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July/August 2019 | Healthcare Financial Management Association

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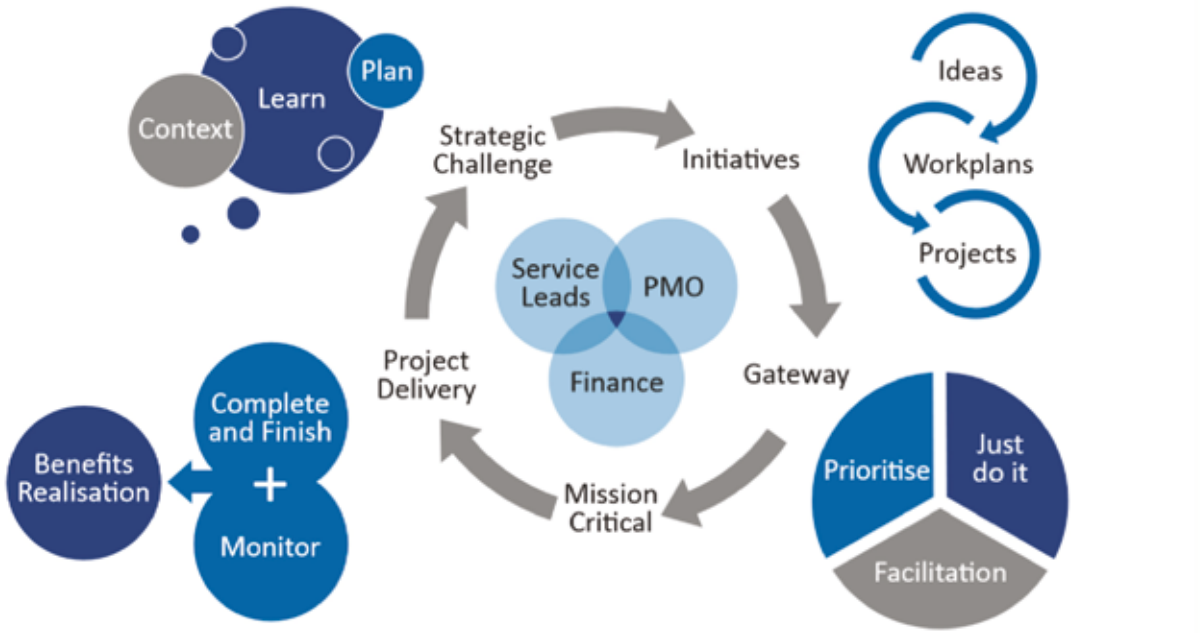

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For client references and to arrange a demonstration please visit our websites

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3M Science. Applied to Life.™

Case study

Optimising outcome, performance and reimbursement improvements through data quality

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

Results

2017 Realised reimbursement improvement

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

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

Financial benefit

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

£383,309

An average increase per month in appropriate reimbursement of:

£47,913

Increased data accuracy

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

Team development

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

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

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

*Clinical Coding Manager. Names withheld by request.

www.3M.co.uk/his

News

Extra funding for systems to implement long-term plan

By Seamus Ward

NHS England and NHS Improvement has announced additional funding of almost £1bn in 2019/20, rising to more than £3.2bn in 2023/24 to support the implementation of the *NHS long-term plan*.

Publishing its implementation framework for the long-term plan, the national body said the five-year clinical commissioning group allocations published in January were the starting point for system planning.

However, the allocations would be complemented with additional funding distributed to all systems on an indicative, fair shares basis. Alongside this, it will allocate targeted funding to be used to meet specific long-term plan commitments through regional and national programmes.

Simon Stevens (pictured) said there was flexibility to move money between priorities "but not on mental health and primary and community services"

The funding will come in two parts – that available to all systems, and funds for specific programmes. In 2019/20, the additional funding allocated to all systems will total £538m and in the following years this will rise to £560m, £814m, £1.2bn and almost £1.78bn. The funding should be used to meet commitments on mental health, primary care and disease areas such as cancer, as well as helping the elderly age well.

The targeted funding is £418m in 2019/20, followed by £939m, £1.1bn, 1.25bn and £1.48bn. This funding will be used to meet long-term plan commitments on a range of areas, including:

- Digital first primary care support funding
- Revenue funding for provider digitisation and local health and care records
- Developing community services for adults and children with learning disabilities and autism.

All the additional funding will be conditional on agreeing five-year strategic plans rather than individual bidding rounds. The funds form part of the £20.5bn long-term settlement unveiled last year. To date, only CCG allocations have been announced.

Matt Tagney, long-term plan programme director, said: 'We want to make as much of the funding tied to the single process of agreeing their plans to make it simpler and easier for them,' he added.

Asked if there was flexibility within the additional funding for systems to move money between priorities, NHS chief executive Simon Stevens said: 'Across the board, generally, yes but not on mental health and primary and community services because those typically have been the two parts that have been squeezed rather than over-invested in.

'Frankly there is no part of the country that is currently doing so brilliantly on its mental health service that we can say, "Take the foot off the gas and at the margin use what was for mental health for something else".'

NHS CONFEDERATION

Draft plans will be shared with regions in mid-September, with final plans agreed with system leads and regional teams by the end of October. NHS England and Improvement will publish a national implementation plan in December.

The framework also set out indicative financial planning assumptions to consider when developing strategic plans. The assumptions cover pay, non-pay and drugs costs, together with the indicative tariff uplift. Strategic plans should explicitly set out how the additional funding being invested will deliver real improvements for their populations.

NHS Providers welcomed 'much needed clarity' for local NHS leaders. Chief executive Chris Hopson said: 'We must, though, be realistic about how much can be delivered for the extra money provided alongside the long-term plan – given how far the NHS has fallen behind existing performance standards, the scale of workforce gaps, the need to deliver more integrated care and the sheer breadth of what we are seeking to deliver for patients.'

NHS England and NHS Improvement will work with the NHS over the coming months and set out further details of the financial framework for 2020/21 and later years.

Other areas identified for further work include the NHS capital regime, workforce development and primary care network and community services development.

HFMA invites awards entries

The HFMA has launched its 2019 awards programme, inviting entries from organisations and individuals that have made outstanding achievements this year.

There are eight awards, recognising excellence in finance teams, governance and costing, as well as individual awards for finance director and deputy finance director. A new category – Value and Innovation Award – seeks to recognise a project or initiative that maximises outcomes that matter to patients at lowest cost.

The deadline for entries is 27 September and the awards culminate in a gala ceremony on 5 December at the HFMA annual conference. Further details and an awards brochure are available at **hfma.to/awards**

THEODORE WOOD

NHS reports surplus despite CCG and provider deficits

By Seamus Ward

The NHS ended 2018/19 with an £89m surplus, but both providers and clinical commissioning groups overspent against plan. And, to ensure the overall position was delivered, NHS England withheld some investment earmarked for transformation and service improvement.

The overall NHS position was revealed at an NHS England and NHS Improvement meeting in common at the end of June. This showed that the commissioning sector had a year-end surplus of £916m – an aggregate underspend of £651m against plan.

Although CCGs reported a £155m overspend at year end – £203m more than plan – this was offset by underspends in other areas, including direct commissioning (£315.4m), NHS England running and central programme costs (£713.2m) and technical adjustments (£42.6m).

The provider sector ended the year with a £571m deficit, which was £177m more than planned. The figure was reached after including the benefit of the provider sustainability fund (PSF) and an exceptional adjustment of £256m following the liquidation of Carillion.

Two hospitals under construction were brought onto the NHS books after the collapse of the firm, which are treated as part-donated assets. Before these and other adjustments, providers had an aggregate deficit of £867m.

The total combined position of the commissioning and provider sectors was a surplus of £345m. However, part-donated assets are not recognised for RDEL reporting purposes (the key measure of departmental reporting), so the final overall year-end figure is an £89m surplus – £218m more than plan.

The year-end finance report tabled at the meeting said 33 CCGs overspent against plan (totalling £219m), while 27 CCGs underspent against plan (£27m).

As a result, CCGs overspent against plan by £264m but this was partially offset by £61m in quality premium that was not earned by commissioners. This produced the final figure of a £203m overspend against plan.

Savings in NHS England central budgets included vacancy controls, income from GP rates rebates and counter fraud receipts.

The report added: 'During the year, NHS England acted to ensure delivery of the overall financial position by holding back investment that would otherwise have been used to fund transformation and service improvement.'

Julian Kelly will address the HFMA summer conference on 5 July. Conference coverage at www.hfma.org.uk/news

NHS chief financial officer Julian Kelly (pictured) congratulated the service on achieving the overall financial position. He added: 'The £89m underspend is quite a feat on £113bn of spend. In aggregate, providers underspent against their capital plans to the tune of about £300m. Relative to previous years, the slippage of what they spent compared with what they said they would spend is much lower.

'It probably indicates both that they are getting better at doing what they said they were going to do and indeed some of the pent-up demand in the system to address maintenance issues, which we will need to keep an eye on.'

• *See A step forward?, page 8*

Four Welsh boards fail breakeven duty

Four health boards in Wales failed to breakeven in 2018/19, though health bodies significantly improved their overall financial position.

The Wales Audit Office said the Welsh government increased revenue spending by £231m in 2018/19, a 1.5% real terms increase.

However, there was still a shortfall on the amount the NHS bodies believed they needed to cover rising cost pressures. To bridge the gap, they made cost savings totalling £158m – around £11m less than the previous financial year.

The WAO said this was mostly due to fewer non-recurrent savings being made – recurrent savings were £125m, an increase of £5m compared with 2017/18.

Overall, the seven health boards and three trusts reported an aggregate revenue deficit of £96m in 2018/19.

In 2017/18 the total deficit stood at £167m. With six bodies achieving small surpluses, the four health boards had an aggregate deficit of around £96.5m.

The four university health boards – Hywel Dda, Betsi Cadwaladr, Abertawe Bro Morgannwg (ABM, now known as Swansea Bay) and Cardiff and Vale – failed to meet their financial duty of breaking even over a three-year period.

Health and social services minister Vaughan Gething (pictured) said the government had set deficit control totals for each of the boards. Three boards – Hywel Dda, ABM and Cardiff and Vale – met these control totals.

In-year, he allocated an additional £27m to Hywel Dda after a zero-based review of its cost base – including this funding, the board improved its position by £7m compared with 2017/18. Cardiff and ABM each received an additional £10m and both improved their outturns.

However, Betsi Cadwaladr's outturn figure was £6.2m higher than the control total. Mr Gething said benchmarking exercises had found potential efficiency savings of at least £85m-£125m.

He added: 'I have agreed that PwC work alongside the health board during the first quarter of this year to improve its planning and approach to deliver sustainable financial improvement. This will help to ensure it has a more robust plan for 2019/20 and a basis for sustainable financial planning for the future.'

NHS Property debt rising

NHS Property Services faces increasing levels of outstanding debt because it lacks the powers to make tenants sign leases and pay their rent, according to the National Audit Office.

An NAO report said that outstanding debt had reached £576m. In 2018/19 the service recovered only 58.4p for every £1 billed and, although GPs occupy only 18% of its properties, they owe some 30% of the current outstanding debt.

Data quality had improved, and a new billing system was introduced in 2017, but many bills are disputed, particularly by tenants without a rental agreement. The percentage of tenants without leases has increased from two-thirds to 70% since 2013/14.

The service does not have the same rights as commercial landlords, limiting its ability to act against non-payers.

NAO head Gareth Davies (pictured) said the Department must address the situation urgently. 'Too many NHS organisations and GPs seem to regard paying for their premises as optional, with almost £700m written off or still unpaid.'

NHS Property Services chair Ian Ellis said the report highlighted the legacy issues it faced. It was keen to work with the NHS to make improvements, such as developing a joint plan to ensure all tenancy details and charges are agreed by 31 March 2020.

Commons committee backs NHS legislation plans

By Steve Brown

Proposed legislative changes to support delivery of the *NHS long-term plan* have been broadly welcomed by the Commons Health and Social Care Committee, whose report said the NHS England and NHS Improvement proposals were 'pragmatic'.

Committee chair Sarah Wollaston (pictured) said: 'This report also represents cross-party endorsement of suggested changes and presents an opportunity to make integration easier, to encourage greater collaboration and reduce some of the burdens from competition rules.'

But the committee caveated its support with concerns that some proposals were too NHS-centric and increased central control, while more detail was needed in other areas.

One of the key proposals is to repeal section 75 of the *Health and Social Care Act* covering procurement and tendering rules.

The proposals would allow commissioners to exercise discretion about when to carry out a formal procurement process, subject only to a best value test.

The committee said competition rules had added cost and complexity without corresponding benefits for patients and taxpayer. But it called for more details on the best value test, which must neither be used to exclude non-statutory providers nor be more onerous than current arrangements.

Allowing clinical commissioning groups and providers in integrated care systems to establish joint committees was sensible, but additional proposals should be developed to involve local authorities, the committee said.

It also rejected proposals to give NHS England and NHS Improvement powers to direct foundation trust mergers and to set capital spending limits for these bodies.

The committee did support proposals to allow greater flexibility locally over payment systems, with national prices published as a formula rather than a fixed value.

However, it said more information was needed on how the formula would work. It warned that local flexibility must not result in a race to the bottom, where providers compete on price at the expense of quality. And there was a danger that greater local flexibility could add complexity for large providers.

NHS Confederation chief executive Niall Dickson said he supported the committee's view that NHS England and NHS Improvement should come together under a single national leadership. '[But] we share its concerns that the centre could become too powerful,' he said. 'That's why we are pleased the MPs agree that the centre should not start to direct mergers, acquisitions and the capital spending limits of foundation trusts.'

