healthcare finance

February 2018 | Healthcare Financial Management Association

www.hfma.org.uk

Alex Gild

Bright future for the NHS

HFMA Qualifications in healthcare business and finance

Bursary available for HFMA postgraduate qualifications

Funding of 50% of study fees is available for the May 2018 intake.

Applications are open for the May 2018 intake. To apply or to find out more about the bursary, please contact the qualifications team:

T: 0117 938 8974
E: qualification.enquiry@hfma.org.uk
W: hfma.to/qualification

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

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

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

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

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

Subscriptions and membership
Flo Greenland
0117 938 8992
flo.greenland@hfma.org.uk

Production
Wheal Associates
020 8694 9412
kate@whealassociates.com

Printer
Pureprint

HFMA
1 Temple Way,
Bristol BS2 0BU

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

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

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

ISSN 1472-3379

Contents

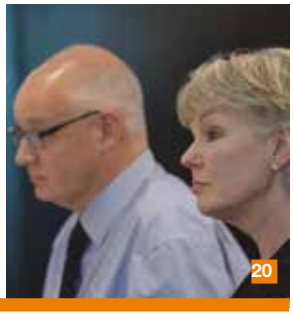
February 2018

News

Comment

Professional lives

Features



Realtime Rostering

hfma Corporate Partner

Quick, simple and easy to use at a competitive price

Accurate, efficient system that allows you to roster all staff groups. Seamless integration with your existing systems. Robust auditing and reporting functionality.

Choose better

Control

- The most competitive solution in the market place
- Not only covers doctors rostering, but all staff rostering
- Flexible,easy to use, and easy to switch
- Reliable customer service and support, including training
- Cost efficient, with significant reduction in admin
- Access from anywhere on any device

Choose a better E-Rostering solution:

realtimerostering.uk realtimerostering@skillsforhealth.org.uk 0117 910 2286

Skills for Health

News

Short-term focus hampering transformation, says NAO

By Seamus Ward

Increased reliance on financial support and non-recurrent savings suggest NHS financial problems have not eased, according to the National Audit Office.

In its sixth report on NHS sustainability, the NAO said it seemed additional funding was spent on helping the NHS cope with current pressures rather than investing in the transformation needed to put the service on a sustainable footing.

The report, *Sustainability and transformation in the NHS*, said the overall financial position improved in 2016/17 – a £1.8bn deficit in 2015/16 became a £111m surplus in 2016/17. But it was hard to measure the underlying position, and two figures indicate finances were not improving.

First, there was a sharp increase in the cash support given to providers. This money was not part of contracts for services, suggesting providers were struggling to deliver patient care under their contracts with commissioners, the auditors said.

In 2016/17, national bodies gave trusts £4.1bn in financial support not linked to commissioner contracts. NHS Improvement had hoped the £1.8bn sustainability and transformation fund (STF) would reduce the need for such cash support – £1bn of STF was given as cash in year.

But on top of this, cash support increased from £2.4bn in 2015/16 to £3.1bn in 2016/17. Most of this (£2.7bn) was revenue support, paid directly to trusts to maintain services.

Second, providers and clinical commissioning groups became increasingly reliant on non-recurrent savings to achieve efficiency targets. The bodies increased their savings overall – between 2014/15 and 2016/17, CCG savings rose from £1.4bn to £2bn, and for trusts from £2.8bn to £3.1bn. But over the same period, the proportion due to one-off savings rose from 14% to 17% for commissioners and 14% to 22% for trusts. This increasing reliance on non-recurrent savings posed a risk to financial sustainability, the NAO said.

"The public purse may be better served by a long-term settlement that provides a stable platform for sustained improvements"
Amyas Morse, NAO

The report said the STF was set up to return trusts to aggregate financial balance and give them the stability to transform services and improve performance. However, the financial reset in July 2016 moved the objective away from transformation to help trusts target a combined £580m deficit in 2016/17 (the final deficit was £791m).

Most of the STF (60% – just over £1bn) was used to reduce or eliminate in-year deficits, with the balance being used to create or increase surpluses. However, this money will not necessarily be available to spend in 2017/18 if trusts are again going to meet control totals.

The report made several recommendations: the NHS should move 'further and faster' to system-wide incentives and regulation; reassess how best to use the STF to support trusts beyond 2018/19; and calculate and publish the underlying financial position in the trust sector annually.

The NAO also called for a timetable for the availability of capital for transformation and backlog maintenance and said NHS Improvement and NHS England should provide financial support for local partnerships making the slowest progress.

'The NHS has received extra funding, but this has mostly been used to cope with current pressures and has not provided the stable platform intended from which to transform services,' said NAO head Amyas Morse (above).

'Repeated short-term funding-boosts could turn into the new normal, when the public purse may be better served by a long-term funding settlement that provides a stable platform for sustained improvements,' he added.

Nuffield Trust senior policy analyst Sally Gainsbury said trusts had been grappling with rising prices and significant cuts to their income per patient. 'This has meant they are relying increasingly on one-off savings and bailouts to balance the books, leading to a significant underlying deficit,' she said. 'This has left hospital trusts with no choice but to spend the money earmarked for reforming services – the STF - on dealing with their yawning deficit.'

CIPFA has warned that financial pressures are undermining sustainability and transformation partnerships (STPs). In a submission to the Commons Health Committee inquiry on STPs, CIPFA said the need to plug gaps in resources and capacity had taken the focus away from STPs, with little evidence of concrete changes or investment in measures that will make services sustainable in the long term.

Gild takes on presidency

Alex Gild became HFMA president at the annual conference in December. Mr Gild (pictured), chief financial officer at Berkshire Healthcare NHS FT, received the chains of office from outgoing 2017 president Mark Orchard. He also unveiled his theme for the year ahead – *Our NHS, your HFMA, brighter together* (page 16).

The conference (page 8) included an awards ceremony for the first 15 students to complete a module of the HFMA's masters-level qualifications. Tracy Parker (pictured) was the first winner of the Tony Whitfield Award, which will be given each year to the qualifications programme student of the year. Ms Parker, assistant director of contracting at East Riding of Yorkshire CCG, is studying for the higher diploma.

• More details about the qualification at **www.hfma.org.uk/education-events/**

Mental heath funding gap grows larger despite income growth in 2016/17

By Seamus Ward

Though mental health providers in England received significantly more funding in 2016/17, the gap with acute spending grew wider, according to the King's Fund.

Its research showed that 84% of mental health trusts received an increase in funding in cash terms – in the previous two years, almost 50% of providers had seen a decrease in income.

However, with priority given to reducing deficits and improving A&E performance, funding for acute and specialist trusts grew more quickly than their mental health counterparts.

The government has committed to ensuring parity of esteem between mental and physical healthcare, providing workforce support and greater equality in funding for mental health services. The latter measure is being driven through the investment standard for commissioners, which requires clinical commissioning groups to increase spending on mental health services each year in line with their own budget rise.

The fund's report, *Funding and staffing of NHS mental health providers: still waiting for parity*, said mental health trust income rose by 2.5% in 2016/17, while in acute and specialist trusts it grew by 6%. Funding for mental health providers increased by 5.6% since 2012/13, compared with 16.8% for acute trusts.

The King's Fund said this squeeze on mental health trust funding, combined with a shortage of available staff, had led to workforce pressures that put the safe staffing of services in jeopardy. It added that the number of mental health nurses had fallen by 13% since 2009 and 10% of all posts in specialist mental health services are vacant.

The fund's analysis of Care Quality Commission inspection reports for all 54 mental health trusts showed staff shortages were identified as a problem in more than half of the providers. This led to a higher risk of inpatient self-harm and suicide, delays in treatment, reduced access to care and bed closures.

It also looked at a small sample of board papers, finding that trusts had difficulties staffing wards on a day-to-day basis, relying on agency and bank workers and staff substitutions – putting in a healthcare assistant when a registered nurse could not be found for a shift, for example.

Helen Gilburt, King's Fund fellow in health policy and lead author of the paper, said it was

Helen Gilburt: 'funding gap between mental health and acute is continuing to widen'

difficult to deliver parity of esteem when the whole of the NHS was under huge pressure. While most CCGs had met their commitments to raise spending on mental health, their focus was on relieving pressure on acute hospitals.

'Unless funding grows more quickly, mental health providers may end up implementing improvements to some services at the expense of others,' she said. 'Despite the commitment of national leaders, the funding gap between mental health and acute NHS services is continuing to widen, while growing staff shortages are affecting the quality and safety of care.

'As long as this is the case, the government's aim to tackle the burning injustices faced by people with mental health problems will remain out of reach.'

MPs call for CPD budget to be reinstated

Health Education England has been urged to reverse cuts in continuing professional development (CPD) budgets to help address the trend of nurses leaving the profession.

In a report, *The nursing workforce*, the Commons Health Committee said the NHS was paying too little attention to retaining its nurses and this has resulted in more leaving the professional register than joining it.

The report said there were a number of reasons why nurses were leaving the profession.

These included workload, pay, lack of CPD opportunities and a general sense that they were not valued.

During the inquiry, the committee was told that CPD cuts had fuelled nurses' belief that they were undervalued.

The report said Health Education England's budget for CPD had fallen from £205m in 2015/16 to £84m in the current financial year.

NHS Employers told the committee that action was needed as CPD was vital in ensuring nurses could do their day-to-day jobs, but also gave them opportunities to move into advanced practice.

In its evidence to the committee, Health Education England said it had taken a conscious decision to shift funds to train more nurses for the future, but indicated its intention to increase funding again for nurse CPD. However, the report said, even if the funding were restored, nurses doubted they would be allowed to take CPD courses as they were so busy.

The report recommended funding allocated to trusts should be ring-fenced for nurse CPD. Specific funds should also be made available to support CPD for nurses working in the community.

It added that the government must monitor closely the impact of removing nursing bursaries – it was particularly concerned about the impact of bursaries on mature students.

Committee chair Sarah Wollaston (pictured), said: 'We met many frontline nurses during the course of this inquiry. We heard a clear message about workload pressures as well as ideas about how to address these.

'We will return to this subject in a year to make sure that improvements have been made in nurse retention, working conditions, and continuing professional development.'

Northern Ireland services need radical change, politicians told

By Seamus Ward

Health and social care in Northern Ireland could become gradually unsustainable if radical action is not taken, local Assembly members (MLAs) have been told.

At a meeting with a cross-party group of MLAs at Stormont in January, Department of Health permanent secretary Richard Pengelly said 2018 would be another difficult year for local services. Winter pressures were intense and unlikely to ease for a number of weeks, though an additional £10m had been found to mitigate the pressure. Co-operation across health and social care (HSC) was also helping, he added.

'Much more radical action is needed,' he told MLAs. 'We cannot consign our hospitals to a future where winter pressures simply intensify year on year, and the whole HSC system becomes steadily more unsustainable. There are no easy or short-term solutions but we owe it to patients and our great staff to start making it better.'

Transformation, backed with strategic investment in staffing and capacity, was the key to addressing winter pressures and other serious problems. 'We need to build up domiciliary care and other aspects of social care, enhance primary care to help people stay well and reshape our hospital services,' he added.

Projections from the Department of Finance showed health funding shortfalls of £151m-£171m in 2018/19 and £265m-£340m in 2019/20 under different funding scenarios.

The scenarios aim to inform an incoming executive's discussions on balancing the overall budget. Health funding would rise by 4.6% to 7% under the scenarios, but the Department insisted the figures were for illustration and no decisions had been made. The North has been without an executive for about a year.

The three scenarios include: a Budget approach broadly in line with 2016/17 and 2017/18 (with extra funding going to health and education); raising funds through additional charges or reviewing existing policies; and reallocating funds to priorities such as schools and health.

The HFMA has issued a briefing examining the differences in per capita healthcare funding between Northern Ireland and England. The document – which presents its findings for debate, not as a statement of what funding levels should be – found a £540m gap between the modelled need and actual funding in 2015.

NAO looks at PFI pros and cons

There is no evidence of increased operational efficiency in privately financed NHS hospitals, though there are a number of potential benefits, according to the National Audit Office.

A briefing on the rationale, benefits and costs of the private finance initiative and its successor, PF2, said the Department of Health and Social Care had used PFI more than any other (127 projects and an aggregate unitary charge of £13bn in 2016/17). Trust payments to their private sector partner range from 5.6% to 20.1% of turnover.

It said private finance had advantages – being off-balance sheet in government accounts and allowing public bodies to invest when capital funding is limited. The NAO did not give a view on value for money, but said: 'Our work on PFI hospitals found no evidence of operational efficiency: the costs of services in the samples we analysed were similar.'

A recent study showed costs such as cleaning were higher in PFI hospitals, though the Department says costs may not be comparable due to risk transfer and different cleaning standards.

Savings can be hard to achieve given the structure of deals, the NAO added.

The public sector has more equity in PF2 – it was believed this would reduce repayments and lower risk, attracting pension fund investment. However, the auditors said the proportion of debt to equity was similar to that in PFI and pension funds had yet to invest.

PAC demands detail of continuing healthcare savings

The Public Accounts Committee has questioned whether clinical commissioning groups will be able to achieve an NHS England target of £855m savings on continuing healthcare (CHC) spending.

