d

An HFMA briefing takes an in-depth look at **personal health budgets** (PHBs). *How it works – personal health budgets and integrated personal budgets* explains what a PHB is and the history of their development in England. With PHBs a key part of plans to give people more personalised care, the briefing explores who can have a personal budget and how the budgets are calculated. It sets out the three options for making PHBs available – as a notional budget, a third-party budget or via direct payment. It also examines the emergence of integrated personal budgets bringing funding together to meet health and social care needs. http://hfma.to/8e

A new **integrated oversight framework** will form a key part of the regular performance discussions between NHS England, NHS Improvement and sustainability and transformation partnerships/ integrated care systems. Alongside this, NHS England, NHS Improvement and STPs/ICSs will continue to review trust-level and CCG-level data to help agree when individual organisations need support or intervention and who should provide that support or intervention. A document setting out the CCG improvement and assessment framework for 2018/19 said the integrated framework would evolve to reflect a population-based approach to improving health outcomes and reducing health inequalities. Its development would be informed by the long-term plan for the NHS, due to be issued shortly after *Healthcare Finance* went to press, to ensure that the ambition described for the NHS is captured in the metrics used to assess CCGs and healthcare systems in the future. http://hfma.to/8g

NHS Improvement has published the ***NHS foundation trust annual reporting manual 2018/19*** (ARM) – issued without consultation as there are no significant changes to the 2017/18 document. There are two new disclosures to the annual governance statement requirements. FTs must now include a statement that they have published their register of interests for decision-making staff, as required by *Managing conflicts of interest in the NHS*. They must also include a disclosure of how the FT ensures that workforce strategies and staffing systems are in place to assure the board that processes are safe, sustainable and effective. http://hfma.to/8f

The move to a single collection of costs at patient-level came a step closer last month. NHS Improvement confirmed that it would not require **reference cost** submissions from acute trusts for admitted patient care (APC), outpatient and A&E services covering the 2018/19 financial year. This is on the back of finding that parallel collections of patient-level costs and reference costs for 2017/18 reconciled very closely to each other (within 1%). In the one case where they did not, the reason was traced back to an inconsistency in the collections guidance. Reference costs for other acute services and non-acute services will be phased out over the next two-to-three years. The 2017/18 reference costs cover £68bn of spending by 232 NHS providers – 62% of total NHS revenue expenditure. They include costs of APC (£27.7bn), mental health (£7.2bn) and community care (£5.5bn). http://hfma.to/8j

New option for acute myeloid leukemia

Technical: NICE

In an unusually quiet November for publications, NICE has recommended two new technologies for use within the NHS, *writes Gary Shield*.

TA545 Gemtuzumab ozogamicin for untreated acute myeloid leukaemia recommends gemtuzumab ozogamicin, with daunorubicin and cytarabine, as an option for untreated de novo CD33-positive acute myeloid leukaemia (AML), except acute promyelocytic leukaemia, in people 15 years and over.

AML is a rapidly progressing form of leukaemia. There is a poor prognosis for patients whose disease doesn't respond to treatment or whose disease responds then relapses. Cytogenetic testing is used to look for specific gene mutations in certain types of leukaemia, which might predict how the disease will respond to treatment.

Gemtuzumab ozogamicin will be used in addition to current treatments and so will be an additional cost. Around 950 people with AML are eligible for treatment with gemtuzumab ozogamicin and it is estimated that 850 people a year will have the new technology from 2020/21 onwards.

The second technology appraisal – *TA547 Tofacitinib* for moderately to severely active ulcerative colitis – recommends tofacitinib, within its marketing authorisation, as an option for treating moderately to severely active ulcerative colitis in adults. It would be applicable when conventional therapy or a biological agent cannot be tolerated or the disease has responded inadequately or lost response to treatment.

Ulcerative colitis is a chronic condition in which inflammation develops in the large intestine. Tofacitinib is the first oral biologic drug to be recommended by NICE for this. It improves patient experience as the oral tablets can be self-administered and no injections are needed. Over 2,000 people per year are expected to have the new technology when uptake peaks.

Both technologies are being made available with confidential discounts.

Gary Shield is NICE resource impact assessment manager


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NHS in numbers

A closer look at the data behind NHS finance

NHS staff

Technical

According to official statistics, there are nearly 1.5 million staff (full-time equivalent) working in the NHS across the four UK health services. Nearly 1.2 million of these work in England, while 139,000, 78,000 and 57,000 work in Scotland, Wales and Northern Ireland respectively.

