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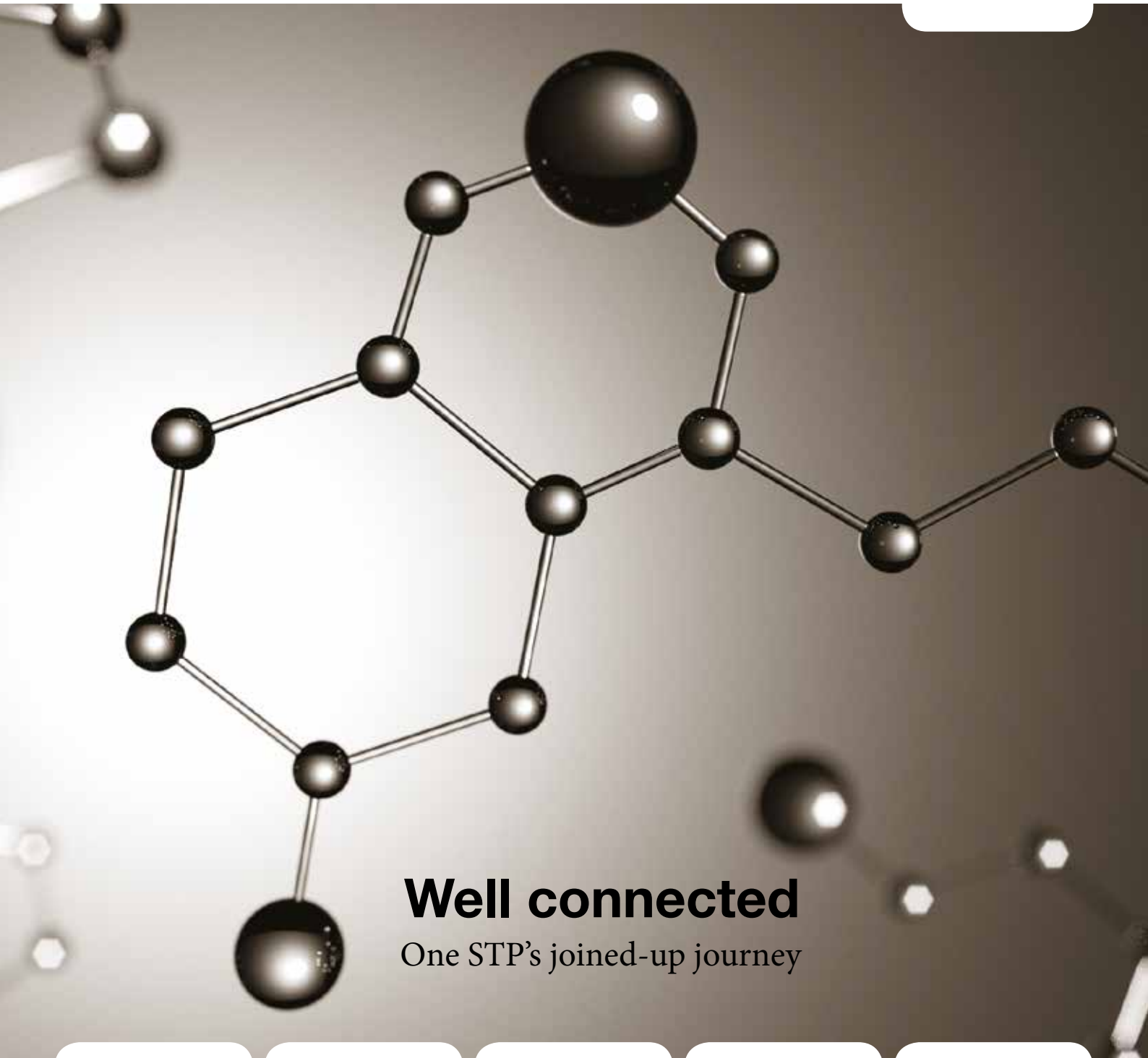

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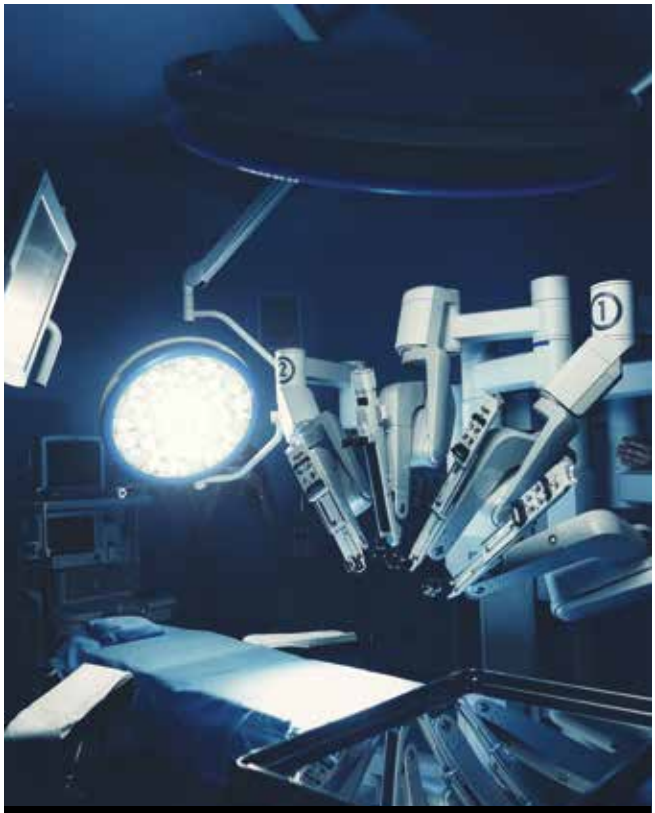

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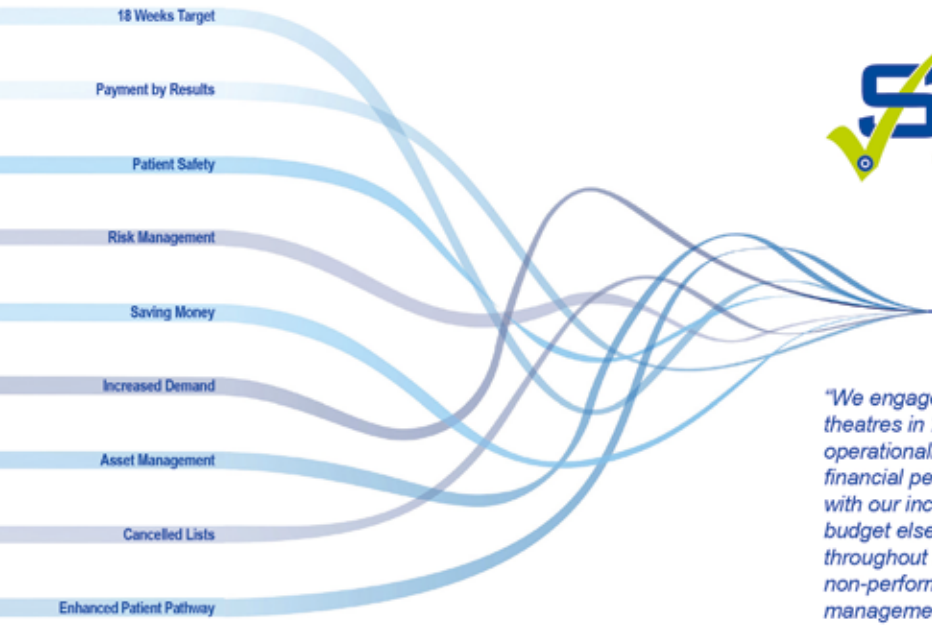
Getting It Right First Time – in the most critical area of your hospital



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Kevin Downs, Financial Director, Royal Derby Hospital

Within the current healthcare landscape, Getting It Right First Time (GIRFT) has a major part to play in delivering improved care, reducing unwarranted variations and controlling costs.

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News

Prime minister outlines new funding and financial tests

By Seamus Ward

The government will set the NHS in England five financial tests to ensure the additional funding in the next five years will be spent wisely.

In mid-June, prime minister Theresa May (pictured) announced that NHS funding would rise to around £149bn by 2022/23 – £20.5bn, or an average of 3.4% more per year, in real terms. The real-terms increase will be 3.6% in 2019/20 and 2020/21, followed by 3.1%, 3.1% and 3.4%.

The overall figure also includes £1.25bn a year to cover additional pension costs, due to an increase in employers' contributions.

Speaking at a Commons Public Accounts Committee hearing, NHS England chief executive Simon Stevens said that, when the £1.25bn is included, real-terms growth in 2019/20 will be nearer 4.6%.

The devolved nations will receive additional funding through the Barnett formula. The figures are yet to be confirmed, but Scotland is likely to be given an extra £2bn in real terms by the end of five years, Wales around £1.2bn and Northern Ireland £600m. This money is not ringfenced for health – it is up to the local administrations to decide how it is spent.

In England, the additional funding will be linked to a 10-year plan – to be developed by the NHS – and five new financial tests. The plan, due in November, will focus on four areas: workforce, technology, buildings and productivity.

Mrs May said: 'This must be a plan that ensures every penny is well spent. It must be a plan that tackles waste, reduces bureaucracy, and eliminates unacceptable variation, with all these efficiency savings reinvested into patient care. It must be a plan that makes better use of capital investment to modernise its buildings and invest in technology to drive productivity improvements. It must be a plan that enjoys the support of NHS staff across the country.

'But NHS leaders at national and local level must then be held to account for delivering this plan,' she added.

Accountability will be delivered through the five financial tests:

- Improve productivity and efficiency
- Eliminate provider deficits
- Reduce unwarranted variation
- Get better at managing demand effectively
- Make better use of capital investment.

It is likely this will lead to a greater focus on RightCare, the Model Hospital, the use of the provider sustainability fund and sustainability and transformation partnerships' capital plans.

The NHS has also received an additional £800m in its 2018/19 baseline, to cover this year's costs associated with the new Agenda for Change pay deal in England.

Mr Stevens said that on a like-for-like basis NHS funding growth is around 3.1% this year – including the pay deal funding – compared with 3.6% next year.

As well as the new funding, the government confirmed several other points. It will consider a multi-year capital plan to support transformation and multi-year funding plan for clinical training. And the green paper on social care, due this summer, will now be published in November.

Although it welcomed the increased funding, the HFMA said it was below the long-term average of 3.7%. HFMA chief executive Mark Knight said: 'The extra cash will help address current shortfalls, but it is unlikely to be sufficient to meet ever-increasing demand, support the transformation and integration of services, and improve services such as cancer and mental health.

'We look forward to seeing additional detail supporting the announcement, including the impact on the wider health budget. But it looks like the NHS is not out of the woods. Difficult choices will have to be made – not only about how the new funds should be spent, but the entirety of the NHS budget.'

Nuffield Trust chief executive Nigel Edwards said the increase was less than the 4% needed to prevent a deterioration in patient care. 'Because it doesn't apply to the whole Department for Health and Social Care budget, it leaves out spending on things like training staff, building hospitals and public health. It appears that the real figure for all spending on healthcare will be lower, closer to 3%.'

Convergence 2.0

The HFMA Convergence 2.0 conference on 5/6 July will focus on the integration agenda and *Healthcare Finance* will be there to cover it. Reports will be available via the 'Top stories' news feed on **www.hfma.org.uk/news** or via the HFMA app

President heads to US HFMA

HFMA president Alex Gild addressed the US HFMA's annual conference in Las Vegas at the end of June. The conference, *Leading and inspiring the business of healthcare*, brought together several thousand healthcare finance professionals from across the US and looked at issues such as reducing the total cost of care; business intelligence and analytics; and payment trends and models.

King's Fund warns of continuing pressures

By Seamus Ward

Some 40% of provider and commissioner finance leads expect their organisation will overspend their budget this year, said the King's Fund.

In its quarterly report on the NHS, which includes a survey of finance leads, the fund said 42% of trust finance directors and 39% of clinical commissioning group chief financial officers believed they would record a deficit or overspend at the end of 2018/19. The survey was taken before June's five-year funding announcement.

The *Quarterly monitoring report* said almost 80% of CCGs in its sample are considering withdrawing funding from more low-value treatments to help manage their financial pressures.

King's Fund chief analyst Siva Anandaciva (pictured) said the provider sector was initially expected to balance its books in 2017/18, but this was revised to a £496m deficit once trust financial plans were submitted. Even so, the sector ended the year with a £960m deficit after the sustainability and transformation fund (STF) was applied.

He added that the STF was contributing to a growing gulf between 'haves' and 'have nots'.

'It is clear the current NHS finance regime is broken, with huge deficits in some trusts and booming surpluses in others. The new funding settlement provides an opportunity to re-think the current system and ensure that financial management in the NHS is proportionate, fair and effective.'

NHS finance directors were increasingly concerned about staff morale, with 24% identifying it as one of their top three concerns – the highest proportion since 2013.

Finance leads were asked for their top three priorities for new investment. Trust finance directors' priorities were social care (67%), community services (53%) and mental health services (47%). For CCG CFOs, the top priorities for new money were general practice (79%), social care (65%) and community services (65%).

Mr Anandaciva said the five-year funding settlement for the NHS provided an opportunity to move more services out of hospital, with the backing of provider and commissioner finance managers. 'Policy-makers have long sought to provide more care in the community, closer to people's homes, to improve patient care and reduce pressures on hospitals.

'These attempts have, for the most part, failed, and hospitals remain full to capacity, while under-investment in community services continues. Our survey suggests that finally delivering this vision should be at the heart of the forthcoming NHS 10-year plan and that additional funding for social care must be a top priority for the forthcoming spending review.'

Finance leads were also concerned about operational pressures, with 23% of trust finance directors and only one of the 32 CCG leads surveyed confident the four-hour target will be met locally by March next year – NHS planning guidance expects the majority of trusts will be meeting the target by that time.

Adult social care needs urgent short-term funding as well as a long-term settlement, according to the Association of Directors of Adult Social Services (ADASS). Its annual budget survey report said recent short-term funding had alleviated some pressures and made an impact on delayed transfers of care out of hospital. More than £3bn from the Better Care Fund and the social care precept on council tax had to an extent counterbalanced the £700m adult social care element of council savings needed in 2018/19. ADASS said councils faced increasing pressure from an ageing population, potential market failure through the closure of homes and the knock-on effects of NHS pressures.

Wales launches health and care strategy

The Wales government has launched a joint strategy that seeks to transform health and social care in Wales, based on its 'quadruple aim' and value-based care.

The strategy, *A healthier Wales*, will be backed by a £100m transformation fund. Under the plan, many services currently provided in hospital will be moved into the community, where there will be more joined-up services.

It is based on the Welsh prudent healthcare philosophy and the quadruple aim – improving population health and wellbeing; better quality services; high-value health and social care; and a motivated and sustainable workforce.

The strategy outlines 10 design principles to translate the quadruple aim and prudent healthcare into tools for delivering transformation. The principles include prevention, safety, independence and higher value.