While spending on CHC will continue to grow year-on-year, the savings are compared to predicted growth in spending on CHC and NHS-funded nursing care and must be delivered by 2020/21.

The influential Commons committee said it was unclear how this could be achieved without restricting access to care either by increasing eligibility thresholds or by limiting care packages.

Spending on CHC grew by 16% between 2013/14 and 2015/16, compared with 6% for the NHS as a whole. Estimates have suggested that spending on CHC and NHS-funded nursing care will increase by 45% by 2020/21 unless action is taken to control costs.

NHS England said that CCGs were on track to achieve the savings against projected spend and that the savings could be achieved by

tackling variation, adopting best practice, speeding up assessment work, reducing administration costs and using better case management.

Along with the Department of Health and Social Care, NHS England insists there is no quota or cap on access and that eligibility criteria will not change.

PAC chair Meg Hillier (pictured) said CHC funding oversight had been poor. 'NHS England's demand that clinical commissioning groups make big efficiency savings will only add to the financial pressures on the frontline,' she said. The committee called on NHS England to give a 'costed breakdown' of how efficiency savings will be made.

News review

Seamus Ward assesses the past two months in healthcare finance

It was inevitable that tales of winter pressures would dominate December and January. Amid continuing rumblings about NHS finances – and the 'reappointment' of Jeremy Hunt with an expanded portfolio that now includes social care – persistent cold weather and a flu outbreak contributed to some of the most difficult weeks the service has faced in the last few years.

The winter pressures hit hard in all four UK nations. By the end of the first week of 2018, the flu rate in Scotland was four times higher than the same week in 2017. GPs in Northern Ireland and Wales saw a big increase in the number of flu-like cases, while in England consultations for the illness rose by 42% between the first and second weeks of January. Flu and the cold weather were major reasons for a drop in A&E performance against the four-hour target – in Scotland just under 80% of patients were seen within four hours in the first week of 2018.

Meanwhile, in England weekly situation reports and monthly figures for December showed increasing strain on the system. Just over 85% of A&E patients were seen within the four-hour standard in December, according to NHS England. This compares with 88.9% in November 2017 and 86.2% in December 2016. The 95% target has not been met since July 2015. The figures show a 3.7% rise in A&E attendance compared with December 2016 and a 4.5% rise in emergency admissions. Overall, between December 2016 and December 2017 there was a 2.9% increase in emergency admissions. However, there was controversy over how the figures were calculated.

Governments and oversight bodies took steps to help the NHS cope. The Welsh government allocated £10m to health boards, the ambulance service and social care to help relieve winter pressures. It has also relaxed the quality and outcomes framework element of the GP contract until the end of March to allow practices to focus on the most vulnerable and sick patients.

NHS England allowed the deferral of non-emergency elective care to be extended until 31 January to help trusts cope. The National Emergency Pressures Panel said over the Christmas period there was sustained pressure on the NHS through high levels of respiratory illness, high bed occupancy, early indications of rising flu prevalence and suggestions that patients were arriving at A&E more seriously ill. The panel recommended measures to help hospitals cope. As well as a temporary suspension of sanctions for mixed-sex accommodation breaches, it said day cases and routine outpatient appointments should be deferred to release clinical time for non-elective care.

NHS Providers said the winter pressures marked a watershed for the NHS – government must accept that the service cannot do all that is required of it within the current funding envelope. In a letter to health and social care secretary Jeremy Hunt, the provider body said that despite greater preparedness than ever, there were not enough beds and staff to maintain standards of care and safety. It called for a review of how the NHS has handled the winter pressures and insisted decisions must be made on the long-term funding of health and social care before November's Budget.

A new year Cabinet reshuffle brought surprises for the NHS in England. Though Jeremy Hunt (left) was widely tipped to move on, he remains health secretary with additional responsibility for social care. Now health and social care secretary leading the Department of Health and Social Care, it is unclear what the change in title means. It was reported that the Department will take responsibility for an upcoming green paper on the future of elderly care. Two new ministers of state – Caroline

The month in quotes

'More people are visiting GPs with flu symptoms and we are seeing more people admitted to hospital with flu. In terms of hospital admission, this is the most significant flu season since the winter of 2010 to 2011 and the preceding pandemic year of 2009, although it is not an epidemic.'
Public Health England medical director Paul Cosford on the increase in flu rates

'The NHS is in the grips of another winter crisis, as patients face long delays, operations are cancelled and staff work under extremely difficult circumstances. What is happening in our A&Es is symptomatic of pressures across the entire system.'
Anthea Mowat, British Medical Association representative body chair, says solutions are required for the NHS as a whole

'The decision to cancel planned operations will have a significant impact on patients but the figures for bed occupancy show hospitals are effectively full. The service has reached the limit of what it can deliver within current funding levels.'
King's Fund policy director Richard Murray calls for a long-term funding solution

'Last year we had a lot of operations cancelled at the last minute. It is better, if you are unfortunately going to have to cancel or postpone some operations, to do it in a planned way. Although if you are someone whose operation has been delayed I don't belittle that for one moment and I apologise to everyone that has happened to.'
Health and social care secretary Jeremy Hunt apologises for the postponement of routine operations

SHUTTERSTOCK

Dinenage, former junior minister at the Department for Work and Pensions; and Stephen Barclay, previously economic secretary to the Treasury – join Mr Hunt.

Winter pressures hit hard. By the end of the first week of 2018, the flu rate in Scotland was four times higher than the same week in 2017

NHS England chief financial officer Paul Baumann (below) was awarded a CBE for services to NHS financial management in the New Year's Honours list. Mr Baumann joined the NHS in 2007 as London Strategic Health Authority director of finance and performance. He moved on to NHS England (then the NHS Commissioning Board Authority) in 2012.

The Department submitted its evidence to the NHS Pay Review Body in December, insisting that, in reaching its recommendations for next year, the body should take account of ongoing negotiations between NHS Employers and trade unions. The government has pledged to fully fund any deal for Agenda for Change staff that meets its requirements of improving staff retention and productivity. A separate letter for the Doctors' and Dentists' Pay Review Body (DDRB) asked it to take account of negotiations with the British Medical Association over consultants' contracts. Though the government's approach to public sector pay was now more flexible, Mr Hunt insisted pay discipline was needed. In a further letter, NHS England reminded the DDRB that no additional government funding has been provided for a pay rise of more than 1% for doctors and dentists.

The Treasury revised the threshold for senior manager pay controls to £150,000 and above from 1 January. The previous threshold of £142,500 will continue to be applied to any proposal made before the start of the year. NHS trusts must seek ministerial approval – FTs must ask for ministerial opinion – on pay proposals at or above the threshold.

Men earn on average 14.2% an hour more than women across the Department of Health and its executive agencies. The Department's *Gender pay gap report 2016/17* said this was despite the fact that just under two-thirds of all staff in these organisations are women. The report also found that 72% of staff in the lower pay quartile are women, down to 55% in the upper quartile.

The health budget in Scotland will rise by more than £400m in 2018/19 and staff earning up to £30,000 will be guaranteed a minimum 3% pay rise, finance secretary Derek Mackay confirmed. The Health and Sport Department resource budget will rise to £13.1bn and capital spending will be £351m. Mr Mackay said the government prioritised investment and reform in the health service and extra funding for frontline health boards would be £354m – 2.2% up in real terms. The draft Budget also increases funding for primary care and mental health, and takes forward capital projects. The public sector pay policy, published with the Budget, sets out pay rises according to current earnings – 3% rise for all earning £30,000 or less; 2% cap on baseline pay bill for all earning more than £30,000; £1,600 limit on the maximum pay uplift for those over £80,000.

Contingency plans were put into action following the announcement of Carillion's insolvency in January. NHS Improvement said national and local organisations had been working on these for a few months. The NHS was a relatively small customer of the firm – Carillion had been subcontracted to provide hard or soft facilities management at 13 trusts with PFI schemes, while a further three and several primary and community care properties had contracted Carillion to provide services. The firm was involved in two sites under construction.

from the hfma

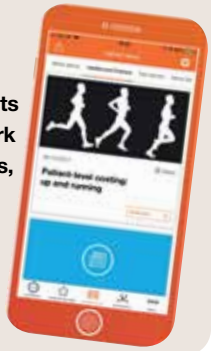
The HFMA published several blogs on its website in December and January, on a range of topics:

HFMA National Payment System Group chair Lee Outhwaite says that while there are clear differences between the NHS and Australia's health service, including the level of public funding for healthcare (67% in Australia compared with 84% in the UK), there are similarities, such as approaches to payment and the need to move to population-based health.

Bill Shields (pictured) continues his series of blogs since becoming chief finance officer at Bermuda Hospitals Board. In the latest instalment, after a trip back to the UK for the HFMA annual conference, he offers his insights on how different health systems are squaring up to similar financial and service pressures.

Can the NHS afford to ignore the environmental sustainability agenda, asks Sandra Easton, the chair of the HFMA Environmental Sustainability Special Interest Group? The association would like to understand if NHS organisations are progressing with the agenda or if it's taken a back seat in the face of financial and operational pressures. She asks members to complete a short survey to get the views of the finance function.

Following the launch of the HFMA app in December, feedback and uptake have been good. The app, which brings together all aspects of the HFMA's work – events, networks, publications and news – can be downloaded from the App Store or Google Play.



HFMA 2017

NHS Improvement's director of resources Bob Alexander

Highlights from the conference in December

Landing this year's position in the 'best shape possible' would be the greatest starting point for continuing the drive for sustainable services, Bob Alexander told the HFMA annual conference in December. Making his last appearance at an HFMA annual conference as NHS Improvement director of resources and deputy chief executive, Mr Alexander praised the finance function for its work to deliver financial plans in recent years – but more had to be done. There was still a 'significant reliance on non-recurrent measures' and too many financial improvements 'skewed to the back end of the year'.

Matthew Style, director of strategic finance at NHS England, told the conference that co-design work was under way on how new shared control totals would work. He highlighted the need for updated payment systems to underpin new models of care pursued by accountable care systems, warning against systems simply adopting block contracts. While payment by results may not suit all service areas, the NHS should not lose all the benefits associated with the approach.

The conference also focused on value-based healthcare, providing a platform for Jason Helgerson, Medicaid director for the New York Department of Health, to brief delegates on how value was driving outcome and cost improvements. One health system in the state fits air conditioning units in the homes of chronic obstructive pulmonary disease patients to improve wellbeing and reduce acute admissions.

From the UK, Aneurin Bevan University Health Board's medical director Paul Buss said there needed to be a much wider adoption of the value-based approach. He called for every foundation trust or integrated health board to have a chief value officer – medical directors were the perfect candidates for these roles.

In a new format, the conference featured a series of short, fast-paced presentations, alongside political insight from BBC political editor Laura Kuenssberg and a motivational session from Olympic triathletes Alistair and Jonathan Brownlee.

The conference showcased the best in NHS finance and governance in its annual HFMA Awards. Eight awards went to individuals and teams in a range of categories, with Manchester finance director Adrian Roberts claiming the overall Finance Director of the Year Award.

• More awards coverage in the HFMA Awards 2017 supplement and conference coverage at www.hfma.org.uk/news (top stories)

HFMA USA chair Carol Friesen

Paul Buss, Aneurin Bevan UHB's medical director

NHS Improvement's director of improvement Adam Sewell-Jones

Jason Helgerson, New York State Medicaid director

Outgoing HFMA president Mark Orchard

The conference's new format included a series of short, fast-paced talks

BBC political editor Laura Kuenssberg

HFMA's 2018 president Alex Gild

The first students to complete modules as part of the new HFMA masters-level qualifications received their certificates

Olympic triathletes Alistair and Jonathan Brownlee

Comment

February 2018

Credit where it's due

Let's recognise the efforts of NHS staff in meeting winter pressures with increased commitment

January saw the NHS continue to suffer an escalation of winter pressure against already stretched workforce and service capacity. This was undeniably a news story, but, unsurprisingly, the media's focus was almost entirely negative – focusing on policy and the overarching finances.

More balanced coverage might also have reflected on the incredible commitment, dedication and resilience of our frontline clinical colleagues. They have often worked at their limit to keep services running and as safe as possible for patients.

People are saying they have not seen pressure like this on the NHS before. That may be true. But as before when times have been tough, NHS staff have responded with remarkable levels of discretionary effort.

This dedication to keeping patients safe must not go without mention. And the burden many of our clinical colleagues feel in relation to the quality of care that can be provided must be a shared concern for us all – one that needs a sustainable solution.

As we move forward, we must positively reinforce communication and support with our clinical colleagues and back them where we can with practical action to relieve the burden.

We can do this by ensuring we are aligned and working together effectively for patients in our systems. We must act as one community of partners, thinking innovatively and without barriers about how we can

HFMA president Alex Gild

Not just about change

The NHS needs new models of care but it also needs more immediate support

The images of over-stretched A&E departments during January have made for harrowing viewing. We have known for some time that access targets are slipping. But patients held in queuing ambulances or waiting in busy corridors for a bed to become available are very visible indicators of a service not able to deliver the standards of care that it wants to.

And – as HFMA president Alex Gild says above –this is despite the often heroic efforts by staff and the deferral of elective procedures and treatments.

