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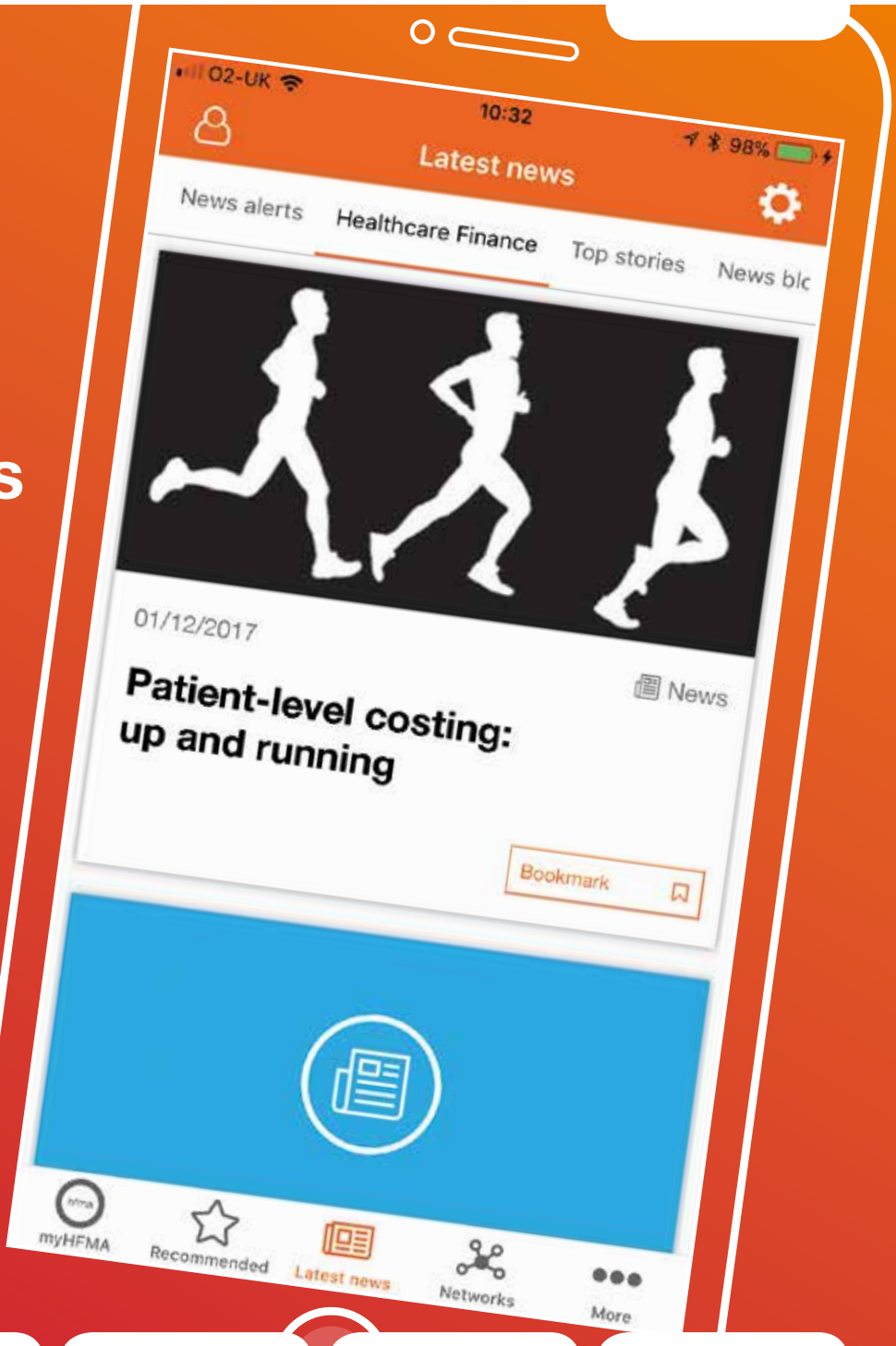

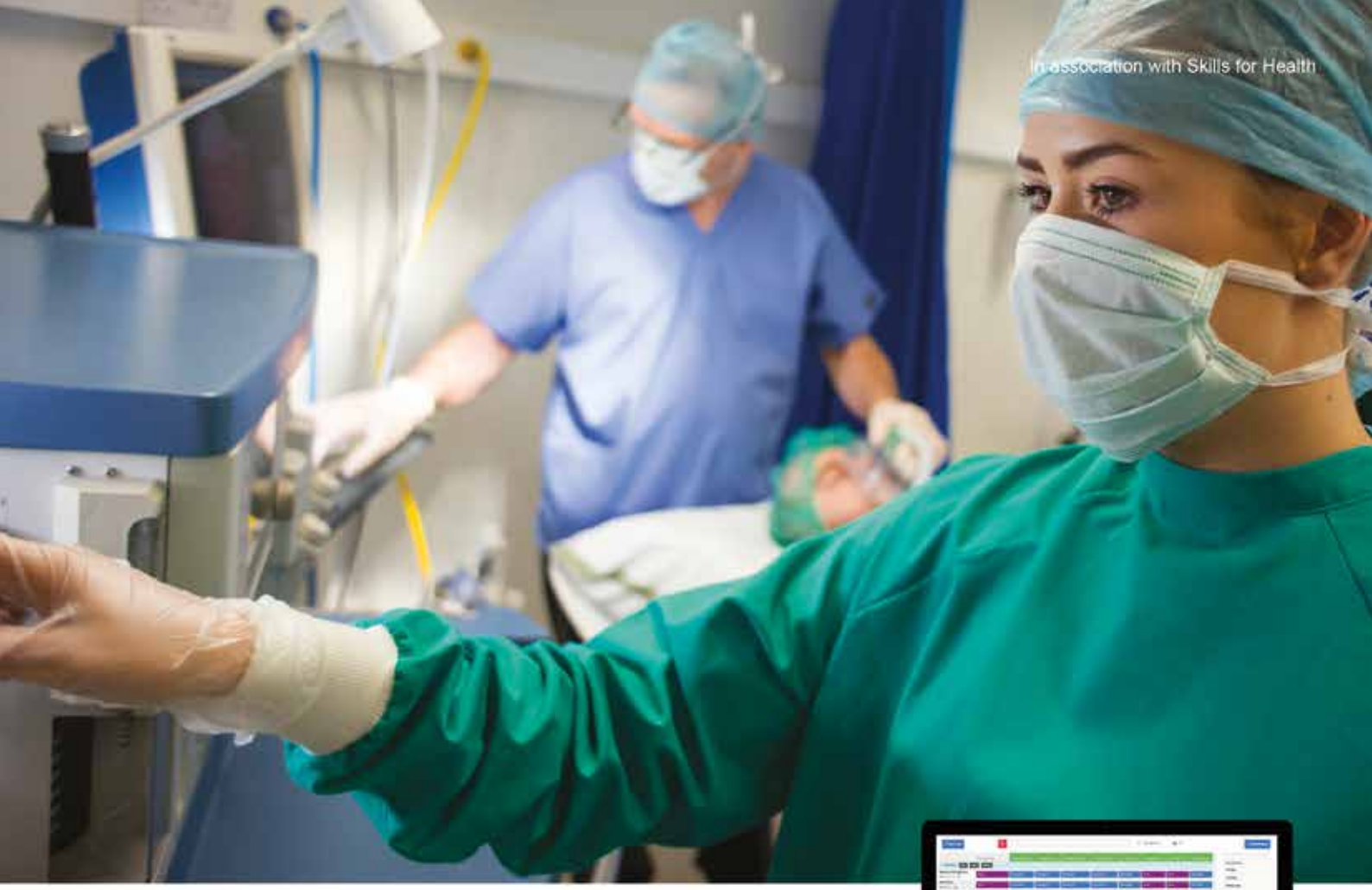

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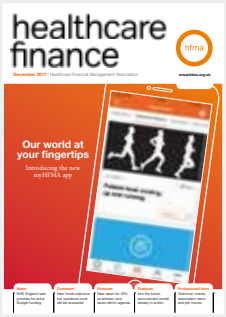

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The next issue of *Healthcare Finance* will be published in February 2018

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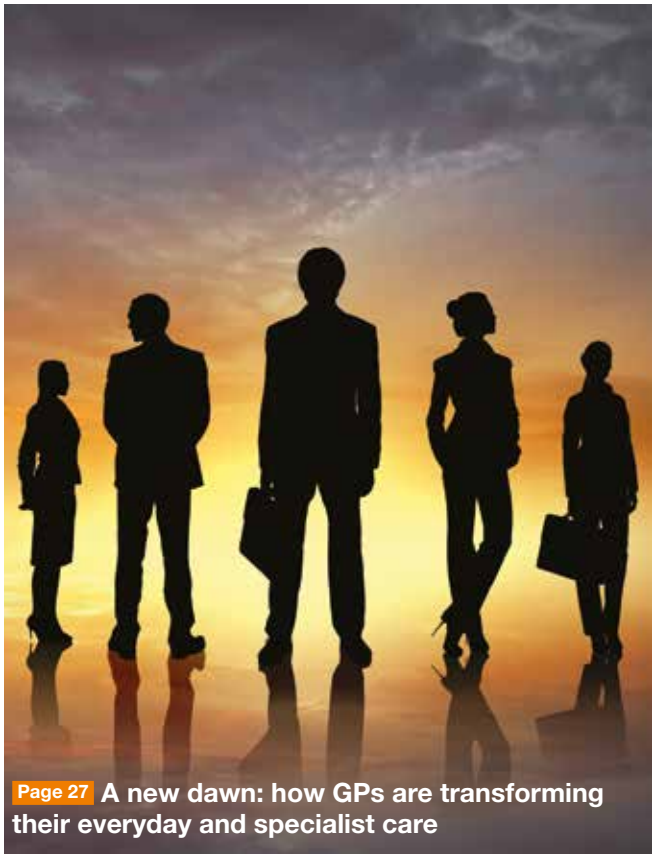

Features

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Conference countdown

This year's HFMA annual conference in London (6-8 December) brings together all the key NHS system leaders and healthcare finance commentators.

If you are not attending the conference, you can still monitor what is being said by visiting the *Top stories* news feed at www.hfma.org.uk. Or download the new HFMA members' app (see pages 24-25 or visit hfma.to/myhfma for details), where the conference news and much more will all be available at your fingertips.

The conference – which is being run under the banner of *Everyone counts*, Mark Orchard's theme for his year as president in 2017 – will also feature the annual HFMA Awards presentation, recognising the achievements of the NHS finance function and best practice across financial management and governance.

News

Budget boost of £1.6bn aimed at activity and vital care

By Seamus Ward

NHS England has set out five principles for its approach to setting priorities for the extra £1.6bn announced in the Budget for 2018/19.

The principles, to be used to develop its 2018/19 operational plan, include funding demand that is driving clinical commissioning group deficits this year, setting realistic emergency care growth plans and protecting funding for cancer, mental health and primary care. However, it admitted other *NHS constitution* targets, such as elective waiting times, are likely to slip.

In the November Budget, chancellor Philip Hammond said the additional funding next year should allow the NHS to improve waiting list performance.

The commissioning body's November board meeting heard that it would engage widely over the next four months to finalise the plan. This is likely to be approved at the NHS England board meeting scheduled for 29 March.

NHS England chief financial officer Paul Baumann (above) presented month seven figures, showing a CCG year-to-date overspend of £267m, with a projected year-end overspend of £223m. He said regular monitoring of risks and mitigations had found further net risks to the CCG position of £550m, most of which were likely to crystallise before the end of March.

"There is an underlying and, in my judgement, a persisting deficit in the CCG sector"
Paul Baumann, NHS England

These included temporary risks such as drug price pressures. Even when CCG mitigations and NHS England interventions were taken into account, the underlying position was a deficit of around £500m.

'There is an underlying and, in my judgement, a persisting deficit in the CCG sector, which, even when I strip out all of the temporary factors, both positive and negative, still seems to be round about the £500m mark,' he said.

A board paper on 2018/19 planning said CCGs were paying for £500m more patient care than they could budget for, because £560m was being held back (£360m from CCGs and £200m by NHS England) as a system risk reserve. In practice, the £500m overspend will be funded from the risk reserve this year.

NHS England chief executive Simon Stevens said patients would continue to need these services in 2018/19.

The first principle guiding its operational plan should be that this activity should be funded from the additional £1.6bn. The second principle focused on emergency care. While progress had been made on reducing A&E attendances, there was no respite in social care pressures and vanguard funding ends in April.

'First and foremost, people look to the NHS to provide safe and responsive urgent and emergency care services,' commented Mr Stevens. 'So we have got to make sure that those are funded properly going into next year.'

Moving on to the third principle, Mr Stevens recommended that planned investment in mental health, cancer and primary care services be protected. The NHS must address unmet need in mental health and cancer care, while 'it would not make sense to go back on commitments' in primary care, which he said was the foundation of the NHS and helped moderate demand going into the hospital sector.

As a fourth principle, he said, the commissioning body must be realistic about what can be achieved with the remaining funding. 'We should be stretching but practical about what that should look like, so as not to set unattainable goals for staff who are already working under considerable pressure,' Mr Stevens said.

The final principle covered the announcement that the Treasury would be funding Agenda for Change pay rises.

Mr Baumann said the additional £1.6bn amounted to a weighted real terms growth per head of 0.9%.

The commissioning sector had overspent by almost £54m after seven months of the financial year, but forecast a small underspend (about £19m) by year-end. CCGs forecast their overspend would be £223m at year-end, again offset by underspends in central budgets (£207m) and direct commissioning (£16m). Following technical adjustments – a £42m adverse variance – the overall forecast position, before additional risks, is an £18.6m underspend.

Providers count cost of missed savings as month six financial position deteriorates

By Seamus Ward

Failure to achieve planned efficiency savings was the largest single factor in the deterioration in the financial position of NHS providers in England in the first half of the financial year, according to NHS Improvement.

In figures for quarter two, the provider sector reported a year-to-date deficit of £1.15bn (against a plan of £1bn), with a forecast full-year outturn of £623m. If accurate, this would be £127m more than planned. The year-to-date position has deteriorated since quarter one, when the sector deficit was £30m up on plan.

NHS Improvement said cost improvement plans (CIPs) had reduced operating costs by £1.26bn (2.9%) in the first six months, but this was behind plan by £169m. Providers had maintained efficiency levels of previous years and were on track to live within the agency cost ceiling of £2.5bn in 2017/18.

Despite this, the largest area of under-delivery is on pay costs, which was £134m behind plan. Trusts forecast that the adverse variance on pay CIPs would be £290m by year-end.

Much of the shortfall on CIPs was due to lower than planned recurrent savings. In the first six months, recurrent savings totalled £961m – £354m less than planned. This was partially offset by non-recurrent savings, which amounted to £296m, £185m more than planned.

The year-end forecast is for recurrent savings to reach almost £2.9bn, £493m less than plan, while non-recurrent savings will rise to £598m – £283m more than plan.

In the latest HFMA *NHS financial temperature check* finance directors were greatly concerned about their ability to deliver CIPs, with 66% not confident they would be delivered. Finance directors were also pessimistic about the delivery of non-recurrent savings plans.

NHS Improvement said £538m (42%) of the total Q2 savings was due to measures related to the Carter recommendations. At year-end, it is forecast they will lead to £1.4bn (41%) of savings.

But the oversight body warned that trusts will have to step up their savings activity – by Q2 they had achieved 36% of forecast efficiencies for the year. However, there was some evidence that providers were able to increase delivery in the second half of the year.

While total income was broadly on plan, changes to the national tariff alongside the introduction of HRG4+ have had an impact on income from elective, first outpatient and follow-up outpatient activity. Elective income was £124m below plan, for example, while non-elective income was £126m above plan, confirming the continued operational pressure in this area. NHS Improvement said non-elective activity had 'crowded out' elective work, resulting in lost productivity, causing trusts to miss their plans and lose access to sustainability and transformation funding (STF). Unallocated STF totalled £292m at month six.

Hopson: provider deficit on track to fall

NHS Providers' chief executive Chris Hopson said the deteriorating financial position was a concern. He added: 'Despite great efforts, trusts are slipping behind on the savings required of them. However, they are still on track to reduce the provider sector deficit compared to last year. Given the overall NHS financial settlement this year, that would be a great achievement.'

Wider focus for nurse workforce planning

Current nurse shortages could be the result of past decisions on nursing needs giving too much weight to affordability, Health Education England (HEE) chief executive Ian Cumming (pictured) told the Commons Health Committee.

He said the HEE was reforming the traditional model, which is based on asking trusts to predict their future needs five years ahead. The arm's length body is now starting to look ahead 10 years. As well as taking account of trust requirements, it is bringing other factors into consideration, such as economic forecasts and potential future spending in the health service.

The number of new nurses in the service this year was due to decisions made four years ago, he said. A projection of future need was necessary, but historically this calculation has always underestimated the real demand.

Asked whether the NHS was planning its future workforce around financial viability rather than patient safety, Professor Cumming said this was one of the problems of the workforce planning model used in the past.

'Employers have always built in affordability and likely budgetary factors into [forecasts of future needs] and I think that has led to the underproduction of nurses historically.

'We have increased the number of nursing commissions consecutively in each of the past five years, but at the moment we are dealing with decisions made in 2009, 2010 and 2011 when, absolutely, financial considerations were fed in probably as too great a factor.'