Embedding value-based healthcare will mean achieving better outcomes and better patient experience at reduced cost, it said. Care and treatment will be designed to produce outcomes that matter to patients. And services will be delivered by the right person at the right time, with less variation and no harm.

Initially, work will focus on six clinical areas: safer medicines management; surgery and surgical pathways; frail elderly care; managing acute illness; equitable health and social care services; and end of life care.

'Value in health and social care is also a way of giving greater focus to the outcomes that matter to individuals and considering their relation to the costs of achieving those outcomes,' the report said. 'This approach interprets efficiency and effectiveness by going beyond cost savings, safety and clinical quality.'

Wales health secretary Vaughan Gething said: 'We have to move on from the idea that the hospital is the first or best place for you to be when you are unwell. That isn't always the case, especially when there are a range of local services that will allow you to remain safely at home.

'I recognise this will take time, but change will begin immediately. By the time we celebrate the 80th anniversary of our NHS I expect to see a stronger joined-up system that will be fit to serve people for generations to come.'

Association takes 30-year view

Three main factors will influence the financial future of health and social care over the next 30 years, according to an HFMA report marking the 70th anniversary of the founding of the NHS.

Looking ahead: the NHS at 100, sponsored by NHS Future-Focused Finance, considers the challenges likely to be faced as the service edges towards its centenary. Demographic change; changing roles of the state, society and the individual; and technological developments will all affect how the finance function works and the skills finance staff will need, it said.

For example, the UK demography is changing. By 2048, the number of over-85s is set to rise to 3.9 million – more than double today's number – and 70% of them will have at least one long-term condition. Investment in prevention requires a long-term outlook, the report said, and the wider public sector must realise that investment in one area may lead to savings in another.

The report, which draws from a roundtable discussion and interviews with senior finance professionals and accountancy bodies, along with published research, also examines how the finance function could change and the issues that must be considered to maintain the support provided by finance professionals in the long term.

Treasury uplifts baseline as pay deal gets green light

By Seamus Ward

The NHS in England has been given an extra £800m this financial year to cover the cost of the Agenda for Change pay deal, but NHS Providers raised concern over the mechanism for delivering the extra money to employers.

NHS Providers said the government must honour its pledge to fully fund the pay deal, estimated to cost £4.2bn over three years.

According to the 2018 NHS pay review body report, the Department of Health and Social Care, employers and staff side accept that the tariff is not an appropriate mechanism for moving the additional pay funding to employing bodies. The review body said a separate mechanism would ensure the funds reach employers and not be diverted to other programmes. There were no details on this mechanism as *Healthcare Finance* went to press.

Phillippa Hentsch (pictured), head of analysis at NHS Providers, said: 'We welcomed the pay deal for staff on Agenda for Change, which has since been agreed by unions' members. But we were clear that the deal must be fully funded and cover the full term of the three-year agreement.

'The proposed funding mechanism could leave provider trusts millions out of pocket if it does not take account of all relevant staff.

'Trusts also face the prospect of a further cost hit, if the government decides on a pay award for doctors of more than 1%.'

The new deal, agreed by 13 of the 14 unions following members' ballots, will broadly see a pay rise of at least 6.5% over three years. The increased pay will be backdated to the beginning of April and will be reflected in pay packets in July or August.

Prime minister Theresa May said higher pay must be accompanied by a new workforce strategy – workforce will be one element of the new 10-year NHS plan.

'It is right that we lifted the pay cap and made a significant pay increase a core part of the new offer to over a million NHS staff,' she said.

The NHS must offer staff greater flexibility and listen to their views about the support they need to deliver world-class care. 'These things are often just as important as pay,' she added.

The deal aims to improve recruitment and retention, offering some staff rises of up to 29% over three years. It will also introduce a minimum salary of £17,460 this year – an increase of more than £2,000 that will benefit 100,000 staff.

The deal marks the scrapping of the 1% cap on NHS pay rises. Starting salaries in all pay bands will increase following a simplification of the bands.

Only GMB members rejected the deal, which the union said meant a real-terms cut. Other critics said the increases amounted to little more than the pay rates they will replace once annual increments are taken into account (*see Paying it forward, Healthcare Finance May 2018*).

Around eight in 10 Unison and Unite members supported the deal. Unison head of health Sara Gorton said it would not solve all the problems in the health service but would ease the financial strain on staff.

Baumann to leave NHS England in November

NHS England chief financial officer Paul Baumann (right) is leaving the national commissioning body in November to become receiver general at Westminster Abbey.

In post since NHS England was established in 2012, Mr Baumann agreed to delay confirmation of his starting date in the new role until the five-year funding settlement was announced.

He said it had been a privilege to work in the NHS. 'This has

been a time of exceptional challenge for the service, and I am deeply grateful for the commitment and professionalism of colleagues across the NHS and within NHS England, who have worked so hard to secure the best possible value – for both patients and for taxpayers – with the public money under our stewardship,' said Mr Baumann.

'With a long-term financial settlement now in place, I wish the NHS well as it moves forward from its 70th birthday to the next phase of its distinguished history of constant innovation and dedicated service.'

HFMA chief executive Mark Knight wished Mr Baumann well. 'His analytical mind and good humour will be a loss to the NHS and a gain for the Church,' he said.

NHS England chief executive Simon Stevens said: 'Paul has done far more than just help steady the ship during a period of intense funding pressure. He has helped drive major gains for patients and taxpayers nationally and locally, helping to ensure the NHS is well positioned to develop a long-term plan for the decade ahead.'

The post of joint CFO for NHS England and NHS Improvement is to be advertised soon.

News analysis

Headline issues in the spotlight

Sustained pressure

Despite significant reductions on agency staff spend in the NHS over recent years, there is continued pressure to reduce temporary staffing costs even further. Steve Brown reports

Providers' agency staff spending continued to fall in 2017/18. The total agency spend of £2.4bn represented 4.6% of the overall paybill. This is a significant fall compared with the 5.8% in 2016/17, and well below the recent peak of nearly 8% in 2015/16.

While this brings the service closer to the proportional levels of spend from 2012 and earlier, NHS Improvement believes there is still more progress to be made and has announced a series of further actions on temporary staffing for the year ahead.

Speaking at an HFMA workforce forum in June, NHS Improvement deputy director of agency intelligence Dominic Raymont said that agency controls introduced from 2015/16 had had an impact. 'But the hard work on cost reductions and the credit is all yours,' he told delegates.

At its worst, agency spending had reached £3.6bn across medical, nursing and other staff categories in 2015/16. 'Now, trusts have taken £1.2bn from the combined agency bill,' he said. 'That is a phenomenal effort.'

Some of that former cost has moved into spend on bank staff – where there was a significant overspend against plan in 2017/18 (see box) – although temporary staff spend overall was still down on the previous year.

This is in line with a major push to get trusts to move from a reliance on agency staff to bank wherever possible, delivering cost savings and often enhancing quality. However, the ultimate goal remains to get temporary staffing spend overall to the optimum level, which will involve a combination of increasing substantive posts where appropriate and possible, getting the demand right and continuing to bear down on temporary staff costs.

Mr Raymont also praised the speed of the turnaround, addressing a problem in two years that had taken four years to build up.

Understandably, the source of savings is changing as trusts have tackled different staff groups in phases. While medical locums accounted for the single biggest chunk of agency cost savings in 2016 (42% compared with 24% for nursing and 34% on other staff categories), medical accounted for less than 20% of savings in the last year.

The service also passed a significant landmark in 2017/18, with spending on bank staff exceeding agency spending for the first time. Bank staff accounted for 5.6% of total staffing spend compared with 4.6% on agency.

However, this split is not mirrored across all staff groups. In medical and dental, spend on agency staff (at 7% of all medical staffing spend) remains higher than bank spend (5%).

Mr Raymont said that the staffing group costing the most in terms of temporary staff as a proportion of overall spend was healthcare assistants. Some 14% of total spend on healthcare assistants went on temporary staff, although the majority of this (12%) was from banks rather than agencies. NHS Improvement will be working with trusts this year where spend on temporary staffing is above the average.

So, the NHS is doing well, with a more sustainable mix of temporary staff beginning to emerge. However, Mr Raymont said there was still 'much further to travel and too much variation between trusts'. He said, for example, that some trusts' spend with agencies on medical locums was still in double figures as a percentage of the medical paybill.

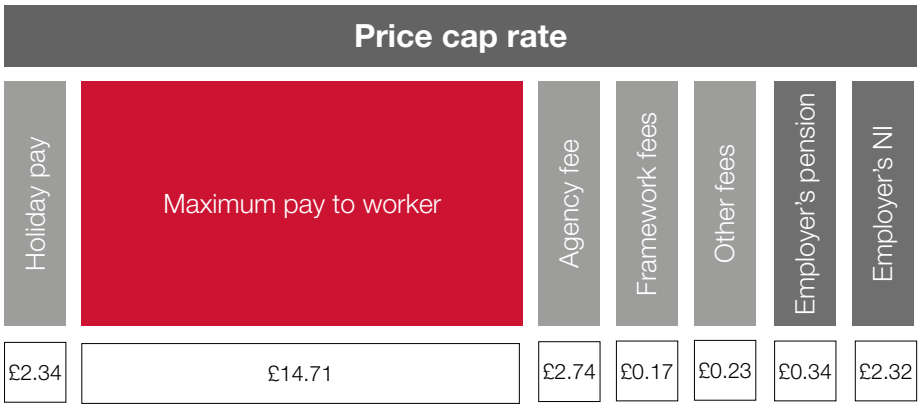
Other cost pressures

The new agency ceiling target for 2018/19 is £2.2bn, which implies further savings of £200m this year on top of last year's outturn agency staff spend. But, in reality, there are other cost pressures. The Agenda for Change pay deal could add an extra £50m to agency staff costs, while growth in activity and vacancy pressures – NHS Improvement said there were 100,000 vacancies across the NHS at Q4 – may add a further £100m.

Add in other inflationary pressures of £50m and the service will actually have to realise savings of £400m to hit its collective target.

NHS Improvement chief executive Ian Dalton wrote to NHS trusts at the end of May, setting out actions they will be required to undertake as part of a further tightening of the regime this year. These include a lowering of the hourly rate threshold at which chief executives are required to sign-off shifts in advance.

This is being lowered from £120 to £100, although it is understood that many trusts already have this lower rate included in their local governance arrangements. Executive directors will now also have to sign off any



The seven pillars that make up the price cap rate with an example for an Agenda for Change band 5 worker of how the money paid to an agency (£22.85 per hour) breaks down

Temporary staff spend in numbers

Providers spent £2,407m in 2017/18 on agency staff. This was, in fact, £93m (3.7%) less than they'd planned to spend, set by the level of their collective agency pay ceilings. The spend was also £527m less than in the previous year – with NHS Improvement describing the 18% fall as 'impressive'.

However, the £2,974m spending on bank staff was £976m or 49% above plan. Putting these figures together means that providers spent a total £5,381m on temporary staff – overspending their budget by £883m.

There was also an overspend on substantive staff budgets of some £602m bringing the total overspend on staff costs to £1,485m (2.9%) on a planned budget of £50,817m. NHS Improvement described the planned staff spending as optimistic. Pay costs rose by 3.3% compared with the previous year, which after taking account of 2.1% pay inflation represented real-terms growth of just 1.2%.

Most of the overspending took place in the acute sector and was attributable to intense operational pressure. And even with the overspend, overall temporary staff costs decreased by £67m (1.2%) compared with 2016/17.

The temporary staff costs are driven both by demand being higher than the levels planned for, but also by significant levels of vacancies. NHS Improvement's Q4 report said there were 100,000 vacancies on top to the 1.1 million whole-time equivalent staff employed by trusts in England.

agency shifts that are 50% or more above the price cap, but where the hourly rate is less than £100. All these 'breaches' need to be reported to NHS Improvement in weekly submissions.

Other than that, there will be continued work to reduce the use of off-framework agencies, continued encouragement to use bank over agency staff and further development of collaborative banks.

Martin Innes, senior operational agency data and intelligence lead at NHS Improvement, told the same workshop there were lots of opportunities to make further savings and even modest reductions in rates paid to agencies could have a dramatic impact on overall spend levels.

Agencies have their place particularly in providing staff for one-off requirements. But trusts should explore opportunities to transfer staff working regularly for trusts through agencies onto their own banks. In many cases, this would have no impact on the money received by the worker, but there could be substantial savings in terms of agency and framework fees. Even paying higher pay rates through the bank could lead to savings overall.

Mr Innes said there were some staff members effectively working full-time and long term, but employed through an agency – up to 15 years in the case of one doctor. Even allowing for the costs of administering these arrangements in-house, Mr Innes said there was potential to save substantial sums on individual members of the temporary workforce.

He also reminded trusts there were opportunities for savings even when adhering to price cap rates under in-framework contracts. For a start, the price caps include the maximum pay rate for the worker concerned – the cap rate for a band 5 worker includes the equivalent pay rate for someone at the top of that band.

'So, someone just one year qualified is not entitled to that rate,' he said. 'You should go back to the agency and ask how qualified the nurse is and where they should be in terms of spine points.' The NHS has had a tendency to accept the maximum pay rate, particularly with nursing staff, Mr Innes said. Changes in the pay component will influence other elements within the overall charge (see diagram opposite).

"There is still much further to travel and too much variation between trusts"
Dominic Raymont, NHS Improvement

Employer national insurance is also allowed for within the cap at a rate of 13.8%. But agencies should only pass on the actual costs of paying these contributions, which is often lower. Pension contributions (based on 3% in the cap) should only be paid if the worker has a workplace pension – many have opted out.

'Break glass' provisions

Trusts are allowed to override agency rules using 'break glass' provisions. This can involve using off-framework agencies, and Mr Innes warned about the hike in agency fees that typically accompany this. He gave an example of one high-cost agency charging more than double the price cap rate for a band 5 nurse, with only a third of the increase going to the worker. In more extreme cases, with off-framework rates over £100, the worker is often only getting about a third of the overall payment.

He added that trusts typically tended to have a stepped process, particularly where shifts were being filled close to the actual shift time, of: check if shift can be filled by overtime or bank; fill through agency on framework; seek to break glass and use off-framework agency.

In reality, he said there were two further steps that should be tested before moving to off-framework agencies. Trusts should first try to fill the shift by increasing the bank rate and then ask the framework agencies if they can supply if the rate increased. Both of these could still be more cost-effective than off-framework rates.

'Work with your bank and your on-framework agencies for a solution,' Mr Innes said.

He stressed that small changes in rates paid could produce significant dividends. 'Every penny taken off the price of agency medics reduces spend nationally by £101,000. And every £5 off the price of shifts above the cap, we save £35m,' he said. 'And if we move every medical shift to cap, we save the NHS £300m.'

With £400m to save this year from already reduced agency spend budgets, every penny counts.

