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Head start

New payment approaches for new models of care

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Contents

July/August 2017

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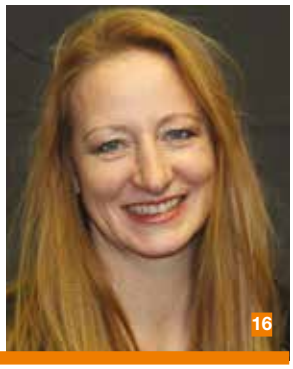
News

Comment

Professional lives

Features



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News

NHSI targets £500m deficit and takes aim at locum costs

By Seamus Ward

NHS Improvement has signalled an even greater focus on reducing staff costs in 2017/18 – particularly medical locum costs – as it targets an overall aggregate deficit of around £500m.

Announcing year-end figures for the provider sector in 2016/17, in which the aggregate deficit fell to £791m, the oversight body said agency staff spending fell by £700m, but this was still short of the planned reduction.

Controls introduced in October 2015 led to agency spending falling from £3.6bn in 2015/16 to £2.9bn in 2016/17, with 85% of providers reporting year-on-year reductions in agency bills.

The oversight body said this was a huge achievement, but more work was needed – providers overshot their planned agency spending by £559m and only 46 providers achieved their expenditure ceiling.

Much of the variance from plan was due to medical locum spending resulting from a shortage in A&E doctors. NHS Improvement is working with the Royal College of Emergency Medicine to target a £150m year-on-year reduction in locum spending in 2017/18. It also wants to address permanent and bank pay costs. The overall provider pay bill was almost £51bn in 2016/17, £811m more than plan and £1.8bn higher than 2015/16.

Pay inflation, including pay rises, drift and pensions were significant elements of this, adding an estimated 3.3% to costs. NHS Improvement said that taking these pressures into account, the pay bill grew by 0.5% in real terms, but this should be seen in the context of a 2.4% growth in cost weighted activity.

Overall, providers finished the financial year with a £791m deficit (£2.4bn in 2015/16), after application of the £1.8bn sustainability and transformation fund (STF). This compared with a planned deficit of £580m.

"Solid progress has been made in controlling the runaway deficits of the last three years"
Chris Hopson (pictured)

NHS Improvement said the final position was driven by cost savings, which totalled £3.1bn (3.7%). The oversight body's work with trusts in financial special measures had generated more than £100m in savings, while its financial improvement programme had identified a further £100m.

NHS Improvement chief executive Jim Mackey said: 'The NHS has delivered this turnaround at the same time as dealing with very high levels of demand – particularly over the winter period. In addition, there have been great efforts made in improving outcomes for patients.

'People should feel justly proud of what they've achieved this year, and go into next year knowing that, while it will be hard, the challenge certainly is not impossible.'

He added that providers had been challenged to achieve an overall deficit of £496m in the current financial year.

In 2016/17, cost savings fell short of plan by £266m, largely due to the adverse variance in pay costs. Three-quarters (£2.3bn) of the savings were recurrent – below the planned level of 92%.

The growth in acute activity and rising costs led to a £1.1bn overspend on plan for non-pay items, largely driven by drugs (£139m), clinical and general supplies (£343m) and premises (£382m). Record emergency demand had reduced providers' elective capacity – many paid for waiting list initiatives or outsourced the work, costing £209m and £381m, respectively.

Pre-audit the overall financial position was a deficit of £735m, but this moved to £791m as two trusts deferred transactions to the current financial year. These were Royal Free NHS Foundation Trust (£47m) and Royal Liverpool and Broadgreen University Hospitals NHS Trust (£10m).

NHS Provider chief executive Chris Hopson (pictured) said: 'These figures should be seen in the context of the enormous financial pressures trusts face, but also the solid progress that has been made in controlling the runaway deficits of the last three years.'

On the world stage

HFMA president Mark Orchard accompanied association chief executive Mark Knight to the US HFMA's annual ANI conference in Orlando towards the end of June. The annual national institute brought together 4,500 healthcare finance professionals and other stakeholders for its exhibition and conference, 'Collaborating for the future'.

Mr Orchard took part in a panel session on international perspectives on healthcare, examining the challenges and opportunities facing health systems across the world.

Mr Orchard (centre) is pictured with (from left): **Mark Lawrence**, vice president HFMA Australia and executive director of finance, capital and contracts for Western Health, which manages three acute hospitals in Melbourne, Australia; **Carol Friesen**, vice-president of health system services for Bryan Health in Lincoln Nebraska and incoming chair of the US HFMA; and **Mary Mirabelli**, vice-president of Global Healthcare Practice at Hewlett Packard Enterprise and 2016/17 US HFMA chair.

Mackey insists CEPs must maintain quality while protecting patients' rights

By Seamus Ward

NHS Improvement chief executive Jim Mackey has told providers that the capped expenditure process (CEP) must not harm patient safety or compromise patients' NHS Constitution rights on choice and maximum elective waiting times.

In a letter sent to the 69 trusts involved in the CEP at the end of June, Mr Mackey said he wanted to clarify the oversight body's expectations of the programme.

The CEP was launched at the beginning of the financial year to close the financial gap in some sustainability and transformation partnership (STP) areas. The STPs chosen for the process are those with the biggest gap between planned expenditure and budget allocation. This includes any allowance for overspends already built into the budget when control totals were set.

In the process, proposed spending on services is prioritised based on value and growth in activity is set at 'reasonable but not excessive levels'. Discretionary investments are taken out and efficiency savings set at a challenging but achievable level.

Mr Mackey said the CEP was one element of the effort to support STPs to resolve their financial issues at a system level. However, initial CEP submissions will only be regarded as proposals at this stage – NHS Improvement, NHS England and the Department of Health will examine them over the next few weeks to understand their impact.

In the meantime, provider boards must be assured that they have considered the consequences of their plans and that they will not have an impact on patient safety and quality. CEP plans must be consistent with constitutional rights on patient choice and referral to treatment.

While backing the objectives of CEP, Mr Mackey urged providers not to be distracted by the process. 'While I support the objectives of CEP – particularly that the process is undertaken on a collaborative basis – this exercise must

BMA questions STPs

Sustainability and transformation partnerships (STPs) lack the necessary upfront funding, there has been poor engagement with clinicians and the public and plans are being implemented without evidence, according to the British Medical Association.

A BMA report said STPs required £9.5bn of capital funding, but were unlikely to receive anything like this amount. It questioned whether STPs would survive. Freedom of information requests had discovered that more than 150 jobs, with combined annual salaries of at least £8.5m, had been created to deliver the plans.

BMA council chair Mark Porter (pictured) said the plans were a cover for cuts of £26bn in health and social care. 'It makes no sense to spend this kind of money on staffing and structure when we already know there is a huge shortfall in capital funding needed to actually put the plans in place,' he said. 'Any money spent here runs the risk of being completely wasted.'

Government hints at pay policy review

There was confusion over NHS pay policy after indications by cabinet ministers, including health secretary Jeremy Hunt, that the government was about to relax the 1% pay cap. These were later played down.

Speaking at the NHS Confederation conference in mid-June, Mr Hunt said he had a 'great deal of sympathy' for the case made by nurses and others to scrap the overall ceiling. The cap has been in place since 2013 and, in England, is currently set to continue until the end of the 2019/20 financial year.

He said the NHS had to live within its budget and that public pay policy was a matter for the chancellor, Philip Hammond.

However, the health secretary will meet nurses' leaders shortly and will report their views to Mr Hammond before a decision is taken about pay.

As the month closed, Labour tabled an amendment to the Queen's Speech, calling for an immediate end to the cap. While this was defeated, two cabinet ministers suggested the cap would be reviewed, while Downing Street reportedly suggested an announcement could be made in the autumn Budget.

Simon Stevens: call for financial balance

During the debate on the Queen's Speech, Mr Hunt suggested the government would wait until the pay review bodies had made their recommendations.

Also attending the conference, NHS England chief executive Simon Stevens (pictured) revealed that the commissioning sector delivered an underspend of £903m in 2016/17. He urged the NHS to repeat the hard work of the past 12 months and take part in RightCare and the model hospital initiatives.

'If we don't get the financial balance in the system, that's going to crowd out our ability to do so much of what we want. And it's also going to undermine our argument that we are effective stewards of further funding for the NHS,' said Mr Stevens.

NHS Improvement chief executive Jim Mackey told the conference that in 2017/18 more detail on the next steps for the forward view would be published and there would be 'a big push on operational productivity'.

While NHS Improvement would not loosen its grip on financial control, quality improvement would come more to the fore in its work, he added.

• *See Funding – a closed case?, page 10*

"This exercise must be regarded as just one aspect of our collective efforts to deliver our financial obligations and live within the resources available"
Jim Mackey, above

be regarded as just one aspect of our collective efforts to deliver our financial obligations and live within the resources available.'

He added: 'It is therefore important that CEP plans, where appropriate, supplement your board approved 2017/18 operational plan that you will already be delivering. Providers must not be distracted from delivering the individual financial savings plans that have already been worked up and assured from a patient safety and quality perspective. It is essential that providers continue the work to deliver these plans and build on the excellent progress made in 2016/17.'

In the latest HFMA *NHS financial temperature check*, finance directors said relationships in STPs are getting stronger, but there were significant concerns that the plans can close the funding gap by 2020/21.

In December's *Temperature check*, only 20% of finance directors thought relationships were strong enough to deliver change, but in the latest survey this rose to 50%.

Despite the stronger relations, trust and clinical commissioning group finance leaders are not confident STPs can close the funding gap.

• *See Continued pressure, page 21*

2017 HFMA Awards nominations now open

Nominations for the 2017 HFMA Awards opened in mid June and already finance professionals are working hard to submit their entries.

As with last year, there will again be eight categories, including a new award category, Finance Team of the Year. This will replace the Accounts Team of the Year Award.

The new award seeks to recognise the work of the wider finance team.

The HFMA said it is 'an award that recognises the contribution that the finance team has made in the last 12 months to promoting and improving teamwork, innovation, collaboration, transformation and governance'.

As well as governance improvements and how the team tackled a challenge or worked to avoid a problem, entrants must also outline how they have acted on the external auditor's recommendations in their ISA 260 report and how they have furthered the HFMA president's theme of *Everyone counts*.

Other awards are for finance director and deputy finance director of the year, and there are categories covering innovation, costing, training, governance and clinician of the year.

The deadline for entries is 29 September, and the shortlisted organisations will be announced at the end of October.

The winners will be announced on 7 December at the HFMA awards dinner.

• *Please visit www.hfma.org.uk for further details*

HFMA stalwarts recognised in Queen's honours

By Steve Brown

Two leading lights from the NHS finance community and HFMA honorary fellows have been recognised in the Queen's Birthday Honours list.

Former HFMA president Tony Whitfield has been awarded an OBE for services to the NHS. Mr Whitfield was association president in 2013 and recently stepped down as finance director of Leeds Teaching Hospitals NHS Trust.

Louise Shepherd, a former NHS finance director and currently chief executive of Alder Hey Children's NHS Foundation Trust, was also awarded a CBE for services to healthcare.

Mr Whitfield spent 34 years working in NHS finance, including 25 as a finance director, and was involved in a number of national programmes and activities.

Passionate about the potential for costing data in the NHS to inform improvement and transformation, he led the HFMA's early work to support the adoption of patient-level costing. An early proponent of the need to develop

new models of care, and an enthusiastic supporter of finance skills development, as association president he encouraged a better mutual understanding between clinicians and finance practitioners.