However, the numbers are not directly comparable as they use some differing definitions. The English figures include GPs and general practice staff in their statistical bulletins, for example, but others do not. Northern Ireland also includes social services staff.

The 1,190,729 figure for England (or 1,375,388 if you prefer headcount) does not include support organisations and central bodies, which add a further 36,646 staff to the FTE total. The vast majority of staff (1,100,929) work within hospital and community health services (HCHS), while just over 126,000 staff work within general practice.

Within these English totals, there are just over 143,000 doctors, 76% of whom work in HCHS while 24% are GPs.

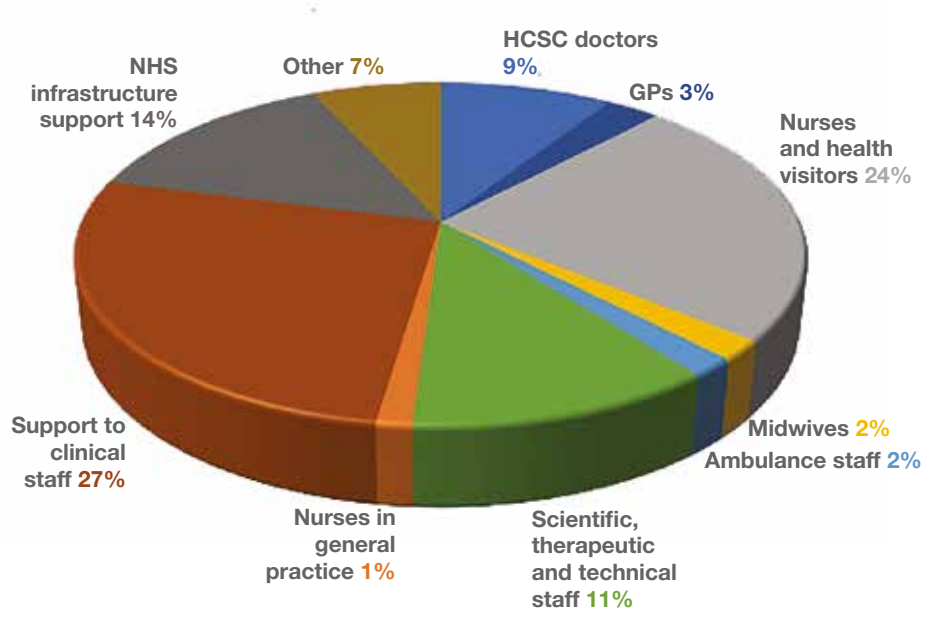
There are just over 323,000 nurses, health visitors and midwives in England, including nearly 16,000 GP practice nurses. Some 318,000 staff work in roles supporting clinical staff, while a further 168,000 are classed as infrastructure support, including central functions such as finance and property and estates functions.

Overall numbers increased in England by nearly 20,000 in the 12 months to March 2018 – an increase of 1.6%. Within this figure, the total number of doctors increased by nearly 2,700 or 1.9%. Meanwhile, nurse and health visitor numbers fell by 0.1% over the year, while midwife numbers grew by 0.9%.

	All staff	Medical (excl GPs)	Nursing and midwifery
England	1,190,729	109,346	**307,535**
Scotland	139,095	12,404	43,838 (qualified)
Wales	77,917	6,321	29,524
Northern Ireland	56,553	4,017	14,984
All UK	1,464,294		

NHS Digital, March 2018; Scotland Information Services Division, June 2018: Wales Statistics for Wales 2017; Northern Ireland NISRA June 2018

NHS STAFF IN ENGLAND (1.2 MILLION)



Across trusts and foundation trusts, NHS Improvement's quarter 2 report for 2018/19 says there are currently 103,000 vacancies including 41,000 nursing vacancies and 9,300 medical vacancies. In both cases, between 80% and 85% are being filled with either bank or agency staff.

A report from The King's Fund, The Health Foundation and the Nuffield Trust in November suggested that the staffing shortage could reach 250,000 by 2030.

The report added that if the emerging trend of staff leaving the workforce early continues and the pipeline of newly trained staff and international recruits does not rise sufficiently, this number could be more than 350,000. The current shortages have also increased reliance on temporary staff.