Professor Cumming added that overall nursing levels depended on retention, as well as the number of newly qualified nurses entering the profession each year.

He would like to reinstate the data collection for the number of actual vacancies for nurses, which ended a few years ago. This was in the hands of the Department of Health and he hoped the collection would begin again soon.

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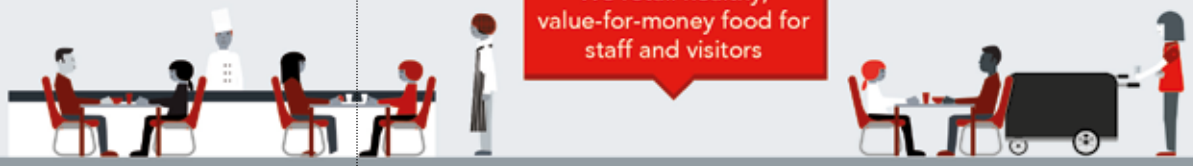

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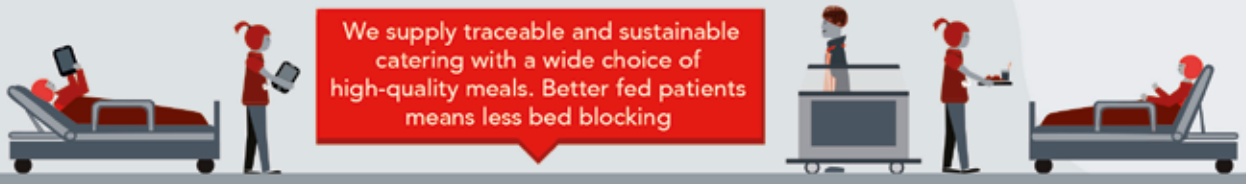

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PAC slams trio over GP correspondence backlog

MPs have criticised the Department of Health, NHS England and NHS Shared Business Services (SBS) over the mishandling of more than 700,000 items of clinical correspondence.

Between 2011 and April 2016, SBS was contracted by NHS England to ensure misdirected clinical correspondence was sent to the correct GP in the East Midlands, North-East London and the South West.

However, a Commons Public Accounts Committee report said a small inherited backlog had escalated and SBS executives did not become aware of the problem until March 2016. Managers did not follow the SBS escalation process of alerting the chief finance officer of the risk, which would then lead to a plan to deal with the backlog. Overall, 709,000 items were found to be mishandled.

While it criticised SBS, the committee welcomed the admission by the joint venture, which is part

owned by the Department, that it made mistakes and that the service it delivered was not good enough.

SBS said: 'We have expressed our regret for this and co-operated fully with the National Audit Office and the Public Accounts Committee in their investigations. SBS no longer provides this service.'

The committee said NHS England and the Department of Health had failed in their oversight of SBS.

Chair Meg Hillier (above) said the scale of the distress to patients would never be fully known. She said: 'It beggars belief that those tasked with tackling a rapidly expanding backlog of correspondence did not recognise its real-world significance. Even now, huge volumes of mail are still to be properly assessed and we are far from confident health officials are on top of the issues.'

Reference cost data published

NHS Improvement has published reference cost data for 2016/17 and restated its aim to replace the reference costs with a single patient-level cost collection in 2019.

The latest reference costs cover £66.1bn of NHS expenditure by 234 English provider trusts – an increase of nearly £2bn compared with the 2015/16 collection. This represents 62% of total NHS revenue spending. It includes £26.9bn spent on core admitted patient care, £10.7bn spent on outpatient attendances or procedures, mental health costs of £7.1bn, community costs of £5.6bn and ambulance costs of £1.9bn.

The average unit cost of a day case was £738, while inpatient episodes cost on average £3,684 (elective) and £1,590 (non-elective). Both figures exclude excess bed days beyond the trim points of different healthcare resource groups. Each excess bed day cost an average £313, while an outpatient appointment cost £120 and an A&E attendance cost £148.

A reference costs index provides a measure of relative cost difference between NHS providers, with an index of 100 indicating national average costs. The full range for 2016/17 extends from 72 to 133, although this is distorted by mental health and community providers, where lack of data means costing is less well developed. The range for acute trusts is much tighter.

A schedule of costs also provides the average costs and interquartile range for different procedures and treatments.

Currently providers are required to submit reference costs. But acute providers are already submitting acute patient-level costs on a voluntary basis as part of NHS Improvement's Costing Transformation Programme. Collections will run in parallel next year and, if they reconcile successfully, there will be a single cost collection for acute services based on patient costs from 2019.

• *Up and running page 15*

London NHS to be incentivised to sell surplus estate

By Seamus Ward

NHS organisations in London will be given incentives and support to sell surplus land and buildings and the receipts will be reinvested in health and care under a new devolution deal.

In November, local NHS bodies, local authorities and national organisations, including NHS England, NHS Improvement, the Department of Health, NHS Property Services and the Department for Communities and Local Government, signed a *Memorandum of understanding* (MoU) on devolution. This acknowledged that there was a greater opportunity to raise funds from selling surplus estate in London than elsewhere – but development of new buildings also cost more.

'While the deployment of capital in the NHS from all sources combined must be equitable in relation to need across different parts of the country, it is recognised that in London there is significantly greater opportunity to raise capital through disposal of surplus assets, but also that the costs of capital investment are also significantly higher than elsewhere in the country,' it said.

The MoU added that the national partners agreed, in principle, to NHS trusts and foundation trusts retaining capital receipts, though a new body – the London Estates Board – will identify how to reinvest the funds to support system-wide priorities. The board will develop incentives to encourage NHS bodies to sell surplus estate.

The NHS is one of London's largest landowners, with an estate estimated to be worth £11bn.

The Naylor report on NHS estates, published earlier this year, said that nationally the health service could release £2.7bn from selling surplus estate – about £1bn could come from London and radical reorganisation of the capital's estate could release even more.

However, it also noted that London accounted for £1.5bn of the overall £5bn of backlog maintenance in the latest figures.

NHS England said that a high proportion of London's primary care estate – including GP surgeries and family health clinics – is in poor condition, with 13% requiring rebuilding and 51% in need of refurbishment.

NHS England chief executive Simon Stevens (pictured) said: 'This strengthened partnership has the potential to unlock funds for reinvestment in much needed modern NHS buildings and clinics across London, as well as kick starting more concerted action on rising health threats such as obesity and air pollution.'

News review

Seamus Ward assesses the past month in healthcare finance

November's news was always going to be dominated by the Budget – lobbying for more funding in the run-up to the 22 November statement and, with the announcement of additional funds, picking through the detail (see page 10). Unsurprisingly, the lobbying for more NHS funding was led by NHS Providers and the NHS Confederation, alongside thinktanks such as the Health Foundation and Nuffield Trust. More surprisingly, Simon Stevens, NHS England chief executive, called for more funding. In a speech to NHS Providers' annual conference, he said it was time to honour the call by the Vote Leave camp in the EU referendum for extra funding to follow a leave vote.

Continuing the Brexit theme, the Nuffield Trust warned that patients could bear the brunt of the negative repercussions of a 'no deal' exit. A briefing examines five areas of the negotiations and what a deal or lack of a deal would mean for the NHS. It said that even if agreements are reached on a financial settlement, citizens' rights and the border between Northern Ireland and the Irish Republic, trade and co-operation deals would be needed to secure the fast, safe passage of vital supplies and drugs, as well as the future of medical research projects. An exit deal will be required to ensure a number of areas are not compromised, including the rights of EU NHS staff, the care of expats and the legal status of approved medicines. Exiting the EU could bring greater flexibilities such as loosening restrictions in the working time directive and in competition regulations, but the trust said scope for flexibility in these areas post-Brexit could be limited.

Despite the additional funding announced in the Budget, there will still be a focus on efficiency and a renewed emphasis on fraud prevention. Launching the NHS Counter Fraud Authority – a new special health authority to tackle fraud, bribery and corruption – at the beginning of November, interim chief executive Sue Frith said its creation was 'good news for the taxpayer, for patients and for the honest majority working in and with the health service'. The authority believes fraud costs the NHS £1.25bn a year.

Following recent criticism of NHS cyber protection measures by the National Audit Office, the service has boosted its data security. NHS Digital announced a £20m project that includes monitoring of threat intelligence and sharing of guidance and advice; help for NHS organisations to assess their cyber security; and offering help to NHS organisations that believe they may have been subject to a cyber attack. The new Security Operations Centre will also employ so-called white hat or ethical hackers to test NHS systems for vulnerabilities.

NHS Improvement encouraged trusts to implement a consolidated 2017/18 pay award for very senior managers (VSMs) in line with the Senior Salary Review Body recommendations. The review body published its report in July and recommended the organisations it covers – arm's length bodies and ambulance trusts – should use in full the 1% available for basic pay rises unless there is a clear reason to do otherwise. A letter from NHS Improvement chief executive Jim Mackey urged other providers to award pay rises in line with this – as has been done in previous years. However, in some circumstances, he would not expect a VSM to get the 1% – if, for example, they were paid above the median (or upper quartile for trusts in special measures).

Staff and employers delivering services under accountable care models would be given access to the NHS Pension Scheme under measures put

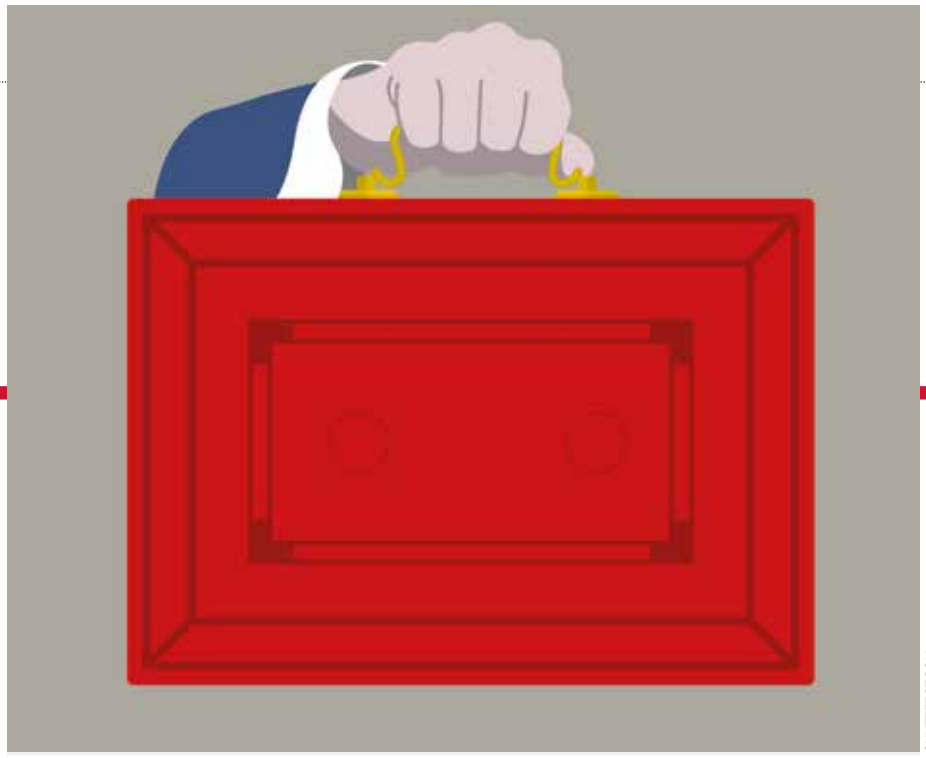
The month in quotes

'During the campaign a promise was made to the British people – in exchange for Brexit there was the possibility to have a better-funded NHS. All I am saying is that was a good promise to make and now is a good time to begin to deliver it.'
Simon Stevens, NHS England

'Fraud in the healthcare system not only undermines public confidence in the NHS but also diverts valuable resources away from caring for patients - it is estimated that prescription fraud alone costs the NHS £217m each year.'
Health minister Lord O'Shaughnessy explains why the NHS needs a new counter fraud agency

'There's a distinct lack of data to identify and evaluate outcomes, including spending and savings. This would be unacceptable for any public money, let alone £8bn. It needs rectifying immediately and a mechanism for facilitating scrutiny of performance, spend and savings put in place.'
Neil Findlay, convener of the Scottish Parliament Health and Sport Committee, asks what local integration authorities have achieved

'We are seeing a continuing rise in nurses and midwives leaving the register, and our data is clear this is being driven by UK and EU registrants. These figures highlight the major challenges faced by the UK's health and care sectors around recruitment and retention of staff. Those responsible for workforce matters will no doubt respond to what these trends are showing.'
Nursing and Midwifery Council chief executive and registrar Jackie Smith raises concerns over nurses leaving the profession



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forward in a Department of Health consultation. As well as technical changes on the operation of the scheme, it proposes that a nomination form would no longer be needed for unmarried or cohabiting partners to claim survivor pensions. The consultation closes on 29 December.

Despite the additional funding announced in the Budget, there will still be a focus on efficiency and on fraud prevention

The Nursing and Midwifery Council said the number of nurses and midwives from the UK and European Union countries leaving the UK register has increased over the past 12 months. The council compared data for October 2015 to September 2016 with October 2016 to September 2017. Over that period, the number of UK graduates leaving the profession increased by 9%, while the number of leavers from the EU increased by 67%, it said. The council oversees the register, which allows nurses and midwives to practise in the UK. It added there had been a dramatic drop in the number of nurses and midwives from the EU joining the register – numbers fell from 10,178 last year to 1,107 this year.

Increased competition in the NHS through patient choice had mixed effects on efficiency, according to a York University study. A report from the university's Centre for Health Economics said greater competition leads hospitals to raise their efficiency. They do so by increasing admissions per bed and the proportion of day cases and by reducing the number of untouched meals. However, hospitals appeared to be less efficient in terms of cancelled elective operations. The researchers also confirmed that the effect of competition was greater for hospitals facing more rivals and, generally, less efficient hospitals tended to respond more to competition.

The Scottish Parliament Health and Sport Committee has published a report that is highly critical of efforts to integrate local health and social service budgets. It said integration authorities spent more than £8bn a year, but the committee was unable to identify what the money had achieved. It was 'unacceptable' that it was impossible to evaluate spending or outcomes, it said. There was concern over the lack of progress towards a shift in the balance of care. Authorities' challenges include budget-setting, measuring outcomes and shifting resources to make transformational changes.

October's operational performance figures for England showed some improvements, but more people waited for elective care. NHS England said 90.1% of patients in A&E were seen within four hours, compared with 89.7% in September 2017 and 89.1% in October 2016. There has been a reduction in delayed transfers of care, with an average of 5,610 beds occupied due to delays each day in September compared with 6,552 a year earlier. There was a 5.1% increase in the number of patients starting elective treatment in the past 12 months, but in September more than 3.8 million people were on the waiting list – 3.8% higher than a year earlier. At the end of September 89.1% had been waiting for fewer than 18 weeks – the figure stood at 90.6% in September 2016.

hfma

from the hfma

Among the blogs on the HFMA's website in November is a commentary on the latest *NHS financial temperature check*. HFMA head of policy and research Emma Knowles looks at the Q2 provider and commissioner financial positions in the context of the Budget and the results of the temperature check survey. The latter showed finance directors are concerned about their ability to deliver their financial targets this year. Ms Knowles concludes that difficult choices will have to be made about the use of NHS funds.

Bill Shields (right) continues his blogs from Bermuda, where he is the territory's hospitals board chief financial officer. In his latest instalment, he describes how patients in need of social care, rather than healthcare, are looked after, and the local tariff, which includes many perverse incentives and disincentives.

The HFMA has published a new tool to help organisations that are undergoing a structural reorganisation such as a merger. With clinical commissioning groups consolidating and more system-wide working generally, be it through accountable care systems, devolved health arrangements, sustainability and transformation partnerships or other organisational forms, this aims to be a °practical checklist for finance teams.

The HFMA and CIPFA have also produced a joint glossary of terms used in the NHS and local government, which includes a brief overview of the structure and funding flows in both sectors in England.

• To read any of these blogs or publications, visit www.hfma.org.uk or download our new app

News analysis

Headline issues in the spotlight

Questions, questions

The Budget brought an unexpected financial boost for the NHS, but few believe it is enough. Seamus Ward reports

As far as the NHS in England is concerned, last month's Budget feels like winding the clock back to the 1980s and early 1990s. During those years, often in the face of an impending difficult winter, non-recurrent funding was found – money that often had to be spent within the remaining three or four months of the year.

Of course, an extra £2.8bn in revenue and £3.5bn of capital over the next few years is to be welcomed, but questions remain about the impact it will make.

Chancellor Philip Hammond made £335m immediately available to the NHS to address winter pressures. In 2018/19, the NHS will receive an extra £1.6bn in resource funding, taking the overall increase in revenue to £3.75bn next year. A further £900m will be allocated in 2019/20 to address future pressures.

The chancellor does not directly allocate funding to health services in the devolved nations – that is a decision for their administrations. But he said that as a consequence of the decisions made in his Budget, the administrations' overall budgets would increase. The Scottish government would receive an extra £2bn, the Welsh government £1.2bn and Northern Ireland £650m.

It appears the funding for the NHS in England is non-recurrent. Compared with figures set out in the Spring Budget, overall health revenue funding in England, including NHS funding, is now planned to be £1.6bn higher in 2018/19 and about £1bn higher in 2019/20.