Mr Whitfield said he was 'touched and surprised' by the award. 'It is particularly moving to realise that people have nominated me for this honour,' he said.

'I am delighted and humbled by it and I know that it is also recognition of the teams I have worked with and of the wider finance community. The NHS involves a team of people working on the frontline and in support services, and finance has a significant role to play in that overall team.'

A former finance director at the Countess of Chester NHS Trust, Ms Shepherd joined Alder Hey in 2008 from Liverpool Women's NHS Foundation Trust, where she was also chief executive. She was made an honorary fellow of the HFMA in 2008 to recognise significant contributions to the association at branch and national level, including a spell as national honorary treasurer.

HFMA chief executive Mark Knight said the awards were fully deserved. 'I'm absolutely delighted that two honorary fellows of HFMA have been recognised in the Queen's Birthday Honours list,' he said. 'Both Louise and Tony have made an enormous contribution to the NHS and to the association.'

News review

Seamus Ward assesses the past month in healthcare finance

With the election over and a new minority Conservative government formed under Theresa May, it looks like it's back to normal for the NHS in England. With the prime minister carrying out only the lightest of reshuffles, Jeremy Hunt kept his place at health. He is one of the longest serving health secretaries, having been appointed in September 2012 – a continuity choice to lead a service that faces a raft of familiar problems over the next few years (see news analysis, page 8), Mr Hunt's reappointment was widely welcomed across NHS think-tanks and pressure groups. Though Philip Dunne and Lord O'Shaughnessy were reappointed minister of state and health lead in the Lords, respectively, two new junior ministers were appointed – Winchester MP Steve Brine and Jackie Doyle-Price, who represents the Thurrock constituency.

The UK's exit from the European Union will dominate matters over the next few years and could have a significant impact on the health service. The Nuffield Trust warned that the NHS could face a £500m bill if retired British expats returned to the UK due to their right to healthcare being withdrawn where they are currently living. Care homes and homecare agencies could face a staffing shortage of 70,000 by 2025/26 if migration of unskilled EU workers is halted after the UK leaves, it added.

There was a further warning on staff numbers as the Health Foundation said the number of nurses from other European Union countries registering to practice in the UK has fallen by 96% since last July. The EU referendum took place in June last year. Figures obtained from the Nursing and Midwifery Council show a decline from 1,304 in July 2016 to 344 in September 2016 and just 46 in April this year. The foundation said this suggested a sustainable, long-term approach to workforce planning was needed. Its figures show that, historically, a greater proportion of registrants came from outside the EU, but since 2008/09 most newly registered overseas nurses now come from EU countries. The foundation said that without EU nurses the NHS would find it even more difficult to find the staff needed to provide safe care.

With risks to the NHS evident, a Brexit Health Alliance was launched at the NHS Confederation conference. It aims to be the voice of the UK health sector as the country leaves the EU. The alliance will focus on areas such as healthcare research and UK citizens' rights to treatment. Members include the NHS Confederation, NHS Providers, the Academy of Medical Royal Colleges and the Association of the British Pharmaceutical Industry.

The NHS is on course to save more than £2m from the first two products bought through a central purchasing programme, according to NHS Improvement. It said the aggregation of national demand for couch rolls and blunt-fill syringes through the NCP (nationally contracted products) programme was on track to make the savings. NHS Improvement had worked closely with NHS Supply Chain to simplify the ordering process, it added.

NHS Improvement is also targeting cost reduction in private finance initiative schemes. Chief executive Jim Mackey (pictured) issued a letter setting out the steps the oversight body was taking to support providers with PFIs. Mr Mackey wants to reduce these costs, which make up a significant proportion of these organisations' cost base – as well as the overall NHS cost base. He asked trusts with PFIs to take part in a

The month in quotes

"[The hung Parliament] does not change the need to undertake a thorough review of long-term demand patterns in health and care – and the associated resource implications. I well understand the pressures ministers face, particularly in a difficult parliamentary situation. I have the t-shirt. But real life will not wait; we all know demand pressures in the system are building.'
NHS Confederation chairman Stephen Dorrell calls for a review of drivers of demand and the cost implications

'This vital investment will help hospitals change the way they assess and see patients so people are given the most appropriate medical care as quickly as possible.'
Health secretary Jeremy Hunt allocates winter preparation funds

'Every one one of us at some point in our lives will use, or know someone who uses a health or social care service. That's why these standards are so important – to ensure everyone in Scotland receives the care and support that is right for them.'
Scotland health secretary Shona Robison unveils new NHS and care standards

'The drop in EU nurses registering to work in the UK could not be more stark – just 46 registered to work in the UK in April. Without EU nurses it will be even harder for the NHS and other employers to find the staff they need to provide safe patient care.'

Anita Charlesworth, Health Foundation director of research and economics, says staffing is one of the chief Brexit issues facing the NHS

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Jeremy Hunt's reappointment as health minister was widely welcomed across NHS thinktanks and pressure groups

survey to give NHS Improvement a better understanding of how existing contracts are managed and what areas trusts are covering in discussions with PFI suppliers.

Procurement and PFI costs are well-known issues. Another – rising activity and subsequent failure to achieve operational targets – was evident in June. According to NHS England statistics, A&E attendances were 4% higher in April 2017 than in April 2016, while emergency admissions were 2.8% higher. The four-hour A&E waiting target was met for 90.5% of patients, below the 95% standard. Referrals to consultant-led treatment increased 5.2% on the preceding 12 month period and 89.9% of patients had been waiting less than 18 weeks – the standard is 92%. The daily average number of delayed transfers of care beds was 5,905 in April, compared with 5,601 in April 2016.

Figures for Northern Ireland showed similar issues. A&E attendances increased by 4.5% between 2015/16 and 2016/17 and just over 74% of patients attending emergency departments were treated, discharged or admitted within four hours in 2016/17. Over the last five years, attendances have increased by more than 11%, with performance against the four-hour target declining by 4 percentage points.

Some of the extra money given to Northern Ireland under the government deal with the DUP will be spent on reducing local waiting times and, in England, the Department of Health said some hospitals will receive more funding to help them prepare for the winter. Health secretary Jeremy Hunt awarded almost £21m to 27 hospitals to ensure A&E departments are ready for winter – earlier, in April, 70 hospitals shared a £56m pot. The funding was announced in this year's Budget to promote triage on arrival and introduce GP practices in emergency departments.

Former health secretary and NHS Confederation chairman Stephen Dorrell (pictured) called for a review of long-term demand for health and care. At the NHS Confederation annual conference in Liverpool in June, Mr Dorrell said the review should also examine the resource implications of long-term demand. He added that it was time to build on the work of sustainability and transformation partnerships and local authorities to deliver more joined-up services.

There will be a new deadline for submitting A&E performance statistics. From August, the statistics will be published a month earlier than at present. NHS Improvement said the 10 August statistics publication will include data for July as well as June, while performance statistics published in September will cover August. The latest NHS Improvement provider bulletin said that, to meet this new timetable, the deadline for submission will move to the second working day of each month rather than the 22nd.

The Scottish government unveiled new health and social care standards, which are due to be implemented in April next year. It said the standards focused on improving patients' experience of care and are based on five outcomes. These cover the quality of care and support, patient involvement in decision-making and the quality of the care environment.

from the hfma

The UK and the US must choose a revolutionary path that leads to greater value in healthcare, according to Jason Helgerson, New York State Health Department Medicaid director. In a blog on the HFMA website, Mr Helgerson, who is due to speak at the HFMA CEO forum in September, argues that a system based on rewarding value has patients at its centre. But providers must also be given flexibility to redesign systems to better meet patient need.

In the first of a series of blogs on the HFMA website, former association chairman Bill Shields (right) describes his first weeks working in Bermuda. Mr Shields moved there in April, after 30 years in NHS finance, becoming the chief financial officer of the territory's hospitals board. He talks about the differences in funding, provider reimbursement and some similarities with the UK.

The HFMA has surveyed members in providers and commissioners on investment in mental health services in 2017/18 and 2018/19. In a blog on the HFMA website, technical editor Sarah Bence says the survey shows national policy is encouraging debate and transparency around funding, but the financial challenge of meeting the investment standards is tough. We need to look beyond the investment standards, focusing on outcomes rather than money put in, she adds.

• **See www.hfma.org.uk/news/blogs**

Other HFMA publications in June include:

- *Accounting for joint working arrangements 2017*
- *Capital collaborations between the NHS and local authorities*
- *Integrated reporting in the context of the* Wellbeing of Future Generations Act (Wales) 2015
- *The importance of strong financial governance*

News analysis

Headline issues in the spotlight

Strength and stability

Seamus Ward looks at what the general election result means for the NHS

While it was clear before June's general election that the next five years would be pivotal for health and social care, the election result is likely to mean that any changes in the health service in England will be evolutionary rather than revolutionary.

Theresa May's government may have returned to office, but, with the support from the Democratic Unionist Party, it only has a razor-thin working majority of 13. That's not a platform from which to launch a major programme of reform. Jeremy Hunt's reinstatement as health secretary was perhaps a sign that the prime minister wants no major upheaval in health, and that most of the action may take place away from Parliament.

In truth, the Conservatives were not planning a huge reform of the service – much of their attention will focus on mental health and a new patient safety framework. They know that most of Parliament's time will be taken up in dealing with exiting the European Union – bringing EU law into British law and scrutinising the outcomes of negotiations with Brussels.

However, in its manifesto Mrs May's party did include a provision to review, and if necessary amend, the NHS internal market. Changes that did not require amended legislation will be brought in for the 2018/19 financial year, it said.

Generally, amendments to the working of the internal market are seen as simply reflecting the direction of travel towards a more collaborative system under the *Five-year forward view.* While changes are still likely, broader changes that would require legislation, potentially such as amending competition rules or creating statutory accountable care organisations, are less so.

'Changes in legislation to support delivery of the forward view now seem unlikely, if only because they would act as a lightning rod for opposition parties seeking to attack the government's stewardship of the NHS,' says King's Fund chief executive Chris Ham.

'In the absence of legislation, NHS England will continue to promote evolutionary changes to the organisation of the NHS, including collaboration and in some cases mergers between clinical commissioning groups.

'Accountable care systems (ACSs), in which NHS organisations come together to plan and deliver care, will also become more prominent.'

Many commentators see the election result as strengthening the hand of NHS England chief executive Simon Stevens, who has reportedly had a tense relationship with Number 10 during the last year. With Downing Street weakened, he will have a freer rein to implement the forward view, they reason.

Indeed, speaking at the NHS Confederation conference in June, Mr Stevens signalled full steam ahead on the plan, rolling out ACS schemes and announcing a new devolution deal for Surrey Heartlands, similar to that in Greater Manchester.

However, the election demonstrated that delivering the forward view through local sustainability and transformation plans, which are already dogged by controversy, will be anything but plain sailing.

Many plans include the reorganisation of services, moving them out of hospital and into the community. However, to the public, the hard, unqualified facts of ward closures or the consolidation of local A&E or maternity services look like cuts.

Conservative backbenchers, many of whom are now sitting on smaller majorities, will be nervous of changes to hospital services in their

Northern Ireland boost

The minority government could be a positive outcome for public services in Northern Ireland. As well as agreements on national policies, such as those on pensions, the deal struck between the government and the DUP at the end of June handed an extra £1bn over two years to the overall Northern Ireland budget.

This will include a minimum of £250m – which is likely to be topped up to around £300m – for health and social care, which previously had a budget of around £5bn.

There will also be greater flexibility over how £500m of funds previously announced can be spent, some of which is likely to benefit health and social care.