The King's Fund also welcomed the report and backed the move towards greater collaboration and integrated care. 'Like the committee, we support the decision to focus on targeted changes, rather than a wholesale review of the legislation,' said chief executive Richard Murray.

'However, it is likely to be a long time before these proposals become law and local systems need to continue their efforts to collaborate more closely within the existing legal framework.'

Providers call for training funds certainty

Funding of NHS training and education must be decided before the full five-year NHS workforce plan is published, according to health charities and thinktanks.

In June, NHS England and NHS Improvement published an interim workforce plan. It acknowledged that the final document, which will set out a fully costed plan, will be delayed until after the next spending review. Though NHS frontline spending is in the first year of a five-year settlement, education and training and capital budgets will not be considered until the spending review.

The review was to take place this summer, but with a new prime minister not due to take office until late July and uncertainty over the future relationship with the EU, the government has been reluctant to make spending commitments.

The interim plan said there would be 'urgent, accelerated action' to tackle nurse shortages, including 5,000 extra clinical placements for this September's pre-registration nursing intake. The five-year plan would aim to reduce the reliance on temporary staff by cutting vacancies to 5% by 2028. It would also seek to return funding for continuing professional development to previous levels over five years.

NHS Providers chief executive Chris Hopson (pictured) said the NHS wanted more complete answers to the workforce problem, but 'given the spending review timing and a Brexit-focused government, that was never going to be possible.'

But he added: 'It's vital these issues are addressed in time for the final plan. That includes the right outcome for NHS education and training budgets in the forthcoming spending review.'

News review

Seamus Ward assesses the past month in healthcare finance

Since our last issue went to the printers, Theresa May resigned as prime minister, precipitating a scramble among Conservative MPs to become the party's next leader and prime minister. But away from the stormy waters in Parliament, the NHS across the UK has maintained course, implementing measures to transform care.

Starting in Westminster, fresh from his own failed prime ministerial bid, health and social care secretary Matt Hancock was called to appear before the Commons Health and Social Care Committee. The committee had asked Mr Hancock for a copy of the government review of NHS overseas visitor charging, and its evidence. However, the health secretary turned down the request twice, insisting that he was unable to publish the review as some information was provided on a confidential basis. This led to his invitation to appear before the committee to explain himself. But the health secretary was unavailable, sending health minister Stephen Hammond and permanent secretary Chris Wormald in his place.

Separately, Mr Hancock confirmed to the committee that he will publish a consultation on patient registration, funding and contracting rules around digital first primary care. He said rapid growth in list size for a digital first GP service can lead to financial pressures. The baseline funding of Hammersmith and Fulham Clinical Commissioning Group – where the GP at Hand online service is based – was increased from the start of 2019/20, taking account of the list growth during 2018/19. A mechanism will be introduced to transfer funding between CCGs during 2019/20 to take account of the financial impact on the CCG of new patient registrations during the current financial year, he added.

A further three integrated care systems (ICSs) were given the green light by NHS England. The North East and Cumbria ICS will become the country's largest, serving more than three million people. The other new ICSs are: South East London; and Buckinghamshire, Oxfordshire and Berkshire West. There are now 15 ICSs, plus two devolved systems in Greater Manchester and Surrey, in total covering one in three people in England. NHS England has also published a guide to setting up an ICS. The paper sets out the different levels of management, describes their core functions, the rationale behind them and how they will work together.

About a third of employers think pension charges for high earners will affect a relatively large group of their employees. An NHS Employers survey said employers were concerned about the impact on retention and staff reducing hours or not taking on extra work. An employee survey showed many were considering taking these actions, as well as early retirement, to reduce their exposure to potential pension tax charges. The survey also cited a lack of understanding of pension allowances, with employers saying more HR time and resources were allocated to queries and complaints.

Cuts to the public health budget of £1bn in real terms must be reversed, said the Health Foundation and the King's Fund. With the government spending review likely to be delayed or limited due to Brexit uncertainty, ministers cannot keep putting off decisions on public health funding, the charities said. Ministers must signal their intention to restore spending to previous levels and ensure there are no further reductions. Cuts made since 2015/16 are having a major impact on services and undermine attempts to influence wider determinants of health, such as housing and transport, they said.

The month in quotes

'We must ensure that the way we commission and pay for care keeps up with the opportunities digital innovation offers, so that the system is not unduly destabilised by new service models.'

Transformation of GP services is at the front of health secretary Matt Hancock's mind

'We must keep a laser focus on making services as convenient as possible – everyone should feel like they are dealing with one system instead of having to repeat their story to a series of different organisations.'

Announcing three new ICSs, Simon Stevens says collaboration is the key to delivering the aims of the long-term plan

'To meet the demands of the future, we need to radically change the way services are delivered. We need to move away from healthcare that focuses on treating people when they become unwell to one that supports people to stay well, lead healthier lifestyles and live independently for as long as possible.'

Healthcare must become more proactive, says Welsh health secretary Vaughan Gething

'This review recognises that local government are best placed to lead on commissioning local public health services and the invaluable skill and expertise they bring to this. The best services are always those commissioned collaboratively with the NHS and this review emphasises the importance of this for every part of England.'

Councils should lead but collaborate when commissioning services, says Public Health England CEO Duncan Selbie

SHUTTERSTOCK

Fresh from his failed prime ministerial bid, health secretary Matt Hancock was called to appear before the Commons Health and Social Care Committee

A government review confirmed that local authorities will continue to commission public health services, but NHS bodies will be given a greater say in decision-making. The Department of Health and Social Care review concluded that councils should work more closely with the NHS to co-commission services such as sexual and reproductive healthcare. The review, promised as part of the *NHS long-term plan*, added that more integrated commissioning would embed prevention in a wider range of services.

The Welsh government announced it has allocated more than 80% of the £100m transformation fund it set up to change the way health and social care services are delivered. Announcing that Cwm Taf Regional Partnership Board would receive £22.7m from the fund, health minister Vaughan Gething said more than £80m had now been distributed to back projects that can eventually be scaled up to deliver the aims of its long-term plan, *A healthier Wales*.

The NHS Counter Fraud Authority (CFA) has set out its priority action areas for 2019/20. They include tackling frauds in areas such as pharmaceutical contractors, procurement and contractors in general practice. It also pledged to detect £22m of fraud, prevent a further £100m of fraud and recover £5m from losses due to fraudulent activity against the NHS.

NHS boards in England are less diverse than they were 15 years ago, prompting the NHS Confederation to call for a review of the appointment process for chairs and non-executive directors. A confederation report said fewer women and people of black and minority ethnic backgrounds were in the posts. The proportion of BME chairs and non-execs has almost halved since 2010 (from 15% to 8%), while that of female office holders has fallen from 47% in 2002 to 38% now.

NHS Providers warned that the service must not draw false comfort from the lack of winter pressures stories in the media. Its briefing, *The real story of winter*, argues that the nation was preoccupied with Brexit. And, though trusts did make improvements, performance data showed a growing gap between demand and capacity.

Malcolm Wright has been appointed chief executive of NHS Scotland and director general of health and social care at the Scottish government. Mr Wright has been in the role on an interim basis since February and was appointed following an open competition. Starting as an administrative trainee at Lothian Health Board in 1975, he has worked across Scotland's health boards and also served as a hospital manager at Great Ormond Street Hospital in London.

The top team continues to take shape at the reformed NHS England and NHS Improvement. Amanda Pritchard was named NHS chief operating officer and chief executive of NHS Improvement. She is currently chief executive of Guy's and St Thomas' NHS Foundation Trust and will take up her new post on 31 July. In her chief operating officer post she will be accountable to chief executive Simon Stevens.

from the hfma

The HFMA published a range of blogs in June. NHS England director of sustainable healthcare Matthew Cripps (pictured) argues that systems must lead value improvement efforts. While individual organisations must focus on value, it is only by combining efforts that value is maximised at population level, he says. Data is vital – showing where to look, helping monitor progress and informing evaluation.

Staying at system level, HFMA Scotland Branch chair Derek Lindsay highlights the belief of the Scottish government and Audit Scotland that the pace of integration of health and social care must quicken. A new HFMA briefing, *Planning for health in Scotland – a regional approach*, looks at the elements needed for productive integration and gives an insight into regional planning.

In a separate blog, MIAA senior audit manager Sarah Dowbekin says getting the right governance can ensure organisations deliver their own and their partnerships' objectives. The governance arrangements needed for partnership are demonstrated in a new HFMA briefing, *Case studies from the HFMA Governance Award 2018*.

Greater integration of services requires new payment systems. Lee Rowland, HFMA Payment Systems and Specialised Commissioning Committee chair, reminds NHS finance staff that payment systems are still in transition. Finance staff must remain involved in their development, he adds.

In his latest update from Bermuda, Bill Shields contemplates the early arrival of hurricane season and a new funding model introduced on 1 June.
www.hfma.org.uk/news/blogs

News analysis

Headline issues in the spotlight

A step forward?

The 2018/19 year-end figures for providers are a mixed bag that show improvements that have been made, and those still needed to achieve financial balance. Seamus Ward reports

The year-end figures for the provider sector in England could be likened to the curate's egg – good in parts. Or perhaps that should be improving in parts. The overall deficit is down, providers treated even more patients than the year before and productivity has improved. But the deficit was bigger than planned and there are still significant numbers of providers in the red.

At the end of the 2018/19 financial year, the provider sector recorded a net deficit of £571m – £395m better than 2017/18 and around £90m better than the year-end position forecast at Q3. NHS Improvement said the provider sector contributed to an overall balanced financial position across the NHS when the commissioning sector managed underspend was taken into account (*see page 4*).

It promised a new financial regime that would move away from blanket control totals after 2019/20 and regional support to improve trust financial controls.

'The NHS 1.1 million staff delivered care to more patients within national standards, improved quality, and stepped up efficiency to deliver one of the best financial performances in the last five years,' said Ian Dalton, NHS Improvement's chief executive. 'The *NHS long-term plan* will build on this achievement by giving staff the support they need to secure the future sustainability of the NHS by managing the needs of an ageing and frail population.'

A good financial position at year-end was important as 2018/19 was a preparatory year for the advent of the new funding settlement and implementation of the long-term plan in 2019/20.

However, the final position was worse than any of the planned deficits set during the financial year. The planned deficit position was reset in-year – first at a £519m deficit, then £439m and finally settling on £394m.

The final position also includes the benefit of technical adjustments following the collapse of construction firm Carillion. Two private finance initiative hospitals being built by the firm were taken back onto the books as part-donated assets, benefiting the overall position by £256m.

And though more than £3bn of cost improvement programmes (CIPs) or efficiencies were delivered, this still fell short of the planned amount. There was also an imbalance in the delivery of recurrent and non-recurrent CIPs.

Providers' underlying deficit at year-end was £5bn – up from £4.3bn – though this would reduce to £2.55bn if the Provider Sustainability Fund (PSF) is deployed.

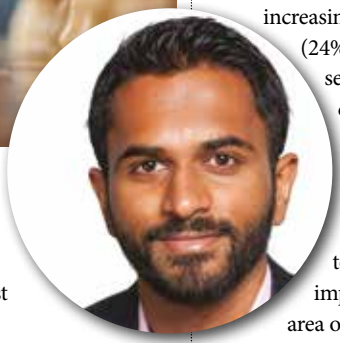
Taxpayers, politicians, and some in the NHS, would argue that providers should be delivering better financial performance given the amounts of funding they have received – including £2.45bn in the PSF – at a time when other parts of the public sector remain starved of cash.

Of course, the NHS is facing more demand

Provider financial performance 2018/19 overview

	Plan (£m)	Actual (£m)	Variance to plan (£m)	Number of deficit providers	Total PSF distribut-ed (£m)	PSF breakdown (£m)			
						Core PSF	Financial incentive PSF	Bonus PSF	General distrib'n
Acute	(1,392)	(1,548)	(156)	89	1,815	861	264	131	559
Ambulance	10	22	12	3	41	16	9	6	10
Community	30	55	25	3	59	25	9	9	16
Mental health	177	414	237	**7**	323	95	128	36	64
Specialist	127	190	63	5	193	55	96	13	30
Control total surplus/(deficit)	**(1,048)**	**(867)**	**181**	**107**	**2,431**	**1,050**	**506**	**195**	**679**
Technical adjustments inc uncommitted PSF	673	59	(614)		19				
GIRFT funded from PSF	(19)	(19)	0		(19)				
Reported deficit before technical adjustments	**(394)**	**(827)**	**(433)**		**2,431**				
Exceptional adjustments (due to Carillion collapse)	0	256	256						
Reported adjusted financial position inc all PSF	**(394)**	**(571)**	**(177)**		**2,431**				

SHUTTERSTOCK



than ever – A&E attendances in the 12 months to May were 4.2% higher than the preceding 12 months and there were 2.2% more completed elective pathways compared with 2017/18.

While activity growth increased productivity (which grew by 2.3%), it is also skewing the overall financial picture by, for example, affecting the delivery of cost improvement programmes, including savings on agency costs. There is also evidence that the growth in non-elective work is displacing elective income.

It was always going to be a slow march back to financial balance – the *NHS long-term plan* told us the provider sector should return to financial balance in 2020/21. By the end of the current year, the number of trusts reporting a deficit should have reduced by half, with no trusts in deficit by 2023/24.