As in the last spending review, the promise of additional funding is for NHS services, not the Department of Health as a whole.

In his Budget speech to the House of Commons, Mr Hammond recognised the pressure faced by the NHS. 'I am therefore exceptionally, and outside the spending review process, making an additional commitment of resource funding of £2.8bn to the NHS in England,' he said.

Immediately after the Budget statement, there was some debate about the word 'exceptionally', but it seems the chancellor was stressing the one-off nature of allocating additional funding outside the spending review process.

Unusually, in the run-up to the Budget, NHS England had joined pressure groups and think-tanks in calling on the chancellor to increase health funding. A figure of £4bn was widely used – a joint Budget submission by the Health Foundation, King's Fund and Nuffield Trust said at least a further £4bn was needed in 2018/19 to meet demand and avoid longer waiting times, rationing and a deterioration in care quality.

Following the Budget statement, NHS England chairman Sir Malcolm Grant said the extra money would go only 'some way towards filling the accepted funding gap'. And he said the country could 'no longer avoid the difficult debate' about what the health service could deliver for patients.

This echoed Simon Stevens' speech to NHS Providers' annual conference in November. The NHS England chief executive said: 'The budget for the NHS next year is well short of what is currently needed to look after our patients and their families at their time of greatest need. After seven years of understandable but unprecedented constraint, on the current budget outlook the NHS can no longer do everything that is being asked of it.'

Health Foundation director of research and economics Anita Charlesworth told a *British Medical Journal* discussion on the Budget that the additional funding for 2018/19 would help relieve the emergency pressures, but it would not be enough to also tackle the waiting backlog.

"After seven years of understandable but unprecedented constraint, on the current budget outlook the NHS can no longer do everything that is being asked of it"
Simon Stevens, NHS England

'The fear is that the debate will not be addressed. And the service that really suffers is one that is much less visible politically but really vital – mental health, community nursing.'

It could be argued that this process of taking tough decisions is already under way, with some commissioners restricting access to certain procedures, including IVF.

For the past few years, NHS funding has been notified well in advance to promote good planning and best value for money. But many in the NHS will feel that it will be difficult to spend the additional £335m for this year well.

'It's hard to see how you can spend that money in a value-for-money way,' said King's Fund chief analyst Siva Anandaciva. 'You can buy extra capacity for operations from the independent sector; you can get more staff on temporary contracts, but all of this would have been more effective if the money had been given earlier in the financial year.'

The additional funds are tied to improvements in efficiency and productivity – Budget papers said additional funding should allow the NHS to meet the four-hour A&E target next year, make inroads into waiting lists and improve performance against waiting times.

Social care was not mentioned in the chancellor's speech – perhaps because it received an additional £2bn over three years in the Spring Budget – but the sector remains challenged.

Ms Charlesworth suggested the NHS could usefully use some of its additional £335m to purchase extra social care packages over the winter. This could reduce delayed discharges and free up beds.

According to the latest NHS performance figures, delayed discharges due to issues in the health service are down, but the number due to lack of available social care is up.

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The Budget was expected to allocate an additional £10bn in capital funding to the NHS and, though this is the headline figure mentioned in the statement, Exchequer funding will amount to £3.5bn over the next five years. This is on top of the £425m announced in the Spring Budget. The chancellor said this is the government's share of the £10bn investment recommended by the Naylor review of NHS property and estates earlier this year.

The £3.5bn of new capital funding will be divided into three lots:

- £2.6bn for sustainability and transformation partnerships (STPs) to transform and integrate care
- £700m to support turnaround at trusts facing the biggest performance challenges and to tackle urgent maintenance issues
- £200m to support efficiency programmes, such as schemes to reduce trust energy costs or to introduce technology that will allow clinicians to spend more time with patients.

Alongside the Budget, the government announced the provisional allocation to 12 STP schemes, using up to 10% of the £2.6bn available.

But with around £4bn coming from the Treasury, the NHS will have to find another £6bn to meet the capital needs estimated in the Naylor report. The Treasury said its capital funding allocation should allow the NHS to increase the proceeds of sales of surplus estate to at least £3.3bn. The Naylor report estimated the NHS could release £2.7bn, so the service has been set a stretching target.

There is also the question of where the surplus land and estates sit. A large proportion is in London, but will organisations in the capital hold on to the receipts or will some go to the regions?

A clue could lie in the *Memorandum of understanding* on the London health devolution, released in the same week as the Budget. This recognised the need for equitable distribution of receipts from sales, but the principle of equity also meant that the higher cost of development in London should be recognised. Health and social care systems needed incentives to release surplus land, it noted. In principle, NHS trusts and foundation trusts could retain capital receipts.

Could the balance of the £10bn of capital come from private finance? The Budget documents said this source of funding could be used where it provides good value for money.

New pay deal?

Pay was the third big issue addressed by Mr Hammond. While the government had said it would lift the 1% cap on pay increases in the NHS, Mr Hammond did not set a figure – preferring not to prejudge the work of the pay review bodies.

In a further development, he revealed that the Department and NHS unions had initiated discussions on a new deal for Agenda for Change staff. He pledged to fund any deal on condition that it improved productivity and was justified on the grounds of recruitment and retention.

'I want to assure NHS staff and patients, that if the health secretary's talks bear fruit, I will protect patient services by providing additional funding for such a settlement,' he said.

But can the pay of nurses, physiotherapists or finance staff – all on Agenda for Change pay scales – be linked to NHS productivity?

First of all, the government and the unions would have to agree a definition of how productivity could be measured – could it be calculated on an individual, team, organisation or national level, for example? And with so many factors influencing productivity that are out of the control of individuals or even teams – for example, staff shortages – would it be fair?

Mr Anandaciva said it's more likely full funding from the Treasury of any pay rise will be linked to reform of terms and conditions that emerges from the pay talks.

The Royal College of Nursing was pleased the government had listened to union campaigns to lift the 1% ceiling. But chief executive Janet Davies warned of the dangers of linking a pay rise to nurses working harder.

'The NHS has been running on the goodwill of its staff for too long, and with more talk of reform and productivity, [the chancellor] runs the risk of insulting nurses who regularly stay at work unpaid after 12-hour shifts. Their goodwill will not last indefinitely.'

The focus on Agenda for Change means medical workforce pay was not addressed in the Budget, leaving further questions. Does this mean doctors and dentists will not receive a pay rise above 1%? If they do, will it be linked to further contract reform?

And who will pay for medics' pay rise? The chancellor has only given an assurance that AFC pay rises will be covered, subject to his caveats on productivity, recruitment and retention. Long-term discussions over a new consultant contract have yet to bear fruit.

The Budget brought some relief to the health service in England – new, though apparently non-recurrent, revenue has been allocated; some capital funding has been found; and there is a promise to fully fund AFC pay rises. But it all comes with further questions and strings attached and no-one is convinced there is enough to cure the service's current ills.

Comment

December 2017

Don't stop believing

Together, let's aim to achieve what at times may again feel impossible

HFMA president Mark Orchard

The aggregate mid-year financial results for the NHS in England confirm the immediate challenges faced by colleagues striving to support the delivery of safe and effective services in a cash-constrained environment. This challenge is equally felt across all three devolved nations and reflects a UK economy unable to support NHS investment in line with either demand or meaningful per capita comparisons.

Neither the provider financial performance to quarter two, nor the consolidated commissioning system results to month seven, will be a surprise. Indeed, the results simply support member responses to our latest HFMA *NHS financial temperature check*.

November's Budget announcements were therefore entirely welcome, albeit substantially less than we may have hoped.

But the NHS has again been singled out from all other public services – this time on supporting a funded pay review.

Indeed, the extra revenue made available for this winter and next year should enable health systems to be more resilient than would have otherwise been the case, even if this funding is not automatically available again in later years.

So where does that leave us today? Let's first assume – despite the immediate lack of clarity – that all the new funding for England is available for optimal deployment in local systems. Let's also assume each of the three devolved nations will

Key questions remain

New funding is welcome but questions still need to be answered

Healthcare Finance editor Steve Brown

In making his Budget speech last month chancellor Philip Hammond insisted there was 'no single magic bullet' to solving the housing crisis. There was also no evidence of the much talked about magic money tree when he turned his attention to the Budget's other key issue – the NHS.

There were extra funds – this year and for the next two years. But the sums fall far short of the amounts needed to face the service's urgent and growing financial challenges.

The £335m 'to help the NHS increase capacity over winter' in the remainder of this year is undeniably welcome. However, the context, as is underlined by the HFMA's latest *NHS financial temperature check* (see page 21), is that this figure represents less than half the deficit/overspend that providers and clinical commissioning groups were forecasting for the year-end at the half way point in the year.

Some commentators have pointed out that the late allocation of the funds makes it harder to spend in a value-for-money way than if local organisations had been able to plan for the extra funds. This is definitely the case. However, even if in reality the extra funds go straight to the bottom line, reducing those forecast deficits, it will be of value.

Quarter two figures show that 111 providers were (pre-Budget) expecting

to be in deficit by year-end. Month seven commissioning sector figures from NHS England make similarly uncomfortable reading (see page 3).

Extra funding that moves

"Thank you for the support you have shown to your colleagues again in 2017"

receive a timely equivalent distribution of funding.

We know the extra revenue (and capital), though welcomed by service commissioners, providers and users, will simply not be enough to consistently achieve the levels of performance standards prescribed by the *NHS constitution*.

We know the underlying financial position of many NHS organisations – the 'normalised run-rate' after adjusting for non-recurrent short-term and often non-cash measures – will not be reversed by non-recurrent funds. This is despite NHS productivity often outperforming comparative health productivity worldwide, as well as our own wider UK economic productivity measures.

But without any doubt, we know that working alongside our service colleagues, NHS finance will continue to support the highest possible standards of service and care within cash limits.

We all know the frequent difficult judgements, choices and risk-based decisions this demands. It is often for this reason that we do what we do. In uneasy times, we make the most difference.

Together, our professional network has in recent years supported the achievement of what many saw as impossible. NHS finance has provided incredible leadership, direction and momentum against which colleagues have been able to thrive.

Despite the extra funding announced in the Budget, we have further significant challenges ahead. Thank you for the support you have shown to your colleagues again in 2017. I am confident we can continue to count on each other for the remainder of this year, next and beyond. And together, we can continue to achieve what at times may again feel impossible.

Contact the president on president@hfma.org.uk

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organisations closer to control totals will reduce the pressure on organisations that are battling pressures and demands, many of which are outside their direct control.

If nothing else, that should lift morale a little and maybe stave off some – but not all – difficult decisions on further cost improvements in the remainder of the year.

The additional funds for 2018 and 2019 are also clearly welcome, although there are lots of questions still to be answered about the seemingly non-recurrent nature of these funds and the realism of tying them to improvements in efficiency and productivity (see *Questions, questions* page 10).

There will be a lot of head-scratching about the government's plans to meet the capital investment requirements identified in the Naylor review – particularly around the level of ambition in asset sales and on the role of private finance.

The additional funding certainly improves the service's prospects, but in no way does it solve the sustainability question. Providers will carry underlying deficits into the new financial year and be expected to make progress on access targets while also targeting moves towards a reduced deficit or balanced position.

There is good agreement that new models of care – more prevention, more support in community settings and earlier intervention when appropriate – hold the key to delivering more sustainable services.

The debate continues to be around how quickly the NHS can be expected to deliver these new models and how it copes with very significant demand pressures in the meantime. Having to continually firefight in-year finances is not the best platform on which to develop plans for transformation.

"Having to continually firefight in-year finances is not the best platform on which to develop plans for transformation"

The question about funding and timeframes has not been changed by the recent Budget announcement. The pitch of the warning bell has merely dropped a notch or two.

The reality is that the NHS faces difficult decisions about what it can deliver with the money available – a point underlined in NHS England's pragmatic board paper at the end of November setting priorities for next year and being clear about what can't be achieved.

NHS England chief executive Simon Stevens evoked the Brexit battle bus in a pre-Budget presentation, suggesting that Leave Europe voters would expect promises to better fund the NHS to be honoured. The point is that a properly resourced health service is a key priority for the public and it now needs to continue to be engaged in the very real challenges facing the NHS.

Merry Christmas and best wishes for 2018 from all at **Bellis-Jones Hill**

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up and running

Three years since plans were unveiled to transform costing in the NHS, the service has completed a patient-level cost submission at scale and the data has been shared with participants. NHS Improvement costing programme director Colin Dingwall believes this is a key milestone for the programme. Steve Brown reports

The push to produce more robust and detailed costing data across the whole of the English NHS has reached an important tipping point, according to NHS Improvement costing programme director Colin Dingwall. However, there is still significant work ahead, with the next year being particularly critical.

Three years ago this month NHS Improvement – or Monitor, as it was then – set out its proposals for a new approach to costing. Its Costing Transformation Programme (CTP) would see the whole service costing activity down to the patient level, with a single submission of data replacing three pre-existing collections (reference costs, education and training costs and a voluntary patient-level cost submission).

Crucially the new approach would require organisations to adhere to new common costing standards – earlier adopters of patient-level costing had used logical but varied approaches. Adhering to detailed new standards would not only support local decision-making, but would open the door to more straightforward benchmarking across providers and better inform national price-setting.

Since then, there have been two versions of new costing standards for acute providers, draft versions for mental health and ambulance service providers – with only community services yet to see their own dedicated costing guidance (this is due to follow early in 2018). And while this requires more of costing teams, we are also seeing the first steps towards the promised single collection.

Next year will see the first combined collection for reference costs and patient-level costs. And in November NHS Improvement consulted on proposals to mandate the collection and submission of patient-level cost data using the standards from the year after (covering financial year 2018/19 onwards). This is an essential step towards enabling the regulator to switch off reference costs at some point downstream – submission of which is currently a licence condition for providers.

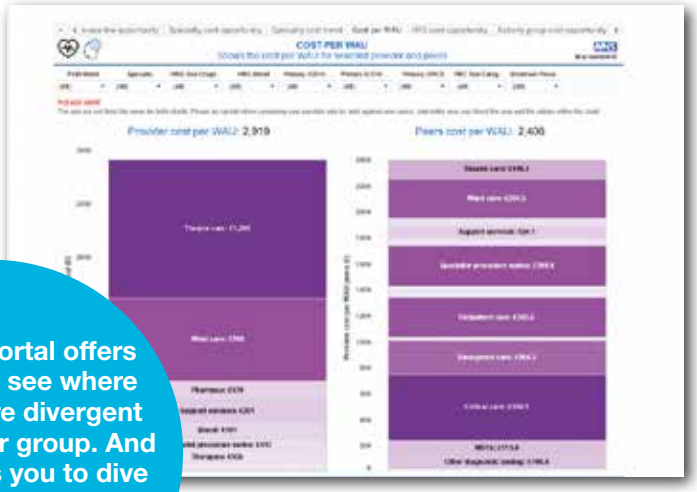
So there has been huge ground covered, but for Mr Dingwall the tipping point is the fact that this year over 60 acute trusts submitted cost data to NHS Improvement using the new standards – representing about £20bn of NHS spending. In addition, so far, 28 trusts have subsequently been given access to a new portal, enabling them to analyse their own data and compare it with all participating providers or a chosen set of peers. Other trusts will get access to their data in the coming weeks.

Delivering value

Robust costing data is not an end in itself – it is using the data to identify and drive improvement that delivers the real value. So enabling providers to start this analysis and comparison through the portal is a key milestone.

'We are starting to get traction,' says Mr Dingwall, who has worked on the CTP since 2015 and has just been appointed to the director role. 'We've spent two to three years piloting and rolling out the standards and we've now got real data to work with. It feels like a tipping point.'

The data has got a lot of people quite excited. 'I've really detected a shift in how much importance is attached to costing among costing teams, clinicians and colleagues across the NHS,' adds Mr Dingwall.



> **The PLICS portal offers "a chance to see where your costs are divergent from your peer group. And it encourages you to dive in and see why you are different"**
> **Colin Dingwall, NHS Improvement**

Reference costs continue to be of value, but there are limitations – too much averaging and an inability to drill down into the averages to see what is driving costs.

Patient-level costs is a potential game changer – still enabling comparison at specialty or HRG level, but also allowing organisations to drill down to see how individual patient costs have contributed to this average. Or they can look at components of overall costs – theatres or pathology, for example – again, at an aggregated or individual patient level. This will help identify and understand variation.

NHS Improvement's teams looking at operational productivity, the Model Hospital and *Getting it right first time*, as well as NHS England's RightCare programme, have all shown a real interest in the more detailed cost data, says Mr Dingwall. They all recognise the huge potential in being able to look at variation in outcomes and pathways and link this to firm patient costs – within individual organisations at first and across whole pathways in time.

Mr Dingwall describes the current position as 'a huge achievement', recognising that it is very much down to the efforts of costing teams and patient-level information and costing system (PLICS) suppliers. However, he stresses that there is still a long way to go. 'Next year will be critical,' he says.

Rolling out

The 60 or so trusts that submitted costs covering the 2016/17 financial year represent the majority of the 78 trusts that had indicated they wanted to take part. They also make up 40% of all acute trusts. Having proved the submission process works at scale, next year the plan is to add as many as possible of the rest of the acutes, along with early implementers from other sectors.

