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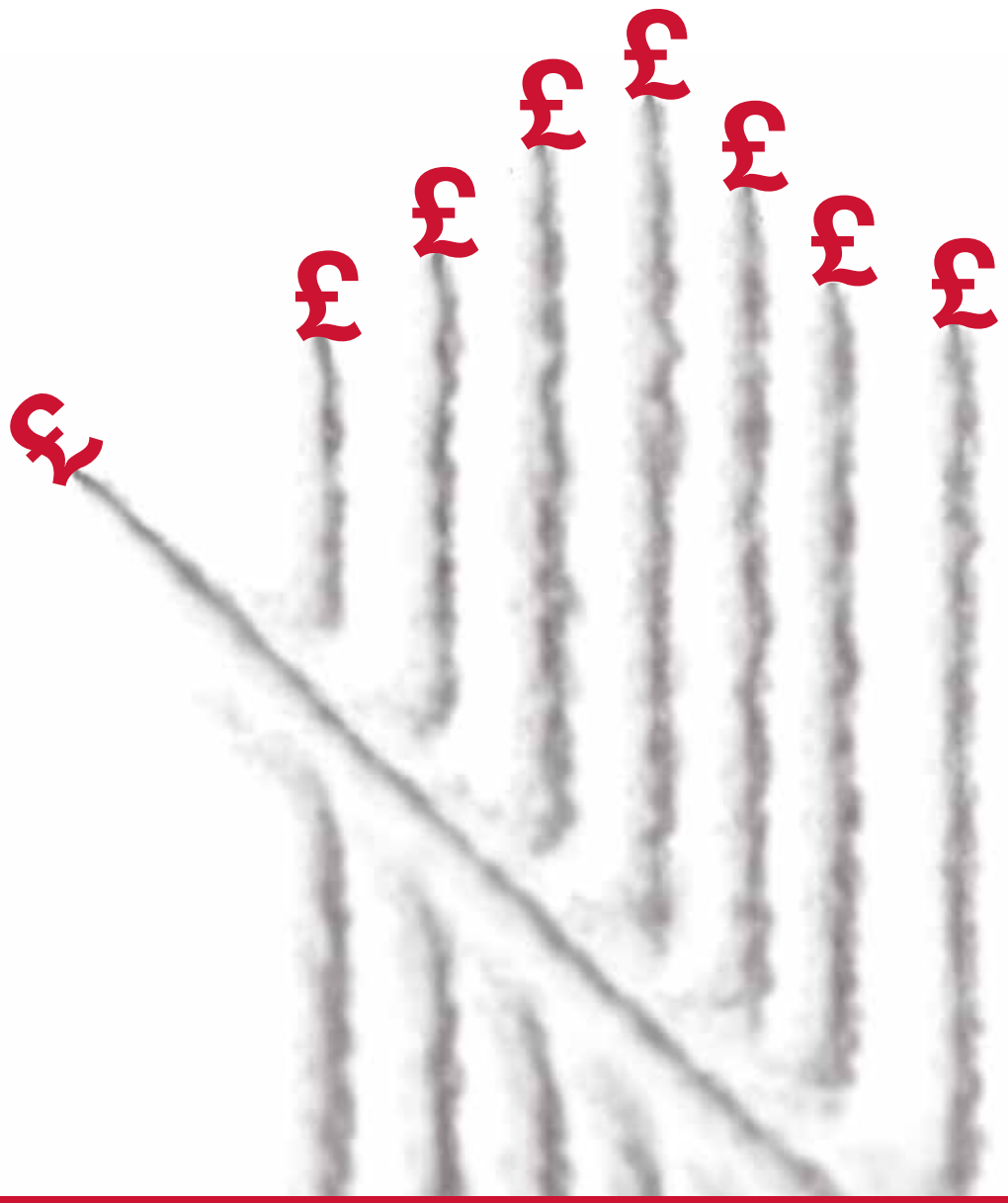

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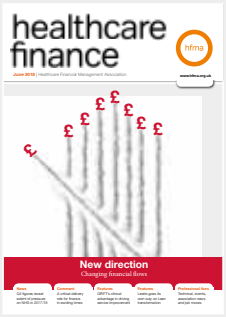

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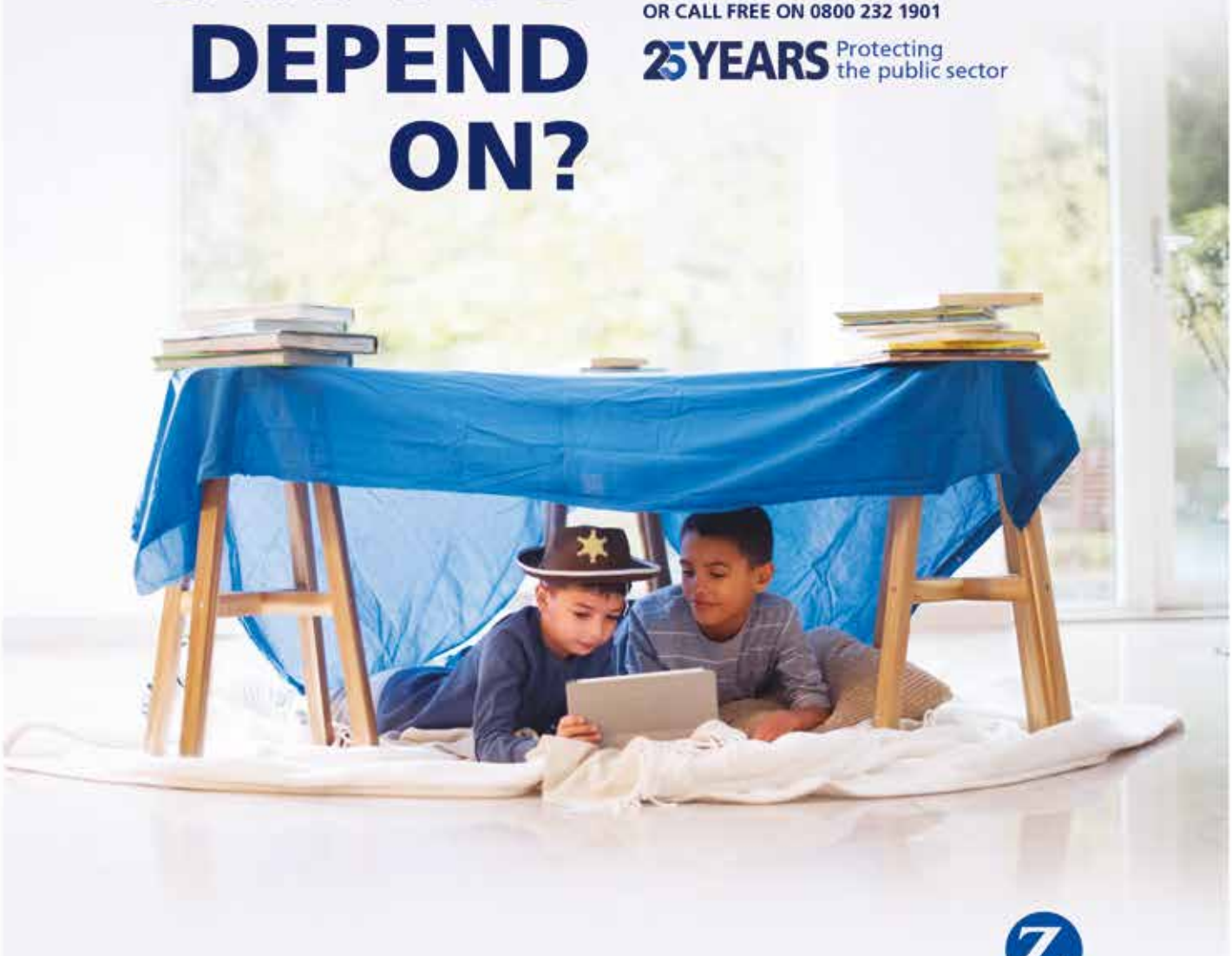

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News

Finances broadly in balance despite £960m provider deficit

By Seamus Ward

Higher emergency demand, which restricted trusts' ability to earn elective income and increased their costs, contributed to a provider deficit of £960m at the end of 2017/18, according to NHS Improvement.

However, with the commissioning sector reporting an aggregate underspend of £955m (*see page 4*), it appears the NHS completed 2017/18 broadly in financial balance.

The provider deficit is nearly double the planned position – a £496m deficit, which was always seen as an ambitious target by NHS Improvement. The overall provider figure includes £1.8bn of sustainability and transformation funding.

The deficit is also lower than the £1.28bn deficit reported at the end of quarter three. Even so, the overall provider position deteriorated in 2017/18 compared with 2016/17, when it stood at £791m.

NHS Improvement linked the year-end deficit directly to rising demand, particularly over the winter. It pointed out that, in aggregate, only the acute sector recorded a deficit (£1.7bn), while specialist, ambulance, community and mental health sectors had surpluses (totalling £631m).

Higher than planned emergency activity and greater bed occupancy shifted the balance between income and costs, which contributed to the acute sector deficit, it said. In emergency work when activity exceeds plan, expenditure tends to exceed income. And greater bed occupancy affected trusts' ability to admit elective patients, which led to lower than planned elective activity (where income tends to exceed expenditure).

Trusts overspent on pay (almost £1.5bn) and non-pay costs (£681m). The latter was partly due to buying healthcare from non-NHS bodies (£173m more than plan), reflecting capacity constraints during quarter four.

These additional costs were partially offset by income above plan – £955m of patient care income and just over £1bn of other income (including £25m of unallocated winter funding).

Overall, there was a combined shortfall in elective and outpatient income of £505m, partly due to winter pressures, NHS Improvement said.

The overspend on the pay bill was not just the result of the rise in activity. Around 100,000 vacancies in the NHS in England had to be managed. Overall, providers spent £52bn on pay, which was £1.5bn more than plan and, taking account of pay growth built into the tariff (2.1%), represents a real-terms increase of 1.2%. Some £1.3bn of the extra pay costs were due to the acute sector and most of the overspending related to frontline medical and nursing staff (86%).

> **"Many NHS organisations are being set annual financial targets they have no realistic hope of achieving"**
> **Siva Anandaciva, King's Fund**

Temporary staff spending was less than in 2016/17 (£67m less or 1.2%). Trusts spent less than planned on agency staff – £2.4bn compared with a planned £2.5bn – though bank staff spending was £976m more than planned. NHS Improvement said it expected the reduction in agency spending to continue in 2018/19, even in the face of ongoing pressure.

Despite the pressures, 132 of the 234 trusts (56%) recorded a surplus at year-end and 156 met or exceeded their year-end plans.

NHS Improvement chief executive Ian Dalton paid tribute to the resilience of the service in the face of the additional demand in 2017/18.

'Despite epic challenges, NHS staff up and down the country displayed incredible resilience and saw more patients than ever before within four hours. More than two-thirds of providers ended the year on budget or better than planned. Given rising demand and record vacancies, this is an important achievement.'

Ian Dalton: 'incredible resilience' of staff

Siva Anandaciva, King's Fund chief analyst, insisted the health service's financial difficulties were due to more than winter pressures. 'While a difficult winter no doubt had some effect, the challenges facing the NHS are not the consequence of a few bad months – they are the result of rising demand for services, a prolonged funding squeeze and a growing workforce crisis.'

He added: 'It is now an open secret that the system for managing NHS finances is fundamentally broken. Many NHS organisations are being set annual financial targets they have no realistic hope of achieving, while providers of community, mental health and ambulance services are effectively underwriting substantial overspends in acute hospitals.'

Chris Hopson, chief executive of NHS Providers, described the £960m deficit as a 'creditable performance' given the pressure on the system. '[These] figures show a substantial part of any additional spending on the NHS in the future will be spent on fixing the shortfalls that have built up in recent years,' he said.

CIPs challenge

Providers did not meet the planned level of efficiency savings in 2017/18, but the sector did deliver cost improvements totalling £3.2bn (3.7%). This was £477m short of plan, mostly the result of under-delivery of planned pay savings (£521m or 30% behind plan), although there was also a shortfall in non-pay savings (£94m or 7%). These shortfalls were offset partially by income generation overperformance (£139m or 27% over plan).

Trusts reported significant underperformance against planned recurrent cost improvement programmes (CIPs). They delivered £2.37bn against a plan of £3.37bn; a 30% shortfall. However, non-recurrent CIPs saved 166% more than planned – £842m compared with a planned £316m. Although efficiencies were behind plan overall, trusts still reduced costs by £110m more than in 2016/17.

Commissioning underspend at £955m

By Seamus Ward

The commissioning sector recorded an underspend of £955m in 2017/18, supported by a planned risk reserve of £640m, according to NHS England.

The underspend was generated despite clinical commissioning groups' month 12 outturn – a £250.5m overspend after applying £440m of the risk reserve and £71m of unearned quality premium. Before this, the overspend was £761m.

The CCG position was offset by underspends in direct commissioning (£228m); NHS England central spending (£891m excluding depreciation); and other technical adjustments (£87m). The system risk reserve was initially £560m – including £360m from CCGs, by holding 0.5% of their allocations uncommitted, and £200m in central uncommitted risk reserve.

A paper on the year-end position tabled at the NHS England May board meeting said a further £80m of reserves 'from other sources' was added to give a total of £640m.

This produced a total underspend of £955.3m, which NHS England said will offset overspends in the NHS provider sector.

However, NHS England chief financial officer Paul Baumann warned: 'For 2018/19, NHS England and CCGs will not be holding any national contingency to cover wider system risks, as £650m has been allocated to expand the provider sustainability fund from £1.8bn this year [2017/18] to £2.45bn next year [2018/19].'

A commissioner sustainability fund will also be introduced.

Overspends were recorded in 124 CCGs, with 65 overspending by more than 1% against plan. Factoring in the risk reserve, these figures fall to 75 and 57, respectively.

Mr Baumann defended CCGs' record. Despite ending the year with an overspend, they delivered unprecedented efficiencies – equivalent to 3.1% of their allocations (almost £2.5bn).

Much of the overspend was due to high levels of concessionary generic drugs prices set by the Department of Health and Social Care. However, the sector was able to offset some of this with an £80m rebate on category M drugs – medicines that are generally available but may be temporarily in short stock. The Department can allow price concessions to ensure availability, but this increases the cost to the NHS.

Mr Baumann said direct commissioning underspending was due to management action over the last two years, particularly in the Cancer Drugs Fund. Underspending on some dental services largely contributed to the underspend in primary care, while action in-year was taken to hold back central funds to offset emerging financial pressures in CCGs. Central budget underspends were a mix of non-recurrent income, central programme and running costs reductions.

Overall commissioner financial position

Net expenditure	M12 outturn				System risk reserve	Excl risk reserve Under/(over) spend	
	Plan (£m)	Actual (£m)	Under/(over)spend		£m	£m	%
			£m	%			
CCGs	80,995.9	81,246.4	(250.5)	(0.3)	440	(690.5)	(0.9)
Direct commissioning	24,485.8	24,257.9	227.9	0.9	0	227.9	0.9
NHSE running/central programme costs excl depreciation	4,064.6	3,173.6	891.0	21.9	200	691.0	17
Other including technical and ringfenced adjustments	(10.3)	(97.2)	86.9		0	86.9	
Total non-ringfenced RDEL under/(over) spend	**109,536.0**	**108,580.7**	**955.3**	**0.9**	**640**	**315.3**	**0.3**

Confederation calls for sustained investment

Patients face 'a decade of misery' without sustained investment and new ways of delivering services, according to the NHS Confederation.