The new financial regime (see news), with its promised shift away from control totals, should lead to more transparency and accountability, as well as support to reach these ambitions.

But the more immediate targets – cutting the number of deficit trusts by half and achieving overall financial balance by 2020/21 – could prove testing. The 2018/19 figures show a number of trusts with relatively small deficits (around 20 of less than £5m when PSF is included), but the total number of trusts in deficit was 107 (it was 102 in 2017/18).

To meet the ambition set out in the long-term plan, at least 54 deficit trusts will need to generate a surplus this year, assuming no further trusts fall into deficit.

NHS Improvement said a small number of trusts 'did not deliver acceptable financial performance' in 2018/19. These trusts accounted for most of the sector's financial problems. Excluding the PSF, 29 providers (12.6%) reported a variance from plan of more than £10m. These providers accounted for £569m (120%) of the sector variance from plan – again, excluding PSF.

Under-delivery of CIPs continues to be one of the biggest reasons for the variance. In 2018/19, £3.2bn of cost savings (3.6% of spend) were made – an almost identical number to the previous year. Providers had planned to make cost savings of almost £3.58bn (4.1% of spend).

All but £451m of the planned savings had been due to come from recurrent measures, but providers failed to achieve this. They delivered £2.2bn of recurrent savings, missing the target by £904m. Much of this shortfall was made up by non-recurrent measures – the sector delivered just over £1bn in non-recurrent savings.

Pay cost savings accounted for the largest under-delivery against plan. They were £322m (22.5%) behind plan, driven by the rise in non-elective activity and recruitment difficulties.

NHS Confederation policy director Nick Ville said: 'The reduction of £395m in trust deficits this quarter compared with the fourth quarter of 2017/18 offers some hope, but this report rightly recognises that we are overly reliant on one-off savings.'

Trust figures show large variances in patient care income (£1.76bn surplus) and pay-related expenditure (£1.95bn deficit), driven largely by the new Agenda for Change settlement. Pay funding was not included in the plan as the deal was agreed during the year. The government provided an extra £783m during the year to cover the cost of pay rises, but NHS Improvement said the new deal had led to cost pressures for a small number of trusts. The overall impact of the pay awards was £832m, leaving a £49m shortfall.

Temporary staffing was another leading cause of overspending against plan on pay. The need for temporary staff can be seen in the vacancy numbers. At the end of 2018/19, 96,350 posts were vacant, a fall of around 2,400 whole-time equivalents (WTEs) compared with the end of 2017/18 – more than 39,000 in nursing.

The reduction in agency spending is one of trusts' key CIPs. Since ceilings on agency spending were introduced in 2015/16, agency costs have steadily declined, ending 2018/19 at 4.4% of total pay costs. Trusts overshot their agency spending ceiling by £201m (9%) due to increases in the volume of staff and not because agency rates have increased, NHS Improvement said. Average prices per shift are 5.4% down on 2017/18, while shift volumes are up 5.3%.

While minimising agency spending, trusts have been able to get the staff they need by increasing bank spending. This was £666m (24%) over plan. NHS Improvement seems more sanguine about these costs, saying they are a financially more efficient way of dealing with activity pressures. 'By controlling agency spending, the changes of the last three years have led to better workforce planning and improved value for money in this area of significant spend,' it said.

Temporary staff needs are fuelled not only by vacancies, but also demand. The huge demand for emergency care is well-known, with performance statistics providing a monthly reminder.

Trusts received more than plan from increased A&E activity – £81m (3.4%) over plan at year-end. Non-elective income was £587m above plan, but costs were higher than planned due to increased activity. This increased income was offset by elective income being less than plan – by £191m (2%).

NHS Improvement said this was a continuance of the trend where emergency pressures displaced elective income – for example, because scheduled procedures have been cancelled due to beds being prioritised for emergency admissions. Non-elective income tends to be loss making.

King's Fund chief analyst Siva Anandaciva (above) said the NHS 'was running to stay still' in 2018/19. 'The NHS is treating more people than ever, and is in the grip of a workforce crisis. The new funding deal for the NHS will not wash these endemic pressures away. Unless the government delivers on its promises to address staffing shortages and provide investment and reform for social care and preventative services, it is hard to see how NHS providers can get back into the black and meet waiting times standards.'

Despite the improvements, the provider sector in England faces a big challenge to return to financial balance in the coming years. Money and resources have been set aside to help, especially providers with the most entrenched financial problems. However, providers do not operate in a vacuum and will continue to be affected by issues such as rising demand and staff shortages. Action on these issues will decide whether 2018/19 marked a step forward.

Comment

July/August 2019

Prioritising prevention

Health systems across the world are trying to shift the focus onto prevention

HFMA president Bill Gregory

One of the privileges that comes with being HFMA president is the opportunity to represent the association internationally. And at the end of June I attended the HFMA USA annual conference in Orlando.

It's now 55 years since an HFMA UK chairman first addressed the US conference, and it's great to have been part of this long tradition.

I am also grateful it only took me nine hours on the plane, compared with the three days it took Reginald Stacey to get there in 1964.

I was asked to give a UK perspective on the social determinants of health inequalities. I based a lot of what I said on the work Sir Michael Marmot did for the UK government – *Fair society, healthy lives*.

This provides evidence to underpin many of the wider social policies we have adopted in the UK, such as the focus on 'place' in the *NHS long-term plan* to create sustainable communities for healthy living.

I sensed more than a touch of jealousy from the American audience when my fellow US president, Mike Allen, shared a slide that showed how far the US is behind the UK when it comes to spending resources on prevention.

However they seem to be struggling with exactly the same problem – how do

Capital shouldn't be an afterthought

Capital is vital for transformation, and the NHS needs to catch up

Healthcare Finance editor Steve Brown

There is growing recognition that the NHS needs more capital resources to ensure its buildings and equipment are up to the job of delivering the high-quality and cost-effective integrated services envisaged by the *NHS long-term plan*. But the overall size of the funding pot is not the only thing that needs attention.

This is not a new phenomenon, nor is it something the government has been blindsided on. The finance function and NHS leaders in general have been raising concerns for years. The Naylor review of capital even put a figure of £10bn on the investment needed – a mixture of Treasury funding, income from sales and private finance (for primary care).

However, concerned voices have rightly reached fever pitch recently. In part, this reflects the fact that the revenue budget is now largely settled for the next five years – while there is still an opportunity to influence future capital spending.

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The likely delay of the spending review hasn't settled nerves. Expectations that long-term capital, training and public health budgets would be unveiled this year – along with all important social care funding – are now having to be revisited.

The deficit in capital funding is glaring. According to the Health Foundation, the

Pictured:: Bill Gregory with US chair Mike Allen (right) and Trenor Williams (left) from analytics firm Socially Determined

we create the incentives for organisations and individuals to focus more on prevention?

The UK system definitely has the edge here, as we rightly see money as an enabler for healthcare improvement, rather than a way of earning profits, with much more flexibility for change as a result.

Before I left Orlando, I invited Mike Allen to our national conference in December. I look forward to meeting him again in London and hearing more about his 'I dare you to move' challenge. He wants finance professionals to step outside their comfort zone to address current challenges.

Before travelling out to the US, I also had the chance to meet with our new national chief financial officer, Julian Kelly.

This was a great opportunity to welcome Julian in his new role and explain how the HFMA supports the finance profession in the NHS.

I was struck by how quickly Julian has acquainted himself with the intricacies of the health service and also the value he places on personal development and talent management.

I wouldn't be surprised to hear more about this over the coming months from Julian.

I've written before about how important it is for the HFMA to influence the design of the future financial regime and, in particular, how we work ourselves out of the issues created by the current financial architecture of control totals, sustainability funding and provider liquidity.

The current challenges around capital are now well understood. The more we can do as a profession to help Julian and his team work through these problems, the quicker we are likely to get to a better place, especially as we enter the next phase of spending reviews.

Julian, who is due to make his first major speech to the finance profession at this month's HFMA summer conference, will also be speaking at the association's December national conference, which will be a great opportunity for more of us to welcome him.

Contact the president on president@hfma.org.uk

UK spends just 0.27% of GDP on healthcare capital, compared with an average of 0.51% across countries in the Organisation for Economic Co-operation and Development (OECD).

NHS England and NHS Improvement made virtually the same point in its fourth quarter report in June. The UK has the fifth lowest rate of capital expenditure as a percentage of total health expenditure out of 34 OECD countries with comparable data. The 2018/19 capital departmental expenditure limit spend was just 4.5% of revenue spend – half the OECD average.

NHS England chief executive Simon Stevens told last month's NHS Confederation conference that capital investment per member of staff has fallen by 17% since 2010.

But while high-level recognition of the problem is encouraging, it is no substitute for funding. And the situation is compounded by continuing capital to revenue transfers. Although these are supposed to be phased out, reports suggest these transfers are now higher than originally planned for 2019/20.

On top of this, the mixed messages that are being given to providers don't help. Providers were offered increased rewards from the sustainability funds in recent years if they could improve on agreed control totals.

The bargain was spelled out as, effectively: cut back more on revenue now and you can increase funds for future capital investment.

This promise of future capital expenditure helped to get clinicians on side with further belt tightening measures.

But then this year's capital limits were not sufficient to accommodate trusts' plans – with providers asked to defer spending where it wasn't essential or where there were no contractual commitments.

Away from the funding issues, there are other problems. As the HFMA has said at some length (*see briefing, NHS capital – a system in distress?*), the way capital is allocated and controlled needs to be overhauled and made far more transparent. Trusts have capital resource limits, foundation trusts don't. Providers with the most internally generated funds aren't necessarily the ones most in need of investment. And the criteria for choosing one project over another for a capital loan are far from clear – with the lack of transparency seen as a major obstacle to taking a long-term approach to planning.

"The criteria for choosing one project over another for a capital loan are far from clear – with the lack of transparency seen as a major obstacle to taking a long-term approach to planning"

If we really do want sustainable services delivered across whole systems, then we need to stop taking a short-sighted approach to capital funding.

Sufficient capital funding should really be the first step - not an afterthought. And it needs to be wrapped in a process that is open to scrutiny, simple to navigate and facilitates planning for the long term.

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Governance Control Transparency

The NHS Wales Finance Academy is focused on improving the skills of all finance staff. Seamus Ward reports

Reaching higher

Around five years' ago the NHS finance function in Wales faced a number of challenges – low morale; few suitably qualified internal candidates for vacant finance director posts; and criticism of NHS organisations' financial performance and governance. So finance directors resolved to take action. They set up the NHS Wales Finance Academy to address the issues, and are already seeing early successes.

Under the umbrella term 'Finance adding value', the award-winning academy has four programmes – *Developing our people; Innovating and adding value; Working in partnership;* and *Driving excellence*. Each is sponsored by a finance director and championed by local lead staff.

Academy director Rebecca Richards (pictured) insists it is very much a solution tailored to the needs of the finance function in Wales and its 760 staff. 'We aim to create a finance function that is best suited to Wales but comparable to the best anywhere,' she says, and highlights the reasons why Wales finance directors set up the academy:

- Difficulty recruiting to finance director roles from staff working in NHS Wales and no obvious pipeline of staff coming through to lead
- An ageing workforce in finance with no obvious approach to succession planning for critical roles
- Little circulation of skills and experience and no purposeful approach to encourage the spread of good practice
- Poor organisational financial performance and a need to demonstrate finance skills and capability
- A strong feeling among staff that the professional profile of the finance function was getting lost and devalued
- Poor external governance reviews that identified areas of improvement needed across multiple organisations
- Little standardisation and efficiency in operations, despite the 'Once for Wales' approach to procuring national financial systems
- Staff feeling undervalued and unsupported to develop.

The programme's ***Innovating and adding value*** theme ties in with value-based healthcare, which in Wales is being developed under the quadruple aim – developing population health and wellbeing; increasing the quality of services; producing high-value, lower cost health and social care; and developing a motivated, well-trained and sustainable workforce.

'Part of the Finance Academy's role is about educating finance staff about value-based healthcare and providing the space to try the approach out for themselves. We also encourage staff to share approaches that work through our innovation compendium, so we can spread great practice across the country,' Mrs Richards says.

The ***Working in partnership*** element of the academy's work focuses on feedback from NHS finance staff, which it then acts on. 'This is about the finance community developing itself and bringing itself forward because it wants to. It's not about what the finance directors or programme team want to do – finance staff are driving the programme.'

Partnership also touches the wider theme of adding value, through closer working with clinicians and other partners.

There are currently 12 clinical and finance partnerships, made up of a clinical director and senior finance business partner with wraparound support from the academy. Each partnership, which started in February, was nominated by its finance and medical directors, and aims to learn more about the local improvement opportunities offered by applying a value-based healthcare lens.

'Clinical and finance partnerships are really important

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to the programme and we are looking to do more clinical-finance development,' says Mrs Richards.

The academy team is examining ways to bring together junior doctors and finance students to forge partnerships at the start of their careers. It has also built strong links with local universities and Rolls Royce. The company approached the NHS body when it was looking to set up its own finance academy. This relationship has, in turn, opened doors to other multinational companies, such as pharmaceutical giant GSK, BAE Systems and Sky. The academy meets with these organisations with the aim of continuously improving its work programme.

The ***Driving excellence*** theme focuses on standardising systems and processes. Two processes stand out, Mrs Richards says – procurement to pay and hire to retire. 'We are trying to standardise end-to-end processes as much as we can, and introduced our "No purchase order, no pay" scheme last year,' she says. 'As for hire to retire, we are developing many benefits for staff, including a common electronic staff record and easier access.'

