healthcare finance

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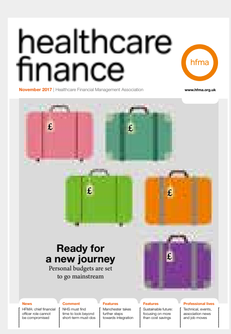

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News

Bullying unacceptable but not systematic, says HFMA

By Seamus Ward

There is no evidence of systematic bullying of NHS finance staff, the HFMA has said, but any cases, even if isolated, must be stamped out.

HFMA president Mark Orchard said he was disturbed by reports from CIPFA claiming that NHS finance staff were feeling bullied by regulators to sign up to figures that they do not think are achievable.

He did not believe that bullying was organised, but added that NHS accountants must always give an honest assessment of the true financial position.

'As a jobbing finance director for an acute hospital, I know all too well that a key part of my role is to deliver an honest and true assessment of the financial position, even when this is often not what anyone wants to hear. Integrity is central to our professional ethical code,' he said.

A range of valid financial instruments, non-recurrent measures and short-term fixes were available to NHS organisations, he added. Unsubstantiated or unrealistic projections were unhelpful and postponed decisions that could be in the best interests of patients and the sustainability of services.

The HFMA has picked up individual comments from directors of finance and chief finance officers about expectations on delivering financial results.

Mr Orchard said some pressures went with the job, with most senior finance professionals under continuous pressure to confirm the deliverability of financial plans.

> **"Our job starts with telling it as it is – not worst case scenario or heroic assumptions"**
> **Mark Orchard (pictured)**

The level of pressure will vary between organisations, as will the maturity and experience of the board, he said in a blog published on the HFMA website. The job can be challenging even for the most resilient, but the chief financial officer role cannot be compromised. This role was outlined in a recently updated HFMA briefing, which is out for consultation.

'Our job starts with telling it as it is – not worst case scenario or spreadsheet pessimism, and neither blind optimism with heroic assumptions.

'We then need to create an environment in which, working alongside our operational and clinical colleagues, we can facilitate the best possible plan – and then work towards delivering that plan step by step. Support from chief executives, boards and governing bodies is paramount.'

At last year's HFMA conference, NHS Improvement chief executive Jim Mackey addressed the issue directly. Accountants were hard-wired to be cautious and were sometimes too negative, he said. A balance had to be struck.

However, he was clear that accountants should not sign up to any figures that made them uncomfortable. He said: 'If anybody tells you to report an answer you don't think is right and there is no resolution to that, come to the senior leaders. If you are feeling compromised and don't feel you are getting anywhere I am happy to take a call from you personally.'

HFMA chief executive Mark Knight said the association had always been a support network for finance professionals. However, he recognised that the function was now under significant pressure to deliver in terms of service and financial targets while delivering new models of care. 'We are now looking at more formal ways for the HFMA to support practitioners and for finance directors and senior finance managers to support each other,' he said. Proposals will be announced soon.

HFMA Awards shortlist unveiled

The HFMA has announced the shortlist for its 2017 Finance Director of the Year Award, and finalists in seven other categories. The four shortlisted finance directors all come from organisations in the north of England:
- **Aaron Cummins** University Hospitals of Morecambe Bay NHS Foundation Trust
- **Adrian Roberts** Central Manchester University Hospitals NHS Foundation Trust
- **Anthony Robson** QE Facilities Limited, a wholly owned subsidiary of Gateshead Health NHS Foundation Trust
- **Emma Sayner** Hull Clinical Commissioning Group.

Two on the shortlist come from North West organisations and the region has at least one representative in each of the other categories. For the deputy director award, there are also two North West candidates – **Andrea Bennett** of Bolton NHS FT and **Claire Liddy** of Alder Hey Children's NHS FT.

Two from Devon – **Angela Hibbard** of Northern, Eastern and Western Devon CCG and **Paul Southard** of Royal Devon and Exeter NHS FT – are also on the deputy shortlist, together with **Vicky Hilpert** of Cannock Chase CCG, South East Staffordshire and Seisdon Peninsula CCG and Stafford and Surrounds CCG.

As well as the personal awards, there are five organisation awards, including Finance Team of the Year, where the shortlist includes Alder Hey Children's NHS Foundation Trust, Manchester Heath and Care Commissioning, Maidstone and Tunbridge Wells NHS Trust, NHS Shared Business Services and Wrightington, Wigan and Leigh NHS Foundation Trust.

The awards will be presented at the HFMA annual conference on 7 December.

• *To view the full shortlist, turn to inside back cover*

Call for short-term hospital spending rise but transformation vital to sustainability

By Seamus Ward

The chancellor has little choice but to spend more on hospitals in the short term to maintain services, according to CIPFA and the Institute for Government.

Chancellor Philip Hammond is due to announce his Budget on 22 November. *Performance tracker,* a new report from the institutes, examined 100 data sets across nine public services. It said the data showed the government was being forced into poor and reactionary spending decisions in hospitals, prisons, schools and adult social care.

In the hospital sector, for example, the government had allocated an additional £1.8bn through the sustainability and transformation fund (STF) in 2016/17, yet the sector had ended the year with a £791m aggregate deficit. Despite the same sum being allocated this year, official estimates forecast a deficit of around £500m.

The Nuffield Trust has suggested that the underlying deficit – stripping out temporary funding increases such as the STF and one-off savings – at the end of 2016/17 was much higher, at £3.7bn.

While overall Department of Health spending grew by 2.1% in 2016/17, spending on the hospital sector increased by 4.3%. This was funded by restraining growth in other parts of the health budget, including prescribing, while spending on primary care and public health was broadly flat, the report said.

Rob Whiteman: honest assessment needed

With demand rising and targets missed despite increased funding, the government had to raise hospital spending, the report said. There was little scope for manoeuvre in the upcoming Budget, but to stop hospital funding climbing ever higher, the service transformation promised by sustainability and transformation partnerships must be realised.

And on pay rises above the 1% cap, it said that before increasing pay the government must clarify the problem it is trying to solve. If it is recruitment and retention, pay rises could be a good solution. But if it is looking to pay more to reward greater workload at the expense of hiring more staff, the issue could be exacerbated.

CIPFA chief executive Rob Whiteman said: 'Government must go beyond moving from one reactive cash injection to the next, because this fails to assess sustainability of many public services. It may now be more effective to stop some services than see them collapse.

'The choices facing the chancellor are limited, but government must do better at medium to long-term financial planning using one set of robust numbers that underpin policy assumptions and budget allocations.

'This requires an honest assessment of current performance and what is affordable, with higher spending in some areas.'

Saffron Cordery, NHS Providers' policy and strategy director, said the tracker was right to highlight high levels of patient satisfaction.

She added: 'However, growing numbers of patients face unacceptable delays for treatment. Despite the best efforts of NHS trusts and their staff, financial pressures and workforce shortages are having a growing impact on the quality and safety of care.

'The report calls for an honest assessment of what can be delivered within current funding constraints. We couldn't agree more.'

Payment system: focused improvement not overhaul

The current NHS payment system as a whole is not fit for purpose, but it may not need a complete overhaul, according to a new study from the Health Foundation and NHS Providers.

The report – *Towards an effective NHS payment system* – identifies a broad consensus that a 'well-designed [payment] system can support positive change for the NHS'.

It said the design and implementation of certain aspects of the current system – broadly a mix of activity-based payments and block contracts supplemented by pay-for-performance schemes – lead to inefficiency and can adversely affect patient care in unintended ways. But other aspects work well. 'Focused improvements to some areas may be sufficient and may be in the best interests of provider stability,' it concluded.

It criticised the current payment system for having too many objectives and called on NHS Improvement and NHS England to set a clear primary purpose for any new approach.

The need for a clear purpose was one of eight principles identified for a future payment system. The other seven included:

- **Realistic expectations about impact**
- **National consistency with local flexibility**
- **Appropriate, aligned incentives**
- **High-quality data**
- **Balance between complexity of design and ease of use**
- **Independent oversight and support**
- **Time to embed and evaluate systems.**

The report acknowledged the need for new payment approaches, such as whole population budgets, to support new models of care and incentivise prevention and early intervention.

It underlined that the payment system did not need to be identical across all settings. However, different approaches all needed to support the same purpose, with complementary incentives.

Phillippa Hentsch, head of analysis at NHS Providers, said the payment system had been used to close the financial gap facing the sector 'forcing prices down while provider costs continue to increase'.

She added that providers wanted the national level to 'go back to basics, simplifying and clarifying the ask of the sector'.

Provider call for extended STF and changes in rules

By Seamus Ward

The £1.8bn sustainability funding must be maintained beyond 2018/19 and there should be immediate changes in the rules governing its allocation, according to NHS Providers.

A new report, *Recovering provider deficits: has it worked and at what cost?*, said the sustainability and transformation fund (STF) had become a key part of provider financing. NHS Providers chief executive Chris Hopson called on the government to confirm that the STF will continue to be directly allocated to providers from 2019 – currently it is confirmed for 2017/18 and 2018/19 only.

He acknowledged that the use of control totals and the STF had played a key role in helping the provider sector to stabilise its financial position.

He added: 'It means that the STF £1.8bn is now an integral part of provider funding. If the STF is taken away from trusts in 2019/20, when current commitments on the use of the fund end, the provider deficit will simply balloon again.'

The report called for a change in rules that double-penalised trusts which did not sign up to their control total or missed their targets. Trusts unable to agree to control totals at the start of the year were denied access to the STF and A&E capital funding, for example.

It also urged a more flexible approach when providers missed their control total for reasons beyond their control – for example, following a terrorist attack.

NHS Providers also highlighted analysis by NHS Improvement – which is expected to be published early this month. It said this suggests trusts could perform 280,000 more operations in 2018/19 if theatres were used more efficiently. Early finishes accounted for the greatest loss of operating time, costing the NHS £280m last year.

Saffron Cordery, NHS Providers' director of policy and strategy, said support to help trusts work more efficiently and reduce delays for patients was invaluable.

'However, it is important to remember that this is not just about scheduling,' she continued. 'Other factors, including staffing and the availability of beds, and wider hospital services, also make a big difference.

'When these are at full stretch – as is the case now – it is much harder to use theatres as efficiently as trusts would like.'

NI savings stand-down

Health and social care (HSC) trusts in Northern Ireland have been able to avoid implementing many proposed controversial or major savings plans after a £40m funding boost.

Northern Ireland's Department of Finance found an extra £40m for local health and social care this financial year.

Local trusts had originally been consulting the public on measures to save £70m in year. But, with updated figures, the Department of Health said the additional funding would reduce the amount of savings needed to £52m.

As a result of the funding, the Belfast HSC Trust was able to stand down all but one of its major proposals – substituting expensive drug treatments for less expensive, clinically suitable and safe alternatives. This will be subject to further consideration.

The Northern HSC Trust was able to stand down all its major or controversial proposals except higher parking fees at acute hospital sites. All the 'low impact' in-year financial management proposals, amounting to total savings of £6.3m, will proceed as planned, it added.

The other three HSC trusts have taken similar steps to stand down plans that would have had a big impact on patient services. The additional funding is non-recurrent and the Department estimates the 2018/19 shortfall will be £430m.

HFMA fellows honoured by Queen

Two HFMA honorary fellows attended Buckingham Palace in October to receive awards made in the Queen's Birthday Honours list.

Tony Whitfield (left), 2013 HFMA president, received his OBE for services to the NHS from the Queen. Mr Whitfield was finance director of Leeds Teaching Hospitals NHS Trust before he retired earlier this year. And Louise Shepherd (right with her family), chief executive of Alder Hey Children's NHS Foundation Trust, received a CBE for services to healthcare from the Duke of Cambridge.

News review

Seamus Ward assesses the past month in healthcare finance

With October dominated by talk of the need for additional NHS funding and avoiding a winter crisis, Ted Baker stepped out of the shadows to grab the headlines. The new chief inspector of hospitals, who had taken up his new position at the Care Quality Commission in late summer, told the *Daily Telegraph* the health service was not fit for the 21st century. Professor Baker bemoaned the fact that the NHS had not adapted the care model to reflect changes in demography. Later, in October, the CQC published its annual *State of care report*, which said the health and care system in England was 'straining at the seams'. However, quality of care had been maintained despite serious challenges and most people were getting good, safe care.

Professor Baker is particularly concerned about A&E and the latest figures showed the four-hour standard was achieved in 89.7% of patients, compared with 90.3% in August. This meant the NHS narrowly missed its target of returning to 90% by September, with a view to the majority of trusts returning to 95% by the end of the financial year. Combined performance statistics showed delayed transfers of care remained relatively stable over the last year, but waiting lists for elective treatment grew by 3.6%. A joint NHS Digital and NHS England report later said more than 8% of patients who attended A&E returned within seven days in 2016/17.