News review

Seamus Ward assesses the past month in healthcare finance

June was a busier-than-usual month for healthcare news, with the build-up to, and then announcement of, the five-year funding deal, together with the report on an independent inquiry into more than 450 deaths at Gosport Memorial Hospital, the NHS Confederation's annual conference and agreement of a new pay deal for NHS staff in England.

The NHS reaches 70 years this month and the pressure mounted on the government to give it a 'present' in the form of a long-term funding settlement. In an open letter to Theresa May, the Health Foundation, Nuffield Trust and King's Fund said 4% a year was needed to maintain services, invest in key areas such as mental health, cancer care and general practice, and continue transformation. Less than 4% risked a further deterioration in standards of NHS care and delays to capital programmes, including vital repairs. At the NHS Confederation annual conference, its chair Stephen Dorrell said both NHS and social care needed 4% a year.

The conference was held before the funding announcement on 18 June, and chief executive Niall Dickson called for urgent investment in new models of care in the community. He said it was 'shocking' that primary care spending had fallen in real terms over the past eight years. Since the mid-1990s, the number of hospital doctors had increased by 72%, while GP numbers had fallen by 5%. He insisted he was not attacking the acute sector, but if services outside hospital were not supported, whole systems would fail. The NHS needed performance management arrangements and financial incentives that support system working and encourage investment in new models of care, he added. An Ipsos Mori poll of more than 1,000 people across Britain – commissioned by the confederation – found that 77% supported or strongly supported a 4% rise. Even more – 82% – backed a 3.9% rise for social care.

Regulators should 'exercise discretion' when deciding whether to withhold sustainability funding due to financial performance, the confederation said in a report launched at its conference. Sustainability and transformation funding allocated to trusts (now known as the Provider Sustainability Fund) has been based on their achievement of control totals, but the report, *System under strain*, argued that denying access to these funds only harms patients in areas where need could be greatest.

NHS England chief executive Simon Stevens and his NHS Improvement counterpart Ian Dalton announced a new plan to free up 4,000 beds in time for winter by reducing long stays in hospital. Working with local authorities, they aim to reduce the number of long-staying patients by a quarter and further reduce delayed transfers of care.

In May, there was an improvement in the performance of A&Es in Wales, despite an increase in attendances. The latest figures show 82% of patients were seen within the four-hour target – 1.9 percentage points higher than in April this year. The 95% target continues to be missed. The number of patients waiting more than eight weeks for diagnostic tests increased – this was driven by the inclusion of additional cardiac tests, according to Statistics for Wales. However, health boards in Wales were warned they will receive their full share of extra waiting list funding only if they meet agreed reductions in their waiting lists. Health secretary Vaughan Gething said health boards had submitted plans to access £30m in funding this financial year.

The month in quotes

'It is shocking that over the past eight years spending on primary care in England has fallen in real terms – indeed from the mid-90s the number of hospital doctors has increased by 72%, whereas in the same period the number of GPs fell by 5%.'

NHS Confederation chief executive Niall Dickson tells his conference that more funding must go into community and primary care …

… while chair Stephen Dorrell calls for greater overall funding for health and care

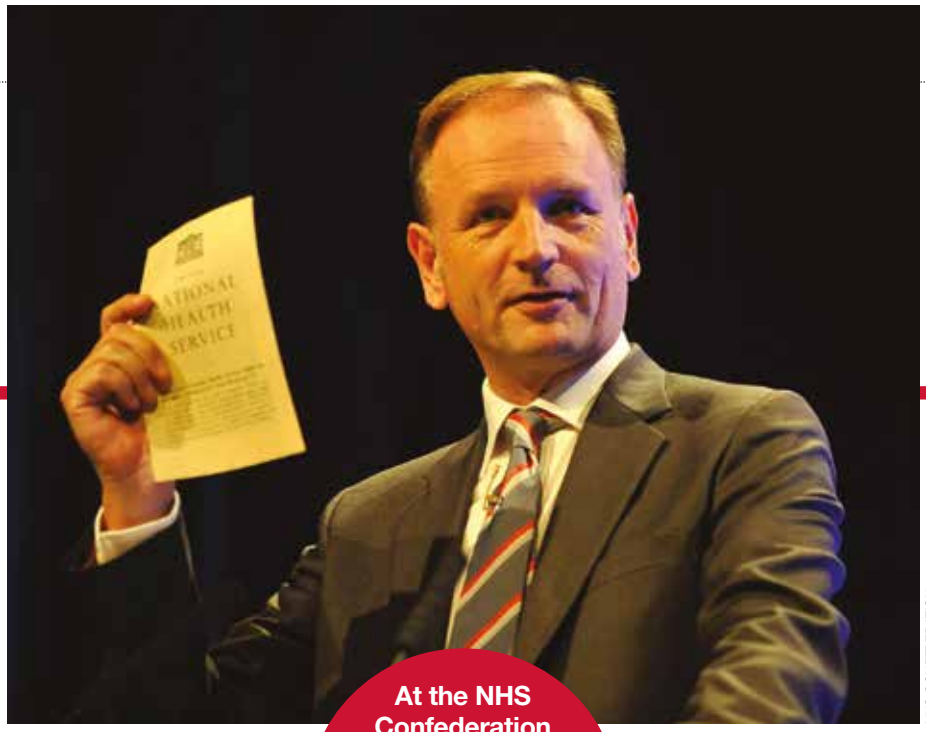
'Not 4% for the NHS and a squeeze on local government – or a special fund to ease the pressures on social care. But 4% per annum for the NHS and 4% per annum for social care, year-on-year, between now and 2030.'

'NHS providers have tried to accommodate an ever-larger number of needy patients with an ever-diminishing bed base. The predictable result has been bed occupancy at record levels and thousands of patients stranded on trollies for more than 12 hours.'

Royal College of Emergency Medicine president Taj Hassan on the 2017/18 winter pressures

'Health boards will need to meet the targets they set out in order to receive the full funding. I expect to see significant improvements on waiting times as we did in the first two years of this fund.'

Wales health secretary Vaughan Gething warns health boards they must meet expectations to access additional funding



NHS CONFEDERATION

At the NHS Confederation conference, Simon Stevens (above) announced a plan to free up 4,000 beds by reducing long stays in hospital

He expected to see significant improvements, as had been achieved over the past two years, when £100m of additional funding was provided to reduce referral to treatment, diagnostic and therapy waiting times.

NHS performance in England continued to be mixed, with, for example, improved waiting times in A&E but more people waiting for elective care as demand rises. Figures released by NHS England showed 90.4% of patients were seen within four hours in A&E in May – up from 88.5% in April and 89.7% in May 2017. Emergency admissions were up 5.6% compared with May 2017. At the end of April 2018, there were four million people on the waiting list for elective care – 6.2% more than a year earlier.

Though many would argue confirmation was not needed, the Royal College of Emergency Medicine said the performance of the NHS emergency care system in winter 2017/18 was one of the worst in the history of the service. A report on winter flows across the UK, said between October and March the average A&E four-hour wait performance was 81.2%, while between January and March it was 79%. This was despite an average of 3,400 operations cancelled each week – a record for the college's winter flow project, which began in 2015.

MPs called on NHS England to deliver on its forward view commitment to move more care out of hospital and into the community. In a report, *Reducing emergency admissions*, the Public Accounts Committee said almost 1.5 million people could have avoided an emergency admission in 2016/17 if hospitals, GPs, community services and social care had worked together more effectively. The committee said it was frustrating that progress had been made in reducing the impact of emergency admissions for patients and hospitals, but there had been little progress in reducing the number of avoidable emergency admissions.

Generic drugs with temporary higher prices cost clinical commissioning groups an estimated £315m in 2017/18, according to the National Audit Office. An NAO report said this cost, which is over and above what would have been spent if the usual drug tariff applied, was seven times greater than the equivalent spend in 2016/17. The report, *Investigation into NHS spending on generic medicines in primary care,* said the cost of some medicines increased tenfold over the year. It was caused by a range of factors, including shortages, increases in manufacturers' prices and concessionary prices that were set too high by the Department of Health and Social Care. The cost of the latter (estimated at £86m) is expected to be reimbursed through established mechanisms over the coming years.

The NHS in England could improve patient experience and outcomes and deliver efficiencies of up to £16.4m in cranial neurosurgery, according to the *Getting it right first time* programme. Its report on cranial neurosurgery said the efficiencies could be made through smarter procurement, avoiding unnecessary admissions and using critical care only where clinically required. Specific savings opportunities included admission on day of surgery to reduce length of stay; increasing the number of minimally invasive day surgeries; and reducing the length of stay in critical care to five nights or fewer.

hfma

from the hfma

The HFMA published a number of blogs in June, including one with a stark message from former health secretary Alan Milburn (pictured) – the NHS financial system must be reformed if the government is to leverage maximum value from the new investment in healthcare. Writing before the government's funding announcement, he said this was the conclusion of research into how funding flows could be redesigned – undertaken by PwC in collaboration with the HFMA. Too much money was invested in increasing hospital activity rather than improving outcomes in the community. A survey of finance staff found strong support for changing the current funding flows and creating a single budget for each health, social care and public health economy. More than three-quarters believed outcomes could be improved by giving greater long-term funding certainty.

Sandra Easton, chair of the HFMA Environmental Sustainability Special Interest Group, blogs that finance staff must bring their concerns for green issues into their working lives. Projects can have a positive impact on the environment and the bottom line, so finance has a role to play, she argues.

In his latest blog, former NHS finance director and current chief financial officer at Bermuda Hospitals Board Bill Shields sees an improvement in the deficit position and a break-even budget set for 2018/19. But it's really only the end of the beginning, and he looks forward to further developments, such as costing and service-line reporting.

• See blogs at www.hfma.org.uk/news/blogs or on the HFMA app

Comment

A happy birthday

Let's focus on the 10-year plan after positive funding announcement

The NHS's birthday came slightly early, with welcome news from prime minister Theresa May about a much needed real-terms funding boost. We might have hoped for – and could make a case for – more. But we should recognise it puts us in a much better position to tackle the significant challenges that face us and to make progress with the transformation and integration agenda.

HFMA president Alex Gild

Austerity, demand and workforce pressures have taken their toll on the service. This announcement must surely be seen as positive political support to help reverse the steady deterioration of our NHS.

An average of 3.4% per annum real growth over the next five years – on the NHS England budget – will still require difficult choices to be made, with underlying deficits and near-term demand likely to eat into this sum. And there remain uncertainties about funding for education and training and the basic protection of public health and social care spending.

Nevertheless, this announcement is positive news. Thank you, Theresa May, and the public. We trust the autumn Budget and next year's spending review will supplement this announcement with more detail and proposals

Payment systems: let's talk about the detail

We need to start exploring the detail of new payment approaches

Healthcare Finance editor Steve Brown

For a service that has been talking about the move to capitation budgets for years, we seem to have done precious little about it.

It has been more than six years since a report for then foundation trust regulator Monitor – *An evaluation of the reimbursement system for NHS-funded care* – concluded that payment by results was not fit for purpose. There has been some progress on the back of some of the findings.

For example, it found that the information underpinning tariff and other reimbursement mechanisms was flawed. NHS Improvement's Costing Transformation Programme – getting all NHS providers in England to cost (and submit costs) at the patient level – is a direct response to this finding.

But the report also highlighted the fact that reimbursement mechanisms currently operate within the administrative boundaries of settings of care (acute, community etc) rather than across them. 'This can sometimes hamper efforts to integrate or shift services.'

This view of payment by results or national tariff is now widely held. And as the integration agenda has really taken off with sustainability and transformation partnerships and integrated care systems, there is a growing consensus that capitation budgets are the way forward.

This might involve giving an integrated care partnership or a lead provider a budget covering the whole population served. Initially set on the basis of historical spend on the services involved, the idea, in theory at least, is that this would move towards being based on an agreed spend-per-capita rate.

But we have seen little central work being undertaken on the detail of how such budgets would work. Instead, the approach has been

"We will be engaged in a *Five-year forward view* plus-plus, with implementation legs"

to address issues across the wider care system.

We must now concentrate all our attention on the development of a 10-year health and care transformation plan. We must because we, the service, will be engaged in its design – a *Five-year forward view* plus-plus, with implementation legs.

This comprehensive strategic plan is needed because there are gaps in detail, not just in understanding the availability and impact of wider system financial resources, but also in the need to nail down the strategic workforce plan for the NHS.

In the context of Brexit, an ageing workforce and clinical education shortages, we simply have to have a realistic plan to staff the integrated, fit-for-purpose, digitally enabled clinical services of our future.

The health service's number one priority in this 70th anniversary year must be to address the NHS and social care workforce risk. If not mitigated, this alone will unravel any long-term plan before the ink has dried.

As I said at the beginning of this calendar year, the finance community needs to involve itself directly in, and support, workforce planning. It's a complex area because in many cases the workforce needed will not exist as we know it. Skills mix and digital support are potential solutions, alongside integrated care models.

One thing is certain: our nursing, human resources and operational colleagues need our continued support and partnership. Let's make this happen, as the funding gives hope and headroom to future-proof our NHS.

Wishing this great old NHS a very happy 70th birthday and many more to come. I hope you all enjoy the celebrations!

Contact the president on president@hfma.org.uk

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to allow local health economies to put in place their own arrangements – informing NHS Improvement where they are stepping away from the tariff and national pricing rules – to support existing services or new ways of working.

In some ways, this supports the 'no one size fits all' approach to new ways of working, championed in the *Five-year forward view*. Health bodies have had some support. There was early national work on different payment approaches such as a three-part payment for urgent and emergency care, for example, and NHS England has produced some guidance on whole-population budgets.

But in general the pace has been slow and the profile of work has been low – there has been nothing like the focus given to the introduction of the tariff, for example.

Payment systems are not the key driver of new ways of working – and some people would dispute the efficacy of financial incentives in the health service – but they should underpin these service models and support the transformation of services and then sustain them.

More central work in this area – or supporting the sharing of local work – makes sense. A report from The Strategy Unit (*see page 25*) makes a great contribution to the debate. It looks specifically at risk and reward mechanisms that could sit alongside capitation budgets, drawing on US experience with similar arrangements.

It explores the details of how such schemes might work. They are likely to be complex (and necessarily so), and we should at least be discussing how this fits with a general feeling that the current tariff system needs to be simplified. We surely need to see more of this type of work happening, with the finance function taking the lead.

"We need a bigger debate about payment systems – including the relative merits of using complex models or simpler approaches"

The HFMA's work with PwC – *Making money work in the health and care system* – also stressed the importance of reworking financial flows to maximise the value of the new funding promised by government.

We need a bigger debate about the future of payment systems – including the relative merits of using complex models or simpler approaches – and this needs to be at a detailed level of how they would work in practice. We need to evaluate what has been done locally – there are some good examples – and share the learning. We don't need to undertake all the same work from scratch in every health economy.

The sooner integrated care models are established, the better for the NHS. And we should not wait for these new models to be in place before getting serious about how we need to change payment approaches.