Driving excellence has also focused on financial governance. 'We have designed an interactive user guide on how to improve financial reports,' says Mrs Richards. 'We can't be prescriptive to boards on financial reports and tell them what they should look like in huge detail. But, nonetheless, we can share best practice and good hints and tips.

'We are also looking at financial forecasting, looking around the health service and further afield with our industry partners, with a view to launching an interactive guide in the autumn.'

The ***Developing people*** theme is about supporting individuals in their career development. It has five talent pipelines, providing leadership development for different groups, from finance trainees to existing finance directors, recognising that development does not stop once this level is reached. One pipeline involves an aspiring director programme and two professionals on it have recently become finance directors in Wales. 'Those in these programmes have said it creates a strong network of people from organisations across Wales in similar positions, having shared experiences and problems they can solve and share for the common benefit,' says Mrs Richards.

All five pipelines are now up and running and those that are coming to an end will be re-run in the autumn, subject to demand. A mentoring platform has also been established, with mentors drawn from across the function. 'It doesn't matter where you are in your career – if you have some experience, you have something to offer,' emphasises Mrs Richards.

The NHS Wales finance function had to step up its training. 'In the past, we would have requests for training in areas such as Excel – which is important but will not necessarily close the skills gap that we have identified,' Mrs Richards says.

The academy is now working to create a personal development needs tool within the electronic staff record, which will enable self-assessment for current and future roles and provide the intelligence to develop a national training strategy for finance staff.

As well as continuing its current work programme, the academy's forward programme will also include developing a digital strategy for the finance function and a suite of financial governance improvement guides, as it seeks to add value to the service's finance staff offer.

A hand up

Emma Doolan (pictured) has put in place a training and development programme for band 3 to 6 finance staff at Swansea Bay University Health Board, which is being rolled out across Wales.

Mrs Doolan, a finance academy people lead and principal finance manager at the health board, says: 'We wanted a programme that would provide our junior staff with an opportunity to develop their management and leadership style and recognise team dynamics. We were really keen to put softer skills into the programme to inspire our people to deliver their best work, manage their teams successfully and increase productivity.'

Following an initial engagement with the health board's staff in these bands, the Swansea Bay team put together a five-day programme, run over a five-month period. The training was delivered to 24 people, split into two groups. The programme covers (in order): managing self and others; team dynamics; managing projects and service improvement; presenting and influencing; and time management and effective meetings.

Mrs Doolan says one of the benefits of the programme is that staff gained an understanding of the work their colleagues produced in other parts of the finance department. 'Some people were producing work on a monthly basis but didn't fully understand how other areas used that work. Strong bonds were formed between each of the cohorts and this led to helpful discussions. As a result, our people have identified opportunities to streamline processes and we are seeing greater movement of staff between departments.'

Working together

The HFMA Wales Branch is working with the Finance Academy to support the training and development of local finance staff.

Tim Kelland, a Finance Academy people lead and innovation champion, who is also deputy chair of the HFMA Wales Branch, says: 'The HFMA branch alone could not meet the succession challenges and development needs that the finance profession in Wales is going to experience in the medium to long term. We were doing continuing professional development and staff development events, but it needed something more. Until recently, finance staff development was viewed as a luxury and not a necessity. But everyone in the Welsh NHS finance family now understands the importance of continuous professional development for all its staff including our non-qualified staff,' he says.

'The academy has the resources to work closely with representatives of the local finance departments to take a systematic approach to identifying the development needs of all staff – that helps us as a branch when planning our own events and development programme.

'The Finance Academy is only too pleased to share with us the development needs they have identified, which they may not be in a position to deliver. This is where, as a branch, we are able to step in.

'We are planning to do more personalised CPD and development events, as well as social networking. We are looking to support members interested in undertaking finance research projects. This has allowed us to ensure our programme is more relevant to our members – there's huge value in that.'

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On the right pathway

The Royal Free London NHS Foundation Trust is on a mission to eliminate unwarranted variation across all its sites and services. Its approach – driven by clinical practice groups – involves multidisciplinary collaboration and early results are encouraging. Steve Brown reports

Addressing unwarranted variation in clinical practice – delivering best practice care more consistently and eliminating steps that add cost but no value – has become the rallying cry of health services across the globe.

The *NHS long-term plan*, the Carter report on productivity, and countless publications, from NHS RightCare and the *Getting it right first time* initiative, are full of references to the potential for improvement both within individual organisations and across the service.

However, identifying the existence of variation is one thing. Finding ways to understand where this variation is unwarranted, eliminating it and then maintaining consistent services has proved more elusive – particularly doing this at scale across multiple patient pathways.

The Royal Free London NHS Foundation Trust is arguably one of the providers that is most advanced with taking this agenda forward, aiming to deliver the same evidence-based pathways across all its sites and services.

The Royal Free was one of a number of providers to test out the idea of a group structure as part of NHS England's acute care collaboration vanguard programme.

It formally started its group model in 2017 with local management teams in place at its three main hospitals – Barnet Hospital, Chase Farm and the Royal Free – all connected by a single group centre. And it is also working with other hospitals outside its own trust.

At the heart of its model are clinical practice groups (CPGs) – inspired by the approach used by the InterMountain Healthcare hospital system in Utah, US, which the trust first visited some four years ago.

The CPGs cut across the vertical site-specific hospital management structure. Currently these CPGs are based on the trust's divisional structure: surgery; medicine and urgent care; women and children's; and transplant and specialist services. It is the CPGs' job to address variation and define the standardised clinical pathways that should be followed on all sites.

Trust group chief executive Caroline Clarke says it is a massive organisational change that will take time. 'We have totally changed the way we run the organisation,' she says. But it is a journey that I think we all need to go on.'

The trust's work on standardisation began by identifying the 30 diagnoses in admitted patient care with the highest total costs. Working with the CPGs, it then identified some 20 pathways that covered treatments for most of these diagnoses as its starting point for standardising practices.

For each pathway, a multidisciplinary team was created including a patient representative and each team then went through a quality improvement process. This starts with understanding the context for each pathway – what clinical guidelines exist, for example – and mapping out each step in the pathway. The teams then gather up and analyse all the available outcome and cost data before agreeing an optimum pathway and the costs of the original and new pathways are calculated.

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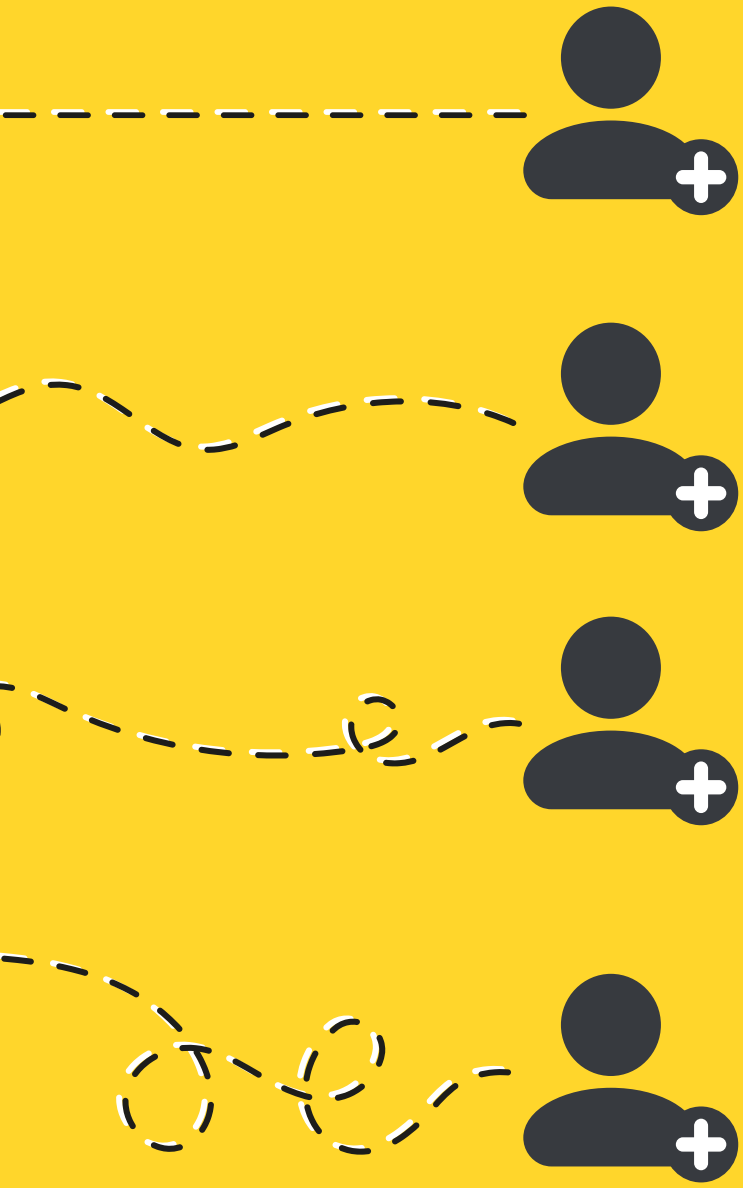

"We have totally changed the way we run the organisation. But it is a journey that I think we all need to go on"

Caroline Clarke, Royal Free London NHS Foundation Trust

Once a pathway is agreed, it is digitised – loaded into the trust's new Cerner electronic patient record. This means the pathway is in the system to support clinicians during treatment and standard tests can be ordered at the click of a button. (Non-standard steps can be undertaken or other tests ordered, but clinicians are required to explain why they are veering off the standard pathway.)

Group chief finance officer Peter Ridley says the process is structured but time-consuming. 'It varies how long it takes from a first meeting to having a revised pathway ready to implement,' he says. 'But it probably takes between six and 12 months depending on the complexity – some pathways are easier than others. It also depends on how many people need to be involved. The women and children CPG moved forward more quickly because there was a smaller subset of people involved.'

The trust has now agreed new pathways for its first 20 pathways, and 2019/20 is its first year of full operation for these pathways. Patients will benefit from more consistent, evidenced-based care that is often also delivered in a more convenient way for them – with test and pre-operative assessments all done as part of the same visit, for example.

Savings target

But the trust believes the improved care will have a financial pay-off too. Based on the level of savings made by InterMountain and its own assessment, it has set a high-level savings target of 6% over three years for each pathway – 2% a year over three years.

The model focuses on costs directly managed by the clinical service lines, which would cover £550m of the trust's £1.1bn total costs, not including tariff-excluded high-cost drugs and devices. The aim is to review pathways in four separate tranches over the three years to 2021/22, covering £330m of clinical delivery costs by March 2022 – which would mean £20m of savings over the three years if targets are achieved.

'This year – the first full year – savings are running at £2.2m to £2.5m, but then it ramps up quite quickly,' says Mr Ridley.

Early work on the gall bladder pathway, for example, identified potential savings of £500,000 – 10% of the total pathway cost – from a combination of quicker turnaround on tests, eliminating unnecessary repeat imaging and greater use of day surgery.

'Part of the current task is making sure these are real savings,' says Mr Ridley. 'Have costs come out or have they been reinvested in doing something else?' And if the new pathway has freed up capacity to help relieve a backlog or tackle waiting lists, can this be identified and a value put on it?

'In elective hip and knee, we've taken out some direct outpatient costs around clinicians and the support that goes around them. And I can see the time that's been put back into surgery and working through the backlog on orthopaedic waiting lists,' he says.

He adds that there will be some stranded costs in outpatient clinics and the administration that goes with them.

But the trust is also considering the impact on income. For example, the women and children CPG has reviewed its pathway to keep mothers and babies together wherever possible.

'Direct costs came out and stayed out and there has been a significant drop in the number of babies going into the special care baby unit (SCBU). We've seen real reductions in agency staffing costs. But we've lost more in income than we've saved,' he says.

'That's not a reason not to do it, but it does mean that you need to look at the relationship with commissioners so that you are still incentivised to do this.'

The trust's clinical commissioning groups have backed the improvement programme – with a representative embedded in the trust's transformation team. Initially, the CCGs and trust tried to agree a new tariff on a case-by-case basis.

'But this is almost impossible when you get more and more pathways,' says Mr Ridley. 'It can't be full payment by results, so this year we have agreed a new contract form using a cap and collar approach.

'The only variables are total referrals and A&E attendances – managed by the commissioners,' he continues. 'It is up to us to reduce the costs of the pathway from that point – so we manage conversion rates and the number of outpatient follow-ups. So if we can reduce the number of babies going to SCBU, we keep the benefit. And if the CCG can stop people coming to hospital in the first place, they keep the benefit.'

Moments of care

The costing team was involved in the process from the outset – with an understanding of current costs (and contribution towards overheads) and the financial impact of changes vital for planning and contract negotiations.

Mr Ridley says the costing approach was quite different, with each pathway broken down into 'moments of care' that all needed to have costs assigned.

While these costs draw on the same patient-level cost data set compiled by the trust, it uses the data in a different way. Recognising the importance of the costing work, the trust created three new roles in its costing team.

The trust's group model extends beyond its own hospital sites. North Middlesex University Hospital NHS Trust has been working with the Royal Free as a clinical partner since 2017 and it was joined by West Hertfordshire Hospitals NHS Trust last year. North Middlesex in particular has been closely involved in the redesign work from the outset, with its clinicians leading on some of the pathways.

"The benefit of what we have done is that the clinicians have worked this up together and so they are going to comply with it"

Peter Ridley, Royal Free London London NHS Foundation Trust

In general, partner organisations are adopting the new pathways that fit with their highest priorities. The aim is to have a consistent approach across all sites, although Mr Ridley says roll-out across future partner sites would need to recognise local factors.