A report on future funding needs, commissioned by the confederation, concluded that even to provide existing levels of services, NHS funding will have to increase by an average of 3.3% a year over the next 15 years, with slightly bigger rises in the short term to address immediate funding problems.

The report, by the Institute for Fiscal Studies and the Health Foundation, said this would take health spending as a proportion of national income from 7.3% to 8.9% by 2033/34. The long-term average for NHS funding rises is 3.7%.

Producing modest improvements in service would require funding increases of an average of 4% a year, with 5% in the short-term. This would increase spending as a proportion of national income to 9.9% and allow the NHS to catch up with waiting lists, increase capital spending and tackle some of the underfunding in mental healthcare.

At the same time, spending on adult social care would need to rise by 3.9% a year over 15 years to maintain services.

The report, *Securing the future: funding health and social care to the 2030s*, said it was likely taxes would have to rise to fund the increases. It estimated this would be equivalent to £1,200 to £2,000 per household over the 15-year period, though it was projected that household income would rise by £8,500 over the same period.

Chief executive of the NHS Confederation Niall Dickson (pictured) said: 'Unless we tackle the funding issue, and build up the workforce, we will see further strain on NHS finances and services. Yes, there are more efficiencies to be made and our services need to be much better at supporting people in the community, but if we want a high-quality NHS and care system we will have to pay for it.

'Without new ways of delivering services and sustained investment, NHS and care services will not cope, and we will face a decade of misery.'

Monthly reporting for Scottish health boards

The financial performance of Scotland's health boards will now be published on a monthly basis, the government has said.

Health secretary Shona Robison confirmed the move in May, having previously committed to reporting board finances every quarter. The first submissions for the 2018/19 financial year are due this month.

The Health and Sport Committee had received the first quarterly financial report on health and social care integrated authorities – this will be published quarterly. Medium-term health service spending plans would be set out later this year.

'In these times of increased pressure, with

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rising demand and an ageing population, it is crucial we have a transparent and open approach to finances and that matters of significant concern come to the fore,' said Ms Robison.

The additional scrutiny of Scotland's NHS finances comes in the wake of concerns about NHS Tayside. The health board was placed in special measures in March over its leadership and its management of finances. An independent review found endowment funds were used retrospectively to bolster its financial position.

'I expect everyone to learn lessons from recent issues at NHS Tayside,' said Ms Robison. 'I have already committed that the Scottish government work with OSCR [Office of the Scottish Charity Regulator] on any recommendations they have on the use of charitable endowment funds.

'I can, however, confirm there is nothing in the responses that gives cause for concern. No boards are showing retrospective payments to improve their financial position as at Tayside.'

New national CFO to oversee commissioner/provider finance

By Seamus Ward

NHS England and NHS Improvement are to further integrate their work, with a new national chief financial officer.

Plans for closer working were unveiled in May at the bodies' first joint board meeting. As well as a joint financial and operational planning process and performance management framework, they will have a joint executive team.

NHS England and NHS Improvement chief executives will lead the team, together with a national medical director, a nursing director and chief financial officer, who will lead the integrated financial, operational planning and performance oversight process.

HFMA president Alex Gild welcomed the proposals. 'With moves towards greater system working, it makes sense to have a more integrated approach from the service's leadership, ensuring better co-ordination and that a single message is delivered across providers and commissioners,' he said.

NHS Improvement and NHS England said they wanted to hold a single conversation with trusts and clinical commissioning groups to avoid contradictory messages. Financial incentives and architecture would be better aligned to ensure whole-system improvement. NHS England and NHS Improvement would simplify and rationalise financial flows and incentives to improve provider efficiency and quality, and add value across patient pathways.

This will inform joint work, led by the new chief financial officer, to design and implement a new approach to managing collective NHS resources and driving value.

Regional directors and their teams will take on more responsibility, while national teams will generally provide support and intervention where agreed by the regional director.

Seven joint regional teams will be set up, fully responsible for quality, finance and operational performance in their areas. They will:

- Oversee local system financial planning and performance against the new framework
- Manage control totals across commissioners and providers
- Oversee delivery of system-wide cost improvement programmes
- Support the design of new payment and risk-sharing models
- Prioritise sustainability and transformation partnership (STP) capital plans.

Regional directors will also support the development of STPs and integrated care systems. Nationally, a new provider strategy lead will oversee reconfiguration of the provider landscape to deliver clinical and financial sustainability.

The improvement of estates, procurement and back-office functions will be led by a new chief commercial officer, while an NHS Assembly – a forum for debate – will oversee progress on the *Five-year forward view* and co-design the proposed upcoming NHS 10-year plan.

Chris Hopson, chief executive of NHS Providers, said trusts would welcome the changes, but there were risks.

'This must be a genuine joint venture of two equal partners,' he said. 'Trusts have been asked to carry significantly more financial and operational risk than they believe is appropriate and this would have been a lot worse without NHS Improvement's voice in the setting of the provider task.'

Carter points to £1bn in savings

Better use of resources and the reduction of unwarranted variations in community and mental health services could release up to £1bn by 2021, claims Lord Carter's latest productivity and efficiency report.

The review, which follows up on Lord Carter's 2016 report on the acute sector, focuses on the mental health and community sectors.

Reviewing 23 community and mental health providers, Lord Carter said each provider demonstrated areas where they performed well. But best practice should be more effectively shared.

He identified unwarranted variations in workforce productivity, particularly in community services, and utilisation, as well as the use of resources in non-pay goods and services. The use of technology and mobile working to improve efficiency and productivity was inconsistent and poor in many areas.

Removing these variations and tackling operational challenges would deliver better care for patients, a more productive workforce and efficient use of funds, he added. This could release up to £1bn a year.

The *Getting it right first time* programme should be extended to community and mental health services and should specify more efficient and high-quality care pathways. Lord Carter also insisted there was scope to examine all areas of spending, including corporate services, procurement and estates.

• *See news analysis, page 8, and Right way to go, page 13*

News review

Seamus Ward assesses the past month in healthcare finance

If an NHS news story is not about funding, it is often about demand and access times, particularly in A&E. While funding and the financial position dominated the news in May (see news, page 3), the difficult winter still affected performance against waiting times standards.

In England, NHS performance against A&E targets recovered a little in April, according to NHS England – 88.5% of patients were seen within four hours, compared with 84.6% in March. In April 2017, the figure was 90.5%. Demand continued to rise, with A&E attendances 2% higher in the past 12 months compared with the previous 12 months. Emergency admissions were up 4.1% compared with the preceding 12 months. NHS Providers published an analysis of the winter, saying that between December 2017 and March 2018 more than 5.8 million people attended A&E.

Wales also saw improvements against access time targets, with similar increases in demand for A&E. Diagnostic waiting times improved markedly in March, when the number of people waiting over eight weeks was at its lowest in nine years. The number waiting over eight weeks fell by just under two-thirds over the month.

There were also improvements in referral to treatment and therapy waiting times. The number of patients seen within four hours in A&E increased by 4.4 percentage points in April compared with March. However, this meant that only 80% were seen within the target period, though A&E attendances continue to climb – they were 2.2% higher than the previous year.

The Care Quality Commission expressed concern about the care offered in emergency departments in England. Its report, *Under pressure: safely managing increased demand in emergency departments,* said that half of emergency departments in England had an overall rating of requires improvement or inadequate. The CQC added that 8% of services were rated inadequate for safety. It found some examples of good practice and praised staff for the dedication they had shown to patients over last winter. But it raised concerns about delayed ambulance handovers, long waits for first clinical assessment and the use of inappropriate spaces – such as corridors – for patient care.

Research by the Health Foundation said the cost of emergency admission was up £5.5bn over the last decade. It said emergency admissions cost the NHS in England £17bn in 2016/17, compared with £11.5bn in 2006/07. The foundation added that actual costs would be higher, as these figures do not include costs accrued after discharge. Its figures reflect increasing comorbidities in patients. One in three patients admitted as an emergency in 2015/16 had five or more health conditions, such as heart disease, diabetes, hip fracture or dementia. This was up from one in 10 in 2006/07, it said.

However, another study offered hope that the NHS could reduce demand on hospital and GP services. The NHS in England has been testing ways of integrating physical and mental healthcare for people with long-term illnesses, such as diabetes or respiratory problems. One site has shown, from a cohort of these patients, that inpatient admissions fell by three-quarters and A&E attendances by two-thirds. At the same time, demand for GP appointments fell by 73%, adding up to an overall saving of £200,000.

The creation of seamless health and social care services took a step forward with the

The month in quotes

'Anyone with arthritis knows it not only slows you down but darkens your mood, sometimes leading to serious mental ill health. Integrated talking therapy services are a big step forward for our patients and a crucial part of putting mental health at the centre of our plans for the future of the health service in England.'
Claire Murdoch, NHS England director of mental health, explains why integrating physical and mental healthcare is so important

'NHSI's proposal to require trusts to self-certify the risks and benefits of creating a subsidiary company will help provide evidence that any new subsidiary companies are not being established to gain VAT advantages.'

Chris Wormald, Department of Health and Social Care permanent secretary, explains the Department's stance on wholly owned subsidiaries

'There is a clear link between effective, sustainable staffing and high-quality care. NHS staffing has increased to a record high under this government, but it's vital we have the right staff in the right place, with the right skills, long into the future.'
Scottish health secretary Shona Robison on introducing a safer staffing law

'Hospital staff have been saying for some time that they are admitting higher numbers of much sicker patients and these new findings show they are right. Staff have worked incredibly hard under pressure to provide emergency treatment for rising numbers of older patients with multiple conditions.'
Rising emergency admissions are linked to higher comorbidity levels, says Health Foundation chief executive Jennifer Dixon

announcement that three areas have been selected as local health and care record exemplars. NHS England said the areas, which cover 14 million people, would share records between hospitals, GPs and social care. The areas selected are: London, Greater Manchester and Wessex, each made up of one or multiple sustainability and transformation partnerships. Each will receive up to £7.5m over two years to introduce electronic shared local health and care records. NHS England will work with other areas hoping to join the programme.

In England, NHS performance against A&E targets recovered a little in April compared with March

The Scottish government believes a new law on health and care staffing will not lead to significant additional costs for the NHS. New legislation will require Scotland's health boards and all other care providers to have appropriate numbers of suitably trained staff in place. The requirement will be enforced regardless of where the care is received. The *Health and Care (Staffing) (Scotland) Bill* said staffing should be evidence-based, taking account of user needs. A staffing methodology should be used, which will include staffing and professional judgment tools, it added. While this could have an impact on staff numbers, the government does not anticipate an overall increase in costs. In fact, it believes there may be an opportunity to reduce spending by using fewer temporary staff.

Department of Health and Social Care permanent secretary Chris Wormald has said the Department and NHS Improvement will ensure trusts are transparent about the formation of wholly owned subsidiaries. In a letter to Meg Hillier, the Commons Public Accounts Committee chair, he said the Department, NHS Improvement, HM Revenue and Customs and the Treasury would work together to ensure subsidiaries comply with tax law. NHS Improvement's proposal requiring all NHS trusts and foundation trusts to self-certify the risks and benefits of creating wholly-owned subsidiaries would ensure subsidiaries are not being formed in order to gain VAT advantages, he added.

Reciprocal healthcare arrangements with the European Economic Area (EEA) could cost £290m more than initially planned in 2017/18. In a memorandum to the Commons Health and Social Care Committee, the Department of Health and Social Care said the net outturn is expected to be in the region of £920m – the net budget was £630m, although it has been topped up in-year with an additional £267m. In 2016/17, the outturn amounted to £739m. The Department said the higher than anticipated costs were the result of changes in the rules governing the calculation of average costs (used to work out most of the UK's bill) and a greater number of travellers from the UK.

Ian Trenholm (pictured) is the new chief executive of the Care Quality Commission. He is currently chief executive of NHS Blood and Transplant and will succeed David Behan, who retires in July. Mr Trenholm was chief operating officer at the Department of Environment, Food and Rural Affairs and chief executive of the Royal Borough of Windsor and Maidenhead.

from the hfma

With further details on the long-term funding settlement for the NHS expected in the next month, it is as important as ever to give a voice

to the views of NHS finance staff, writes Ian Moston (pictured) in a blog on the HFMA website. The association policy and research committee chair acknowledges that time is tight, so the HFMA's new-look, shorter *NHS financial temperature check* aims to ensure finance opinion is heard. He adds that detail will still be covered, despite the shorter survey. As well as examining overall confidence levels, the latest survey also looks at progress on efficiency initiatives such as *Getting it right first time*, the Model Hospital and NHS RightCare.

HFMA head of policy and research Emma Knowles used a blog in May to encourage members to help shape the association's work programme. While some projects are already fixed – updates to HFMA introductory guides and the continued expansion of the popular HFMA/NHS Improvement *NHS efficiency map* – members were asked to prioritise other proposals. One area of study could focus on the savings delivered by new models of care, while another proposes an exploration of what functions might need to transfer to provider bodies or systems as part of moves to integrated care.

In a further blog, NHS Improvement head of improvement analytics Sam Riley argues statistical processes offer more powerful ways of analysing data than the traditional RAG ratings. Statistical process control could help identify if a variation is a natural occurrence or an indication of an issue that must be further investigated, she adds.

News analysis

Headline issues in the spotlight

Productivity revisited

Lord Carter has already reviewed productivity in acute providers. But more recently, he has been examining community and mental health services for opportunities to drive efficiency. With his report just out, Steve Brown looks at the key messages

There are critical and unwarranted variations in all key resource areas across mental health trusts and providers of community services and addressing these could release up to £1bn a year, according to Lord Carter's latest productivity review.

Lord Carter has previously looked at productivity improvement in acute trusts, with his 2016 report estimating acute providers could realise £5bn of efficiencies from their total spend of £52bn by addressing variation in their sector. This follow-up report expands the area of scrutiny to the £17bn spent on mental health and community services in England.

Both the mental health and community sectors are critical areas for the NHS in the coming years. Community services are vital to the vision set out in the *Five-year forward view,* with Lord Carter suggesting average length of stay in acute hospitals will need to shorten from seven days to something approaching the 5.5 days found in Denmark. To achieve this, community services would need to be 'considerably strengthened'.

In his foreword to the new report, Lord Carter said that in contrast, the key challenge for mental health services is to meet significant levels of unmet demand. 'Even taking into account the significant expansion in children's mental health services, workforce constraints mean that by 2020/21 we only plan on meeting the needs of a third of children with diagnosable mental health conditions,' he said.

In total, the report makes 16 recommendations, many of which aim to drive standardisation across mental health and community services

He added that improving productivity in both sectors was an important part of the answer to these challenges.

The report identifies four areas where operational improvement needs to be made. Unsurprisingly, staff head this list – with some £10.4bn of total spending on these services consumed by staff costs.