That, perhaps, should be all anyone needs to see to understand that changes are essential to help the NHS deal with current levels of demand. Yes the service needs to be transformed – new models of care supporting people out in the community and much greater levels of prevention – but it also needs more money right now. In fact, the failure to provide more funding in the short term is actively stopping systems from focusing on the hugely important task of making services sustainable for the future.

The latest report from the National Audit

Healthcare Finance editor Steve Brown

SHUTTERSTOCK

"Real issues need to be discussed about what should be provided, who should pay and how services are funded"

improve flow, maintain safety and deliver the best possible care for patients.

Support can be given wherever we work. This could be within our own finance teams, by increasing awareness of what our clinical teams are dealing with and helping unblock issues that get in the way of delivering great patient care. You will find other ways too.

Hopefully the pressure will ease as the season changes, because even with rigorous planning, normal operation of the NHS has been seriously challenged already this winter. Moving from one crisis to the next is not what the public should expect from our NHS.

Financial challenges in the NHS typically lead to calls for some form of long-term review and the current crisis is no different. While demands for such a review to be cross-party may be unrealistic, there is a real need to cast our eyes forward to ensure our health and care system remains able to deliver the highest quality care in a sustainable way.

Real issues need to be discussed about what should be provided, who should pay and how services are funded. Strategic options are needed and have been for some time. HFMA is keen to play its part in any such review and is planning a series of forward-looking analyses to contribute to the debate.

We will want your input and views on this important piece of work to help inform policy and decision-makers.

Bringing our focus back to 2018, Bob Alexander, at his last HFMA annual conference as NHS Improvement deputy chief executive, set a pragmatic target – deliver our plans overall as an NHS group so we are in the strongest position possible for 2018/19. That would be a fantastic achievement and would provide us with a solid foundation to move forward.

We need to maintain a shared constancy of purpose to do the best we can for patients as a community of partners. And we must do everything we can to support and sustain our frontline clinical colleagues. Then together we can help shape a brighter future for our NHS.

Contact the president on president@hfma.org.uk

Office – *Sustainability and transformation in the NHS* – underlines the point. This is hardly a body known for hyperbole or emotive language. But its conclusion is emphatic. Funding that should have been used to move towards sustainability has had to be used to meet existing pressures.

'Repeated short-term funding boosts could turn into the new normal, when the public purse may be better served by a long-term funding settlement that provides a stable platform for sustained improvements,' the NAO's head Amyas Morse said, as the report was published (page 3).

Commissioners and trusts reported a combined surplus of £111m in 2016/17, which looks commendable given that average real-terms growth between 2014 and 2021 is around 1.9% – well below the long-run average of 3.7%.

But you don't have to look far beneath the surface for signs of extreme financial strain. Trusts reported an improved, but still sizeable, £791m deficit for 2016/17. While overall commissioner underspends offset this, more local commissioners reported a cumulative deficit than the previous year.

And short-termism was evident in measures such as the transfer of £1.2bn of capital funds to revenue budgets. This comes at a time when the service is in desperate need of capital funding to help make a reality of sustainability and transformation partnership system re-engineering plans.

(The NAO's other report in January on the private finance initiative and its replacement, the PF2, did not set out to form a view of the value-for-money of PFI, but it did point out that there is still a lack of data on the benefits of private finance procurement. Private funding seems unlikely to fill the NHS capital gap any time soon.)

According to the NAO, national bodies gave £4.1bn in financial support to trusts outside of service contracts with commissioners, which it said 'does not support effective planning'.

Delivering funds in this uncertain way can push trusts into making ambitious assumptions over capacity and workforce pressures and to operate without the necessary headroom to deal with one-off increases in demand – let alone the sustained increases we have seen over this winter.

"The preoccupation with short-term funding is hardly a good basis for developing the right incentives in the system to drive the right behaviours"

The preoccupation with short-term funding is hardly a good basis for developing the right incentives in the system to drive the right behaviours. The current payment system is known to have flaws. At its heart, it doesn't encourage system-wide responses to meeting patient and population needs. But no payment system will help deliver the right outcomes if the quantum of funding is insufficient.

There is huge potential for transformation – new models of care underpinned by capitation-based funding approaches – to move the NHS towards a much greater level of sustainability. But if we ask too much of it, it will fail before it has had a chance.

A report on the future of health and social care in Wales calls for integrated services underpinned by a value-based approach. Seamus Ward reports

Completing

For several years, many NHS organisations have been keen on value-based healthcare – improving quality and efficiency hand in hand – but to date its implementation in the UK has been limited to individual providers or local health economies. But, if Wales follows the recommendations of the recent Parliamentary review of health and social care, it could soon be seen across a national system.

The review team's final report, *A revolution from within: transforming health and care in Wales*, sets out a vision for the future shape of services and recommends steps to achieve that vision. There should be a seamless system of health and social care, with services based around individuals, and provided as close to home as possible, it says.

Set up by the Welsh government and chaired by Ruth Hussey, the former Wales chief medical officer, the review panel also included US value guru Don Berwick and respected healthcare researchers and commentators. It says a new value-based approach to maintaining and improving the quality of health and care is needed.

The need for change is being driven by a number of well-known factors – workforce shortages, outcomes that are not improving as quickly as desired, and variation in the quality of services. In the meantime, spending is outpacing economic growth.

Dr Hussey says shifting a greater proportion of Welsh government spending to health and care could impact adversely on other areas of public spending, such as education, housing and the arts, that can influence health and wellbeing. This made the need to maximise value achieved in care more pressing.

'The scale of the challenge ahead should not be underestimated,' she says. 'It is clear change is needed and even clearer that this should happen quickly. We have detected an appetite for change and a desire to get on with it. A strong commitment to transform not just how much is done, but what and how it is delivered, is needed. We hope this report will be a catalyst for the action needed, and help to guide the future of health and social care in Wales.'

When the report was published in January, health secretary Vaughan Gething said a new government long-term plan for health and social care, due in the spring, will take account of the report's recommendations.

Essentially, there are two parts to the report – a strategic element sets out a vision for change to an integrated, patient-centred service that delivers care closer to home, uses technology to improve access to and delivery of care and seeks to continuously improve quality. The second element looks at how change can be achieved, mainly through stronger management using tools such as realigned financial incentives, benchmarking of outcomes and costs and revised GP contracts.

Quadruple aim

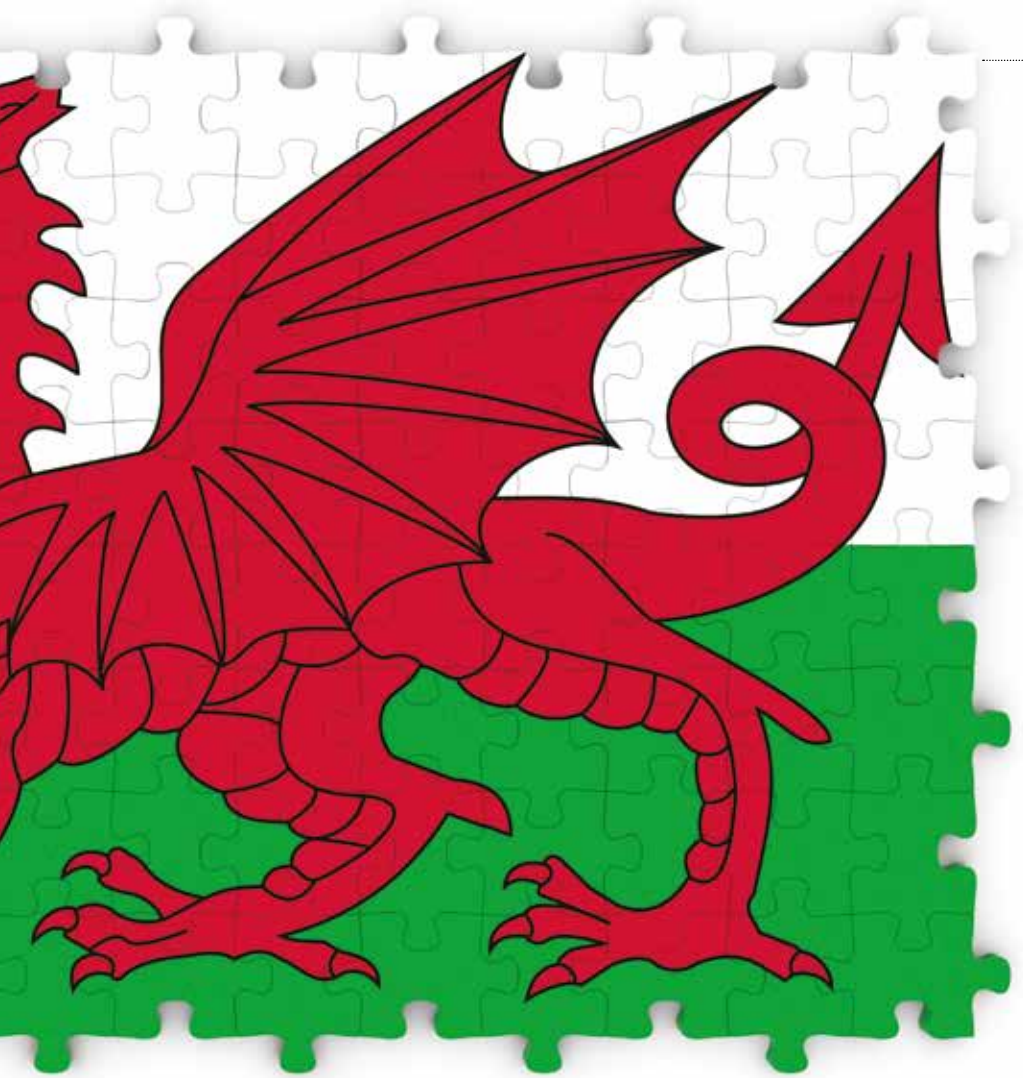
The vision for the future is underpinned by delivering the quadruple aim – an expanded version of the triple aim developed in the United States. The quadruple aim includes four mutually supportive goals that seek to:

- Improve population health and wellbeing through a focus on prevention
- Improve the experience and quality of care
- Increase the value achieved from the finances available, through improvement, innovation, use of best practice and elimination of waste
- Increase the wellbeing, capability and engagement of health and social care staff – the extra component added to the triple aim.

The report insists that every plan, strategy and practice should be driven by the quadruple aim. This could lead to radical changes. For example, to achieve the first aim, the Welsh government and health boards would have to redistribute funding to support prevention

Benchmarking would play a key role in driving the better value and reduced waste element of the quadruple aim. Identifying meaningful measures, especially in workforce productivity, would be critical. Wales could even adapt work being carried out in England, such as the Carter review, *Getting it right first time* and the new Care Quality Commission use of resources assessment.

It adds that extending the work based on the International Consortium for Health Outcomes Measurements (ICHOM)



SHUTTERSTOCK

the picture

programme – ICHOM has been working with Aneurin Bevan University Health Board – could provide the focus for the value element of the quadruple aim. ICHOM aims to drive value by measuring patient outcomes and costs and believes that if care is restructured around outcomes, with financial incentives for better outcomes, health systems can improve quality and curb inefficiencies.

The underlying financial system should be strengthened and support the costing of care pathways. These costs could be combined with clinical outcomes data to assess value.

The report says a wider approach to implementing the quadruple aim and new models of care could also include changes in financial rules. New, more creative incentives could be introduced, covering revenue, capital and transformation funding, such as pay for performance and pay for quality, including productivity.

New models of care could be accelerated through integrated capital funding and simpler rules on access to funds, especially where the new models run across organisational boundaries.

Better use of metrics would be needed to support the domains of the quadruple aim, while performance and outcomes should be regularly benchmarked across Wales, the UK and internationally. Patients should be given the ability to choose between NHS providers and there should be investment to improve quality and system learning. Contracts for GPs and community pharmacists should be revised to boost community service provision.

Wales is already moving in the direction described in the report, with its policies of integrating health and social care and prudent healthcare. But broad strategies have not always translated into actionable priorities, it says – to achieve the progress outlined in the report, more central action will be needed.

'Faster progress will require at least, as the Organisation for Economic Co-operation and Development (OECD) put it, a "stronger central guiding hand" to play a more prescriptive role,' it says. Traditional targets and

A&E concern

Although the review's remit did not include commenting on the level and sources of funding for health and social care, it did acknowledge these are major issues. Indeed, shortly after its report was published, A&E consultants in Wales wrote to first minister Carwyn Jones warning that safety in their departments was compromised and this was due to under-funding of health and social care.

Signed by almost 50 consultants from the six health boards in Wales, it followed a similar letter to UK prime minister Theresa May from emergency department doctors in England. The Welsh letter said that A&Es did not have enough staff or beds, while performance against the four-hour standard was similar to some of the worst performers in England. Welsh departments were overcrowded; patients could be waiting for days to be admitted to a ward; makeshift arrangements were needed to accommodate surplus patients; and ambulances often had to queue up outside.

There was evidence that overcrowding adversely affects patients' morbidity and mortality in line with the amount of time they spend in overcrowded emergency departments, they added.

While the doctors acknowledged that NHS Wales and health boards had put enormous effort into planning for the winter, those plans had fallen short of what was needed to deliver adequate care for patients.