'The interesting part will be if we take on other clinical partners and we've already got an established pathway – you can't just lift and shift a pathway,' he says. 'So the methodology for how you do any local changes will be important. You can't just impose it.

'The benefit of what we have done is that the clinicians have worked this up together and so they are going to comply with it. That's different from being given a clinical guideline from somewhere else that they haven't been involved in.'

The Royal Free has completed the redesign of its 20 pathways, covering about £75m of clinical delivery costs, and has a second tranche of pathways curently being worked up.

However, this is not a one-off review. Having redesigned the pathways, the CPGs will take a major role in monitoring compliance, ensuring the benefits are realised and making further changes where needed.

The stated goal is to deliver outstanding services, with Care Quality Commission ratings to match, and to demonstrate costs that are 10% below the average. Although the latest CQC rating saw the trust lose its overall 'good' rating, it says this was by a fine margin, with good ratings in three of the five domains. And its most recent reference cost index puts the trust at 4% below national average costs.

However, the trust sees itself on a journey and the real aim is to embed a cycle of continuous improvement.

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Getting personal

HFMA ROUND TABLE

Personal health budgets have a big part to play in the personalisation agenda, and new targets signal a major expansion of the programme. NHS managers at a recent HFMA roundtable discussed progress to date and how the use of PHBs could be increased. Steve Brown listened in to the discussion

The delivery of more personalised care is one of five major changes set out in the *NHS long-term plan*. And personal health budgets (PHBs) are arguably the most visible mechanism for putting this into practice – in many cases giving people direct control over the care they receive and how it is delivered.

The government's commitment to personalisation is clear. From February, people have a legal right to have a PHB for wheelchairs and, if they are eligible, for section 117 mental health aftercare services. As of April, PHBs should be the default method of funding for those in receipt of continuing healthcare (CHC) in the community. But there is a clear desire to see PHBs move into other areas – perhaps particularly supporting people with long-term conditions

This has all been backed up with demanding targets to increase the number of people in receipt of a PHB to 200,000 within five years – a four-fold increase on the 54,000 already holding budgets.

While NHS England says the expansion is ahead of schedule, meeting the goal presents significant challenges for clinical commissioning groups as they look to manage risks and put the necessary processes in place to manage PHBs at scale.

At the end of May, the HFMA organised a roundtable discussion, bringing NHS managers together to share progress and plans to expand the use of PHBs in their local areas.

The roundtable was supported by the team behind PHBChoices, a financial management system incorporating a care marketplace provided by NHS Shared Business Services (NHS SBS). The system helps CCGs handle the


Steve Ham


James Rimmer


Sam Matthews

Participants

- Jon Baker, PHBChoices director
- Harry Bourton, Caretrack operations manager, CHS Healthcare
- Paul Brown, chief finance officer, North West London CCGs
- Sarah Day, policy and research manager, HFMA
- Clay Flattley, continuing healthcare business manager, Telford and Wrekin CCG
- Steve Ham, head of business services, Norfolk Continuing Care Partnership
- Jim Manton, senior contracts manager, East Leicestershire and Rutland CCG
- Sam Matthews, associate finance manager, South Warwickshire CCG
- John Ridler, deputy chief finance officer, Bath and North East Somerset CCG
- James Rimmer, chief finance officer, Southampton City CCG
- Tracey Simpson, deputy chief finance officer, Tameside and Glossop CCG

administration of providing PHBs and enables PHB holders to manage their budgets and source the services and goods they need.

NHS England suggested recently that PHBs were already being successful, with 86% of people saying their PHB had delivered the outcomes they were seeking, with costs 17% below conventional service packages (for CHC care). James Rimmer, chief finance officer of Southampton City CCG and chair for the roundtable, asked whether these improvements were also being demonstrated locally.

There was broad agreement that outcomes and patient satisfaction improve with the adoption of PHBs, but evidence remains anecdotal.

Steve Ham is head of business services at Norfolk Continuing Care Partnership, which oversees CHC for four Norfolk CCGs and currently runs 100 PHBs on a direct payment basis. He said the PHB process itself was an improvement on the way many services were co-ordinated as it provided the opportunity to sit down with an individual and work out what outcomes they wanted. And there were clear benefits in terms of greater flexibility for the service user and continuity of care – for example, where people directly employed personal assistants, rather than receiving their care from a range of different agency-provided carers.

'But one trouble is that it is difficult to prove if it has reduced GP or A&E visits – an indicator that their health and wellbeing is improving – with the data challenges we have,' he said.

Although this would not always be a good proxy for improving health, being able to link CHC data with data from the Secondary Uses Service would be a good step forward, he added. However, PHB holders' survey feedback was largely positive and even the act of holding a budget had proved to be an empowering experience for many.

Sam Matthews, associate finance manager for personalised care across three Coventry and Warwickshire CCGs, on a part-time secondment from Arden and Greater East Midlands Commissioning Support Unit, agreed there was a lack of hard data. But she also said there were good arguments for greater personalisation.

Having a personal assistant at a time that suits the patient, rather than at the time an agency could manage, might be what was enabling someone to stay at home rather than going into residential care. 'And the fact that they can choose and individualise their care, and that they and their relatives are involved, would hopefully help their wellbeing,' she said.

Blocking the way

The roundtable discussed current levels of PHBs and the blockages to making progress. There was concern that the current levels of reported PHBs – 54,000 or an average of just over 250 per CCG – seemed high compared with some participants' local experience, where levels were often measured in tens rather than hundreds.

Jon Baker, director of PHBChoices, wondered whether all organisations counted in the same way. 'It is down to the interpretation of the definitions,' he said. 'Different CCGs may be counting in different ways – is someone in a care home being counted as a notional budget?'

Continuing healthcare could be an area

Sarah Day

Jon Baker

John Ridler

Job opportunity

The HFMA is looking for a home-based Assistant technical editor to support the HFMA's developing educational agenda

This is a 12-month secondment/contract role which involves preparing, reviewing and updating the HFMA's intermediate level qualification, as well as supporting the development of the association's CPD and apprenticeship offering.

A job description can be found at: hfma.to/ate

Deadline for applications: **15 July 2019**

For an informal discussion, please contact Sarah Bence:
sarah.bence@hfma.org.uk

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HFMA ROUND TABLE

for expansion, given the new requirement for PHBs to be the default funding mechanism – although this may well be in terms of increasing notional budgets rather than direct payments. But delegates said there was potential for rapid progress with wheelchair PHBs. Offering vouchers meant costs were tightly controlled and users could choose to supplement the specification if they wanted to customise the chair with extras.

Bath and North East Somerset CCG is arguably one of the more advanced commissioners in terms of personalisation, with more than 600 PHBs in place. However, deputy chief finance officer John Ridler said that even at this level, it did not yet feel as though PHBs had been mainstreamed. Again, it depended on what was currently being counted as PHBs.

The bulk of these PHBs are being delivered through a learning disabilities joint funding pool. Around 80% of these are on a notional budget basis – where the NHS continues to hold funds on behalf of the patient and purchases agreed care and support on their behalf.

Moving towards other PHB options – involving a third-party budget or direct payments where these were found to be more appropriate – would present more challenges. However, the CCG does have 15 CHC patients on direct payment and direct payment is now the default position for all community packages not including residential homes.

The CCG, together with its local council, has commissioned Virgin Care to deliver a joined-up community health and care service, and CHC and learning disabilities – including the PHBs – are included in these arrangements.

CCGs on board?

Board commitment to PHBs was another concern. Most participants said their organisations were committed to personalisation in terms of integrating services and wrapping care around the patient – but PHBs specifically weren't always a priority for boards. The

Clay Flattley

Tracey Simpson

significant transformation agenda – with a move to integrated care systems – and the wider financial challenge meant that the focus was often elsewhere.

Tracey Simpson, deputy chief finance officer at Tameside and Glossop CCG, said Greater Manchester's city-wide devolution was focused on delivering place-based care. 'This is putting the patient at the heart of what we do, under an overarching aim of "starting well, living well, ageing well"', she said. But within this, PHBs were not currently the highest priority in all localities.

Existing contract arrangements and lack of funding were seen as obstacles by all participants. 'There is no money to pump prime – that's a major barrier to extending further,' said Mr Ham. 'Most people who would benefit from a PHB are under block contract arrangements and most providers are financially challenged.' This makes it difficult to discuss transferring funds out of the current block arrangements to create the PHBs.

Ms Simpson agreed. 'The reality of taking money out of budgets for PHBs is extremely difficult,' she said. Rather than trying to shoehorn personalisation into existing models of care, a 'major mindset change' was needed.

Jim Manton, senior contracts manager at East Leicestershire and Rutland CCG, but on secondment to NHS England working on personalisation, said the answer was to start small. 'If you have three people eligible for section 117 aftercare on PHBs, that's a good place to start. A provider won't be destabilised by this level of activity moving away. And you should work with the providers – what are the services that are difficult for them to deliver that they may be happy to release?'

Starting at the margins is exactly what Telford and Wrekin CCG has done, leaving existing CHC clients on current arrangements initially.

'We've started with the new CHC clients and we are making a PHB offer to them in the first instance,' said Clay Flattley, the CCG's continuing healthcare business manager. The CCG has small numbers of direct payment arrangements across adults' CHC and children's continuing care, with larger numbers of notional budgets.

Returning to concerns about destabilising existing providers, Mr Manton added that moving someone onto a PHB – whether direct payment or notional budget – didn't necessarily mean a provider would lose out. It might just mean they are paid directly by an individual rather than the commissioner.

'You need to challenge providers – they won't lose any business if they are the best option,' he said, adding there was an opportunity for providers to revise their service offerings to retain users. 'Most patients don't change their provider at all – they are happy with the service they are getting,' he said.

Paul Brown, chief finance officer of North West London CCGs, wondered whether empowering clinicians to personalise care might be a way around the need to move service users out of existing block contract arrangements.

'Perhaps capitation budgets can achieve the same thing for a volume of patients rather than a single patient, if the right partnerships are in place,' he said. 'That way you could make resource decisions around a cohort of patients but empower people to make individual care decisions around the patient.'

In some cases, PHBs will mean moving services away from current providers – perhaps recruiting personal assistants. 'But maybe the business model is to provide a service to source personal assistants rather than providing care,' Mr Baker said. 'Perhaps there's an opportunity to highlight the greater flexibility of being a personal assistant to former NHS nurses, who may wish to return to delivering care without being directly employed by the NHS.'

Addressing risk

The roundtable saw the biggest obstacle as the perceived risk of moving to PHBs. A large part of this is financial risk – would PHBs destabilise finances? Mr Rimmer said: 'This really feels

Paul Brown

HFMA ROUND TABLE

like a good thing to do, but we can't really evidence that it stacks up. We haven't quite got the business case yet,' he said. Mr Brown added that current pressures meant new approaches had to be affordable. 'We need to demonstrate there is money coming out,' he said. 'We can only do things if there is some payback.'

However, Mr Baker said evidence was beginning to emerge that the introduction of PHBs could not only be delivered within existing budgets but could lead to savings across systems.

'In North West London, there are three CCGs using PHBChoices which, combined with new ways of working, has enabled cash-releasing savings estimated to be between 20% and 30%, representing £680,000. We need to sit down with someone from finance to confirm the exact figures, but the potential savings are significant,' he said. However, he stressed that systems and standardised processes would be key to delivering at scale.

'At the moment, based on our experience, the ratio of PHB holders to a full-time equivalent member of staff within the CCG (including finance, administration and assurance staff) is approximately 10:1,' he said. He added that PHBChoices could help enable CCGs to get to the ratio of 50:1 or even greater.

While a business case demonstrating savings would be helpful, CCGs were also worried about the potential for overspends or funds in PHBs being spent on items and services not deemed as appropriate.

'CCGs are concerned about the financial risks on direct payments and the risk around allowing people to have their own personal assistants,' said Ms Matthews. 'Are the personal assistants appropriately trained or are the patients paying the employer's national insurance contributions for these personal assistants, for example.'

She said there needed to be good monitoring arrangements in place, with red flags raised as quickly as possible to identify any concerns.

There are ways to address this. For example, Telford and Wrekin uses a third-party organisation to handle all the payroll and employment issues for services commissioned through personal budgets. 'The provider then sends in clients' accounts every quarter, highlighting overspends and underspends,' said Mr Flattley.

He admitted this had pros and cons. It arguably provided some assurance that controls were in place and gave an audit trail, but the three-monthly submission of accounts meant that if issues did arise, they could carry on for longer before being spotted and addressed.

HFMA policy and research manager Sarah Day suggested that CCGs needed to think about proportionality when they considered the potential risks on PHBs. While individual CHC budgets might typically stretch into tens of thousands of pounds, lots of other budgets would be for hundreds of pounds, perhaps buying services alongside an existing CCG-commissioned package of care. 'The amounts involved are often very small compared with a CCG's overall budget,' she said.

Mr Rimmer agreed CCGs were approaching PHBs with excessive caution. 'We don't ask for payroll details of our acute providers,' he said. 'And on CHC we pay providers relatively happily when we receive invoices – but on PHBs the trust appears to be very low.'

Harry Bourton is operations manager for CHS Healthcare, whose Caretrack software supports the management of people with CHC, funded nursing care and complex mental health funding. He believes people need to be helped to feel more comfortable with the new approach to personalisation. 'In some of our contracts we are the end-to-end CHC provider. We have some nurses who had to be taken on a journey to feel more confident about PHBs. They are also thinking about the clinical risks too.'