Much of the new money will be spent on reducing waiting lists and transforming care, although £50m has been allocated for mental health service improvements.

Northern Ireland has some of the longest waiting times – in 2016/17 just over 74% of A&E patients were treated, discharged or admitted within four hours, while in December 2016 almost a quarter of a million patients were waiting for a first outpatient appointment – 47,000 of them for more than a year.

However, with the local parties at an impasse over forming a new Assembly executive – though talks continued as *Healthcare Finance* went to press – health and social care and other public spending programmes do not have a confirmed budget for 2017/18.

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constituencies. They will point to Canterbury as a warning, where Labour candidate Rosie Duffield, who opposed changes in local hospital provision, narrowly beat the incumbent Tory MP – the first time in more than 100 years that a Conservative has not taken the constituency.

'Some STPs include plans to reconfigure acute hospital services—for example, by centralising services to tackle workforce shortages and improve patient outcomes. The new government is likely to be sensitive about these changes in the light of public concerns about the downgrading of local hospitals,' Professor Ham said.

Nuffield Trust chief executive Nigel Edwards said local changes could be more difficult to achieve. 'Several MPs have run explicitly against changes in areas such as North Oxfordshire and West Devon, where the winning Conservative candidate has vowed to leave his party if the local A&E is closed.

'Meanwhile, the Labour Party's proposals to halt the STPs and oppose hospital closures seemed to resonate with public concerns and may well have been behind some of the high-profile swings to Labour, such as the dramatic result in Canterbury.'

Public engagement is vital, Health Foundation chief executive Jennifer Dixon insisted. '*Next steps on the NHS five-year forward view* outlines five key principles for public engagement and four tests where significant hospital bed closures are on the table. These appropriately require a lot of shoe leather diplomacy – communication, communication, communication – a task which, because of the election results in some areas, just got a whole lot harder,' she said.

While the task is local, the government could smooth the process by ensuring proposals are robust, consulted on and adjudicated adequately. 'There is little mention of these issues in the 2017/18 *NHS mandate*. Without more action, surely the result will be an avoidable and drawn-out challenge, and the government having to back off some needed change,' she added.

"The prize for being the largest party in this election is being in power at the point that the health and social care system has run out of financial road"
Nigel Edwards, Nuffield Trust

NHS funding will remain under question. In the manifesto, the Conservatives promised a minimum of £8bn for the NHS in real terms over five years. Commentators such as the Nuffield Trust and the Health Foundation said this was insufficient for the service's needs – a conclusion they reached on all the main parties' NHS spending pledges.

According to the Nuffield Trust, the pledge would mean an increase of overall health spending in England to £131.7bn by 2022/23. The organisation said the NHS will require between £137bn and £155bn a year by that time.

It remains to be seen if chancellor Philip Hammond will stick to the manifesto plans, especially as Labour's gains in the polls are being interpreted as a vote against austerity. How will the spending plans square with Jeremy Hunt's comments at the NHS Confederation conference last month, when he hinted that the 1% cap on pay rises – for nurses in particular – could end?

The Nuffield Trust's Nigel Edwards said finding additional funding will be difficult. There is little room to cut other services, especially with newly empowered Conservative backbenchers ready to use their influence. And, the agreement with the DUP (see box) means the government cannot implement its planned end to the triple lock on state pensions (which ensures a 2.5% rise each year) or introduce means testing for winter fuel allowances.

'If running a government with no overall majority were not difficult enough, the prize for being the largest party in this election is being in power at the point that the health and social care system has run out of financial road,' Mr Edwards said.

He added that the focus on operational performance, such as the key four-hour A&E waiting time target, will be ramped up in response to public concern about the NHS.

There are a further two questions, which will remain outside the control of the NHS – the settlement on EU exit and the long-term funding of social care. While the government has promised a consultation on the latter, the former will dominate this Parliament.

The NHS will want a deal that maintains economic growth (underpinning rising spending) and clarifies the future of EU citizens working in the health service. In June, as negotiations began, the prime minister outlined plans to give reciprocal settled status to EU nationals who have lived in the UK for at least five years. While not referencing EU workers in the NHS specifically, she added that EU citizens who have lived in the UK for less than five years will be able to stay and apply for settled status once the five-year threshold has passed.

Broadly, the election has changed little for the NHS in England – there will still be austerity, high levels of cost savings will be required and there will be pressure on operational performance targets. And the service will embark on STP engagement with a sceptical public with, potentially, less political support than they might have hoped for before the general election.

Comment

All together now

As finance leaders roll up their sleeves, the focus must be on collaboration

HFMA president Mark Orchard

As the English health system moves further away from competition and philosophically closer to the integrated models employed by the three devolved nations, the indications are that we have arguably just pulled off the biggest collaboration of all.

It looks as though 2016/17 provider deficits have been dampened by sustainability and transformation fund income and offset with the reserve protected by commissioners. And achieving this overarching 'system control total' is in the end what counts. All focus has now switched to 2017/18, and repeating aggregate financial delivery within the total allocation will be another colossal challenge.

Meanwhile, we have a UK government with a weakened mandate and a single parliamentary focus for the next two years on exiting the EU in the best possible shape. No-one would expect either an NHS revenue funding injection or a meaningfully concluded public debate ahead of Brexit on the future of health and social care. As one commentator suggested, we will remain in the 'sleeves rolled up' period for the foreseeable future.

Dorset has taken huge steps towards collaboration, including all five NHS parties (commissioner and four providers) agreeing to share financial risk from April 2017. There isn't any magic bullet behind our agreement – after all, there's no more money. In our case a single county-wide clinical commissioning group with a flat allocation settlement was only ever going to mean flat cash for planned flat activity, translating into flat workforce at best.

If delivered, this at least puts us on trajectory for an agreed five-year system transformation plan.

The current year efficiency

Funding – a closed case?

Could a pay cap review trigger a broader look at NHS funding?

Healthcare Finance editor Steve Brown

It's a case of 'as you were' for the NHS following last month's general election. That is certainly how it seems on face value.

The different parties had set out different funding proposals in their manifestos. They had confusingly used different ways to describe this funding – making comparison less than straightforward. But the general conclusion of NHS commentators was that the Conservative proposals offered the smallest direct investment in health services over the next five years.

What they offered with their £8bn in real terms over five years was basically the already announced spending plans extended by two years. There is a small bonus of promising real-terms per capita growth for each year of the Parliament, which changes the existing spending profile – although we have heard nothing more about this. We are also promised £10bn in capital spending, but in line with the Naylor report, not all of this will come from the taxpayer.

The vociferous calls during the campaign to meet the service's clear challenges with more

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"Strip away the different funding mechanisms and it's clear we all face the same issues"

ask that falls out of this approaches 5% – slightly ahead of the average indicated by responses to the HFMA's latest *NHS financial temperature check* (see page 21). We have a monthly governance system to ensure all parties, individually and collectively, are doing what they said they would do.

Only time will tell if this approach works for Dorset, but the mind-set change is tangible, with all five finance leaders and colleagues modelling the future.

I write this column having spent some time at the US HFMA ANI conference. While there, we shared experiences with our global HFMA partners, including chief finance officers from some of the most renowned US healthcare bodies and Australian health systems.

Strip away the different funding mechanisms and it's clear we all face the same issues, from Kaiser Permanente to Gold Coast Health. We are all focused on maintaining the prevailing health 'offer' in light of funding and efficiency expectations. We all face the challenges posed by demographic population growth, rising user expectations and workforce recruitment, development and retention challenges.

All the CFOs saw collaboration, not competition, as the answer to improving value. This was underlined by the theme of this year's HFMA US conference 'Collaborating for the future' – a bold statement in a health system built on fee for service.

Back at home, the first real indication of Dorset's position will come from the analysis of finance and performance results at the end of Q1. What is the story behind our leading numbers for I&E run-rate, the A&E four-hour standard (with associated STF income link) and cash? That will help us build out our 2018/19 opening position and compare with the original plan. Then we can adjust our organisational focus to set efficiency plans for next year, while dealing with any under-delivery in this year.

This is a path well trodden by all of us. But let's not take for granted the leadership role we play in maintaining this momentum. My time with US and Australian colleagues reminded me that while these are among the toughest leadership roles, they are often also the most rewarding. And in the words of the incoming HFMA US chair 'where passion meets purpose' – that's where the magic happens.

Contact the president on president@hfma.org.uk

appropriate levels of additional funding have gone unanswered. And so that is that in terms of funding – or is it? The election may not have triggered a change in government, but it looks set to have an impact on the style of government and maybe soften its 'austerity at all costs' approach.

No-one in NHS finance would plan for a funding boost in the short term. As HFMA president Mark Orchard says (see above), it's a case of roll your sleeves up and focus on submitted plans.

But there are other things at play here. There have already been hints that the 1% public sector salary cap could be reviewed. Many leaders in the NHS would back such a move given the efforts of staff in recent years and the importance of staff buy-in to the transformation agenda. Surely such a move would have to be accompanied by an adjustment to the NHS settlement? It would be fanciful to expect providers to cover this cost pressure within existing budgets.

Of course a funding change to accommodate increased pay wouldn't help trusts address current imbalances. But it just might provide an opportunity for a broader review of funding. There are definite signs of growing support for a less austere approach to public services, backing key areas such as the NHS, social care and public safety with more than just words.

An argument that has been put forward a number of times in recent months has been that the NHS cannot ask for extra money before it has eliminated the waste from its existing systems. National programmes such as *Getting it right first time* have already flagged up significant variation across orthopaedic surgery and it has moved on to other areas. RightCare data also suggest there is significant potential to address variation and release cost.

But the existence of potential efficiency opportunities should not rule out the need for additional resources. There is clearly major potential to improve services for patients and reduce costs by addressing variation in clinical and support services. But these opportunities will not be realised overnight.

"There have already been hints that the 1% public sector salary cap could be reviewed. Many leaders in the NHS would back such a move"

Clinical engagement and leadership will be vital to driving this agenda. But that is difficult without the headroom to allow them to lead. In some cases that will need additional staff to backfill shifts to enable fast progress to be made with transformation. It will also take time if transformation is done properly – which it has to be – involving public consultation, understanding and support for local change programmes.

The system-wide approach to developing new models of care and responses to major service pressures is the right one. But insufficient funding might mean it takes longer to achieve. And maybe a change of mood among the public and a government more in listening mode might bring this issue back onto the table.

SHUTTERSTOCK

incremental gains

With greater efficiency and productivity vital to the NHS, a Sussex trust has embraced continuous improvement. Seamus Ward looks at how it has embedded this culture in its day-to-day work

The NHS is no stranger to the continuous improvement (Kaizen) and Lean techniques first developed in the Japanese car industry. Hospitals have used the methodologies to, for example, reorganise storage cupboards so their contents can be accessed quickly or to give an at-a-glance picture of patients as they move from preparation to surgery to recovery.

These can improve the patient experience, engage and empower staff and, sometimes, save money. But in many trusts they are isolated projects, often dismissed as too small to have a lasting impact.

Western Sussex Hospitals NHS Foundation Trust, however, has taken the mantra of continuous improvement and applied it across the organisation. The improvement programme, known as *Patient first*, sets out the trust's long-term approach to transforming and delivering its hospital services, explains executive director of strategy and delivery Peter Landstrom. Be it small steps or complex change, he says, the programme is a continuous process of improvement within existing processes and pathways, leading to measurable improvements for patients and staff.