The letter continued: 'We appreciate the financial constraints under which the Welsh government must operate. However, we feel that the current situation demonstrates that both the Welsh NHS and Welsh social care are severely and chronically under-resourced. We have neither sufficient staff, nor sufficient beds (in either acute hospitals or the community) to cope with the needs of our ageing population.'

The consultants called for an increase in social care funding, a review of the number of acute care beds, a workforce strategy to improve recruitment and retention and the abolition of the four-hour A&E standard.

performance management were too narrow and produced limited results – but progress could be made with stronger management, at local health board level particularly, and new ways of measuring progress. The latter could include new national support, incentives, benchmarking, accountability, regulation and transparency.

The review panel believes the central NHS Wales national executive must be strengthened to achieve these changes in funding flows, regulation and performance analysis. Currently, it does not have enough capacity. To comply with the OECD's view that there should be a stronger guiding hand at the centre, 'national assets' such as specialised services, commissioning and the NHS Wales Informatics Service should not be held at health board or trust level.

And to give the service headroom to progress with transformation, as a minimum NHS Wales should set an efficiency target that allows it to break even and implement new ways of working, the report says. These targets should be backed by clear metrics, benchmarked at health board level. 'Improving quality and reducing waste is really important – the day job really matters to people, so doing that well and getting value from it will help achieve efficiency savings,' it says.

Government response

Responding to the report, health secretary Vaughan Gething said: 'I'm pleased that the report suggests what we are already doing in Wales with regard to the integration of health social care services is right. But we will need to carefully consider the findings of this review to see how this can be improved in the future.

'The new long-term plan for health and social care will be published in the spring, taking account of recommendations in this report. I believe that what we have seen from the panel will set firm foundations for the future of health and social care in Wales for many years to come.'

The response to the report from within health and social care has been largely positive. British Medical Association Welsh Council chair David Bailey says national management must be strengthened. 'BMA Cymru Wales welcomes the report, and many of the recommendations, particularly the recognition that the national executive function in NHS Wales needs to be strengthened; that technology and infrastructure developments must be accelerated; and that medical engagement must be a priority.'

Vanessa Young, director of the Welsh NHS Confederation, says the report is a major contribution to the debate on how to create a sustainable health and care system in Wales. 'Our members agree that a different system of care is needed, one that's seamless across health and social care, physical and mental health, and secondary and primary community care.

'The report recognises we have been moving towards a more integrated system for a number of years and there are many good examples of new models of care that are already working in Wales. The challenge is how we can be more radical and ambitious, to accelerate the pace in moving to a genuinely seamless system.'

Value-based care will be important, she adds. 'We agree with the panel that it's crucial for us to increase the value we achieve from the funding of health and care.

'It is also helpful the panel recognises that the level and sources of funding for health and social care remain key national issues. As we develop plans to transform the health and care system, we must ensure they are supported by sustainable funding.'

Pressure groups highlight the fact that the level of funding was not in the review's remit, with one group describing it as the elephant in the room.

Huw David, Welsh Local Government Association health and social care spokesperson, says: 'One immediate challenge is the need for appropriate levels of funding and a long-term funding model to support the health and social care system outlined in the report. The reality is that without adequate funding and new investment for health and social care in the future, the changes outlined in the report will not be enough to ensure a sustainable health and care system. Bold leadership is required at all levels.'

Funding will remain an issue, but as the report says, whatever the overall funding level the current and future demand for health and social care means every pound must be spent effectively – and that is why it recommends a nationwide value-based approach.

EPR funding call

The NHS in Wales and the Welsh government face tough decisions on funding and priorities if the electronic patient record (EPR) is to be implemented in a reasonable timeframe, according to the Wales Audit Office.

In a report on informatics, the WAO said better information systems led to better outcomes for patients.

NHS Wales had a clear vision for the installation of a series of local EPRs that can communicate with each other. However, despite this goal of a national system going back more than a decade, no funding had been agreed and there was no implementation plan. There had been disagreement about the flexibility to develop local systems and the delivery of a national system, but the NHS was clarifying these areas, the auditors said.

The WAO estimated that spending on information and communications technology was less than 2% of NHS Wales funding – significantly less than recommended by Sir Derek Wanless in his 2003 review of health and social care in Wales.

In 2016, the health service estimated it would need £484m on top of existing budgets to implement the EPR vision over a five-year period. The WAO said the Welsh government had acknowledged that this estimate should be tested and the underpinning assumptions made should be confirmed.

Auditor general Huw Vaughan-Thomas (below) said: 'We know better access to information leads to better outcomes for patients and fewer mistakes by clinicians. Putting the vision of an electronic patient record into practice means all parts of NHS Wales, including Welsh government, need to take some tough decisions, particularly on funding, priorities and enabling clinicians to have the time and space to lead on this agenda. Unless it addresses the issues identified in my report, the NHS risks further frustration among frontline staff and ending up with systems already outdated by the time they are completed.'

FLICKR/DG EMPL

"It is clear change is needed and even clearer that this should happen quickly. We have detected an appetite for change and a desire to get on with it"

Ruth Hussey, former Wales chief medical officer

AVAILABLE
Early booker rates
NOW!

hfma

5–6 July 2018

Convergence 2.0

Our summer conference

Coming together to collaborate and share learning

East Midlands Conference Centre

For more information, or to book:

converge@hfma.org.uk | 0117 938 8349 | hfma.to/converge

#HFMAConverge

"I want to build on our support to members to help them work more collaboratively in their teams, organisations and partners to build the resilience they will need"

With the NHS in the throes of winter, the focus is, rightly, on patients and delivering care as safely as possible. But the stark images of patients in makeshift wards or corridors, or hearing their elective surgery has been postponed, has prompted further calls for a long-term review of the health and social care system. New HFMA president Alex Gild is one of those highlighting the need for a strategic, long-term review.

Contributing to the debate on the future of health and social care is one of the workstreams that will flow from the theme for his year as HFMA president, *Our NHS, your HFMA, brighter together.*

There are two interlinked elements of his theme. In a nutshell, it is about working with colleagues across the four nations and partners in the NHS and beyond, and supporting HFMA members in the day-to-day and strategic challenges they face. '*Brighter together* means focusing across our teams, partner organisations and systems with a common aim to improve patient care and experience,' he says. 'If we are not all pulling together to improve services in our local areas then we are not doing the right thing for patients.'

Mr Gild, chief financial officer at Berkshire Healthcare NHS Foundation Trust, explains that *Our NHS, your HFMA* is about supporting members. 'It's about our network and the benefits the HFMA can bring. The association is seeking to help set the agenda, reflecting new partnerships and priorities in the NHS but also reflecting on the needs of its members. Negatives are always being highlighted by the media and some commentators but we must reflect on the fantastic work that is done for patients, both by frontline clinical services and by our support services, including finance. The work under my theme aims to help us understand how we can best support and help improve clinical services.'

With the 70th anniversary of the establishment of the NHS this year, Mr Gild wants to create the headroom for the association and others to look forward 30 years to what the NHS might look like on its centenary. The HFMA NHS at 100 programme will focus on a number of subjects – perhaps areas such as the future role of the NHS finance professional or the impact of technology. 'We want to project the NHS forward, realistically informed by the current operational and financial pressures, to do some strategic thinking and development of options,' Mr Gild says.

He adds the partnership work could include other professional bodies, such as CIPFA, NHS Improvement and NHS England, together with HFMA partner associations in Australia and US. 'It's about carving out the headspace to do it – balancing the day-to-day pressures so we can do some work on the future outlook for the NHS. But it is challenging to do this when the service is under such pressure.'

This chimes with recent calls for a royal commission or cross-party work on the future of the NHS. 'That would call for some cross-party alignment and support for an analysis and review of what services are provided and how they are funded. And if this work went ahead, the HFMA with others is well placed to support it,' Mr Gild says.

'There has never been a better time to use the capacity and expertise

The future is bright

While remaining realistic about the current pressures on the NHS, HFMA 2018 president Alex Gild is optimistic and wants the association to support its transformation, says Seamus Ward

of HFMA's network to get the right people around the table, including our geographical network – across all four UK nations and our colleagues overseas, all facing similar challenges – to look at what the future holds and how the NHS might change to meet it. The HFMA has a role in looking forward to alternatives to the current model.'

He adds: 'We have got to bring social care and public health into this discussion, being so closely aligned with health services and because of the impact those services have on populations within the emerging partnership and planning remits of STPs and ACSs.'

Supportive role

The association could support wider efforts to examine difficult subjects, such as new approaches to funding. 'The HFMA and other bodies are saying we are ready to do this work – let's do it together and make the offer with others to scope the work,' he says.

During his inaugural speech at the HFMA conference in December, Mr Gild struck a positive note, saying he was optimistic – a word rarely associated with health and care in recent years. What are his grounds for optimism?

'I think there's been a positive shift in operational and leadership relationships and understanding of one another's contribution in the health and social care system,' he says. 'If you take the two exemplar accountable care systems [ACSs] that are developing in my trust's local area [Frimley and Berkshire West], we have around the table local authorities, primary care and other health partners working together to innovate and improve the health and care of the population. Joint visions are being forged, goals aligned and it's been a significant shift in quite a short space of time. Relationships are strong – I know that it is different in other places, but these relationships are a fundamental condition to system working and in our ACSs we can see collaboration for change and that's good for everyone, especially patients.

'The challenge for all systems with constrained resources is to prioritise initiatives that have the greatest health outcome impact for our local populations, using evidence wherever possible. This has been difficult to achieve so far but we know what we need to do.'

Health funding continues to be protected and, though less than the service had hoped for, the additional funds announced in the November Budget are welcome. Mr Gild adds: 'As our STP and ACS systems develop across the NHS we are seeing a helpful shift in intention and action from NHS Improvement and NHS England in aligning their approach to supporting and enabling our systems, such as offering capacity and expertise where it is needed in the developing ACSs. Aligning approaches to system oversight and regulation is also critical and encouragingly we hear that will happen.'

While the wider system aligns, he says there are significant opportunities providers could consider as a route to sustaining long-term operational improvement, alongside traditional cost savings activity. 'NHS Improvement's backing of quality improvement through lean management and transformation is an example. This should not be seen as a top-down regulator initiative; it's evidence based and aimed at helping trusts empower frontline clinical staff to identify continuous improvement opportunities and reduce waste.

'The cultural impacts of innovation and engagement are also a major benefit. I'm really encouraged about this from NHS Improvement. It also naturally focuses our corporate services to align with clinical teams in the delivery of improvement. I recommend colleagues look at the QI support offers available and the learning from others. QI programmes designed to engage the workforce and sustain improvement gains

Alex Gild on...

- **The HFMA qualification:** 'The qualification is about how the association is developing its offer to members as well as supporting members in their learning and development. The backing from NHS Improvement and NHS England and feedback from the first cohort is testament to the quality of the qualification content. I've been encouraged by the early results and feedback and we have a high-quality product. I want to encourage take-up. It offers an alternative to traditional CCAB and other accounting qualifications – perhaps for people who haven't wanted to take these qualifications, those who want to forge a career in NHS finance or who are qualified by experience and want to develop further.'

- **The new HFMA app:** 'Feedback about the app has been extremely positive. And my own view is that this is exactly how we need to get content through to members. It gives us high-quality HFMA content at our fingertips – that's the way we like to work now with technology. We will push on with this, helping us to engage with and inform members. It has huge potential.'

- **Going paperless:** 'The association spends too much on paper and photocopying, so by the end of 2018 I am committed to ensuring that all our events should be driven through digital channels.'

THEODORE WOOD

Alex Gild: CV

A business graduate, Alex Gild joined the NHS in 1996 with a placement at the Radcliffe Infirmary, Oxford. He stayed in the Oxford acute sector (Radcliffe Infirmary, John Radcliffe and Nuffield Orthopaedic Centre), working his way up to deputy director of finance level.

He moved to Thames Valley – later South Central – Strategic Health Authority in a planning and performance role, before joining Berkshire Healthcare NHS Foundation Trust as deputy finance director in 2006. In 2011 he was appointed chief finance officer at the trust, shortly after the integration of primary care trust community services. Berkshire Healthcare is now a combined £250m mental health and community provider.

He has a number of responsibilities outside trust finance, including:

- Trust lead for mental health, the Global Digital Exemplar programme
- Sponsor, trust-wide lean transformation quality improvement programme
- Support to Frimley and Berkshire West ACSs
- Member, Southern Procurement Customer Board
- HFMA South Central Branch chair, 2012 to 2017
- HFMA Board Trustee since 2013
- Executive reviewer, Care Quality Commission well-led programme.

over the long term are in my view an antidote to some of the pressures providers face'

He acknowledges the financial and operational position is extremely tight across all sectors, but he believes the response must be all encompassing from a partnership perspective. In recent weeks the strain of winter pressures has been evident with A&E performance falling and elective care postponed (albeit with the support of NHS England) – it is evident part of the solution will come from collaboration between health and care organisations, including ACSs.

'We need to do something fundamentally different over the next few years,' he says. 'We will not get to the solutions to the current issues straight away, but in the new approaches being modelled we have collaboration and developing relationships in the system. The service will benefit as they develop. There is extreme operational pressure at the moment and the NHS is being resilient, to a point. It is important to progress the system work.'