He underlined the importance of getting financial risks into proportion. 'We need to get on and let people have a go with PHBs,' he said.

However Mr Baker warned that PHB spend could become very significant over time and that CCGs would need to establish the right systems from the outset. In 2015, there were just 10,000 PHBs registered. 'With an average CHC budget of £70,000 in our experience, that is annual spend of £700m, which is relatively small compared with the £120bn NHS budget,' he said.

'But at 100,000 PHBs, it becomes £7bn. And 200,000 becomes £14bn. Without the right financial governance in place, there are greater risks around transparency, control and compliance as spend increases.'

In summary, the roundtable agreed that PHBs had real potential to deliver flexibility and improved outcomes for patients. There were perceived obstacles in the form of existing contracting arrangements and concerns about losing direct control of some parts of the budget – even though there was a recognition that the sums involved currently were small compared with overall spending.

Jim Manton

The targets were demanding, but there was recognition that issues would need to be addressed and more progress would need to be made quickly – with all parts of the service more focused on the agenda. Mr Bourton pointed out: 'There hasn't been the uptake we had been expecting and at some point there is likely to be more pressure on CCGs to increase the numbers.'

Perhaps more importantly, there was a concern that other pressures would distract CCGs from pursuing a key ingredient in delivering the personalisation agenda and helping to transform services in general.

Mr Ham expressed the views of the group when he highlighted a potential imbalance between the long-term plan and NHS England view of PHBs and the priority given to them so far locally. 'My concern is that we might find ourselves in five years' time not having done something really important – because it never quite got to the top of the pile,' he said.

For more information about PHBChoices, email jon.baker3@nhs.net or visit www.phbchoices.co.uk

Harry Bourton

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Events, people and support for finance practitioners

Leasing standard implementation is now urgent priority for finance teams

Technical

It seems as though we have been talking about the new accounting standard for leases for decades, *writes Debbie Paterson.* That is almost true – there was an exposure draft back in 2010 – although the new standard bears little resemblance to that proposal. And IFRS 16 was published three and a half years ago in January 2016.

In essence, the new standard ends the distinction between operating and finance leases from the lessee's perspective. In future, the lessee will recognise a right-of-use asset and lease liability for all material leases with a term of more than 12 months.

We now have all of the accounting guidance that is needed to apply this standard in the public sector – the Treasury published an update to its application guidance in April 2019.

As *Healthcare Finance* went to press, we were awaiting the imminent publication of the final piece of the jigsaw – the guidance on how the standard will affect public sector budgets. Our understanding is that the budgeting will follow the accounting, which means that after 2020/21 all lease contracts will have a CDEL impact but the budgets will be revised to take account of the new requirements.

So, there is no longer any excuse to put off implementation. In fact, with a conservative estimate of 55,000 leases across the public sector, this should now be an urgent project.

The application date may be 1 April 2020, but the 2020/21 financial plans will have to be completed before that and will have to reflect the financial impact of this standard.

Organisations that apply European Union adopted IFRS – the commercial sector, including a few companies within the Department of Health and Social Care group, such as NHS Property Services – are already deep into the

SHUTTERSTOCK

application of this standard as it is applicable for accounting periods starting on or after 1 January 2019. The NHS can therefore learn a number of lessons from them.

Adopting this standard will require system change and will have an impact outside of the finance department. The standard requires that the question 'does this contract contain a lease?' be asked at a contract negotiation stage.

In some cases, the answer will clearly be 'no' as there is no asset involved in the contract. However, where the contract refers to an asset, explicitly or implicitly, then the lease assessment will have to be undertaken.

So, for example, managed service contracts and contracts for continuing care placements that look like service contracts may include a lease as a service is delivered using an identifiable asset. This means that any staff member who has delegated authority to sign a contract needs to know enough to at least ensure that they contact someone in finance to tell them about the new arrangement.

Recording all of the information necessary to assess the accounting treatment and make the appropriate calculations may need more than a spreadsheet. It will depend, in part, on the number and the complexity of the leases an organisation has.

We all know that spreadsheets can contain errors and it is far too easy to overwrite a cell or calculation, but using a spreadsheet does not require any further investment. There is a cost/benefit assessment to be made.

We asked NHS bodies back in January whether they were contemplating a lease management system, and only one had purchased one at that stage. We will be asking the question again as part of our year-end survey and it may well be that the answer will change.

The latest version of the application guidance from the Treasury (dated April 2019) provides a worked example of how lease liabilities will be discounted and how the discount rate will be issued to public sector bodies.

It also confirms that the right of use asset will be subsequently measured using a fair value or revalued amount less subsequent depreciation rather than cost.

Initially, the Treasury had indicated that the cost model would be used meaning assets would be measured at cost less accumulated depreciation. However, this would not be consistent with the approach taken for owned assets, so the revaluation model will be adopted.

Having said that, it is expected that for most leases, a suitable proxy for fair value or current value in existing use will be historic depreciated cost. Whether this proxy can be used will be assessed on the same basis as currently happens for purchased assets. For leases that do not contain provision to regularly update the lease payment, and where the value of the underlying asset is likely to fluctuate significantly, a professional revaluation will be needed.

This is most likely to be the case for property leases. The example in the guidance involves a 30-year lease with only one rent review scheduled for the end of year 15 where the market for the property is active and volatile.

Debbie Paterson is HFMA policy and technical manager

Technical review

The past month's key technical developments

Technical

The National Audit Office published its report on the **whole of government accounts** for 2017/18 at the end of May. The WGA provides a complete picture of the financial performance and position of the UK public sector, capturing the accounts of over 8,000 public sector bodies, and sets out what the government receives, pays, owns and owes. It covers £815bn of expenditure. The comptroller and auditor general concluded that the WGA gives a true and fair view of the state of the WGA affairs and expenditure, but again qualified his opinion on specific areas, including the Ministry of Defence and the Department for Education. hfma.to/9m

A **costing assessment tool** (CAT) has been added to NHS Improvement's online costing assurance programme resources. The tool provides an assessment of the quality of a trust's costing and the degree to which costing standards have been implemented. It should help costing practitioners to record and measure progress against the standards. It will also help NHS England and NHS Improvement to identify and share good practice and to assess the status of costing in the sector, informing decisions on national initiatives to improve costing quality. The information provided in the CAT may also form the basis of providers' assessment under the costing assurance programme. The tool should be completed and submitted to NHS England and NHS Improvement by 20 September. hfma.to/9n

NHS England and NHS Improvement has outlined the steps for clinical commissioning groups to validate their 2018/19 year-end position to meet the **mental health investment standard** (MHIS). Under the standard, each clinical commissioning group must ensure their mental health spending rises at a faster rate than their overall programme funding. CCGs must publish a statement setting out if they have met the standard or not, validated by auditors. Under the standard, eligible expenditure excludes learning disabilities and dementia and should be adjusted for non-recurrent spend. It includes spending on main mental health provider contracts as well as mental health-related spend in other contracts, including smaller mental health providers, non-mental health providers and non-NHS providers. hfma.to/9o

The NHS England and NHS Improvement pricing team is considering rolling over the price relativities used for the 2019/20 tariff into next year. The **2020 national tariff prices** would still be subject to adjustments such as for inflation, efficiency and to meet the agreed cost base. But the relative difference between prices would not change unless there was a manual adjustment to address illogical relativities or other identified issues. The current tariff is based on the healthcare resource group HRG4+ currency design with the relativities informed by the 2016/17 reference costs. Feedback on the relativities and where corrections might be needed is due back, using an issued Excel spreadsheet, by the middle of July.

Trusts with non-clinical or clinical unregistered **off-framework agency spend** will be expected to eliminate this by September, NHS England and NHS Improvement has said. The bodies consulted on two proposals to restrict use of off-framework agency workers to fill non-clinical shifts and to restrict the use of admin and estates agency workers, with exemptions for special projects. While both proposals will go ahead, the national bodies have amended aspects, including creating a transition period to the new rules. As well as allowing three months for implementation, trusts will still be able to use break-glass arrangements for non-clinical workers if there are exceptional patient safety reasons. A similar transition has been set for admin workers, again with break-glass arrangements still applying. IT staff are also being exempted from the restriction. hfma.to/9q

Focus on multiple sclerosis

Technical: NICE

NICE published five new technology appraisals during June 2019, including a drug to treat a rarer form of multiple sclerosis in adults.

TA545 Ocrelizumab for treating primary progressive multiple sclerosis recommends the new technology as an option for treating early primary progressive multiple sclerosis (PPMS) where imaging reveals inflammatory activity in adults.

It is recommended only if the company provides it according to the commercial arrangement. This is the first disease-modifying treatment for PPMS.

An estimated 2,700 people with PPMS are eligible for treatment with ocrelizumab and it is believed that around 2,300 people will have ocrelizumab by 2023/24 once uptake has reached 90%.

NICE also published two clinical guidelines in June, including *NG133*, an update of the *Hypertension in pregnancy: diagnosis and management* guideline, and *NG134, Depression in children and young people: identification and management*. Costs associated with implementing both guidelines are unlikely to be significant.

NICE also published a medical technology, *MTG45 Endocuff Vision for assisting visualisation during colonoscopy*. During bowel cancer screening, a colonoscope is used to check the inside of a person's bowel. Endocuff Vision is a disposable sleeve that fits over the end of the colonoscope. Evidence shows that this makes it easier to detect bowel cancer and adenomas (abnormal growths that can develop into cancer).

Endocuff Vision can be used for people having a colonoscopy as part of bowel cancer screening, if they have had a positive stool test. Cost modelling shows that for people having a colonoscopy as part of bowel cancer screening, using Endocuff Vision is cost saving.

Gary Shield is NICE resource impact assessment manager

NHS in numbers

A closer look at the data behind NHS finance

Drugs spending

Technical

It is well known that the bill for medicines dispensed by the health service has been rising – seemingly inexorably – over the past few years. The latest NHS Digital figures show the NHS in England spent an estimated £18.2bn on drugs in 2017/18, an increase of almost 40% since 2010/11, when costs stood at £13bn.

Before examining the figures, it is worth noting that the costs presented by NHS Digital are not necessarily those the NHS actually paid. They are estimates based on list price excluding VAT and do not take account of nationally or locally negotiated prices. Hospitals are often able to access lower prices, either through a commercial access agreement or patient access schemes, such as the discount on beta interferons for the treatment of multiple sclerosis in adults.

Drugs dispensed in the community can be available at reduced cost, allowing community pharmacies to generate a margin that is taken into account in their funding arrangements. NHS Digital says £800m of margin earned on medicines contributes to the provision of pharmaceutical services.

Setting this aside, the overall figure is rising, and medicines dispensed in hospitals now make up more than 50% of the overall estimated NHS drugs bill (see chart 1). Conversely, the proportion prescribed and dispensed in primary care – traditionally much higher – fell from 66.5% in 2010/11 to 48.9% in 2017/18.

The cost of medicines dispensed in primary care has risen, but at a much slower rate than the rise in costs in hospitals. The estimated bill for medicines in primary care increased from £8.6bn in 2010/11 to almost £8.9bn in 2017/18 (a 3.5% increase). The hospital medicine bill stood at £9.2bn in 2017/18 – a 119% rise on 2010/11.

In 2017/18, the total hospital cost at list price increased by 10.8% on the previous year, while in primary care it decreased by 1%.

The shift in the cost of medicines dispensed in hospital is due not only to the rising cost of drugs, but also the introduction of new and innovative treatments, as well as the greater use of specialist medicines. Of the drugs appraised by the National Institute for Health and Care Excellence in 2017/18, the greatest overall cost was for Adalimumab, used to treat autoimmune conditions – it cost the NHS £494.5m in 2017/18, £471m of which was incurred in hospitals.

Indeed, of the top 20 drugs on which the NHS spends most, only three incur higher costs in primary care than in secondary care.

One of these three is insulin glargine (£83.7m in 2017/18), used to treat type 1 diabetes, but there is concern about the rising costs of treating all types of diabetes. The prevalence of diabetes in England was 6.8% in 2017/18, but this is expected to rise. Based on current trends, it could increase to more than 8% by 2035.

Overall, drugs used in diabetes accounted for 11.4% of the total primary care net ingredient costs (NICs) in 2017/18, as well as 4.9% of all prescription items. NICs are also based on list prices, but they may differ from actual costs as they exclude charges, for example, for containers or delivery.

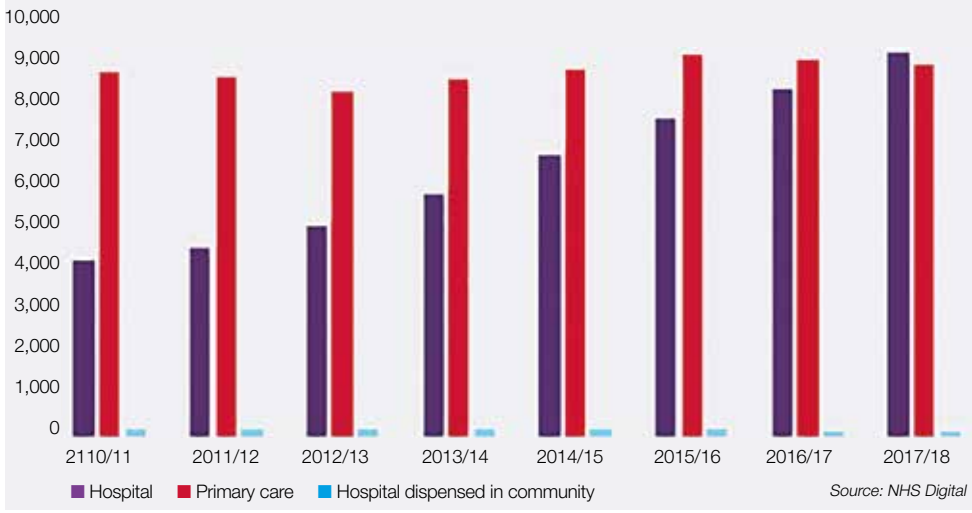
NHS Digital says just over £1bn was spent on diabetes prescribing, almost £422m more than in 2007/08, a rise of around 71%. Anti-diabetic drugs – taken orally to help manage sugar levels in the bloodstream, which are generally used in type 2 diabetes mellitus – made up the biggest proportion of the costs (47%) at £476.7m.