• *Getting the balance right, page 25*

3M Science. Applied to Life.™

Improving data quality to deliver more accurate reimbursement

An NHS Foundation Trust in the East of England that provides acute hospital and community care services to around 280,000 people has taken steps to deal with significant financial pressures and a requirement to maximise value for money with the available resources. 3M's Health Information Systems (HIS) business enjoys a strong working relationship with the Trust's clinical coding team, which uses 3M™ Medicode™ Clinical Encoder as its primary clinical coding tool.

Project requirement

Complete, accurate clinical coding is essential in NHS Trusts. The National tariff payments system means that a Trust's revenue is dependent on its coding quality. The Trust had previously engaged an external firm to review the quality of its coded clinical data, however this had resulted in a significantly increased workload for the senior coding team, as the suggested changes were often inappropriate and had to be reviewed carefully. The Trust's Clinical Coding Manager contacted 3M's HIS team to see how it could help the Trust to better use its resources to improve data quality.

Identified needs

3M's HIS team quickly recognised three key insights.

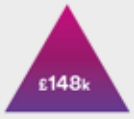
Firstly, it was important to build on the coding team's existing knowledge of Medicode clinical encoder. Secondly members of the existing senior coding team were best placed to identify and assess anomalies in their own data. Thirdly it was necessary to reduce data to a manageable quantity by screening out activity that did not require review.

The addition of three new 3M Medicode modules was proposed to improve the coding process, optimise data quality and maximise the capacity of both the clinical coding auditor and clinical coding trainer:

One of the modules was the 3M™ Data Quality Analytics Solution (DQA) which reviews all coded episodes and reports against the national clinical coding standards, alerting the user to potential errors. Target review areas are identified effectively and efficiently at episode level. DQA fits into the daily coding process where alerts can be reviewed by people trained to recognise the impact of errors.

The results

Financial benefit



A more accurate data submission has led to an income improvement of £148,000 in the first six months, meaning an average of £24,000 per month increase in appropriate reimbursement.

Increased data accuracy

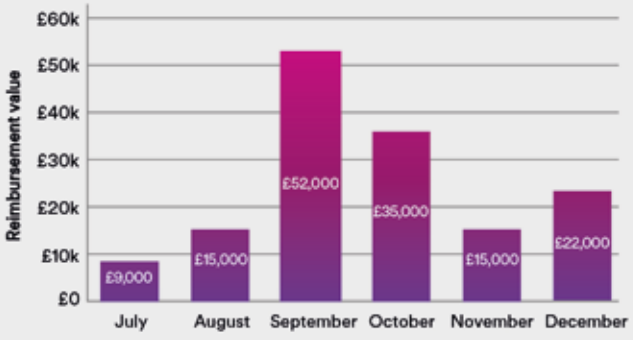
The new modules have led to improved accuracy and quality of data for both internal and external use.

Increased capacity for audit

The introduction of the new modules has meant that all coded data can now be audited internally using existing resources.

Development of people skills

DQA has allowed the existing team to optimise its efficiency and initiate a cycle of continuous learning and development.



First six months all saw improved reimbursement results, with £52,000 generated in September 2015 alone. Data on file with the Trust's Clinical Coding Department 2015.

"Twice-weekly running of DQA means that the coding team has immediate feedback, in more detail. Our month-end checks are fewer and completed nearer to the time of coding, meaning that we are able to quickly correct errors and feed back to the coders."

Clinical Coding Manager

For more information on the 3M DQA Solution:
Freephone **0800 626578** or email **help.his.uk@3M.com** or visit **www.3M.co.uk/his**

Financial results were produced by processing six month's data and amending codes, i.e. using a more specific code and also adding codes where DQA highlighted a potential error and on further investigation where extra codes could be added. Data on file 3M and Medicode are trademarks of the 3M company. J432824.

future vision

The NHS is getting more funding and will need to find new efficiencies. But could Lord Darzi (pictured) offer a framework for the next stage of NHS transformation, asks Seamus Ward

Robots in radiology. AI in A&E. A bot by your bedside. It's a favourite trope of science fiction that advanced machines will take over some of the services currently delivered by health and care professionals. But, looking at the needs of health and social care over the next 12 years, respected clinician Ara Darzi believes such significant technological advances should not remain in the realms of the imagination.

Of course, robots are already a feature of some hospitals – in urology and cardiothoracic surgery as well as pharmacies, for example – but Lord Darzi wants the NHS to make huge strides to increase efficiency and reduce unnecessary variation.

Although the NHS in England will be receiving an extra £20bn in real terms by 2023/24, it will also have to continue to increase its productivity. And, as part of a 10-point plan for reform and investment, Lord Darzi, a former Labour health minister, offers a vision for a technological NHS.

His final report on health and care to 2030, *Better health and care for all*, sees significant untapped potential for automation in the NHS. The report was commissioned by the Institute for Public Policy Research and its analysis shows a potential productivity improvement of £12.5bn a year – around 10% of the current NHS budget in England (see table overleaf). In social care, the productivity opportunity amounts to £6bn.

Echoing Nye Bevan's famous quote on the health service, Lord Darzi says: 'In the 21st century NHS, it might not be the sound of a bedpan dropping that is heard in Whitehall, but that of a robot picking it up.'

The report, put together with a panel of politicians from all three major parties and clinicians, says that unlike other industries, automation in health and care has the potential to complement human skills and talents, rather than replace them. It speculates on some of the new automated roles – bedside robots could help patients with meals and mobilisation (portering), while AI assessment suites could carry out a digital first triage of patients.

Perhaps more likely in the short term is the suggestion that

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automation could reduce administrative tasks, such as sharing medical notes, booking appointments and processing prescriptions.

Diagnostics has significant potential for improvements in productivity, the report says. There is evidence that artificial intelligence-based systems could improve the accuracy of diagnosis in radiology (X-rays, CT scans and MRIs), for example. Equally, research has shown positive results in diagnosing conditions such as pneumonia, breast and skin cancers, eye diseases and heart conditions.

> **"In the 21st century NHS, it might not be the sound of a bedpan dropping that is heard in Whitehall, but that of a robot picking it up"**
> **Lord Darzi**

There would be barriers to overcome, such as redesigning pathways, retraining staff and a lack of investment in the technological infrastructure. But the report insists the opportunity is too good to miss, recommending that a 'sizeable' amount of a new transformation fund should be dedicated to removing these barriers.

Some commentators have criticised the methodology used by the report to calculate the savings – though they accept there will be some savings, they doubt it will be of the same magnitude reported.

They add that using new technologies such as AI could be costly – for instance, the NHS may need to build up robust datasets to produce reliable algorithms that will deliver the right care at the right time. There are also questions about information sharing and whether personally identifiable data will be needed.

While the potential for automation to produce savings and improve the patient experience caught the eye, it was only one point in Lord Darzi's 10-point plan to secure the future of health and social care. As well as increasing automation, the report insists the government must invest in health – by embracing health in all government departments and 'getting serious' about tackling obesity, smoking and alcohol consumption.

Published ahead of the government's funding announcement, the report says the NHS needs a long-term funding settlement – ending the 'feast or famine' cycle of funding by returning the NHS to its long-term growth trajectory of around 4% in real terms. It recommends paying for it by ringfencing National Insurance increases.

In his interim report, published in April, he called for additional investment of at least an extra £50bn for the NHS (returning to the long-term funding trajectory) and £10bn for social care by 2030. To an extent, the government has started to address the points on investment with its announcement that NHS spending will rise by £20bn in real terms by 2023/24. However, it is short of the long-term trajectory, averaging 3.4% in real terms and applying only to NHS England funding and not the Department of Health and Social Care budget as a whole.

The government is unlikely to divulge its thinking on social care funding until later this year – a green paper that was due to be published in June or July has now been postponed until November and will likely be published alongside the NHS long-term plan.

Even if his £50bn NHS requirement is met, Lord Darzi believes radical reform will be needed to improve productivity – hence his insistence on a rapid expansion is the use of cutting-edge robotics.

In addition to the tilt towards tech, investing in health and long-term funding, the other points in the reform and investment plan are:

- **Unlock the potential for health to drive wealth** – significantly increasing research and development spending (from 1.7% of GDP to 2.6% over five years) to boost economic growth and giving the National Institute for Health and Care Excellence a remit over all medicines and devices
- **Make social care free at the point of need** – fully funding the service as part of a new social contract. Initially, free care would apply to those with the greatest needs, but it could be extended to others in time.
- **Establish a new deal for general practice, community and mental health services** – creating a new option for integrated care trusts (ICTs) providing out-of-hospital services and shifting funds and power away from acute care by increasing the proportion of funding that goes to primary, community and mental health services each year. ICTs would be allowed to take on whole care capitated budgets for population groups.
- **A radical simplification of the system** – joining up all the arm's length bodies, including NHS England, NHS Improvement and Health Education England into a single body – NHS Headquarters – with commissioning functions handled at regional level by between five and 10 health and care authorities. Clinical commissioning groups, NHS England local area teams and NHS Improvement regional offices would be abolished.
- **Revitalise quality as the organising principle of health and care** – creating a coherent strategy for health and care, overseen by a relaunched National Quality Board.

Potential productivity improvement from automation

Position	Potential time freed up for care and value-added activities (%)	Value of time released (£m)
HCHS doctors	23	1,563
Nurses and health visitors	29	2,605
Midwives	11	80
Ambulance staff	35	196
Scientific, therapeutic and technical staff	25	1,193
Support to clinical staff	57	3,433
NHS infrastructure support	30	1,567
GPs	31	962
GP support	53	880
Total		**12,479**

Source: Better health and care for all/IPPR analysis of McKinsey and NHS Digital research

Landmark reports in the NHS

The NHS in England has seen several landmark reports on its future since the turn of the century.

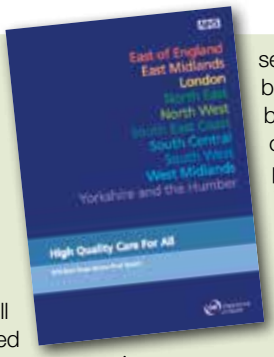
2002: the Wanless review
Former banker Derek Wanless assessed the funding needs of the NHS over the next 20 years, given the growth in public expectation and an ageing population. In his final report in 2002, Mr Wanless set out a vision for NHS needs over the next 20 years under three scenarios:

- Slow uptake – no change in public engagement and the NHS has low productivity. An annual budget of £184bn would be needed by 2022/23
- Solid progress – a more responsive NHS with higher rates of technology uptake and people more engaged in their health. NHS spending of £161bn a year would be needed
- Fully engaged – where public engagement is high, use of resources is more efficient and the NHS is responsive with high rates of technology uptake. An annual budget of £154bn would be required.

Under the new plans, NHS spending will rise to £149bn in 2023/24.

2008: High quality care for all
Lord Darzi published the final report of the clinically led *NHS next stage review*. Marking the 60th anniversary of the NHS, it was commissioned by the Department of Health. Like Wanless, it set out the societal challenges facing the NHS and emphasised the need to prevent ill health. Recommendations included giving patients a right to choose, personal health budgets and the development of best practice tariffs – all still evident in NHS policy today.

Lord Darzi's report was overshadowed by a row over polyclinics – a network of local clinics providing integrated and enhanced services he had proposed in an earlier report on London's health services. Objections ranged from patients worrying the traditional doctor-patient relationship would be destroyed to claims polyclinics were nothing short of privatisation. In the end, *High quality care for all* suggested GP-led health centres and did not refer to polyclinics.



2014: NHS five-year forward view
This set out a vision of a more integrated service, breaking down the barriers within the NHS and between health and social care. It called for better prevention, saying the Wanless warnings on the costs of ill-health had not been heeded. New care models were outlined, including multispecialty community providers (MCPs) and primary and acute care systems (PACS). It promised a redesign of urgent and emergency care and 'meaningful local flexibility' in payment rules and regulation.

The gap between demand and funding would be around £30bn by 2020/21, but following the subsequent spending review and increased funding, it was estimated at £22bn. This gap has fluctuated over the following years due to increases in funding and demand to the point where it is now rarely mentioned.

Late year's *Next steps on the five-year forward view* built on the original document. It focused on efficiency and integration – by establishing sustainability and transformation partnerships and local accountable care systems.

- **Invest in the talent of the team** – ensuring adequate staffing by creating an integrated skills and immigration policy and offering fair pay across health and care. The government has indicated the cap on immigration for senior skilled workers will be lifted, as recommended in the report. A workforce strategy – which is in the pipeline – is needed
- **Provide time and resources to transform health and care** – setting out a fully funded transformation fund, including capital funding, of 2% of NHS spend. This should be in addition to the core funding settlement for health and social care.

The report labels the cost of private finance initiatives 'a serious legacy problem'. Though trusts' PFI payments average 5% of provider income, some are paying up to 16%. To equalise the cost of capital across the NHS, it recommends pooling total capital costs, with each trust charged a uniform rate as a percentage of capital employed.

In the foreword to the report, Lord Darzi and former Conservative health minister Lord Prior insist that a properly funded NHS is the foundation of a fair, cohesive and inclusive society.

'We call for greater public investment: a long-term settlement that returns the NHS to its historic rate of funding growth. In return, we propose a simplified, reformed and improved service. This means embracing 21st century technology, joining up health and care around the individual, and freeing up staff on the frontline to care.'

They add: 'Our plan for investment is also a plan for reform. High-quality health and social care is a moving target; to stand still is to fall back. In this year of anniversaries, we must embrace and accelerate change to capture all the possibilities of the decades that lie ahead.'

Saffron Cordery, the deputy chief executive of NHS Providers, welcomes the report. 'It is right to emphasise the need for clarity over long-term funding. It is also important to ensure there is sufficient time and resources set aside to facilitate the transformation of services, so they can adapt to the changing needs of the communities they serve. And we agree that quality of care should be the organising principle for health and care. We would do well to hold fast to these principles as we shape services to meet future challenges.'

Niall Dickson, chief executive of the NHS Confederation, believes health and social care has reached a watershed moment. 'Lord Darzi is right to identify significant action is absolutely essential for social care. An Ipsos Mori poll we commissioned recently suggested 82% of the British public backed a spending uplift in this sector,' he says.

'Similarly, we agree systems need to be simplified, locally led and patient-centred with care shifted away from hospitals and into the community. There needs to be more investment in primary care. The new long-term funding deal announced by the prime minister simply will not work if we carry on doing the same things in the same ways.'