Berkshire Healthcare NHS Foundation Trust provides mental health and community physical healthcare and he is the first HFMA president from a provider of these services, and from the HFMA South Central Branch. How does he feel about the outlook for his sectors? 'It's good to see the engagement, interest and understanding of mental healthcare developing within systems as these services provide part of the answer to keeping our populations well and out of hospital. It has been a bit of a battle for mental health services to be able to articulate the impact of services among health and care partners, and the public in terms of what services do for patients, but that is changing,' he says.

The *Five-year forward view for mental health* was a big step forward. 'The economic evidence for investing in mental health services is provided clearly in that analysis. This comes back to my point about evidence-based decision making, particularly in relation to system investment decisions. With the immediate pressures in other sectors, particularly acute, it can be challenging for finance directors to make the longer-term economic case for investment in mental health. But increased capacity in mental health, community, primary and social care is vital if out-of-hospital and prevention ambitions are to be achieved.'

He insists it is important to go back to the clinical, economic or existing service improvement evidence, for example from vanguards, to make the case for investment in the right services.

Mr Gild highlights an evidence-based example of the integrated care decision-making hubs that are being developed in the Frimley ACS. These hubs draw in and integrate the skills and expertise of community partners in supporting patients away from hospital. The evidence for the proposed investment in the East Berkshire hubs came from North East Hampshire vanguard and Surrey Heath outcomes. 'We need to keep looking for the evidence together. We must not be defensive about solutions invented elsewhere – if a new service improves integration and care experience for patients at scale, and we can deploy it at lower cost than the current model, we need to prioritise it,' he says.

Though the bigger picture for the NHS is important, the HFMA's engagement with and services offered to its members are also a priority for Mr Gild. He pays tribute to his immediate predecessor, Mark Orchard, and his work to engage members. During his year as president, Mr Orchard visited every branch, linking with and understanding the needs of members. Membership increased by 7% over the year. 'Mark connected with the membership and he can be very proud of what he has achieved,' Mr Gild says.

'I want to want to build on our support to members to help them work together and more collaboratively in their teams, in their organisations and their partners to build the resilience we will continue to need; to recognise that everyone's bright ideas are important, no matter what level they are in an organisation; and keeping us focused on why we are here – for patients.'

Collaborative work

He highlights the importance of the association's joint project with NHS Improvement to develop improvement practitioners. 'This is a great opportunity for finance to get alongside clinicians and learn improvement techniques, and then apply them.' He also plans to support finance staff with a series of free events organised at branch level. 'These will be about things like collaborative skills, building resilience and understanding how to manage through change.'

And there will be a focus on supporting current finance directors and CFOs. Mr Gild says: 'Many of us in finance leadership positions have operated or developed into these roles from a different place and time for the NHS. What's expected and required from us as finance leaders now is to move away from thinking just about your own organisation to system working for the benefit of patients. A change in mindset and skillsets are needed at a time when our services face huge challenges. It requires a step change in finance leaders' skills and contribution.'

While softer skills, such as communication, are important, technical knowledge is also needed. 'We must know how to plan and prioritise investment at a system level and manage risk and upside in a system, on the back of transformation, rather than just in our own organisations; to support and encourage the identification of opportunities; and enable collective decision making in the system. All this is needed while also maintaining leadership contribution, oversight and grip within our own organisations. This is a stretching context for finance leaders and so I have asked the HFMA to design a pilot personal development programme to support existing finance directors and chief finance officers.'

As with so many of his peers, working hours are long and he likes to spend his spare time with his wife and two children. He also enjoys walking and travelling. The coming months will be tough, both personally as he juggles the demands of the presidency and his day-to-day work, and for the NHS, but he remains optimistic that the future is brighter, together.

HFMA e-learning
Healthcare finance and business training

hfma

HFMA e-learning

Improving performance through a better understanding of the NHS

Find out how you or your organisation can access HFMA's e-learning

hfma.to/elearning 0117 938 8323 info@hfma.org.uk

Debating value

An HFMA roundtable set out to understand the key components of delivering value-based healthcare and to identify obstacles to its wider establishment. Steve Brown listened in

HFMA ROUND TABLE

You don't hear many people arguing against the concept of value-based healthcare. Decisions should take into account quality, measured in outcomes and patient experience, and cost. Value means questioning how patients are treated in particular ways and asking if a different approach could produce better outcomes and reduced costs. But despite this widespread backing for the principles, only small numbers of UK healthcare bodies have actually put value-based healthcare into routine practice.

An HFMA roundtable in December, supported by medical technology company Getinge, set out to explore progress in moving towards value-based healthcare.

Specifically, the invited finance directors and senior leaders from providers and commissioners wanted to identify the essential building blocks that need to be in place, and the obstacles that need to be overcome, if a value-based approach is to be successful.

Clinical variation

Costs form the denominator of the value equation and so cost data is key to value-based assessments. It can provide a way to highlight variation in clinical practice, which can lead to pathway improvements that improve outcomes and reduce costs. But clinicians, finance directors and boards all need to engage with this approach, recognising it as a useful way to drive improvement.

While there are examples of clinicians engaging with cost and outcome data, more clinical champions are needed. And the roundtable agreed that the language used was crucial to their engagement in the value agenda. 'It is about variation in clinical pathways not variation in costs,' said Susan Rollason, director of finance and strategy at University Hospitals of Coventry and Warwickshire NHS Trust (UHCW). 'When you look at it like this, you can engage clinicians. They are interested in what value you can get when you vary the pathway – what the different outcomes might be,' she said. 'If you can focus on variation in clinical practice, that allows you to start a discussion. The cost data merely gives you a way in.'

The starting point with clinicians in the UHCW prostate cancer service was to focus purely on outcome data, establishing robust data and looking at the variation in outcomes to start understanding the value being delivered. Just looking at links between different pathways and outcomes really engaged clinicians, who were keen to improve performance against national access standards.

Ian Moston, Salford Royal NHS Foundation Trust's director of finance, agreed with the need for a common language. 'Costing won't get anyone excited,' he said. 'We found better engagement where you can see variation in clinical indicators. Understand that variation and then look at the associated cost. You need to find a different lens than the cost.'

He encouraged organisations to see value as a long-term piece of work. 'If it is about making a single decision, there will be no engagement,' said Mr Moston. 'It has to become the way we do business.' He compared it with the way the NHS engaged with risk management a decade or so ago. 'We don't hold the risk register separately, we embedded risk in how we operate. The same has to be true for value.'

Catherine Phillips, finance director of North Bristol NHS Trust, underlined clinicians' focus on quality and safety. While variation in costs might help identify variation in length of stay, for example, clinicians were interested in the link between length of stay and outcomes, not the costs per se. But she warned that the current financial environment in the NHS made clinical engagement more difficult. Clinicians were more likely to see value as a cost-cutting exercise.

'There needs to be some trust,' she said. 'And that's a real leadership challenge. We need to approach value while not focusing specifically on the financial imperative.'

That might mean not looking at value as part of a traditional cost improvement programme with target savings identified up front. Instead,

Pictured this page, clockwise from far left: John Graham, Karen McDowell, Su Rollason, Tim Bryant and Ian Moston, with Duncan Orme, centre

Facing page, clockwise from far left: Catherine Phillips, Caz Sayer and Chris Calkin

it means starting a value approach to enhance understanding about outcomes and costs – even if this subsequently, as evidence suggests, leads to downstream cost savings through appropriate standardisation.

Duncan Orme, operational director of finance at Nottingham University Hospitals NHS Trust, agreed that NHS bodies were in a tough position, made more difficult by the increasing command and control nature of regulation. Spending less money is now a fundamental requirement, but he said that clinical solutions to find best value can require more imagination. Improvement work at the trust in plastic surgery had taken the service from a £3m loss on turnover of £12m to profit within three years.

'But to do this we had to make investments to get best value, including putting two surgeons on the rota for complex lists,' he said. Doubling up on your most expensive resource may have increased overall direct costs, but it led to significantly better value.

> **"Costing won't get anyone excited. We found better engagement where you can see variation in clinical indicators"**
> **Ian Moston**

Karen McDowell, chief finance officer of Surrey Heartlands Clinical Commissioning Groups (Guildford and Waverley CCG, North West Surrey CCG and Surrey Downs CCG), said value had to look across sectoral divides – looking at pathways that move from acute settings to primary and community care settings. So a value project in an acute hospital should also involve primary care clinicians and vice versa.

But she agreed the key focus should be on the benefits to patients – and ensuring that the outcomes measured and monitored were the ones that were important to patients.

Caz Sayer, GP and former chair of Camden Clinical Commissioning Group, which has been pursuing value-based commissioning for a number of years, also stressed the importance of a system-wide approach. But she suggested that it was difficult for primary care to release clinicians to get involved in these projects.

In general, she said, for value to be successful, people needed to be given the time to get involved – expecting them to engage

Round the table

- Chris Calkin, former HFMA chairman and roundtable chair
- John Graham, finance director, Royal Liverpool and Broadgreen University Hospitals NHS Trust
- Karen McDowell, chief finance officer, Surrey Heartlands Clinical Commissioning Groups
- Catherine Mitchell, head of costing and value, HFMA
- Ian Moston, director of finance, Salford Royal NHS Foundation Trust
- Duncan Orme, operational director of finance, Nottingham University Hospitals NHS Trust
- Catherine Phillips, finance director, North Bristol NHS Trust
- Susan Rollason, director of finance and strategy, University Hospitals of Coventry and Warwickshire NHS Trust
- Caz Sayer, GP and former chair of Camden Clinical Commissioning Group
- In attendance from sponsor Getinge: Tim Bryant, Emilie Erhardt and Louise Hamilton

around value improvement in addition to existing workload was unrealistic.

Given clinicians' time constraints, she said data also had to be in the right format. 'It is vital that it tells stories that relate back to outcomes and patient experience,' Ms Sayer said. She called on finance directors to be 'as excited about changes in clinical models' as they are about improving cost performance. 'We need to think about what is important to patients as people – not think of them as conditions.'

While most of the discussion centred on engaging clinicians, John Graham said that finance directors also needed to engage. The finance director of Royal Liverpool and Broadgreen University Hospitals NHS Trust said it could not be taken for granted that all finance directors were signed up to value – they ranged from fully engaged to seeing the value approach as something that won't help them meet control totals in the short term.

He also underlined the importance of seeing value as a new way of working – and not a short-term fix. The organisations that have been successful have been at it for a long time, he said, starting with establishing robust outcome and cost data and then using this to analyse variation. He added that training would be important to the engagement challenge. 'We need to find ways to help senior clinicians and nursing staff become more literate in data so that they can understand what they are reading and feel able to challenge it where appropriate,' he said.

Key components

The attendees were asked to identify the key components that should be present for value-based healthcare. Dr Sayer said value partnerships had to be in place across whole systems and there needed to be common values across the various organisations within the system. And ideally this should be across broader public services not just healthcare.

She highlighted the difficulties of 'losing' young mental health service users in the transition to adult services – with these people often reappearing in the system later with more severe problems that would potentially cost more to address. By taking a systems approach to this problem, there was a potential fourfold return on investment if you also factored in savings from other parts of the public sector, such as the criminal justice system.

Chris Calkin, former HFMA chairman, who was chairing the roundtable, suggested that it was also important to consider how you judged value. Clinicians might view PSA as the core outcome test for prostate cancer treatment but, for the patient, the real measure of a good outcome might be avoiding urinary incontinence.

"We need to think about what is important to patients as people – not think of them as conditions"
Caz Sayer

Dr Sayer agreed. 'You have to start with the patients. Sit with them and ask what is important to them. You can't do that with them all at the individual level, but you can at the population level and get them grouped into segments. Once you have patient-defined outcomes, you will find there are very few of them that don't require you to respond as a system.'

In Camden, where the CCG is using an outcome focused population health approach, the patient's voice comes through a 1,000-strong citizen's panel. 'This has helped us to identify what is not working, define outcomes and design pathways. They've also been involved with tendering and monitoring performance.

'It is not just the right thing to do [involve patients],' she continued. 'It is a sound business decision.' The panel tended to understand the pressures facing the system in a more detailed way and were more likely to share some responsibility for any difficult decisions that had to be made.

Ms Phillips agreed. 'Value has to be for the patient and this needs to be seen by all the different parts of the system,' she said. 'Value for a patient might mean staying in work or being able to stay at home.' She said there were a lot of people tying up bed days or people simply not coping out in the community. Case management for these individuals was likely to deliver a much better outcome for them and potentially free-up resources. Having identified the desired outcome the challenge was then to get the system aligned so that all organisations played their part.

Ms McDowell picked up on the need for trust within partnerships from earlier discussions. She said that all sustainability and transformation partnerships need to have the necessary trust in place between all organisations in order to make value-based decisions across the whole system.

Examples include the need to ensure that there is agreement of funding flows between providers rather than a focus on the loss of income to individual providers within the system. Ultimately this is about delivering the best pathway for the patients, she said, which might mean transferring activity from acute to community settings.