There have been major efforts to bring down the costs of agency staff in recent years – both reducing agency rates and by using bank staff as a preference where the posts cannot be filled substantively.

Costs have decreased since the introduction of controls and rate caps – with costs now falling from more than 7% of the overall pay bill to below 5% now and forecast to fall to 4% by the end of this financial year.

However, rising demand continues to challenge local health economies, with higher than planned activity often requiring increased use of temporary staff.

Flexible learning

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

Training

I talked about the HFMA's new intermediate diploma back in October. But we've had some interest from potential students and their managers in the ability to study individual components of this qualification. In fact, flexibility really is the name of the game with this qualification.

The intermediate diploma is a level 4 qualification that is similar to the first year of undergraduate study. It is aimed typically at Agenda for Change bands 4-6 within the finance function – complementing technical accounting studies and graduate schemes, for example – and outside it. Anyone who could benefit from a better understanding of the fundamentals of NHS finance would get value from this qualification – nurses, junior doctors, budget holders or first line managers, to name just a few.

Studied as a whole qualification, the diploma involves studying a mandatory *How finance works in the NHS module* (20 credits) and two optional modules (10 credits each) chosen from topics including costing, management skills, governance and transformation tools.

There has been a really positive response to the content in this qualification from potential students and from finance directors wanting to develop their teams or raise financial understanding among other teams.

We've fielded a lot of queries about the ability to study the separate sections that make up the diploma – rather than committing to the full diploma from the outset.

This is very definitely an option. And while we are keen to encourage as many as possible to commit to the full diploma, we recognise that signing up to individual sections may suit some individuals or organisations better. So the options are:

- Full diploma (core module plus two optional modules) – 40 credits
- Certificate (core module) – 20 credits
- Award (optional modules) – 10 credits each.

This could drastically cut down the amount of time that people have to commit to upfront. While the full diploma involves an estimated 400 hours of study time, a single optional module should take more like 100 hours. And some people may feel more comfortable taking on that smaller commitment – even if we'd hope it would whet their appetite for the full diploma.

Continuing our flexible approach, we are happy to discuss the potential to run the qualification (diploma, certificate or award) for a cohort of students from the same organisation at a specific point in the year. There are benefits to studying with fellow students from different organisations – seeing different perspective or different challenges.

But there are also advantages to studying alongside colleagues – helping to cement relationships across departmental boundaries and between clinical and support functions and enabling discussions to really focus on how the content applies to the specific local context. We will support what works best for your organisation.

There are even discounts available to organisations putting forward multiple people to study at the same time – whether studying as part of an organisation-specific cohort or as part of the regular national intake. These start at 15% and rise to 25% depending on the numbers of students involved.

We are really excited to get the new diploma under way in January. We will initially be running the core *How finance works in the NHS* module, with the optional modules being launched a little later into 2019.

As an introductory offer we are providing good discounts on the diploma (reduced from £3,000 to £2,250), certificate (reduced from £1,250 to £850) and award (reduced from £950 to £699) levels of the qualification.

• See **hfma.to/qualifications** for more information or call **0117 938 8350**

FFF develops behaviour and skills framework

Future focused finance

NHS Future-Focused Finance has produced a *Finance staff behavioural skills framework*, outlining the behavioural skills finance staff should develop to carry out their jobs in the best way possible.

The framework is a response to a Finance Leadership Council (FLC) request earlier this year. The FLC asked FFF to produce a piece of work, as part of its *Workforce and leadership* delivery theme, to support all finance staff to identify how they can best use their talents in NHS finance. The framework recognises how we do our jobs is at least as important as what we do.

FFF worked with the senior responsible officer for *Workforce and leadership*, Claire Yarwood, chief finance officer at Manchester Health and Care Commissioning, and HR specialist Karen House, of House HR, to create the framework. Development work included interviews with 12 finance directors, three chief executives, a selection of finance leaders, two focus groups consisting of Skills Development Network leads, and the attendees at an FFF Foundation meeting.

The framework is organised around FFF's *Four strengths*, which have previously been developed and are already being used by finance departments across the country. It is designed to be used flexibly and in a variety of ways – added into people's job descriptions; as a tool for setting individual objectives; as a checklist to help people to develop personal development plans; and assisting with recruitment.