Despite this, the CQC reported that most patients who attend A&E had positive experiences, though many were concerned about waiting times, discharge arrangements and access to timely pain relief. The CQC surveyed more than 45,000 people who attended A&E departments in England in September 2016. Most had confidence in the quality of care and felt they were treated with respect and dignity. But 29% of those who requested pain medication in a type 1 (major) A&E department said they waited more than 15 minutes to receive it and 7% said they did not receive it at all. More than half said they did not receive comprehensive information about symptoms to watch out for on discharge.

The NHS Confederation said that more than 90% of health and care leaders in England are concerned about how their organisation will cope with pressures this winter. The confederation said that 62% of its members were extremely concerned as they prepared for a more challenging winter period. It was lobbying the government for a comprehensive review of which services should be provided, how much they will cost and how they will be funded.

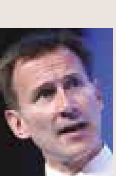
The Scottish government announced an additional £5m to enhance winter resilience and fund additional staff to help with weekend discharge from hospital. The funding is on top of previously announced £50m to support waiting time performance and £9m for A&E performance. Each territorial health board will receive a share of the additional £5m, based on their target share according to the national funding formula.

NHS England has several strategies to help the service through the winter, including a major campaign on the flu vaccine and GP indemnity against clinical negligence. This winter the indemnity fund for out-of-hours GP services has been doubled to £10m to encourage more family doctors to be available and take pressure off emergency departments.

The month in quotes

'One of the things I regret is that 15 or 20 years ago, when we could see the change in the population, the NHS did not change its model of care. It should have done it then – there was a lot more money coming in but we didn't spend it all on the right things… on transformation of the model of care.'
CQC chief inspector of hospitals Ted Baker tells the *Daily Telegraph* transformation should have begun in the 1990s

'NHS organisations will continue to find it hard to meet patient demand and public expectations in the next two years within the budget proposed. One of the biggest challenges facing the NHS is the need to reconfigure services to meet current and future demand and that requires support from politicians, partners and the public.'
Welsh NHS Confederation director Vanessa Young predicts tough years ahead



'By introducing targeted support for vulnerable areas and tackling head on critical issues such as higher indemnity fees and the recruitment and retention of more doctors, we can strengthen and secure general practice for the future.'
Health secretary Jeremy Hunt on government action to prop up GP numbers

'Last year it was said that the service was just about coping, but for many of our members this year looks more challenging. Not only is there the prospect of ongoing pressure, high bed occupancy, and delayed transfers of care blockages in flow, but the worry too of a serious flu attack combined with bad weather.'

NHS Confederation chief executive Niall Dickson urges the chancellor to revisit health and care funding allocations as he warns of a difficult winter ahead

SHUTTERSTOCK

More than 90% of health and care leaders in England are concerned about how their organisation will cope with winter pressures

The Department of Health also unveiled proposals for a state-backed indemnity scheme for general practice in England across all NHS services, not just out of hours. It acknowledged that the cost of clinical negligence cover was a concern to GPs, who – unlike their hospital-based colleagues who are covered by the Clinical Negligence Scheme for Trusts through their NHS employers – must get personal insurance. The Department said it was seeking a more stable and affordable system and would enter discussions with GP representatives and others.

While the indemnity plan aims, in part, to retain GPs, health secretary Jeremy Hunt also announced proposals to recruit GP trainees. He said they will be offered a one-off payment of £20,000 to work in areas where training places have been unfilled for a number of years. Announcing measures on recruitment and retention in general practice alongside the proposed indemnity scheme, he added that the new Targeted Enhanced Recruitment Scheme would begin in 2018. He also announced new flexible working arrangements for GPs considering retirement, new international recruitment and a consultation on physician associate regulation.

Last May's Wannacry cyber attack affected at least 34% of NHS trusts in England, the National Audit Office said. In a report, the NAO said that computer systems in 603 other NHS organisations were infected, including 595 GP practices. While no NHS organisation paid the ransom, the cost of the attack is not known.

The number of nurses and health visitors has fallen for the first time since 2013 on a year-on-year basis, according to the King's Fund. There were fewer nurses and health visitors in post in April compared with April 2016 and this pattern continued in May and June.

A reduction in the number of nurses from EU countries was a key factor in the fall, the King's Fund said.

The ending of reciprocal healthcare arrangements between the UK and European Union countries after EU exit, could cost the UK £500m a year, according to the Brexit Health Alliance. Without the European Health Insurance Card (EHIC), patients with existing health problems may not be able to afford the insurance to travel to Europe, it said. And, with no reciprocal arrangements in place, almost 200,000 UK pensioners who live in the EU could have no option but to return to the UK under a no deal exit.

The electronic prescription service has saved the health service £130m over three years, according to NHS Digital. The system, developed by NHS Digital, allows GPs to send prescriptions directly to pharmacies.

The NHS in Wales will receive additional revenue of £230m in 2018/19 and £220m in 2019/20, according to the Welsh government's draft Budget. Budget documents said the additional funding, together with recurrent revenues, would allow a medium-term approach to service reform and drive improvement in service delivery and outcomes. The funding includes an extra £40m over two years for mental health services, while capital funding would increase by £90m over three years. However, it was estimated that the NHS in Wales could face a £2.5bn funding gap by 2025/26 if funding was maintained in real terms.

from the hfma

Tower Hamlets and New York State are rarely mentioned in the same sentence, but they have a lot in common, according to Jason Helgerson, Medicaid director for the US state. In a blog on the HFMA website, he wrote that both are trying to bring together health and social care organisations and pledges to work with NHS England to share learning between local innovators in England and New York.

In another blog, head of the HFMA Healthcare Costing for Value Institute Catherine Mitchell said last month's international symposium demonstrated that value-based healthcare is a practical solution to current challenges. The event showed that health systems are using value to pursue similar goals. But there is no single approach that can be parachuted in to existing, differently structured health systems.

The challenges of system governance in an era of new organisations, such as sustainability and transformation partnerships and accountable care systems, are addressed in a blog by HFMA research manager Lisa Robertson. The HFMA has produced briefings to help, including one on developing robust governance arrangements. This briefing, published in October, includes a diagnostic tool that can identify where good governance arrangements are already in place and where more work is needed. The tool was developed by the HFMA Governance and Audit Committee and can be used to inform board or governing body discussions on governance.

• To read any of these blogs, visit www.hfma.org.uk/news/blogs

News analysis

Headline issues in the spotlight

All about the money

While efficiency and maintaining standards remain the key focus of the NHS, its leaders have told MPs that progress can only be achieved with additional funding. Seamus Ward reports

Select committee hearings in the Commons can be attritional affairs. MPs grandstand, frequently interrupting witnesses in the manner of the hard-nosed inquisitors of Radio 4's *Today* programme. Witnesses, it seems, generally set out to be as helpful and open as possible, but can end up defensive under the onslaught of questions. But some come to the hearing with a message – and so it was when Simon Stevens and Jim Mackey appeared before the Health Committee in October.

The chief executives of NHS England and NHS Improvement were clear. The health service was doing as asked – reducing spending, transforming care and largely maintaining quality standards – but it needs more money.

While we've heard that refrain before, the timing – with the chancellor preparing his first autumn Budget on 22 November – is interesting. It also means that two of the most senior officials in the health service have publicly asked their political masters to find additional funding – something that is usually confined to the corridors of Whitehall.

Either the officials are sure of their ground and more money is coming or it's a last-ditch attempt to get a wave of public opinion demanding funds be forthcoming.

At a hearing on the work of NHS England and NHS Improvement, the MPs kicked off with questions about the Care Quality Commission's latest annual *State of care report*, published in October. The report said the quality of health and social care had been maintained over the previous year despite some significant challenges. Most people were receiving good, safe care. However, the changing nature of people's health and care needs meant that the service was at full stretch.

"The pencilled-in funding for the service for next year and the year after looks extremely challenging and, if not amended, it is going to be very hard for the NHS to do all that is being asked of it"
Simon Stevens

Mr Stevens paid tribute to NHS staff, but soon moved the discussion to money. The CQC report had made it clear that the integration of care and the *Five-year forward view* programme were needed to future-proof services, he said, continuing: 'But that cannot be done without proper funding along the way. That shows up clearly in social care – but not just in social care; that is also a live issue in many parts of the National Health Service.'

Asked about the four key performance standards – A&E, elective, cancer and ambulance waiting times – Mr Stevens said NHS England was committed to their achievement. But this year something had to give.

'[Elective waiting times] clearly will slip during the course of this year. Prospects for next year and the year after will be determined by the budget for the NHS in those years,' he added.

One MP, Ben Bradshaw, said funding increases of 1.8% this year, 0.7% next year and then 0.2% and 0.1% were the lowest rises in NHS history, representing real-terms cuts per head. Because of this, a further deterioration in quality must be expected.

Means to an end

Sustainability and transformation partnerships (STPs) are a means to an end that will see integrated local planning and delivery of services, Simon Stevens told the Commons Health Committee.

The NHS England chief executive said joining up care was effective. Highlighting data published in March, he said that where hospitals, GPs and community services are integrated in primary and acute care systems (PACS) vanguards, the number of emergency bed days was 0.1% higher than in 2014/15. For the rest of England it was 1.8% higher.

Committee chair Sarah Wollaston asked about the feeling that STP plans were being kept secret, while managers were fearful of sharing plans with the public and elected representatives.

NHS Improvement chief executive Jim Mackey told the committee that early public engagement was key to the success of transformation plans.

He added: 'Our most troubled systems generally have a system problem that has existed for a very long time, and virtually nobody disagrees that there is a problem. What they all disagree on is what the solution is.'

Those who suggested a solution often get caught up in 'a massive political mess', Mr Mackey said. Mr Stevens commented that politicians should be more supportive and acknowledge the difficult financial environment in the NHS.

'Being open and engaging is not the same as saying that you do not also have to help people understand that we are having to operate in very constrained circumstances, which is the consequence of seven years' worth of the NHS budget growing in the zone of 1% compared with our historical rate of 4%.

'We are spending £23bn a year less than if we were spending at French or German levels, and there are consequences to that.'

SHUTTERSTOCK

Mr Stevens replied: 'It is no secret—and I am not saying anything I have not previously said—that the currently pencilled-in funding for the National Health Service for next year and the year after looks extremely challenging and, if not amended, it is going to be very hard for the NHS to do all that is being asked of it over the course of the next year and the year beyond.'

The good news is that the government understands this, he added. 'The prospects for the kinds of measures that you are talking about for next year depend on decisions that are made on 22 November.'

But if health and care get more money, will it be well spent? Social care has, of course, received additional funding this year – an extra £1bn, with a further £1bn spread over the following two years.

Mr Mackey was asked why the additional funding had yet to make an impact on delayed transfers of care. There were several reasons for this, he said, including the time it takes to create a local market – for home care, for example – or because the money is non-recurrent making it hard for councils to plan ahead.

'From our point of view, we argued hard for the extra money and for it to be spent in social care, and we rightly expect to see an impact from that,' Mr Mackey said.

Controlling pay rises to an average of 1% a year has been an important element of the health service's attempts to hold down spending,

"The NHS is generating serious levels of efficiency. It is very hard to imagine how that sort of pay award could be internally financed"
Jim Mackey

but health secretary Jeremy Hunt has indicated that next April's increases will break through that ceiling. This is supported by the Scottish government.

Health service managers, aware of the pay cap's impact on recruitment and retention, will also be in agreement. The difficulty is, how will this be paid for? A pay rise of more than 1% had to be funded, Mr Mackey told the MPs.

'The NHS is generating serious levels of efficiency. It is very hard to imagine how that sort of pay award could be internally financed.'

Mr Stevens added: 'We said from the get-go that over time it will be necessary for NHS staff to get rates of pay that are consistent with that [public sector pay policy] and the rest of the economy. It is not reasonable indefinitely to expect people to take the kind of net pay cuts that they have seen, but that does need to be funded.'

Leaving aside the question of more funding, the committee wanted assurances that the NHS was spending the money it does have well.

Mr Mackey was asked about variations in clinical practice that can lead to additional costs – for example, revisions of hip fractures within 30 days of surgery.

MP Andrew Selous said in some hospitals no revisions were needed, but in others up to 7% were revised. A tariff for the revision operations was paid 'no questions asked', he added. Physiotherapy was known to reduce the incidence of revision but was given only to 50% of patients.

Mr Mackey said NHS Improvement was working with trusts to improve on this, but analysing the data was a labour-intensive job and the system was under intense pressure – managers and clinicians simply did not have the time to do it.

The committee asked if, in the spirit of integration, the two organisations should be merged. Mr Stevens said there would be 'merit in more fusing of our functions and teams' – as has happened in the South West, where the regional director reports to both national bodies.

He believes this would happen more and more. 'We each want to take further significant administrative savings out of the overhead of the NHS, modest as it is by international standards at 2p in the pound relative to 5p or 6p in Germany and France.'

A full merger would require legislation and this was unlikely to happen soon.

Mr Mackey agreed. 'There is an awful lot more we could do to simplify. We should seriously reduce our overhead and I am instinctively a devolution person. So, I think we should be looking, wherever possible, to push things into the local system – simplify the architecture – but to formally merge requires a change in the law.'