All insulins, including insulin glargine, accounted for £350.5m, while £181m was spent on diagnostic and monitoring devices (see chart 2).

The rise in the cost of anti-diabetic drugs has been due to an increase in the volume of prescriptions and higher costs.

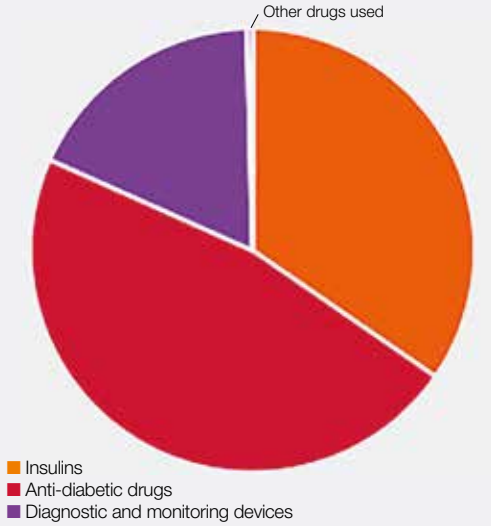
The latter followed the introduction of new, more expensive drugs and changes to prices under the category M scheme (which manages cost rises due to market forces) and the PPRS (pharmaceutical price regulation scheme).

Chart 1: Estimated drugs cost at list price



Source: NHS Digital

Chart 2: Diabetes drugs spending 2017/18



Source: NHS Digital; total spending was £1,021.4m

Apprenticeship offer

Philip Kemp, HFMA head of professional development
News and views from the HFMA Academy

Training

The HFMA Academy is now a main training provider for apprenticeships and plans to have a level 4 accountancy apprenticeship up and running by the start of 2020.

This is a major step for the HFMA. It means that it can now offer accountancy training as part of an apprenticeship, enriching this core training with contextual content to support students working in healthcare. And for NHS employers, it enables accountancy training to be supported by apprenticeship levy funds.

All employers with a pay bill of more than £3m now pay the apprenticeship levy, calculated at 0.5% of their annual pay bill. These funds sit in each employer's account, topped up by government, and can only be used to fund the costs of approved apprenticeships.

The academy is looking to offer apprenticeships in accountancy level 3, 4 and 7 and a masters senior leader level 7 among other relevant apprenticeships. However, the focus initially will be on the level 4 apprenticeships.

This will involve working with a delivery partner to teach the accountancy qualification content. The HFMA will work with the employer to determine whether the apprentice should study towards an ACCA, CIMA, AAT or ICAEW qualification.

Being part of an apprenticeship, students would be guaranteed time during their working hours to spend on their studies.

Wrapped around this accountancy core is a suite of material and support that helps students to place their technical training in the context of the health service they work in.

The HFMA has established level 7 and level 4 qualifications in recent years, with level 4 material covering a basic *How finance works in the NHS* module, along with more specific detail on costing, management governance and transformation.

The apprenticeship package will draw on this material, but it will be tailored to provide accountancy technician apprentices with a strong contextual understanding of the NHS and many of the issues they will come across in their day jobs.

All of the content – both the core accountancy modules and the enriching contextual material – has been designed solely for online delivery.

Students will face the usual formal exams as part of their accountancy qualification, but there will be no additional exams on top of these.

However, skills coaches will see the students every two months to review progress and ensure that students are accessing the necessary materials and developing at the right pace.

The end point assessment to complete the apprenticeship is set by the accountancy professional body.

Under an apprenticeship, 20% of each apprentice's working time must be spent in training and development. While this includes time off for professional qualification study, the HFMA Academy will also support employers in identifying current development activities that already count towards this target.

It will also help with the design of any additional activities required.

A level 4 accountancy apprenticeship pilot is targeted to start in January, when the academy will be looking to take on around 15 apprentices. This may be a national intake or focused on a specific region, with a further pilot group starting in the summer.

The association is hoping to have the masters senior leader level 7 apprenticeship ready by September 2020.

The new apprenticeships aim to meet real demand from the NHS finance sector. Apprentices will gain their professional qualifications with an enhanced understanding of the NHS.

Employers will benefit from apprentices' richer knowledge of the NHS – graduating from the scheme better equipped to contribute to their teams and departments.

In addition, organisations will be able to resource the training using funds from the apprenticeship levy.

Putting value at the heart of decision-making

Future focused finance

It's hard to argue against the concept of value-based healthcare. Decisions should take account of the outcomes that matter to patients and the cost of providing the service. A value-based approach encourages organisations or systems to challenge how patients are treated and to ask if a different approach could produce better outcomes and help reduce costs.

Despite general agreement on the principles, few UK healthcare organisations have put value-based healthcare into practice. FFF and the Healthcare Costing for Value Institute are working to deliver the best possible value (BPV) decision framework to help organisations or systems put the theory of value into practice.

The decision framework provides a standardised step-by-step approach that is specifically designed to help systems (or organisations) make value-based decisions.

The 12 templates guide people through a structured decision-making process starting with framing the real decision to be made, then introducing a methodology for groups to agree what good looks like and how to measure it.

Finally, there are templates that help to manage the project itself and build a value-based evidence log. Ultimately it supports stakeholders to work through different options for a decision and ensure the best value choice is identified.

The institute and FFF are also currently offering NHS organisations the opportunity to have a BPV facilitator come to their organisations and guide the key stakeholders for a decision through the framework. Once one project has been successfully completed with the support of a facilitator, it is much easier to apply the principles to other areas.

• **Visit hfma.to/9j for details**

Diary

July

2 (N) Webinar: the digital workforce in healthcare (12:00)
2 (B) London: VAT level 1
4-5 (N) HFMA summer conference, Bristol
9 (N) Webinar: decisions with value – a whole system approach to healthcare (12:30)
11 (N) Webinar: automating and improving control in financial management processes in the NHS (12:30)
17 (B) London: successful leading and managing change
18 (B) Yorkshire and Humber: integrated care models

September

12-13 (B) South Central: annual conference
18 (I) Institute: introduction to costing, London
19-20 (B) Wales: conference
23-24 (N) CEO forum and dinner, London
25 (F) Provider/Commissioning Finance: technical forum, London
26-27 (B) South West: conference, Bristol

October

3 (I) Institute: international symposium
10 (F) Chair, Non-executive Director and Lay Member: forum, London
11-12 (B) Kent Surrey Sussex: conference
17 (I) Institute: costing together
17 (N) Mental Health Finance: conference, London
18 (B) Eastern: conference, Newmarket
24-25 (B) Scotland: conference
27 (I) Institute: technical costing update, London

November

7 (N) Estates forum, London
7-8 (B) Northern: conference
12 (N) Charitable funds, London
13 (F) Audit conference, London
14-15 (B) East Midlands: conference
14 (F) Commissioning Finance: forum
21 (B) London: VAT level 2
21-22 (B) Northern Ireland: conference
27 (I) Institute: technical costing update

December

4-6 (N) HFMA annual conference, London

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

Mental Health Finance annual conference
17 October, 110 Rochester Row

The HFMA Mental Health Finance faculty annual conference comes at a crucial time for mental healthcare.

The *NHS long-term plan* and 2016's mental health five-year forward view have made improving mental healthcare one of the key priorities for the health service in England. The long-term plan pledged record investment – an extra £2.3bn by 2023/24 – and faster access for patients.

However, though the investment and the plan for mental health have been widely welcomed, there is some concern about how they will be put into practice.

This one-day event is aimed primarily at finance professionals in mental health, but it will also be of value to community finance colleagues, commissioners, non-executives, service managers and clinicians. There will be opportunities to discuss progress on the five-year forward view and the long-term plan, as well as the development of mental health services in the future. Besides discussions with colleagues, delegates will hear from technical leaders and experts. Speakers will include Tim Kendall (pictured), national clinical director of mental health at NHS Improvement.

• **For more details, email josie.baskerville@hfma.org.uk**

HFMA annual conference
4-6 December, London

The HFMA annual conference – the most important event in the NHS finance calendar – returns to London at the beginning of December. Under the theme of 2019 HFMA president, Bill Gregory – *Value the opportunity* – the finance function will gather from across the UK.

It is a time of significant transformation and ambitious plans across the UK as nations seek to address challenges such as ageing populations, staff shortages, rising demand and increasing costs. At the same time, the NHS must face external challenges, such as the UK's exit from the EU.

The annual conference offers an unparalleled opportunity to hear from the leading thinkers on healthcare finance from home and abroad, catch up on best practice and network with colleagues. There will also be a chance to celebrate the best of NHS finance at the annual HFMA Awards ceremony, which is held during the conference. Conference speakers include NHS England and NHS Improvement chief financial officer Julian Kelly, NHS productivity and efficiency leader Lord Carter (pictured) and BBC Europe editor Katya Adler.

• **Email josie.baskerville@hfma.org.uk or visit the HFMA website for details**

Meeting your needs

Association view from Mark Knight, HFMA chief executive

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

My HFMA

The HFMA exists to meet the needs of health and social care finance professionals by influencing policy, promoting best practice and providing opportunities for you to develop and network. We believe we do a good job, but the true test is what members think about the support and services we offer. So, we recently asked members to give us their views in the latest of our regular member surveys.

First, thanks to all who took part. We had responses from about 10% of our core members. The vast majority are fully qualified senior finance managers – one in five are directors or deputy directors of finance. Half have been members for five years or more – an endorsement in itself. But, more important, more than 90% plan to continue membership – and more than half of those thinking of leaving will do so because they are retiring or have moved sector. And 90% said membership provided value for money and the vast majority would recommend it to colleagues.

That's a gratifying response overall, but we were keen to learn more about what people valued about membership. Policy and technical publications, networking and *Healthcare Finance* magazine were seen as the top benefits, although webinars and weekly news alerts (and opinion blogs) also won praise.

It was good to see the HFMA app, myHFMA, recognised. We think this is a brilliant way of making our resources more accessible to you at your convenience. The free member app already puts our news services in your pocket, gives you access to all our publications and enables you to keep track of HFMA events. We plan to enhance this service with interactive elements – so if you haven't downloaded it yet, consider it soon.

Most people think we get it about right on qualifications, blogs and events, but there are always opportunities to provide guidance and support across the complex area of healthcare finance and governance. With our own capacity limitations, we have to prioritise, but we are keen to hear from members – through technical committees and special interest groups or direct – if there are areas we aren't addressing.

HFMA chief executive Mark Knight

There is a clear appetite for more webinars and this is already in train. Although we need to be careful not to eliminate the networking opportunities members value so highly, we recognise the value of getting a quick update on key issues without having to leave the office.

People asked for better communication about getting involved with committees, so we will ensure we improve our signposting for this.

More than 90% of the respondents rated our policy and technical work as high or very high quality – though we know we must do more to make everyone aware of our outputs.

The relevance of topics was applauded, helped by members having an influence over the selection of projects. We again sought feedback on projects for the year ahead and our policy team will use this to finalise the programme.

As report cards go, it was very encouraging. However, we are not complacent. We will try to keep getting things right – but are reassured that you will tell us if we don't.

Member news

The HFMA South West Branch annual awards programme is now open for nominations. The awards recognise local achievements, hard work and commitment from within the region. You can submit your nominations in seven categories, including:

- Deputy Director of Finance
- Finance Team
- Unsung Hero
- Professional Development.

To find out more, visit **hfma.to/swawards2019**

Andy Ray (pictured), chief finance officer, Mid and South Essex Joint Commissioning Team, is taking part in a

fundraising run for the Polly Parrot children's services appeal for Basildon and Thurrock University Hospital. This summer, he and daughter Amy and her partner Oli Markham, will run 75km between them in support of the charity, which raises funds to improve the hospital's children's wards and departments. Support them online at **www.justgiving.com/fundraising/75kmchallenge**

Would you like an HFMA piggy bank for your desk? If you recommend the association to a friend, they will get two months of membership for just £1 and you will get a piggy bank. Email **membership@hfma.org.uk** and quote **FRIEND19**. Terms and conditions apply. Find out more at **hfma.to/members**

Team HFMA is getting ready for its Three Peaks challenge in October in aid of mental health charity Mind. During the HFMA summer conference, delegates will have an opportunity to help the fundraising efforts by taking part in a raffle to win prizes donated by HFMA supporters. If you can't attend the event, but want to show your support, you can donate at **hfma.to/3peaks** – where you can also find out about Team HFMA's Three Peaks preparations.

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Member benefits

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

Network focus

My HFMA

HFMA Commissioning Finance Faculty Steering Group

Achieving the best possible experience for patients often means blurring the lines between health and social care. NHS continuing healthcare is one solution. It entails the commissioning of a package of care by the NHS for an individual with a primary healthcare need. This could include social care and even accommodation if needed.