He adds that it empowers frontline staff to make improvements themselves – by providing the training, tools and freedom to work out where the opportunities are – and gives them the skills and support to make change happen, and then making it sustainable. A Kaizen office is one element of *Patient first*, equipping staff with the right skills (see box overleaf).

'It's based on Lean methodologies and continuing improvement of processes and pathways across the whole organisation,' says Mr Landstrom. 'It's less about isolated individual improvement projects and more about the way we do business – improving the quality of our care, safety and financial performance, among other things.'

With the overarching *Patient first* programme embedded in the trust's strategy, day to day it focuses on what it calls True North – how services can be delivered to improve patient outcomes and experience.

This is supported by a number of objectives in four areas: sustainability; staff; quality improvement; and systems and partnership.

While Mr Landstrom accepts that a lot of hospitals will focus on similar goals, he adds: 'What we feel is unique is how we have oriented them to the concept of True North goals and how we are putting all our improvement effort into achieving those goals. It's about how we build the capabilities of our staff and their awareness and ability to use improvement methods, expert support, leadership behaviour and how we as a senior team work.

'As a senior team we talk about removing the rocks from the shoes of our staff so their efforts are going into improving patient care and delivery of services.'

True North includes a number of measures of success:

- Excellent patient experience – assessed through the friends and family test
- Sustainability – balancing the books so it can continue to invest in services
- Quality improvement – achieving 99% harm-free care (the trust is in the top 20% in the country for lowest hospital standardised mortality ratio)
- Staff engagement – listening to, training and supporting staff to work on continuous improvement, assessed through the annual staff survey
- Systems and partnership – streamlining processes to improve patient flow and meet A&E and referral to treatment waiting time targets.

Each measure is further broken down into breakthrough objectives.

For example, in sustainability the trust aims for break-even or better. This objective is not linked to the trust's control total and is seen as a long-term aim. The trust's control total in 2016/17 was a surplus of £17m, taking into account sustainability and transformation funding. Though it failed to achieve the control total – largely due to missing its financial target in Q4, which in turn limited its access to STF – it still made a retained surplus of £8.8m.

'The biggest improvement on this breakthrough objective was reducing agency spend,' Mr Landstrom says. 'Like a lot of areas, we have a lot of workforce challenges. Reducing agency spending was our key breakthrough, looking at areas like market management and recruitment. And in the last financial year, we reduced our agency spending from £23m to £18m – that's a real saving of £5m.'

"*Patient first* is less about isolated individual improvement projects and more about the way we do business"

Peter Landstrom, Western Sussex Hospitals NHS FT

Lean techniques – getting to the causes of the spending with the help of staff – played a role in reducing agency spend.

'We asked what are the drivers of this spending and out of that came the question of how we can better manage specialling – which is one of the biggest challenges. And because of that it became a quality driver, focusing on the care we give our patients, rather than a purely financial one.'

In quality, the breakthrough objective in 99% harm-free care in 2016/17 was reducing falls. Mr Landstrom explains that the data clearly showed falls as a priority. The risks and causes of falls in hospital were stratified and this led to the development of a bespoke solution for each ward. Also, after each fall, staff on a ward will look at where it occurred, check the environment and discuss the patient's condition, frailty, and medication to determine the cause and address it.

'This is part of the power of our continuous improvement approach because it helps us understand the clinical requirements,' says Mr Landstrom. 'We've had a 30% reduction in falls over the past year. This is huge for us as it has saved bed days and avoided harm to patients.'

The trust has improved its delayed discharge record in intensive care – an area for improvement noted in its Care Quality Commission report. It used a Lean problem-solving approach to bring the right people together to review in detail the entire discharge process from ITU to the wards.

After an in-depth analysis, they identified the top three interventions that would have high impact and not be too difficult to implement. This included agreeing a new standard for board rounds and infection control guidance.

According to Mr Landstrom, in 2016/17 Western Sussex was one of the few trusts to achieve the CQUIN payment for a 30% reduction in critical care bed days occupied by patients who are ready for discharge to a ward.

'This obviously had an impact in terms of patient experience, resources deployed in critical care and patient flow. There was some financial benefit as we received the CQUIN payment and it also links back to our True North quality improvement – we have seen better flow through critical care so the overall lengths of stay have improved.'

The trust has rolled out the training to wards and clinical areas to give staff the tools to carry out their own improvement work. There has been a lot of work on patient flow.

For example, on one of its general medical wards – Castle Ward – staff have been trying to speed up the discharge process by focusing on the timeliness and accuracy of TTOs (to take out medication).

'TTOs are an age-old problem,' says Mr

Landstrom. 'We did a focused piece of work around it and one of the underlying issues was the accuracy of TTOs on the ward. A baseline exercise showed that the accuracy was 50%.'

The Lean work led to a change in the system for issuing TTOs on the ward. Previously, junior doctors would write them up and the prescriptions would be sent to the pharmacy to be checked. Even if the TTOs are accurate, there are some inefficiencies and delays in the system. Under the new system, doctors and pharmacists sit together to write up the TTOs, speeding up the process and making it more accurate.

'The accuracy went from 50% to 95% and the average time taken for TTOs to be verified and issued went down from three hours to 10 minutes,' Mr Landstrom adds. 'It was about using the improvement techniques to critically think through the underlying issues. We have been able to turn the dial on this with no extra resource. We have rejigged the way the teams work – they are doing what they were already doing but in a smarter way.'

The flow improvement work resulted in a 25% reduction in average lengths of stay on the ward, with knock-on improvements in patient experience, bed availability and savings.

Staff engagement

Mr Landstrom says *Patient first* has increased staff satisfaction – they want to be engaged with the improvement work. For example, band 2 healthcare assistants working on one ward suggested and drove forward a project on improving bed turnaround. They were frustrated that, say, a bed could be ready for a patient to be admitted from A&E but it could take a long time for the patient to arrive.

The HCAs came up with a two-part solution. 'First, they standardised the way beds should be turned over, setting out what needs to be in place to make a bed available – how to make a bed and clean it so it meets infection control standards. This is also great for training and induction of new staff,' he says.

Second, they now go and collect patients when their bed is ready. 'This has all sorts of benefits, including greater continuity of care and a large reduction in the downtime of beds. We saved about 50%. This had a huge impact on the delayed flow to wards. The ward now manages its own admissions and there is a better patient experience.

'Small improvements can make a big difference. It's about getting into simple improvements and then, through continuous improvement, you start seeing bigger results.'

Mr Landstrom says the support of the organisation's leadership is vital to the success of *Patient first*. 'We have senior leaders – the board and executives – who understand this is worthwhile. In challenging times, it could be easy for this work to be thrown off course, but we are holding true to the belief that this is the way we go about meeting some of these challenges,' he says. 'You need to be a relatively stable organisation. We are a medium-sized trust with two acute sites serving a big geographical area, but we are stable and this enables us to take the extra step forward.'

Individually, the issues addressed by Lean and other improvement techniques can seem to have little impact, but, as Western Sussex shows, rolling them out trust-wide can improve staff morale and patient experience, avoid costs and even attract income.

US health value guru Professor Don Berwick (far right) listens in at an improvement huddle at the trust's Worthing Hospital

Improvement programme

Western Sussex's *Patient first* work and the staff engagement it has created played a key role in the Care Quality Commission awarding the trust an overall 'outstanding' rating last year. The trust has trained hundreds of staff in Lean and other improvement techniques and 20 wards have been involved in the improvement process.

'Doing more of the same was not going to continue to drive improvement,' says the trust's executive director of strategy and delivery Peter Landstrom. 'We needed a different strategy to see us through to the future. There are good examples in the US and emerging examples in UK vanguards, doing elements of what we are doing, but they are not quite as comprehensive as we are.'

He adds: 'We feel we are unique because we are not doing everything in isolation. It's part of our whole system approach and that's been the take-home message for trusts that have come to see how we do things.' Visitors have included US value expert Don Berwick.

The trust's Kaizen improvement hub oversees training and the sharing of learning across the trust. Managers and clinicians are seconded from other parts of the trust, with support from KPMG.

Russ Jewell, a director at KPMG's healthcare consulting practice, who has a clinical background, says consultants tend to be called in when something goes wrong, savings are needed or there are quality issues. But such crisis points are often symptoms of a deeper malaise.

'It can be frustrating as a consultant that you rarely get to address the root causes. So we took a step back and asked what we would do if we had two years with an organisation? What would we put in place in terms of capabilities and infrastructure?'

KPMG was able to do this at Western Sussex. The trust was not at crisis point but had realised pressures in the NHS meant it had to change. The consultants worked at three levels – the executive; the front line, giving people the skills to drive improvement at trust or ward level; and the Kaizen office, which ties these levels together.

Mr Jewell agrees with Mr Landstrom that pulling together the trust's improvement efforts through the Kaizen team and ensuring continuous improvement is part of the trust's DNA are crucial.

Mr Jewell admits to being a convert to Lean, having experienced traditional, project-based Lean schemes. 'I was a massive Lean sceptic,' he says. 'You do some improvement work, but when the focus moves on to another project it slips back to the way it was. So people concluded Lean doesn't really work in the NHS.

'But what we are doing is very different – it's about sustainability around the management system and changing the way the organisation runs itself.'

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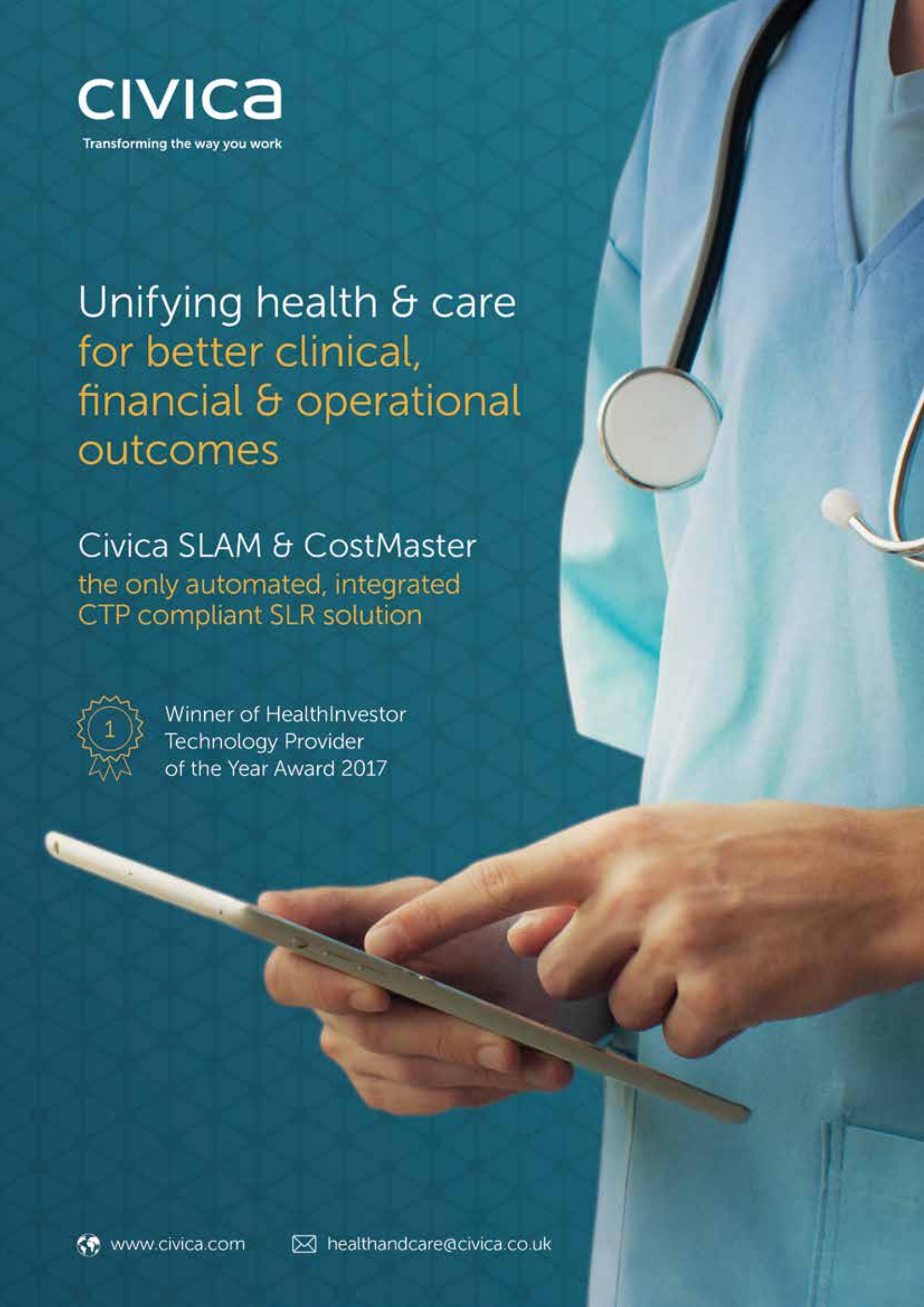