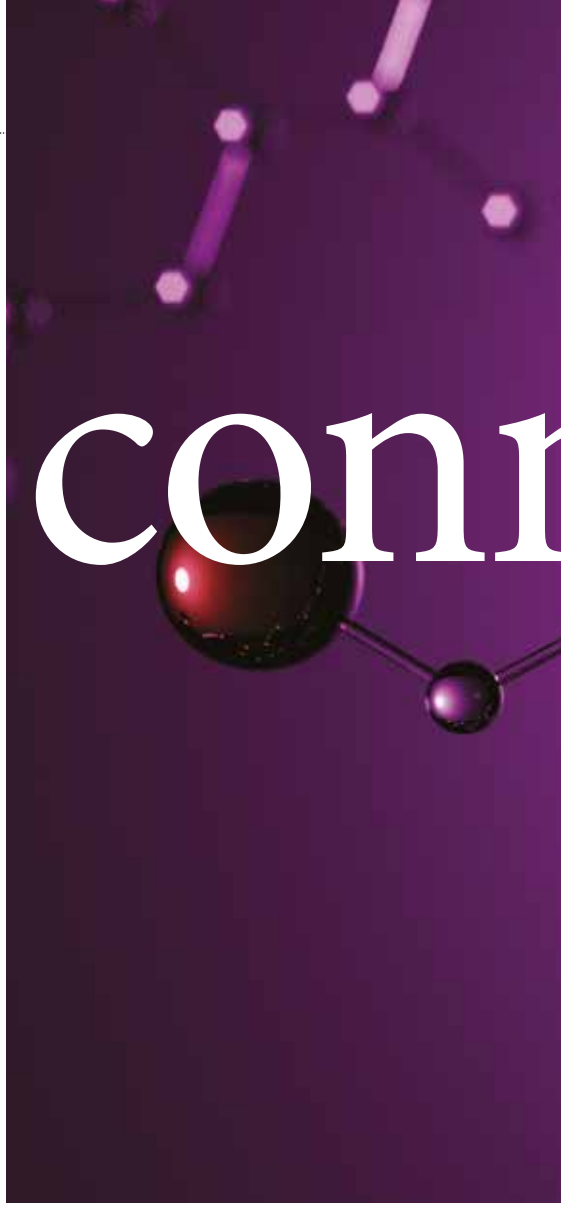
The final report also includes a 10-point offer to the public, setting out what health and care services could provide if the investment and reform plan is adopted. For instance, there would be a promise of free personal and nursing care; fast and convenient access to primary care; shorter waiting times, with no trolley waits and no cancelled operations; and enough nurses and doctors in hospitals and GP surgeries.

Some of the report's ideas may seem fanciful or some way off – robot carers, for example – but some parts of the NHS are already reaping the productivity and efficiency benefits of automation.

And Lord Darzi is in a position to bring forward some of this agenda. After the report was released, he was appointed chair of the Department of Health and Social Care's Accelerated Access Collaborative. This will seek to ensure innovations, including medical and diagnostic devices and digital products, are adopted quickly by the NHS.

The report may have been overshadowed by the government's five-year funding announcement, but it may be seen as a good starting point as the NHS prepares its long-term strategic plan.

Making the right conn



Nottinghamshire has been on a journey towards integrated care for years and has won fans in high places. Steve Brown reports on work to date and plans to learn the lessons so far in spreading the approach across the whole county and all services

Partners working collaboratively across Nottingham and Nottinghamshire Sustainability and Transformation Partnership (STP) have made some major strides forward in creating an integrated care system over the last few years. They have implemented new models of care, made some initial forays into using capitated budgets and done more thinking than most about the infrastructure and framework needed to make integrated care a reality.

Prime minister Theresa May highlighted the work in mid-Nottinghamshire in particular as an existing example of the 'NHS we want to build for tomorrow' when she announced details of the increased funding for the NHS from 2019 in her speech in the middle of June (see page 3). But rather than build on successes in a piecemeal, service-by-service way, the STP is now keen to explore how it can learn the lessons from its journey so far and implement a whole system approach to transformation across the whole county.

The STP covers a population of just over one million and has a collective health spend of some £3bn. Its 'do nothing' gap across the whole STP was £473m by 2020/21 – with a further £155m if you add in a social care shortfall. As with the rest of the country, more collaboration and system working is seen as the solution to some of this gap – although Nottinghamshire has arguably been at it longer than many other systems.

With six clinical commissioning groups, two acutes and an integrated mental health and community provider – and eight local authorities – the county has been exploring opportunities to collaborate and transform services since the formation of clinical commissioning groups in 2013. Its enthusiasm for transformation is reflected in the fact that it provided five vanguards out of the 50 selected by NHS England to pilot new ways of working following the *Five-year forward view*.

Recognising its existing work in this area, last year it was unveiled as one of eight new accountable care systems (subsequently rebadged as integrated care systems) that would pioneer a more formal approach to system-wide collaboration.

At the time of the announcement, NHS England said the initial focus would be on Greater Nottingham – one of two distinct delivery units alongside mid-Nottinghamshire.

But Marcus Pratt, programme director for finance and system efficiencies for the STP, says the clear aim now is to see the whole county as a single integrated care system and to reduce the delineation between the two.

It is in discussion with NHS England about this. It is also starting to get a bit more clarity about the different roles of the different players within the system.

STPs have been set up as partnerships of commissioners and providers and the future is definitely about much closer working. The ICS – evolving from the STP – will undertake strategic system planning, commissioning and oversight, aligning with the King's Fund's view of ICS functions.

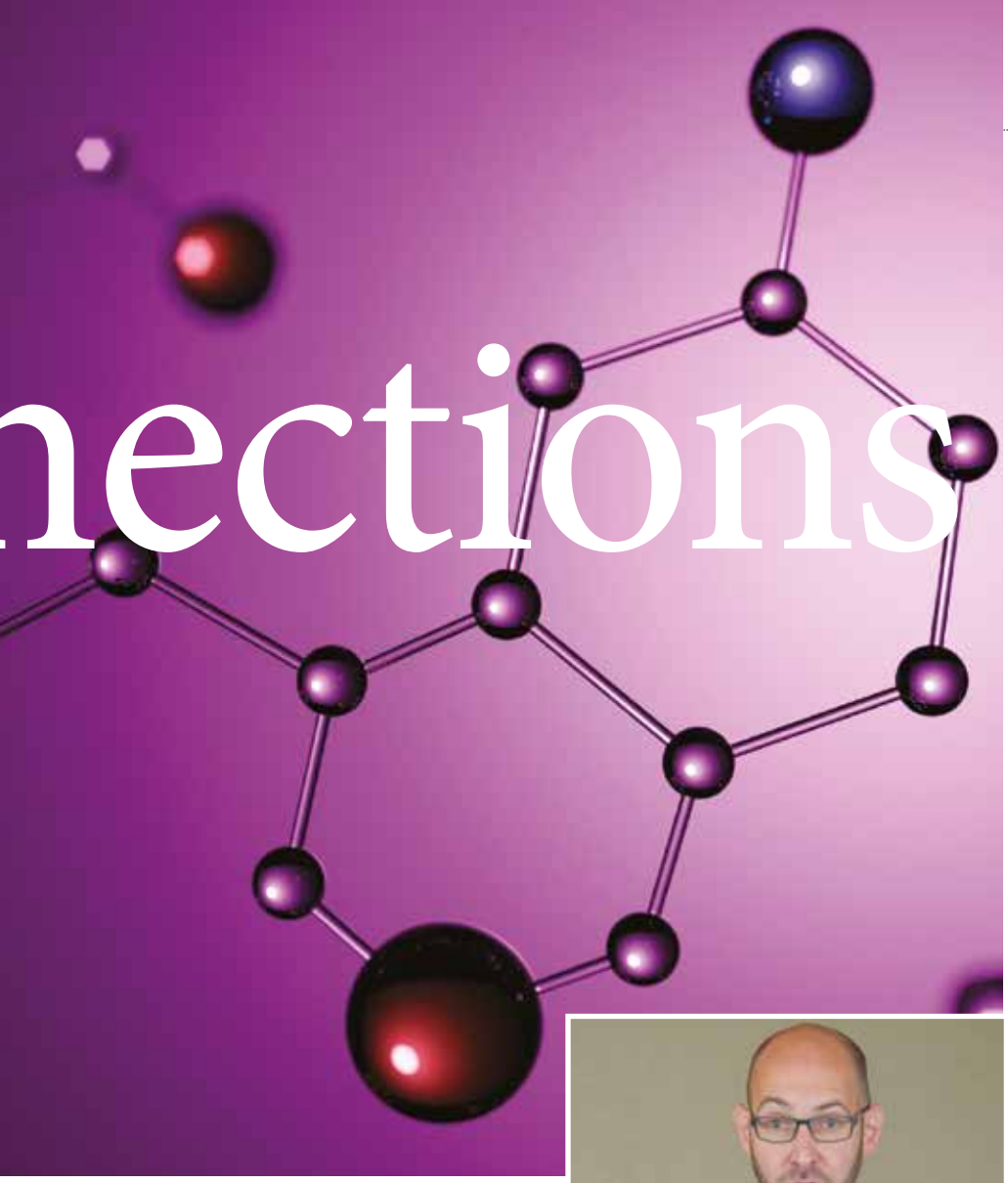
The King's Fund also talks about integrated care partnerships as alliances of providers collaborating to deliver care that meets the requirements specified by the ICS. In Nottinghamshire, the STP contains two collaborative partnerships, made up of NHS and local government organisations, focused on delivery of the strategic objectives – mid-Nottinghamshire and Greater Nottingham, each built around separate vanguard programmes.

Tactical moves

Nationally there has been some discussion about how the move to integrated care could see commissioning roles split with some 'tactical' commissioning functions – particularly around supply chain management and co-ordination – moving within integrated care organisations or provider alliances.

There is a common goal of delivering the best possible outcomes and best value for money, but Mr Pratt says the STP is 'currently defining the roles and responsibilities of the ICS and the delivery units that sit within it'.

To an extent, the ICS may be interested in setting outcomes that address the specific



nections

needs and priorities of its population. The provider partnerships would decide the best way of delivering those outcomes, integrating to meet these requirements.

Mr Pratt says it is feasible that the provider partnerships could implement services to meet local requirements, although the overall standards and outcome measures will be the same across the whole area. But there will be cases where the ICS will want to be more specific. 'It might specify a standard pathway across the whole area, so the design will have to sit at the ICS level,' he says, although in reality he suggests it may need to be done by providers and commissioners working together.

Nationally, there is an expectation that some of the roles currently undertaken by commissioners – particularly those related to more transactional activities– are likely to move inside ICPs or provider alliances, where different contracts and sub-contracts will fix the preferred pathway in place.

This inevitably would leave smaller commissioning organisations, which are then likely to come together – in partnership or more formal arrangements – providing a strategic commissioning function that can look across the whole population and take a longer term view (see box overleaf).

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"We saw some quick wins initially but then we started noticing a spike in non-elective admissions… Some people were getting stuck in primary care"

Marcus Pratt, Nottingham and Nottinghamshire STP

CCGs in Nottinghamshire are already working very closely together. There are shared management arrangements across the two CCGs in mid-Nottinghamshire and also across the four Greater Nottingham CCGs, which also have a joint commissioning committee.

Mid-Nottinghamshire's transformation journey has been under the banner of its *Better together* programme, which started in 2013 and gained vanguard status in 2015. The programme initially identified four key areas of focus, similar to many areas around the country – urgent and proactive care; planned care; women and children's care; and community and mental health services.

It has had some good success with a clinical navigation system – a manned, IT-supported service to help clinicians refer patients to the most appropriate service rather than automatically referring to secondary care. It has won plaudits for its single front door to A&E, with a single triage service directing patients into a primary care or full A&E service – seen as an interim measure until other measures deflect the activity that would be better handled in a different setting.

And it has also reduced admissions from care homes by improving the advice and support provided to homes, particularly around prescribing and administering of drugs.

Prism service

Perhaps its most high-profile transformation project has been with the use of risk profiling, multidisciplinary teams and virtual wards to support the top 2% of the population most at risk of hospital admissions. Its Prism service, in operation in the mid-Nottinghamshire area for more than five years, has helped to offset growth in avoidable admissions. Over a five-year period from 2012/13 to 2017/18, mid Nottinghamshire saw an absolute increase of

3% in non-elective admissions compared to an all-England average of 14%.

'We saw some quick wins initially but then we started noticing a spike in non-elective admissions,' says Mr Pratt. 'We realised that as it became business as usual, some people were getting stuck in primary care.'

Rather than being within the Prism service for a finite duration, people were simply staying there, reducing the capacity for new patients, who then entered the system via more traditional routes. However, commissioners and providers worked together to re-specify the service and maximise its efficiency and effectiveness.

Also of note has been a new musculoskeletal service, with a dedicated consultant-supported but physiotherapy-led triage service massively reducing the number of patients being seen in specialist outpatient clinics. Once fully operational some 13,000 patients would be expected to go through the triage service each year. The costs involve an investment in physiotherapists to deliver the triage service and to accommodate the transfer of a small number of patients who would previously have been on a surgical pathway. But there was an expectation of a 25% reduction in outpatient activity and an initial 5% reduction in inpatients (rising to 15% by year 3).

The service has been running for just over a year and Mr Pratt says it delivered its target in financial terms. 'But it came in a slightly different way to expectations,' he says. Overall inpatient activity reduced by more than expected, while the outpatient reduction was not as high as hoped.

Overall savings were £2m in 2017/18, which was seen as a good result. However, more is expected of the service in 2018/19, when the system hopes to deliver a further £2.5m on top of the 2017/18 savings.

Logistical approach

In Greater Nottingham, the focus has been more on understanding the logistics of setting up a shared health and care system. This has been supported by international experts Centene and Ribera Salud, which have significant experience of integrated care models across the US and in Spain.

An actuarial analysis, which benchmarked Greater Nottingham activity and cost compared to international 'well managed' integrated care systems confirmed a significant value opportunity. This has been the starting point for decisions to be informed by patient/population and system value rather than organisational benefit.

The emerging design solution to achieve the value opportunity provides a totally new approach. This involves:

- Flow of consistent data
- Application of new analytical capability
- In-built monitoring and oversight
- Continual improvement processes
- Freedom to act and invest where change is required
- Agreed outcomes
- Strengthened accountabilities.

Together, Mr Pratt says this makes the whole model far greater than the sum of its parts. 'It embeds best practice into the whole system aligning all providers in their ability to achieve their roles and responsibilities within a well-managed system,' he says.

Early impact and benefit is already being realised. For example, the establishment of a new integrated discharge function has resulted in an increased number of weekly supported discharges from the acute sector (240 compared with 180 per week). And the locally

Search for a commissioning strategy?

An open and honest conversation about the future of commissioning. That's what NHS Confederation chief executive Niall Dickson told delegates was needed at the membership body's conference in June.

Discussion about the future of commissioning has been relatively quiet in the move to creating integrated care systems (ICSs). There has been a crystallising of thinking on the provider side – with integrated care partnerships (ICPs) or integrated provider groups (IPGs) expected to lead within ICSs on care delivery. But less has been said about what commissioning might look like.

Given that NHS England chief executive Simon Stevens once described the introduction of ICSs (or accountable care systems as they were previously) as effectively 'ending the purchaser-provider split', some could be forgiven for wondering about the future of commissioning bodies.

In fact, views have already developed. The confederation – informed by NHS Clinical Commissioners – believes we will see the development of strategic commissioning, operating at a bigger scale to clinical commissioning groups and bringing in local government. 'We believe it would be a mistake to return to a closed system of allocations without significant local accountability for provision,' Mr Dickson told delegates.