The point is to get organisations used to the process – collecting, submitting and resubmitting after having data quality issues highlighted. 'Getting clinical engagement and the quality of the data up will be a challenge that will be with us for the next few years,' says Mr Dingwall. 'But I feel like the building blocks will be in place and we can start doing some really good work.'

NHS Improvement opened its PLICS portal in October, with 28 trusts being given access to their activity and cost data to help them identify productivity opportunities. 'It's a chance to see where your costs are divergent from your [self-selected] peer group,' says Mr Dingwall. 'And it encourages you to dive in and see why you are different.'

Users can look at costs by service line, HRG or specialty, and they can see their cost per weighted activity unit (WAU) – the weighted activity unit introduced by the Carter review. They can look at this at the component level – for example, pharmacy or radiology costs per WAU – and in due course they can see trends over time.

On their own data, users can drill down to the patient level for different procedures and treatments. And a new data quality tool will also help organisations with the quality of their submissions – highlighting where trust data lies outside the typical range and potential data issues to investigate.

Organisations are still getting used to the new approach laid out in the standards and not all organisations have the feeds in place to supply the required information to allocate all costs accurately across patients.

'There are of course some data quality issues – but this is a shared challenge and we'd rather push the data out and work with trusts on those issues, because they know what's going on in their trusts', says Mr Dingwall. 'In fact, if we don't take on the data quality challenge, we will never get the cycle of improvement.'

He says trusts have to embark on a 'long iterative path' to improve quality, but that clinical challenge is a core part of the process.

This year, patient-level cost submitters were given additional time to submit reference costs. Next year, the parallel collection of reconciled sets of both costs will be a challenge to costing teams.

But if the submissions reconcile and the new system is shown to work, NHS Improvement says, 'from 2019 we expect there to be a single national cost collection for acute services'. These costs would then replace reference costs in informing the tariff.

Avoiding this year's late release of the reference costs grouper should help reduce some stress, but there is another measure that aims to reduce the burden of collection. The integrated education and training reference costs submission will not be required next year. Instead reference costs will be submitted net of education and training income.

This is a one-year only measure and only relaxes the requirement to

submit data. 'Education and training needs to be costed every year,' says Mr Dingwall. 'If you are spending any significant amount of money, you should be able to monitor and manage your costs.' As well as reducing the burden on costing teams, this will enable the education and training costing process and tariffs to be refined (see box).

Acute trusts face the earliest deadline for switching to patient-level costing. During October and November, NHS Improvement consulted on making it mandatory for acute trusts to report patient-level costs in line with the standards from 2019 (covering the 2018/19 financial year). Mr Dingwall is confident this can be achieved.

Some 84% of acute trusts have implemented a PLICS system. A further 10% are mid-implementation and the rest are planning implementation. But again, he encourages all trusts to take advantage of learning from next year's voluntary submission. He says suppliers are more experienced this year to support new submitters and a further package of support is being planned by NHS Improvement for both first-time and repeat submitters.

He also insists the focus is not solely on acute providers. Ambulance services have taken the programme 'very seriously', with four pilot trusts submitting data this year and he hopes that more trusts will get involved next year. Mr Dingwall believes the data from this part of the exercise will be a critical step forward towards gaining a better appreciation of the whole patient pathway. There has been good progress too with mental health and community service providers, he says – a mental health pilot collection was under way during November. However, the sheer volume of work being undertaken and the need to support different collections next year means that NHS Improvement is now planning to phase some of its outputs over the next year.

Changed timetable

So January will see publication of the third version of acute and second version of ambulance standards, along with transitional education and training standards for use in 2018. Then there will be a second publication in March of mental health (version 2), community (version 1) and draft education and training standards, setting out the PLICS-based approach to costing training activities.

Although the phasing is a reflection of the workload at the centre, Mr Dingwall also says it is important that NHS Improvement is able to give 'very specific attention to each sector' rather than publishing everything at the same time and then being spread too thin to support everyone.

He is full of praise for the costing community. It is supportive of the programme, willing to engage and demanding of information. But there have been suggestions that finance directors have yet to fully engage with the costing agenda. Mr Dingwall admits the programme has focused

The price of education

Education and training tariffs were introduced in 2013 to remunerate providers for the costs they incur delivering medical and non-medical training. However, these interim tariffs were relatively blunt – effectively one rate for each placement type: non-medical; undergraduate medical; and postgraduate medical – all based on a placement fee with the postgraduate medical tariff also including some salary support.

Since then, trusts have been required to submit cost data based on revised guidance covering their training activities. This has served two purposes – to improve costing information for both training and service costs and to help develop training tariffs that more accurately match the costs of delivering training.

Data from the first three years of training cost collection have been used to design a new currency – known as education resource groups – and this will be subject to a stakeholder engagement exercise in 2018.

Under the new proposals for non-salaried training (undergraduate and non-medical), there is likely to be a single currency for each profession – for example, adult nurses, mental health nurses, pharmacy technicians and radiographers.

For the salaried postgraduate medical placements, groups would be focused on the foundation years, core training and higher specialty training – with tariff split by specialty. This reflects the fact that the cost phasing can be different in different specialties – neurosurgery requiring more consultant support in the late stages of training, for example.

The postgraduate tariffs are likely to be in a similar 'placement fee plus variable element' format, linked to salary levels, although not a direct percentage.

Jennifer Field (pictured), head of finance strategy at Health Education England – the body tasked with developing the new currency – says any proposed changes to tariffs will need a full impact assessment and there would potentially need to be some transition.

'But there would not be the same big gains and losses that accompanied the introduction of the interim tariffs in 2013,' she says. The cost data collected to date suggests that, overall, NHS providers are paid less for training than it costs, indicating some cross-subsidisation between service and training. This is not across all activities, however. 'The tariff for medical placements is higher than the costs, but the payment for non-medical is lower than trusts say it costs,' she says.

This may not change funding overall for a trust – as most will provide both medical and non-medical training. But a more detailed currency and robust costs would enable prices to be set to cover specific costs, enable funding to flex with training activity changes and allow the Department to incentivise increases in activity where appropriate.

There will be no education and training cost collection next year (covering 2017/18), although trusts are encouraged to keep costing activities locally. Guidance for netting off training income (for 2017/18) will be released in January with new costing standards – putting training costing guidance into the NHS Improvement format – in March.

The sector's feedback to the proposed currency will be reviewed, although April 2019 is the first time the new currency could be introduced.

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more on working with costing teams and has had 'less opportunity' to engage with directors so far. But they are vital to the success of the programme as they, along with their board colleagues, are key to properly resourcing the initiative and then changing organisational processes so that costing data is used routinely to drive improvement and inform decision making.

> **"Our attention has been on getting the technical building blocks in place. Our focus will shift in the coming months to concentrate more on finance directors"**
> **Colin Dingwall**

However, he suggests that they instinctively understand they should be doing this – underlined by the fact that every acute provider has made a business case for PLICS. He points out that there has also been a good response so far to the invitations to submit data voluntarily.

'Our attention has been on getting the technical building blocks in place,' says Mr Dingwall. 'Our focus will shift in the coming months to concentrate more on finance directors than we have so far.'

He is clear that patient-level costing has to be about more than submitting better quality data – it has to be used in local health systems. 'If this becomes about compliance, we will have the same problems that we have had with reference costs,' he says.

However, he believes there is genuine enthusiasm for the data, not just among the various initiative leads (such as GIRFT and the Model Hospital), about how costing can lead to better outcomes. For example, the NHS Improvement team is already engaging with the nine pilot accountable care systems. 'It feels like we are pushing at an open door and there is a lot of demand there.'

Mr Dingwall argues that the case is compelling and finance directors understand this. The consultation on mandating collection for acute activity suggests a mandated approach would cost no more than the current 'business as usual' (mandatory reference costs and voluntary patient-level costs slowly getting dropped over time). The average annual cost of this steady state for a trust is estimated to be £225,000 a year, compared with £222,000 for the patient-level approach.

While the impact assessment makes no attempt to quantify the service-wide financial benefits of mandated patient-level costs, it offers a range of examples where recurrent benefits far outstrip costs. 'Each example we've found shows that the costs of using patient-level costs are typically recouped by just one use of the data,' says Mr Dingwall. 'The business case is fairly self-evident.'

There are plans to work with NHS Digital and NHS England on bringing cost data together with outcome data. And new costing regional forums, being run in conjunction with the HFMA, aim to build knowledge, capability and confidence on how to use cost data to deliver value. These discussions aim to involve non-costing practitioners too, including clinicians, informatics and transformation managers.

Mr Dingwall insists he is not downplaying the challenges that still lie ahead. He recognises that the current financial position means that time – to improve costing and to start using patient-level cost data in discussions with clinical teams – is limited. But the service has turned a real corner with this year's release of data back to the service.

The quicker organisations start to mainstream use of robust cost data, the sooner it can start to help ease financial pressures. 'Yes, there is an overhead to patient-level costing, but the benefit coming out is potentially very significant,' he says.

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-Rachel Lei, Costing Accountant, Royal National Orthopaedic Hospital NHS Trust

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-Rosalyn Davies, Chief Corporate Accountant, Mid Cheshire Hospitals NHS Foundation Trust

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Taking the pulse

The latest HFMA NHS financial temperature check shows that finance leaders are concerned they will not be able to deliver challenging financial plans this year. Seamus Ward examines the findings

While the additional NHS funding announced in last month's Budget was welcomed, it was generally agreed that it was not enough. Even NHS England chair Sir Malcolm Grant reportedly spoke of a difficult debate that would be needed to decide commissioners' priorities. Phrases like 'tight financial climate' or 'significant deficit' are now used so often when describing the NHS that they are almost accepted as normal. But the financial challenge facing providers and commissioners is real and it is laid out in detail in the latest HFMA *NHS financial temperature check*.

The temperature check outlines the financial performance figures for the NHS in England at month six. The provider sector reported an aggregate deficit of £1.15bn halfway through 2017/18 – after including the £630m sustainability and transformation fund (STF).

While 87 trusts reported an adverse variance against plan, 152 said they were in deficit after six months of the year – 63 trusts (27%) forecast they would have an adverse variance from plan at year-end, with 111 forecasting a deficit. For the full year, trusts forecast that they will report an aggregate £623m deficit, after receipt of the £1.8bn STF – a deficit that would be £127m more than planned.

At the six month point, CCGs had overspent against plan by £186m, with 83 reporting an overspend. Twelve CCGs are predicting they will end the year with an overspend on their budgets – with an aggregate overspend of £96m forecast for year-end. Subsequently, month seven figures suggested that, when all risks were taken into account, the underlying CCG overspend could be £500m at year-end.

The HFMA welcomed the Budget funding injection of £335m to help the NHS cope with winter pressures in 2017/18. However, it pointed out that this was less than half the combined month 6 forecast provider deficit (£623m) and commissioner overspend of £96m. And it said NHS organisations will have to move quickly to change their plans if the additional funding is to have a significant impact on this year's winter pressures.

Looking at the wider financial outlook, HFMA head of policy and research Emma Knowles says most finance directors feel they are working in a system that has less funding than they think is needed. 'The additional money will not be sufficient to resolve the financial pressures. Finance directors are calling for more openness about NHS resources and what is affordable. There is no doubt that difficult choices will need to be made about the use of NHS funds,' she adds.

Despite the forecast deficit this year, the temperature check said providers had delivered significant savings, totalling £1.26bn in the first six months of the year (£169m below plan). Over the year, savings plans totalled £3.7bn and trusts forecast they would fall short of this figure by £210m.

CCGs also fell shy of their efficiency savings plan, reporting savings of £1bn (£1.2bn planned) at month six. At year-end, they forecast savings will be £443m less than the planned level of £3.1bn.

While many organisations were able to use one-off measures to improve their figures

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in the second half of 2016/17, there was much less scope for doing so once again in the current financial year. The temperature check stated: 'The scale of the challenge to turn round the reported mid-year position and deliver the year-end forecasts should not be underestimated. NHS organisations are delivering more care to patients, but the increase in activity levels has not been matched by increased funding.'

Overall, the picture is of a service striving to hit ambitious savings targets, largely using recurrent measures. Just over three-quarters of trust savings in the first half of the year were recurrent, though this fell short of the planned proportion (the plan aimed to have 92% of savings as recurrent). And the level of recurrent savings is similar to the proportion recorded at the same point in 2016/17.

This national picture, reported by NHS Improvement and NHS England, was backed up by the temperature check survey of finance directors and chief finance officers. Finance directors and chief finance officers from 80 provider trusts (34%) and 56 clinical commissioning groups (27%) responded.

The survey said 38% of CCG chief finance officers and 40% of provider finance directors believe there is a high level of risk in their organisation's financial plans. Perhaps unsurprisingly, 71% of CCG finance leads and 66% of their provider peers were not confident that recurrent savings plans would be delivered.

The HFMA acknowledged that the level of pessimism among finance managers was similar at the same point in 2016/17. But finance leads were more pessimistic this year about their ability to achieve non-recurrent savings. It said 39% of commissioner chief finance officers and a third of provider finance directors were not confident they could deliver their plans for one-off savings. With a greater proportion of savings pencilled in for the second half of 2017/18, the second six months will prove challenging for the service.

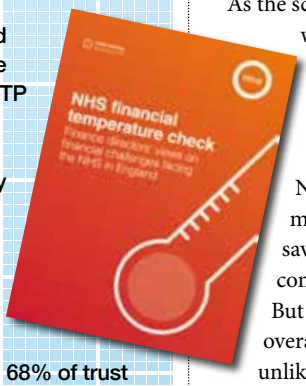
Threats to balance

Finance directors and chief finance officers set out the biggest threats to financial balance – missing savings targets, agency staff costs, winter pressures, increased demand and delayed discharges. CCGs added that prescribing and continuing healthcare costs could also pose risks to their financial position.

The prescribing cost pressure may relate to the lack of availability of some generic drugs – they are being substituted by more costly branded medicines. This additional cost is not reflected in the reported financial positions.

Other findings

- 56% of CCG finance chiefs and 65% of provider finance directors said their 2017/18 control total was less achievable than the control total for 2016/17
- 69% of trust finance directors and 54% of CCG chief finance officers (CFOs) said leaving the European Union posed a medium or high risk. Recruitment and retention of staff, general cost inflation and increased drugs costs were the main concerns
- 59% of CCG CFOs and 71% of trust finance directors do not expect the additional £2bn social care funding, announced in this year's spring Budget, to have a material impact
- Although relationships between organisations in sustainability and transformation partnerships (STPs) are improving, 43% of CCG CFOs and 60% of trust finance directors remain concerned about governance. Alignment of STP decision-making with organisational accountability remains the key governance concern
- 81% of CCG CFOs and 78% of trust directors are not confident that their STP has the ability to deliver a plan to help close the funding gap by 2021. Key issues raised include the lack of capital for transformation and differing regulatory approaches
- 87% of CCG CFOs and 68% of trust finance directors believe NHS England and NHS Improvement should merge



Almost a fifth of trust finance directors and 23% of their CCG counterparts expect their year-end position to be worse than plan, while around one in 10 commissioner and provider finance leads believe their final financial position will be better than plan.

The survey was taken after the government indicated it would relax the 1% cap on rises in public sector pay, and clearly this issue concerned finance managers. Three-quarters of respondents believed the cap should be lifted, but only if the cost is funded fully by the government. Only 2% said the cap should go even if no additional funding is made available.

Over the past year, national organisations have urged greater consolidation of back-office functions to ensure as much as possible is spent on frontline patient care. Much of this is based on Lord Carter's report on efficiency and productivity in the NHS, which recommended that corporate and administration costs should be no more than 7% of income by April 2018, falling to 6% by April 2020.

According to the survey, 94% of respondents' organisations were exploring consolidation to reduce costs and increase efficiency. More than half of respondents were considering consolidating payroll, procurement, human resources, information technology and the finance function.

Impact of Carter

Programmes such as the Carter-inspired Model Hospital, as well as *Getting it right first time* and NHS RightCare, aim to support the Carter vision of saving £5bn a year by identifying and eradicating unwarranted variation. Asked how implementation of these programmes had affected organisations' finances, 58% of acute providers reported a slight improvement and 7% a significant improvement. A third said there had been no impact and 2% a slightly negative impact.

As the scope of the Carter recommendations widens into mental health, community and specialist services, it is likely their impact will increase, the HFMA said.

There are positives in the current NHS landscape – the service is making unprecedented levels of savings and productivity is high compared with the rest of the economy. But this year's targets are stretching and, overall, finance directors feel they are unlikely to be achieved.

Despite the financial picture, most respondents in the HFMA survey believe that the quality of patient care will stay broadly the same this year. The association defined quality as 'services that are patient-centred, safe, effective, efficient, equitable and timely'.

However, 21% of CCG finance leads and 15% of trust finance directors think it will deteriorate. On the other hand, 21% of CCG and 23% of trust finance directors believe it will improve.

Though the proportion remains small, an increasing number of finance directors think that patient outcomes or patient safety are at risk. More money than expected has been allocated to the NHS. It is less than many in the service believe is needed. But is it enough to ensure finance directors' darkest fears about outcomes and safety never happen?