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new payment model

A new capitated budget will go live in mid-Nottinghamshire this autumn, underpinning a new musculoskeletal pathway. Steve Brown looks at the new model of care and how the money will flow

New models of care will need new payment systems, incentivising more integrated and sustainable services. To date, much of the work around these payment approaches – which will often involve capitated budgets – has remained at the theoretical level. But in October, the Mid-Nottinghamshire health economy will go live with one of the first new capitated budgets to underpin its new service approach for musculoskeletal services.

Mid-Nottinghamshire's *Better together* programme started in 2013 – covering the population served by Mansfield and Ashfield and by Newark and Sherwood clinical commissioning groups. Its aim was to join up services, putting more focus on prevention and moving more services into the community, while addressing an estimated £140m funding gap that was expected to open up over the coming 10 years.

At the start of 2015, it was named as one of NHS England's 50 vanguard sites – one of nine health economies exploring the potential to set up primary and acute care systems (PACS).

A PACS is one of a number of different care models being tested as part of the vanguard programme. While both PACS and multi-specialty community providers (MCPs) look to bring together primary, community, mental health and social care services, the PACS model also includes most hospital services, opening up the potential for new accountable care systems to be developed.

A number of accountable care systems have recently been identified for central support to accelerate their development and share learning. Nottinghamshire Sustainability and Transformation Partnership has been selected as one of these systems, although the immediate focus will be on Greater Nottingham, Mid Notts' STP partner.

With all these new models of care, revised pathways have to be put in place first. But, once established, new payment systems will be needed to ensure all providers are properly remunerated to cover appropriate costs and incentivised to work together to deliver sustainable services for patients and reduce system costs.

Having spent a long time thinking about the practicalities of using capitated budgets, Mid Nottinghamshire will be one of the first communities to put the theory into practice when it launches its new payment approach this autumn.

Better together has four strands:

- Urgent and proactive care (long-term conditions)
- Planned care
- Women and children's care
- Community and mental health.

A lot of the early work in Mid Nottinghamshire has been around urgent and proactive care (see *Healthcare Finance,* July/August 2016, page 16). As part of this work stream, CCGs commissioned a new service based on integrated community teams.

The service – known as Prism, which stands for 'profiling risk integrated care self management' – uses risk profiling to identify the people in the top 2% of the population most at risk of hospital admission. The new integrated teams proactively support these people, improving their care and reducing unwarranted hospital admissions.

The service has been working well. A new Prism+ integrated home support service also looks to reduce length of stay once patients are admitted to hospital by ensuring the right package of services is put in place to enable discharge.

While initial plans had aimed to launch a capitated budget to support this new model for urgent and proactive care, it was decided that the complexity of the service – with lots of interdependent services – made it a poor choice for the area's first foray into capitated budgets.

New MSK model

Step forward the musculoskeletal (MSK) service. A new model of care has also been put in place for MSK services – the more self-contained nature of these services made it a more appropriate testing ground for a new payment system.

Redesign of MSK services is part of the programme's elective care work stream. Services in scope included elective orthopaedic, pain management, rheumatology, podiatry and the less complex elements of the spinal service.

'The vast majority of these services were provided in the acute sector and, from a cost point of view, we benchmarked high, with a lot of people attending outpatients and being hospitalised compared to our peers,' says Marcus Pratt, associate chief finance officer for both CCGs. 'We were confident a lot more could be done in the community to the benefit of patients and potentially lowering the overall cost of services.'

This summary is backed by RightCare data that suggests MSK is the single biggest saving opportunity for mid-Notts, amounting to £5.2m if it matches the average performance of the best similar areas.

Analysis of its activity revealed that about 45% of its first outpatient appointments resulted in a patient being further referred to a physiotherapist or discharged with no treatment. They hadn't needed the outpatient appointment in the first place.

So a physiotherapy-led triage service has been introduced for all elective orthopaedic patients. This service is supported by hospital consultants (about two programmed activities per week), but should

free up significant amounts of consultant and other practitioner time previously spent in outpatients.

Started in February this year, Mr Pratt says it had an immediate impact on outpatient activity, with a 25% reduction in February, March and April. This crept back up in May, as physiotherapy referrals outstripped capacity. Additional community-based therapists are now being recruited.

The aim is for all MSK referrals to go through the triage service. Elective orthopaedics is already in place, with back pain and other services to be redirected in the future.

Having spent a long time thinking about the practicalities of using capitated budgets, Mid Nottinghamshire will be one of the first to put the theory into practice this autumn

At this point, 13,000 patients would be expected to go through the triage service a year. Mr Pratt says it's about getting the patient seen in the most appropriate setting and involving consultants and surgeons in the cases as appropriate, although there is also an expectation that surgical intervention will reduce.

'At the moment our conversion rate for first outpatient to surgery is below 50%,' he says. 'Our ambition is for this to be 95%, so we broadly filter out everybody who doesn't need surgery before outpatient stage.'

The triage service – known as MSK Together – is being run by Sherwood Forest Hospitals NHS Foundation Trust in collaboration with community service provider Nottinghamshire Healthcare NHS Foundation Trust. There is no formal payment system to underpin this currently, despite the fact that the trust is seeing reduced income from reduced outpatient activity. However, this will change when the new payment system comes in later this year.

There is also some interesting interplay in terms of alliance working. The community physiotherapy service is run by Nottinghamshire Healthcare but some physiotherapy is also provided in the acute sector.

'With fewer inpatients and so less inpatient physio, we are looking to see if we can utilise some of these physiotherapists out in the community or in a different way – without changing the workforce or employee contracts – to support the community activity,' says Mr Pratt.

Payment system

Now that the revised pathway is effectively in place, attention has turned to getting the right payment system to underpin it. With a plan to use a capitated budget approach, two stages need to be considered – calculating the right overall budget and then setting out how rewards and risk will be shared across the whole alliance.

The capitated budget for each provider, which will operate from

Capitation budgets: an evolving picture

There are 50 vanguards in total, including nine primary and acute care systems (PACS sites) and 14 multi-specialty community providers.

A PACS framework document, published last year by NHS England, said these two new care models already covered about 8% of England. However, it added that nearly all sustainability and transformation plans involve population-based accountable care models of this kind. National coverage is expected to grow to 25% this year and 50% by 2020.

So there is a lot of interest in understanding what works and how to optimise models. And while everyone is clear the new pathway has to be put in place first, the focus is increasingly on how to design a payment system that supports the new models and puts the right incentives in the right places to maximise the quality of patient care.

NHS Improvement chief pricing officer Monique Duffy-Brogan (pictured) says NHS Improvement is working with about 10 health economies with new payment systems at different stages of development – Mid-Nottinghamshire is one of the most advanced.

She says that getting the payment approach right is complex and requires trust between the various stakeholders

and good-quality data – although imperfect data shouldn't be used as an excuse for not starting the process.

'We've used some gain/loss sharing simulations with the early implementers to highlight how difficult some of this is,' she says. 'Getting everybody around a table as early as possible to start these discussions is so important.'

In terms of setting capitated budgets and devising gain/loss sharing, approaches need to balance technical accuracy, simplicity and achievability, she says. 'We don't have perfect data yet, so let's use historic commissioner spend and supplement this with cost data. Start simple and move on and as the data evolves we can be more sophisticated.'

NHS Improvement has been working with NHS England and local health economies to co-develop new payment approaches. This has been used to share learning and develop guidance applicable to the wider health economy.

While supporting documentation will continue to evolve, guidance to support systems developing new care models outside the vanguard areas is expected to be published over the summer.

The soon-to-be-published handbook will include a step-by-step process that will take providers and commissioners through the stages necessary to develop integrated budgets and gain/loss share arrangements.

If the service is moving towards capitation and other new forms of payment, does that mean the demise of nationally determined prices?

Ms Duffy-Brogan says she is asked this a lot, but that the tariff is 'not going away anytime soon'. Clearly, NHS Improvement still has a legal obligation to produce a national tariff, which includes nationally determined prices, but even without that obligation, she says, these prices are the starting point for most negotiations around contracts – cross-border activity, contracts with the private sector and block contracts.

And it is being used by early implementers to inform capitated baseline budgets to underpin new models of care.

October this year, started out with the baseline budget for 2015/16 converted to current prices. This is then adjusted for planned activity changes (for example, the expected reduction in acute inpatients) and then the additional costs of the new model have been added in. This might include a new head of MSK, the triage service and the new community physiotherapists.

Crucially, the budget is then also adjusted for stranded costs. This recognises that even if an acute provider reduces inpatient activity, it may take time to eliminate the full costs of delivering that activity – so-called stranded costs, which may, for example, be tied up in overheads. (Sherwood Forest has a big element of fixed estate costs in its private finance initiative unitary charge.) Adjusting the budget by the full tariff rate would create an additional financial pressure for the trust.

'If we are going to see an overall win for the system, we don't want to simply shift cost around,' says Mr Pratt. 'Under the tariff system, you could see cost come out of the CCG budget translating into a loss for the provider. Instead, we need to allow time for providers to manage the costs out. We are all under a lot of financial pressure and the aim has to be to take out as much cost as possible as a system.'

In total, current spend on MSK services is £34m, although just over £6m of this relating to prescribing and high-cost drugs will initially be managed outside of the capitated budget. Just over 62% of this currently goes through Sherwood Forest, while a further 9% is accounted for by the contract with Nottingham University Hospitals NHS Trust. Just 3% starts off with the community provider Nottinghamshire Healthcare.

Budget reduction

A planned £2m reduced overall budget in 2018/19 – based on a 5% fall in inpatients and 24% fall in outpatients – will see reductions in all components of the contract apart from that provided by Nottinghamshire Healthcare. The community provider will see a more than 40% cash increase – taking its overall share of the budget up to 5%. Under the plan, a slightly smaller proportion of the overall budget would be spent with non-alliance NHS and non-NHS providers. Further reductions in 2019/20 will see an overall cut in total budget of £5.9m.

Additional activity undertaken by acute providers above the levels included in the capitated budget will be viewed as a 'cost to the system.'