NHS Clinical Commissioners' *Making strategic commissioning work* report says these reformed commissioners would provide: system-wide leadership and service planning across a defined area; understand the requirements of populations; monitor system performance; redesign system architecture; and reposition services to better meet local needs. The focus is delivering improvements over the longer term and across a wider area.

There would also be a need for more tactical commissioning – focused on transactional activities and individual relationships with providers. NHS Clinical Commissioners says the consensus is that the tactical end of commissioning would reside in an integrated care organisation. It has called for clarification on the future movement of commissioning functions.

This configuration also fits with an emerging central view. It is clear system leaders want to be able to focus on larger systems in terms of setting control totals and linking to sustainability funds. But it recognises that the energy and relationships for driving integration exist at levels covering smaller footprints, often aligning with local authority boundaries.

Julie Das-Thompson, head of policy and delivery at NHS Clinical Commissioners, believes the STP evolving into the strategic commissioner would be 'sensible', as it could hold the ICP or provider alliance to account for the delivery of local services for its population. 'This strategic commissioner could be a single body in the end, but for now it could be done through a collaboration of CCGs,' she says.

Moving to a single body with different functions could require legislative change, which prime minister Theresa May has said the government is willing to consider. This would be needed to 'allow some flexibility in the procurement and competition rules and the delegation of some commissioning functions'.

named F12 project has established best practice referral templates built into primary care clinical systems. This is resulting in reduced clinical variation and making everyday tasks easier and more efficient.

Mr Pratt says the Greater Nottingham work, which also includes aligned payment and incentive mechanisms, will inform further work across the system. For example, the Prism model could arguably be rolled out across the whole of Nottinghamshire. However, there is a similar model operated by the Greater Nottingham CCGs and the system is keen to have a consistent approach. 'Informed by the work from Centene, we'll look at both models to come up with a best practice standardised approach to delivery,' he says.

The advice on payments and incentives will also be helpful. The system has done some detailed work on capitated budgets (*see Healthcare Finance July 2016 and July 2017*). But last October it moved from theory to practice by launching a capitated budget to support the MSK work in mid-Nottinghamshire.

This involved a mechanism to share risks and rewards across commissioners and providers – something that is likely to be needed alongside any future capitated budgets used as part of integrated care systems.

"We want to learn the lessons and implement a whole system model with a single budget across all services, possibly differentiating between emergency and elective care"

Marcus Pratt, Nottingham and Nottinghamshire STP

This work involves setting a budget informed by current levels of spend, adjusted for planned and expected activity changes and for stranded costs. There is also a risk share arrangement involving marginal rates and a system risk/reward pool.

It is complex, but attempts to assign risk relative to the amount of influence different organisations have over the drivers of that risk.

While this approach continues to be developed in 2018/19, there has been no rush to expand the approach across other service areas at this point. In part, this is so any future approach can reflect the recommendations emerging from the Centene work.

Mr Pratt says that the system is also keen to avoid a piecemeal expansion. 'We want to learn the lessons and implement a whole system model with a single budget across all services, possibly differentiating between emergency and elective care,' he says.

The priority at the moment, particularly in an environment of such limited finances, is to ensure the system as a whole is as efficient as possible rather than move faster with revised payment systems. There are other ways to move money around the system.

'As all STP partners are working to reduce costs across the system, the acute-focused payment by results isn't helpful in some areas but it is not a huge barrier to transformation at this point in our journey,' he says, although new payment mechanisms will be needed in the medium term.

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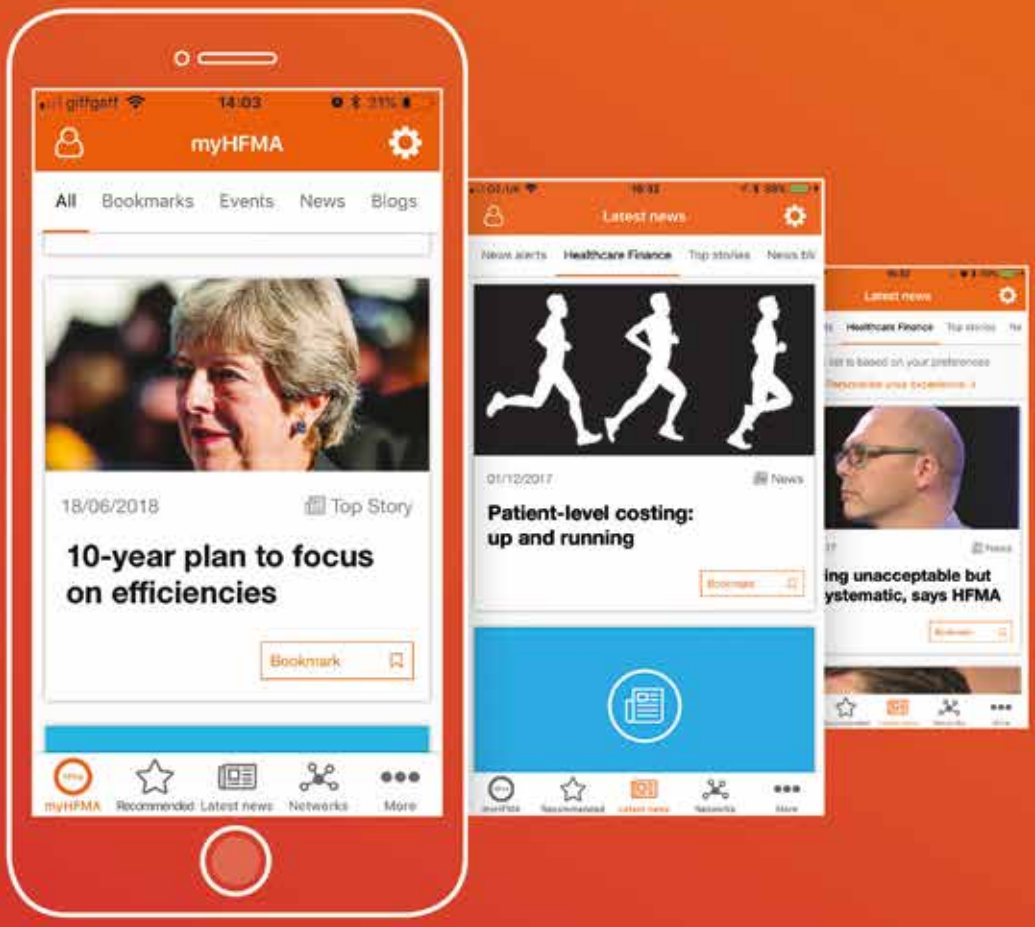

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Next steps

FFF has updated its workstreams to help it meet the Finance Leadership Council's new objectives. Seamus Ward reports

Future-Focused Finance (FFF) has become part of the everyday language of the NHS finance profession in England and, to an extent, some clinicians. But, with the Finance Leadership Council (FLC) recently extending the programme to 2022, and redeveloping its own strategy, the time is right to look again at FFF's aims and how these will be delivered.

The FLC set up FFF in 2014 to help provide NHS finance professionals and the NHS as a whole with the skills needed to help the service transform, deliver better value and recruit and retain staff.

With its 'Making people count' tagline, FFF gained ground quickly, particularly through its value makers – local champions of FFF's aims – publications and toolkits.

It set out four strengths typical of a modern finance professional, a decision-making framework, and a method for examining value in back-office functions. Many finance directors signed up to its aims through a finance director declaration.

Working closely, FFF, the HFMA and the Finance Skills Development network (FSD – now the Skills Development Network or SDN) used existing networks to grow. And in 2015 the three organisations established a foundation to secure the aims and objectives of FFF in the longer term.

The HFMA is the programme's prime strategic partner, contributing resources in the form of secretariat support and hosting FFF budgets and contracting.

Originally, FFF had six action areas: *Great place to work; Skills and strengths; Close partnering; Best possible value; Efficient processes and systems;* and *Foundations for sustained improvement*.

The extension of the programme prompted senior responsible officers (SROs) to review their action areas, leading to refreshed themes. Perhaps more importantly, there was a desire for the foundation to play a more active role in the development of FFF and ensure that FFF and SDN were working much more closely to deliver the FLC's requirements. Currently there are no plans to integrate FFF and SDN.

These requirements have been laid out in the FLC's new strategy, which outlines six objectives:

- Improve equality of access and diversity – giving equal access to all who have or are interested in a career in NHS finance
- Build resilience – across individuals, teams and the wider NHS finance function. This will also include talent management, including professionals at the mid-point of their careers, particularly where they are impacted by mergers or changing roles
- Measure consistently and provide evidence of function standards – including the roll-out of accreditation to ensure high standards in staff development, efficient transacting and working environment
- Commit function-wide to staff development – recognising that work must be done in some areas to ensure commitment to staff development is consistent nationally. FLC is committed to ensuring finance directors lead staff development, including developing finance skills in non-finance staff
- Grow talent and leaders – by developing networks for staff at all levels and underpinning this with tools showing different career routes and opportunities
- Drive value – by supporting finance departments to improve outcomes or reduce the use of resources in their local health economies. The finance function should also focus on patient care using value-based decision-making during system change and increased pressure.

These objectives have helped to shape the new FFF themes – essentially, this is a refresh rather than a reboot of FFF's work. The six action areas will now be replaced with five new themes.

Much of the work carried out in previous action areas will continue to be developed in the new themes, although *Foundations for sustained improvement* – an action area that covered programmes underpinning the work of FFF – has now been incorporated into the everyday work of the FFF team. The themes are:

Culture

Led by: Loretta Outhwaite, deputy chief officer, Isle of Wight CCG

In terms of the old FFF action areas, *Culture* comes closest to the *Great place to work* action area. However, as well as promoting a working environment where all staff can fulfil their potential, it also means building resilience in both individuals and the function as a whole. This means recognising that good performance is as much about wellbeing as technical ability and that good organisational culture is essential to the delivery of excellent patient care.

There are four workstreams, which will play a key part in achieving FFF's strategic aims in this theme:

- Diversity, led by Edward John, director of operational finance at Frimley Health NHS Foundation Trust, will focus on exploring, through 'safe-house' discussions, personal experiences in relation to equality and diversity, to inform the projects for the year.
- Accreditation, led by David Ellcock, FFF

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FFF opportunity

Ms Outhwaite plans to step down in the autumn from her FFF role, which she describes as 'incredibly positive, exciting and inspiring', so FFF is looking for a new finance leader to take the Culture theme forward. If you are a finance director/chief finance officer and would like to learn more about role, email lorettaouthwaite@nhs.net or david.ellcock@nhs.net

programme director, will continue to promote accreditation and supporting organisations through the process.

- Finance and clinical educators, led by AK Maheswaran, consultant anaesthetist at University Hospitals Leicester NHS Trust, and Value makers, led by Suzanne Robinson, director of finance, performance and digital at North Staffordshire Combined NHS Trust. This workstream will build on the success of their networks, to attract more members, hold frequent events and produce new animations to demystify more NHS finance topics.
- Wellbeing and resilience is a brand new FFF workstream, which will be established over the coming months.

Workforce and leadership

Led by: Claire Yarwood, chief finance officer, Manchester Health and Care Commissioning

'This workstream brings together programmes and tools to support talent development, create networks for development and support and most importantly identify skills and behaviours we will need for the workforce of the future and hopefully attract the brightest young people we can recruit,' Ms Yarwood says.

It is closely aligned with the previous *Skills and strengths* action area and includes workstreams such as the senior talent programme, career stories, the characteristics framework, positive psychology and promoting NHS finance careers.

'I am passionate about supporting the development of finance staff across the NHS and, in the future, social care,' says Ms Yarwood. 'I have grown through the system and been lucky enough to benefit from FSD courses, good mentors, coaches and sponsors and would not be in the position today without the support of senior finance directors over the years. It is absolutely critical in this time of shrinking resources and changing environments that we are able to recruit and keep the best staff possible and ensure that they have skills and experiences to improve services for patients and the population.'

She adds: 'I am really pleased to see staff who have worked for me previously develop and attain senior posts. I have loved the role of SRO for value makers, ensuring we are encouraging staff to network, develop relationships and share good practice.

'My career story has been useful to help others determine a career path, enable them to develop resilience or provide support in finding a new way forward. By sharing our stories others can see a way forward when perhaps career paths are not clear for them.'

Engagement and development

Led by: Simon Worthington, finance director, Leeds Teaching Hospitals NHS Trust

This theme shares a lot of elements of the *Close partnering* workstream – seeking to develop finance knowledge across organisations and not just for those working in NHS finance departments.

A number of programmes are included, such as the four strengths, finance for clinicians and mentoring and coaching.

'I am delighted to have the opportunity to lead the *Engagement and development* theme,' Mr Worthington says. 'It's very early days for me having only agreed to take this one recently but I am clear that:

- Clinical engagement and leadership on getting the best value for the NHS pound is absolutely vital. I will look to build on the great work that has gone before under the leadership of Sanjay Agrawal and AK Maheswaran, while working with AK and others to generate new ideas.
- All NHS finance staff round the country deserve access to the very best finance skills development. The more skills we have, the better we can support clinicians and managers to get the best value out of the NHS pound. I will want to encourage the best to be available for everyone.

'I will engage with as many people as possible on what we should be doing to help. I want to work closely with the value maker community in doing this. Most of all, I am sure this is going to be a lot of fun and rewarding,' Mr Worthington adds.

Efficiency and value

Led by: Adrian Snarr, director of financial control, NHS England

This theme will look at promoting better outcomes and more efficient use of resources in ways where achieving one does not compromise the other. It will look at shared services and where system-wide change can lead to benefits for all parties and better value for taxpayers.

Much of the work of the former *Best possible value* and *Efficient processes and systems* action areas will be incorporated into this theme. These action areas previously developed practical tools to ensure organisations as a whole and finance functions in particular delivered maximum value.

For example, *Best possible value* produced a decision-making tool to encourage value-based decision making. And *Efficient processes and systems* developed tools to benchmark the efficiency of an NHS organisation's financial systems.

It will include work on the Quality Service Improvement and Redesign programme, efficient transacting and process maps.

Adapting to system change

Led by: Caroline Clarke, group chief finance officer and deputy chief executive, Royal Free London NHS Foundation Trust, and Richard Alexander, chief financial officer, Imperial College Healthcare NHS Trust

This is a new theme and, although it is still early days, it could focus on ensuring the finance system can support emerging new care models and other system developments. It could, for example, look at costing whole care pathways and system-wide risk management.

According to the FFF strategy, the theme will challenge perceptions of what can be achieved, as well as the pace and scale at which it can be done. It will look at how other sectors fared in embracing innovation while maintaining continuity of services.

'This means reviewing change through the system lens, acknowledging the climate of financial deficit, to identify the right opportunities to deliver sustainable improvement even where this feels uncomfortable,' says FFF.