Mr Graham said there needed to be better risk management across systems, rather than a focus on risk transfer. This was completely tied up with trust and could be delivered through gain and loss sharing mechanisms. 'The test is when things go wrong and whether people revert to silo behaviour,' he said. 'And if things do go wrong, does the system stand behind you.' He reinforced earlier discussions, suggesting the regulatory system didn't always support this system approach to risk management.

Mr Moston said he was a firm believer that higher quality often meant lower cost – benefiting from getting things right first time,

Caz Sayer and Duncan Orme (left); Getinge's Emilie Erhardt (below)

reducing re-work and eliminating unnecessary or wasteful steps in the pathway. But he said there were occasions when people might accept 'lower quality for very low costs'. He said you could see the approach in budget airlines, where there was still an absolute expectation of safety and timeliness, but the public consciously traded add-on services for lower prices. The important point was engaging with public and patients so they made informed choices. This could only work in the NHS where 'savings' were poured back into other priority services. 'We don't take this debate to the public,' he said.

Data considerations

Data on costs and outcomes were seen as fundamental foundations for value-based decision making, but it needs to be robust and delivered in a timely fashion. Ms McDowell said that trying to have conversations with clinicians with out-of-date information could damage the whole approach.

She said full analysis of the RightCare data packs should be undertaken due to the potential time lag from when the CCG packs are put together and current commissioning arrangements. However, she did state that they were a useful data source to use for both commissioner and provider discussions. Others in the group agreed with this view, emphasising the need for good quality data.

Mr Moston pointed out that Salford's experience was that the data would only improve by using it, creating a positive loop of identifying and correcting data issues. He added that the trust had made good progress with the use of service line data in the past year – thanks to the rolled-over tariff prices.

'This has been the easiest year to have conversations with clinicians because the tariff has been stable,' he said. 'With tariff fluctuations in the past, they don't understand how they can improve their costs, but the income drops. So we've been able to set up an efficiency programme with constant prices and focus the clinical community above the EBITDA line, with the corporate centre looking below it.'

He added that historical costing practices might mask some of the impact of clinical variation. 'One consultant might use a particular piece of kit while another doesn't for the same healthcare resource group. But often the way we allocate costs means that both get a share of the use of the kit,' he said, meaning that variation in practice wouldn't be visible through the cost data.

Mr Orme said that costing data in general in the NHS hadn't been good enough and still needed to improve. It needed to be accurate and at the patient-level – something that NHS Improvement's Costing Transformation Programme (CTP) aimed to deliver. However, he raised questions about whether the NHS as a whole and provider finance directors locally were making costing improvement enough of a priority. 'I'm not sure our profession has got the strength and depth to make it better within the given timescales,' he said.

The 50 or so acute submissions as part of the 2018 voluntary submission within the CTP had 'stretched professional colleagues and suppliers', and the next cohort of providers were likely to be less advanced in general in terms of costing. 'And as we move into mental health and community services, it is likely to be tougher again.

"The test is when things go wrong and whether people revert to silo behaviour. And if things do go wrong, does the system stand behind you?"
John Graham

HFMA ROUND TABLE

'As leaders in the profession, how can we encourage a suitable level of investment to get capacity of the service up to be able to answer this in a better way,' he asked.

Dr Sayer again stressed the importance of looking at whole pathway costs and at outcomes across whole systems – data and metrics that focused just on the organisational level risked decisions that did not make sense in system terms. Mr Graham agreed, but pointed out that organisations still needed to focus on their own data quality as this would provide much of the component data for total pathway costs. This in turn would support better understanding of what was happening across the whole patient journey to deliver the overall system outcomes.

Mr Graham added that while data could improve, in many cases it was already good enough to inform decision-making.

Ms Rollason described the adoption by UHCW of outcome sets developed by the International Consortium for Health Outcomes Measurement (ICHOM). These clinically developed outcome sets pull together clinical outcomes and key survival and disease management metrics with patient reported outcome measures. She said the trust was attracted to them because they were established and the consortium had plans to create pathway outcomes for 80% of the healthcare burden.

Its initial focus has been with the prostate outcome set. A lot of the information was already being collected as part of audit information – though there were problems with data quality. And the trust had also introduced patient questionnaires to meet the PROM requirements. A clinical outcomes portal had 'really engaged clinicians' and the trust is now trying to factor in what happened to patients before they came to hospital.

Dr Sayer said that in general coding needed to be taken more seriously and not seen as something solely related to payment. 'If you are coding wrongly, you are creating a clinical risk.'

Mr Orme said there was a capacity issue similar to that connected with improving costing data. 'We are not training enough coders and not enough people want to work in this area,' he said.

Putting it into practice

Participants also discussed how their organisations were putting value-based healthcare into practice. Ms Rollason said the work around prostate cancer at UHCW had

HFMA executive coaching
Enhancing your personal impact and performance

Time to reach your potential

When did you last prioritise your own development?

A heavy workload, dealing with complex and sensitive issues and a packed diary, leaves little time for career aspirations, preventing NHS finance professionals like you from achieving your goals.

HFMA executive coaching has a strong track record of delivering results for people who are motivated and proactive in maximising their leadership potential.

Working with a coach will create space to build the clarity, insights and tools that you need to boost your performance and impact. One-to-one coaching sessions deliver key learning and insights that can be put into practice immediately.

Coaching also creates a powerful ripple effect for your team, your peers, and the areas of work that you lead and influence.

10% off

Offer ends
28 February 2018

To find out more about HFMA executive coaching contact:

claire.merrick@hfma.org.uk
0117 938 8359

hfma.to/coaching

HEA.FIN.171 11/17

HFMA ROUND TABLE

produced some good initial benefits in terms of improving data quality and submitting more comprehensive data to national registries. It now plans to start looking at pathway variation, relative treatment options and outcomes. And its data portal is being expanded to cover a broader range of cancer data – including patient-level cost data, outcomes data and clinical audit data.

Ms Rollason said that with infrastructure in place and quality of life information starting to be captured, the ambition was for the reporting tool to support patient decision-making. 'We want to overlay information about the type of cancer a patient has with the quality of life impacts and the different treatment options available to patients,' she said.

Salford NHS Foundation Trust has been widely recognised as a leader in terms of high quality and safe services. However, Mr Moston was clear that while the trust had quality and safety embedded in its DNA, it faced the same financial challenges as many other areas with a significant year-on-year cost improvement programme.

It now operated a rolling programme of improvement activities, which involved service change and measuring productivity gains. And it recognised the need to consider pathways outside of the hospital in its improvement work. 'We're not an accountable care system as we don't have primary care fully involved. But we are an integrated care organisation, with adult social care staff now part of our team,' he said. Stable leadership had helped to sustain progress, he added. 'This is a long-term approach. You can't achieve it with a high turnover of leadership.'

Camden CCG is one of the commissioners leading the way on the use of population health management tools to help it target its resources where they are most needed and can be most effective. Analysis has shown that small sections of its population are consuming a significant proportion of resources. In 2014/15 1.2% of Camden's population had four or more non-elective admissions, representing 20% of the total hospital spend.

The population health management tool identifies segments of population by developing groups based on similar health needs. The aim is to understand what combination of disease and demographic factors drives patients to fit into one of the groups. Services can then be developed to better meet the needs of these population segments.

It has been pursuing a transformation programme informed by this better understanding of population for a number of years, focusing initially on long-term conditions, mental health, frail elderly and children and primary care. More recently, it has entered into a value-based contract for diabetes based around an integrated practice unit model.

Dr Sayer told the roundtable that the approach did work. 'We brought people together and invested in supporting reduction in the variation in primary care – you can't reduce hospital activity if you don't invest in out-of-hospital services,' she said. 'In two years, the percentage of people with long-term conditions who felt looked-after improved against the national average, and we've reduced non-elective bed usage.

'The model can deliver and that breeds confidence and trust – and it can be replicated even within the constraints of the current contractual and regulatory framework.'

However, she warned that while Camden had reduced non-elective bed use, it hadn't been able to take costs out of the hospitals. 'So, given demographics, it might be more about pegging costs,' she said.

Investment framework

In Surrey Heartlands, the STP has put value into practice by developing an investment framework that uses the value-based decision process set out by Future-Focused Finance as part of its *Best possible value* workstream. The framework uses the value equation (defining value as quality divided by costs) throughout to measure the impact of strategic and operational decisions in organisations and local health economies on clinical outcomes, patient experience and safety. The CCG now wants to roll out use of the framework across all its partner organisations.

Nottingham University Hospitals NHS Trust was one of the organisations that took part in the HFMA Costing for Value Institute value challenge pilot. This had set out to test how easy it was in practice to link costs and outcomes at patient level.

The pilot looked at applying the process in two settings: trauma and orthopaedics; and diabetes. While there were challenges – particularly in acquiring comparable outcome data from different sites, the project concluded it was possible to link costs and outcomes in a useful way that can support pathway redesign.

Mr Orme said that, for him personally, the project had identified three clear accelerators of value-based healthcare and improved performance: patient-level information and cost data; good leadership; and clinical leaders.

Overall, there was consensus that trust between clinicians and managers and between organisations was key to making progress on value-based healthcare. And leadership was central to building this trust. There was also agreement that organisations need to understand what patients want from their treatment and this needs to be the focus of the value delivery – rather than health bodies deciding in isolation what counts as successful treatment.

But there was also agreement that while the current financial challenges made progress with value-based healthcare more difficult, it also made it more essential. As such, the current climate provided a major opportunity to change the way decisions are taken to ensure that services make the best possible use of tax-funded health budgets.

Clinical forum

A clinical forum on 22 March will bring clinicians together to explore the concept of value in healthcare and their role in putting value-based principles into practice.

The forum is being organised by the HFMA Healthcare Costing for Value Institute in association with the Faculty of Medical Leadership and Management with the aim of encouraging more clinicians to get more involved with the value agenda.

Value-based healthcare is all about maximising the outcomes that matter most to patients at the lowest cost. Clinicians have a huge role to play in identifying the right outcomes. But they are also key to understanding pathway variation and redesigning pathways with cost data providing a way to identify and understand that variation.

'Value-based healthcare needs to become the focus for clinicians and finance alike as they look to deliver high-quality sustainable healthcare services,' said Catherine Mitchell, head of the institute. 'The clinical forum offers a great opportunity for clinical and finance colleagues to start having that conversation.'

Clinicians are encouraged to bring a finance colleague with them, and Healthcare Costing for Value Institute member organisations are eligible for two free places at the forum (one clinical place and one finance place). Clinical staff from non-institute member organisations are also welcome to book onto the event. Details at **www.hfma.org.uk**

Thank you to all HFMA corporate partners for their continued support

hfma

advanced
People. Partnership. Solutions.

ALLOCATE

civica
Transforming the way you work

Clarity

expenses by selenity

fleet SOLUTIONS

GENMED MANAGED SERVICES

genesis

GETINGE

Grant Thornton

Hewlett Packard Enterprise | intel

IMS Health & Quintiles are now IQVIA

Johnson & Johnson MEDICAL DEVICES COMPANIES

Lexmark

LIAISON

NHS Employers

NHS Improvement

NHS Professionals

NHS Shared Business Services

OLYMPUS

Roche

serco

Skills for Health

hfma Corporate Partner

For more information about becoming a corporate partner, please contact Paul Momber
E paul.momber@hfma.org.uk T 0117 938 8972

hfma
professional lives
Events, people and support for finance practitioners

Updated accounting guidance amounts to minimal changes for 2017/18

Technical update

The NHS finance community received an early boost to its 2018 reading list in the form of updates to the *Group accounting manual* (GAM) from the Department of Health, the *Annual reporting manual* (ARM) for foundation trusts from NHS Improvement, and the *Greenbury guidance* from the NHS Business Services Authority, *writes Debbie Paterson*.

For those who like to skip to the last page to find how it all turns out, the real news is that 2017/18 is a year of little change.

The Department of Health (or Health and Social Care to give it its new expanded title) did issue additional guidance alongside the GAM, including eight FAQs, six of which apply to all NHS bodies. However, there were no surprises.

The FAQs that will have the biggest impact deal with statutory changes that occurred in April 2017. The first (FAQ 3) covers accounting for the apprenticeship levy. The Treasury has determined that the levy will be treated as a tax and, therefore, payment of the levy must be recognised as an additional social security cost as it arises. It cannot be treated as a prepayment.

Accounting for the benefits arising from the use of the digital account will depend on whether the NHS body is a training provider or not. For non-training providers, the amount of employees' training funded by the levy will be recognised as a non-cash expense in the period that the training occurs. This is matched by non-cash grant income.

For those NHS bodies providing the training themselves, receipt of cash from the digital account will be treated as grant income. Expenditure incurred in delivering the training is accounted for in the usual way.

FAQ 8 deals with reporting off-payroll engagements. Officially, this FAQ does not apply to NHS foundation trusts as the guidance is included in chapter two of the GAM, which is not applicable to them. However, NHS Improvement will issue an amendment to the ARM soon and it is unlikely to be very different to FAQ 8.

As expected, the Treasury's reporting requirements have been amended to reflect the change in the off-payroll (IR 35) legislation from April 2017. In addition, the threshold for engagements that must be reported has been increased from £220 a day to £245 a day.