Payment model will come later

Health and care bodies across Morecambe Bay are working to develop an accountable care system that delivers more integrated care for patients while also providing greater support for the local population to stay healthy and self-manage any conditions. But the focus right now is on getting the pathways right, with a conscious decision to keep contractual issues to one side for the time being.

The area first launched its new clinical care strategy, *Better care together,* in 2013. It came on the back of well-publicised problems in maternity, which led to the critical Kirkup report. There had also been wider problems that contributed to the University Hospitals of Morecambe Bay NHS Foundation Trust being put into special measures in the summer of 2014.

The new strategy underpins key improvements in recent years. The Care Quality Commission recently included the trust in a set of improvement case studies on the back of a 'good' rating at the beginning of 2017.

The strategy proposed an accountable care system-type solution. The Bay Health and Care Partnership – involving 10 local health and care organisations – became a vanguard site in 2015 on the back of targeting a system that was increasingly being seen as a national model for more integrated care.

***Better care together's* key focus is the frail elderly community and those with long-term conditions. It aims to more closely match services to local needs, support self-management of conditions where appropriate and improve health and wellbeing more generally.**

At the heart of the approach are 12 integrated care communities. These have primary care at their core but pull together multi-disciplinary teams from different organisations.

While they have different local priorities, their common goal is delivering care as close to home as possible and avoiding the need for hospital admissions wherever possible.

There are already early signs of success. The area has seen a 3.1% reduction in emergency admissions and a 1.5% reduction in total bed days compared with 2014/15. Paediatric bed days have also reduced by 10%.

There was also a reduction of nearly 4,000 new outpatient attendances last year, compared with 2015/16.

Aaron Cummins (pictured), director of finance and deputy chief executive at the foundation trust, says the new service model continues to operate under a mix of tariff payments and block contracts.

'We are looking to develop a framework for financial flows that enables the system to operate under the principle of "one system, one budget",' he says.

Initially the economy has 'steered away from contractual issues' to ensure this 'noise' didn't get in the way of mobilising communities.

'We want to make this as light on the bureaucracy and contracting overhead as possible, with our focus being on incentivising the right behaviours to mobilise the clinical model at scale and pace,' says Mr Cummins.

'Income reductions on the back of reduced acute admissions or fewer outpatient attendances are fine as long as there is a net financial benefit for the whole system.

'That's the dialogue we are having with the regulator to ensure that is how we are performance managed.'

With the trust currently struggling to fill all its medical and nursing posts – similar to most providers – it is having to rely on more expensive agency staff to sustain rotas.

'The amount of premium cost to service current activity is significant, so if we can reduce demand and activity, any loss we suffer will be mitigated,' adds Mr Cummins.

Hear more about the work in Mid Nottinghamshire and in Morecambe Bay at the HFMA Convergence conference, 5-7 July, www.hfma.org.uk

Instead of this activity attracting a marginal rate for the specific provider involved, the value of the activity – charged at a marginal rate of 32% in year 1 and 50% in year 2 – will be put into a risk/reward pool. This will then be shared across all alliance providers using predetermined shares.

Each organisation's share of this risk/reward pool has been calculated taking account of how much influence it has over the different elements that drive performance. Sherwood Forest, as lead provider, takes on the biggest amount of risk/reward (51%), with the CCGs taking on a further 24% and the rest spread across the other providers.

Some risks sit with individual providers. For example, the risk of the new community physiotherapy services is viewed as being within the community provider's control. Funding for increased practitioners has been included within the capitated budget.

However, if the provider decided more physiotherapists were needed to meet demand, it would carry the cost – although it may want to discuss the issue as part of a service and financial review of the first six months at the end of 2017/18.

The health economy has modelled two further scenarios. These cover a downside case, where the reduction in inpatient and outpatient activity doesn't reach the levels used in setting the capitated budget, and an upside case where these reductions are exceeded.

Its examples suggest that the sharing mechanism could range from a risk of £1.3m to a shared reward of £1.7m and it has mapped out how this would be shared across the members.

There is no separate payment mechanism tying payment to outcomes. According to Mr Pratt, although an outcomes contract had been in place for proactive care last year, this had used the existing CQUIN (commissioning for quality and innovation) mechanism. But the prescriptive nature of this year's CQUIN approach made it inappropriate to have a further element of payment at risk.

Mr Pratt acknowledges that new pathways are the key focus. But he says that payment systems are also vital to incentivise the revised pathway and that the system can only make the savings it needs to make by working together.

Looking ahead

At the moment, he recognises that the calculation of the budget (on the acute side) draws heavily on the national tariff in setting the baseline position. But he expects that in future the health system will develop a much more granular understanding of local costs, informed in particular by better patient-level costs.

He believes this will open up the potential for budgets to, at first, be informed by local costs. Then, further down stream, he suggests it could move more towards being based on the efficient local costs of the optimum pathway.

Next April, the local health system will review the operation of its first six months under the new payment approach. It will not just be the local health economy that is interested in this assessment.

outcome and risk

Stockport is well on the way to establishing a new payment model that links to outcomes and shares risk across the system. Steve Brown reports

Stockport's health and social care economy has been developing a new system sustainability plan since the start of 2015. Like many areas, it is putting in place new models of care – and has made good progress. But where it is arguably ahead of many other areas is in thinking through the detail of how payment can be linked to real outcomes and how financial risk can be shared across the whole system.

Working together, the five local health and care organisations (CCG, acute and community provider, mental health provider, GP federation and local council) have developed a plan – *Stockport together* – to deliver integrated services that increase independence and reduce the need for hospital services.

New models of care will be developed to serve the whole community, although the initial focus has been on older people with complex needs. The approach is being developed as a multi-specialty community services provider and Stockport was named as one of the key test sites in NHS England's vanguard programme.

Structural benefit

The focus is prevention at scale underpinned by transformed out-of-hospital care based on integrated neighbourhood teams. While all systems are looking to work in a more integrated way, Stockport's relatively simple and well-defined structure gives it an advantage. There is one commissioner, which is coterminous with one local authority; one GP federation (Viaduct Care); one acute and community foundation trust (Stockport); and one mental health FT (Pennine Care).

This helps, but Mark Chidgey, chief finance officer at Stockport Clinical Commissioning Group, says what they are trying to do is still massively challenging. The starting point was leaders coming together to look at future needs and challenges as a system rather than single organisations. 'We'd always set separate strategies, or been led by our regulators to set strategies that didn't align,' he says.

The new system-wide approach has prompted some refreshing statements – the acute trust chief executive acknowledged the hospital needs to be smaller in the future, while the commissioner recognised the importance of a strong acute provider.

Four business cases have been published alongside a summary economic case, setting out key pathway changes.

For example, an ambulatory care business case sets out to address the fact that Stockport currently admits around 30% more patients to hospital than similar systems, many of which have ambulatory care sensitive (ACS) conditions. New model plans will establish collaborative triage in primary and secondary care, as well as co-locating a primary care ambulatory illness team in the emergency department and extending the hours of the ambulatory care unit.

As well as setting out the planned service changes, Stockport has done a lot of work on enablers such as a single patient record system accessible by all care providers.

> **"We've not agreed the contract value split yet – it could be anything from 60:40 to 90:10 – but it has to be the right level to support change"**
> Mark Chidgey

Mr Chidgey says there are already signs of a positive impact, with the system being one of the few to see a reduction in non-elective admissions in 2016/17.

Getting the money right to support the new system is vital, as all parts of it currently face financial challenges. The pressures on local authorities are well known. The CCG delivered a 0.7% planned surplus in 2016/17, short of the national 1% requirement. And Stockport NHS FT ended the year in deficit, albeit improving on its control total. 'The challenge in 2017/18 – most immediately at Stockport FT – is really significant,' says Mr Chidgey. However, he says the difference to previous years is that this is now seen as a system problem to be tackled collectively across health and social care.

The system has made a lot of progress on a future payment system based on a capitated budget and linked to outcomes.

'Without the outcome part, it is just a block contract, and that won't drive improvement,' says Mr Chidgey. 'The risk is that it would just mean things will stagnate.'

With support from consultants BDO and Outcomes Based Healthcare, the area has developed 38 outcome measures (25 clinical and 13 personal) to supplement existing NHS Constitution targets. These will form the basis for how a more strategic commissioner will describe requirements in future contracts.

The approach could involve a far greater proportion of contract value than existing CQUIN incentives. 'We've not agreed the split yet – it could be anything from 60:40 to 90:10 – but it has to be the right level to support change,' says Mr Chidgey.

Should the outcome target improvement be moderate and linked to a large proportion of overall spend, for example, or much more aspirational and linked to a smaller amount of spend?

The capitation budget baseline will be set using historic spend levels adjusted for the impact of the business cases. After looking at more complex ways to share risk of over-performance, the agreed proposal to the health and social care economy from its finance leaders is a simple three-way split – with any overspends or gains within the scope of the business cases shared equally by the CCG, the local authority and the provider alliance.

Resource distribution between the providers and between, say, acute and community services would be 'primarily for the providers to determine', says Mr Chidgey. However, some of the outcome measures would have a clear influence on this – personal outcome measures around keeping people in their own homes, for example, or enabling people with mental health problems to return to work.

The payment model is not there yet. There are key decisions to be made around how much should be linked to outcomes, what happens to funds that are not paid out if outcomes aren't achieved, and how different providers should share in any unpaid elements. But the system is well on the way to a payment model that actively supports its more integrated service delivery.

continued pressure

Sustainability and transformation partnership relationships are getting stronger, but finance directors identify high levels of financial risk for 2017/18. Steve Brown reports

Relationships with sustainability and transformation partnerships are strengthening, according to NHS finance directors. But there are still significant concerns that sustainability and transformation plans can help close the funding gap by 2020/21.

STPs – an acronym that now appears to stand for both the 44 system-wide plans and the partnerships delivering them – are crucial to delivering new models of care at the heart of the *Five-year forward view*. And finance leaders have previously backed STPs as a good way to find system solutions to the challenges of rising demand, an ageing population and greater prevalence of long-term conditions.

With plans completed by the end of 2016, the focus is now on implementation. And the relationships between different stakeholders in each local partnership will be key to success.

When the HFMA asked trust finance directors and commissioner chief finance officers about STP relationships in December, only 20% thought they were strong enough to deliver change. This did not appear to be a major vote of confidence in the transformation programme. So it is encouraging to see this figure rise to a more reassuring 50% in a survey undertaken as part of the HFMA's latest *NHS financial temperature check*, published at the beginning of July.

Within this improving picture, there remain pockets of concern – more work is needed to strengthen ties with the voluntary and ambulance sectors, for example. And trusts in particular feel general practice links should also be improved.

But while these core relationships are starting to gel, what they are trying to achieve – or at least the timescale that it needs to be achieved in – looks just as daunting.

STPs are expected to play a major part in the transformation of care services that will help the NHS close an estimated £22bn funding gap by 2020/21. But the *Temperature check* finds that 89% of trust finance directors and 77% of clinical commissioning group CFOs are either not confident or not very confident that STPs can deliver the plans to close this funding gap.

Most finance directors said their operational plans are aligned with STP plans but only half of trust and CCG finance directors believe their actual contracts are aligned to STP plans. Some went as far as to say that contracts 'bear little resemblance' to agreed plans. The *Temperature check* concludes that moving from planning to delivery at the STP level might require 'significant effort if competing organisational priorities are not to get in the way'.

Capital concerns

Capital – or the lack of it – is a major obstacle. Just 1% of trust finance directors and 3% of CCG CFOs think there is enough capital to support STP transformation programmes. (The survey predates the Conservative party's pre-election response to the Naylor review and its promise of the 'most ambitious programme of investment in buildings and technology the NHS has ever seen'.)