Senior figures often refer to an implicit deal with the Treasury – reform, show continuing efforts to be efficient and get best value for money and it will consider funding increases. As far as Mr Mackey and Mr Stevens are concerned, the NHS is doing its bit, but to maintain standards and recruit and retain staff the service needs the Treasury to hold up its end of the bargain.

Comment

November 2017

Leaning into the future

We need to deliver for today and tomorrow in equal measure

Most of us are now firmly focused on 'the business end' of the year. That means doing all we can to deliver what we said we would do this financial year, while laying down tracks to ensure safe passage into the next.

My personal version of this reality is a quarter two run-rate that requires significant corrective action to ensure Poole Hospital stays on course during the remaining six months of 2017/18.

At the same time, we have to reaffirm assumptions for year two of the Dorset collaborative agreement and work up the detail of a clinical services review that has already confirmed a significant acute care reconfiguration over the next five years.

All of this is equally important, but it is only by delivering on today that we will retain the autonomy to continue to plan for tomorrow. You will all have your own local versions of this.

At times the demands can feel relentless for even the most experienced finance professional and call upon levels of deep personal resilience. Our network has always provided a safe space to share and learn, however challenging things may look.

We must build on this and continue to support each other both now and into the future.

Local challenges of course are framed by the broader national challenge and the financial envelope we work within. November should give us some insight into how we are meeting that challenge as a whole service. First, we will see the publication of the quarter two NHS provider results in

Squaring up to the time pressure

As if short-term must-dos aren't enough, the NHS needs to invest time in future sustainability

The NHS needs a model of care that is fit for the 21st century and the population as it is now. And it is a shame that the NHS did not change its model of care 15 to 20 years ago, when it could see the coming changes in population and had more money at its disposal.

So said Ted Baker, the new chief inspector of hospitals at the Care Quality Commission in an interview at the end of September.

Few in the NHS would argue with this assessment – the ageing population and the growth in prevalence of long-term illnesses were no secret and the levels of funding growth available at the time could have provided a firm foundation for transformation.

The funds bought improved access and reduced waiting times among other things. But the NHS may have missed an opportunity.

At least now it has – belatedly – set itself on the right track, recognising that current service models are simply not sustainable. There is an acceptance across the UK

SHUTTERSTOCK

“Our network has always provided a safe space to share and learn. We must build on this and continue to support each other”

England. It will be helpful if the sector – in aggregate with commissioners – remains able to deliver financial balance again in this year, as we achieved in 2016/17.

Then, later in the month, the chancellor’s Budget should provide some clarity around the parameters for future planning.

Despite the medium-term economic uncertainty created by Brexit, there is a clear expectation that the 1% pay cap for NHS staff will be lifted from 2018/19.

If this is followed through, the detail of how it would be funded – and any other potential investment – will provide essential reading for the whole finance community.

However, we should all be encouraged that despite the significant pressure on the NHS, a report from the King’s Fund and Ipsos MORI recently confirmed that public support for the NHS has remained consistent over the last two decades.

Some 77% believe that the NHS should be maintained in its current form, with two thirds of adults willing to pay more tax to fund it.

I would also like to use my column this month to thank Bob Alexander on behalf of the association. The deputy chief executive and executive director of resources at NHS Improvement confirmed last month that he will be taking up a new role in the new year, leading the Sussex and East Surrey Sustainability and Transformation Partnership.

Bob has made an enormous contribution to finance professional development over many years. He has always made time to speak at our branch events, as well as at the national HFMA conference.

He has supported the annual HFMA awards judging panel and was instrumental in ensuring Future-Focused Finance got the support and direction needed from the very outset.

On a personal level, Bob has been there for me when I needed his wise counsel, reflection and advice, and for that I will always be grateful.

We can be sure that Bob will continue to be an advocate for strong financial management and the importance of our function to the quality and sustainability of the NHS.

Contact the president on president@hfma.org.uk

that there needs to be a greater focus on prevention and self-management, and that care services need to be more integrated and delivered at the right time and in the right place. And that will mean changes to how and where services are delivered.

The challenge is making rapid and significant progress on this agenda, while meeting hugely demanding targets on access, quality and finance in the short term.

As Mark Orchard says above, NHS finance managers need to deliver for today and tomorrow in equal measure.

This is a daunting ask as the transformation and sustainability agenda is broad. Sustainability cannot just mean that services are sustained within budget and using staff numbers that can realistically be trained and retained. It also needs to be sustainable in terms of its environmental impact.

The environmental agenda has almost certainly been seen as a ‘nice to’ rather than ‘must do’ by finance professionals – though this is completely understandable given what must seem like more pressing, critical deliverables. The reality is that this is too short-sighted. Changes in service provision or procurement decisions that increase air pollution will come back to haunt the NHS with increased demand in future years (*A broader view, page 24*).

Processes need to change so that environmental sustainability is factored into the decision-making process. The good news is that there remain opportunities to deliver environmental wins that also cut costs.

In addition, there are increasing numbers of clinicians and managers who believe that a move to value-based healthcare – an evidence and data-driven approach that seeks to deliver value with every decision, measured in terms of both outcomes and costs – is the way forward.

The clear evidence from the HFMA Healthcare Costing for Value Institute’s second international symposium (*Value in action, page 13*) is that a value approach can deliver the very cost and service improvements needed to meet shorter term financial goals – as well as locking services into a cycle of continuous improvement.

“The environmental agenda has almost certainly been seen as a ‘nice to’ rather than ‘must do’ by finance professionals”

No-one pretends that this is easy – far from it. An immediate injection of cash from November’s Budget would clearly help. A realistic longer term settlement for the health and social care sector would be better. But in the interim, NHS leaders need to find ways to address the time pressure.

Finance practitioners and colleagues have a huge agenda currently, but they need to be given time to support these major changes in approach and look beyond immediate short-term targets.

The alternative is that in another 15 years’ time, we will find ourselves lamenting yet another missed opportunity for the health service.

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value in action

Value-based healthcare may not be widespread. But there are increasing examples around the world where it's moved beyond the theoretical stage and is starting to deliver. Steve Brown reports from the HFMA's international value symposium

Value-based healthcare is a concept that most people would sign up to. Health services should target the delivery of value that takes account of the quality of services measured in outcomes and the cost of providing those services. Putting this into practice as part of the day-to-day delivery and management of healthcare is a harder prospect. But organisations around the world are showing it can be done.

The HFMA Costing for Value Institute held its second international symposium in October – *Turning value theory into practice – an international perspective.* Its purpose was to showcase some of these value pioneers. It became clear that there is no single, off-the-shelf model that organisations can adopt. Local ownership and development are important, and local context – existing structures and working arrangements – needs to be taken into account.

There were clear common messages. Data is the foundation for value-based healthcare. Outcome data needs to be right (robust enough for decision-making) and the right data (the outcomes that matter most to patients). And cost data must be accurate and detailed enough to reliably show up where costs are arising for individual patients and cohorts.

This data then needs to be brought together in a usable format – typically dashboards showing outcomes, process measures and costs – so that multidisciplinary teams can discuss and target improvement. Get it right and it becomes a process that staff of all disciplines want to be involved in, creating demands for better, wider and more detailed data, and creating a virtuous circle of improvement.

The **Karolinska University Hospital** in Sweden has been running a value-based operating model since 2011. It delivers specialised and highly specialised care for Stockholm County Council. Like many European countries, Sweden has seen healthcare spending rise rapidly in recent years as a proportion of gross domestic product (GDP). And it faces a number of familiar issues – fragmented care, variations in treatment method and outcomes and cyclical economic challenges.

A value-based approach was seen as the solution and started with reorganising around patient pathways. A matrix model sees the hospital organised in themes (such as children and women's services of cardiovascular) served by different functions such as pathology, the emergency room and imaging.

Interdisciplinary teams – including clinicians, finance and patient representatives – lead the work within each patient flow, taking joint responsibility for outcomes and costs. 'The challenge for the finance department is to help provide the data they need,' said Claes Ruth, the hospital's head of central control. 'We provide a finance statement in a cost centre structure and we use a cost per patient system, so we can show line and cross-functional views.'

He added that the cost per patient data was an important enabler. 'It connects the patient's journey to care events and cost structure,' he said.

Digital scorecards

The groups are given digital scorecards bringing together agreed outcome and process measures and cost data. Data is produced in more or less real-time, with data extracted from medical records on a daily basis. Insight reports then allow in-depth analysis, with the group using the data to identify areas of variation, poor outcomes or high cost for further exploration.

Mr Ruth said that around 45 scorecards had been developed for different patient flows. The aim is to have 200 live by next year. There is already pressure from existing teams to revise the metrics used in their scorecards. Mr Ruth said this had to be balanced with the need to get scorecards rolled out to all parts of the hospital.

The hospital is also starting to use the information in a proactive way with a new multi-resource planning tool. So if a clinic or team is given an activity target, because the hospital knows the detailed costs of care and contributions from different functions (for example, the number of X-rays that will be needed), it can start to identify the budget and other resources it will need. Four units are trialling this and Mr Ruth said it would be 'fully operational' next year.

Across the hospital the approach has led to the harmonisation of processes on different sites and other improvements. Mr Ruth admitted that changing behaviour is the tricky part – although it is happening – and the finance department has had to 'let go of budget meetings'. But he said there was better transparency of data and 'improved dialogue between functions in a controlled and fact-based way'.

A value-based initiative in the Netherlands has seen an initial alliance of six hospitals – recently expanded to seven – start to compare outcomes and drive improvement across all the organisations involved. Working under umbrella organisation **Santeon**, the hospitals started by developing and publishing outcomes for prostate and lung cancer, following this up by adding breast and colon cancer.

As with the Karolinska, the initiative is clinician-led, again based on multidisciplinary teams that include patient representatives. And these teams look at scorecards comparing outcomes, processes and costs across the different sites. Samyra Keus, a programme lead for value-based healthcare, says that to construct the scorecard it was important to 'use readily available data and to keep it simple'.

Available outcome data could involve data already collected for registries or using established outcome measures (such as those produced by the International Consortium for Health Outcomes Measurement, ICHOM). Cost metrics looked at the highest cost drivers such as treatment days, time in theatre and high-cost drugs. Processes might focus, for example, on the number of days from referral to an outpatient visit or time from outpatient to diagnosis.

Once a scorecard is agreed, the data collection can start and analysts from each site stay in touch to ensure data is comparable. All data is approved by key clinicians before it is shared across the group. Meetings identify variation, and attempt to understand the root cause, which could be data, patient mix, treatment decision,and treatment execution.

Out of this analysis, the team would then decide to focus on one or two variations to explore with a couple of improvement cycles each year.

There have been significant changes on the back of this value work. For example, prostatectomies have been concentrated in one centre. In breast cancer care, there has been an improvement in the percentage of day care surgery for primary lumpectomies – which has involved clearer communication to patients and better planning around theatres.

Also in breast cancer, there has been a reduction in the number of re-operations caused by post-surgical wound infection. One hospital had shown no such infections, and analysis suggested this was due to the use of preventative antibiotics. This was subsequently implemented across all six sites. 'We only did this because of the data,' said Dr Keus.

She left the delegates with key messages, including the need to keep things simple and to 'use data as a mirror: don't judge but learn'.

Alfa D'Amato, director of activity-based management for **New South Wales Health** in Australia, made his second consecutive appearance at the international symposium. At the first symposium in 2016, Mr D'Amato described the state's patient activity and cost portal being rolled out across Australia (*Healthcare Finance* July 2016), and this time he gave a progress report on the development and use of the portal.

The state uses an activity-based funding approach for hospital care and, since 2014/15, Mr D'Amato said money had been taken out of the system. The portal was a tool that helped the more expensive hospitals – and others – to improve productivity. Mr D'Amato said confidence in the data was paramount. The New South Wales system had reached the point where the debate was about what to do on the back of the data rather than arguing about the data itself.

Getting the data 'fit for purpose' had been helped by a mandatory audit programme for costing that started in 2014/15. This programme is a condition of receiving state subsidy, and hospitals have to involve their own internal audit teams. The challenge now was to build capability in the hospitals, so that they could use the portal more extensively.

Mr D'Amato's colleague Susan Dunn, who leads on stakeholder and clinical engagement, said her team spent a lot of time demonstrating how the system could highlight variation and identify opportunities for improvement. She highlighted examples where the central team had

Other speakers

The Quebec healthcare system faces the same financial and service challenges as all health systems. However, to add to the management challenge, it has recently undergone major reform, merging 182 organisations into 34 and is moving to a fee-for-service funding model. The **Centre Integré Universitaire de Santé et de Services Sociaux** in West Central Montreal is unique in the province in meeting the challenges with a formal approach to value. Anne Lemay (right), associate director for support, administration and performance programmes, described the system's value journey involving the creation of integrated practice units, the development of patient-level cost data and moves to establish outcome measures. If the organisation did not want to simply shift costs to patients, restrict services or reduce provider compensation in a simplistic way, 'measuring and improving value was the only solution to reforming healthcare', she said.