Of the three tables that still need to be completed for off-payroll engagements, tables 1 and 3 will be familiar.

Table 2 requires that the number of new off-payroll engagements entered into in 2017/18, or those that reached six months in duration during 2017/18, are disclosed (split between whether they fall under the remit of IR35 or not). These must be shown along with the number engaged directly and on the payroll, the number that have been reassessed for consistency/assurance during the year and the number that have changed status as a result of that review.

FAQs 1 and 2 provide annual updates on discount rates for provisions and post-employment benefits, as well as the probability of non-recovery of injury cost recovery revenue. FAQ 6 simply tidies up the manual by removing a reference to guidance that is no longer available.

Two other FAQs (4 and 5) will have an effect on limited numbers of organisations. There is new guidance for newly formed NHS foundation trusts and NHS trusts, while the guidance on how to deal with a change in statutory status is retained. NHS trusts have new guidance on reporting against financial duties and targets. Supplementary guidance on how the statutory break-even duty applies to NHS trusts will be issued later.

Finally, FAQ 7 updates the GAM to reflect changes made to the Treasury's *Financial reporting manual* (FReM). Some of these will require changes to the annual report of all non-NHS foundation trust bodies.

For NHS foundation trusts, the annual reporting guidance in the ARM has also been amended to reflect the changes made to the Treasury's FReM. In addition, the requirement in *Managing public money* to report fees and charges has been reflected in the ARM.

Debbie Paterson is an HFMA technical editor

Technical review

The past two months' key technical developments

Technical roundup

The HFMA and consultancy PwC are to explore how funding structures can be used to **incentivise better outcomes**. Announcing the joint work in a blog, David Morris, a PwC partner, said the research would examine how money should flow through health and care systems and how to incentivise behaviours to deliver the outcomes users need. The study is due to be published in the spring.

The HFMA has backed proposals for reporting the new **use of resources assessment** for providers. In a consultation document last November, the Care Quality Commission and NHS Improvement proposed publishing the new use of resources rating alongside an overall quality rating, with the quality rating based on the CQC's existing five key quality areas (safe, effective, caring, responsive and well-led).The consultation also proposed combining the resources assessment with this quality rating to produce an overall rating. Three examples of how this might look were put forward. The HFMA said the dual approach made the 'finding and impact on overall rating clear'. However, it raised concerns that the use of resources rating and existing quality rating for well-led may overlap and could lead to double counting of an issue. The HFMA Provider Finance Faculty is running a forum on use of resources in March – contact clare.macleod@hfma.org.uk.

How the new ratings might look

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

The 2018/19 Treasury ***Financial reporting manual*** (FReM) was published at the end of December and the Department of Health and Social Care followed this up with 2018/19's draft ***Group accounting manual*** a month later. The key proposed changes are:

- Adoption of IFRS 9 *Financial instruments*
- Adoption of IFRS 15 *Revenue from contracts with customers*
- Adoption of the amendment to IAS 7 *Statement of cash flows*
- Amendment to the guidance on discount rates as a result of the Treasury's move to nominal rates
- An additional requirement to disclose medical locum staff costing more than £142,500 per annum
- Amendment to the disclosure of 'NHS' and 'non-NHS' receivables and payables
- Clarification of PDC dividend calculation

In addition, there is a consultation question around the use of the external financing limit (EFL) as a performance measure. Consultation ends on 23 February – and the HFMA will be submitting a response – please email comments to debbie.paterson@hfma.org.uk.

A recently published briefing from the HFMA describes a new national centralised system for purchasing **expensive medical devices and implants** used in specialised services. Roll-out of the system, a response to recommendations in the Carter review of productivity, began in 2016/17. As well as describing how the system works, the briefing also considers the accounting implications of one NHS body procuring stock that is held and used by another body. And it also identifies lessons that could be applied to other centralised procurement arrangements.

NICE guideline targets macular degeneration

NICE update

NICE has recommended anti-VEGF treatment be considered for late age-related macular degeneration (AMD) (wet active) in eyes with visual acuity of 6/96 or worse, only if a benefit in the person's overall visual function is expected, *writes Nicola Bodey*.

The guideline (NG82) also raises awareness that anti-VEGF treatment for patients with late AMD (wet active) and visual acuity better than 6/12 is clinically effective and may be cost-effective depending on the regimen used.

AMD is the commonest cause of severe visual impairment in older adults in the developed world. The two main late AMD phenotypes – geographic atrophy and exudative AMD – are responsible for two-thirds of registrations of visual impairment or blindness in the UK. It is estimated a quarter of a million older adults in the UK alone suffer from blindness due to this condition.

There has been a significant increase in hospital activity in England for treatment and monitoring people with a primary diagnosis of AMD from less than 10,000 visits in 2005/06 to over 75,000 in 2013/14. The most common primary procedure in hospital visits of people with a primary diagnosis of macular degeneration involves intravitreal injection.

About 80% of people with late AMD (wet active) have visual acuity between 6/12 and 6/96. In current practice anti-VEGF treatments (anti–vascular endothelial growth factor therapy given as intravitreal injections) tends to be in line with NICE guidance on ranibizumab and pegaptanib (TA155) and aflibercept (TA294).

More prescribing is anticipated as a result of the guideline recommending treatment for people with late AMD (wet active), and visual acuity not within the range 6/12 to 6/96.

Diary

February

7 (N) CEO forum, London
8 (N) Integration summit, London
13 (I) Healthcare Costing for Value: introduction to NHS costing – regional networking and training event (South)
14 (F) Chair, Non-executive Director and Lay Member: forum, London
15 (B) Northern: pre-accounts planning, Durham
15 (F) Mental Health Finance: workforce forum, London
27 (B) Eastern: accounting standards update, Fulbourn
28 (I) Healthcare Costing for Value: value masterclass

March

13 (F) Chair, Non-executive Director and Lay Member: operating game for new NEDs, chairs and lay members
14 (I) Healthcare Costing for Value: introduction to NHS costing, regional networking and training event (North)
14 (B) Kent Surrey and Sussex: accounting standards update, Gatwick
22 (F) Provider Finance: preparing for the use of resources assessment forum, London
22 (I) Healthcare Costing for Value: clinical forum, London
22 (B) London: quiz

April

18 (I) Healthcare Costing for Value: costing conference, London
24 (B) London: VAT focus group level 3 strategic workshop, Rochester Row

May

10 (F) Commissioning Finance: prescribing forum
10 (B) South West/South Central: developing talent conference, Bristol
16 (F) Provider Finance: directors' forum, London
16 (F) Mental Health Finance: directors' forum
17 (F) Chair, Non-executive Director and Lay Member: forum
24 (B) London: VAT focus group level 1 refresher workshop, Rochester Row

June

15 (B) Eastern: annual conference, Newmarket
21 (B) London: annual conference, Rochester Row
28/29 (B) North West: annual conference, Blackpool

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

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

Events in focus

Integration summit
8 February, London

Integration between health and social care is moving from small-scale joint working to something much bigger. New models of care have emerged, including accountable care and primary and acute care systems. Potential benefits include seamless care for patients delivered by multidisciplinary teams, but finance staff must also create shared financial mechanisms and governance structures. At this, the third HFMA/CIPFA integration summit, NHS provider finance directors, clinical commissioning group chief finance officers, local authority treasurers, sustainability and transformation partnership finance leads and directors of adult social care will have a chance to discuss the integration challenges they face. Speakers include Jon Rouse (pictured), chief officer at Greater Manchester Health and Social Care Partnership, who will describe how leading the integration agenda in Manchester feels in practice, what challenges the partnership has faced, and how the conditions of success can be replicated and shared across the country.

- **For further details, visit hfma.to/summit18**
- **Email jonathan.richards@hfma.org.uk for details**

Convergence conference
5-6 July, Nottingham

The Convergence conference brings providers and commissioners together to facilitate networking and shared learning. Since the creation of sustainability and transformation partnerships and moves towards accountable care, the roles of providers and commissioners are becoming increasingly blurred. Systematic issues around governance, payment and contracting are being discussed at length, with no one-size-fits-all solution. Cultural issues around different organisations working together are introducing a wave of fast-paced and widespread change to everyday working lives, which newly appointed system leaders need to manage effectively.

Delegates will hear from STP leads and directors of finance about how organisations are aligning and moving towards a patient-centred model. If you would like to share early experiences of your local converging systems, please get in touch. Former NHS Improvement chief executive Jim Mackey (pictured) will deliver the opening keynote speech on progress at the Northumberland Accountable Care Organisation, with personal reflections on his time at NHS Improvement and what the future may hold for commissioners and providers.

- **For further details, visit hfma.to/converge2**
- **Email emily.bowers@hfma.org.uk to share your experiences at the Convergence conference**

However, earlier prescribing (for people with visual acuity better than 6/12) should require less treatment overall.

A small resource impact is anticipated occurring gradually over the next five years – a resource impact report and template are available on the NICE website. List prices of anti-VEGF treatments included in the template have discounts in commercial confidence.

Age-related macular degeneration services are commissioned by clinical commissioning groups (CCGs). Providers are NHS hospital trusts and community optometrists.

Nicola Bodey is senior business analyst, NICE

Pressure and funding

Association view from Mark Knight, HFMA chief executive

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

SHUTTERSTOCK

My HFMA

Interesting to see Boris Johnson (pictured) throwing his hat into the 'more funding' ring, reportedly calling for an extra £100m a week for the NHS. He was quickly slapped down, with the chancellor pointing out that Mr Johnson was the foreign secretary. That may be the case but Mr Johnson, like Mr Hammond, is a local constituency MP and backbench Tory MPs are feeling the pressure from constituents. Although Brexit dominates our political horizons, it is the NHS that dominates the here and now and remains at the very top of the political agenda.

I remain optimistic that these calls will be heeded after an unprecedented surge in activity. The question of how we pay for any increase in funding as a country is just something that needs to be tackled. The HFMA will continue to monitor the issue and comment appropriately.

However, two central concerns remain for us – how do we support our members in the current situation and what's the long-term picture? What, for example, will be the state of the service when the NHS turns 100 in 2048?

The HFMA's 2018 president, Alex Gild, asked the first question in his opening address to the annual conference – what can we do to support members? Some of you are natural networkers, moving around HFMA and NHS circles to gather contacts and find support. But a significant number won't be, so we want to ensure we can provide a system that allows members to just 'plug in'. We're discussing this at the moment and any ideas are more than welcome – email me at chiefexec@hfma.org.uk.

The second project we want to develop is to look at the 'NHS at 100'. We all have a vested interest in this, but why do we spend our time lurching from one crisis to another? Commons Health Committee chair Sarah Wollaston has called for a long-term coordinated plan for health and social care. And discussion is growing around the need for a cross-party consensus.

For our own part, we are committed to contribute to the debate and will take a look at key issues. These include how we make the most of IT in the future and the changing role of finance function as accountable care organisations and system working become the established business model.

HFMA chief executive Mark Knight

It's been a busy few weeks for the HFMA. Our new group of students is starting the HFMA qualification and the association is hosting the National Association of Primary Care's new practice manager programme on its platform.

We have run events with different faculties and our usual pre-accounts planning courses hit Manchester and London at the start of February. For those planning ahead, look out for the first release of our annual conference tickets. We like to get them out early to enable you to secure your place well in advance.

Attending events – branch and national – and contributing to the association's committees and work programmes remains vital to retaining a vibrant and informed finance function. While time out of the office is difficult in the current climate, staying up to date, sharing good practice and maintaining those networks is perhaps more important than ever right now.

We continue to value your support – let us know if we could do things differently or there are topics we should be covering.

Member news

Several key decisions were taken at December's AGM:

- Alex Gild, director of finance at Berkshire Healthcare NHS FT, was elected 2017/18 president
- Bill Gregory and Caroline Clarke became vice presidents
- Elizabeth O'Mahony, Carol Potter, Sanjay Agrawal and Lee Outhwaite joined the board of trustees for a three-year term
- All annual subscriptions remain unchanged. Discounts for lower bands start at £3 per month with a direct debit..

The chairs of several faculties and committees were named:

- David Chandler, Commissioning Faculty and Technical Issues Group
- Kevin Stringer, Governance and Audit Committee
- Suzanne Tracey, Provider Finance Faculty
- Jonathan Stephens, Payment Systems and Specialised Services Group
- Mike McEnaney, Healthcare Costing for Value Institute Costing Group

Grasp that nettle: five steps to sustainable confidence – simple practical steps to lasting confidence your own way is the first book by HFMA executive coach Chris Brown. The former NHS finance director's book promises to help you 'understand who you really are (and therefore who you are not)'.

- For executive coaching, email lily.chapman@hfma.org.uk or call 0117 9388320.

Beth Pidduck (pictured) won the Sue Rosson award at the North West branch annual general meeting, for improving processes at Lancaster Teaching Hospitals NHS FT. The award recognises good practice in trainees or recently qualified staff. Shaun Weaver (Wigan Borough CCG) and Adam Wardle (Countess of Chester Hospital FT) were runners-up.

hfma

Member benefits

Full members can now access the MyHFMA app, which offers every member a personalised experience that puts a wide range of essential content at their fingertips. Download it now from the App Store or Google Play

Branch focus

My HFMA

Weat Midlands Branch

In November, the research and development committee of the West Midlands Branch published a *Best practice tariffs* (BPTs) toolkit and dashboard – an overview of BPTs in place for 2017/19.