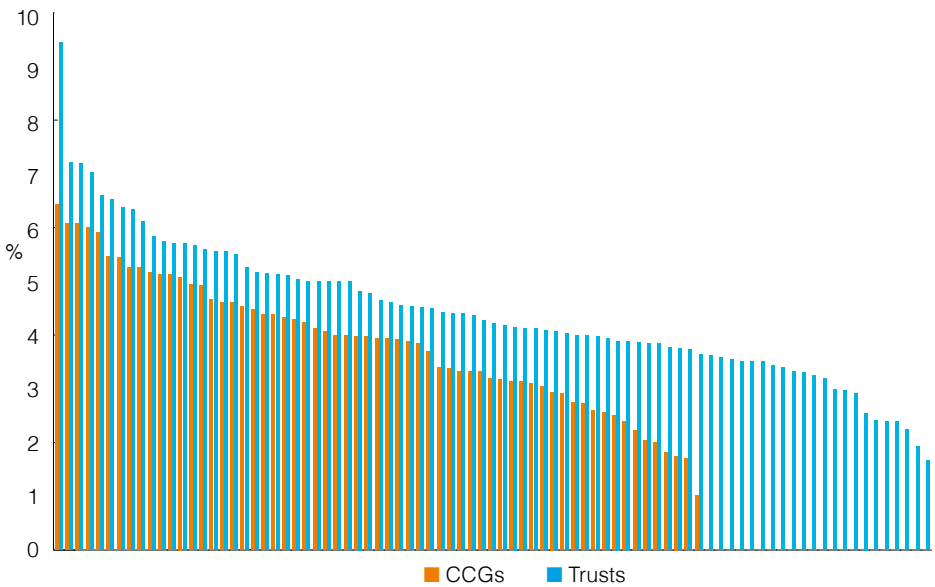
Concerns also remain about governance arrangements for STPs, although respondents recognised that STPs are still at an early stage.

Finance directors' views need to be seen in the context of the extreme financial challenge being faced by the whole service. The Q4 report from NHS Improvement showed providers ended the year with a £791m deficit after receiving £1.8bn from the Sustainability and Transformation Fund. Month 11 forecasts for CCGs – the latest figures published – suggested a £550m overspend, although this was before the release of an £800m risk reserve.

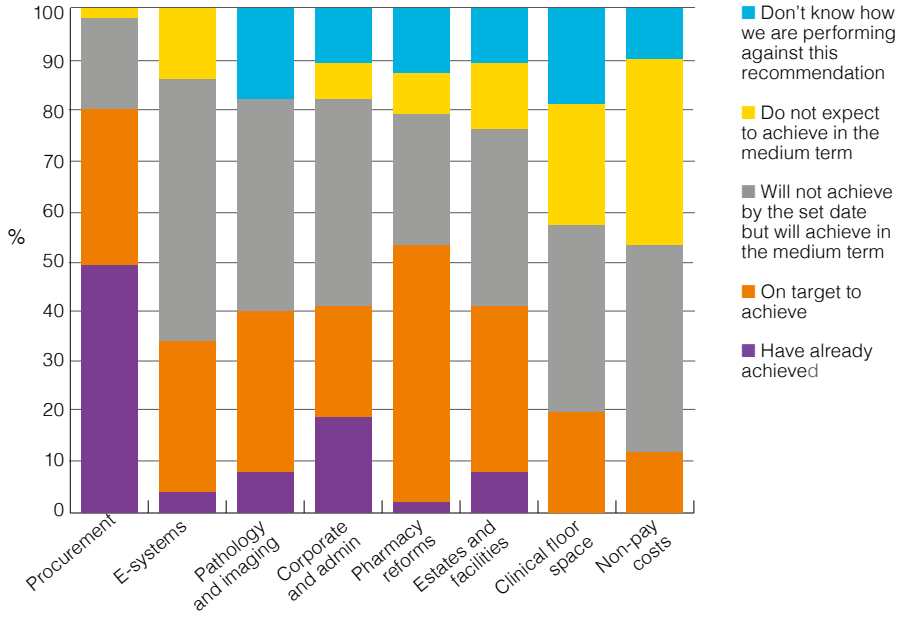
Providers' deficit compared with a planned deficit of £580m and the CCG risk reserve was intended to provide a balancing mechanism for system-wide imbalance. But the risk reserve was primarily seen as a means to offset provider deficits rather than commissioners' own overspends. Despite providers and commissioners reporting an aggregate worse-than-plan position, 63% of CCGs and 84% of trusts said they performed the same or better than planned at the start of 2016/17 – a reversal of 2015/16, perhaps indicating a shift of pressure from providers to commissioners.

Agency staff costs remain a major challenge, with two thirds of providers identifying this

2017/18 planned QIPP and CIP as percentage of income



Progress against Carter recommendations



as a major negative variance against plan. This is consistent with NHS Improvement figures, which show a £700m year-on-year reduction in agency spending – recognised as a 'huge achievement' – but with providers still spending £559m more than plan and only 46 providers meeting their agency ceilings. A more general underachievement against savings plans was identified by 58% of trusts, with delayed transfers of care another major overspend.

For CCGs, the main overspends were related to underachievement of savings and over-performance on acute contracts.

Some 44% of trusts (105 of 238) ended 2016/17 in deficit. The *Temperature check* suggests a similar position in 2017/18, with 45% predicting a deficit, though 34% of trusts expect to post a deficit in 2018/19. The acute sector continues to face the most pressing financial challenges, with 82% of acute providers predicting a deficit this year.

CCGs predict an improving position over 2017/18 and 2018/19. But both commissioners and providers stress that there are lots of risks attached to the achievement of plans. Some 94% of CCG and 95% of trust finance directors said there was a medium or high risk that they wouldn't achieve their financial plans.

Finance directors tend to be cautious – some might say pessimistic – by professional nature, but their concerns seem well founded. Trusts on average are targeting a 4.5% cost improvement as a percentage of income, while CCG plans are based on 3.9% QIPP savings.

Trusts average saving target outstrips the 3.7% cost improvement (as a proportion of expenditure) reported by NHS Improvement for 2016/17. After month 11, NHS England was forecasting QIPPs of 2.6% against a plan of 3.2%. NHS England chief financial officer Paul Baumann described last year's QIPP target (itself a step up from 2.2% in 2015/16) as 'the highest ever level of QIPP efficiencies'. The 3.9% plan suggested by the *Temperature check* is clearly a significant further step up.

Trusts' failure to achieve CIP targets would put both achievement of control totals at risk and, as a consequence, access to the £1.8bn STF money. Some finance directors who had signed up to control totals said they had also flagged up the risks around achieving their required CIP to NHS Improvement. A quarter of those in the survey who had signed up to control totals said they did not expect to meet all the conditions, which cover finance, agency spend and access, in 2017/18. This percentage increases for 2018/19.

Trusts are planning to deliver 82% of savings recurrently in 2017/18 – a step up from the 71% achieved in 2016/17. CCGs are planning a similar level of recurrent savings this year (73%) as last year. But more than half of finance directors said they were not very or not at all confident that their recurrent savings plan could be delivered. Confidence levels were much higher for non-recurrent plans.

Reducing unwarranted clinical variation, removing services with limited clinical value and redesigning acute pathways were each highlighted by more than 80% of CCGs as key ways of meeting QIPP plans. Integration was also flagged up by three quarters of CCGs.

Trusts remain focused on agency staff costs, procurement savings and estates rationalisation as the main tools for improving efficiency. They also flagged up concerns that Brexit could add pressure on recruitment and retention.

Productivity progress

The *Temperature check* questioned finance directors on progress delivering the savings identified by the Carter review of productivity in acute trusts. The review suggested £5bn of savings could be achieved by 2020/21 from measures in pharmacy, pathology, procurement, estates and corporate costs.

Over 50% of trust respondents said they expect to meet the Carter recommendations to reduce unwarranted variation in operational productivity in all areas in the medium term. Most progress has been made against the recommendation to report productivity information monthly to NHS Improvement. Nearly half have already achieved this.

Only 8% of respondents have achieved the recommendations to achieve agreed benchmarks in pathology, imaging and estates (targeted for April this year). However, finance directors were confident of achieving these in the medium term. The least developed areas are in non-pay costs and clinical floor space.

On corporate costs, Carter urged providers to ensure corporate and administration costs did not exceed 7% of income by April 2018 and 6% by 2020. Nearly all reported that they are considering consolidation options, such as shared services, outsourcing and collaboration with other organisations.

Mark Orchard, HFMA president, described recent years as 'the most financially challenging that most of us in the NHS can remember' with challenges set to continue. 'However, there are reasons to be positive. The level of efficiency savings delivered in 2016/17 by finance staff working with their clinical and management colleagues should be applauded,' he said.

'In many ways, though, this is just the beginning,' he added. 'The efficiency challenge in 2017/18 is even tougher. Collectively, everyone in the NHS needs to find ways to be more resourceful, more innovative and more collaborative to address the financial challenge in front of us.'

The *Temperature check* provides a useful snapshot of the current financial challenge. Finance directors are clear that 2017/18 looks set to be the most difficult year yet in a run of difficult years. There is clear evidence that finance directors see potential for improvement and greater efficiency through greater integration, implementation of the Carter review, rollout of the RightCare programme and use of new care models.

But the report concludes that 'there is no single panacea and significant uncertainty that in aggregate these approaches will be able to achieve what they need to if they are to restore the system to financial balance'.

It highlights the high levels of risk associated with ambitious 2017/18 savings plans and underlines that 'the financial challenges are set to continue'.

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Skills for Health

Under starter's orders

Following pilots last year, the full launch of the new HFMA qualifications marks a significant step for the association, as Seamus Ward reports

Launched last year with a pilot exercise, the HFMA qualifications in healthcare business and finance have reached a landmark with the first cohort of students joining the course. The training, which could lead to an MBA, allows NHS professionals to study for a dedicated qualification in healthcare business and finance.

Aimed at clinicians, finance staff and other healthcare professionals, the programme went live in May with 16 students – mostly finance staff, but also clinicians and other NHS managers – and there has been a lot of interest from NHS professionals hoping to begin study in September.

Initially, there are two masters-level qualifications, the HFMA diploma and higher diploma. Each is worth 60 credits – by completing three 20-credit modules – and successful completion may allow a student to move on to complete an MBA (worth a further 60 credits), which is being developed by the HFMA's partner BPP University.

Already a successful and long-established provider of e-learning, the new diplomas mark a milestone for the HFMA as an education provider. 'It's a whole new area for us and a completely different ball game compared to what we have done before,' says HFMA director of education Alison Myles.

They are deliberately modern qualifications, she says, building on the ethos of the HFMA e-learning courses by offering flexible, online study designed to fit into the busy lives of those working full-time in the NHS. As well as eBooks and YouTube videos, the HFMA Academy offers the opportunity for online discussion forums with other students and tutors, while there is more direct interaction with tutors and other learners in weekly online Academy Live sessions.

Feedback from the pilot, where volunteers took one module, has been positive. Students found the eBooks useful to guide their study and have enjoyed the variety of other materials and activities, such as key NHS reports and YouTube videos.

The networking opportunities were also highly prized. Students highlighted the benefit of the discussion forums and Academy Live sessions, which they said allowed them to share experiences from the real world. It also offered the tutors a chance to interact with students in these discussions, maximising the value of the learning experience.