Martin Wetzel (left), GP and head of Germany's Kinzigtal GP Federation, described a joint venture – **Gesundes Kinzigtal** – between the physicians' network and healthcare management company OptiMedis. The joint venture is responsible for organising care and improving health for its insured population. The value-based population health approach, which uses prevention and health improvement programmes and has boosted outpatient services, focuses on complex, chronic and cost intensive diseases and has improved health outcomes and reduced per capita costs. Most savings have come from reduced hospital costs.

At the symposium (l-r): Alfa D'Amato, Claes Ruth, Samyra Keus and Susan Dunn

helped organisations to explore variations exposed by the data. She said there weren't enough people taking the maximum benefit out of the system but 'seeing it in action' was key to building this capability.

The UK has started to lay the foundations for a move to value-based healthcare. NHS Improvement's Costing Transformation Programme is working towards getting all provider bodies in England to collect granular costs at the patient level using common costing standards and definitions. While many organisations, particularly those in the acute sector, have established patient-level costing in recent years, there has been little consistency in the approaches used. Using a single specified methodology to establish costs will provide robust costs within each organisation and open the way for benchmarking across organisations.

There has been no national approach to establishing standard condition-specific outcome measures, though a number of organisations across England and Wales have separately adopted outcome standards produced by the ICHOM. There are few examples of organisations bringing this together in a formal approach to value-based management.

HFMA value challenge

The HFMA value challenge pilot set out to prove that it can be done. Duncan Orme (deputy finance director at **Nottingham University Hospital NHS Trust**) and Jean Macleod (consultant physician in medicine and diabetes at **North Tees and Hartlepool NHS Foundation Trust**) briefed delegates on what they had learnt. The ambitious project, initially given a three-month timeframe, looked at applying a value process in two specialties: trauma and orthopaedics; and diabetes.

The project set about identifying a specific condition in each specialty to focus on and to establish what data can be gathered to examine outcomes, costs and variations. The pilot ran into a number of challenges. Even where registries existed for collecting outcome data, the pilot found that data was often incomplete – particularly where data is needed after patients leave hospital. Other consistency issues included different tests as part of order sets for diabetes patients and different definitions for tests. Consistency in costing was also an issue.

Despite this, the project concluded it was possible to link costs and outcomes, and the project team sees huge potential for this area of work. Even though it is a starting point rather than a finished project, there had been positive benefits so far – greater awareness of the sources of data available and improvements in some of the data collected. Improvements have also been made to the allocation of theatre costs in one trust.

Mr Orme said clinicians taking part in the project recognised that patient cost data alongside outcomes gave them a useful tool to improve services for patients and increase value. The work had helped to underline three accelerators of improved performance – patient-level cost data provided by a patient cost system, leadership skills, and clinical leaders.

As other countries have demonstrated, the project showed that if the data can be established and trusted – covering outcomes and cost – there is significant potential for improvement. This will take time to get right, but there is a recognition that organisations pursuing value-based healthcare are on the right road. Some benefits will flow immediately – based on closer working between disciplines. Others will emerge as core data improves. But the clear consensus of the HFMA symposium was that all organisations need to be moving in this direction.

• HFMA Healthcare Costing for Value Institute members can download presentations from the symposium at www.hfma.org.uk (search for the symposium in events archive) or via Catherine Mitchell's blog, *The value in getting together* **www.hfma.org.uk/news/blogs**

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On a new journey

The NHS England *Mandate* and the *Five-year forward view* outlined plans for the expansion of personal budgets into the mainstream. From next year that's set to become a reality. Seamus Ward reports

Around 20 years ago, personalisation was said to be the future of commissioning and the NHS responded by offering greater patient choice in where and when to be treated, as well as experimenting with personal health budgets.

These measures were launched in a time of relative plenty, but responding to individual needs has perhaps been lost as the service has sought efficiency savings. Consolidating services on fewer sites, for example, arguably limits choice. Even so, NHS leaders still regard tailoring care to individual needs as important and believe that in many cases providing budgets to individuals to commission their own care can lead to better outcomes and less money spent overall.

As ever with the NHS, the terminology around personal budgets can be confusing, as funding can come from clinical commissioning groups, local authorities or both. NHS England offers these definitions:

- **Personal health budgets** The NHS wholly funds the budget
- **Personal budgets** The local authority wholly funds the budget
- **Integrated personal budgets** The budget includes funding from both the local authority and the NHS
- **IPC (integrated personal commissioning) personal budgets** Umbrella term describing personal budgets, where funding could be from a local authority, the NHS, or both.

For children and young people with education, health and care plans, a personal budget can include funding for special educational, health and social care provision.

IPC was launched in 2015 and there are 18 demonstrator and early adopter sites, involving clinical commissioning groups, local authorities and, in some cases, providers. Integrated personal budgets are due to become mainstream models of care by 2020. They are not supported with new money, but aim to free up funding from existing contracts. For example, a person who has paraplegia may develop sores. The dressings need to be changed daily by a district nurse, which often makes them late for work. Instead, they could use their personal health budget to train their personal assistants to change the dressings.

In October 2014, those eligible for NHS continuing healthcare (CHC) or children and young people's continuing care were given a legal right to have a personal health budget, unless there are exceptional circumstances. However, the demonstrators are widening the scope to include other people with complex physical and mental health needs and long-term conditions.

NHS England estimates that IPC could be the mainstream model of community-based care for 5% of the population – up to 3 million people – and it is striving to increase the numbers with integrated personal budgets. *Next steps on the NHS five-year forward view* said IPC should be extended to reach more than 300,000 people by the end of 2018/19 and substantially scaled up thereafter.

It added that the provision of personal health budgets should be expanded to cover 20,000 people by 2017/18 and double that number in 2018/19. According to the *NHS England Mandate*, commissioners should make progress on giving personal health budgets to 50,000-100,000 people by 2020/21.

The new CCG improvement and assessment framework includes a personal health budget metric, with quarterly reporting and benchmarking. Sustainability and transformation partnerships (STPs) must include expansion plans for personal health and IPC budgets in their plans.

Better signposting

NHS England's Personalised Care Group senior strategic finance lead Sarah Day says IPC is not just about personal budgets. For most people, the initial interaction with IPC will give them signposts to community groups to help meet their needs. At the next level, more complex needs will be met through the personalised care and support planning process, which allows them to have a conversation with commissioners and clinicians about their needs and what is important to them.

'This leads to a better understanding of that person and can lead to signposting to different services,' she says. 'It won't necessarily result in a personal budget, though some will be eligible for a personal health budget or a social care direct payment. A small number will require an integrated budget, combining health and

social care funding, and potentially funding from education for younger people.'

There is guidance on direct payments, setting out what they can and can't be spent on – so an A&E attendance wouldn't be included.

However, within these boundaries, there is some flexibility over how the money is spent, Ms Day says. 'It's down to local discretion. Where it's spent more creatively, there tends to be more benefit for the person as they have greater choice and control over decisions on their health and social care needs.'

While greater system-wide integration is necessary in terms of providing seamless services and reducing bureaucracy, Ms Day says it can limit choice and personalisation.

Ms Day explains that IPC can be seen as a counterweight to the development of STPs and accountable care organisations and systems – providing a necessary option for those with complex needs.

'A budget may not necessarily cover someone's whole care plan. It has to make sense for the person and the system. For example, if the system is already commissioning something that completely fits with what the person wants, you wouldn't give them a budget to buy that service,' Ms Day says.

The IPC work at Herts Valleys CCG and East and North Hertfordshire CCG initially focuses on older people with multiple long-term conditions who live in their own homes. The CCGs, working with Hertfordshire County Council, are early adopters of IPC, joining in the second wave (December 2016).

Though the work is concentrated in the two localities, the patient cohort was chosen as it aligned with the local Herts and West Essex STP priorities. It is also a local priority as primary care and acute hospital costs are higher in this group than any other.

Jo Reeder, the integrated personal commissioning programme lead, explains that they deliberately chose a group of people outside of CHC. 'In Hertfordshire, personal health budgets are very much mainstream in adult CHC, so we decided with the IPC programme to focus on people with primary health needs who don't meet CHC criteria but are living at home with high levels of frailty.'

The team is concentrating on preventing GP and A&E visits, through personalised care and support planning. Much of the initial work has been on giving the workforce a greater understanding of the different roles across the community and working through the STP to sign up local providers.

This was vital, Ms Reeder says, but they are moving on to examine the costs of individual services and the detail of contracts – for example, when they expire or can be varied to release funding for individual budgets.

'We need to improve people's lives and demonstrate we can save money. If we can save resources and also improve people's lives, that's not a language people are going to ignore. We can save on GP time particularly, and reduce A&E attendance, so there will be financial savings, though it's not our primary driver.'

Budget control

There are three options for managing a personal budget. An IPC personal budget can include a combination of these approaches and all must be available:

- **Notional budget** The local authority or NHS body manages the funding and arranges care and support
- **Third-party budget** An organisation independent of the person, NHS commissioner and local authority manages the budget and ensures the right care is in place, working with the person and their family to ensure agreed outcomes are achieved
- **Direct payment** The funds are paid into the budget holder's bank account or equivalent (for example, through a prepaid card) and they are responsible for purchasing care and support. The budget holder can be the patient or someone acting on their behalf. Patients eligible for CHC could use this method to hire staff, to ensure greater continuity of care.

The costing work is being helped by a linked dataset that provides cost information across primary, community and secondary care, as well as social care in the East and North Hertfordshire CCG area. 'We can look at information on, for example, older people diagnosed with multiple long-term conditions and start to see who are the top 10 in terms of the biggest cost to the system,' says Ms Reeder.

'This helps us target preventative care, making a difference to the individuals and reducing primary care contacts, emergency care and inpatient days. The dataset is not perfect, but it's the way forward to look at cost information across multiple organisations.'

Mandate targets

Nationally, there is some way to go on reaching the *Mandate* targets – by the end of June this year, there were almost 12,000 people with personal health or integrated personal budgets. However, NHS England's Ms Day says commissioners are on the right trajectory to achieve the targets.

She adds that moving people to personal budgets was always likely to be a phased process as a lot of the funding is locked up in existing contracts. As these are renewed, funding can be freed up for personal budgets where they are required, although variations are also possible during the contract term.

'Some IPC sites are working closely with providers to understand where opportunities exist, particularly for groups that are not well served. Others have been looking at groups of people on long waiting lists because of vacancies in provider organisations – exploring if they can free up some of the vacancy funding to give people budgets to do something different. In many ways, IPC is supporting the system to address existing problems.'

Value for money is almost a secondary concern in the move to personalisation, but it can produce savings.

'IPC is important due to the fact that people with the most complex needs are often passed

around different services, which is not great for them or the system,' says Ms Day. 'There's a lot of potential duplication and wastage from that, but with IPC, people are receiving more appropriate care so they turn up for it – there are some financial benefits from a system perspective.'

Personal health budgets were piloted between 2009 and 2012 and a Department of Health evaluation at the end of that period concluded that it had improved care-related quality of life, and was more cost-effective. The evaluation showed that indirect costs, such as hospital admissions, for those receiving CHC reduced by approximately £4,000 per person,

Since then, the use of personal health budgets has expanded and NHS England is updating the Department analysis of cost-effectiveness and outcomes. Although still in the early stages, and the sample is small and self-selecting, the signs are good.

Ms Day says: 'We found that in continuing healthcare for personal health budgets, there was a 17% direct cost saving for the same level of need – that's the difference between a traditional package of care and a PHB and allows for the fact that we assumed there would be an increase in admin costs. It's early days, but the CCGs that provided information made savings in the range of 0.5% to 36%. 'We haven't yet looked again at indirect costs and related outcomes, but we are pretty confident from previous work that outcomes will have improved.'

Herts progress

It's also early days for IPC in Hertfordshire, but the area introduced personal health budgets for CHC two years ago.

'We've found this to be 10%-15% cheaper than if we commissioned directly,' Ms Reeder says. The figure allows around 5% for higher administration costs, she adds.

The team is also working with the county council on sharing its back-office function to save on overheads. Local authorities have been making direct payments for social care for some time and several demonstrator CCGs are working with their local authorities to take advantage of this expertise.

Although IPC does not necessarily mean a payment into a patient's bank account (see box previous page), finance managers may be concerned about whether it is spent appropriately and achieves value for money. On the other hand, there are fears that heavy-handed oversight could put off some candidates for IPC.

Ms Day insists that audit and monitoring should be proportionate. 'It's public money, so we have to make sure it's used effectively and the cost is appropriate. There's a requirement to monitor direct payments at three months and at a minimum every year to make sure people are okay with it. A CCG might look at a CHC budget of £50,000 once a year, but want to look at a £500 personal health budget every month.

'It's really important to take a proportionate approach and have a good care and support plan that makes it clear to both sides what the money's for,' she says.

She suggests that commissioners could hold financial and clinical reviews in parallel. 'The financial analysis can inform the clinical one and vice versa – if people are not spending the money, what are they doing? Are they causing issues for their health or were they given too much money?