Staff were praised for their hard work and brilliant services despite significant pressure. But the report recognises that, with critical labour shortages in all grades, using staff time to the best effect is of utmost importance.

Despite this, the review found that more management attention could be given to important areas such as staff rostering, job planning and managing sickness absence.

The other key areas include:

- Contract specification – inconsistent and overly bureaucratic
- Technology – lagging behind other public sector services, with a quarter of trusts' community nursing services operating paper-based systems
- Delivery – central leadership could be better.

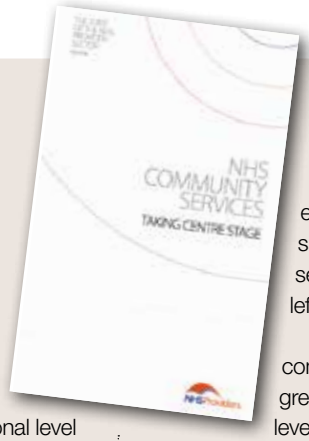
Lord Carter's work also identified a number of structural issues that were well recognised but had not been adequately dealt with. Delayed transfers of care, for example, account for about 5,000 beds at any one time, with the main reason for delays because patients were waiting for further non-acute NHS care.

Time to make good on promises

Promises to bring more patient care closer to home by prioritising community services have fallen flat, according to a recent report from NHS Providers, *NHS community services: taking centre stage*.

Consecutive governments have all identified the importance of stronger community services helping people to stay well and avoid hospital treatment where possible. However, despite some successful examples of places where this has worked, the report concluded that support on the ground has failed to match the rhetoric – leaving many providers marginalised, underfunded and short staffed.

In a survey, leaders in more than half of community trusts said funding in their area had fallen this financial year and nearly a third said they had cut staff. The report concluded that community services were not sufficiently understood or prioritised at national or local level. They were overstretched, underfunded and understaffed. The lack of national level data, quality measures and targets – a point reinforced by the Carter review of productivity in community and mental health services – had also hindered progress.



NHS Providers chief executive Chris Hopson said that community services were all too often left behind.

'We need to see to see community services given greater priority at national level and within sustainability and transformation partnerships and integrated care systems,' he said.

THEODORE WOOD

In some good practice examples, effective use of community health services and social care had reduced average length of stay in acute beds by four days, the report said.

Wound care is another known problem area. While the NHS spends an estimated £5bn a year managing wounds, undertaking 40 million patient visits, most trusts do not capture clinical information or operate within nationally defined pathways, the review found.

The report recommended an extension of the *Getting it right first time* (GIRFT) initiative to community health services.

Some areas have inpatient community hospitals, while others don't. But the report said it could find no evidence that 'the often expensive provision of inpatient community hospitals improves outcomes'.

A much clearer idea of 'what good looks like' was needed, but the report said that an isolated 10-bed inpatient facility was 'unlikely to be clinically or financially secure'.

The report also called for a much greater focus on elderly patients – pointing out that nearly half of the lifetime health and social care costs of an individual in England are incurred after the age of 65.

The report makes 16 recommendations, many of which aim to drive standardisation across mental health and community services.

In addition to the extension of GIRFT to community services, in particular for wound care services, Lord Carter said an extension of the initiative to support mental health services should help support the elimination of inappropriate out-of-area placements for adult mental healthcare by 2021.

The review worked with a cohort of 23 trusts to understand a number of key metrics on how clinicians spend their time. These included:

- Total time spent with patients each day
- Number of patient contacts a day
- Average duration of contact

Improving productivity of services is an important part of the answer to challenges in both the community and mental health sectors
Lord Carter (pictured)

- Number of contacts per patient over the reporting period.

Using these measures to understand productivity, it then drilled down into two specific services – community nursing and adult community mental health services – and found significant variation.

For example, in community nursing it found the average time clinicians spent delivering care to patients ranged from 33% to 80%, with some services delivering twice as many contacts per clinician per day compared with others. There was also a 75% difference in the average duration of face-to-face contacts, and the number of contacts per patient over the reporting period ranged from 14 to 45.

While some of this could be explained by case complexity, geographies and the way services are commissioned, the report concluded that 'variation of this scale is unwarranted'. If the direct care time for all community nursing services were improved to the median, this would free up nearly 300,000 days per year nationally and allow these services to support nearly 90,000 more patients – the equivalent of an additional 1,600 staff.

Similar variation was found in mental health services. If all direct care time were moved to the median, this would free capacity of more than 90,000 days per year and enable a further 20,000 service users to be supported – the equivalent of an additional 500 staff.

While this variation was found across a range of services, most trusts do not review data on their clinical workforce productivity, with performance reports typically focusing on volumes of activity without considering the resources used delivering them.

The report recommended that trusts should be given access to this type of benchmarking data through NHS Improvement's Model Hospital, noting that the introduction of patient-level costing would enable increasingly robust comparisons across providers. Some new compartments should be added to the Model Hospital as soon as April 2019.

The report also called for changes to the contracting process. Just 4% of mental health service providers currently use an episodic payment approach, with a further 2% using a capitated approach. However, it highlighted promising examples in Oxfordshire of areas developing outcomes-based models.

This should be supported, the report said. '[NHS Improvement and NHS England] should further develop currencies and the payment systems for mental health and community health services to allow a clear categorisation of services, and incentivise the collection of high quality activity, cost and outcome data,' it added. This would support longer-term benchmarking between providers.

NHS Providers' head of policy, Amber Jabbal, said the review's findings addressed many of the concerns raised in its own report on community services (see box). 'Highlighting unwarranted variation in key areas for the first time presents a new opportunity for trusts to improve their productivity,' she said.

'This report is right to draw attention to the complex commissioning and contracting environment, discrepancies in the way performance is measured, and the importance of harnessing IT to provide better care.'

However, Ms Jabbal added that improving productivity was not the answer to all the services' challenges. 'Above all, these services need adequate funding, and action to address staff shortages,' she said.

Comment

June 2018

Exciting times

A chance to celebrate the NHS's past – and perhaps more certainty over future funding

HFMA president Alex Gild

Birthdays are exciting times, often yielding surprises and occasionally satisfying high expectations. The NHS's 70th birthday on 5 July 2018 is going to be no different. It will be a national celebration of all that is good about this prized public service and the people who work together to make it the best it can be for patients. It will surely be a very happy birthday for our NHS.

However, expectation is building so much for this particular birthday that we might wonder if there are to be any surprises.

It certainly comes as no surprise that 2017/18 was one of the toughest years in recent NHS history, with significant pressures seen across the service and public concern as to the impact on patients and staff from demand, workforce and financial pressures.

NHS finance teams have just submitted accounts, giving one view of the huge challenge of the year gone by, but also of fantastic delivery for patients across the service, in spite of this.

Sadly, in a sometimes bitter backdrop to our positive work, there is occasional criticism of the finance function, some of which is personalised to particular finance leaders from certain quarters of the media.

We know the objectivity and integrity of our profession is strongly sustained by the work we do in our teams every day, influencing the required culture of integrity, truth and transparency against which we provide our professional support to our organisations.

Focus on the right challenge

The right level of funding will provide the best starting point for the NHS to address significant challenges

Healthcare Finance editor Steve Brown

The argument about whether the NHS needs additional funding may have been won with the government promising a long-term settlement for the NHS. But the size and phasing of that settlement will be crucial. The right amount and the NHS has a serious chance of establishing sustainable services – perhaps even showing other health economies around the world how to move towards more integrated services built around greater levels of prevention.

Too little, and the service will continue to focus on crisis management – leaving little time or energy for pathway redesign and potentially taking short-term decisions that actually hamper long-term transformation.

NHS Improvement's Q4 report, published at the end of May, provided a good summary of just how difficult the last year has proved to be for the NHS. Providers ended the year with a £960m deficit – not much increased from the Q3 forecast but £464m more than its ambitious plan for the year. The oversight body rightly recognised that this outturn position was only achieved as a result of hard work by providers to tightly manage their finances in the last quarter.

But performance has also been hit in the face of record demand for services. Providers' A&E four-hour performance, for example, fell further behind target in the quarter. Clinical commissioning groups were also overspent, even after the application of this year's risk reserve – requiring underspends in other commissioning budgets to deliver an overall commissioning underspend that can help offset the provider deficit.

"We are a learning profession, and we should be seen to learn and adjust from mistakes, openly and transparently"

The majority of us come to work to do a good job for patients. We are a learning profession, and we should be seen to learn and adjust from mistakes, openly and transparently. Don't let the media or others devalue in your own mind the strong, positive contribution our finance teams make to the NHS every day.

With that nod to boosting our confidence, it's time to look forward with increased hope. There are positive changes signalled that herald a birthday present the NHS, staff and patients really need.

First, and at last, there is explicit political support to ensure the safe future of the NHS. Second, NHS leaders, validated by economic commentators, are able to be really clear what funding increase is needed over a longer period than political cycles, and our health secretary understands the position.

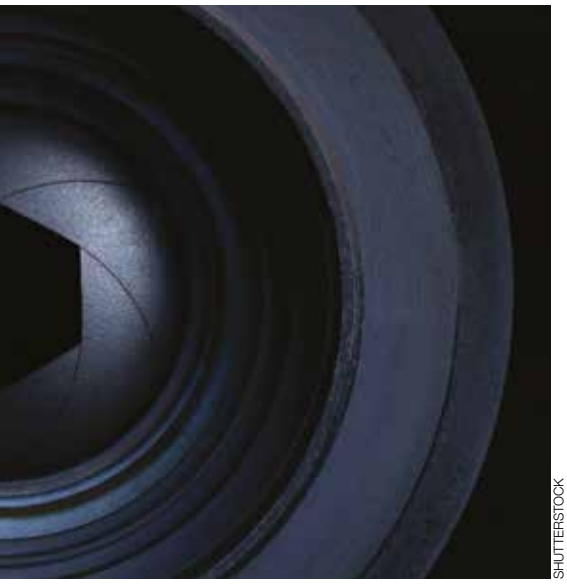
A shared strategic intention to develop a 10-year plan for the NHS that government may back with enough funding to keep pace with the needs (health education, prevention and treatment) of our growing and ageing population could be a tremendous gift for the future. It would give certainty and help our NHS push on to 100 years and beyond.

The recent announcement that NHS England and NHS Improvement are to combine executive leadership and management structures to support emerging system integration, organisation improvement, operational delivery and regulation across regions with a single voice is very welcome news indeed. It's a positive sign of the times, becoming brighter together, with an assembly of stakeholders who care about, and are invested in, the NHS – which should provide the framework necessary for the NHS to be fit for the future.

As the NHS finance function, and valued people and professionals, we have much to offer and do in this next phase. So let's continue to be that key influencer and absolutely critical delivery partner to the NHS's ongoing development.

Exciting times? I think so. Happy birthday our NHS.

Contact the president on president@hfma.org.uk



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The Institute for Fiscal Studies has pinned its colours to the mast (*see news, page 4*). An average 3.3% increase over 15 years would deliver the status quo, it argues – describing this as a 'low bar'. It would take 4% a year in real terms on average to deliver a modernised NHS, with 5% increases in the early years.

The public knows the NHS needs more money, but it cannot be expected to understand exactly how much. These figures from the IFS provide a clear benchmark against which any final settlement can be judged. While the numbers seem large, there is a real opportunity to reset the NHS on the right course.

Even with the right level of funding in place, the service will still face major challenges. New models of care may be the right approach – more multidisciplinary teams working to support patients to manage their own care and avoid unnecessary acute care downstream. But establishing them will place significant demands on services and NHS staff – and the financial impacts of pursuing these right models is still not completely understood.

Productivity improvement will remain an ongoing challenge under any realistic funding scenario. Lord Carter has thrown a spotlight on opportunities within the community and mental health service sectors (*see page 8*).

Delivery of these opportunities in all sectors – supported by Model Hospital data and the *Getting it right first time* initiative (*see page 13*) – will demand that clinicians and support staff work together. This won't happen if they are constantly trying to deliver impossible efficiency requirements and control totals.

"Productivity improvement will remain an ongoing challenge under any realistic funding scenario"

Staffing challenges also won't be solved by simply increasing funding. NHS Improvement's Q4 report highlighted 100,000 vacancies across the provider community. This can only be addressed through long-term training of the right numbers of staff, as well as some changes to staff roles – along with some thinking around how to address particular geographical problem areas.

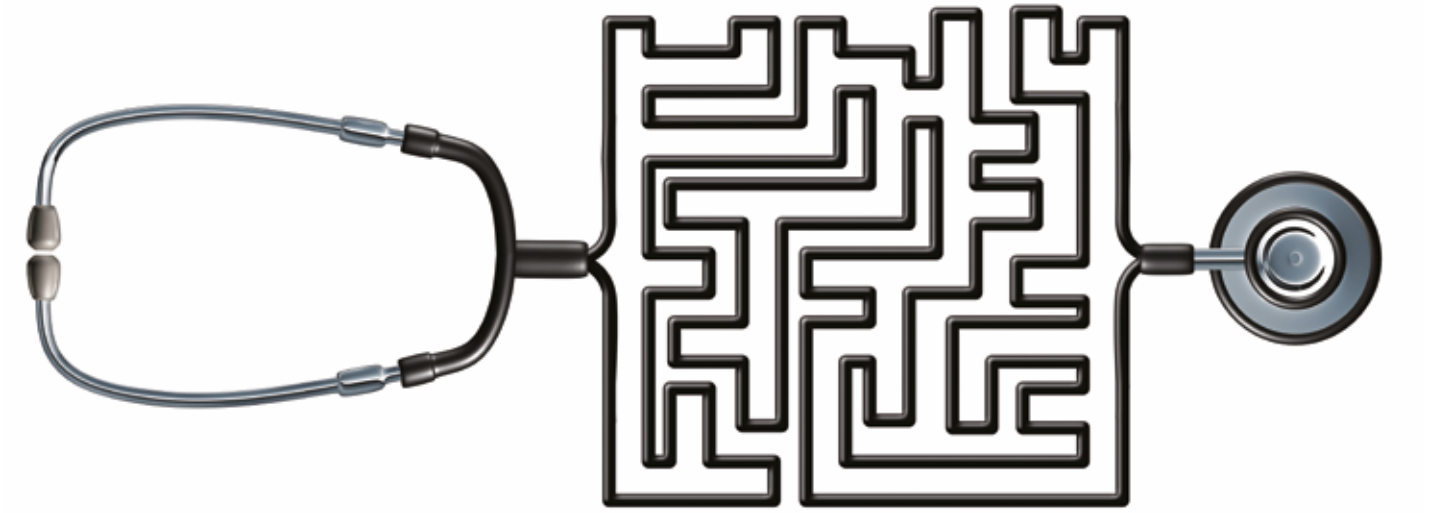
And even if the global NHS budget is right, the service also needs to pay attention to how the money flows through the system so that it gets to the right places and incentivises the new care models (*see Change of direction, page 16*).

So there's a huge agenda ahead. The right level of funding won't solve all the health service's problems. But it might at least enable the service to apply itself properly to the task.