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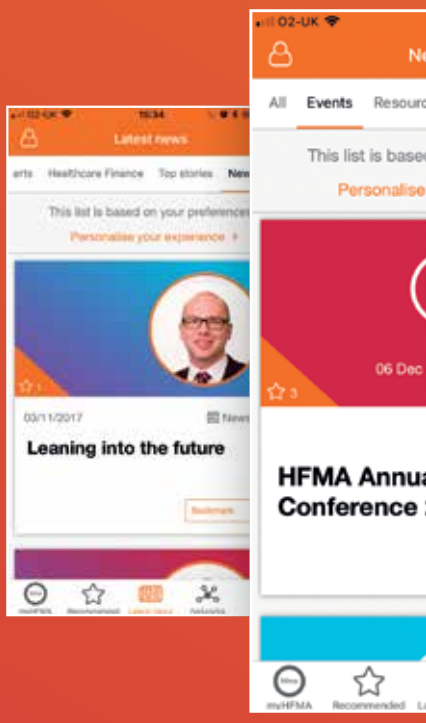

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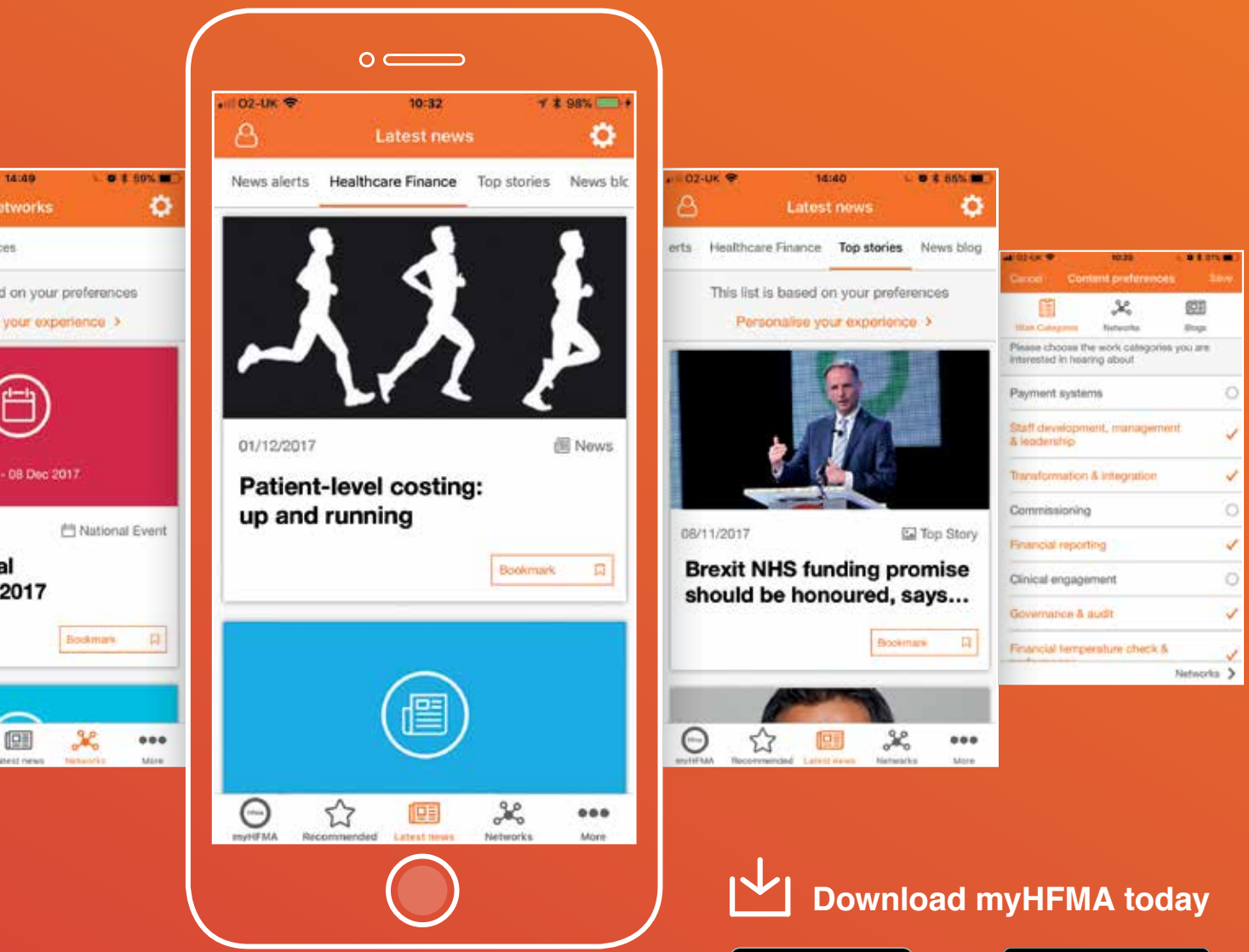

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A new dawn

Rising demand and the impact of service transformation has created an urgent need to reform general practice. Seamus Ward reports on how primary care is adapting

Last month there was uproar as online GP provider Babylon Health started offering its services to patients in London. GP leaders warned that the provider would cherry-pick younger, less costly patients, leaving traditional general practices with older, frailer patients with chronic illnesses and comorbidities.

Babylon Health, which operates under a general medical services contract, offers patients the ability to book an appointment in seconds via an app and then have a video consultation with an NHS GP, typically within two hours of booking. If needed, a face-to-face appointment can be booked on the same day or the next day at clinics in central London, Monday to Saturday.

To use corporate lingo, this is disruptive technology – tech that tears up a long-held way of doing things by being more efficient, more effective and consumer driven. But NHS England had already begun updating general practice in response to rising demand and the need to cater for services coming out of hospital. Last year's *General practice forward view* boasted that its plans would likely produce a triple revolution – modernising general practice as a career, as a business and as a way of delivering services to patients.

The GP forward view said NHS England would work across five areas – investment, workforce, workload, infrastructure and care redesign. The latter includes the new models of care vanguards, particularly multispecialty community providers (MCPs), although primary and acute care systems (PACS) are also creating vertical integration between primary and secondary care (see box).

Speaking at last month's HFMA Commissioning Faculty conference on the future of general practice, Arvind Madan, NHS England's director of primary care and deputy medical director, said the forward view committed NHS England to increasing spending. Speaking before the Budget, he said this would rise from £9.6bn in 2015/16 to £12bn in 2020/21, a 14% real-terms rise when the rest of the NHS gets 8% more.

More than £27m has been spent on practice resilience so far, which provides support for 2,100 practices, with a similar amount to come over the next three years.

NHS England is funding GP clinical insurance this winter and the Department of Health is seeking to set up a state-backed indemnity scheme. It has also pledged to fully reimburse the costs of Care Quality Commission inspections.

Staff exodus

Some surveys have shown that a third of GPs are looking to leave the profession in the next five years, including two-thirds of all family doctors aged over 50. The NHS clearly needs the additional 5,000 whole-time equivalent GPs by 2020/21 promised by the forward view. This number includes specialists working in general practice and GPs in training.

Outside of this, NHS England is working to develop the wider primary care workforce,

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adding numbers of other clinicians such as nurses, pharmacists and physician associates, as well as developing the role and training of practice managers.

Working in multidisciplinary teams led by GPs could reduce GP workload and benefit patients, Dr Madan said. For example, sending patients with musculoskeletal disorders to physiotherapists as their first contact could mean that most cases are closed without needing to see a GP.

He added that about 16 million contacts with GPs each year were of low value. 'Many of these could have been tidied up in hospital – where they were sent home without medication or where a fit note wasn't issued, for example.'

NHS England is also working with the General Medical Council and the CQC to reduce the demands for data on practices.

More than 750 schemes have been completed under the forward view estates and technology fund, with 200 being delivered and more than 600 in the pipeline. NHS England is also offering financial support for stamp duty land tax and reimbursement of VAT.

Undoubtedly, technology will play a central role in the transformation of general practice – through online consultations, for example, for which NHS England has earmarked £45m, with £15m allocated this year.

Online services offered by Babylon in London have caused some concern, with clinical commissioning groups and GPs worried that this service will attract younger, tech-savvy and less ill patients – the types of patient who rarely see a doctor but who, because GPs are paid largely on a capitation basis, are vitally important to the financial viability of practices.

The Carr-Hill formula used to allocate funding to practices does not account for the emergence of digital providers. Many senior GPs argue that it will have to be rethought but any changes must ensure the digital care and practice-based care can develop and complement each other.

Evolving picture

Even before the *GP forward view*, general practices have been reorganising, often in response to demand pressures and lack of doctors in secondary care. They have aimed to provide enhanced services, such as asthma or diabetes care, as well as bread and butter general practice – patients with coughs, low-level mental health issues or those who require referral to specialists.

Dr Madan said GPs were beginning to work together across a number of different options, from loose natural groupings covering 30,000 to 50,000 patients, through to more formal

"Every day contracts are being handed back and citizens are being disenfranchised. Not enough resources are going back into the system"

Robert Harris, Lakeside Healthcare

arrangements that will perhaps develop into MCPs or accountable care organisations.

Looser arrangements are usually called alliances or federations. Those that have merged – with all practice income pooled – are often referred to as super practices, though terminology can differ across the country. A super practice doesn't necessarily have to be large – it could have a relatively small number of GPs under a single management board.

Lakeside Healthcare is a large super practice, and one of the best known, with more than 200,000 patients covering a swathe of the East of England. It is hugely ambitious, with chief executive Robert Harris aiming for a list size of one million by 2020.

'We are at a tipping point and real change has to come from the provider side in primary and secondary care,' he says. 'We are in denial about a lot of things. Every day contracts are being handed back and citizens are being disenfranchised. Not enough resources are going back into the system and at the same time demand is going through the roof.'

He points to analysis of hospital activity and costs, including admissions, outpatient consultations and A&E attendances, which divided patients into three groups – the sickest and most vulnerable (5% of patients); those with a single chronic disease or at risk of a major procedure (20%); and those who are generally healthy (75%).

'We have about 5% of our patients who account for about half of our costs and this analysis applies nationally, regionally and locally. The next 20% of people, if not managed properly, could account for up to 40% of costs.'

Three years ago the practice became a vanguard MCP and, like others, has redesigned and expanded the care provided by primary care clinicians. Professor Harris says it looked at what capitated budgets might mean for its risk management, the broader workforce and the areas of specialisation it could offer. It realised that a bigger practice is more resilient – attracting more income – and allows GPs to specialise should they wish. 'You can't possibly do that in a small practice and it makes us a more attractive place to work,' he adds.

On joining the practice, GPs dissolve their former practice and become equal partners in Lakeside. In return, GPs have to give up the autonomy they enjoyed previously, Professor Harris says. 'That's the only debit. Everything else is a benefit – we do the clinical governance, the corporate work, we have a single IT system, we do the financial management and HR. We do it once and we do it centrally.'

Often, there is no single reason for practices to come together, but they can range from the benefits of population health and developing GP specialisms, to clinical and financial sustainability.

Cornish merger

In St Austell in Cornwall, the prompt for a merger was the failure of the largest GP practice in the town in 2014. The three other local practices rallied round and merged a year later to form St Austell Healthcare. The decision was driven by issues such as concern over recruitment and retention, the need for cost savings, service redesign and innovation.

Bridget Sampson, St Austell Healthcare's managing partner, says the practice is working towards an MCP contract model. It has separated planned and acute care onto different sites, with a central acute hub open 8am to 8pm on weekdays. Access is based on telephone triage and a multidisciplinary team, including doctors, nurses and pharmacists, delivers care.

'The benefits of doing things at scale mean we have created teams – a back-office team, a secretarial team, a QOF team and a prescribing team, for example – which gives us career progression. That is something you don't often see in general practice. We can also develop services, and offer some that are usually seen in secondary care.'

A consultant comes from the acute hospital to offer ophthalmology services, including glaucoma monitoring, for example, while GPs are leading multidisciplinary teams covering chronic illnesses such as asthma and diabetes.

Funding for new services at practice level is often tied up in existing contracts and commissioners are working to disentangle funds for services that can be offered in primary care.

York approach

Vale of York Clinical Commissioning Group has developed a gain share arrangement for primary care dermatology. Local hospital dermatology was facing a number of pressures, including staff shortages that had an impact on the 18-week waiting time, and a surge in urgent referrals (a 30% increase in two week waits). At the same time, GPs were performing less minor surgery.

Under the CCG scheme, GPs are encouraged to use dermatoscopes to photograph dermatological problems and send it for review. This allows specialists to identify cases that can be successfully managed in primary care. The scheme saved £121,000 in 2016/17, with practices receiving a total of £38,000 under the gain share agreement for investment in primary care dermatology services.

Professor Harris says the Lakeland practice realises success lies in its ability to unlock existing funds. 'Ideally, we will do so working with a hospital on some kind of gain share and working with commissioners to redesign services,' he says. 'When the MCP started we didn't say: "Give us more money". What we wanted was the licence to design and deliver new care models.'

This has manifested itself in a number of ways – supporting hospitals to shift surgery from overnight to day case; providing care in community facilities run by the practice; and allowing teams led by extensivists (GPs who specialise in the care of frail elderly patients) to spend more time with patients with the greatest needs and complexity. These patients may have two or more comorbidities, such as dementia, liver disease and COPD, together with risk factors such as obesity.

Segmentation of the practice population into risk categories has helped identify the degree of care patients need. Other patients with chronic illness – congestive heart failure or diabetes, for example – are cared for by enhanced primary care teams, while patients needing less complex surgery, including some ophthalmic, orthopaedic and dermatology procedures, can be operated on in its ambulatory surgery centres. Professor Harris says this provides commissioners with lower cost care through a smaller fixed cost base and economies of scale across the practice area. 'The biggest potential blocker here is how you agree the gain share with the hospital and CCG,' he adds. 'We are seen to be a threat, rightly or wrongly, to hospitals. We could take away up to 60% of what they do currently. We believe there's a different and viable alternative to what's gone before, but it requires guts on the part of regulators and on the part of commissioners to decommission a service and recommission elsewhere. We should be agnostic about who is providing the service.'

General practice is the foundation of the NHS, but, like its secondary care counterparts, will need to modernise the 1948 blueprint. IT, including video consultation, will be part of this vision, as will more collaborative teamworking, but perhaps the biggest change will be ensuring GPs have more time to counsel and treat patients with the most complex needs.

Primary move

The Royal Wolverhampton NHS Trust is a provider of acute and community services and, increasingly, primary care.

Royal Wolverhampton's PACS went live on 1 June 2016, with the trust taking on five practices and a population of about 23,000. It now works across 11 sites with a list size of about 60,000 and several other practices in due diligence.

The trust is approaching around a quarter of the practices in Wolverhampton under its ambit and has begun to expand into South Staffordshire.

All its GPs are salaried and the trust runs an integrated delivery model with primary, secondary and community services staff working closely together.

Sultan Mahmud, the trust's director of integration, says it has already seen some benefits. 'We've seen a seismic shift in primary care access, with 10,800 additional primary care appointments since June 2016, so patients have seen a very real difference in access. We have worked with established primary clinical systems providers like EMIS to be able to monitor the difference we are trying to make.'

In terms of system metrics, early data is encouraging. There has been a reduction in emergency department attendances of around 1%, which Mr Mahmud says is modest but encouraging.

'In terms of emergency admissions, we have seen a reduction of 10% and also a reduction in emergency readmissions by 8%.

'These are encouraging signs, but our clinicians and informatics team are drilling down into patient-level data to understand how further improvements can be made. Wolverhampton CCG has worked hard with all GP groupings and the trust to reduce demand.'

Explaining these figures, he says: 'Causality is difficult to pin down, it's not that straightforward. But once you start to integrate primary and secondary care clinicians you can make a difference to healthcare delivery because incentives are aligned. There are opportunities to scale up and streamline processes – to reduce the admin burden, for example,' he says.

While much of the local focus has been on bread and butter general practice, the vertical integration programme is also looking to develop GPs' role to take care out of hospital, but with adequate resources and the infrastructure to manage risk.

Primary and secondary clinicians are working on a number of workstreams to manage more complex patients, discussing patient pathways and working out where GPs with a special interest or consultant outreach is the best option for patients.

The trust is actively working with local partners across the Black Country to develop an accountable care system. 'We have decided that as a trust our future lies in being a driving force in population health management and supporting clinicians to move care to the most effective setting, cutting down on unnecessary bureaucracy and using our leadership and change management track record to benefit the wider system.

NHS England's Arvind Madan (left) believes multidisciplinary teams led by GPs could reduce GP workload and benefit patients

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Looking into the future

The Department of Health's response to Lord Carter's challenge to improve procurement is the Future Operating Model, but it is already up and running for some products. Steve Brown reports

When Lord Carter set his £5bn productivity challenge for the NHS, procurement of basic goods, such as stationery and everyday medical consumables and high-cost medical devices, was very much in his sights. He suggested that £700m of the £5bn overall target by 2020/21 could come from better procurement and went further by targeting a reduction of 'at least 10% in non-pay costs' by April 2018.

The Future Operating Model (FOM) is how much of this will be delivered. In essence, it is a re-procurement of the current NHS Supply Chain – although it will also involve significant transformation of the existing model. It is part of a wider Procurement Transformation Programme (PTP), the launch of which predates the publication of the Carter report. However there is clear alignment between the objectives of the PTP and Lord Carter's challenge.

The variation in prices paid by NHS providers for often basic goods and consumables has been a long-running story. Back in 2011, the National Audit Office estimated £500m a year could be saved if trusts got together to buy consumables in a more collaborative way. It identified an average 10% variation between the highest and lowest prices paid – with much bigger differences for some items. Trusts were also buying too many different types of the same product.