'A clinical review might show that they've spent three months in hospital, so the finance people need to understand it's not been spent because of that. Needs can also fluctuate, particularly in mental health.'

IPC is clearly in its infancy, but both commissioners and providers must be ready for it to gear up and become a mainstream option for patients with complex and long-term needs. Evaluations of personal health budgets have shown the personalised route to be more cost-effective, but, perhaps more importantly, it gives patients a voice in getting the services they need.

COPD focus

Personal budgets are being used in Stockton-on-Tees to help people over 65 with respiratory problems live with fewer acute episodes.

'The programme looks at people who are the next step down from those with CHC needs. We are looking at prevention and how to maintain them for longer without the need for intervention,' says Gemma Clifford, IPC programme manager at Catalyst, the voluntary sector support organisation working with Hartlepool and Stockton-on-Tees CCG, North Tees and Hartlepool NHS Foundation Trust and Stockton Borough Council.

She says there were several reasons for choosing COPD, including a high prevalence of respiratory problems due to the area's industrial past and high levels of smoking. Individuals have used their personal budgets to buy the care they need – accessing swimming lessons to help with cardiovascular fitness, physiotherapy and breathing equipment.

Many people do not feel the need to access other services once they've been through the personalised care and support planning process, Ms Clifford adds – the process often highlights areas of support people weren't aware of.

While numbers are too small to be definitive, the programme has led to reductions in medication use and fewer GP visits.

The local programme, one of the original national demonstrator sites, looks at the cohort across four workstreams: finance and data; care model; communications; and community assets. The finance and data workstream created a linked dataset of costs across health and social care locally.

Ms Clifford says the dataset project took longer than expected, largely due to governance issues. Costs are based on patient-level data from the local trusts for acute, community and mental health activity; social care costs are based on the cost of packages of care; while primary care is based on a sample of 50 COPD patients.

Rough costs were produced for voluntary sector services, based on contracts with commissioners, though Ms Clifford acknowledges the cost of other voluntary services may have been underestimated.

Armed with the costs dataset and a statement of resources – which sets out the typical COPD pathway and what services could be covered under a personal health budget – the team is re-examining packages of care.

It is also looking to expand the service into diabetes and frailty.

Stockton's industrial past has led to respiratory issues

Renal success

A programme to improve the detection and management of acute kidney injury in one trust has led to big improvements in patient outcomes and reduced costs. Steve Brown reports

Acute kidney injury (AKI) – or acute renal failure, as it used to be known – is a major problem among hospitalised patients. If there are delays in detection and it is left untreated, it can lead to serious problems such as uraemia, acidosis or hyperkalaemia, and ultimately death. Despite a national focus on this area in recent years, there remains a feeling that major improvements could be made in patient outcomes while also realising significant cost savings.

There are a number of potential causes of AKI, including dehydration, low blood pressure, some drugs, severe infections, urinary tract blockages, and the dye used for some types of scan. Symptoms can include passing less urine, nausea and sickness, poor appetite, swelling and breathlessness.

Strategies to reduce the incidence of AKI are well known, involving identifying key risk factors, observation and monitoring blood for levels of creatinine, and taking rapid action once AKI is suspected.

Despite many of the preventative steps being part of core healthcare, it is more prevalent than many people would think.

A study by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) in 2009 suggested that prevalence among hospitalised patients in the US was 4.9% (although there were no comparable figures at the time for the UK).

Definition issue

However, there are various definitions of AKI and this has contributed to different estimates of prevalence (see box). Crucially, the NCEPOD study indicated that 30% of AKI cases could be preventable.

South Tees Hospitals NHS Foundation Trust participated in the original NCEPOD study. Despite this, a care audit in 2012 indicated that little had improved, so more recently it set about addressing the issue, with a particular focus on surgical patients.

Why surgery? Ruth James, director of quality and performance at the trust, explains that AKI was not traditionally seen as a surgical problem – unlike deep vein thrombosis, say, where DVT prevention was embedded in surgical team culture. 'There was simply less awareness of AKI and the steps that should be taken to reduce risk and to ensure early detection,' she says.

As recommended nationally, the trust operated an AKI alerting system – flagging up potential AKI indicative test results to consultants. But it recognised that it needed to embed this better into current practice and to develop and sustain an 'AKI aware' culture.

Its aim was to accurately measure its AKI rates and then reduce incidence by at least 20% within 12 months – an ambitious target but within the potential improvement identified by the NCEPOD report.

The trust commissioned CRAB Clinical Informatics (C-Ci) to measure morbidity and mortality rates using clinical coded data. This involved extracting patient episodes involving relevant ICD-10 codes as either primary or secondary diagnoses.

Mark Ratnarajah, a paediatrician and managing director of CRAB, says the company was already involved in supporting work around clinical risk prediction for the trust and was pulled in to support the AKI work. 'We were asked to get involved because we can do the baselining in real time, and because we were already using coded data,' he says.

Another possibility would have been to look at pathology results. However, given that some definitions of AKI involve comparing blood creatinine levels with a patient-specific normal level, a single result would not have been sufficient to indicate AKI. In fact, an AKI diagnosis is made by a clinician informed by pathology results as just one part of the evidence.

While the presence of an ICD code may mean some very minor or early detected cases of AKI – where no code was assigned – are missed, this was seen as a more robust approach in identifying the real incidence.

IMAGE COURTESY OF THINK KIDNEYS CAMPAIGN, WWW.THINKKIDNEYS.NHS.UK

The C-Ci system enabled the trust to track the incidence of AKI in surgical patients over the 12 months to June 2016. This was shown to have been rising to a maximum of 1.7% of admissions by June 2016. With access to the national dataset, the company confirmed that this was within the national range for surgical cases of 1% to 2% (the range for medicine is 3% to 6%). But the trust was convinced it could deliver an improvement on this rate.

In parallel to the data baselining exercise, the trust set up an AKI awareness programme, starting in mid-2015. Its aim was to alert staff from all roles and specialties about avoidable patient harm associated with AKI – although the trust has only monitored the impact within surgical specialties.

Staff workshops

It delivered more than 50 workshops for small groups of staff. These workshops promoted the proper use of the existing alerting system. Training slides were refined on the basis of results and feedback throughout the programme. Prompt cards were developed and handed out as part of a 'think kidneys' campaign. The e-alerts were also linked to newly developed AKI guidelines, so that there was a consistent response to the presence of such an alert.

Guidelines were also developed for nursing staff, recognising they play a major role in AKI prevention and detection. They are key to ensuring patients get the right fluid intake and to monitoring for early signs of fluids getting out of balance, including any reduction in urine output. They also dispense drugs that can impact on AKI care.

The final step for the trust was to appoint an AKI/renal advanced nurse practitioner. The nurse practitioner plays a major role in training but also has a daily presence on high risk wards and liaises with primary care, for example ensuring discharged AKI patients are flagged up to GPs helping to avoid readmissions.

The results have been impressive. While it was targeting a 20% reduction over a full year, five months on from its June 2016 baseline, the data showed a 36% reduction in recorded AKI incidence across its surgical wards. And by March 2017 the trust had seen a reduction from its starting point of 1.7% of all surgical patients to just 0.6%.

"Long after the awareness campaign formally ended, AKI rates continued to fall. Every month has been the lowest month"
Mark Ratnarajah, CRAB

Dr Ratnarajah says many trusts have run awareness campaigns around AKI. The difference at South Tees was that it had embedded the approach. 'You'd typically expect rates to fall and then plateau, but we've noticed that long after the awareness campaign formally ended, AKI rates continued to fall. Every month has been the lowest month – that can't continue for ever but it is impressive.'

He puts it down to a change in culture – it is now reinforced with junior doctors outside of formal training and by the presence of the advanced nurse practitioner, with prescribing and discharge rights.

The trust's patient-level cost team calculated that AKI was costing the trust £1.65m a year at the 1.7% prevalence rate. The fall in incidence of AKI equated to 118 episodes a year. And with the difference in costs for patients with and without AKI calculated to be an average of £4,500 – total savings have been estimated at £500,000. This converts into a 6.8 fold return on investment.

'Reduced length of stay and avoidance of critical care were the key factors in these savings,' says Ms James. The trust has used the figures to develop a business case to expand its existing service to the full seven days by appointing a further advanced nurse practitioner.

A national issue

Acute kidney injury (AKI) is a much more widespread issue than is commonly thought. But pinning down actual incidence is not straightforward. It is fairly easy to find different sources suggesting figures in the range of 5%-15% of hospitalised adult patients, with some publications reporting even higher rates.

Some data is based on coding. Others use automated laboratory data (underpinning the AKI e-alerting systems), with AKI being indicated based on an increase in blood creatinine over a baseline level. Research studies may use combinations of these approaches or more manual methods.

Even with laboratory data, different results could emerge, depending on which baseline is used. One study in 2009 suggested that there were more than 30 definitions of AKI used in various literature leading to different levels of 'recorded' cases.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study in 2009 estimated prevalence among US hospital patients of 4.9%. But a clinical guideline from the National Institute for Health and Care Excellence (CG169) – published in 2013 and developed in response to the NCEPOD study – suggests that AKI is seen in 13%-18% of all people admitted to hospital.

Most of these patients are under the care of healthcare professionals outside the nephrology department.

The NCEPOD study found that only 50% of AKI care was considered good and that 30% of cases may be preventable.

With an inpatient mortality rate for AKI of 25%-30%, the NICE guideline is clear that prevention or amelioration of AKI could improve outcomes and prevent deaths. But there is a secondary financial benefit too. NICE's guideline and costing statement suggests that AKI costs the NHS between £434m and £620m (2013 estimate not including community services). More recent estimates put the acute costs at more than £1bn in England.

Savings are likely to come principally from length of stay, which is estimated to be 4.7 days longer for patients with AKI than people of the same age in the same healthcare resource group without AKI.

Many of those extra days may be in expensive intensive care services.

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Manchester lights the way

Manchester's health and social services integration is beginning to get some traction as it moves ahead with the underpinning financial mechanisms. Seamus Ward reports

The devolution deal that placed about £6bn of health and social care funding in the hands of organisations based in Greater Manchester is often held up as the precursor – or even blueprint – for sustainability and transformation partnerships (STPs). But while it is clearly well advanced in some areas, it readily admits that some STPs are further forward in others.

It is perhaps a sign of the scale and scope of the work programme faced by STPs that change in Greater Manchester is only now beginning to bite – 18 months on from devolution. Finance is one area where progress has been made, buoyed by taking control of £6bn of annual funding.

Speaking at the HFMA Chair, Non-executive Director and Lay Member forum in Manchester last month, Steve Wilson, executive lead, finance and investment Greater Manchester Health and Social Care Partnership, explained that the funding is an aggregate of all the region's health and social care funding.

He has been in the job just over a year and believes relationships between the sectors are stronger in Greater Manchester than elsewhere in the NHS. A key difference with other parts of the country is the availability of the £450m NHS transformation funding given to the region up front as part of the devolution deal.

'This has bound everybody in,' Mr Wilson told the forum. 'It's no more than our fair share of the total transformation funding, but it comes to us frontloaded and entirely within our discretion, within reason. For example, Greater Manchester still has to meet constitutional standards and the objectives set out in the *Five-year forward view*.

'We are in a privileged position and sometimes we forget that. The problem with having money is that it is never enough, but we have an opportunity that others don't have and we need to make sure we take advantage of it.'

Mr Wilson said all applications for the transformation fund are assessed against strict criteria to demonstrate value for money, strategic fit and robustness. Each application is then independently reviewed by consultancy BDO to ensure the process has been applied correctly. The fund is also governed by a performance management framework, which includes an assessment of delivery against a range of health and social care outcomes.

Mr Wilson said the consolidation of the financial data across the organisations involved is one of the tests of delivery for the Greater Manchester Partnership.

The partnership has developed an integrated place-based finance report that shows provider, commissioner and social care positions. These include provider cost improvement plans, CCG risks and local authority budgets, including use of reserves. Effectively, this operates as a shared control total for each of the 10 Greater Manchester localities, with delivery against this measured through the transformation fund investment agreement. It will form part of the quarterly monitoring of delivery of the investment agreement.

Accessing capital

Access to capital is a big issue for STPs, with some estimates claiming £9bn is needed across England. In Greater Manchester, the partnership is looking at different ways of accessing capital, particularly via local government, which can access prudential

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"We have an opportunity that others don't have and we need to make sure we take advantage of it"

Steve Wilson, Greater Manchester Health and Social Care Partnership

borrowing from the Public Works Loan Board.

'If we do it right, the local authority can secure a recurrent income stream from the NHS so they can invest without reducing their overall borrowing ability,' Mr Wilson said. 'This would often represent better value for money for the NHS and would be particularly appropriate for developing the integrated neighbourhood hubs that are critical to the delivery of the Greater Manchester strategy.'

The partnership wrote its sustainability and transformation plan a year before the other parts of the country and initially its funding gap was £2bn. Since then, however, the government has announced additional funding, extra money in the Better Care Fund, and the social care precept, which has reduced the gap to £1.2bn.