'This theme will be essential in identifying challenging objectives for delivery from 2020,' it adds.

getting the balance right

There is a clear ambition in the NHS in England to establish integrated care systems funded potentially using capitated budgets. Steve Brown looks at a new report examining how risk and reward sharing mechanisms could operate as part of this change

Accountable care organisations (ACOs) and accountable care systems (ACSs) in the NHS were remarketed earlier this year as integrated care organisations and systems (ICSs). This was in part to counter confusion with US-based ACOs and concerns that moves to integrate care would lead to US-style privatisation of NHS services.

The Commons Health and Social Care Committee has helpfully debunked this, which it is hoped will enable health systems around England to focus on more productive issues when engaging with their populations about integration plans.

But, while the comparison has not been helpful, there are some things the NHS can learn from US ACOs, set up in 2012 as part of President Obama's health reforms to improve care and reduce growing costs.

In particular, a new report from NHS consultancy the Strategy Unit – hosted by the Midlands and Lancashire Commissioning Support Unit – suggests there are lessons to learn from the US's experience with risk and reward sharing as part of payment approaches.

Risk and reward sharing for NHS integrated care systems (**hfma.to/76**) warns that while risk and reward sharing appears a simple and attractive concept, robust schemes are likely to be complex, require careful construction and should be tested and evaluated. The report focuses on mechanisms to allow commissioners share the risks of cost rises related to growing demand – and to reward providers where they help offset these demands.

There is a wide recognition that the NHS needs to change its models of care. Even with promised increased funding, a growing and ageing population with higher levels of long-term conditions means the service needs to focus more on prevention, earlier intervention and supporting people to manage their conditions better in the community.

Existing payment systems – using fee-for-service models or tariffs for acute services and block contracts for mental health and community activity – do not support this transformation. Instead, capitation-based models are seen as a better way forward. And the report suggests risk and reward sharing offers a transition to capitated contracts or could provide a longer term payment mechanism alongside capitated budgets.

In the US, 561 ACOs hold a contract with the Centers for Medicare and Medicaid Services – the US government funded health insurance programmes for elderly people and those with limited resources. Together, these ACOs serve 10.5 million patients, making them substantially smaller than the new and future ICSs in England, which have or are expected to evolve from the existing 44 sustainability and transformation partnerships.

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US ACOs' budgets are based on expected annual spend and they sign up to one of three risk sharing tracks. Track 1 is an extreme asymmetric or one-sided arrangement, which does not expose the ACO to any risk. If its priced activity exceeds expected levels, the commissioner pays at the unit price specified in the contract. But if savings are made, ACOs can receive up to 50% of the savings. However, while this encourages ACO sign-up to the programme, they can only be on this track for a maximum of two three-year contracts. In tracks 2 and 3, ACOs can benefit from a higher proportion of savings, but also share in losses associated with cost over-runs.

Performance against a series of quality measures also influences the level of savings or losses the ACO can share in. And there are overall capping levels for the savings that can be made as a proportion of total expenditure (10%, 20% and 30%) for the three tracks.

In January, some 91% of the ACOs on the shared savings programme were on track 1 (including a more recently introduced track 1 variant), with just eight ACOs (1%) on track 2 and 38 (7%) on track 3. The report authors argue that this implies a limited appetite for risk and that it provides an insight into the level of confidence that ACOs have in their ability to moderate cost growth.

According to the report, early NHS England guidance on possible payment approaches for ICSs (or ACOs, as it referred to them at the time) was considering risk and reward or gain and loss sharing in three specific cases: between commissioner and ICS; between providers within an ICS; and between commissioner, ICS and providers outside ICS. The report covers all three.

Impact analysis

Looking specifically at commissioner/ICS deals, the report provides basic illustrated examples of the impact of different contract types – fee for service, capitated and risk and reward sharing – on commissioner costs and provider income depending on actual levels of activity growth.

With risk share, it points out that the scale of the incentives to increase or decrease activity is dictated by both the sharing rate (proportion of the risk and reward that the provider is required to cover) and its marginal rate for delivering one additional unit of activity (as a proportion of the average cost). If these add up to 100%, then the provider has no incentive to increase or decrease activity. The commissioner's incentives are dictated only by the sharing rate.

Analysis of the US shared savings programme shows risk-reward schemes can become complex, with providers failing to anticipate some of the financial implications.

Even the calculation of the counterfactual – the estimate of the level of priced activity expected under normal circumstances – is far from straightforward. In the US, the process – made even more complicated by the existence of different insurance plans – uses weighted, casemix-adjusted price activity per head, calculated over three years. These can be adjusted to take account of prior-year performance to avoid an ACO being penalised in the year following a year of good performance.

Schemes also need to take account of high-cost patients, unforeseen disease outbreaks and other issues. Schemes operating between providers in an ICS and involving providers outside the ICS can add further layers of complexity. But the report is clear that the complexity is necessary. 'Simple schemes are unlikely to exhibit all of the characteristics [required],' it says. 'Robust schemes are likely to be complex and require careful construction.'

It also warns that risk-reward sharing is likely to increase transaction costs – at least in the intermediary stage of moving to capitated budgets. Asymmetric schemes, such as the US track 1 approach, might also involve some short-term cost increases.

The stand-out message is that, if this is the path for the NHS, it must invest in 'developing, testing and documenting the underpinning methods and process'. And it should evaluate the schemes as they are implemented.

Head of strategic analytics at The Strategy Unit Steven Wyatt says the briefing was aimed at provoking more discussion about changes to payment approaches. 'If the NHS is to make best use of risk and reward sharing, then it must be aware of the complexities and hazards inherent in these arrangements, as well as the potential benefits,' he says.

Commentators have been calling for a move to capitation-based funding arrangements. But to date, there have been few attempts to explore in detail what this might involve. The report makes a welcome starting point for a much needed detailed debate.

No easy task

Payment systems need to move towards rewarding outcomes rather than volume of activity, according to a recent report from PwC and the HFMA. *Making money work in the health and care system* argued that there should be a combination of contracting for outcomes and better joint accountability across the system. 'Potential funding mechanisms that could be considered by systems include a single, incentivised shared outcomes framework across all providers and the introduction of gain/risk share arrangements,' it says. However, it acknowledged that moving towards a meaningful gain/risk share arrangement was 'not an easy task'. If this was not done thoughtfully, it could have the potential to reduce integration, with poorly designed agreements leading to combative relationships between organisations. **hfma.to/money**

Aims and things to avoid

The report suggests risk and reward schemes should encourage ICSs to:

- **Reduce healthcare costs the right way.** It should not encourage ICSs to reduce costs by rationing or restricting access to cost-effective services, nor to reduce quality.
- **Plan and act ambitiously, but not recklessly.** Small incentives may not be sufficient to motivate an ICS to innovate and seek improvements. But if too large, then providers might act irresponsibly.
- **Plan thoroughly while acknowledging uncertainties.** An ICS needs to plan to accommodate a range of scenarios and there should be an expectation that this uncertainty is priced into contracts.
- **Accurately record activity.** Incentives should be used to encourage providers to record data accurately to enable commissioners to assess performance and develop future plans.
- **Collaborate and share information.** It should never be in an ICS provider's interests to withhold information from its partners.

However, ICSs should not be able to benefit from cost shunting (minimising costs at the expense of another organisation). The report argues that highly simplified schemes are likely to be ineffective. Schemes should be defined in sufficient detail and all the processes transparent – both to enable providers to review and to enable other ICSs to plan their own schemes.

hfma
professional lives
Events, people and support for finance practitioners

New standard calls on accountants to review financial instruments

Technical update

The phrase 'financial instruments' seems to make all but the most dedicated of technical accountants' hearts sink, *writes Debbie Paterson*. Related issues seem to sink to the bottom of any 'to do' list but, this year, it must be tackled again.

The reporting standard *IFRS 9 Financial instruments* is applicable to accounting periods starting on or after 1 January 2018. For NHS bodies, this means it is applicable in 2018/19. But, as expected, the standard is not applied in full, it is applied in accordance with the interpretations and adaptions set out in the Treasury's *Financial reporting manual* (FReM) and the Department of Health and Social Care's *Group accounting manual* (GAM).

The standard replaces *IAS 39* and there are two key changes to be aware of.

First, the classification of financial assets has changed. There are now only three classifications available:

- Amortised cost
- Fair value through other comprehensive income (OCI)
- Fair value through profit and loss.

To determine the appropriate classification, each financial asset must be reviewed to determine its contractual cash flow characteristics. Those arrangements with cash flows that are solely payments of principal and interest (the SPPI test) are either classified as amortised cost or fair value through OCI. This test is applied on an instrument-by-instrument basis.

Failing the SPPI test means the assets are classified as fair value through profit and loss – changes in value affect the bottom line. Examples include equity instruments; any instrument involving a derivative; and any instrument where the interest rate is linked to another characteristic such as EBITDA or income.

Provisions in contracts that could change the timing or amount of the contractual cash flows might result in the SPPI test being failed.

SHUTTERSTOCK

Most common financial assets in the NHS – trade receivables, straightforward loans (even interest-free ones) – will pass the SPPI test.

For those financial instruments that pass the SPPI test, a business model test is then applied to determine which classification each group of financial instruments falls into. The test is applied to groups of financial instruments because, while an organisation might only apply one business model, it could be that both models are in operation for different groups of asset.

Assets held simply to collect the interest and the principal are classified as amortised cost financial assets. This will include trade receivables and loans held to collect the interest.

Assets being held to collect and sell are classified as fair value through OCI. This would include loan books that are held to collect interest but that will also be sold on in the right circumstances.

As most NHS bodies classify their financial assets as amortised cost under IAS 39, it is unlikely that the classification will change. But any complicated arrangements will need to be reviewed under the new standard particularly as any new standard attracts auditor and regulator interest.

The second key change to accounting for financial instruments relates to impairment of debt instruments classified as amortised cost or fair value through OCI. Essentially, this is a move back towards the old 'bad debt provision'. The Treasury has mandated that a simplified approach is used in the public sector for trade receivables, contract assets and lease receivables – with an allowance recognised equal to the lifetime expected loss. Under IFRS 9, this allowance is recognised against all financial assets, including those that are not yet overdue. The GAM sets out an example calculation of expected credit losses for one year – the same calculation is used for a lifetime calculation, but the probabilities used are over the whole term of the financial asset.

For all other financial assets, a three-stage approach is applied. This means that the credit risk needs to be assessed at each reporting date to see if it has changed significantly since initial recognition. The stage applied will depend on the credit risk and instruments can move up and down the stages as the credit risk changes.

NHS bodies are not allowed to recognise any impairments against intra-DHSC balances as it is expected that they will be recoverable. Where there is objective evidence of impairment, NHS bodies are expected to consult with their regulatory body before writing off the debt or establishing an impairment allowance.

Debbie Paterson is HFMA policy and technical manager

Technical review

The past month's key technical developments

Technical roundup

NHS Improvement has published a proposed timetable for the **costing mandation** project. Using the 2016/17 reference cost submissions, the oversight body has identified each trust's main service and when it expects it will be required to submit patient-level costs for acute, community or mental health services. Designated acute trusts have been mandated to submit patient-level costs from 2018/19. Subject to mandation approval, if a trust's main service is mental health but it also provides community and acute services, its proposed first year for mental health costs will be 2019/20. Its acute services would also be submitted in 2019/20, with community to follow in 2020/21. It is proposed that a community health trust that also has some acute and mental health services would submit patient-level costs for all three services in 2020/21. Submissions for ambulance trusts would go ahead from 2019/20, according to the timetable. http://hfma.to/75

The HFMA has updated its briefing on the application of the international financial reporting standard *IFRS16 – Leases*. The **leasing standard** applies to NHS bodies from 2019/20 and will remove the distinction between operating and finance leases. The updated briefing reflects the recent Treasury exposure draft on the application of IFRS16 in the public sector and adds a second worked example. It warns application of IFRS16 will be time consuming and shows practical steps that can be taken now, as well as issues to be considered when applying the standard for the first time. http://hfma.to/73

The expanded **agency staff data collection** will begin on 25 July, NHS Improvement has announced (*see Sustained pressure, page 8*) The revised collection comes in the wake of changes to sign-off thresholds and steps to reduce agency costs for administrative staff. The first of the expanded weekly submissions will report data for the week commencing 16 July.

The Department of Health and Social Care must consider the impact of extending the right to **personal health budgets** on finance departments, according to the HFMA. Responding to the Department consultation on extending personal budgets beyond those in receipt of NHS continuing healthcare, the association's response said it broadly supports the proposals. However, it said the support staff requirements in clinical commissioning groups must be considered. Finance staff in mental health providers knew little about personal health budgets, and expansion plans must include these NHS organisations, the HFMA added. http://hfma.to/74

NHS Improvement has added a new imaging compartment to the **Model Hospital**. The tool is accessible by NHS staff and is organised in five lenses: board-level oversight; clinical service lines; operational; people; and patient services. Within each lens, there are a growing number of domain-specific compartments enabling users to drill down into wide-ranging performance metrics. In total there are now more than 1,500 metrics published within the Model Hospital based on 2016/17 data collection.

The HFMA has published an overview of **treasury and cash management** in the NHS. The briefing, trailed in the June issue of *Healthcare Finance*, looks at these areas across the NHS, examining treasury management in detail together with best practice in reporting treasury and cash management issues. It also considers the management of working capital and how NHS bodies can improve their cash flow. http://hfma.to/71

Hearing loss assessment proposals

NICE update

NICE has published a guideline (NG98) offering best practice advice on hearing loss in adults, *writes Nicola Bodey*. The NHS England *Action plan on hearing loss* identifies the need for improved early identification of hearing loss and early treatment.

Hearing loss affects over nine million adults in England. A *Hearing matters* paper from charity Action on Hearing Loss estimates that 5.6 million adults in England would benefit from having a hearing aid. Of these, an estimated three million adults in England already have one.

Some of the recommendations are likely to have a resource impact. This is particularly the case for recommendations affecting people with hearing difficulties presenting to healthcare professionals for the first time, who would not currently be referred to audiology services, and people in the general population who have hearing loss but have not previously been referred.

Where hearing difficulties are not caused by impacted wax and acute infections, patients should have an audiological assessment and be referred for additional diagnostic assessment if needed.

About 491,000 people are involved in such cases in England each year, and around 73% of them currently go on to have an assessment. Hearing aids will be recommended for just over half of the people having an assessment, and it is estimated that 85% of people will have a hearing aid for both ears. It is anticipated that the guideline will be implemented at a linear rate over the next five years, with an annual cost from year five onwards of £20.7m in England.