NHS Supply Chain was originally set up in 2006 to provide an outsourced end-to-end supply chain for the NHS. As part of a contract extension, adding two years to the original end date of September 2016, it has been tasked with delivering £300m of cash-releasing savings by September 2018 and, as of September this year, reported that it had already achieved £250m. However, a fundamental problem has been the low proportion of NHS spend that goes through this system.

Of the £5.7bn spent on goods across NHS England, only 40% (£2.2bn) is going through NHS Supply Chain. The rest is being procured by procurement hubs (40%) and some 200-plus trust procurement teams (20%). By taking a fragmented approach to procurement, the NHS as a whole is not believed to be getting the full benefits of its considerable buying power.

The clearly stated aim of the FOM is to increase the market share going through NHS Supply Chain to 80%, eliminating the significant variation in prices paid by different NHS providers for the same goods and releasing £615m in funds annually from 2021/22.

The new design of the NHS Supply Chain service sees different types of goods divided into 11 category towers, sitting under an NHS-hosted management function known as the Intelligent Client Coordinator. Consolidating more purchasing through NHS Supply Chain will create further efficiencies through the use of a single national logistics provider and consolidated invoicing.

These will be underpinned by a transactional services provider – providing accounts payable/receivable and query management – and an IT service provider to ensure the supporting technology infrastructure is in place.

The clearly stated aim of the FOM is to increase the market share going through NHS Supply Chain to 80%, eliminating the significant variation in prices

Within the 11 category towers, there are six medical towers. For example, one covers ward-based consumables, while another covers orthopaedics, trauma and spine, and ophthalmology. The two capital towers cover diagnostic equipment – divided into large and standard equipment. The three non-medical towers cover office solutions, food and hotel services.

The towers, which could be run by public hubs or private companies in deals lasting initially three years, will manage all the goods in their category. There is no competition between towers as they are dealing in different types of goods. The benefits for trusts come from having category tower providers that understand the markets, the demand patterns, and the clinical needs of the NHS. Clinical evaluation will take place on an industrial scale within all product categories.

All these factors contribute to the rationalisation of the NHS product catalogue to better meet the needs of the NHS, says Howard Blackith, PTP programme director at the Department of Health. According to Lord Carter's productivity report in 2016, a sample of 22 trusts were using 20,000 different product brands and more than 400,000 manufacturer product codes.

The first tower covering office

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How Barcoding is Boosting Efficiency and Safety in the NHS

Genesis Automation explores five ways in which inventory management is delivering big wins for NHS Trusts

In 2014, The Department of Health announced its £12m Scan4Safety initiative to test how barcoding can help acute NHS Trusts track and trace medical supplies, from the point of receipt to the patient. This pioneering programme is designed to improve patient safety, increase clinical productivity and drive operational efficiency. Originally launched in six pilot sites – Royal Cornwall, Salisbury, Plymouth, Leeds and Derby, North Tees and Hartlepool – it was hoped that Scan4Safety could deliver savings of £800 million over seven years. A year after tests began, that estimation was increased to £1 billion.

As a company selected to help three of the six pilot sites, Genesis Automation is at the centre of this transformation. Our market-leading solutions are helping to drive a fundamental change in how Trusts take control of their supply chain in order to improve safety, compliance, cost audits and traceability. We are now working with 23 NHS sites which are now seeing real and measurable benefits.

What are those benefits? Here are just five areas where real advantages are already being realised, with potential to be replicated across the NHS.

1. Tackling waste

Saving money by reducing waste is probably the biggest reason the NHS wants to overhaul supply chain management. The Carter Review in 2016 estimated that the NHS wastes £1bn on procurement. A more efficient approach to buying drugs – including cutting back on wasted stock – could save another £1bn, according to the review. At Aintree University Hospital NHS Trust which began working with Genesis in September, the technology enabled a 38% reduction in stock on shelf. Cutting waste like this equates to cost savings of £90,000, says the Trust. Another Genesis customer, Doncaster & Bassetlaw NHS Trust, saved £700,000 on Loan Kits over 12 months. Across the six demonstrator sites, reduction in wastage and obsolescence has already saved nearly £500,000.

2. Delivering accurate patient-level costing

If hospitals don't track items being used on individual patients during their stay, how can they calculate a total cost of treating that patient? The demand for this level of cost transparency has pushed patient-level costing high up the agenda. Point of care barcoding technology has the potential to scan all aspects of patient care including surgical equipment, medicines, linen and food from the moment the patient enters the hospital to when they leave, enabling accurate patient and procedure-level costing.

3. Cutting variation in care

If Trusts can clearly see inventory flowing through the system, with insight into which patients are receiving which procedures, drugs or implants (for example) it's possible to iron out disparities in care around the NHS. Variation in care is one of the biggest cost inefficiencies in the NHS – also with major implications for patient safety.

4. Boosting safety and compliance

Safety and compliance is another area where major gains can be made. As the PIP breast implant scandal of 2012 showed, an inability to trace patients who have received faulty implants can have dangerous consequences. Barcode scanning – of the supplies and the patient – means everything can be tracked and traced if a recall is necessary.

5. Automating labour-intensive tasks

And then there are savings that can be gained by freeing clinical staff from manual tasks that can be automated. For example, an estimated 4,000 nursing hours are spent each year on manual supply chain duties – such as logging stock. Automating this process can deliver those hours back into hands-on patient care.

There are many more advantages and savings to be discovered by using our pioneering supplies management, traceability and analytics solutions. By connecting vital healthcare data throughout the workflow process, we give Trusts accurate information in real-time for better decision making.

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solutions was awarded to Crown Commercial Service and began operating in October.

'Other suppliers should not be able to beat FOM prices on a sustainable basis,' says Mr Blackith. 'This is due to the new category tower providers performing world-class category management and taking advantage of national scale. The FOM will continuously be reviewing prices and benchmarking to identify its position in the market and we would expect our NHS partners to challenge us to be the market leader in terms of price and quality of service.'

Trusts have been encouraged to merge their buying clout before, through hubs or buying off pre-arranged framework contracts. But many trusts have continued to do their own thing, convinced they are getting a better deal on their own. So what is different this time around?

Currently the operating costs of NHS Supply Chain are financed by the addition of a margin on top of the product cost. In effect, an element of the funds that flow into tariff funding (and other funding arrangements) is there to cover this overhead margin.

Top-sliced funds

But under the new system, the operating costs of the FOM will be top-sliced prior to flowing into tariff and other funding routes, and then allocated directly to the FOM. This will mean an extra adjustment in tariff prices for the year starting April 2019, when the top-slice model takes effect. Until then the existing level of margin will continue to be applied. The Department of Health is currently working with NHS England and NHS Improvement on how the top slicing will be applied.

Having covered the operating costs via the top-slice, the buy price – the price paid by NHS Supply Chain – will be equal to the sell price (the price paid by trusts).

This achieves two things; – increased transparency in pricing and central funding that allows NHS Supply Chain to develop and support the infrastructure required to maximise the buying power of the NHS.

With the top-slice operational, the Department believes the value delivered through the FOM will be completely clear. But it says that even in the run-up to April 2019, the NHS Supply Chain model is beginning to move in the direction of the FOM.

'For example, the current model is partnering with NHS Improvement to determine national strategies on certain product ranges that fall within the Nationally Contracted Products (NCP) programme and is beginning to deliver good value to the NHS,' says Mr Blackith.

The category tower service providers (CTSPs) will be paid using a two-part mechanism. They will be paid operational costs, with an annual target in the contract. A gain share mechanism will also operate with CTSPs only making a profit when savings are delivered. The more savings, the more profit. The contract includes a minimum level of savings and incentives to encourage CTSPs to overachieve on their savings targets.

This will not be an overnight change and trusts will instead see changes over time – apart from the switch over to the top-slice model.

'New category strategies will be developed and framework contracts replaced over time when there are opportunities such as current frameworks expiring or new mini competitions being run,' says Mr Blackith. 'Our aim is not a "big bang" change in the way we interact with our NHS partners. We expect there to be a transition into an improved approach to account management, core services and ultimately price. We will make changes in a way that doesn't risk continuity of supply, is in line with NHS expectations and moves the NHS procurement landscape to a more efficient one.'

League of their own

Procurement departments now have their own league table after NHS Improvement published rankings for acute providers in November.

While not part of the Department of Health's Procurement Transformation Programme, the league table provides an assessment of the relative performance of procurement departments in acute providers.

Trusts are rated based on their performance against five indicators. Two of these measure process efficiency – for example, the proportion of non-pay spend in NHS Improvement's price comparison tool. Three metrics cover price performance, including the percentage saving if the provider's top 100 products had been bought at the average of the median and minimum price.

The metrics are combined using set weightings.

Using 2016/17 data, a total of 11 trusts were assessed as 'exceeding expectation' overall, 77 met expectation, while 48 were below expectation.

From 2018, the league table will be refreshed on a quarterly basis.

In addition, the table suggests a savings target range for each trust.

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In the bank

Pay remains a major pressure this year. But within the overall figures, trusts are continuing to reduce their spend on agency staff and there are signs of increased use of in-house staff banks. Steve Brown reports

Six months into the year and pay costs are almost inevitably a problem – more than £250m of a problem according to NHS Improvement's quarter two report. The forecast overspend on pay has also increased significantly since quarter one. It is this pay pressure that is mainly to blame for the overall forecasts to end the year with a bigger deficit than planned. Yet NHS Improvement still sees much to be cheerful about the service's progress to tackle its main pay problem – the cost of agency staff.

Looking at the detailed figures, the £256m overspend on pay in the year to date is driven by an overspend on bank staff of £407m. That's not all bad news. Spending on agency staff is £78m lower than the planned level at this point in the year – a level determined by each trust's set agency ceiling.

This positive variance of 6.1% against the planned ceiling has grown from 1.5% at Q1 and trusts are now forecasting that agency spend will come in 10% lower than the ceiling over the full year, although the bank overspend is expected to grow further.

Agency controls started to be phased in from October 2015, combining caps on rates paid to agencies with a mandatory requirement to use approved framework contracts.

'In the 18 months since April 2016, we are now up to £1bn of reduction in agency spending,' says Dominic Raymont, NHS Improvement's deputy director of agency intelligence. The £319m of additional reduction this year adds to the £700m from last year, all compared with what the service would have been spending on agency staff if it had maintained its 2015/16 run rate.

'Of the £319m cost reduction on agency, £119m is an overall reduction on temporary staff,' he says, 'with £200m invested back into bank.' According to the Q2 figures, the £2.6bn spent on both bank and agency staff represents a 4.3% reduction on spending in the same period in 2016/17.

The £407m overspend on bank staff is likely to mean two things. Trusts have done better than they expected in transferring staff from agency to bank. And then they have sourced the staff required to meet increased demand and to cope with high levels of vacancies from their own banks not agencies.

The increase in demand has been significant – bed occupancy has gone up driven by a 3.4% increase in emergency admissions and increases in delayed discharges. Despite these pressures, trusts have made progress back towards the four-hour A&E target and treated more patients within 18 weeks than in the same period last year, although 18-week waits have slipped further behind the 92% target.

Coupled with the year-on-year reduction in overall temporary staff spending, NHS Improvement also says the average number of price cap overrides per trust has fallen.

Overall agency spend is now 4.6% of the total provider pay bill. This compares with 5.8% for the full year last year and a planned level of 5%. A further fall to 4.4% is currently anticipated by the financial year-end.

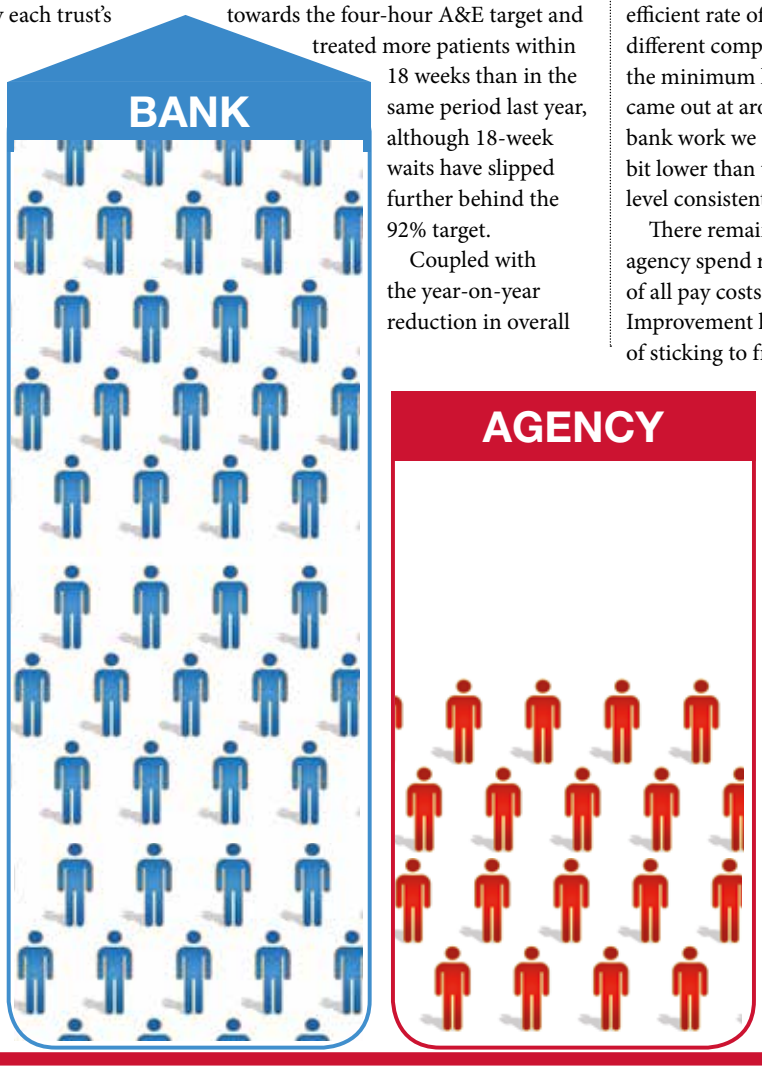
Agency costs rose dramatically over the four years prior to the introduction of caps. But before then, agency costs were relatively steady at around 4% of overall pay.

Agency target

Mr Raymont thinks this is the level the service should be targeting. 'We did some economic work at NHS Improvement to look at the efficient rate of temporary staff – looking at the different components and asking what would the minimum look like,' he says. 'That also came out at around 4%. Potentially with the bank work we are doing, we could get a little bit lower than that. But if we could get to that level consistently that would be good.'

There remains significant variation, with agency spend ranging from less than 1% of all pay costs to more than 18%. NHS Improvement has underlined the importance of sticking to framework contracts in all cases except where going off-framework is the only option to maintain safety. While workers from high-cost agencies may take home a higher hourly rate, agencies fees make up a larger proportion of the total cost.

In one example of a band 5 worker, fees might account for 25% of the capped £22.85 per hour rate. But with a high cost agency, more than 40% of the higher rate (£51.95/hour in one example) could be going to the agency. And while the presumption would be that off-framework usage is a last minute emergency practice, through its ongoing data collection NHS Improvement



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can now see that in one week in June, 66 band 5 nursing shifts had been booked more than 32 days before the shift.

In total, the cost of all band 5 nursing shifts booked with high-cost agencies more than seven days in advance that week was £166,669. Mr Raymont says that most of these costs could be avoided by more efficient booking of shifts.

He adds that the make-up of savings has changed a little since last year. About 42% or £300m of the £700m savings last year came from medical staffing – a mix of price reductions and volume reductions. This year, medical staff account for about a third of savings to date, with nursing staying consistently at 24% and admin and estates staff accounting for the biggest proportion.

Mr Raymont says this is to be expected as last year will have included some initial big savings simply by applying the agency rules and adhering to frameworks. He admits that there was also probably a non-recurrent reduction in medical locum spending at the start of the year as some clinicians registered a protest to the IR35 rule change – meaning more medical locums have tax deducted at source rather than it being dealt with through intermediary companies.

However, he believes the IR35 change has not had any lasting impact. 'We've seen a return to a more normal trend, the locums have in the main come back and the supply issue appears to be no worse than before,' he says. 'There is still an undersupply of doctors in certain specialties, but that is not because of IR35.'

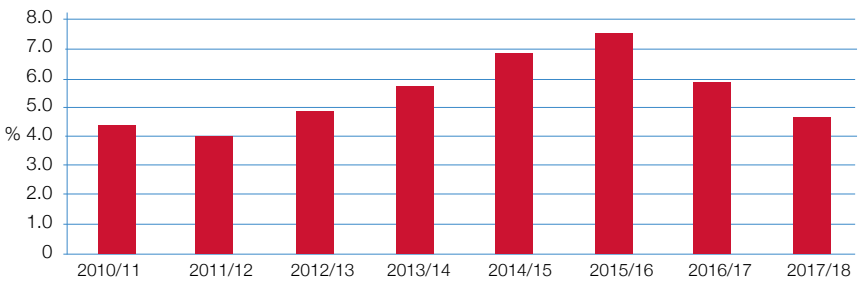
Locum action

NHS Improvement is working with the 30 trusts with the highest locum spend last year to help them meet their locum reduction ceilings. Twelve of these are on track with seven others within £0.5m of their trajectory. Of the 11 off trajectory, five are moving in the right direction while six are not improving. And on the undersupply of doctors generally, the organisation is working with a number of trusts on overseas recruitment.