HFMA
AWARDS 2018

The National Healthcare Finance Awards

Recognising healthcare finance innovation
and achievement for over 10 years



Right way to go

Getting it right first time – or GIRFT – may be clinically led and seek to improve patient care, but it can also provide trusts with opportunities to increase their productivity and efficiency, says Seamus Ward

With the NHS focused on integration together with the current and future financial position, steps to improve the quality of patient care have arguably taken a back seat. But separating quality and financial sustainability would be foolish – reducing unwarranted variations and sharing best practice can improve care and patient outcomes, reduce the amount of unnecessary procedures and cut costs. Often such improvement programmes have been managerially led, leading to accusations that they are being driven by cost cutting. That's where *Getting it right first time* (GIRFT) has an advantage – the programme is clinically led and based on spreading best practice.

GIRFT was piloted in orthopaedic surgery and, though primarily aimed at improving clinical quality, the savings it generated immediately caught the eye. After the pilot, an NHS Improvement survey of more than 70 trusts found they had saved £30m in 2014/15, with a further £20m forecast in 2015/16. Extrapolated across the 140 trusts visited by the orthopaedic pilot, savings would reach almost £100m.

In November 2016, the programme was expanded, with £60m funding from the Department of Health. It now covers 31 medical and surgical specialties, four clinical services (including pathology and imaging) and six cross-cutting workstreams (including coding, litigation and medicines optimisation). Health secretary Jeremy Hunt said at the time GIRFT would help save the NHS £1.5bn a year.

When the expansion was announced, GIRFT chair Tim Briggs – who led the orthopaedic pilot – said: 'Because GIRFT is led by clinicians, frontline medics in the specialties being reviewed welcome it because they can share both their best practice and their challenges with people that understand clinical service. But importantly, good patient outcomes and safety have remained paramount throughout the programme.'

GIRFT is now part of the Carter efficiency and productivity work, and though run by NHS Improvement and the Royal National Orthopaedic Hospital NHS Trust, is seen as complementary to NHS RightCare.

It is both a national and local programme. Generally, the GIRFT process has a number of stages. Trusts to be reviewed answer an extensive questionnaire prior to a visit from the GIRFT team. The team combines this with relevant existing data to produce an information pack, identifying areas of opportunity that are discussed in detail during a visit to the provider. GIRFT teams also offer support to trusts to help them implement their recommendations. The reviews of individual trusts are merged to produce a national report, which draws out trends and potential savings, together with recommendations for reorganising services.

"Because GIRFT is led by clinicians, frontline medics welcome it because they can share both their best practice and their challenges"
Tim Briggs, GIRFT

To date, four reports have been published. As well as the initial report on orthopaedic surgery, there have been reports on general, cardiothoracic and vascular surgery (see boxes overleaf for the recent reports).

GIRFT has been praised nationally. In a report last year, the King's Fund said that, on the limited evidence so far, the programme was achieving real gains in procurement, productivity and quality. However, buy-in varied and it was important that clinicians and managers work together to deliver the programme's full potential, the thinktank said.

Trusts such as Maidstone and Tunbridge Wells NHS Trust have used GIRFT, patient-level costing and Model Hospital data to improve efficiency, performance and quality (see report on HFMA Healthcare Costing for Value Institute website, http://hfma.to/6t).

SHUTTERSTOCK

It is also having a significant impact on services. In the south of England, some trusts have reportedly stopped performing procedures after being identified as an outlier by the GIRFT programme.

University Hospitals of Leicester NHS Trust deputy head of operations Judy Gilmore says that GIRFT has provided the trust with information that has helped to support clinical and operational developments. Three of the trust's departments have been involved in GIRFT reviews – the cardiac and thoracic departments, which are separate in the trust, and vascular surgery.

Tackling inefficiency

Ms Gilmore, who manages the trust's renal, respiratory and cardiovascular clinical management group, believes using the review information in conjunction with the Model Hospital data is a useful tool against inefficiency and links well to the trust's cost improvement programme (CIP). While GIRFT identifies the opportunities, the Model Hospital data is used to pin down the potential financial benefits.

She says: 'Opportunities identified tend to be on efficiencies, but also support clinicians. Day of surgery admission is one of the key areas – some wards are doing that really well, others not, because we don't yet have the buy-in across all clinicians.'

The cardiothoracic review showed good compliance in many areas, together with opportunities for clinical and operational development. As well as the day of surgery admissions, which applied to both cardiac and thoracic departments, these included recommendations to improve processes to have a positive impact on patient care.

In cardiac services, for example, the review recommended weekend consultant-led ward rounds – these are being held on an informal or voluntary basis pending review of job plans and probably further investment.

In thoracic surgery, the review found that the unit performed 41.6% of lung resections for cancer via video-assisted thoracoscopic surgery (VATS) in 2016, which is below the 51.6% national average. However, the thoracic surgery department does not have access to a surgical robot – most of its peers are developing a robotic surgery programme, and access to a robot would facilitate an increase in robotic-assisted resections in line with the GIRFT recommendation.

VATS surgery for empyemas is below the national average, though it is likely to be due to coding discrepancies. Ms Gilmore says the service is likely to achieve the GIRFT-recommended 50% VATS empyema surgery target within six months.

The review also gave recommendations on litigation and bed numbers. In cardiac services, it suggested litigation cases be presented at regular mortality and morbidity meetings, with a biannual report to the clinical management group board. The thoracic group will aim to implement a five-point litigation plan as soon as trust-wide guidance has been produced.

To comply with GIRFT practices, the review said there should be ring-fenced beds for cardiac surgery in intensive care and on wards. Added pressures in winter 2017/18 forced thoracic surgery to accommodate breast care, vascular and cardiac surgery patients. No intensive care beds were ring-fenced for thoracic surgery patients.

The trust is realistic about the GIRFT recommendations – for example, ring-fencing beds to increase activity is an opportunity, but it is difficult, especially during the busy winter period. This year it has prioritised working up a case to support ringfencing beds in the winter to reduce cancellations.

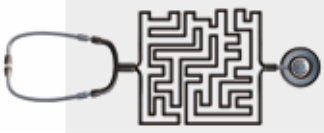
It is also prioritising reducing length of stay by increasing day of surgery admission in both cardiac and thoracic surgery; standardisation of techniques; and supporting development, for example robotic surgery.

"The surgeons just want to operate – they don't want to have to cancel operations because there are no beds"
Judy Gilmore, University Hospitals of Leicester NHS FT (pictured)

'We have good clinical engagement. The surgeons just want to operate – they don't want to have to cancel operations because there are no beds – so they are willing to support the management team to become more efficient,' Ms Gilmore says.

Claire Wilson, chief finance officer at Liverpool Heart and Chest Hospital NHS Foundation Trust, which was also reviewed for the cardiothoracic report, is positive about the trust's experience with GIRFT. 'It had real credibility with the clinicians, so they fully engaged with it. It was led by an experienced cardiothoracic surgeon, who our clinicians knew or knew of, so he had a high level of

Cardiorthoracic surgery review



Designated specialist teams and better bed management could lead to better outcomes for patients with debilitating chest, heart, and lung conditions and greater efficiency, according to the GIRFT cardiothoracic review.

The review, published in April, examined all 31 NHS cardiothoracic units in England and made 22 recommendations to improve practice, process and outcomes, including:

- Making bed management more efficient by ensuring surgery on day of admission is delivered routinely, helping reduce delays and time spent in hospital
- Ringfencing beds on intensive care units and general wards for the care of cardiothoracic patients
- Moving to sub-specialisation for certain critical procedures, such as aortovascular surgery for aorta rupture
- Using less invasive thoracic surgery (VATS) for lung resection surgery – the report says VATS reduces complication rates as well as length of hospital stay.

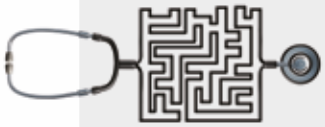
Cardiothoracic surgery can benefit patients suffering from conditions such as blocked arteries, lung cancer and heart valve disease. According to the report, emergency surgery rotas for major trauma should be covered by both thoracic and cardiac surgeons, ending the practice of using cardiac surgeons to provide cover for emergency thoracic surgery.

It also proposes that all patients should be reviewed by a consultant both pre- and post-operatively, seven days a week, to ensure more timely patient discharge, particularly over weekends.

The efficiency savings could reach £52m overall when other savings such as better procurement and reduction of litigation costs are factored in.

Vascular surgery review

A network model for vascular surgery would save 100 lives a year, improve recoveries and save the NHS up to £25m a year, according to the vascular review.



The national review, published in March, said a vascular surgery network would reduce the likelihood of strokes, TIAs (transient ischaemic attacks), aortic aneurysms and arterial blockages.

Seventy NHS trusts in England perform vascular surgery and though many collaborate in a local network, there is no standard network model across the NHS and there are large variations in size, staffing and throughput.

GIRFT said a nationwide, 7/7 vascular surgery 'hub and spoke' network of specialist units treating every vascular surgery case as 'urgent' could save 100 more lives, substantially reducing the risks associated with blocked arteries such as sudden death, strokes, restricted movement and amputations. The network would ensure that early diagnostics, decision-making expertise and intervention – which are so often essential to the successful treatment of vascular conditions – are available around the clock.

GIRFT said the report identified a gross notional financial opportunity of between £7.6m and £16m, with a further £6.5m savings opportunity in procurement.

credibility and clinical data was taken from strong data sources.'

This was reinforced by the GIRFT review team knowing the trust's data pack 'back to front' and being able to triangulate the clinical and productivity information, she adds. This gave its clinical and managerial leaders detailed information on where the trust's cardiothoracic services excelled and where they could potentially be improved.

'I imagine that to achieve that level of depth and triangulation is very resource intensive, but it was incredibly powerful. They gave us plaudits, but also pointed out where we could potentially improve and the clinicians listened.'

Leicester's Ms Gilmore, who trained as a radiographer, says the GIRFT reports can increase clinician buy-in as the programme is clinically, rather than managerially, led. It has also helped bring together finance staff and clinicians to engage in reduction of unwarranted variation. 'We've found GIRFT to be a useful programme. Sometimes it just tells you what you already know, but it gives us a focus and impetus to look at length of stay and day of admission. It helped me bring the clinicians on board.'

CIP programme

GIRFT is an integral part of the trust's CIP programme and is used alongside the Model Hospital data to identify transformation schemes included within the CIP plans. This is particularly true in vascular services, which has six component notifications in the Model Hospital dashboard. A number of actions have been identified to improve efficiencies and outcomes for patients, and these include:

- Reduction in re-admissions specifically in revascularisation including bypass and angioplasty
- Reduction in length of stay for abdominal aortic aneurysm procedures through day of surgery admission and prehabilitation
- Increased frailty/geriatrician support.

'Judy's clinical management group is more advanced than most others, and that's where we want everyone else to be,' says Ben Shaw, Leicester's director of efficiency and CIP. He oversees the productivity improvement work at the trust, including GIRFT, Model Hospital and its CIP, and says the GIRFT programme is very useful.

'We set the CIP targets and then the department should use GIRFT as one of the key tools to help identify and deliver those improvements. These improvements range from identifying the need to reduce the average length of stay, theatre efficiency or even revise our clinical pathways. All of these can ultimately help us to become more efficient as a trust but most importantly the changes are good for our patients.

'This year, we've used the Model Hospital data to help set CIP targets. It's helpful in identifying what each department is more or less efficient in. We can then set varying targets based on the data and challenge those departments where there are greater opportunities for efficiencies or service improvements. GIRFT shines a torch on the opportunities.'

Clinician focus

GIRFT has the advantage of being a clinician to clinician programme. 'If it had a corporate focus it would be difficult to engage clinicians, but the challenge is coming from fellow clinicians,' continues Mr Shaw.

'At one review meeting, the lead clinician from the GIRFT review asked our clinicians questions such as whether they knew the cost of an additional night's stay and if not, why not. He also explained to our clinicians that after two nights, any additional night is going to end up in a loss for the trust. Many didn't know that.'

Apostolos Nakas, a consultant thoracic surgeon who is the trust's head of service for thoracic surgery, allergy and immunology, says: 'Although some data appeared inaccurate, we felt that an external review was helpful in providing benchmarking to peer services.

'Having said that, the report does not delve into depth in reasons for variance, such as casemix or regional workload, and some of the recommendations have been contested in specialty fora.'

Mr Nakas says the service will aim to comply with the recommendations clinicians find useful and feasible, such as day of surgery admission. He adds: 'Others, such as proportion of VATS cases or ring-fencing ITU beds, are going to be more difficult to implement and are likely to cause some friction.'

The review information and recommendations are informing the Liverpool trust's clinical and operational planning, as well as its financial targets. 'We have a £150,000 CIP this year in one of the areas they picked up – pre-operative bed days – though the greater benefit will be in the improvement in patient experience,' Mrs Wilson says. 'While we already had plans to address this, the GIRFT report helped provide evidence for the business case and encouraged us to speed up the implementation – our same-day admission ward is due to be up and running from 1 June.'

Trusts now have a lot of benchmarking information to support their planning and cost reduction processes.

'At Liverpool Heart and Chest Hospital, we are bringing together all of this information, together with listening to our staff to get their ideas, and this will inform our improvement priorities for the next few years,' Mrs Wilson says. 'Some of this benchmarking data is in the Model Hospital – the Model Hospital is a really useful tool, though there are challenges with data in some areas, which we will need to address. Specialist trusts have not yet been brought into the use of resources assessment, but we will be incorporating a shadow use of resources framework into our internal reporting processes to support our productivity work.'

Though some clinicians remain cautious about GIRFT recommendations, it has established a new level of engagement both nationally and locally. Retaining that clinical support will be crucial as the programme clearly has a lot of potential to be a major driver in improving efficiency, productivity and quality.

change of direction

A new report from PwC, produced with support from the HFMA, argues for fundamental changes in the way money flows around the NHS. Steve Brown reports

The government has accepted that the NHS needs increased funding in a long-term financial settlement. Recent weeks have seen the long-awaited debate about exactly how much funding is needed finally get under way. But new research from PwC, carried out in conjunction with the HFMA, suggests that the NHS needs more than just more money – it also needs a major overhaul of the way money moves around the system.

There is general recognition that the current system of funding flows does not support the proposed new models of more integrated care proposed by *Five-year forward view.* Payment by results, for example, was introduced to drive reductions in waiting times by incentivising greater throughput from providers.

It does not support current moves to work as systems or to re-engineer patient pathways so that patients are supported more in the community and helped to avoid more serious hospital-based treatment.

Former health secretary Alan Milburn, chair of the PwC Health Industries Oversight Board and closely involved with the new report, believes change is urgently needed.

'More resources will fail to deliver results unless there are major reforms to the current NHS financial system,' he says. 'It is caught in a time warp and needs to catch up with the new policy imperatives. They need to move from competition towards collaboration; towards systems and away from institutions; towards more services in the community and less in hospital; away from rewarding activity and towards outcomes.

'Unless the way money moves around the system is changed, the government will not get the biggest bang for its buck.'

Making money work in the health and care system identifies a number of problems with the current financial system:

- Current payment approaches incentivise treatment rather than prevention
- The flow of money is overly complex and not fit for purpose
- The separation of local health, social care and public health budgets compounds fragmentation
- Debt owed to the Department of Health and Social Care to fund hospital deficits is becoming unmanageable.