• The framework is available to download at **www.futurefocusedfinance.nhs.uk/behavioural-skills-framework**

Diary

December

5-7 (N) HFMA annual conference, London
11 (N) Making tax digital webinar
12 (I) Institute: the importance of the I in PLICS: collaborative working to improve data quality, webinar
12 (B) South Central: technical update, Reading
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
22 (F) Provider Finance: director forum, London
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

7 (N) HFMA/CIPFA integration summit, Rochester Row
11-12 (N) Chief executive forum and dinner
13 (F) Mental Health Finance: technical forum, Rochester Row (AM)
13 (F) Provider Finance: technical forum, Rochester Row (PM)
27 (I) Institute: value masterclass

March

1 (B) Eastern: accounting standards and VAT update, Fulbourn

May

9 (B) South Central and South-West: developing talent (with SDN), Reading
15 (F) Provider Finance: forum, Rochester Row (AM)
15 (F) Mental Health Finance: forum, Rochester Row (PM)
16 (F) Chair, Non-executive director and Lay Member: forum
22 (F) Commissioning Finance: forum

June

13 (B) West Midlands: annual conference, Birmingham

June

21 (B) Northern: Keep stepping, Durham

July

4-5 (N) HFMA summer conference, Bristol

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

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

Events in focus

Integration summit: sharing learning from across the devolved nations

7 February, Rochester Row, London

Health and social care integration is at the top of the agenda across the four nations in the UK. The devolved nations have their individual structural designs and local challenges, but, broadly speaking, many of the issues they face are common. This event seeks to share the learning from all four nations.

The event – the fourth annual integration summit – has been organised by the HFMA and CIPFA to bring together a wide range of stakeholders, from local authority treasurers to NHS provider finance directors, directors of adult social services, integration authorities, commissioner chief finance officers and system leaders.

Speakers from the devolved nations will include Steve Elliot (pictured), Welsh government deputy director of finance for health and social services, and Richard McCallum, deputy director of health finance and infrastructure at the Scottish government.

The summit will also examine the NHS long-term plan for England and hear views on the impact of the government green paper on social care.

• For further details or to book a place, email joanne.hitchen@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

The circle of NHS life

Association view from Mark Knight, HFMA chief executive

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

My HFMA

What a year it's been! The main event was the announcement of a large injection of funding into the service. As I write, working groups are looking to develop a long-term plan for the NHS, and NHS Improvement and NHS England are busy merging – or not merging!

When I started at the association in 2000, someone told me the NHS tended to work in cycles. Sure enough, the direction of travel is now very much towards strong regions with a smaller centre – we even have a new 'NHS plan'. It could recycle the old strapline – 'a plan for investment, a plan for reform' – although the investment is not yet enough and we also need to see a plan for social care.

With each region in England being £10bn-£20bn, it is hard not to make comparisons with former regional health authorities or the more recent strategic health authorities with a smaller, but powerful, executive sitting above them. The HFMA's role is perhaps one of the constants – part of the system, supporting one of the key functions crucial to the delivery of transformation and sustainable health services.

It is interesting to see how the system is reshaping itself despite a legislative framework designed for a different structure. It will be good to see strong regional leaders and finance directors emerge as we take on the next phase in the service's development. We all know that the settlement isn't quite what everyone wanted and there will be considerable strings attached. It's important we work together to deliver the best healthcare for our population.

If you are reading this at the annual conference, on Friday at the annual general meeting our new president, Bill Gregory, will unveil his theme for the year. I think you'll find it galvanises us to cope with the changes we face.

Our president for 2017/18 has of course been Alex Gild. Our first mental health leader and one of only two people who have represented the South Central patch, Alex has worked tirelessly to promote the HFMA. His theme, *Your NHS, your HFMA: brighter together* has struck a chord with members and captured perfectly the need for the NHS and its partners to work collaboratively to integrate services and meet the needs of patients and growing demand.

HFMA chief executive Mark Knight

SHUTTERSTOCK

I'd like to thank Alex for his tireless commitment during the year. He has never shirked from the task. His good humour, wise counsel and continuing support have been enormously helpful to me and my colleagues. He remains on the HFMA board and will very much be part of our activities going forward.

Bill is our second mental health finance director, like London buses – we've had 67 years with none and then two turn up at once! This is particularly appropriate given the priority being given to improving mental health services as part of the long-term plan as we look to deliver parity of esteem between physical and mental health.