Across all disciplines, says Mr Raymont, trusts have been getting to grips with long-serving temporary staff, as submitted data highlights the issue. 'In some cases people have been with organisations for several years – they clearly like working there,' he says. '[Making it visible] has helped trusts to have conversations with these people about what could be done to enable them to move across to payroll.'

Another example revealed a temporary finance manager at the same trust for five years. Mr Raymont questions whether this could be justified on higher agency rates. 'If they have a requirement for not working school holidays or working part-time, this can be accommodated in a full-time contract or at least we could move them onto the bank as a stepping stone to that.'

Agency as a percentage of total pay bill



He is aware that the weekly data submissions are a burden on providers, but insists the intelligence is helping. 'We are constantly reviewing what we need,' he says. 'We no longer collect the maximum wage rate for example – we stopped this when we started collecting the bank information. We use NHS Providers as a sounding board for data changes and are advised by a senior stakeholder group.'

Some software providers are starting to build functionality into systems to facilitate simple reporting of the regulator's requirements.

NHS Improvement's major focus this year has been around staff banks, which it sees as the key to making cost shifts permanent. It wants to do three things:

- Improve use of existing banks
- Improve reach (for example, encouraging medical banks where they don't yet exist)
- Encourage collaboration.

A toolkit was due to be launched at the beginning of this month to support its first target. This will include case studies, checklists and suggestions of how to improve the running and use of banks.

Some of the tips are simple – for example, engaging with the temporary workforce. Others are more practical – letting staff interact via a smart phone app, ensuring there are options for weekly pay, reducing the lead time to get someone approved for bank work and ensuring the process for requesting staff builds in an opportunity to challenge the requirement.

"On the technology side, agencies do well. Doctors are very tech savvy and prefer to book shifts using their phone"

Dominic Raymont, NHS Improvement

'On the technology side, agencies do this well. Doctors are very tech savvy and they prefer to book shifts using their phone,' says Mr Raymont. With a market emerging in these sorts of technology solutions, NHS Improvement plans to help trusts evaluate and select the ones that will work best for them.

A summer survey found that just three quarters of trusts with a staff bank of some sort had a medical bank. And some of these were not really transacting business. So as part of its work to improve reach, NHS Improvement is targeting to increase this proportion to 90% by this month, as well as increase the number of temporary shifts filled by bank staff.

On the collaboration side, it says there are already collaborative banks in operation or under development in 30 out of the 44 sustainability and transformation plan areas. A hub and spoke model – where a trust cascades shifts out to bank workers of other trusts – is the most common model to date, but it wants full coverage over the coming months

The big challenge for the NHS for the remainder of the year – operationally and financially – will be the winter. A bad winter leading to increased demand could provide significant challenges in meeting existing financial forecasts overall and for agency and bank spending.

That would be disappointing, as Mr Raymont feels the moves are all in the right direction on temporary staff. Next year, as the bank work takes hold, he believes the service could start to see a permanent shift away from agency and into bank. However, he says the centre will continue to stay interested and keep pushing for improvement. 'If we stop pushing before this permanent shift happens, we could slip backwards,' he says. 'We need to get the banks properly established and temporary staff used to working through them.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Audit committee key to system working and preparing for unforeseen events

Technical update

The theme of the recent HFMA audit conference – *Changing for the future* – reflects a time of significant challenge and transformation in the way the NHS is being operated, *writes Lisa Robertson*. As the service looks to meet these challenges – including greater system working, the ongoing financial pressures and the need to be prepared for unforeseen events such as a major cyber-attack – clarity will be a key requirement. Audit teams and good governance are fundamental to delivering that clarity.

'Governance principles hold good - governance models change, but the same governance principles apply.' This was the clear opening message from Paul Dillon-Robinson, former director of internal audit and risk at the House of Commons.

Governance is largely about decision-making and the key is to have the discussion about why, not just how. Internal audit can make a big impact by speaking the truth to power, taking on the big issues and applying judgement. Mr Dillon-Robinson – a former chairman of the HFMA's Governance and Audit Committee – acknowledged that being an effective audit committee may not always be a comfortable role.

However, it has a key part to play in establishing a full understanding of the wider picture and providing independent assurance. It should ensure there is more than a tick-box approach to governance and have a proactive involvement in audit, being clear on what assurance it wants internal audit to provide.

Both Mr Dillon-Robinson and Paul Moore, director of governance and quality improvement at Sherwood Forest Hospitals NHS Foundation Trust, agreed that the risk register and process can assume more importance than managing the risk in some cases. The focus should be on the response to the risk first, rather than debating the score.

They pointed to a danger that some risks are overcontrolled or that appropriate risks are not being taken to maximise value. Organisations should be clear on their risk appetite and a risk appetite statement can be a helpful employer/employee engagement device.

May's WannaCry ransomware attack hit more than 200,000 computers across the world. While the NHS was not the target of the attack, the NHS did face disruption. Robert White, director at the National Audit Office, described how the NHS was affected, the lessons learned and the role of the audit committee in cyber security.

The NAO has recently published *Cyber security and information risk guidance for audit committees*. Audit committee members will need to know which questions to ask, seek independent assurance and ensure they know how to respond when faced with these challenges – asking information technology teams to explain this is a really helpful step. It is not if, but when, for the next cyber-attack. The next one is likely to be more sophisticated and, should the NHS be ill-prepared, more disruptive.

The governance of sustainability and transformation partnerships (STPs) was a key area of concern for many attendees – particularly the lack of non-executive and lay member involvement and the conflict between organisational accountability and commitment to the STP.

Sam Simpson, director of finance at Cheshire and Merseyside STP and Tim Crowley, managing director of Mersey Internal Audit Agency, talked about how the audit committee can play a championing role in ensuring a clear understanding of the STP and where decisions are made.

In October, the HFMA Governance and Audit Committee published a tool to support and help audit committees explore the key elements of STP governance.

With a move to a system approach based on relationships, trust and a shared vision, there were positive examples of change – clear open book accounting; top slicing of individual audit plans to allocate days to system plans; and discussions about formal STP audit committees or informal non-executive lay member meetings.

Throughout the day, there was a clear focus on the important role of the audit committee – to ensure clarity, use internal audit and robustly challenge – providing a clear line of sight for organisational and system wide changes.

• *Lisa Robertson is an HFMA research manager*
• *Member organisations of the Chair, Non-executive and Lay Member faculty can download conference slides and videos at* ***hfma.to/audit1***

Technical review

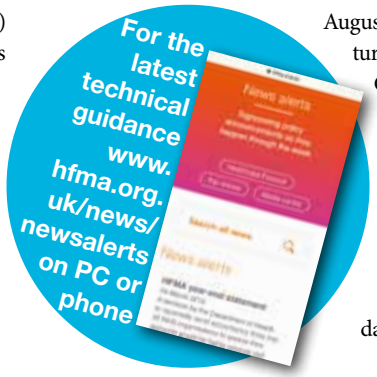
The past month's key technical developments

Technical roundup

The Financial Reporting Council (FRC) has written to companies to highlight areas where **improvements to annual reports** can be made. Some recommendations are not applicable for NHS bodies, but others are:

• The requirement to make detailed, quantitative disclosures, explaining the expected impact of the three new reporting standards (IFRSs 9, 15 and 16) and their likely impact. For NHS bodies, it is not expected that IFRSs 9 and 15 (covering respectively financial instruments and revenue from contracts with customers) will have a material impact unless they are party to material longer term or unusual contracts for income. Research contracts and long-term contracts for new models of care might be impacted by IFRS 9. IFRS 16 (leases) will have a material impact on the accounts and should be discussed at more length

• Improvements to disclosures in relation to critical judgements and estimates and accounting policies. For NHS bodies, one of the areas of judgement that has a material impact on the accounts is the valuation of non-current assets. Other areas of judgment include income recognition and whether or not provisions are established.



A glossary for **NHS and local government finance and governance** has been published by the Integration Finance Network – a partnership between the HFMA and CIPFA. With the two sectors increasingly working together to deliver public services integrated around the needs of users, practitioners on both sides need to understand the terminology being used by their partner organisations. The briefing, updating an earlier version, begins by outlining 'who does what' in the NHS and local government and then explains frequently used terms used for finance and governance.

NHS Improvement and the Care Quality Commission (CQC) are conducting a consultation on how the new **use of resources assessment** will rate trusts and how the ratings will be reported. The move follows the publication of the use of resources framework and methodology in August. Feedback is being sought on how the CQC will turn the proposed use of resources ratings into the final CQC rating; and how this rating will be combined with the CQC's quality ratings (safety, caring, effective, responsive and well-led) to produce an overall trust rating. The consultation closes early in January. Use of resources assessments are already under way in non-specialist acute trusts – with all acute trusts due to have been assessed by the end of 2019. The assessments take place alongside, but not on the same day as, core service and well-led inspections.

The Northern Ireland Audit Office has published a good practice guide on preventing **bribery and corruption** in the public sector. The guide aims to help officials and public sector bodies identify how bribery and corruption can occur, highlight key risk areas and gives advice on how these can be mitigated. The guide includes a self-assessment checklist. NIAO comptroller and auditor general Kieran Donnelly said the risk in Northern Ireland was low, but bribery and corruption were still present, and complacency carried its own dangers.

Initial results from an HFMA survey on use of the new **apprenticeship levy** in England suggests most organisations expect to get back less than 25% of the amount they have paid into the levy this year. Organisations can access the amounts they have paid, plus a government top-up, through their own digital accounts. They have two years to access the funds. Only a few of organisations taking part believed they would ever be able to use more than 75% of the levy. The finding follows wider national figures showing a 60% reduction in the numbers starting apprenticeships across all sectors in the first quarter following the introduction of the levy. However, the HFMA survey also found that about half the respondents had taken on apprentices as a result of the levy, covering wide-ranging areas, from finance and catering to nursing and biomedical sciences.

NICE revises guideline on inherited high cholesterol condition

NICE update

NICE published a clinical guideline (*CG71*) on the identification and management of familial hypercholesterolaemia (FH) in 2008, *writes Nicola Bodey*. Recently the evidence was reviewed for case finding and diagnosis, identification using cascade testing and management using statins. An updated guideline was published last month.

The prevalence of heterozygous FH in the UK population is said to be one in 250, which means that in England about 220,000 people are affected. In England, only around 18,000 people are diagnosed with FH, so there could be about 202,000 with undiagnosed FH. The elevated serum cholesterol concentrations that characterise FH lead to a greater than 50% risk of coronary heart disease by the age of 50 in men, and at least a 30% risk in women aged 60.

Currently FH is diagnosed by clinical assessment and a lipid profile. DNA testing plays a limited role and people are assessed as they present to healthcare services with little active case finding.

The guideline recommends systematically searching primary care records for people at high risk. Currently case finding for FH is done opportunistically, and people with high cholesterol are assessed as they present in primary care.

Under the newly recommended active strategy, primary care settings would identify people with potential FH, assess them and, if appropriate, refer for genetic diagnosis. There will be increased costs from staff workload and referrals of those with suspected FH for an outpatient appointment in secondary care.

The guideline recommends carrying out cascade testing using DNA testing to identify relatives of people with a genetic diagnosis of FH. Testing relatives of people with FH is

Diary

December

12 B South Central: technical update, Reading
15 B Northern Ireland: Christmas cracker & AGM, Belfast
16 F Chair, Non-executive Director and Lay Member: annual chairs' conference, London

January 2018

16 F Chair, Non-executive Director and Lay Member: annual chairs' conference, London
23 F Provider Finance: directors' forum, Rochester Row
25 B London: Q and A forum, Rochester Row
25 B Northern: annual quiz, Durham
25-26 B Yorkshire and Humber: annual conference, Broughton
29 B Eastern: introduction to NHS finance, Fulbourn
31 N Pre-accounts planning, Manchester
15 B South Central: introduction to NHS finance

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, Durham
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

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cost-effective, especially when children and young people can be identified. There will be increased costs from DNA testing and referrals for an outpatient appointment.

However, DNA testing for known relatives is cheaper than testing for an unknown mutation because the specific mutation is known.

There are also anticipated longer term savings (see NICE's resource impact report) from a reduction in premature cardiac disease and reducing premature mortality in people who have been successfully identified, diagnosed and treated.

Nicola Bodey, senior business analyst, NICE

Events in focus

Integration summit
8 February 2018, London

Integration between health and social services is moving from small-scale joint working on specific services to something much bigger. New models of care have emerged, including accountable care systems, primary and acute care systems and strategic transformation partnerships (STPs). The benefits include the potential for seamless care for patients and clients delivered by multidisciplinary teams, but finance staff must also create shared financial mechanisms and governance structures to fit these integrated services.

This third HFMA/CIPFA integration summit will give NHS provider finance directors, clinical commissioning group chief finance officers, local authority treasurers, STP finance leads and directors of adult social care a chance to discuss the integration challenges they face, together with new financial and governance structures.

Speakers include Michael Dixon, NHS England national clinical champion for social prescribing (pictured), Jon Rouse, the chief officer of the Greater Manchester Health and Social Care Partnership and Mark Webb, the chair of North East Lincolnshire Clinical Commissioning Group.

• **For more details and to book, visit hfma.to/summit18**

Mental health workforce forum
15 February 2018, Rochester Row

The design and delivery of mental health services has changed over the last few decades and with it the workforce – for example, there has been an increase in the number of psychological therapy staff following the implementation of the *Improving access to psychological therapies* programme. And, with the renewed focus on mental health, the *Five-year forward view* outlined a workforce development plan that would create an additional 19,000 posts by 2020/21.

A recent study, led by the Centre for Mental Health, said there are major challenges recruiting and retaining people to work in mental health, particularly in nursing and psychiatry.

Delegates at this one-day event will hear from one of the report's authors, Centre for Mental Health deputy chief executive Andy Bell (pictured), on the report's conclusions and the key areas for workforce development and planning.

It will also showcase a number of case studies, including how one multispecialty community provider is developing the role of its workforce.

• **For more info and to book, visit hfma.to/wf**

Tour de force

Association view from Mark Knight, HFMA chief executive

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

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My HFMA

As the next president of HFMA prepares to take office, it's great to reflect on a very positive year for HFMA. Mark Orchard (above) has completed his nationwide tour of our branches, the first leader to accomplish that feat since Bill Shields in 2009. Mark has been a superb president – staking his claim to be the first 'gen X' leader, his Twitter account ever at the ready.

His blogs have been informative and reflective and who can forget his entrance into our lives as president? He has also been very supportive of the staff in encouraging us to continue the HFMA's long process of development. We've seen a real focus on membership during this year, with strong growth figures in all categories.

His theme – *Everyone counts* –has been uplifting and in my view that's a major role for the HFMA in these difficult times. The recent Budget settlement was welcome, but not enough to meet the demands facing the NHS. We have produced our latest analysis of the half-year figures and finance director views in our *NHS financial temperature check*. And HFMA head of policy and research Emma Knowles underlined in a recent blog that there are difficult decisions ahead following the Budget announcement.

We speak to the service continually and I hope that next year we can provide further help and support. Some people criticise us for not being more vocal – but those people misunderstand the role of the HFMA in providing a conduit to those in power. And we've certainly been doing that. We are acutely aware of the issues and are communicating loud and strong to those in power. In many cases, we see this as the most constructive way of reflecting the service's views.

And so we move on. Our new president – Alex Gild, chief financial officer at Berkshire Healthcare NHS Foundation Trust – has come through a traditional route as branch chair and a founding member of the South Central Branch in 2008. Alex will introduce his year on the Friday of annual conference, providing the perfect follow-up to Mark's *Everyone counts* year.

We've only had one previous leader from South Central area, way back in the 1970s, so it's great to see another. Recently I've done a bit of work tallying up where the elected leaders have come from. The West Midlands leads with 12, followed by South West on 10 and Yorkshire on 8. Every region has been represented, which is great and Bill Gregory, who follows Alex, will take the North West total up to seven.

HFMA chief executive Mark Knight

One region where we have been working hard to develop our activity is London. Our capital branch is growing thanks to a hard working bunch of volunteers led by Kate Anderson. So I'm delighted that our 70th president in 2019/20 will be Caroline Clarke from the Royal Free London NHS Foundation Trust, who is also former chair of the branch. Her election to vice president will be announced at the annual general meeting on Friday 8 December.

We will be saying goodbye to three trustees – Chris Hurst, Susan Goldsmith and Shahana Khan. All three have made long and enduring contributions to the association and I'd like to personally thank them for all their efforts.

So, onto our annual conference, where the association assembles. We have a different format this year but we trust you will enjoy it if you're coming. See you there!

Member news

Russell Caldicott is the new chair of the West Midlands Branch. Kim Li joins him on the committee as vice-chair, with Rebecca Coldrick as the new student representative.

Tim Saunders has become the Eastern Branch's treasurer, taking over from Laura Rawlings. Simon Rudkins joins the committee and Boladale Adams is now a student rep.

Catherine Grant is the new Northern Branch administrator after Lynn Hartley stepped down from the role. Ms Hartley will continue being part of the branch's committee.