More than 200 finance leaders were surveyed as part of the research and they provided further support for change.

Some 78% of respondents felt there should be a single budget for health and care, while 77% believed that outcomes would improve if there was greater certainty on funding over a longer period and 83% identified a conflict between long-term financial sustainability and short-term efficiency savings.

Using these views, further interviews and roundtable discussions, the report's authors

recommendations

Short-term simplification

Capital funding

The capital funding system should be redesigned to enable longer term investment in out-of-hospital infrastructure and a reduction in backlog maintenance. As part of this, the report calls for an end to capital-to-revenue transfers and for the creation of a national restructuring fund with clear access rules and prioritisation criteria. The quantum of capital funding needed at national, regional (sustainability and transformation partnerships, or STPs) and organisational level should be determined with clear allocation methods.

The proposed restructuring fund would be aimed towards the development of the out-of-hospital assets and infrastructure needed in emerging new models of care. But the reports says it could also be used to deliver the resources needed to deal with structural issues causing significant deficits in some providers.

Internal debt

The report argues for a restructuring of internal debt. It highlights the use of interest-bearing loans from the centre to fund cash shortfalls

in providers driven by financial deficits. Total debt across NHS providers at the end of 2016/17 stood at £4.9bn, with an associated interest cost of £169m. Some 42% of providers had debt associated with working capital or revenue support loans from the Department of Health and Social Care (DHSC), with over half in deficit.

As providers get into more financial distress, the interest rates increase – rising to 6% for trusts in financial special measures. The result is that trusts experiencing significant financial challenges are further financially penalised. 'For some trusts, this debt burden is likely to grow and become unsustainable, with little to no prospect of it ever being repaid,' the report says.

The report authors call for 'serious consideration' to be given to resetting internal debt within the NHS. While there is no net cost to the NHS of providing loans (provider interest payments equalling DHSC interest income), they consume management time and 'amplify the difference between financially healthy organisations and those in difficulty'.

The report adds that 'any aspiration to develop financially sustainable integrated care systems in the future will inevitably be hampered if organisations inherit the financing costs of their predecessors'. Consolidating debt at a consistent cost of finance across the service would start to provide a level playing field.

Control totals

More progress is needed towards replacing organisation-based control totals with system-wide targets. The report calls for currently separate accountabilities – providers to NHS Improvement and commissioners to NHS England – to be tackled head on to avoid further confusion in the move to a place-based approach to healthcare. The report's suggestion is for an integrated care system to hold the budget for the local health system, with payment to the ICS on a whole capitation basis with the existing CCG allocation formula providing the 'logical starting point' for calculating the budget.

Personal budgets

The report calls for an expansion of the personal health budgets programme and backs the creation of a stretch target of one million of the 15 million people living with long term conditions to be holding personalised budgets by 2025.

argue that three areas should be given more focus in current thinking. First, financial flows should be aligned with the emerging place-based architecture. They argue for a balance between national levers and local accountability and 'an urgent shift towards system-wide capitated budgets, combined with appropriate governance, to help break barriers to integrated working'.

Second, systems should be given more clarity through longer term funding, adding that the financial mechanisms in the acute sector have also become excessively complex. Third, money should be focused towards achieving better outcomes.

Key pointers

The report makes a number of detailed recommendations, broken down into changes that are needed in the short and longer term (see boxes). Short-term recommendations include changes to the capital funding regime, ensuring capital funding is not sidelined to ease short-term financial pressures, and overhauling the current mechanisms for funding provider cash shortfalls.

Over the longer term, the report argues for the payment system to be refocused on the delivery of outcomes rather than activity and for a big step to be taken in bringing together health, social care and public health budgets.

The vision of health systems given capitated budgets with elements of payment linked to outcomes and risk/gain sharing mechanisms in place between different providers is not new. As long ago as 2014, NHS England and Monitor (NHS Improvement's predecessor)

published a paper exploring capitation as a new payment model to enable integrated care. 'Rather than paying providers for particular treatment or inputs, capitation allows commissioners to reimburse providers for making available specified services and possibly delivering specified outcomes for a defined target population,' the 2014 paper said.

The focus subsequently has been more sharply on capitated budgets for whole populations, but progress has been slow – reflecting the difficulty in moving to a new payment approach and the significant financial challenges facing the service.

Integrated system

The report envisages integrated care systems being paid on a whole system capitation basis. This might be a single organisation assuming accountability for the provision of all care, including primary care, via direct provision or by subcontracting some services.

The report also considers three levels of financial flow that need to be considered once the system is aware of its financial envelope – organisation, pathway and individual levels. Under the recommendations, the accountable body would be free to choose its preferred contractual mechanism to commission services from other bodies within the system. These could involve different mixes of tariff-based, block and capitated-budgets and risk and gain share agreements would be needed.

"Unless the way money moves around the system is changed, the government will not get the biggest bang for its buck"
Alan Milburn

Under one option put forward for consideration, GPs 'buying into' an ICS might receive dividends based on the performance of the health economy. Where organisations are given responsibility for co-ordinating patients along a particular care pathway, an outcome-based approach is preferred, with top-ups for adherence to best practice pathways and processes. The report also considers how NHS staff and patients could be incentivised to support the improvement in outcomes and engage more in their own health and care.

HFMA chief executive Mark Knight believes the priority for the NHS is to put new models of care in place. 'However, to sustain these into the long-term, we need to have the right payment systems in place,' he says.

'While local health economies have been given the freedom to develop their own local financial flows to support new integrated models of care – for example, by exploring capitation-based budgets and outcome-based payments – it is important that we share the learning from these approaches and accelerate their development.

'Changing the way the money flows around the NHS and an increase in NHS funds are both now urgently required to put the NHS on a sustainable financial footing and support the development of urgently needed new models of care.'

The report acknowledges that the proposals imply some 'quite profound consequences for systems', including an end to the purchaser-provider split as it currently exists and different roles for clinical commissioning groups and those working in them.

The focus would also move away from foundation trusts and nationally negotiated contracts – such as that for general medical services – would need greater flexibility. However, it says that not acting now would represent a 'huge missed opportunity and could be highly detrimental to the service.

recommendations

Longer term restructuring

Payment systems
The report is clear that payment systems need to move towards rewarding outcomes rather than volume of activity. Local systems should be given the power to determine their own internal contractual mechanisms, choosing episodic reimbursement, block-style contract or capitated budgets – but the focus should be on outcomes, with the majority defined at a national level. This reflects the 'national system' nature of the NHS and protects against 'postcode lotteries'.

But it also avoids separate STPs and systems spending time and money defining broadly the same outcomes. Local systems would then be able to supplement contracts with local priorities.

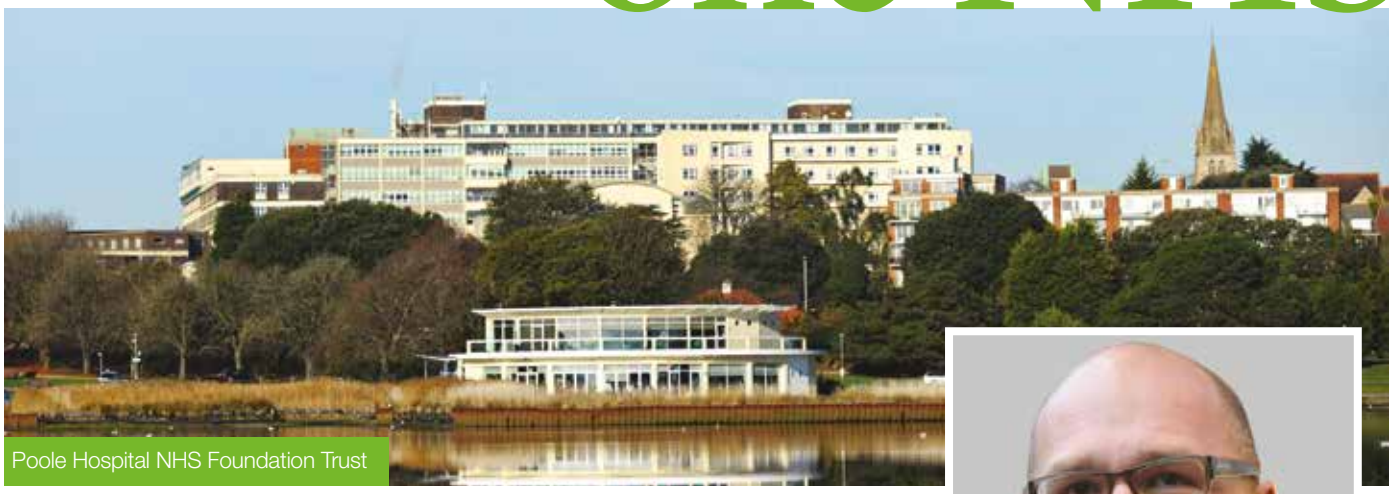
Accountability would also need to move to being based on the delivery of system outcomes, rather than institutionally driven targets. The tariff would still be needed under these proposals, but its role would be more limited – providing a basis for payments between systems, for benchmarking and to support the move to capitation-based budgets.

Integrated budgets
The report lends its voice to calls for full integration of health, social care and public health budgets within a health economy – highlighting difficulties with the current lack of ringfenced social care funding and reducing public health grants. The report suggests this could require significant legislative change or could build on existing section 75 agreements. The report recognises that tensions between free healthcare services and partly means-tested social care would still remain. But bringing budgets under a common leadership would reduce difficulties.

Long term allocations
Any long-term financial settlement for the NHS should be replicated within systems, the report says. This would enable systems to plan and invest for the long term. Although the service has moved towards indicative five-year allocations and a '1+1' planning approach, committed funding has consistently remained short term. This does not fit with the goal of investing in the prevention of illness, which has a longer term payback in terms of patient outcomes and cost. If the service is given a five-year plan when new funds are announced, this should translate to five-year allocation plans for local systems, the report says.

Individual incentives
The report also calls for a 'detailed assessment' of how financial incentives for frontline and management staff could be used to improve cross-organisation working.

One vision one NHS



Poole Hospital NHS Foundation Trust

Dorset is one of eight integrated care systems leading the way in taking collective responsibility for resources and population health. Poole Hospital NHS Foundation Trust finance director Mark Orchard (right) gives an update on progress

The Dorset health and care system is currently organised across nine statutory bodies, six responsible for health and three local authorities. This is set to change over time – on both sides of the health and social care divide – as the Dorset system leadership is committed to the consolidation of entities, not creation of new ones.

Within Dorset, we are fortunate. Not only because of our clean, sandy beaches, but because we have one large countywide NHS commissioner with the scale to host its own in-house 'commissioning support unit'. And, crucially, we have had continuity of system leadership at all levels in an environment where maintaining trust and effective relationships are so vitally important.

Dorset's NHS system can also claim a history of relatively strong financial and operational performance. We have good heritage, having previously been strategically led by Sir Ian Carruthers OBE, Ian Tipney and Bill Shields at the helm of the Dorset and Somerset and, more recently, South West strategic health authorities. 'Do what we said we would do' has always been our mantra, and we have a solid track record of delivering good services for local patients within the context of also managing upwards with 'no surprises'.

Dorset has a population of just over 800,000, with more than half living in the urban east Dorset within Bournemouth and Poole. Across our north and west, we have vast areas of rural population. Most of our NHS provision is directly managed by primary, community, secondary and mental health providers within the county.

At an aggregate level, the system works well, but at an organisational level, we have serious sustainability concerns. More than 90% of Poole Hospital's inpatient activity is currently non-elective. Due to local population demographics, we admit more patients with fractured neck of femur than anywhere else in Britain. We also provide trauma, maternity and paediatric services on behalf of the whole of east Dorset.

Historically, this has limited the organisation's ability to deliver cash surpluses under the payment by results/foundation trust funding model. This is compounded further as these services attract a disproportionate share of the national risk pooling cost under the Clinical Negligence Scheme for Trusts (CNST).

Sustainability challenge

Each Dorset provider equally has a structural sustainability challenge. All of us recognise that individually we are not sustainable in our current forms. Despite being an all foundation trust health system for many years, both Dorset County Hospital and Poole Hospital have experienced periods 'under financial investigation' for reasons of sustainability by the former regulator, Monitor.

However, in autumn 2013, a proposed organisational merger between the Royal Bournemouth and Christchurch Hospitals and Poole Hospital was prohibited by the Competition Commission on the basis of reduced competition not demonstrated to be in the interest of patients. Further, both organisational boards signed a legally binding undertaking not to merge without the explicit agreement of the competition authorities for a further 10 years.

To its credit, Dorset Clinical Commissioning Group responded by launching a full system clinical services review (CSR) in October 2014. Following a structured process of clinical and public engagement, this led to a formal consultation between December 2016 and February 2017 on a significant restructuring of service provision across acute, community, mental health and primary care.

Alongside this, the three acute providers were selected as a national acute care vanguard, with a vision of working towards 'One NHS in Dorset'. Its aim was to remove organisational barriers to change by enabling joined up clinical and support services, supported by enabling IT systems and infrastructure.

By the time NHS England had called for sustainability and transformation plans to be developed, and created sustainability and transformation partnerships (STPs), collaborative working was already a reality in Dorset.

In committing to our 'one NHS' vision, all NHS bodies in Dorset agreed a two-year financial framework for 2017-19. This includes a commitment from the group to deliver its aggregate financial control total commitments, maximising the receipt of national sustainability and transformation funding and related income into our system.

There wasn't any magic bullet behind our agreement – after all, there was no new money as our commissioner was set to receive almost flat funding. This could only ever sensibly mean 'flat cash' contracts for 'flat activity', translating into an opening 'flat workforce' assumption and significant cost improvement assumptions to offset inflationary cost pressures.

At the same time, we established a monthly governance system to ensure that all parties – individually and collectively – were doing what they said they would do. A formal joint monthly meeting of all chief operating officers and finance directors reports into a system-wide leadership team comprising all chairs and chief executive officers.

Time will tell if this approach continues to work, but the mindset change from 2017 was tangible.

To be completely fair, NHS England and NHS Improvement responded jointly and effectively to our new ways of working. Our journey, alongside other systems, no doubt supported and stretched thinking nationally. This is certainly true in terms of the creation of 'system control totals' – Dorset has arguably run ahead of national guidance at times, with support at all times from regulators.

In 2017, the Dorset health and care system was identified as one of eight accountable care system pilots. This would both provide a fast track to improvements set out in *Next steps on the five-year forward view* and take forward the recommendations of the CSR. And from 2018, the group has been formally recognised by NHS England and NHS Improvement as working towards an integrated care system (ICS).

As part of this, we have already exercised our ability to agree an overall set of net neutral control total offsetting adjustments as part of our 2018/19 operational plans (see table).

Further in-year offsets of financial over-performance in one organisation against financial under-performance in another are permissible across the ICS, where the overall net impact is neutral.

At this stage, we have not sought to extend our financial risk sharing across health and social care, given the very different financial regimes that underpin the respective sectors. But we will keep this under review.