'The significant area is the social care gap within that,' Mr Wilson said. 'The social care gap has been in every version of our strategic financial plan but we've not solved it. We have to integrate to deliver services better, but there is an unsolved financial issue.'

The strategic plan includes five themes, common to many STPs:

- Focusing on population health
- Transforming community-based care and support
- Standardising acute hospital care
- Standardising clinical support and back office services
- Enabling better care.

Picking out two of these – transforming community-based care and support, and standardising acute hospital care – Mr Wilson explained that transformation was focused on 10 localities. These were based on local authority areas, with CCGs broadly coterminous with each council, and an additional 'locality' covering what can be done at Greater Manchester level.

To support the transformation of community care, support services and acute care, a commissioning review was completed, which led to the planned creation of 10 integrated health and social care commissioning functions. They will follow a population-based commissioning model.

Local care model

Some commissioning will be devolved to further organisations, known as local care organisations (LCOs), which are similar to accountable care organisations. Where it makes sense, the commissioning of high-volume services will be at the Greater Manchester level, either through a lead CCG or a single Greater Manchester commissioning hub.

The LCOs will foster integrated health and social care provision and will include primary, community and social care, together with urgent care and some acute services. They could be in a number of forms – a single provider, a lead provider or an alliance.

In the new model, payments by the strategic commissioning functions are likely to be based on a capitation basis rather than the payment by results tariffs. Population outcomes measures will be the key indicators and risk and gain share arrangements with providers.

Local care organisations may then use a variety of incentives to drive the appropriate models of care within each locality – for example, incentivising self-care and early intervention.

Mr Wilson said the shift to LCOs meant close alignment with the Greater Manchester acute strategy was 'crucially important'. 'If the LCOs move care out of hospitals, for example, we need to understand, and where appropriate mitigate, the impact on stranded estate.'

Devolution was not just about driving economic growth, but also to drive the integration of public services to maximise the contribution they make and the value they deliver. Although Greater Manchester has a strong, growing economy, the area also has pockets of deep deprivation.

Collaborative roots

To an extent, the agreement to devolve decisions about health and social care to Manchester was an acknowledgement of what was already happening in the city. The 10 local authorities had worked together for a number of years – on their joint ownership of the city's airport and the establishment of the Greater Manchester Combined Authority, for example.

Greater Manchester is taking a place-based approach to the commissioning of services, which naturally leads to the integration of public sector services, Mr Wilson said.

NHS England has defined a range of devolution, starting with: 'a seat at the table', which allows flexibilities within current legislation; co-commissioning; delegated commissioning arrangements; and finally the full transfer of the commissioning functions (such as in Scotland and Wales).

'The reality is that Greater Manchester is more delegation than devolution, but I don't think that matters at this stage,' said Mr Wilson. 'It's something that will evolve over the years. All the CCGs are co-commissioning primary care, for example, but CCGs across the country are allowed to do that.'

While acknowledging that some would call the partnership's governance structure burdensome, he insisted it had been useful in bringing together what were originally 37 local authority and NHS organisations.

The Greater Manchester Partnership works closely with NHS Improvement and a director sits on the partnership's management team, Mr Wilson added, but the organisations are not fully integrated. The representative reports into the NHS Improvement management structure. Local integration between NHS Improvement and NHS England may be further forward in other parts of the country.

The Greater Manchester Health and Social Care Partnership may be different to STPs in several ways – the transformation fund being available up front, for example – but it has much in common with them, including the scale of the challenge.

NHS finance managers need to get better at evaluating the economic case for sustainability in all projects on top of any cashable returns. Steve Brown reports

A broader view

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Considering environmental, social and economic impacts, such as air pollution, health inequalities and local jobs in a sustainable health and care system is, according to the NHS Sustainable Development Unit, increasingly being viewed as a health opportunity and cost-effective investment, rather than a cost. But can NHS bodies really make progress on developing sustainable services – in their broadest sense – while in the throes of such a difficult financial challenge?

It has to. That's the simple response from Jerome Baddley, head of unit at the Sustainable Development Unit (SDU). Sustainability for the NHS is about much more than making its contribution to reducing the country's carbon footprint and the emission of greenhouse gases – important though that is. It is intrinsically linked with managing demand for services. 'If we are serious about prevention, every health pound spent should also leverage improvements in population health, driving down demand for healthcare and the consumption of resources to meet that demand,' he says.

Viewing carbon reduction, environmental sustainability and the wider determinants of health as a separate issue from other decisions – should we invest in access, reduce costs or improve our environmental performance, for example – is the wrong approach.

'Thinking about reducing carbon is too limited,' says Mr Baddley. For example, travel is clearly a major contributor to the UK's carbon footprint and some 5% of all travel is estimated to be health related. However, health-related travel is also a significant contributor to air pollution, contributing at least 10,000 life years lost each year, according to the SDU. So the air pollution impacts of procurement and commissioning should be considered not only because the service needs to meet greenhouse gas reduction targets, but because it has an impact on health. Any negative impact on health will translate into increased demand for services in future. The new Health Outcomes of Travel Tool (see following page) developed by the SDU can help finance staff quantify the health in quality adjusted life years and social cost of travel in any business case.

'Some things have a longer term value in terms of health and we need to get better at evaluating the economic case for some of these investments on top of any immediate cashable returns,' says Mr Baddley. He adds that factoring in the environmental impact and sustainability issues often also leads to other improvements.

'When you authorise people to look with this mind set – making these considerations valid in the decisions they take – you often find things that have a financial benefit,' he says. 'Taking a step back and asking how something could be done in a more sustainable, environmentally friendly way often leads to finding a better way to do it.'

Having said that, the direct reduction of carbon emissions is a key part of the sustainability strategy. The *Climate Change Act 2008* requires the UK to cut greenhouse gas emissions by 80% by 2050 (compared with a 1990 baseline). The NHS contribution to this has been mapped out, first in a carbon reduction strategy and more recently in a sustainable

development strategy reflecting the broader view around sustainability.

An initial target, of a 10% reduction in emissions by 2015 (compared with 2007 baseline) was achieved – in fact, slightly exceeded. And this was against a backdrop of an 18% increase in inpatient admissions over the same period. But the next target of a 34% cut (compared with 1990) by 2020 looks a bigger ask all together – especially as the NHS is currently facing significant financial challenges.

Mr Baddley recognises that the current financial climate adds challenges to making progress with the sustainability agenda. Projects with quick paybacks should be no problem, as they will support trusts in achieving often demanding cost improvement programmes. But it is medium- to long-term payback that might prove more difficult to get off the ground.

A five-year payback might seem 'fantastic' in any other business sector. But he recognises that with provider capital funding scarce and revenue budgets constrained by control totals, a simplistic view of business cases as merely investing in environmental issues will not work.

'There is a big role for finance in this,' he says. 'We need to make sure there is the knowledge and awareness in finance teams of the importance of the broad economic case that sits alongside the decision-making process,' he says. 'Carbon reduction, social value and air pollution – they all need to be adequately weighted and valued when making decisions, if we are to cost the full impact or benefit of our decisions on the health system.'

Some of the NHS's overall contribution to reducing greenhouse gases will be delivered by factors outside NHS bodies' direct control. The government's *Clean growth* strategy, launched in October, highlighted that 47% of UK electricity came from low-carbon sources in 2016 – twice the level in 2010 – in part supported by the world's largest installed offshore wind capacity. This has already helped the NHS deliver its climate change commitments and, as the energy the NHS consumes gets even greener, it moves closer to its further reduction targets.

In fact, SDU figures suggest that 30 percentage points of the required 80% cut by 2050 will be delivered by expected national and international government actions.

That still leaves a lot for the NHS to do to make up the difference. SDU projections suggest that government actions and expected health sector actions – including greater energy efficiency, reduced health related travel and better procurement – will still leave the health and social care sector more than 20 percentage points short of its 80% 2050 target. More opportunities need to be identified and realised.

Some managers suggest that the lack of meaningful hard targets at individual organisation level, means that environmental investment – or at least investment that adds to the short-term financial challenge – gets overlooked. Managers want to make more progress with the green agenda, but direct patient care, access and financial stability are their – and their regulators' – prime focus.

The new *Clean growth* strategy talks about increasing the funding available in the existing public sector energy efficiency loan scheme. It also sets an ambition for the public sector to become a leader in reducing carbon emissions. Recognising that only parts of the public sector have set emission reduction targets to encourage a greater focus on carbon and energy production, the strategy trails the introduction of wider public sector voluntary targets, with a view to these becoming mandatory.

Could this mean mandatory targets for individual NHS bodies, rather than the current national NHS target with NHS bodies encouraged to contribute? Mr Baddley certainly suggests the strategy represents a strengthening of the language around the importance of individual organisations playing their part in carbon reduction.

"Taking a step back and asking how something could be done in a more environmentally friendly way often leads to finding a better way to do it"
Jerome Baddley, SDU

There are already mandatory requirements for organisations to have sustainable development management plans (SDMPs) in place and to report environmental impacts annually. But these requirements are not yet fully met by all organisations, and the SDU says the quality of SDMPs and reporting is variable.

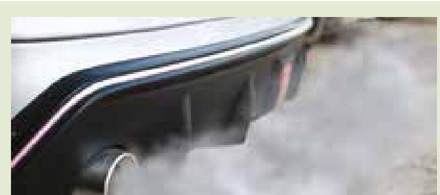
Recent concerted work by the SDU, NHSI and HFMA, however, has shown some real impact on the quality of sustainability reporting, with the percentage of reports identified as good or excellent this year likely to increase substantially from last year. The SDU will be focusing on SDMPs over the coming year.

There are other potential levers to drive more sustainable behaviour – clinical guidelines, for example. Respiratory inhalers using hydrofluorocarbon propellants have been estimated to account for up to 3% of the NHS's entire carbon footprint – a staggering figure that is actually lower than some earlier estimates. Alternatives, such as dry powder inhalers, are used far more extensively in parts of Europe than in the UK. The SDU is working with NICE to understand how environmental impacts could be considered alongside other value

Transport tool

A new Health Outcomes of Travel Tool from the NHS Sustainability Unit helps organisations measure the impact of their travel in environmental, financial and health terms. An organisation simply selects its name in a dropdown menu and the tool populates itself using publicly available data sources – staff numbers, patient activity and mileage based on averages for staff business, staff commuting and patient/visitor travel distances. Patient travel survey data can also be used.

The tool will calculate a baseline position so organisations can explore scenarios involving different levels of: avoiding the need for travel; active travel (walking or cycling); and using public transport, shared occupancy or single-occupancy vehicles.



Rick Lomax, sustainability projects analyst at the SDU, says the tool enables organisations to produce quantifiable information to help in decision-making. 'You may not always take the lowest pollution solution, but you can at least quantify the impact of different options,' he says.

A version of the tool for ambulance trusts has been used by the North West Ambulance Services NHS Trust to explore the potential of expanding a pilot programme that has added four electrically powered rapid-response vehicles to its fleet.

Similar approaches to quantifying the health and economic value of issues such as green space and local spend are on the radar for the SDU.

assessments when producing technology and treatment guidelines. Mr Baddley says asthma is one area being looked at in a pilot study.

Rod Smith is project director at East Sussex Healthcare NHS Trust and spokesman for the HFMA Environmental Sustainability Special Interest Group. He acknowledges that the current financial position can be a distraction from achieving important environmental goals. 'People are understandably giving priority to the day job,' he says. 'It is up to us to help them see that there are aspects of what we are proposing that make a good contribution to that day job.'

Combined heat and power (CHP) and low-energy lighting are often rolled out as the classic 'cut costs and emissions' projects. 'All these things are being done somewhere,' he says. 'But not everyone has done these things or not to an appropriate level.'

Echoing Mr Baddley, Mr Smith says that it mustn't become a fight between different investment options. 'We know the pressure financial people are under, but we also recognise that lots of people really care about this agenda,' he says. 'So we need to support them by making it easier for them and bringing the opportunities to light.'

Sussex success

East Sussex is facing significant financial challenges, and is working to come out of financial special measures, but it has been able to take a CHP project forward on its Conquest site, supported by external advisory bodies. But Mr Smith is clear that the scale of financial difficulties facing trusts shouldn't be a reason not to explore cost-effective sustainability projects.

Estates and finance teams need to work closely to get projects off the ground. The estates team understands the technology involved in a CHP plant, for example. Finance can help construct the business case, taking account of uncertainty over future gas and electricity prices – prices that will be avoided for buying the trust's electricity and the price paid for selling excess power back to the grid.

'Ideally there should be regular meetings between finance and estates teams,' says Mr Smith. 'But there is a question over whether they have enough time to take this forward systematically in the current climate.'

Greater use of the Treasury's five-case model for business cases – requiring strategic, economic, commercial, financial and management cases to be made – would support more holistic decision-making, he adds. 'Only by looking in the round, as the five case model requires, can you do a proper evaluation of proposals and produce a credible plan.'