At the East Midlands Branch conference in October, HFMA president Mark Orchard presented six branch awards:

- Student of the Year – Anesu Pasipamire, finance apprentice, Leicestershire Partnership NHS Trust (sponsor: HAYS Recruiting Experts Worldwide)
- Innovation of the Year – Derby Teaching Hospitals NHS FT (sponsor: Asteral)
- Team of the Year – East Midlands Ambulance Service NHS Trust (sponsor: Neyber)
- Outstanding Leadership Contribution – Gill Killbery (pictured, centre), deputy chief finance officer, West Leicestershire CCG (sponsor: Sellick Partnership)
- Unsung Finance Hero – Keith Seddon, Nottinghamshire Healthcare NHS FT (sponsor: Obillex)
- Chairman's Special Recognition Award – Derek Stewart, associate director of finance – financial services, Northampton General Hospital NHS Trust (sponsor: HFMA East Midlands)

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Member benefits

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

Network focus

My HFMA

Provider Finance Faculty

Providers' work environment is changing – patients are living longer with more complex care needs; prevention and general wellbeing are seen as increasingly important; and new care models and regulatory processes are emerging.

'It's more important than ever for the NHS to provide value for money,' says Rob Forster (pictured), Provider Finance Faculty Technical Issues Group chair.

The faculty is committed to helping its members cope with these challenges. 'The faculty gives us access to regulators and decision-makers, which means we are able to influence policies from an early stage,' adds Mr Forster. Sharing best practice in the network is also vital for improving services across the country, he says.

The next opportunity for members to come together is the directors' forum on 23 January. Delegates will hear from Duncan Selbie, chief executive of Public Health England, and Andrew Hood from the Institute of Fiscal Studies. Directors will also consider how to generate value from costing with Colin Dingwall, costing improvement director at NHS Improvement (see page 15).

The faculty also hosts a number of technical forums every year where finance professionals can learn and discuss more about the latest technical developments in the industry. 'Providers are currently learning about the use of resources assessment, there are a number of key lines of enquiry,' says Mr Forster.

Initially, the new use of resources rating will be published alongside the Care Quality Commission's overall quality rating – the CQC assesses quality against five key questions: is a provider safe, effective, caring, responsive and well-led? However, the CQC and NHS Improvement are currently consulting on how the assessments could be merged into a single overall rating. All non-specialist acute trusts will be assessed for use of resources by the end of 2019. To prepare its members for the new assessment, it will be the main focus of the faculty's forum on 22 March.

'It is very important this assessment is an evidenced action to show we are providing value for money,' says Mr Forster. 'It will be possible for organisations and for the finance function to drive this and to prove, hopefully, they're providing good value across clinical services, support services, people, corporate services and of course finance.'

• **Visit hfma.to/4k or email clare.macleod@hfma.org.uk**

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Appointments

Dinah McLannahan (pictured) is now deputy director of finance at Sandwell and West Birmingham Hospitals NHS Trust. Over the past three years, she has been head of business and finance (West Midlands) at NHS Improvement. Before joining the body she held various NHS roles, including acting director of finance at Dudley and Walsall Mental Health Partnership Trust.

Darren Cattell is now interim chief finance officer at the Isle of Wight NHS Trust. He has taken on the role following the retirement of **Chris Palmer**, executive director of financial and human resources, this month. Mrs Palmer joined Isle of Wight in 1990 and was appointed director of finance in 2007. In 2015, she also took over the responsibility for the HR function. Mr Cattell was previously interim director of finance at Medway NHS Foundation Trust..

NHS Orkney has appointed **Gerry O'Brien** interim chief executive. Mr O'Brien was previously director of finance and logistics at the Scottish Ambulance Service. He will work alongside current chief executive **Cathie Cowan** until she moves to become chief executive at NHS Forth Valley at the beginning of 2018. Mr O'Brien was director of finance at NHS Orkney between 2009 and 2015.

Paul Taylor (pictured) is leaving his role as director of finance and information at The Dudley Group NHS Foundation Trust at the end of December after three years at the trust. He will continue as head of finance for NHS England's new care models team and as a management consultant. **Chris Walker**, deputy finance director at Dudley, will take on the acting finance director role until the trust makes a new appointment.

Simon Lazarus, director of finance at Northampton General Hospital NHS Trust, is moving to a new permanent position as director of financial recovery at Nottingham University Hospitals NHS Trust. **Phil Bradley** (pictured), currently director of finance at Hertfordshire Community NHS Trust and a longstanding member of the HFMA Policy and Research Committee, will replace Mr Lazarus on a six- to nine-month secondment as interim director of finance. In Mr Bradley's absence, **Kevin Curnow**, deputy director of finance at Hertfordshire Community NHS Trust, will be the organisation's acting director of finance.

Rose Robertson has become deputy director of finance at NHS Fife, following a directorate-wide transformation programme in which Ms Robertson had a big input. **Carol Potter** was appointed director of finance at the organisation earlier this year, following a period as acting finance director.

Appointments continued on page 47

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Obituary
Margaret Ann Gunn MBE

Margaret Ann Gunn, an inspirational and formidable finance professional working in Wessex across two decades from the early 1970s, has died peacefully in her Winchester home aged 69

If you were lucky enough to have met Margaret, it is unlikely that you will ever forget her, *writes Letsie Tilley*. Margaret was a remarkable woman, who was truly inspirational and also quite formidable. If she asked you to do something, it was impossible to say no to her, as her instructions were always direct and unambiguous.

She was also one of the most intelligent and determined women I have ever met. Her wisdom, common sense and great judgement also meant, infuriatingly, that she was almost always right about everything!

Margaret possessed many other qualities that I admired, including her positivity, decisiveness and courageousness. She made light of the challenges she faced in life [*editor's note: Margaret had muscular dystrophy from childhood*] and never complained, even though she often had more cause to do so than many.

Margaret started her NHS career on the national finance training scheme, joining Southampton University Hospital Management Committee around the beginning of 1970 as a senior administrative assistant. Following the 1974 NHS reorganisation, she joined the Winchester District Management Team within the Hampshire Area Health Authority as deputy treasurer. She initially carried this role into the Winchester District Health Authority as part of the subsequent further reorganisation in 1982.

It was just after this that I first met Margaret in 1983, when she took a chance by appointing me as her district management accountant. It was a bit of a risk for both of us as it was my first job working in the NHS, but Margaret was a brilliant mentor who taught me many valuable lessons that I have carried with me and passed on to others.

Through her own example, energy and enthusiasm, Margaret nurtured my interest in finance staff training and development. She sent us out onto the hospital wards and theatres to discuss finance with clinicians, which, although commonplace now, was then virtually unheard of. And from the moment I joined the health authority, she encouraged me to attend the local meetings of the Association of Health Service Treasurers (forerunner of the HFMA), where I benefited from meeting colleagues from other NHS organisations, some of whom have become lifelong friends.

Beyond work, Margaret had many wide-ranging interests, including travel, genealogy, theatre and the arts. At one point, she was also a board member of the charitable trust for the local Marwell Wildlife Conservation Zoo.

When she retired from the NHS in the early 1990s – still at Winchester DHA – Margaret continued to work tirelessly to help others.

She worked with the Winchester Area Access for All group on improving access for people with physical impairments. She was also a Justice of the Peace and a volunteer at the Citizen's Advice Bureau.

Margaret was always very modest, but her significant contributions were appreciated by many and recognised through various awards, including being made a Member of the Order of the British Empire (MBE) for services to the community in Winchester in the 2000 New Year's Honours list.

Margaret will be greatly missed.

• *Letsie Tilley is an HFMA Academy module leader, HFMA executive coach and former NHS finance director*

INSET PHOTO COURTESY OF THE SOUTHERN DAILY

Appointments (continued)

Dave Mountford is now interim chief finance officer at Thurrock Clinical Commissioning Group. He was previously assistant director – contract finance at South, Central and West Commissioning Support Unit. He has over 25 years' experience of working in NHS finance, and takes over the role from **Ade Olarinde**.

Calderdale and Huddersfield NHS Foundation Trust has appointed **Gary Boothby** (pictured) executive director of finance. He was first appointed acting director of finance in the organisation in November 2016. Mr Boothby has been working in senior NHS finance positions for over 15 years.

Caroline Trevena, Northern Branch deputy chair, is retiring as director of finance at North Tees and Hartlepool NHS Foundation Trust at the end of the year. She has been a member of the HFMA since the start of her NHS career and has previously spent time as an active member of the Kent, Surrey and Sussex Branch. **Robert Toole** is now interim director of finance at the organisation. He was interim director of finance and financial improvement consultant at Northern Lincolnshire and Goole Hospitals NHS Foundation Trust.

Sean McKeever (pictured) has been named non-executive member to the Northern Irish Department of Health's Business Service Organisation. Having worked in England and Northern Ireland, he has a broad range of healthcare finance experience. His most recent NHS role was finance director and deputy chief executive officer at Lincolnshire Community NHS Trust, before he semi-retired in 2015.

Jonathan Bemrose, chief finance officer across Nottingham North and East, Nottingham West and Rushcliffe clinical commissioning groups, has also been appointed CFO at Nottingham City Clinical Commissioning Group. With over 25 years' experience in health and social care, he has held senior finance roles in social services, NHS commissioning and providing. **Louise Bainbridge**, who was chief finance officer at Nottingham City Clinical Commissioning Group, is now chief finance officer at four CCGs – North Derbyshire, Southern Derbyshire, Erewash and Hardwick clinical commissioning groups.

Obituary
Trevor Rippington CBE

Trevor Rippington, an influential and hugely respected figure in NHS finance during the 1970s and 1980s – and a former chairman of the HFMA's predecessor body – has died in Bristol aged 93


RIPPINGTON SUITE

Trevor Rippington CBE

Joining the NHS in 1949 from local government, Trevor Rippington started work at West Dorset Hospital Management Committee. Subsequent career moves took him to Middlesex, London and Swindon before he returned to West Dorset as treasurer in 1962. Now a chief officer, Trevor joined the association and within a few years was honorary secretary of the Wessex branch. Following a period as deputy treasurer at the predecessor regional board, he became regional treasurer of the new South Western Regional Health Authority in 1973 and joined the council of the newly named Association of Health Service Treasurers as the regional treasurers' representative. Trevor became national chairman of the association in 1978/79 and was made a CBE after his year in office. Mr Rippington was one of the most influential NHS finance directors of his day and one of those responsible for securing the finance director's place on each NHS board

Trevor's health service career began in 1949, when he left local government and started work with the West Dorset Hospital Management Committee, *writes Arthur Wilson*. During the next 24 years he held a variety of health service finance posts in Middlesex, London, Swindon, Dorset and Bristol, gaining his CIPFA qualification in 1962.

When hospital services and health services provided by local authorities were brought together under the umbrella of regional health authorities (RHAs) in 1974, Trevor was appointed regional treasurer of the South Western RHA, a position he held until his retirement in 1985.

The role combined the operational and strategic. In those days, the employment contracts of hospital consultants were held by the RHAs, which also managed the major building programme and distributed revenue funds within their regions. It was a period that saw the tightening of government's grip on public expenditure, manifest in the NHS by the introduction of cash limits in 1976.

That same year, 1976, I became Trevor's deputy and was immediately struck by his single-minded focus on NHS issues, as well as the leadership he provided. This leadership was evident not only within the South Western region, but also among health finance professionals nationally. I was fortunate enough to find myself working for one of the most respected men in NHS finance.

There was a regular flow of papers and reports from his office on all manner of subjects. If an issue needed to be tackled, Trevor could be relied upon to write an insightful paper that would inform the debate.

I remember using our car journeys to meetings with treasurers in various parts of the south west to pick his brains. Looking back, I can see what a privilege that was.

It was in the 1970s that the huge disparity in funding levels – and, therefore, services between different parts of the country – first began to be tackled. Trevor took the cause to heart.

He was a member of the Resource Allocation Working Party (RAWP), set up by the health minister to examine and advise on ways to distribute funds more equitably between regions.

But Trevor also pioneered new methodologies within the south western region with the aim of ensuring that the population of deprived counties, such as Cornwall, had the same access to healthcare as the people of Bristol. It was a task fraught with difficulties, but the trust that Trevor inspired enabled him to deal with the conflicts that arose.

Trevor was elected chairman of the Association of Health Service Treasurers, subsequently to become the HFMA, for the year 1978/79. His contribution in the field of NHS finance was recognised when he was made a CBE in 1980 and a suite of rooms in the HFMA's London conference centre, 110 Rochester Row, bears his name.

Trevor married his wife, Muriel, in 1950 and they had two sons, Nicholas and Timothy. Muriel died in 1981. He remarried in 1983 and is survived by his sons and second wife, Jean.

• *Arthur Wilson was regional treasurer of the South Western RHA from 1985 to 1993*

Trevor Rippington (centre) with other HFMA chairs in 2010 as part of HFMA's 60th anniversary celebrations

Finance development recognition

Future focused finance

'I would wholeheartedly endorse the process to others considering applying for FFF accreditation.' So said Simon Holden, interim chief finance officer at Countess of Chester Hospital NHS Foundation Trust. The trust, Bolton Clinical Commissioning Group and Midlands and Lancashire Commissioning Support Unit were awarded level 2 accreditation by the Finance Leadership Council (FLC) this year.

There are three levels of accreditation, based on self-assessment and, in the top levels (2 and 3), peer assessment by another NHS organisation. The levels aim to reflect continuous development of financial competence throughout the organisation.

Mr Holden said: 'Going through the accreditation brought members of the [finance] department closer together as a team and provided an opportunity to reflect. This has led to internal changes including improvements in our training strategy, where we have tried to align provision much more closely to the needs of the organisation.'

With another seven organisations due to submit their applications to the FLC in January 2018, FFF said NHS organisations are acknowledging the importance of external recognition of their finance skills development culture and practices.

Claire Yarwood, director of finance at Tameside and Glossop Integrated Care NHS Foundation Trust, and David Ellcock, FFF's programme director, will run a workshop on the accreditation process at the HFMA annual conference this month. The session will offer a finance director's perspective of the process, outline organisational benefits and give tips on approaching the process.

• **Visit** www.futurefocusedfinance.nhs.uk/great-place-work/accreditation

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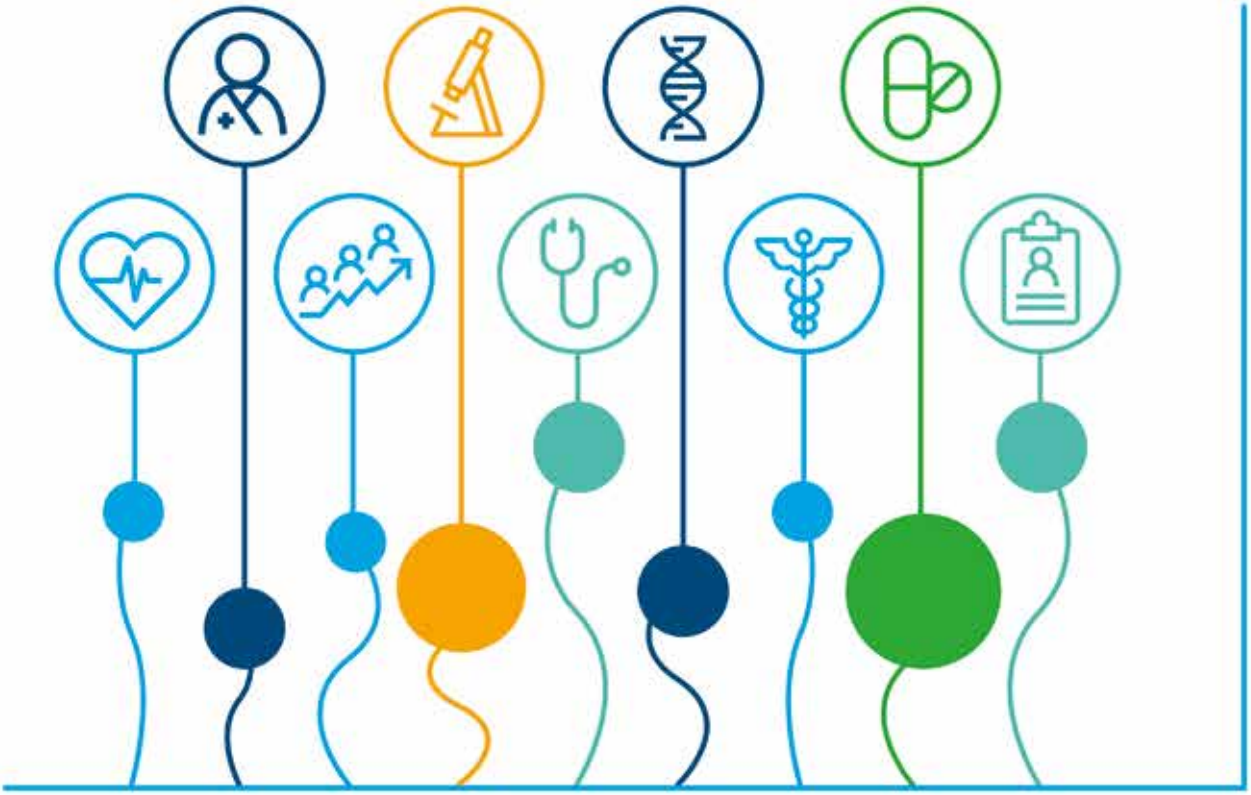

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