In 2018, we added a Dorset finance and investment committee to our system governance structure to oversee system-wide investment decisions.

The challenge for the Dorset system remains balancing operational delivery during continued funding restraint, while also creating capacity to achieve an ambitious clinical service redesign across the acute, community and mental health sectors. The east Dorset acute hospital reconfiguration component of the CSR represents a significant change programme, with workforce and operational continuity challenges extending over the next six to seven years.

Dorset control totals

2018/19 financial control totals (including STF and related income)	Original notified control total	ICS offset (£m)	Control total (£m)
Dorset CCG	-1.6	2.8	1.2
Dorset County Hospital	-0.2	-1.1	-1.3
Dorset Healthcare University	2.3	0	2.3
Poole Hospital	-1.2	-2.5	-3.7
Royal Bournemouth and Christchurch Hospitals	-3.2	0.8	-2.4
Aggregate Dorset NHS group	-3.9	0	-3.9

Note: South Western Ambulance Service NHS FT sits outside the control total due to its regional footprint

At the centre of this acute hospital change programme, the Poole and Royal Bournemouth hospitals will specialise as major planned and emergency centres respectively. This brings three key deliverables, alongside sustaining business as usual:

- Revisiting the organisational merger that was prohibited in 2013 to create a single clinical leadership to oversee and deliver the commissioner's model. Both parties are being supported by NHS Improvement to revisit a merger proposal with the Competition and Markets Authority.
- Capital investment: £147m has been earmarked for the ICS to enable the reconfiguration of acute services across the two hospital sites concerned. (The CSR's preferred option was to redevelop Poole as a major planned hospital and the Royal Bournemouth as a major emergency hospital. Detailed planning has been undertaken with outline and full business cases expected to be presented to the Treasury in 2019.)
- Reconfiguration of acute services: as already noted, the future for Poole Hospital lies within a merged organisation with the Royal Bournemouth to secure clinical, operational and financial sustainability across the two acute sites. Both sites will be expected to continue to provide existing essential services until completion of the enabling works in 2022/23, with the related clinical and operational efficiencies being delivered from 2023/24.

Financial model

A long-term financial model is being revisited to inform three levels of cash-releasing savings. First, there will be business-as-usual annual cost improvement programme opportunities (before merger assumptions are applied), supplemented by post-merger pre-reconfiguration organisational synergies. On top of this will be clinical reconfiguration efficiency – the total system efficiency element of which is estimated at £19m per year.

More recently and through working together, the Dorset NHS group individually and collectively delivered on its financial 'control total' commitments for the year ended 31 March 2018. The system achieved this by broadly delivering on its flat activity, flat cash, flat workforce agreement, supported by new care models outlined in the CSR and sustainability plan (see box).

Several commissioning strategies were adopted to manage demand:

- Referral management – based on peer review and audit
- Commissioning strategies for low-value interventions: reducing

Royal Bournemouth Hospital

activity in areas of limited clinical value
- Encouraging shared decision-making – enabling patients to make informed decisions about their care together with their clinicians
- Redesigning urgent care pathways in primary care to enable a more rapid and effective response to those at risk of an admission
- Proactive case management of patients in the community and risk stratification tools for GPs to enable GPs and community services to focus on at-risk patients and help them manage their condition.

Again, nothing in this list looks like a magic bullet, but by working together to jointly own demand, this has been effective. It has delivered activity trends in most cases better than national averages. Acute referrals from GPs were down 6.4%, creating extra capacity to manage increased urgent care demand, particularly over the winter. Non-elective admissions were up by just 0.6%, which compares with 3.5% nationally, according to NHS Improvement figures. Elective admissions were down 3.1%, due in part to non-elective pressures, but also because of changes in pathways and referrals. Outpatient attendances (first and follow-up appointments) were also down 3.4%. And A&E attendances, in line with the rest of the country, were up 2%.

However, these percentages hide the fact that some providers – including Poole Hospital – have seen a significant increase in the number of patients presenting with more complex and challenging medical conditions by ambulance to A&E. Ambulance conveyances across Dorset were up 6.7% on the previous year.

Despite all bodies having agreed individual and a collective system control total for 2018/19, Poole Hospital needs cash support and has access to this from the Department of Health and Social Care's uncommitted interim revenue support facility. The trust has already drawn £1.6m repayable cash support during May. This is consistent with the operational and strategic plans agreed with the regulator in 2014, when it exited financial investigation. It will continue until such time that a financially sustainable plan is implemented, and the associated efficiency benefits realised, as part of the CSR.

Given this dependency on external cash funding, organisations such as Poole have limited scope for investment beyond that prioritised as being both urgent and essential for securing ongoing safety and service continuity.

Despite structural financial challenges that relate to the clinical service portfolio, which is not planned to change until 2023, Dorset is performing well across a range of important clinical, operational and value-for-money benchmarks and external assessments (including the Model Hospital, where it benchmarks in the upper quartile, staff survey results and Care Quality Commission ratings).

There are significant pressures, perhaps particularly at the organisational level, but the system is making good progress towards the delivery of more integrated care. There are many challenges ahead, but the first steps appear to be taking us in the right direction.

• *Mark Orchard is director of finance at Poole Hospital NHS Foundation Trust and immediate past president of the HFMA. He has also worked in other roles across the Dorset system – as finance director at the former primary care trust and at the local NHS England office*

Our Dorset

Dorset's STP plan – *Our Dorset* – identified three programmes of work to transform healthcare services across the county – prevention at scale; integrated community and primary care services; and one acute network – supported by two enabling workstreams that focused on working differently and maximising use of technology.

The prevention programme aims to help people to stay healthy and avoid getting unwell. This is broken down into a number of strands focused on staying, living and ageing well. Work is ongoing, for example, to support smoking cessation and to expand a health check programme.

As part of the integrated community and primary care services programme, a number of community hubs have been established to provide a focus for a number of services, including rapid same-day access to GP-led urgent care with on-site diagnostics, rehabilitation services and secondary care consultations.

The one acute network strand will deliver the redesigned acute configuration preferred by the clinical services review, which has been through extensive consultation. It is increasingly focused on the renewed merger proposals. The decision to reconfigure Poole and Bournemouth sites into elective and non-elective specialist hospitals has created some retention and recruitment pressures in affected specialties.

As part of enabling works, a single Dorset care record has been established across the county and is expanding its user base.

Leeds lights up

Leeds Teaching Hospitals has seen a remarkable turnaround over the past few years and is looking to a brighter future. Seamus Ward reports

The recent story of Leeds Teaching Hospitals NHS Trust has been one of improving finances, while delivering better care for patients and being leaders in costing and procurement. Its financial position is at a 20-year high and it is one of only five trusts selected to work with the renowned Virginia Mason Institute to improve services to patients.

While it would by no means claim to have all the answers – it faces some significant risks in relation to its five-year financial plan and capital development programme, for example – a lot of the trust's gains have been built on a strong staff culture. The Leeds Way, inspired by staff, sets out the trust's ambition to be patient-centred, fair, collaborative, accountable and empowered. Its goals are to: be the best for patient safety, quality and experience; be the best place to work; be a centre for excellence for specialist services, research, education and innovation; offer seamless, integrated care; and be financially sustainable.

Of course, many trusts have similar ambitions, but director of finance Simon Worthington says staff have taken the values and goals to heart.

'For me, the Leeds Way symbolises the effort put in before I started here, when [chief executive] Julian Hartley joined, to engage with frontline staff and create the right culture.

'This is a culture of patient-centred accountability. The goals and values are real – people talk about them. They say, "That's not the Leeds way", for example. It took a huge amount of effort, but you can feel the results when you walk around the organisation. One of the benefits of staff engagement is that people understand the challenges, but feel empowered to tackle them.'

Improvement method

The aim is for the Leeds Improvement Method – which the trust is developing with Virginia Mason – to underpin its work and deliver its vision of being the best trust for specialist and integrated care.

'You can feel people's desire to improve. When it comes to finance, there is a foundation of great work that has built over a number of years,' Mr Worthington says.

He pays tribute to his predecessor (and former HFMA president), Tony Whitfield, for helping lay these foundations. 'Four or five years ago the trust had an underlying deficit of £100m on a turnover of £1.2bn. But the trust worked away at the deficit and, through the work that Tony started, by 2017/18 it had gone from a deficit to a surplus by fully achieving the control total.'

Before Mr Worthington joined the trust, it had been looking at a deficit of around £22m for 2017/18. The trust's control total target was a deficit of £14m, which the board had not signed up to initially. However, he felt the trust should be as ambitious in its financial targets as it was being in its operational dealings. The trust signed up to the control total.

'It has paid off because we achieved a surplus of £18.9m after the final distribution of sustainability and transformation funds [STFs],' Mr Worthington says. 'We received an initial £23m of STF to give us a £9m surplus, but we overachieved by around £3m, so we received additional STF to bring the surplus up to £18.9m. It's the biggest surplus the trust has had in its 20-year history.'

Moving into the post, Mr Worthington made a number of recommendations. One of these was to shift the thinking away from budgets to focus on the run rate.

But as well as changing how staff and budget

SHUTTERSTOCK

holders viewed the financial position, he also wanted to change the language of savings programmes. 'In Leeds, we talk about waste reduction where others might talk about cost improvement.'

This is important in engaging staff and in meeting a cost savings target of around £65m in 2017/18. Most of the trust services are managed through clinical service units (CSUs) – each led by a doctor (who is the accountable officer), a nurse and a manager. But in the first two months of 2017/18 all CSUs were rated 'red' in the trust's performance management system and were 10%-15% off their planned financial position.

In his previous job at Bolton NHS Foundation Trust, Mr Worthington often spoke of the 'art of making people bothered' to go the extra mile to deliver efficiencies. Concerned that the size of the efficiencies needed, together with the position at month 2, would discourage staff from even trying to achieve the savings plans, Mr Worthington and his team looked for ways to reduce the savings needed at each CSU.

'We looked at depreciation, balance sheet – all the things people haven't necessarily talked positively about – and the savings needed from the CSUs came down by about £27m.

'We also had some central reserves, so we put all of that out to the CSUs and told them about the technical stuff – we called it back-of-the-sofa money. They still had to deliver, but it was a much more reasonable amount.'

A revised CSU performance management framework focuses on monthly forecasts – if a deficit of more than 1% is forecast, the unit is categorised as red; between 0% and 1%, amber; and green for a forecast surplus. Within a short period of time, many CSUs were rated green.

Mr Worthington continues: 'The framework is motivational and they are proud to see they can manage their financial challenge while delivering quality. At the end of the year, virtually all the CSUs were green, due to the smaller control target, the performance management framework and the real feeling of accountability and engagement.'

Waste reduction has been supported by the trust's costing team – which won 2017's HFMA Costing Award – and he again pays tribute to Mr Whitfield for developing a costing infrastructure that is now regularly helping teams to investigate their cost structures and come up with improvement ideas.

Day one reporting

He says the introduction of day one reporting played a big role in identifying issues before they became a big problem. This involves providing financial statements to budget holders on the first day of each month.

Mr Worthington is a long-time advocate of day one reporting, having implemented it at Bolton and now Leeds. 'My contention is that if you can do it at Leeds Teaching Hospitals, there's no reason why everybody cannot do it. It focuses people's minds and it's easy to remember the report will be there on the first day of the month.'

Setting financial targets is one thing, but delivering them is another. At the trust, efficiency programmes are underpinned by the Leeds Improvement Method, overseen by a Kaizen Promotion Office (KPO). This is a management programme that aims to deliver organisational improvement (see box overleaf). Improvements made as a result of the programme can lead to financial benefits.

Becky Vickers, clinical services manager in the trust's neuro rehabilitation department, says the team has been able to increase sessions from fewer than one to three per week. One useful innovation was a people link/performance board, which has linked projects together, reducing repetition of work. Through the board, service challenges are transparent and targets are identified, together with the staff involved in addressing them and timescales.

'This feels to me much more organised,' she says. 'I don't need to repeat myself in communication as much and feel more consistent in the messages I'm giving to the whole team. Also, sharing ideas across the teams has been really inspiring for each other.

'One big challenge remains – this is on my office wall and my teams are across all sites, so sharing it quickly and effectively is my next challenge.'

Ms Vickers believes that working out realistic targets – developed using Takt time (which reflects the rate of production needed to meet demand) – has helped reduce pressure and stress on staff and freed up time to engage in improving performance, using tools such as the 5S methodology and waste walks.

'These and other service development have made us all more productive as a team,' she says. 'Developing greater confidence in my own abilities, the culture of my team and the direction of travel of the trust has been the best bit. I've loved linking with other people working at a similar level to me within other areas of the trust and with the KPO team, who have been extremely supportive.'

She adds: 'There's lots of other work we've done around making the culture of the ward more therapeutic, empowering healthcare support staff to support patients to do more for themselves rather than have things done for them. This has also had a big impact on patient outcomes and being ready for discharge

"One of the benefits of staff engagement is that people understand the challenges, but feel empowered to tackle them"

Simon Worthington, Leeds Teaching Hospitals NHS Trust

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and reduced demand on the physio team by making sure the right person with the right skills is doing the right thing at the right time.'

Mr Worthington says the trust is developing a system for measuring the financial impact of Leeds Improvement Method changes. And, while large-scale waste reduction programmes are important, often the biggest savings come from trained and empowered staff tackling day-to-day problems.

The 'Finance the Leeds Way' improvement plan has taken a programme management approach, getting a 2018/19 financial plan and a new five-year plan agreed by December 2017. The 2018/19 plan was modified when the control totals were published.

Finance efforts

The finance team has been engaging with the wider trust and patients – for example, finance staff joined a week-long effort to improve A&E – and generating ideas to make its own services better. It is also taking part in the Future-Focused Finance accreditation process, aiming to reach level 2 by the end of next year before progressing on to level 3.

'Our mission statement is to provide the best finance and procurement services to support the delivery of patient care in the Leeds Way.

'It's important our people are involved, so we are encouraging them to become FFF value-makers. We had three or four and put out a call for others to step forward – we thought 15 expressions of interest would be good, but it was more like 30 who came forward.

'They are now applying to be value-makers and that group will act as the finance staff development group – I'm excited about that.'

The trust is implementing the aligned incentives contract, developed in Bolton, and has agreed this with Leeds Clinical Commissioning Group and for NHS England's specialised services contract.

Broadly, aligned incentives contracts move away from national tariff and share risk, giving providers a minimum income with incentives to reduce costs.

'I think we are the first trust to do that with specialised commissioners and it's given us lots of momentum for people to think about integration that works with the aligned incentives contract that do not work under payment by results,' Mr Worthington says.

'In 2018/19 the trust is looking to save £75.7m to achieve a control target deficit of £3.5m. If we do so, we will get £32m in provider sustainability funds [PSF] to get a surplus just short of £29m. Around £15m of that £75m savings comes from savings identified in the aligned incentives contract.'

One of the biggest risks in its savings plan is whether it will be allowed to set up a wholly-owned subsidiary to provide non-clinical services, including estates and facilities, procurement, clinical engineering and new capital developments. Other trusts in West Yorkshire, as well as other parts of the NHS, are also hoping to establish subsidiaries, but the planned move has attracted a lot of criticism locally, particularly from MPs.