The AGM will also see the association install Owen Harkin as a vice president alongside Caroline Clarke, who becomes president in 2019/20. Owen, our first non-English president, and only our second Northern Irish leader, will lead us in 2020/21. So, we have exciting times ahead and we look forward to continuing to support our members and the wider finance community. See you all in 2019.

Member news

In November, the Northern Branch held its most successful conference yet, with 220 delegates. The event ended with a dinner and awards ceremony, at which winners in seven categories were named:

- Accountancy Technician of the Year – Angela Buckley, City Hospitals Sunderland NHS Foundation Trust
- Accountant of the Year – Richard Turnbull, Northumberland CCG
- Large Team of the Year – North Tees and Hartlepool NHS Foundation Trust financial management team
- Small Team of the Year – South Tyneside CCG finance
- Student of the Year – Jemma Cheetham, County Durham and Darlington NHS Foundation Trust and Sean Charlton, Gateshead Health NHS Foundation Trust
- Chairman's Award – Tarryn Lake, Sunderland Clinical Commissioning Group and John Maddison, Gateshead Health NHS Foundation Trust
- Graeme Smart Award – David Craig, North of England CSU

The Kent, Surrey and Sussex Branch raised £1,018 with a charity raffle at its 24-hour event in October. Branch chair Sheila Stenson and committee member Stuart Wayment visited Kangaroos in Haywards Heath (pictured) to hand over the donation. The charity runs a range of clubs, activities and trips for children, young adults and families. They do not let members' disabilities hold them back and help them, in a safe and supporting way, to take part in the kind of activities that we all take for granted.

hfma

Member benefits

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

Network focus

My HFMA **CEO forum**

Chief executives of NHS organisations are in a tough position. Not only are they held to account for organisational performance, but they must also think about the whole system.

'There is a tension, but if you can acknowledge this and identify ways in which you can address today so you can build for tomorrow, you'll get the balance right,' says Suzanne Tracey (pictured), who in July became the chief executive of Northern Devon Healthcare NHS Trust in addition to Royal Devon and Exeter NHS Foundation Trust. The two have a collaborative agreement to cope with challenges such as recruiting medical workforce and safeguarding services.

Peer support, such as the HFMA CEO forum, and system and nationwide collaboration are vital, she says. 'Regulators are increasingly open to looking at what you're doing on a system-wide level, as long as you're clear about how you're managing the challenges for the individual organisations.

'I think it's the right thing to do. Given the size of the challenges organisations face at the moment, particularly around workforce, it'll be difficult for a single organisation to address them effectively.'

Within Devon Sustainability and Transformation Partnership, providers and commissioners have a mutual support principle to improve patient outcomes and minimise risks to patient safety caused by demand and capacity imbalance. 'If one of the organisations is having a short-term challenge due to vacancies or sickness, for example, this mutual aid agreement allows them to formally request help from other providers in the area and we have all committed to support wherever possible,' says Ms Tracey.

'Northern Devon has benefited particularly from the agreement – with providers across the Devon system providing short-term support to help maintain clinical services.'

Ms Tracey is an active member of the HFMA CEO forum, which offers chief executives the opportunity to talk about challenges they face.

'Sometimes you've got your head down in the day-to-day work and it's difficult to see things from a different perspective,' says Ms Tracey. 'The CEO forum is a great way to step back from it for a short while and bring new ideas back to your organisation.'

The next CEO forum event is on 12 February, with an informal dinner on the previous evening. Find out more at **http://hfma.to/forum**

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Appointments

Jonathan Wilson (pictured) is now chief financial officer at Moorfields Eye Hospital NHS Foundation Trust, having earlier spent nine years as the organisation's deputy director of finance. He was previously director of finance at Homerton University Hospital NHS Foundation Trust. Mr Wilson is taking over from deputy chief financial officer **Jenny Greenshields**, who has been acting up in the role over the last six months. He started his career in the NHS in 1998 on the NHS Graduate Financial Management Training Scheme. **Phill Wells** is succeeding Mr Wilson at Homerton.

NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group has appointed **Jim Hayburn** interim chief finance officer. Mr Hayburn takes over from another interim CFO, Bernard Chalk.

North West Anglia NHS Foundation Trust has appointed **David Pratt** (pictured) director of finance. He joined the trust in September, first as interim finance director after former finance director and deputy chief executive **Caroline Walker** was appointed chief executive. The substantive appointment follows a rigorous selection process. Mr Pratt has held director of finance and director of efficiency roles at several hospital trusts, including Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, United Lincolnshire Hospital NHS Trust and Ealing Hospital.