He believes this detailed approach – normally reserved for major financial projects – would help NHS bodies factor in broader considerations such as environmental impact and the long-term effect on public health. While he accepts it is a major undertaking for smaller schemes, a scaled-down approach that 'asked the right questions' could force organisations to take more of a team approach, ensuring solutions deliver the best broad benefits and not measured just in financial costs.

The HFMA Environmental Sustainability Special Interest Group has a part to play, says Mr Smith. 'Working with the SDU and Public Health England, we can get a balanced message out and ensure the finance community is fully aware of the need to make progress with the sustainability agenda in its broadest sense.'

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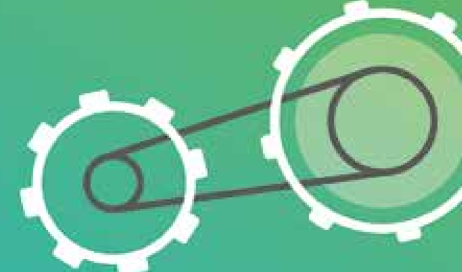

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HFMA revises example annual report and accounts for NHS charities

Technical update

Ahead of October's HFMA charitable funds finance conference, the association updated its example NHS charity annual report and accounts, *writes Debbie Paterson*.

The updated document takes into account the revisions to the FRS 102-based SORP (statement of recommended practice) that were made by *Update bulletin 1*, as well as the recommendations made in *Information sheet 1*, which was published in April 2017. We looked at the detail of these requirements in the technical update in the July issue.

From 2015/16, all charities with gross income of more than £500,000 are classified as large charities and will therefore have to meet the additional reporting requirements set out in the SORP. This did not affect the example set of accounts, because the example charity was already classified as large. But all NHS charities with income of between £500,000 and £1m will be affected by this change.

The FRS 102 SORP requires that prior period comparatives are included in the accounts in all instances other than where FRS 102 specifies otherwise. The information sheet reminds preparers of accounts that this requirement applies to the note that analyses movements in funds.

The HFMA understands that the requirement for comparatives for this note was often overlooked by charities when they adopted the new SORP. All charities need to make additional disclosures in relation to fundraising from accounting periods starting on or after 1 November 2016.

For NHS charities, this will be 2017/18 but early adoption is encouraged and NHS charities may want to early adopt these new disclosures in their 2016/17 accounts. The new reporting requirements are set out in section 9 of CC20 *Charity fundraising: a guide to trustee duties* and are applicable to large charities.

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The Charity Commission has recently issued several pieces of guidance that may be useful for NHS charities. First, it has amended its guidance to charities issuing grants to non-charitable bodies. As most NHS charities are grant making and their main recipients, NHS bodies, are not charities, this guidance represents best practice.

Essentially, when grants are made to non-charitable bodies it is important to ensure that the grant is used only for activities, services or outcomes that will further the charity's purposes for the public benefit. The guidance sets out how this can be achieved.

Second, the guidance on reporting serious incidents has been updated following consultation. The guidance has been revised to make it easier to follow and now includes checklists and examples. Auditors of charities are now required to report if they issue a modified audit report.

The Charity Commission has reviewed all audit reports that were modified and has pulled together the lessons learnt in a document. Most modifications were due to lack of evidence to support the numbers in the accounts or material non-compliance with the SORP, usually relating to group accounts or valuation of property, plant and equipment or pension liabilities. Hopefully, none of these issues would be found at an NHS charity.

Third, any independent examination of a charity must comply with the new directions to independent examiners in relation to accounts reviewed or signed on or after 1 December 2016. Early adoption is encouraged.

• *Debbie Paterson is an HFMA technical editor*

Technical review

The past month's key technical developments

The HFMA has issued a briefing on the **apprenticeship levy,** which updates the discussion document issued in December 2016. All employers pay into the levy, but there are different arrangements for how or if they can then access funding to support eligible apprenticeships. In England, NHS bodies will be able to draw down resources from their own digital fund. The earlier HFMA document identified three possible accounting treatments for the apprenticeship levy. The accounting firms have now settled on one treatment that was discussed in the technical review (*Healthcare Finance* December 2016, page 44), with different approaches depending on whether the body intends to run eligible apprenticeships or not. However, the Department for Education is still considering its approach. The Department of Health will mandate the accounting treatment in an update to the group accounting manual – it is hoped, before month 9 reports are due.

An upfront charging operational framework to support the identification and charging of **overseas visitors** has been published by the Department of Health. NHS bodies are required to establish whether a person is an overseas visitor to whom charges apply and to recover charges for non-urgent services in full and advance. The requirement for upfront charging was previously recommended practice. A guidance document sets out the different roles of clinicians and administrative support staff and sets out the steps needed to estimate costs for upfront charging purposes using a cost estimate price list, which has been published by NHS Improvement. The prices are not mandatory for providers to use and do not need to replace existing pricing practice where a system is in place that works.

The HFMA has launched a diagnostic tool to help sustainability and transformation partnerships develop their **governance arrangements**. Developed by the association's Governance and Audit Committee, the tool will underpin board, governing body or audit committee discussions by identifying areas where strong arrangements are in place and where more work is required.

For the latest technical guidance www.hfma.org.uk/news/newsalerts on PC or phone

The mandatory national collection of **patient recorded outcome measures** (PROMs) for varicose vein surgery and groin-hernia surgery is being discontinued, NHS England has announced. But hip and knee surgery PROMs will continue to be collected. The decision follows a 2016 consultation on how the PROM programme is working, which raised concerns about the lack of specific metrics and generic nature of the varicose vein and hernia data. NHS England said it would 'seek to drive digital collection of PROMs data', which would reduce the collection burden and increase timeliness of data. It is also working with NHS Digital to establish an accredited PROMs supplier list to open the suppliers market to new ideas and innovations.

NHS providers have been reminded that they will be expected to complete the 2016/17 **corporate services** data collection template by 17 November. The template was scheduled to be issued at the end of October and will cover cost and performance data across seven corporate service areas, including finance, payroll, HR and legal functions. The corporate services compartment within the model hospital went live for all provider sectors in September.

HM Revenue and Customs has written to NHS finance directors to clarify the rules around the **VAT treatment of salary sacrifice lease car** arrangements. The move follows the ruling on VAT and a salary sacrifice scheme for employees at pharmaceutical firm Astra Zeneca. The letter includes an FAQ outlining some of the detail of the HMRC review of VAT treatment of salary sacrifice lease cars in the NHS.

NICE backs some cataract removal earlier in pathway

NICE's new guideline *NG77* includes recommendations on the diagnosis and management of cataracts, *writes Nicola Bodey.* Cataract management usually involves a multidisciplinary team of ophthalmologists, optometrists, nurses and technicians. Cataract surgery is the most commonly performed elective surgery in the UK, with over 370,000 operations in England in 2015/16. The demand for cataract surgery is increasing because of the ageing population.

The clinical threshold used to access cataract surgery is commonly based on visual acuity and, in many areas, priority is given to first-eye surgery. Variation in commissioning policies has resulted in differences in access to cataract surgery. A study by the Royal National Institute of Blind People (RNIB) found noticeable variation in first- and second-eye operation rates, large variations in time to treatment, and a consistent reduction in the number of cataract operations in some areas.

Wrong lens implant errors are the most common 'never events' for implants in England, with 19 incidents in 2016/17. Never events are serious, largely preventable patient safety incidents that should not occur if national guidance has been implemented.

The guideline recommended access to cataract surgery is not restricted on the basis of visual acuity. Providing additional cataract operations for people previously denied access because of visual acuity, or because it is a second eye, may result in additional costs in the shorter term.

These operations are likely to be carried out anyway, but it is now recommended they happen sooner in the pathway. This could prevent further development of the cataract and reduce the need for a more complex operation later. It may also greatly improve quality of life for patients.

Commissioners and providers should ensure processes are in place to identify

Diary

November

3 B East Midlands: annual conference, Loughborough
8 N Annual mental health conference, London
9 B London: VAT, Rochester Row
9 B West Midlands: AGM, Birmingham
10 B Northern: annual conference, Durham
10 B South Central: technical update, Southampton
10 B North West: student event, Liverpool
14 N Audit conference, London
15 F Commissioning Finance: future of primary care and general practice forum, London
21 B North West: AGM, Liverpool
21 B Wales/South West: road to resilience, Chepstow
22 B Eastern: health sector insight briefing, Cambridge
23 F Provider Finance: directors' forum and new year lunch, London
24 B Northern Ireland: annual conference, Belfast
27 B West Midlands: autumn budget briefing, Birmingham

December

4 B South Central: technical update, Reading
6-8 N HFMA annual conference, London

January 2018

16 F Chair, Non-executive Director and Lay Member: annual chairs' conference, London
25-26 B Yorkshire and Humber: annual conference, Broughton
29 B Eastern: introduction to NHS finance, Fulbourn
31 N Pre-accounts planning, Manchester

February 2018

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

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

B Branch N National
F Faculty I Institute

complications after surgery and ensure there is prompt access to specialist ophthalmology services. It also recommends in-person first-day reviews are not offered to people after uncomplicated surgery.

The large majority of patients with no postoperative complications can receive an assessment in a community setting, provided the outcome is communicated back to the secondary care unit. The cost of an outpatient ophthalmology appointment is £139; the cost of community optometry assessments will vary according to local commissioning contracts.

Having well defined processes to identify post-cataract surgery complications may generate offsetting savings from the avoidance of unnecessary post-op referrals.

Nicola Bodey is a senior business analyst at NICE

Events in focus

HFMA annual conference
6-8 December, London

The HFMA annual conference offers finance managers an opportunity to discuss developments and hear the latest thinking from the Department of Health, NHS Improvement and NHS England, as well as commentators from home and abroad. Under the banner of 2017 HFMA president Mark Orchard's theme of *Everyone counts*, the conference will hear from finance staff, general managers, clinicians and political commentators. Keynote speakers include Bob Alexander, NHS Improvement deputy chief executive and director of resources; Jason Helgerson, New York State Medicaid director; and BBC political editor Laura Kuenssberg (pictured).

- **For details or to book, email rose.bennett@hfma.org.uk**

HFMA annual chairs' conference
16 January, London

Department of Health permanent secretary Sir Chris Wormald (pictured) will address the annual event, which is open to chairs of all NHS bodies. He will look at key messages and challenges facing the service over the next few years. Royal Navy leadership guru Andrew St George will look at how the NHS can learn from the navy in terms of leadership, culture and collaborative working. And Alan Burns, chair of The Princess Alexandra Hospital NHS Trust and Kettering General Hospital NHS Foundation Trust, will share his experiences of turnaround.

- **For further details email grace.lovelady@hfma.org.uk**

Provider Faculty directors forum
23 January, London

The faculty's annual new year lunch and forum is a key opportunity for provider directors of finance to get together. Confirmed speakers include Duncan Selbie (pictured), chief executive of Public Health England, who has argued strongly for greater investment in prevention in its widest sense. He believes that a relatively small proportion of an individual's good health is due to spending on reactive healthcare, but the wider determinants of health, such as housing and education, are more important.

- **Email clare.mcleod@hfma.org.uk for further details**

Planning for sustainability

SHUTTERSTOCK

Association view from Mark Knight, HFMA chief executive

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

My HFMA

We are in unprecedented times, with services in general and finance staff having to deliver more for less.

We've been told continually that the government has given all it can to the health system and we must make do. But there are hopeful signs of a change in this mantra, with confirmation that the pay cap will be scrapped. There is a consensus this is the right decision.

Staff income has been eroded in real terms. They need to be treated fairly – morale and staff buy-in are fundamental to meeting the ongoing day-to-day demands of delivering healthcare and the transformation challenge. It is also pragmatic given current labour shortages and continuing pressure to reduce agency spending.

What we haven't heard anything about is how increased pay flexibility will be funded. It seems inconceivable that local health bodies could be expected to meet the increased cost pressure from the previously announced settlements.

NHS bodies are performing heroics to improve the service's financial position but deficits, particularly among providers, remain a problem and provide an imperfect foundation for transformation. I am nervous about a 'sticking plaster' approach to meeting current funding challenges, though any increased funding would be welcome.

I am reminded of the end of the millennium when the then new Labour government stuck doggedly to the previous government's spending settlement and dripped funds out to the service when extreme needs demanded it.

As president Mark Orchard has commented, what we need now is a sustainable plan for the next 30 years, not the next six months. The danger is that short-term plans and 'turnaround' behaviours take over because NHS bodies have to meet their control totals. As one finance director said to me recently: 'Whatever happened to value?'

The HFMA Healthcare Costing for Value Institute is championing the cause. Its international symposium showcased examples of where organisations round the world, including the UK, are pioneering the approach with exciting results. But there is no doubt that we need to see a much wider take-up.

HFMA chief executive Mark Knight

The institute has a healthy crop of clinicians involved and it is they who are driving the value agenda. This is really encouraging and we need to ensure the finance function stays fully in step with these clinical champions.