As an NHS trust, the Leeds plan must be approved by the health and social care secretary. 'It's a difference between what you can do as a foundation trust without needing permission and what you must seek approval for as an NHS trust. It's frustrating because it's a substantial improvement opportunity,' says Mr Worthington.

In its five-year plan, the trust is targeting a £45m surplus by year four (2021/22) – crucial if it is to move forward with planned major development of the Leeds General Infirmary site in the city centre. The project will cost £300m-£400m, with revenue consequences of £36m a year. The trust board wants an annual surplus in place to cover this cost. 'There is a concern that if we don't get the wholly-owned subsidiary through, we will be unable to earn the PSF and that will have an impact on our redevelopment plans,' Mr Worthington says.

Despite this, with finances stabilising and a renewed focus on quality, Leeds Teaching Hospitals is looking to a brighter future.

"Developing confidence in my own abilities, the culture of my team and the direction of travel of the trust has been the best bit"

Becky Vickers, Leeds Teaching Hospitals NHS Trust

Chemotherapy improvements

Phil Wood, Oncology CSU clinical director, worked with the team on the day case chemotherapy unit to improve patient experience and consequently increase productivity.

Initial observations identified that up to 90% of patients' time on the unit was spent waiting for something to happen – blood test results, for example, or chemotherapy drugs delivery. Although patients reported that the staff on the unit provided excellent care, the number of different processes used in providing the chemotherapy made the environment stressful for nursing and pharmacy staff.

Dr Wood worked with the nursing and pharmacy teams using tools from the Leeds Improvement Method. After an initial waste walk and 5S work in the treatment delivery room, the unit team, in collaboration with pathology, piloted a new method to speed up the return of blood test results by over 30 minutes, significantly reducing the time patients waited prior to treatment.

An electronic chemotherapy scheduling system, which had previously been purchased but not used, was implemented over the next few months. This significantly improved the readiness of treatment for patients when they arrived, allowing the team to plan more effectively with patients when they could attend. This increased the unit capacity to treat patients by 20%, enabling the team to add one extra treatment per day.

The work was part of the trust's Lean for Leaders programme, a six-month programme run by the KPO, giving formal training in Lean methodology.

Alyson Beckett, senior sister on the Chemotherapy Day Case Unit, said: 'Taking part in the Lean for Leaders programme has really empowered the team to make changes and see the impact that small incremental changes can make safely for patients. It has greatly improved the patient experience, which has been wonderful to see.'

HFMA costing module pilot

'Supporting quality care with patient-level costing'

The HFMA Academy are developing a new level 7 qualification module focused on supporting quality care with patient-level costing. The module is open to a wide range of learners, including costing practitioners, finance staff, general managers, clinicians and other healthcare professionals.

HFMA are running a pilot of the module in September 2018 for up to 20 learners at a reduced rate.*

Deadline for applications: **25 June 2018**

*For full details and fees please visit hfma.to/costingpilot
To apply please contact academy@hfma.org.uk or call 0117 938 8315

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Aaron Cummins takes first chief executive role

Cash management and board visibility of cash position thrown in the spotlight

Technical update

It has hard to miss the recent publicity around the separate financial difficulties of Barking, Havering and Redbridge University Hospitals NHS Trust and construction/facilities management company Carillion, *writes Debbie Paterson*. Both cases have highlighted the use of delaying payments to creditors as a working capital management technique and the perils of not reporting this key performance metric to boards in an accessible way.

In their annual report and accounts, NHS bodies are required to report their performance against the better payment practice code of paying all payables within 30 calendar days of receipt of goods or a valid invoice. There is no requirement for it to be reported to boards more frequently than that. However, recent experience shows that this one metric can act as an early indicator of bigger financial problems.

NHS Improvement's Single Oversight Framework (SOF) includes two metrics that relate to cash management:

- Capital service capacity – the degree to which income covers the provider's financial obligations
- Liquidity – the number of days of operating costs held in cash or cash equivalent forms.

Again, there is no requirement to report the metrics that feature in the SOF other than, for foundation trusts, in their annual report. However, if these are the metrics that the regulator is looking at, then it makes sense that they should be reported to board members and senior management.

Cash management – covered in a new briefing* from the HFMA – is more than simply delaying payment of creditors. On the cash outflow side of the equation, it involves entering into a constructive dialogue with suppliers. Some will accept longer payment terms for the peace of mind of knowing when they will be paid and not having to chase further for payment. Others may need to be paid within 30 days (or even the 10 days that central government bodies work towards).

Some NHS bodies are only making a single payment run each month, which has efficiencies and allows time for proper review of invoices. Others are changing authorisation levels to manage outflow.

On the cash inflow side of the equation, income streams are largely predictable for most NHS bodies. Commissioners in England, as well as health bodies in the devolved nations, are funded direct from government through allocations that they can draw down monthly.

NHS provider bodies in England rely on the standard contract for the majority of their income, so the payment terms are known – although this is not always advantageous as it can take three months for 'over-activity' to be paid. Recent guidance aimed at maximising overseas patient income can be used for other income streams, such as private patients.

Overarching all of this, cashflow forecasts are vital to ensure that finance is available when needed. Forecasts should be routinely made for the short term (to the end of the current financial year and milestones within that year) and reported to senior management.

Medium- to long-term cash forecasts (two to five years) will be made as part of the annual planning cycle, but may need to be reviewed more frequently if plans change.

The more precarious the financial position, the more important it is to be able to accurately predict how close to cash plans the organisation will be at the end of the financial year (the short term) and in the longer term.

The frequency that cash forecasts are prepared and reviewed will vary from NHS body to NHS body. However, as cash balances become smaller, accurate and regular cash forecasting becomes more critical.

A deteriorating cash position may be an early sign that an NHS provider is in financial distress. The cash position should always be considered alongside other metrics.

For example, if cash balances are declining, but there is no corresponding deterioration in the surplus/deficit position, questions may be asked about why this is. It may be due to a capital project which will not impact the revenue position, that the level of receivables is increasing and income is not being collected or that savings plans are showing reduced expenditure but are not affecting cash flow (for example by reducing depreciation charges).

SHUTTERSTOCK

Debbie Paterson is HFMA policy and technical manager

* *Treasury and cash management in the NHS* is due out in June. See www.hfma.org.uk/publications

Technical review

The past month's key technical developments

Technical roundup

NHS Improvement has published a costing assessment tool for acute services. It is intended to provide an objective assessment of the quality of costing at each trust and the degree to which patient-level costing standards have been implemented as costing practitioners move towards full implementation of the *Healthcare costing standards – acute*. The tool, the latest release as part of the **Costing Transformation Programme**, should be submitted to NHS Improvement on 21 September, with analysis dashboards issued back to submitting trusts in October. http://hfma.to/6m

A case study published by the HFMA demonstrates how one trust **improved confidence in its costing data** by triangulating the cost data with two national benchmarking sources – the Model Hospital and *Getting it right first time*. The case study describes how the external sources validated information clinical teams had been given to help understand financial losses in ophthalmology services over several years. It is available for download by members of the HFMA Costing for Value Institute as part of a growing collection of such resources. http://hfma.to/1x

Training materials have been released by NHS England to support invoice validation for **integrated single finance system** staff. The training relates to occasions when personal confidential data is included in scanned invoices requiring validation for patient care. http://hfma.to/6n

NHS England has updated its ***NHS standard contract technical guidance 2017-19***. The guidance is applicable to the full length and shorter version of the contract and the updates include sections to support the new General Data Protection Regulation (GDPR). http://hfma.to/6o

NHS Improvement is giving intensive support to 50 acute trusts it believes have the greatest potential to improve **recovery of costs from overseas visitors**. In a provider bulletin, the oversight body said the trusts accounted for almost £44m of the potential £54m to be recovered. The new programme will look to recover 95% of this potential; increase the collection of invoiced income to reduce debt; introduce new techniques to identify chargeable patients; and develop metrics, including the Model Hospital, to help trusts review data. http://hfma.to/6p

No significant findings – indicating no material non-compliance with the *Code of audit practice* – were found in a **review of a sample of NHS foundation trusts' 2016/17 audits**. The annual review, by the Quality Assurance Department of the Institute of Chartered Accountants in England and Wales, highlighted other matters in areas including: audit evidence; documentation of audit work; in-year FT authorisation; presentation of financial statements; letters of representation; and limited assurance reporting on quality report/indicators. http://hfma.to/6q

The International Accounting Standards Board (IASB) has issued a revised ***Conceptual framework for financial reporting.*** An updated *Financial reporting watching brief* from the HFMA explains that the framework is not a standard itself but helps the IASB frame new standards and is available for entities to use when developing accounting policies in the rare cases that their transaction is not covered by an accounting standard. Key changes include the introduction of concepts on measurement and presentation. http://hfma.to/6r

The Treasury and HMRC have started a consultation on **tax avoidance in the private sector**, proposing that off-payroll rules will be changed in line with those made in the public sector. They have also published the results of research on the implementation of these changes in the public sector, which found the changes had minimal impact on how public bodies recruit and their ability to fill vacancies. However, there has been a small reduction in the use of off-payroll contactors and some impact on rates, particularly where the roles were for skills in short supply such as doctors and nurses. A fact sheet on the proposals said the public sector reform had raised an additional £410m of income tax. http://hfma.to/6s

Lung cancer treatment gets green light

NICE update

NICE guidance (TA520) recommends atezolizumab as an option for treating locally advanced or metastatic non-small-cell lung cancer (NSCLC) after chemotherapy, *writes Gary Shield*. It is recommended only if:

- Atezolizumab is stopped at two years of uninterrupted treatment or earlier if the disease progresses
- Roche provides atezolizumab discounted as agreed in the patient access scheme.

Locally advanced or metastatic NSCLC that has progressed after chemotherapy is often diagnosed late in life and has a poor prognosis. It is a debilitating condition with many distressing symptoms.

Platinum-based chemotherapy is given as a first treatment in people whose tumours are not epidermal growth factor receptor (EGFR)-positive, followed by docetaxel, or nintedanib plus docetaxel for people with adenocarcinoma. For those with EGFR-positive tumours, treatment starts with a tyrosine kinase inhibitor followed by platinum-based therapy.

For those with anaplastic lymphoma kinase (ALK)-positive tumours, standard treatment is ALK inhibitors followed by platinum-based chemotherapy. NICE technology appraisal guidance recommends pembrolizumab for treating PD-L1-positive NSCLC after chemotherapy; pembrolizumab is also recommended as an option for untreated PD-L1-positive NSCLC if the tumour expresses at least a 50% tumour proportion score. Nivolumab is also recommended by NICE for use within the Cancer Drugs Fund as an option if tumours are PD-L1 positive.

The annual incidence of adults with NSCLC in England is 33,300. It is estimated 4,000 people in England with NSCLC who are PD-

Diary

June

7 (B) West Midlands: annual conference, Sutton Coldfield
8 (B) West Midlands: NHS finance – the next generation, Sutton Coldfield
13 (B) Kent, Surrey and Sussex: branch event, Brighton
13 (B) Yorkshire and Humber: collaboration, Pontefract
14 (B) Eastern: positive psychology to improve wellbeing and resilience, Newmarket
15 (B) North West: health sector insights, Liverpool
19 (B) South Central: introduction to NHS finance, Newbury
20 (N) Brighter together: workforce forum, London
21 (B) London: annual conference, Rochester Row
26 (B) Northern Ireland: communicating financial information effectively, Newtownabbey
28/29 (B) North West: annual conference, Blackpool
29 (B) Wales: collegial conversations

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) HCVI: introduction to costing (South)
19 (B) Eastern: student conference, Cambridge
19 (N) CIPFA/HFMA health and social care finance conference
20 (F) Provider Finance: technical forum, preparing for IFRS16
20/21 (B) South West: annual conference, Bristol
25 (N) CEO forum, Rochester Row
27/28 (B) Wales: annual conference, Hensol
27 (F) Mental Health Finance: annual conference, London, Rochester Row

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

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

L1-positive are eligible for treatment with atezolizumab each year; 1,800 who are PD-L1-positive will have atezolizumab from year 2019/20 onwards once uptake has reached 44%.

It is also estimated that 2,100 people in England with NSCLC who are PD-L1-negative are eligible for treatment with atezolizumab each year; 1,900 people will have atezolizumab from year 2019/20 onwards once uptake has reached 90%.

A resource impact template has been produced to support implementation of the guidance The comparators – pembrolizumab, nintedanib and nivolumab – also have patient access schemes. The use of atezolizumab is commissioned by NHS England. Providers are NHS hospital trusts.

Gary Shield, resource impact assessment manager, NICE

Events in focus

Convergence 2.0
5-6 July, Nottingham

With all sides of the political divide, thinktanks, pressure groups and staff agreeing that the NHS needs a long-term funding settlement and greater integration, the annual Convergence conference could not be more timely. Locally and nationally in England, there is greater integration between commissioners and providers, through sustainability and transformation partnerships (STPs) and the emerging integrated care systems (ICSs). And last month, NHS England and NHS Improvement unveiled measures that will lead to closer collaboration between the organisations, including a single finance and performance regime and a national finance chief. Other parts of the UK are seeing further moves towards integration or, in Northern Ireland, have already integrated health and personal social services.

Local STP chair David Pearson (pictured) will outline Nottinghamshire's experiences of integration, while his colleagues will hold workshops on embedding out-of-hospital care and mental healthcare in the STP and ICS.

In addition, the NHS will mark its 70th anniversary during the conference, presenting an opportunity to consider the next 30 years and what the service will look like at 100. Delegates will examine issues likely to be faced in the coming years, such as workforce and advances in technology.

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

Brighter together: workforce forum
20 June, London

HFMA 2018 president Alex Gild's focus is on collaboration and partnership, supporting innovation and bright ideas. He wants to support the formation of alliances across teams, organisations and health and care systems with the aim of improving services to patients.

A large element of his theme is support for HFMA members, with sessions on three topics – workforce, procurement and estates. These sessions will offer members a chance to work with colleagues and find fresh solutions to the challenges faced in these areas.

The next session – on workforce efficiency and value – will feature case studies, interactive workshops and networking opportunities. There will also be insights into the new NHS workforce strategy, which is due in July.

The event is free for full individual HFMA members and they are encouraged to bring along an HR colleague (price: £99 for non-members).

• To book, please email clare.macleod@hfma.org.uk

A sunny outlook?


SHUTTERSTOCK

Association view from Mark Knight, HFMA chief executive

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

My HFMA

May's welcome sunshine will have got many of us hoping for a long, hot summer. Our last big event before then is the summer conference – or Convergence 2.0 as it's called. This event is our joint commissioning/provider forum and is to be held at Nottingham University.

It is the second time we've bought together our provider and commissioning faculties' annual conferences, because system working remains the service's major focus as we face up to current challenges.

The event will also see the launch of a special publication – *NHS at 100*. This briefing, informed by a roundtable discussion held in May, will think beyond this July's 70th birthday to imagine what the NHS – and its finance function – will look like in 2048.