Barking, Havering and Redbridge University Hospitals NHS Trust has appointed **Nick Swift** chief financial officer. Mr Swift has more than 20 years of board experience in international finance, most recently as chief financial officer for British Airways until 2016. Since leaving, British Airways, he has pursued a keen interest in health and the NHS – having studied a masters in health and medical science at University College London. He has also been a non-executive director at East and North Herts NHS Trust. The appointment follows the departure of interim director of finance Ian O'Connor.

Emma Sayner, (pictured) chief finance officer at Hull Clinical Commissioning Group has also taken the role of interim chief finance officer at North Lincolnshire Clinical Commissioning Group. Over the past 10 years, she has held a number of senior finance roles in the NHS. Her most recent work in North Lincolnshire has been to lead the CCG's financial recovery programme, which has seen it exit legal directions at the first available opportunity.

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

"We are grappling with a lot of things and it's hard work. But, at the same time, we are trying to keep the show on the road, and are implementing ambitious group strategic transformation plans"
Peter Ridley, Royal Free London NHS FT

Ridley moves back into senior finance role

On the move

Peter Ridley has been appointed group chief finance and compliance officer at the Royal Free London NHS Foundation Trust, stepping up from another director role at the trust.

Mr Ridley, who succeeds Caroline Clarke (now group deputy chief executive), has been director of planning at the Royal Free since May 2016. The planning role was strategic, looking after the trust's performance and external relationships with commissioners.

'I was keen to get back into finance,' he says. 'All my background has been in finance and I wanted to get closer to the action as we're doing lots of interesting work here. At the end of the day I am an accountant.'

He previously worked at the trust as director of financial operations (2010-13) and during his time he gained an affinity for the Royal Free. 'It's a bit of a homecoming for me. People are committed to the Royal Free and it feels like we are all pulling in the same direction.'

Mr Ridley joined the NHS in 1999 as part of the national graduate management training scheme and over the three years of the training scheme worked in a mix of organisations.

He worked at Haringey Primary Care Trust, before moving to providers – the Royal Marsden, Royal Free and Royal Surrey County Hospital NHS Foundation Trust, where he was director of finance and informatics.

He also spent time on assignment with NHS IMAS (interim management and support).

Mr Ridley's new job title has two parts – finance and compliance. The latter is an oversight role for the Royal Free's hospitals. Each hospital has its own management team, he explains, and he will hold them to account for hitting their access standards, quality targets and budgets. 'My role will be to supply additional support and analysis if things aren't quite going to plan. I am also the first point of contact for NHS Improvement and other regulators.'

He has set himself a number of objectives – to ensure the finance function supports the delivery of the trust's long-term strategy and provides accurate data and analysis that will lead to good decision-making.

'The key to this is making sure we make this an organisation where it's easy for people to do the right thing. How do we get good decision-making? How do we help them get a business case through? We want to help rather than create barriers.'

He says the finance department must ensure clinical groups talk to the right finance people at an early stage of developing a plan or putting together a business case, he says.

"My role will be to supply additional support if things aren't quite going to plan. I am also the first point of contact for regulators"

Transactional processes in finance can be more efficient, he believes, and work has commenced on the potential for automation.

The trust shares many of its challenges with its counterparts across the NHS.

'We are running a deficit and have long-term plans to get out of that. On access to services we have similar challenges to everyone else. We are grappling with a lot of things and it's hard work. But, at the same time, we are trying to keep the show on the road, and are implementing ambitious group strategic transformation plans.'

Some of that transformation is already in place with the redeveloped Chase Farm Hospital now open and providing a range of outpatient appointments, diagnostic tests and day case procedures.

Mr Ridley says the trust's finance function also has to balance the day-to-day requirement of hitting financial targets with the necessity to look forward and facilitate transformation.

'We have a strategy and plans for four years and it is going to take a lot of effort to deliver on these. We need to provide investment up front and trust people to deliver change. It would be easy to go back to slash and burn and focus on short-term cost savings, but our long-term ambition is strategic change.

'We are doing all the right things and asking people to get on and deliver without micro-managing them. Our board is clear on that. It's helpful as we can focus on the long term.'

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1. Care Quality Commission. The state of health care and adult social care in England 2015/16 (October 2016). Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561730/State_of_Care_15-16_web.pdf. Accessed November 2017.
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