The resource impact for people with hearing loss but who have not previously been referred for a hearing assessment

Diary

July

5 B London: VAT focus group level 1, Rochester Row
5-6 N Convergence 2.0, East Midlands Conference Centre
11 B Kent, Surrey & Sussex: keep stepping, Crawley
20 B West Midlands: social care and public health briefing (half-day event)
25 B Kent, Surrey and Sussex: introduction to finance, Crawley

September

7 B Northern Ireland: patient/client focus, venue tbc
13/14 B South Central: annual conference, Reading
14 B West Midlands: STP briefing, Staffordshire/Stoke-on-Trent
18 I Institute: introduction to costing (South)
19 B Eastern: student conference, Cambridge
19 N CIPFA/HFMA health and social care finance conference
20 F Provider Finance: technical forum, preparing for IFRS16
20/21 B South West: annual conference, Bristol
25 N CEO forum, Rochester Row
27/28 B Wales: annual conference, Hensol
27 F Mental Health Finance: annual conference, London, Rochester Row

October

3 I International symposium
10 F Chair, Non-executive and Lay Member: forum, London, Rochester Row
9 I Institute: costing together (South)
12 B West Midlands: HPMA/HFMA joint event, Birmingham
12 B South Central: football tournament
12/13 B Kent, Surrey and Sussex: annual conference, Crawley
16 F Chair, Non-executive and Lay Member: operating game for new non-executives, London, Rochester Row
16 I Institute: costing together (North)
17 N Provider Finance: directors' forum, London, Rochester Row
18 N Charitable funds, London, Rochester Row
19 B Eastern: annual conference, Newmarket
25/26 B Scotland: annual conference, Glasgow

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

key B Branch N National F Faculty I Institute

is less certain. A resource impact report and template considers this. It is estimated that for every 10% uptake in the prevalent population, there would be a cost in England of around £10m across the implementation period.

Prices for hearing assessment and hearing aid provision are agreed at a local level and commissioners are advised to use the template to calculate local impact.

Services for people with hearing loss are commissioned by clinical commissioning groups. Providers are NHS hospital trusts, community providers and primary care.

• Guidance and templates can be found at https://www.nice.org.uk/guidance/ng98

Nicola Bodey is a senior business analyst at NICE

Events in focus

Brighter together: estates forum
13 November, London

The NHS must transform its services and how they are delivered over the coming years. While changes of this kind can lead to discussions on financial flows and staffing, it also means local services must rethink their estates provision. Last year the British Medical Association estimated that sustainability and transformation partnerships would require around £10bn to meet their estates plans. The government appears to have accepted that figure in its capital funding plans, with the money found from a mix of public and private funds, together with the proceeds of the sale of land and buildings no longer needed. STPs must develop an estates and capital plan that is in line with their transformation plans and strategies for financial sustainability.

To support NHS bodies and as part of his *Brighter together* presidential theme, HFMA president Alex Gild (pictured) has set up a series of free one-day events for members, including a forum on estates on 13 November. Members are encouraged to bring along an estates colleague (charged at £99 for non-members).

As well as examining strategic estates planning, the event will also look at managing backlog maintenance, the challenge of demonstrating value for money and manging the estate to maximise benefits to patients.

• For more information or to book a place, email josie.baskerville@hfma.org.uk

Mental Health Finance annual conference
27 September, London

Mental healthcare will be one of the key areas of the *10-year plan* being developed by the NHS in England. These services have been given increasing priority in recent years, including the policy of parity of esteem with physical healthcare, and the mental health funding standard. Like all parts of the NHS, mental healthcare faces a full agenda, including greater integration, prevention of mental ill health and patient-level costing.

This conference, entitled *Integrating mental health in new models of care,* will feature keynote speeches from Tim Kendall (pictured), NHS England and NHS Improvement national clinical director for mental health. Former health minister Paul Burstow, who is now a professor in mental health policy and trust chair, will provide the closing address.

• For more information or to book a place, email josie.baskerville@hfma.org.uk

Deal puts value in spotlight

Association view from Mark Knight, HFMA chief executive

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

My HFMA

The announcement of a sustained long-term funding deal took us all a little by surprise. The Saturday ahead of the announcement I was asked to attend a speech on Monday at a 'secret' location in north London and on Sunday it was released to the media.

As we commented at the time, the funding deal, while welcome, isn't quite what we wanted. The Institute for Fiscal Studies/NHS Confederation report had suggested an average 4% increase was needed above inflation over the next 15 years to enable services to modernise. And they also suggested this would need to be frontloaded with 5% increases for the first five years. Against this measure, 3.4% – and confined to just the NHS England budget – still leaves the NHS with significant challenges.

The naked politics of the whole thing looks pretty opportunistic, linking the funding to a Brexit dividend. And then there is the whole debate about how the increase will be paid for. We'll leave the politics to others, shall we? The reality is we'd have liked a bigger increase, but the system asked for more investment and it has it. It puts the service in a much better position than it was in and that has got to be good news.

The prime minister indicated there would be an increased focus on ensuring every penny of taxpayer's money is 'well spent'. This suggests a greater push with the value agenda and a reaffirmation of initiatives such as Carter, *Getting it right first time* and RightCare. Underpinning these will be the Costing Transformation Programme led by NHS Improvement and supported by our own Healthcare Costing for Value Institute.

The association has supported the push to get all NHS bodies costing at the patient-level for the best part of a decade. The work remains vital – better cost data means more informed local decision-making. Those involved in these efficiency initiatives are excited about the potential more granular cost data will deliver.

There is still a lot of work to do on costing, with key landmarks for the CTP over the next few years. But even once we've established a foundation of robust patient-level cost data, we need to embed the use of this data (alongside meaningful outcome data) in the week-to-week work of multidisciplinary teams – clinicians working with finance and managerial colleagues.

HFMA chief executive Mark Knight

The delivery of value is surely the overarching aim of the transformation agenda.

All these components are reflected in the themes set by the Institute: confident costing; translating data; driving value; and innovation.

The Institute is the association's forward agenda, not just concerned about healthcare today and tomorrow but long into the future. I'd like to thank all the organisational members of the group for their support, without which we would not be able to undertake this work.

Finally, I'd like to wish NHS England chief financial officer Paul Baumann well for his new role at Westminster Abbey. His analytical mind and good humour will be a loss to the NHS and a gain for the Church. I also congratulate past president Shahana Khan on her OBE (see page 32) – a great encouragement that the work of our finance leaders can be recognised in this way.

Member news

During its recent annual conference, the West Midlands Branch presented the following awards:

- Innovation of the Year Award – 'Excellence in e-rostering' at Sandwell and West Birmingham Hospitals NHS Trust
- Finance Team of the Year Award – North Staffordshire Combined Healthcare NHS Trust
- Lifetime Contribution Award – Kevin Stringer, chief financial officer at The Royal Wolverhampton NHS Trust
- Student Award – Mark Bailey, South Warwickshire NHS Foundation Trust

Stuart Wayment, finance skills development manager NHS South (East), completed a wing walk to fundraise for University Hospital Southampton NHS Foundation Trust's Planets cancer charity. He walked on the wing of a 70-year old Boeing Stearman with the support of aerobatics team The Flying Circus. Mr Wayment underwent major surgery in the hospital five years ago. You can support his cause at https://mydonate.bt.com/fundraisers/stuartwayment1

HFMA policy and research manager Sarah Day will walk 50 miles along the Western Front through France and Belgium in September to raise funds for the Royal British Legion and commemorate the centenary of the end of World War I. Ms Day is undertaking various activities in the lead-up to the walk, including a bake sale in the HFMA Bristol headquarters. If you would like to donate, please visit https://www.justgiving.com/fundraising/sarahs-western-front-trek

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Member benefits

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

Network focus

My HFMA

Mental Health Finance Faculty

'Across the cohort of mental health trusts it soon became clear that we resource our service teams with different staffing models; we use different job titles for members of staff who are effectively in the same roles; and we are commissioned to provide different services funded in different ways through a variety of different contracting models…So it is easy to see why real nationwide benchmarking is such a challenge.' So says Sarah Connery (pictured), director of finance and information at Lincolnshire Partnership NHS Trust, and member of the steering group of the HFMA Mental Health Finance Faculty.

Productivity and efficiency in mental healthcare and community services were recently reviewed by Lord Carter, who made 16 recommendations that could release up to £1bn a year. Ms Connery says she agrees with all of them.

Her trust was one of the 23 organisations that took part in Lord Carter's pilot. NHS Improvement gathered data from the trust, while encouraging it to try new initiatives that would improve productivity and accumulate savings.

One of those offered individual training for ward roster creators to improve the roster analyser reports. The team engaged staff that owed hours to the trust. Repayment of the hours was negotiated, which led to a 23% reduction in the costs of agency and bank staff in six months across two wards.

The Carter report for mental health and community services has been on the Mental Health Finance Faculty's agenda for 18 months. During its directors forum last May, Mrs Connery shared best practice from the pilot cohort. This was followed up by an NHS Improvement workshop at the annual mental health finance conference. 'The faculty is an excellent networking opportunity. It's great to hear about other systems across the country. It's a safe space to raise issues and it's good to hear what's going on elsewhere,' says Mrs Connery.

This year's mental health finance conference is on 27 September, featuring representatives from NHS England, NHS Improvement, service users and other healthcare finance professionals.

• To book a place or find out more about the faculty, visit **http://hfma.to/mentalhealth2018** or email **emily.bowers@hfma.org.uk**

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Appointments

Glen Burley (pictured) will become George Eliot Hospital NHS Trust's new chief executive. At the same time, he will continue to be chief executive at South Warwickshire NHS Foundation Trust and Wye Valley NHS Trust. Mr Burley began his NHS career in 1983 as a finance trainee and worked as a director of finance at South Warwickshire Mental Health Services NHS Trust. In his new position, he will be taking over from **Kath Kelly**, who will be retiring.

Colin McInnes is moving on from his post as Health Education England's head of finance (South) to become deputy director (finance) for the Commonwealth Games Delivery Unit for Birmingham 2022. Mr McInnes leaves the NHS after working for 23 years in the South West and South of England.

Barking, Havering and Redbridge University Hospitals NHS Trust has appointed **Chris Randall** to the position of interim assistant director of finance. Mr Randall was previously interim head of financial management at Essex Partnership University NHS Foundation Trust and chief finance officer at West Norfolk Clinical Commissioning Group. He brings to the role more than 30 years' experience in the finance sector, including working for private companies, the NHS and housing associations.

Howard Martin (pictured) is the new chief finance officer at West Norfolk Clinical Commissioning Group. He was previously deputy director of finance, contracting and performance at West Essex Clinical Commissioning Group. Mr Martin started his NHS career in 2003 as part of the National Finance Training Scheme and spent 11 years working in different roles at West Essex.

Keith Griffiths (pictured) has been appointed director of finance at University Hospitals of Morecambe Bay NHS Foundation Trust. Previously, he was interim director of finance at the trust and was appointed to the permanent role following a competitive selection process. Prior to joining the trust, Mr Griffiths was director of sustainability at East Lancashire Hospitals NHS Trust. He has worked as a director of finance in specialist and acute NHS providers across the north of England for more than 20 years. **Aaron Cummins**, the previous director of finance, is now its chief executive.

Get in touch
Have you moved job or been promoted? Do you have other news to share with fellow members? Send the details to seamus.ward@hfma.org.uk

"The HFMA is its people and I have had the honour to work with such a variety of folk with so many talents. I do see the HFMA as my extended family"
Shahana Khan OBE

Birthday honour for former HFMA president

On the move

Shahana Khan, the HFMA's president in 2015/16, was awarded an OBE in the Queen's Birthday Honours, for voluntary service to healthcare and social housing.

A former director of finance and performance at George Eliot Hospital NHS Trust, Ms Khan was the first black and minority ethnic chief finance officer of an acute trust in the UK. She also held a non-executive position at Accord Housing Association. Now, she is executive director of finance at Sidra Medicine in Qatar.

She is one of a number of current or former NHS finance directors to receive honours in recent years – there have also been OBEs for Tony Whitfield, Jane Tomkinson and Lorraine Bewes, and a CBE for Louise Shepherd.

On hearing of the honour, Ms Khan said: 'This was a real surprise for me and I feel over the moon to receive it. I have been reflecting on my journey and there are so many wonderful people who have been part of it, supporting and encouraging me along the way.'

Accord is a large housing association in the West Midlands, where Ms Khan held the role of vice chair and chair of its audit committee for almost eight years.

'I was asked to join by the chairman at the time, who was also a non-executive at Walsall Healthcare NHS Trust, where I was working as the CFO. I wanted to gain an understanding of how the housing sector worked as it has a direct impact on health – and as sectors we have tended to work in silos.

'I gained so much insight that I was able to use in both health and housing and I worked with some great people who really care about people. I tried to veer away from the finance arena and get exposed to other aspects of the business, but despite best efforts I ended up as chair of the audit committee!'

Ms Khan was an HFMA trustee for more than six years, including her year as president. She was also heavily involved in the West Midlands Branch, where she was branch chair and executive committee member.

'It is such a vibrant branch and a great way to network with people,' she said. 'I knew I could always pick up the phone or meet colleagues to discuss issues, share ideas and brainstorm.'

She continued: 'The HFMA has a special place in my heart. I'm so proud of its achievements and how it has gone from strength to strength, particularly under Mark Knight's leadership. The HFMA is its people and I have had the honour to work with such a variety of folk with so many talents. I do see the HFMA as my extended family; I have had the honour to get to know so many wonderful people, who have always been happy to provide support when required.'

HFMA chief executive Mark Knight commented: 'Shahana is a great example for aspiring finance leaders everywhere and I am delighted for her. She has made an enormous contribution to the work of the association, both at branch and national level, and this honour is well deserved.'

Looking from outside the system, but with recent knowledge of it, Ms Khan is confident the finance function will continue to provide solutions and increase productivity while service models and system architecture evolve.

'The finance function is the backbone of the NHS and has faced so many challenges during its history. We, as a profession, have always been the voice of reason and have always had to step up to whatever challenges have been thrown in our direction.

'I am confident that, with the talents of our people, we will continue to do so, providing innovative solutions to knotty problems.'

Future leader support

Future focused finance

Developing future finance leaders has been identified as a priority in the new Finance Leadership Council (FLC) strategy. In support, the HFMA, NHS Skills Development Network (SDN) and FFF have established a senior talent management programme to help staff gain the skills and development to further their careers.

The programme has a network for future leaders, designed for anyone who aspires to be a finance director/chief financial officer and is in a band 7 post or higher. It also has a finance leaders' network, for those

at band 8C and above who wish to develop their skills and strengthen their networks to help them move into their next role.

FFF will work with NHS Improvement, NHS England and the HFMA over the coming months to develop a programme for new-in-post FDs/CFOs, to support them during the initial phase of their new role.

As part of HFMA president Alex Gild's theme, *Brighter together,* FFF is supporting masterclasses that allow finance leaders in health and social care to meet, share experiences and develop their potential to lead sustainable system transformation.

David Ellcock (pictured), FFF programme director, said: 'We are delighted to be working with our SDN and HFMA colleagues to help finance staff develop themselves to be the best they can be in their chosen role.

If you would like to be involved in the development of these programmes, or join one of the future finance leaders' networks, visit **www.futurefocusedfinance.nhs.uk** or email **futurefocusedfinance@nhs.net**

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