If I live that long, I'll be 82 and the chances are that I'll be having many more interactions with healthcare services than I do now. Demography, technology, changing lifestyles all present challenges for the service. But there are opportunities too, with a greater focus on prevention, for example, enabling people to be healthy for longer, as well as reducing some of the demand for healthcare services.

Some of the decisions taken now and in the coming years will determine whether any vision of our health service is based on what we would like to see or what we are able to deliver within available resources.

Perhaps the most high-profile uncertainty is around funding, and we are eagerly awaiting further details of what resources might be made available to underpin a new long-term plan for the service. The media is full of speculation, ranging from real-terms increases of anything from 2% to 4%. Last month's Institute for Fiscal Studies report actually argued that a 'modernised' NHS would need any settlement to be frontloaded, leading to even higher increases in the early years.

But the size of the funding pot and its phasing are not the only questions that the NHS needs to address. It also needs to be thinking through how this money flows through the system, getting to the right places in an equitable way, while incentivising integrated care.


HFMA chief executive Mark Knight

This is an issue addressed in new research from PwC, carried out in conjunction with the HFMA and published at the end of May. Changing financial flows will not be a straightforward process, but we need to start thinking about what mechanisms we need in place to drive and underpin sustainable services across the NHS. With its depth of financial expertise – both in the association's central team and in its practitioner-dominated membership – HFMA is the right organisation to be involved in this work and I am delighted we are playing a part in raising the profile of this key issue.

Looking ahead into the association's own future, its new qualifications are likely to play a bigger and bigger role. There has been huge interest in our MBA-level and other qualifications, and we see this continuing.

There is a real appetite out there for further qualifications relevant to people's day-to-day roles and we are excited about these initiatives.

Finally, any senior professionals interested in becoming an HFMA trustee (*see page 24*), please contact me at chiefexec@hfma.org.uk

Member news

A photo by East Midlands Branch treasurer Scott Jarvis is featured on the Derbyshire Wildlife Trust (DWT) Twitter account. Mr Jarvis has been a member of DWT for years and often sends photos into its social media channels or magazine. 'Birdwatching and photography takes my mind off work at the weekends,' says Mr Jarvis, who is also director of operational finance at Derby Teaching Hospitals NHS Foundation Trust.

Last year at the HFMA annual conference he won a photography competition for the annual calendar of CY Executive Resourcing – his photo features in the March page and he won the overall vote from the public.

Northern Branch chair David Chandler organised for more than 140 kids football kits to be sent to India to support Tender Heart – a charity that runs a school to give basic education to 450 children. The school also has a programme to help local women create items to sell. Mr Chandler, who organised the kit collection in North-East England, said: 'The North-East is a hotbed of football and we quickly collected the football strips from lots of generous mums, dads and kids. They've gone to a very good home over in India (mostly to children who live in the poorer area). Who knows, maybe one day one of those kids will end up playing for the Toon.'

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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

Branch focus

My HFMA

East Midlands Branch

Last April, the intermediaries legislation (also known as IR35) was amended to ensure that people doing the same job in the public sector pay roughly the same amount of tax, regardless of how they are employed. Under the new legislation public sector bodies must assess whether personal service companies meet the contract criteria or whether an individual should be paid through payroll, having deducted tax and national insurance contribution.

How this affects finance staff and the day-to-day details of working with the new regulations were among the topics that the East Midlands Branch Technical Issues Group discussed in its first year. Launched last May, it has since gone from strength to strength.

'The group offers a different level of debate – the people attending are actually doing the things we discuss on a daily basis,' says Ken Godber (pictured), assistant director of finance at Chesterfield Royal Hospital NHS Foundation Trust and chair of the national HFMA Charitable Funds Special Interest Group.

Mr Godber, chair of the branch TIG, usually circulates the agenda and minutes from the HFMA Provider Technical Issues Group at the branch TIG meetings. 'This allows us to discuss the more technical aspects of the agenda on a local level,' he says.

The East Midlands Branch Technical Issues Group usually meets after the senior finance staff forum, held quarterly and hosted by branch treasurer Scott Jarvis. This month's forum attendees will hear from NHS Improvement and NHS England, who will review the 2018/19 planning round.

'I'm sure the people filling in the finance, workforce, activity and triangulation forms will have lots of questions for the people who designed them,' says Mr Jarvis.

An East Midlands costing forum, run by Scott Hodgson, head of costing at Nottingham University Hospitals NHS Trust, is also part of the branch's portfolio of networks.

And the branch runs an awards programme with five categories, including unsung finance hero and team of the year.

• For more on the East Midlands branch, go to http://hfma.to/eastmids or email Joanne Kinsey, branch administrator, at dhft.hfmaeastmids@nhs.net

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

Appointments

Helen Stratton, chief finance officer of South Norfolk and North Norfolk clinical commissioning groups, has been appointed interim chief officer. The move follows chief officer **Antek Lejk**'s appointment as chief executive officer at Norfolk and Suffolk NHS Foundation Trust.

Lincolnshire Community Health Services NHS Trust has appointed **Sam Wilde** interim director of finance and strategy, following the appointment of **Danielle Cecchini** (pictured) as Leicestershire Partnership NHS Trust's director of finance. Mr Wilde was previously associate director of finance at Norfolk Community Health and Care NHS Trust.

Adrian Marr, NHS England Midlands and East (East) director of finance, will succeed **Andrew Pike** as interim director of commissioning operations at the Midlands and East regional team. Mr Pike will replace **Clare Culpin** as managing director of Basildon and Thurrock University Hospitals NHS Foundation Trust. Mr Marr has over 30 years' experience in NHS finance, working in both provider and commissioner organisations across the East of England.

Patrick Crowley (pictured) will retire at the end of the month as chief executive of York Teaching Hospital NHS Foundation Trust after 11 years in the role. He first joined the organisation in 1991 and has held several finance and performance management roles since, including director of performance and finance director, a post he took up in 2001. Six years later he was appointed chief executive. **Mike Proctor**, deputy chief executive, will become acting chief executive at the trust.

Scott Urquhart has become director of finance at NHS Forth Valley. He was previously assistant director of finance at the organisation and takes over from **Fiona Ramsay**. Ms Ramsay has retired after a longstanding career in the NHS. Mr Urquhart has over 20 years' experience with the NHS.

The Finance Delivery Unit, a recently established unit within NHS Wales to support delivery of improvements in financial performance, has made appointments to its senior team. The director, **Hywel Jones**, came into post in January 2018, from his previous role of assistant finance director at Aneurin Bevan Health Board. Further appointments have now been made, with **Emma Wilkins** appointed as deputy director, and **Tim Kelland** (pictured), **Claire Green**, and **Stacey Taylor** appointed as assistant directors. All four currently work in senior roles within NHS Wales.

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

"It's one of the most privileged positions in the NHS to be a chief executive. Why would you not want this job?"
Aaron Cummins, University Hospitals of Morecambe Bay NHS Foundation Trust

Cummins takes exec role

On the move

University Hospitals of Morecambe Bay NHS Foundation Trust's Aaron Cummins had a long-held ambition to be an NHS chief executive. So, when the trust's chief executive, Jackie Daniel, decided to stand down, he jumped at the chance. And, following an open recruitment exercise, he started in the post in April.

'Since I completed the national graduate training scheme in 2004, I had an ambition to be chief executive of a hospital. My career plan was always about gaining the best opportunities, development and training, as well as learning from others to better understand the chief executive role,' he says. 'I am proud to be appointed. It's one of the most privileged positions in the NHS to be a chief executive. Why would you not want this job?'

Mr Cummins' determination to achieve his ambition led him to the troubled Mid Staffordshire NHS Foundation Trust, where he was director of finance/deputy chief executive for about two years. 'I wanted to experience leadership in a challenging environment,' he says.

Morecambe Bay was next. He joined in January 2014 as deputy chief executive and finance director.

The trust had its own quality issues, but has been transformed in the past few years – in 2017 the Care Quality Commission rated it outstanding in the 'caring' inspection area and gave the trust an overall rating of good.

Mr Cummins says his knowledge of the Morecambe Bay trust has helped him settle in quickly. 'I was well prepared, but from day one I've been keen to point out that it's an entirely different role for me,' he says. 'I've asked people to treat me like a new chief executive – I am going out to listen to people with fresh ears.'

He has three clear objectives. Quality, including patient experience and services, is his first priority. The second relates to the successful transformation of community services as local integration gains pace. The trust is taking on local community services and is due to transfer in around 750 community staff this year.

Dealing with national priorities is his third objective. 'We are in a good position to continue the improvement journey we are on. Would I like more staff? Of course. Would I like more capital to accelerate the pace of change? Yes. But we are not waiting for these things to happen.'

He says the trust is in a good position, both operationally and financially. Headline figures, such as the four-hour A&E target and the referral to treatment target, are improving, while feedback from the staff survey and Friends and Family test remain positive.

Mr Cummins continues: 'This organisation can hold its head up high. We don't get it right every time, but we do our best and the sense of optimism from staff is palpable.'

Financially, the trust has achieved its targets in each of the last five years, with cost improvement programmes of between 4% and 5% each year. However, a structural deficit of £34m-£40m needs to be tackled while maintaining access to safe services for patients.

Staff development is at the forefront of Mr Cummins' mind. He was disappointed to find so few accounts of what it's like to move into the chief executive role. And he found the HFMA's recent NHS finance census and survey worrying, with its findings that few deputies hope to become finance directors.

As a result, for the first 100 days in his new post, he is tweeting each day and publishing a blog each month reflecting on his experiences. He wants to inspire staff to strive for more senior positions – deputy finance director to finance director and finance director to chief executive.

'I want to encourage colleagues to bear with the current environment, because it will improve. The skill set of the finance community is well suited to the deputy chief executive and chief executive roles.'

• *Aaron Cummins' blog can be found at www.uhmb.nhs.uk*

FLC outlines strategy

Future focused finance

The Finance Leadership Council (FLC) has agreed a new strategic direction to take it through to 2022.

The new strategy will see Future-Focused Finance working closely with the Skills Development Network to develop a diverse, appropriately skilled, adaptable and resilient finance function and workforce, to ensure value for money and quality services for patients. Existing work programmes will be extended where necessary, while they will also develop new areas of work to meet new challenges faced by the function.

The work will fall under five key themes. The first is ***Driving and designing finance to adapt to system change***. This will require the function to participate in system-wide changes to create real improvements for patients.

Second, the FLC has challenged the function to continue developing its ***Culture***, by promoting good values, attitudes and beliefs, resulting in environments in which all staff can fulfil their potential.

The third theme is ***Workforce and leadership***. Here, FFF and FSD are being challenged to provide programmes to support talent development, not just for those with the appetite to be finance leaders but also for those who create stability and sustainability through their experience and dedication to the function.

The fourth area, ***Engagement and development***, will embed equitable access to opportunities for all to develop their knowledge of NHS finance.

Finally, the focus on ***Efficiency and value*** will promote ways of working that improve outcomes or reduce resources without compromising either to improve value for patients and taxpayers.

HFMA Qualifications
Masters-level qualifications in healthcare business and finance

Funding support for HFMA's masters-level qualifications

There are different funding options available to support you to study HFMA's masters-level qualifications in healthcare business and finance. Funding support includes:

- **NHSI/E bursary**
- **HFMA branch bursary** (devolved nations)
- **Professional career development loan**

Contact HFMA to discuss the best options available to you:

hfma.to/feesandfunding
0117 938 8315
qualification.enquiry@hfma.org.uk

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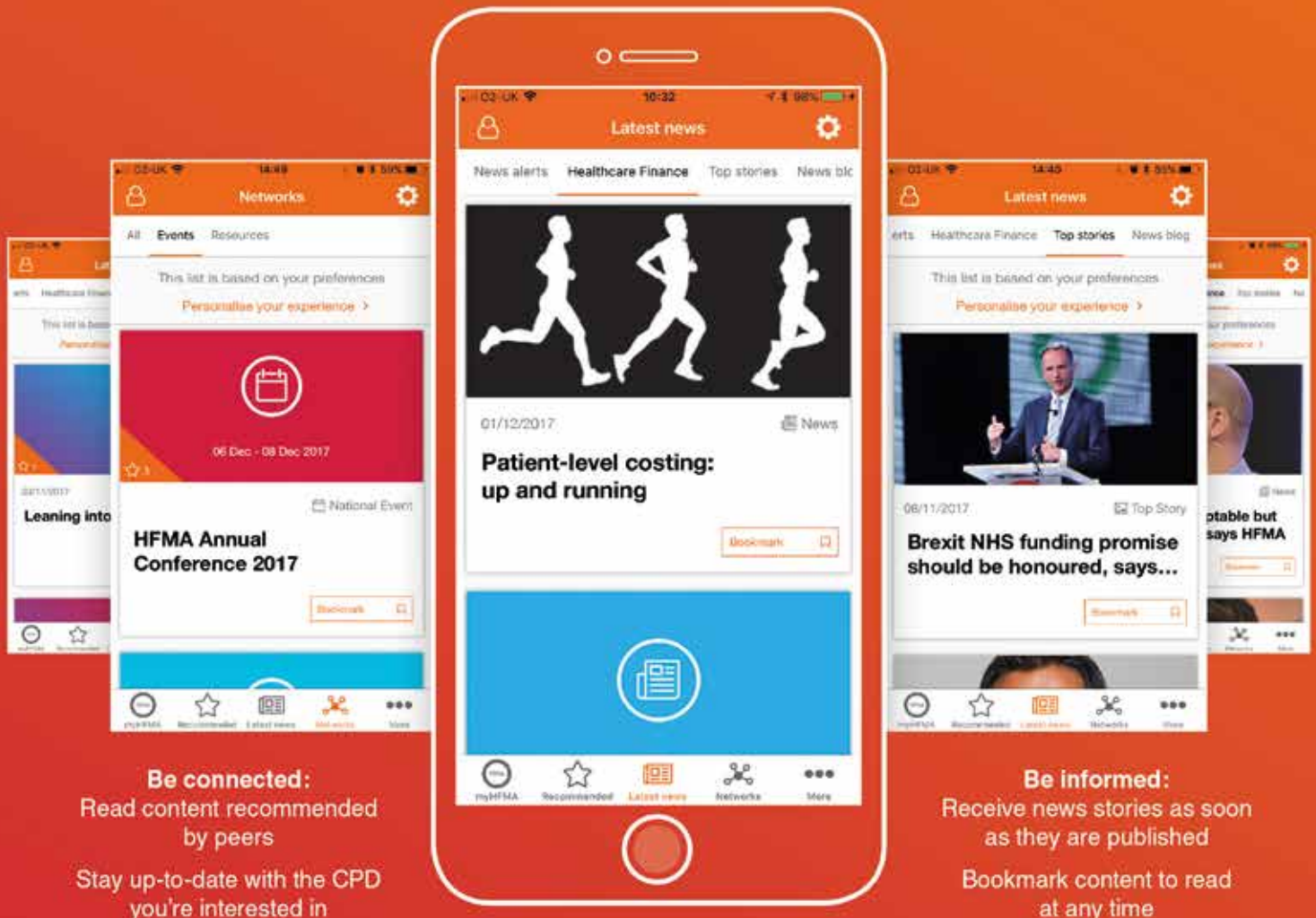

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