As part of creating sustainable services, the NHS must continue to embrace new technology. Speakers at a recent HFMA USA event talked about the tipping point – where technology ceases to be a cost and becomes an efficiency tool. As an example, the speaker credited technology with a dramatic reduction in US air fares over recent decades. The NHS must exploit this type of transformation – reducing GP and outpatient appointments or facilitating virtual consultations and supporting people to manage their own health and conditions.

I'd like to finish by recognising Tony Whitfield, who last month received his OBE from the Queen. It was a tremendous day for him and his family. And two days prior to that, Louise Shepherd, another former board member and honorary HFMA fellow, received her CBE. Many congratulations to them both!

Member news

Hardev Virdee, chief finance officer at Central and North West London NHS Foundation Trust, has joined the HFMA Mental Health Steering Group.

HFMA corporate business development manager James Blackwell played for England in the World Cerebral Palsy Championship in Argentina in September, and the team made it to the semi-finals. 'It was an amazing experience and our highest ever finish,' said Mr Blackwell. 'We're getting closer to a medal, which we hope to get at the European Championship next year. San Luis in Argentina was a great setting. We visited a local school – it was very humbling to see how much it meant for the kids to meet us.'

The South West branch held its awards ceremony in September:

- Outstanding Contribution and Achievement: Dorset STP (pictured)
- Finance Team of The Year: Taunton and Somerset NHS FT
- Workplace of the Year: Royal Devon and Exeter NHS FT
- Student Achievement Award: Alistair Symmonds, Devon Partnership NHST
- Influence on Patient Care: Michelle Winfield
- Outstanding Contribution: Tim Goodson

The Kent, Surrey and Sussex Branch also held its awards ceremony in October:

- Finance Personality of the Year: Natalie Wallace
- Finance Team of the Year: Maidstone and Tunbridge Wells NHS Trust
- Collaborative Working: Dena Walker
- Student of the Year: Matt Chapman
- Outstanding Contribution: Richard Sykes

Member benefits

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

Branch focus

Northern Branch

Until recently, the NHS organisations in the patch covered by the HFMA Northern Branch enjoyed relative financial stability. But the magnitude of the challenges the NHS is facing across England has started to have a significant impact on all NHS organisations in the North East.

"We've had relative financial stability compared with the rest of the country and, from a non-financial perspective, we've been performing pretty well. We are now seeing the same challenges as the rest of the country.' says branch vice chair Caroline Trevena (pictured).

'There are issues around providing additional financial information and challenges from regulators,' adds Ms Trevena, whose branch is almost exactly coterminous with the Cumbria and North East (CNE) Sustainability and Transformation Partnership. 'The pressure for individuals is enormous and that's where it is a huge benefit to work closely with teams and to have the support of the HFMA so that you can network with various people and talk about the similar issues you are facing.'

Currently, in terms of individual members, the Northern Branch is the smallest in England. The committee is looking to recruit more people from the northern area of the branch, as well as junior finance professionals, in order to reflect the diversity of the members in the decisions it is making.

Despite the small branch size in terms of member numbers, its annual conference is very well attended with around 200 delegates every year. This year's event will take place on 10 November and will present both a national and a regional perspective on some of the current challenges in NHS finance. The speakers include Bob Alexander, currently NHS Improvement's director of resources and deputy chief executive, Alan Foster, STP lead for Cumbria and the North East and Graham Evans, chief information and technology officer at both North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust.

The conference will conclude with a gala dinner where the winners of the five branch awards will be announced and guests will have the opportunity to network. For details, visit **www.hfma.org.uk/our-networks/branches/northern**

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Appointments

Andy Ray (pictured), chair of the HFMA Eastern Branch, is now director of financial operations at Barking, Havering and Redbridge University NHS Trust. He was previously deputy director of finance at Basildon and Thurrock University Hospitals NHS Foundation Trust. Mr Ray was shortlisted for HFMA Deputy Finance Director of the Year 2010 Award, and was part of the winning team for the HFMA Efficiency Award in 2010.

Salisbury NHS Foundation Trust has appointed **Lisa Thomas** director of finance and procurement. She has over 18 years' finance experience in NHS organisations, having started her career in 1999 on the graduate financial management training scheme. She was previously deputy director of finance at Royal United Hospitals Bath NHS Foundation Trust, and succeeds **Malcolm Cassells**, who has retired.

Pippa Moger (pictured) has been named director of finance at Taunton and Somerset NHS Foundation Trust. She will be carrying out the role alongside her current position of director of finance at Somerset Partnership NHS Foundation Trust. She joined the partnership trust in 2013, before which she was deputy director of finance at Yeovil District Hospital.

Norfolk and Suffolk NHS Foundation Trust has named **Julie Cave** chief executive. She was director of finance and deputy chief executive at the trust and takes over from **Michael Scott**, who retired at the end of September. Ms Cave has 30 years' experience in the NHS, having begun her career as a regional finance trainee. **Daryl Chapman** has been appointed interim director of finance at the foundation trust. He spent the last 16 months as finance lead for Norfolk and Waveney Sustainability and Transformation Partnership. Mr Chapman was deputy director of finance at Norfolk and Suffolk NHS Foundation Trust between February and October 2013.

Bob Alexander (pictured) is taking on a new role leading the Sussex and East Surrey Sustainability and Transformation Partnership. Mr Alexander will initially be with the STP for three days a week while he continues as NHS Improvement's director of resources and deputy chief executive until January. The regulator's chief executive **Jim Mackey** was due to return to his previous position as chief executive at Northumbria Healthcare NHS Foundation Trust on 1 November. He will retain his formal responsibilities at NHS Improvement, working two days a week, until his successor has taken up the post.

"I feel the trust is going places. It is developing a health and wellbeing campus, which I'm excited about"
Haq Khan, George Eliot Hospital NHS Trust

Khan's talent pool boost

On the move

The dramatic difference between the role of deputy director of finance and the top finance seat is often said to be one of the reasons why deputies don't feel able to step up. However, this year NHS Future-Focused Finance and the HFMA launched a programme that aims to help aspiring finance directors to bridge that gap.

Recently, it scored its first successes. Two deputies in the new talent pool – originally announced by Paul Baumann at the 2016 HFMA annual conference – have gained their first finance director jobs (see below), one of whom is Haq Khan.

Mr Khan was recently appointed director of finance at the George Eliot Hospital NHS Trust, succeeding former HFMA president Shahana Khan, who has relocated to the Middle East.

He believes the programme, together with a spell as acting director of performance at his current trust – Worcestershire Acute Hospitals NHS Trust – helped him secure the new job.

Before joining the talent pool, he applied for the then vacant finance director post at the Worcestershire trust. 'It's a large trust with a number of challenges, so they were rightly looking for an experienced finance director to join a substantially new board,' he says.

He did receive 'invaluable' feedback – he needed a broader range of experience, which he gained through the board-level performance director role. He was encouraged to apply for the talent pool programme, which includes a development centre, support to produce personal development plans, one-to-one executive coaching, national masterclasses and discussions with national NHS finance leaders.

'It helped me get my new role, but it also helped build the support network to help me make that step up. There aren't the nursery slope jobs for finance directors any more and we don't have the support network that strategic health authorities provided previously – this is putting some of that support back in and turbocharging it,' he says.

Selection into the talent pool is by a competitive application process designed to reflect a finance director/chief finance officer application procedure. This helped when applying for the George Eliot job.

'It was a lot easier to complete my application, and come up with examples to demonstrate the required capabilities.'

The personal development plan (PDP) and the coaching helped him reflect on how he could further cultivate his strengths. 'A lot of people focus only on improving weaknesses in their PDP, but it's more impactful to improve your strengths and build on that.

'Getting onto the talent pool was a confidence boost and raised my profile. It also gave me a better understanding of the finance director role and the kind of finance director I wanted to be -– it's then about finding the right role and performing on the day of the interview.'

He is due to take up the post at George Eliot on 4 December. As it is a small trust, its focus is on clinical and financial sustainability. 'Its financial challenge is no different to a lot of trusts and, as a proportion of turnover, is similar to here in Worcestershire. Its financial position is stable and one of the key challenges will be to develop a financial strategy to improve that position while managing the issues around clinical sustainability.'

The trust is moving towards greater clinical networks and collaboration as part of its sustainability work. Mr Khan sees part of his role as building relationships internally and with other health and social care organisations, including regulators, and acting as a corporate director as well as the finance director.
He says: 'I feel the trust is going places. It is developing a health and wellbeing campus, which I'm excited about. And culturally the board is a good fit for me as a first finance director job.'

Aspiring leader success

Future Focused Finance

Two participants in FFF's Aspiring Finance Leaders (AFL) talent pool have been promoted to their first finance director roles. Sheila Stenson, deputy finance director at Maidstone and Tunbridge Wells NHS Trust, has been named finance director at Kent and Medway NHS and Social Care Partnership Trust, while Haq Khan, acting director of performance at Worcestershire Acute Hospitals NHS Trust, is to take up the director role at George Eliot Hospital NHS Trust (see story above).

Bob Alexander, executive director of resources/deputy chief executive at NHS Improvement, and chairman of the AFL Steering Group, said: 'I'm delighted Sheila and Haq have been appointed to their new roles and pleased they have so obviously benefited from their participation in the AFL programme. I hope their success acts as a signpost for senior finance staff who aim to reach director level to apply for a place on the next intake of AFL in December.'

FFF will open the application process to join the 2018 AFL talent pool on 12 December. The pool is designed for individuals working at deputy director level, or equivalent, who aspire to be finance leaders. Following application and interview, successful candidates will be enrolled onto the pool and will have access to a range of development opportunities – a two-day development centre to assess their readiness for a CFO/FD role, one-to-one coaching, national masterclasses and top table discussions with NHS finance leaders.

For details, visit **www.futurefocusedfinance.nhs.uk/great-place-work/**

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- Carol Frieson, chair, HFMA USA
- Dr Luke Kane, GP and participant on the Channel 4 survival show Mutiny
- Adam Sewell-Jones, executive director of improvement, NHS Improvement

We're also looking forward to hearing from:

- Jason Helgerson, medicaid director, state of New York – Department of Health
- Bob Alexander, deputy CEO/director of resources, NHS Improvement
- Laura Keunssberg, BBC Political Editor
- Alistair and Jonny Brownlee, British Olympic triathletes

The full programme is now available from hfma.to/hfma2017

For more information or to book contact camilla.godfrey@hfma.org.uk

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HFMA Awards 2017 shortlist announced!

Finance Director of the Year

- Adrian Roberts, Central Manchester University Hospital NHS Foundation Trust
- Aaron Cummins, University Hospitals of Morecambe Bay NHS Foundation Trust
- Emma Sayner, NHS Hull CCG
- Anthony Robson, QE Facilities Limited

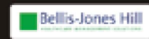
Finance Team of the Year

- Alder Hey Children's NHS Foundation Trust
- Manchester Health and Care Commissioning
- Maidstone and Tunbridge Wells NHS Trust
- NHS Shared Business Services
- Wrightington, Wigan and Leigh NHS Foundation Trust

Deputy Director of Finance of the Year

- Claire Liddy, Alder Hey Children's NHS Foundation Trust
- Andrea Bennett, Bolton NHS Foundation Trust
- Angela Hibbard, Northern, Eastern & Western Devon CCG
- Paul Southard, Royal Devon and Exeter NHS Foundation Trust
- Vicky Hilpert, Cannock Chase, South East Staffordshire and Seisdon Peninsula and Stafford and Surrounds CCGs

Costing Award

Sponsored by 

- University Hospitals Coventry and Warwickshire NHS Trust
- Leeds Teaching Hospitals NHS Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- Pennine Care Foundation Trust

Governance Award

- NHS Chorley, South Ribble & NHS Greater Preston CCGs
- Hampshire and Isle of Wight Sustainability and Transformation Plan
- The Christie NHS Foundation Trust
- Belfast Health and Social Care Trust

Working with Finance – Clinician of the Year

- Dr. Paul Buss, Aneurin Bevan University Health Board
- Dr. Jean MacLeod, North Tees and Hartlepool NHS Foundation Trust
- Gill Gaskin, University College London Hospitals
- Dr. Yasir Abbasi, Mersey Care NHS Foundation Trust

Havelock Training Award

- North Staffordshire Combined Healthcare NHS Trust
- Countess of Chester Hospital NHS Foundation Trust
- North West Skills Development Network - hosted by Warrington & Halton NHS Trust
- Stockport NHS Foundation Trust

Innovation Award

Sponsored by

- Lancashire Care NHS Foundation Trust
- The Christie NHS Foundation Trust
- Chelsea & Westminster Hospital Foundation Trust
- Leeds Teaching Hospitals NHS Trust

Future-Focused Finance Award

Sponsored by

- Winner to be announced on the night

For more information please visit hfma.to/awards or contact awards@hfma.org.uk

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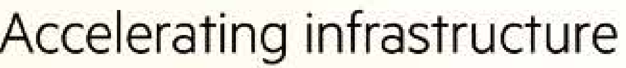

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