The author, Dudley Group of Hospitals NHS Trust head of service improvement Amanda Gaston, also conducted a survey that found more than 60% of the respondents felt that BPTs' objective to incentivise high-quality and cost-effective care had been met.

BPTs have a significant role as part of the current payment and incentives framework. However, Kim Li (pictured), new vice chair of the branch and director of finance at South Warwickshire NHS FT, is clear this is likely to change in the move to accountable care systems.

'Tariff systems unfortunately put us in a situation where we have potential conflicts with our commissioners, and they can't afford to pay for the activities we do,' says Mrs Li. 'What we'll need to do in the move towards accountable care organisations, is to be much more collaborative and to use more outcome-based measures and different ways of incentivising organisations to do the right thing.'

The West Midlands Branch is the only branch with an active research and development committee. Chaired by David Melbourne, chief finance officer at Birmingham Women's and Children's NHS FT, it is working on projects on the economic impact of investing in the NHS, the regional financial management graduate scheme and delayed transfers of care. In the past year, the committee published a popular briefing on stress management in the finance function.

It is also in the process of launching a students committee, with its first meeting set for Monday 19 February in Birmingham. 'The initial aim is to support each other in our development, and this may be, for example, by organising events to suit the needs of students or discussing current issues and how they affect our organisations,' says branch student representative Becky Coldrick.

The West Midlands is the biggest HFMA branch in terms of membership. It also hosts the largest branch conference, with 320 delegates attending last year's event.

• Find out more about the branch at **hfma.to/westmids**

branch contacts

Eastern kate.tolworthy@hfma.org.uk
East Midlands joanne.kinsey1@nhs.net
Kent, Surrey and Sussex elizabeth.taylor@wsht.nhs.uk
London nadine.gore@hfma.org.uk
Northern Ireland kim.ferguson@northerntrust.hscni.net
Northern catherine.grant2@nhs.net
North West hazel.mclellan@hfma.org.uk
Scotland alasdair.pinkerton@nhs.net
South West rebecca.fellows@hfma.org.uk
South Central alison.jerome@hfma.org.uk
Wales katie.fenlon@hfma.org.uk
West Midlands rosie.gregory@hfma.org.uk
Yorkshire and Humber laura.hill@hdft.nhs.uk

Appointments

Sharon Murphy (pictured) has been appointed interim director of finance at Leicestershire Partnership NHS Trust. She has been deputy director of finance at the organisation since 2014 and took up the new role at the end of December, following the departure of **Pete Cross**. After over 15 years in senior financial positions in the NHS, Mr Cross became chief finance officer at De Montfort University in January.

Alistair Mulvey is now chief finance officer at the six Staffordshire clinical commissioning groups. He was chief finance officer at North Staffordshire and Stoke-on-Trent CCGs. In East Staffordshire CCG he will succeed **Wendy Kerr**. In the other three – Cannock Chase, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds clinical commissioning groups, Mr Mulvey takes over from acting chief finance officer **Vicky Hilpert**, who took the position after **Paul Simpson** was appointed acting chief accountable officer at the three organisations. Ms Hilpert is now director of finance at the Institute of Occupational Safety and Health, while Mr Simpson is corporate director of resources at Milton Keynes Council.

NHS Ayrshire and Arran has appointed **Rob Whiteford** (pictured) assistant director of finance for operational services. Mr Whiteford is also the new chief finance officer for the South Ayrshire Health and Social Care Partnership. He was previously chief finance officer at Enfield Clinical Commissioning Group. He takes over from **Sharon Lindsay**, who has retired.

Clare Stafford is now director of finance at Brighton and Sussex University Hospitals NHS Trust. She was director of finance at Queen Victoria Hospitals NHS Foundation Trust, where **Jason McIntyre** has stepped up as acting director.

Tom Jackson, who was previously chief finance officer at Liverpool Clinical Commissioning Group, has taken up the role of director of finance at Dudley Group of Hospitals NHS Foundation Trust. He takes over from **Chris Walker** who was acting director of finance following Paul Taylor's departure. Mr Walker will be returning to his position of deputy director of finance at the organisation.

Helen Shields (pictured) is retiring as chief executive officer at the Isle of Wight Clinical Commissioning Group. Mrs Shields, whose background is finance, has more than 30 years of experience working in the NHS on the Isle of Wight. She was previously director of finance for the Isle of Wight Health Authority and then the primary care trust.

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

"I have missed working directly with service users, patients and clinicians and this new role gives me that opportunity"
Patrick McGahon, Tees, Esk and Wear Valleys NHS FT

McGahon steps back into provider sector

On the move

Patrick McGahon admits that the lure of once again working with frontline services attracted him away from the NHS Business Services Authority (BSA) after more than four years. Mr McGahon has been appointed substantive director of finance and information at Tees, Esk and Wear Valleys NHS Foundation Trust, succeeding Colin Martin, who became the mental health and learning disability trust's chief executive in 2016. Drew Kendall has been the trust's interim director of finance and information since then.

Currently the BSA's director of finance and commercial services, Mr McGahon has more than 20 years' board-level experience, mainly in NHS provider organisations, as finance director and in strategic roles, as well as periods as acting chief executive. He is expected to take up the new post in April.

'I always wanted to move back to the front line. I've worked for this national body for four and a half years and wanted to move to a trust in particular – that was one of the key drivers for applying for this job.'

An additional factor was the chance to work once again in a mental health provider – he worked in the sector around the turn of the century and has also served as a mental health services commissioner.

'I always thought mental health didn't get a fair crack of the whip in terms of funding and priorities, but the *Five-year forward view for mental health* and parity of esteem funding means that mental health is coming back to the fore,' says Mr McGahon. 'It receives a relatively small percentage of total NHS funding, but it has a massive impact on a large part of the population and on what can be done to ease the pressure on the system as a whole.

'The trust itself has an exceptionally good reputation nationally, with a good Care Quality Commission rating. Its leadership is rated outstanding and it's a high performing trust. My focus is on supporting the trust and our service users to continue to improve services.'

He is a member of the HFMA's Policy and Research Committee, Future-Focused Finance's *Great place to work* group, and is an HFMA mentor and chair of Carlisle College. He remains committed to the HFMA and to the work of FFF.

With the NHS in England moving towards outcomes-based contracting for some services, Mr McGahon is keen to examine the scope for expansion in mental health contracting. 'The critical thing is the outcomes for the service users. I want to work closely across the clinical commissioning groups and sustainability and transformation partnerships to look at this.'

He adds: 'The trust has always delivered its financial targets since it was formed in 2008 and, looking at 2017/18, it is broadly on track to deliver its control total. Looking forward to 2018/19, there is further work to be done.'

As with all NHS organisations, the trust faces a number of challenges, including recruitment. He says: 'How do you encourage clinicians to come and work in different parts of the trust geography? How do you bring developing technology such as robotics, AI and apps into the mainstream of mental health and learning disability?'

Improving the trust's electronic patient record will be high on Mr McGahon's list of priorities, as will digitisation – this will save clinicians' time by ensuring patient data only needs to be input once and supporting clinical decision-making.

He is sorry to leave the BSA. 'There have been lots of positives – for example, we saved £800m for the wider NHS and developed an HR shared service for the arm's length bodies sector. However, I have missed working directly with service users, patients and clinicians and this new role gives me that opportunity.'

Efficiency focus

Future focused finance

The Future-Focused Finance *Efficient processes and systems* action area has been relaunched recently under the guidance of Adrian Snarr (pictured), director of financial control at NHS England.

Assisted by John McLoughlin, winner of the FFF prize for 2017, Mr Snarr has pulled together a delivery group from across the NHS, including representatives from NHS England, NHS Improvement, the Department of Health and Social Care and provider organisations. Shared service providers, including NHS Shared Business Services and East Lancashire Financial Services, are also represented on the group.

The group met for the second time in late January and has set its sights on improving systems and processes in areas such as non-contract activity and e-invoicing, while working to ensure that sustainability and transformation partnerships and accountable care systems/organisations make the most of the systems currently available to them. The action area's previous focus on benchmarking will also continue.

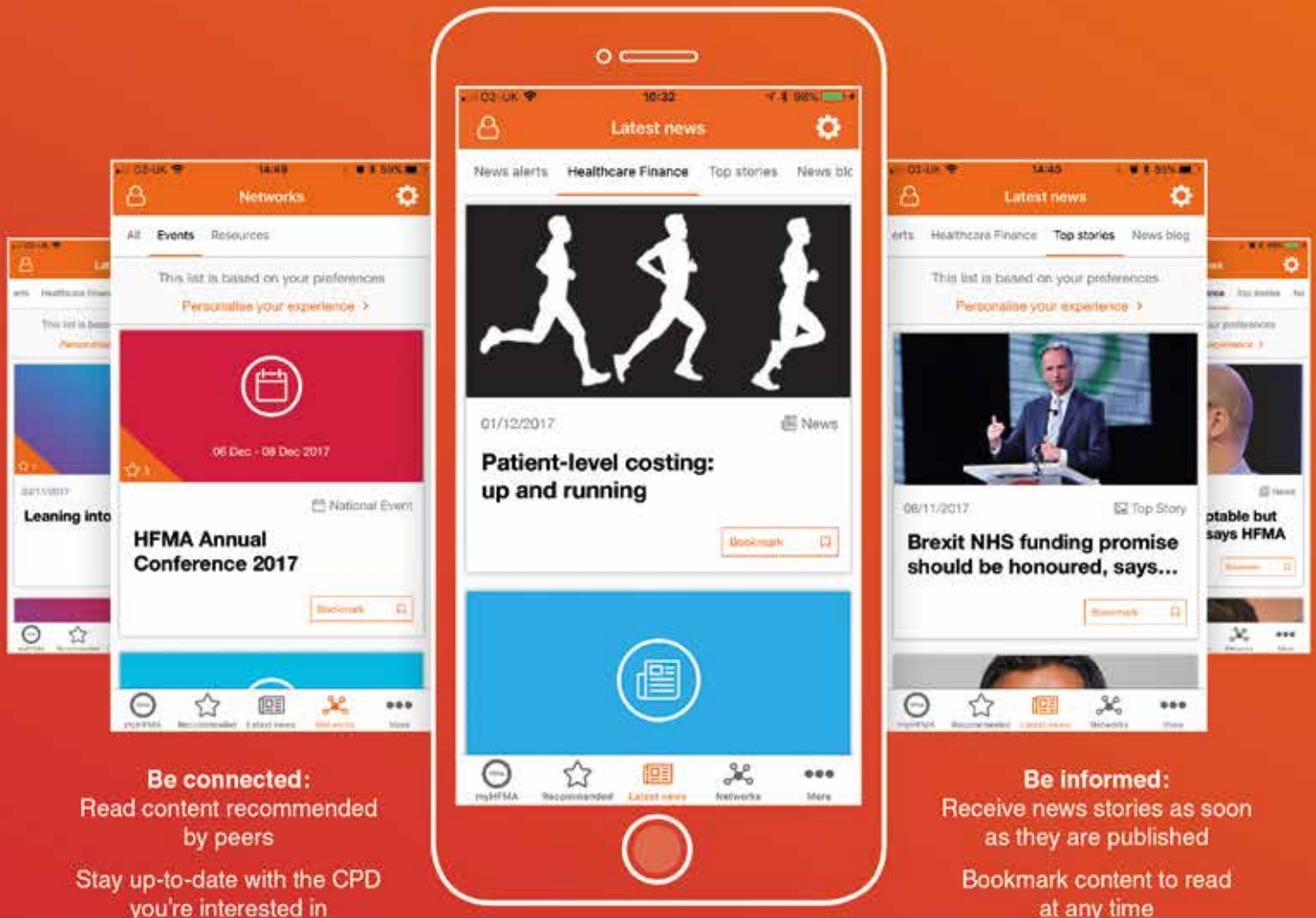
Speaking after receiving the FFF Award at the HFMA conference in December, Mr McLoughlin said: 'The NHS processes as many as 20 million invoices a year and e-invoicing could generate savings of more than 50% in processing costs per transaction. If the service saved £1 per invoice, commissioners could save as much as £5m in hard costs through e-invoicing. Across the NHS as a whole, efficiencies gained could be more than £20m.'

The delivery group is looking for more volunteers to help take its plans forward. To get involved in any aspect of its work, please email **futurefocusedfinance@nhs.net.uk**.

Our world at your fingertips

myHFMA

myHFMA is our exclusive app for individual members, delivering up-to-the-minute news, comment, policy and technical information that matter to you.



Be connected:
Read content recommended by peers

Stay up-to-date with the CPD you're interested in

Keep in touch with HFMA network activity

Be in control:
Select the topics, networks and blogs that matter to you

Push notifications reach you fast

Manage your membership on the go

Be informed:
Receive news stories as soon as they are published

Bookmark content to read at any time

Access *Healthcare Finance* magazine articles

Download myHFMA today and be mobile

Download on the App Store

GET IT ON Google Play

Visit **hfma.to/myhfma** for more details