Continuing healthcare and personal health budgets were the main topics discussed at the recent Commissioning Finance Faculty forum in May. David Chandler (pictured), chief finance officer at Sunderland Clinical Commissioning Group and chair of the HFMA Commissioning Finance Faculty Steering Group, says: 'We heard from NHS England and NHS Improvement, clinical commissioning groups and foundation trusts – examples of how getting personal health budgets and continuing healthcare right can improve services for patients but can also be more cost-effective. A patient speaker also brought the importance of this to life.'

The group has released a briefing on NHS continuing healthcare – see **hfma.to/continuinghc**

Mr Chandler says: 'The group provides members with a regular forum that enables people who work in commissioning to explore the hot topics of the day and consider what themes we need to be exploring in more detail. It is a great opportunity to influence NHS policies, provide feedback and hear about issues that other CCG chief finance officers are dealing with in other parts of the country. In this regard, it's a bit like a peer support network and can be really helpful.'

The group recently discussed non-contract activity with NHS England and NHS Improvement. These are case-by-case activities paid for by commissioners. They generate a lot of work for CCGs and providers, as they involve raising invoices and chasing approvals.

'The non-contract activity accounts for up to 25% of all invoices that go to NHS Shared Business Services,' says Mr Chandler. 'We reflected on the issue and provided feedback to NHS England and NHS Improvement that we'd like to see that simplified into something like an annual adjustment to commissioner budgets much like overseas visitor adjustments.'

The HFMA Commissioning Finance Faculty Steering Group is looking for members passionate about influencing the commissioning agenda. Email **joanne.hitchen@hfma.org.uk**

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Appointments

Jackie Chai, who was most recently deputy director of finance at Dorset Healthcare University NHS Foundation Trust, has now retired. She was an active supporter of the HFMA and a member of the association's Mental Health Finance Steering Group.

Dawn Scrafield (pictured) has been named as the new chief finance officer at the Mid and South Essex Hospitals Group. She will take up her new position in September. Ms Scrafield is currently director of finance at East Suffolk and North Essex Foundation Trust. She has nearly 23 years' experience working in senior NHS finance roles.

Julia Newton (pictured), director of finance at Sheffield Clinical Commissioning Group, has retired after 27 years in the NHS. **Jackie Mills** has taken over her role on an interim basis. Ms Mills has nearly 30 years' experience in the NHS.

Neil Mulholland has taken up the role of interim director of finance at Coventry and Warwickshire Partnership NHS Trust, following the retirement of **Gale Hart**. Mr Mulholland was previously deputy director of finance at the organisation.

Tracey Cotterill is now interim director of finance at Kingston Hospital NHS Foundation Trust. She is an experienced finance director and her most recent role in NHS finance was as director of finance at Medway NHS Foundation Trust. She takes over from **Jo Farrar**.

North East Ambulance Service NHS Trust has appointed **Kevin Scollay** (pictured) director of finance and resources. Mr Scollay joins the trust from the North Tees and Hartlepool NHS Foundation Trust, where he was deputy director of finance. In his new role, he takes over from **Lynne Hodgson**, who has retired from the trust.

Yeovil District Hospital NHS Foundation Trust has appointed **Mike Barber** interim chief finance and commercial officer. Mr Barber has experience as a strategic adviser to the NHS and supporting organisations to deliver finance-focused transformational change. Mr Barber is director of Seagry Consultancy, and was previously a director at Ernst & Young, with responsibility for the health sector. He has taken over from **Timothy Newman**.

The Hillingdon Hospitals NHS Foundation Trust has appointed **Jenny Greenshields** director of finance. She brings more than 25 years of experience in NHS finance to the role. She joined the trust from Moorfields Eye Hospital NHS Foundation Trust, where she was deputy chief financial officer and acted up as a chief financial officer for six months.

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

"The collective leadership challenge will be to work together to drive excellence in care for patients and communities, particularly within urgent care, in a much more outwardly integrated way"
Mark Orchard, Portsmouth Hospitals NHS Trust

Orchard to make move to Portsmouth

On the move

HFMA 2017 president Mark Orchard is to join Portsmouth Hospitals NHS Trust as its chief financial officer later this year.

Mr Orchard, who will succeed Chris Adcock, has been director of finance at Poole Hospital NHS Foundation Trust since May 2015. It is one of four NHS providers working together with the Dorset Clinical Commissioning Group as a wave 1 integrated care system (ICS).

Mr Orchard, who lives with his two children in Lee-on-the-Solent, said that by joining the Portsmouth trust, he was fulfilling a career ambition.

'The attraction of combining the privilege of working for a very significant NHS provider with a large defence medical group, while at the same time serving my home health and care community, has never been greater,' he said.

Over his career, Mr Orchard has worked across NHS organisations, including commissioners, providers and systems. Before joining Poole Hospital, he was finance director and deputy area director for NHS England (Wessex) from 2012.

He spent the previous eight years in commissioning bodies, including: the Bristol, North Somerset and South Gloucestershire PCT Cluster (as director of finance and information management and technology); Bournemouth and Poole Teaching PCT (director of finance, information and performance); and South and East Dorset Primary Care Trust (deputy director of finance).

Poole chief executive Debbie Fleming paid tribute to Mr Orchard, saying he had consistently provided strong, effective financial leadership for the trust board.

'Mark has also been closely involved in the work to develop an integrated care system in Dorset and his strong partnership working approach has delivered financial stability in a very turbulent time. His input has also been invaluable as the organisation has been developing plans to merge with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.'

Under his guardianship, the trust has achieved the financial position agreed with NHS Improvement/Monitor in each of the past four years. He also contributed significantly to the ICS *One NHS in Dorset* finance and activity framework – with 2019/20 being its third year operating under an NHS group financial control total, underpinned by a county-wide clinically led programme for demand management.

Mr Orchard also supported the submission of an outline business case to the Treasury bidding for capital funding to separate planned and emergency care across the Poole and Bournemouth hospital sites. His experience at Poole and across the Dorset system will be relevant in his new position, Ms Fleming added.

The Portsmouth trust, which has planned income of around £603m during 2019/20 (after having assumed £17.5m national income linked to delivering the financial control total), faces significant financial challenges.

Mr Orchard said it is clear the immediate years ahead will be as demanding as any in Portsmouth's history. It must ensure further significant waste-reducing efficiencies are identified to maintain a robust liquidity position, to deliver the agreed 2019/20 breakeven financial control total, and to continue to make sustained progress towards an operating surplus in future years.

Overseeing a significant total capital investment programme (including £58m to redevelop its urgent care facilities at Queen Alexandra Hospital in Cosham) and prioritising the trust's limited local capital to maximise its return on clinical and operational efficiency, will also be important. Ensuring that the trust's £256m private finance initiative deal (for its Queen Alexandra Hospital) delivers value for money will also be a priority.

Mr Orchard is optimistic about the potential for greater partnership working and the introduction of innovative models of care across Portsmouth, South East Hampshire and the Isle of Wight. 'It is clear that the collective leadership challenge will be to work together to drive excellence in care for patients and communities, particularly within urgent care, in a much more outwardly integrated way.'

Mr Orchard said he was excited by the challenges and opportunities that the new role presents. He is convinced his personal values are perfectly aligned with the vision and values of the organisation.

He is particularly excited to support the already strong finance, procurement and estate functions through their next stages of development and is committed to investing in people for continuous improvement.

Hunter steps down

Stuart Hunter (pictured right), chief finance officer and deputy accountable officer at Dorset Clinical Commissioning Group is to retire. Mr Hunter is also the finance lead for the Dorset Integrated Care System, one of the first-wave ICSs operating under a single control total. He will retire at the end of December, following an NHS career spanning 37 years.

Mr Orchard said Mr Hunter's retirement has created a 'significant CFO opportunity in an ambitious and forward-thinking integrated care system'. Mr Hunter's successor will take both roles. The ICS covers a population of more than 800,000 and has 18 primary care networks. Though the financial challenge across Dorset is significant, the ICS believes it is well placed to address this, with finance leaders working through a collaborative agreement and shared control total.

FUTURE FOCUSED FINANCE

MAKING PEOPLE COUNT

FUTURE-FOCUSED FINANCE IS ABOUT IMPROVING NHS FINANCE FOR EVERYONE; RECOGNISING THE NEED FOR STRONG FINANCIAL SKILLS AND UNDERSTANDING ACROSS ALL PROFESSIONAL GROUPS TO DELIVER GOOD PATIENT CARE AND VALUE FOR TAX PAYERS.

This national initiative has been designed to improve the quality of finance teams and financial management across the NHS. Delivery is through a range of networks, frameworks and toolkits, as well as events, workshops and other learning and development opportunities.

In 2018, the Finance Leadership Council refreshed their strategic aim and objectives. This means, with the support of the Finance Development Foundation and Skills Development Network, we're working to develop a diverse, appropriately skilled, adaptable and resilient finance function and workforce, to ensure value for money and quality services for patients.

We have five delivery themes and each is supported by committed finance leaders from among the NHS:

CULTURE

Promoting good values, psychology, attitudes, beliefs and experiences.

WORKFORCE & LEADERSHIP

Looking forward to identify the skills that the workforce will need in the coming 5-10 years and helping people develop those skills.

ENGAGEMENT & DEVELOPMENT

Equitable access to opportunities for all to develop their knowledge of NHS finance.

EFFICIENCY & VALUE

Promoting ways of working that improve outcomes or reduce resources without compromising either.

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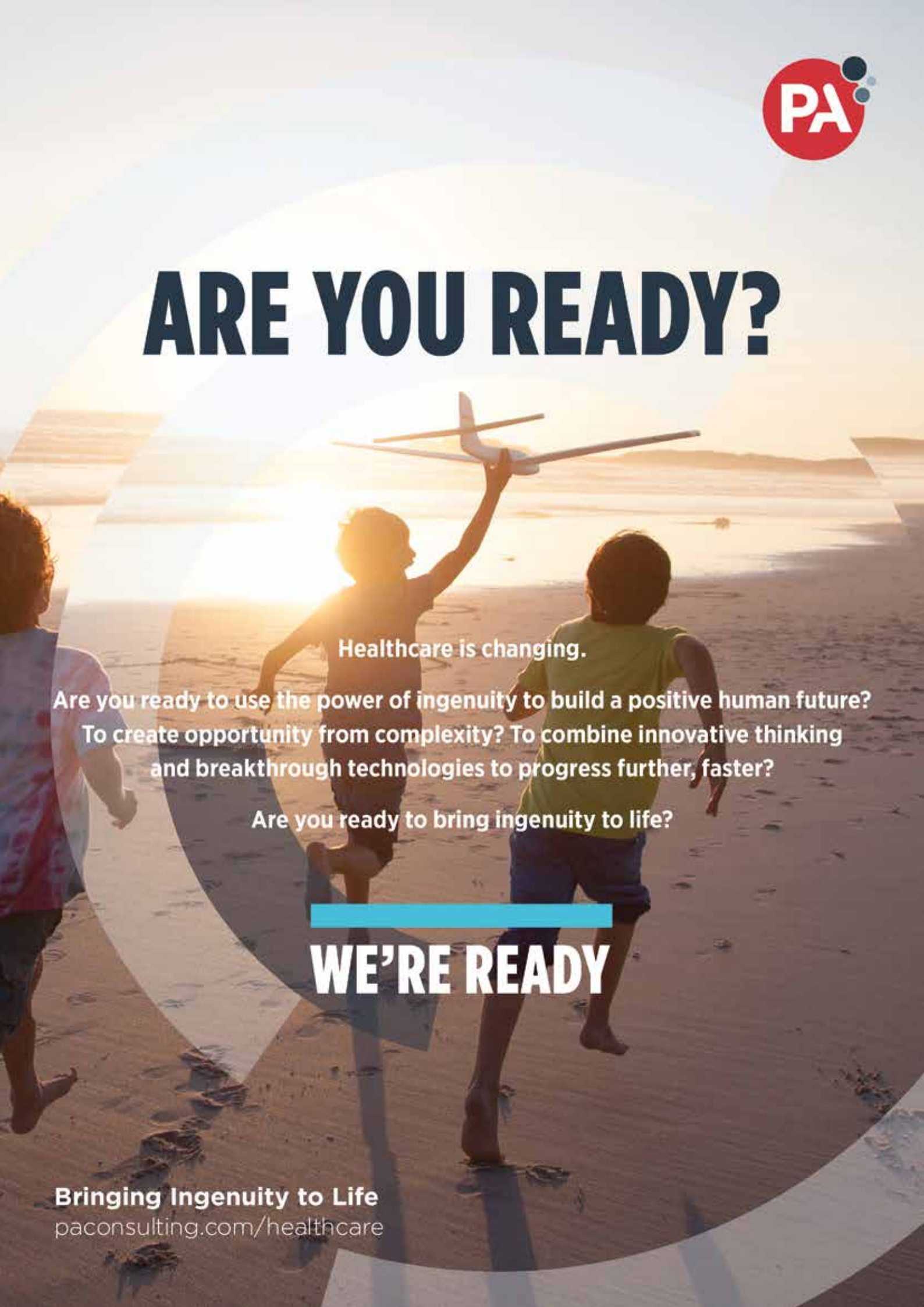
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ARE YOU READY?
Healthcare is changing.
Are you ready to use the power of ingenuity to build a positive human future?
To create opportunity from complexity? To combine innovative thinking
and breakthrough technologies to progress further, faster?
Are you ready to bring ingenuity to life?
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