'The pilot feedback was positive, detailed and helpful,' Mrs Myles says. 'I would like to give a big thank you to the people who were involved in piloting the modules. Their engagement has been invaluable and the amount of feedback we asked them to provide was quite a commitment. We took their comments and suggestions seriously and were able to make changes and tweaks as a result.

'So far, since the main launch in May we have a good response from

MBA goal

John Leiper (right), head of financial reporting at Cumbria Partnership NHS Foundation Trust, piloted the *Creating and delivering value in UK healthcare* module and has already signed up for a further module in September. Once he completes the higher diploma, his ultimate aim is to gain an MBA through the HFMA/ BPP University route.

He applied for the programme just after taking on his current role, which has a greater strategic focus. 'I wanted to build on the technical skills my previous roles and professional qualification gave me and I believe the HFMA qualification will give me the management and leadership skills I require to work at a more strategic level,' he adds.

Has he been able to apply the learning in his everyday work? 'The *Creating and delivering value in UK healthcare* module covered a number of topics including health economics, payment methods, costing, cost improvement programmes, investment, private sector involvement, measurement of outcomes and board decision making,' he says. 'I had previous experience in some of these individual areas but what I took from the course was the relationship between them and how value cannot be thought of in isolation.'

He is impressed by the online learning, which allows networking with fellow students and tutors. 'When I did my professional accountancy exams, distance learning meant being sent the text books and sitting an exam six months later – things have moved on significantly with online workbook and the Academy Live sessions.

'I particularly enjoyed the topical discussions with the tutor and the other students – it was interesting to discuss how travel times between different A&Es are problems in central London as well as rural Cumbria, albeit for very different reasons.'

people in terms of interacting in the group discussions – we have seen a much higher rate of interactions in the live sessions than during the pilots. And, having been through the pilots, the tutors have been able to further develop ideas to encourage that.'

One student from the May intake was particularly impressed, saying: 'I am thoroughly enjoying the course so far and the resources and live sessions are great. I wanted to particularly praise the organisation and pre-course communication. I don't think I've ever done a course either distance or face to face where it has been so excellent.'

The association has amended some elements of the courses as a result of the feedback, Mrs Myles explains. One is the amount of reading – now, the reading list includes greater direction on which texts should be read, while others, though desirable, are optional. 'Some people were surprised at the amount of work and the level they were being asked to perform at, particularly when it came to the assignments,' she adds.

As it's a masters level programme, learners need to be critical and analytical, not just descriptive. The HFMA has made clear the demands of the course in information given to students before they sign up and to new students in their handbook. Mrs Myles says the commitment is 200 hours per module (including the assignment) – a significant amount of time given that most students will also be working full time.

To alleviate some of the pressure – following feedback from the pilots – the HFMA has introduced two, one-week study breaks into the programme to allow for catch up if needed. Also, the weekly study programme has been rescheduled to run from Wednesday to Wednesday, allowing learners a weekend in the middle of each weekly cycle help them keep on top of their diploma work.

A further tweak is giving students the option of submitting a piece of writing six weeks into the module to see how they are doing. 'It gives the learner and tutor the chance to see if there are issues and this informal assessment doesn't count towards the final assessment,' Mrs Myles says.

The new qualifications are a landmark for the HFMA and in late summer or early autumn the full MBA, which has been approved by the BPP University school review board, could overcome a final hurdle by being verified by external assessors.

The HFMA is also developing a diploma in advanced primary care management with the National Association of Primary Care and law firm Capsticks. This will be similar in structure to the new HFMA qualifications and should be piloted in the autumn. HFMA education services seem ready to jump from one landmark to the next.

• ***Visit www.hfma.org.uk/education-events/qualifications***

Clinician view

Yash Gupta, an A&E consultant and clinical governance lead at London North West Healthcare NHS Trust, piloted the *Comparative health systems* module.

'What attracted me to do the pilot was to have an insight into leadership development and comparative healthcare systems – what can we learn from understanding the nature of finance and its relation to the provision of healthcare? This has all been very helpful, especially the thoroughly prepared, referenced and nicely delivered lectures via a superb media interface. I feel more empowered to be able to have a view on the improvements in the NHS that can be delivered in cost effective and efficient ways.'

He adds: 'I would like to take part in further studies but to get the cost from the NHS is a big barrier in itself. I encourage more clinicians to understand and get involved in decision-making in healthcare, which can affect patients not under their direct care.'

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SORP revisions lower charities' threshold for more detailed accounts

Technical update

Now that the NHS body's annual report and accounts have been prepared, audited and submitted, it is time to turn to the preparation of the NHS charity trustees' report and accounts, *writes Debbie Paterson*. Thankfully, 2016/17 is a year of little change for most NHS charities. But some new guidance has been issued that is worth considering,

In 2015/16 charities could choose which statement of recommended practice (SORP) to adhere to when preparing their accounts. They could either use the FRSSE version (*Financial reporting standard for smaller entities*) or the FRS102 version (the standard applicable in the UK and Republic of Ireland).

2016/17 is the first year that all charities must adopt the FRS 102 version. We do not think that any NHS charities adopted the FRSSE version of the SORP in 2015/16. But for any that did, 2016/17 will mean another restatement to apply the FRS 102 version.

The plot thickens as *Charities SORP* (FRS 102) has itself been amended by *Update bulletin 1*, applicable from 2016/17, but which some NHS charities (except those in Scotland) may have adopted early in 2015/16 (see HFMA briefing on 2015/16 year-end reminders for charities, published in March 2016).

The update bulletin makes changes to the SORP in relation to donated goods and services, goodwill and intangible assets, impairment of goodwill and charity mergers – none of which are likely to be of interest to NHS charities. However, two amendments will affect NHS charities.

'Larger charity' redefined

The first is that it changes the definition of a larger charity. Previously it was the audit threshold (charities whose gross income exceeds £1m or whose gross income exceeds the accounts threshold and the aggregate value of its assets at the year-end is more than £3.26m). From 2016/17, larger charities are those with a gross income exceeding £500,000 (UK) or €500,000 (Republic of Ireland).

This means that many more charities will fall into the classification of a larger charity, which will require them to include more detailed information in their annual reports and more disclosures in their accounts.

Statement of cash flows

The second change is that only larger charities are required to prepare a statement of cash flows. Previously, the *Charities SORP* (FRS 102) required all charities to prepare this statement which was a significant change from the old 2005 *Charities SORP*. For this reason, some NHS charities may have early adopted the update bulletin.

In April 2017, *Information sheet 1* was published by the SORP-making body. This does not amend the *Charities SORP* (FRS 102) but contains advice and clarification on the application of it.

The information sheet covers many issues, but those of interest to NHS charities include:

LINKS TO GUIDANCE

The guidance referred to can be found at:

- **www.gov.uk**
- **www.charitysorp.org**
- **www.hfma.org.uk/publications**

See article online for detailed links

- **www.hfma.org.uk/news/healthcare-finance/**

- Reference to a new statutory requirement for charities subject to audit in England and Wales to disclose extra information on their fundraising practices. Further information can be found in section 7.9 of *Charity reporting and accounting: the essentials, November 2016*
- A reminder that comparatives are required for the summary of assets and liabilities of each category of fund
- A reminder that governance costs must be apportioned to fundraising activities as part of the allocation of support costs
- Guidance on the treatment of funding 'clawed back' by funders
- Guidance on the treatment of employers national insurance contributions in employee benefit disclosures
- A reminder of the thresholds for accounts preparation and audit for charities in Northern Ireland.

National guidance

The Charity Commission for England and Wales, the Office of the Scottish Charity Regulator and the Charity Commission for Northern Ireland have also issued guidance to auditors and independent examiners on matters of material significance reportable to them. This guidance is applicable to all audits or independent examinations that are conducted and/or reported after 1 May 2017.

In relation to the independent examination of charities, we understand that the Charity Commission will be issuing new directions to independent examiners over the summer. This may affect NHS charities that are subject to independent examination later this year.

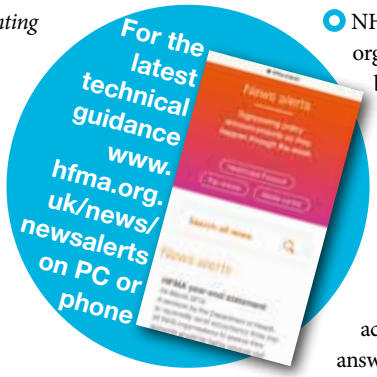
Debbie Paterson is an HFMA technical editor

Technical review

The past month's key technical developments

Technical roundup

The *Department of Health group accounting manual 2017/18* has been published following a delay because of the purdah period prior to June's election. The consultation draft of the **accounting guidance** was published in December. Among the main changes from the 2016/17 manual is a revised annex on accounting for pooled budgets and joint arrangements. This replaces previous annexes on the Better Care Fund and other pooled budgets. This guidance has been made more concise with additional information on agency relationships. But there has been no fundamental change to the underlying principles. Previous guidance on disclosures and content of financial statements has been collected in a new 'Form and content of financial statements' chapter. Previous guidance on legislation and accounting framework underpinning financial reporting is in a new 'Financial reporting framework' chapter.



A new joint briefing paper from the HFMA and CIPFA, *Capital collaborations between the NHS and local authorities,* aims to clarify the **capital financing** frameworks in both sectors and raise awareness of the different constraints and systems. For example, local authorities, which adhere to CIPFA's *Prudential code for capital finance in local authorities,* generally borrow from the Public Works Loans Board at interest rates determined by the Treasury. Affordability and meeting policy goals or generating a return are the key criteria. NHS bodies, which have different capital frameworks depending on the type of body, have an overriding control of all borrowing to be contained within the Department of Health departmental expenditure limit. The briefing points out that any joint working between the NHS and local authorities must result in assets that do not count against this limit. It looks at possible joint investment schemes.

NHS bodies are increasingly looking to work with other organisations using a range of innovative arrangements. A briefing from the HFMA deals with how **joint working arrangements** should be accounted for. *Accounting for joint working arrangements* considers which accounting standards should be applied and what to ask when determining the appropriate accounting treatment. It looks at how the question of who has control can be assessed in accounting terms for the entity and in terms of the preparation of the national accounts. While these questions are being posed to answer an accounting question, they can also be used to tease out governance issues and possible weaknesses in financial management. The briefing considers practical issues such as VAT and governance, as well as difficulties preparing a consolidated set of accounts.

NHS Improvement has added a patient-level information and costing system (PLICS) **self-assessment checklist** to the approved costing guidance section of its website. The checklist forms one of several quality assurance phases for data to be submitted to the 2016/17 acute PLICS cost collection, to be completed by all trusts participating in the collection. There are 22 questions to be answered – some look at processes, reconciliation and sign-off, others describe data sense checks.

With an increasing focus on **financial governance and leadership** in providers and commissioners, a new HFMA briefing looks at themes that tend to emerge when there are governance weaknesses, identifies early warning signs and sets out key steps. *The importance of strong financial governance* – prepared for the HFMA Governance and Audit Committee by PwC – considers: the over-optimistic outlook; poor budgeting with lack of ownership; inadequate financial information; unclear ownership and accountability; lack of excalation of risks and exceptions.

Lung cancer treatment available through CDF

NICE update

NICE has recommended pembrolizumab for use within the Cancer Drugs Fund as an option for treating untreated PD-L1-positive metastatic non-small-cell lung cancer, *writes Nicola Bodey.* Technology appraisal TA447 sets out the criteria that need to be met.

There are currently limited treatment options for people with this condition and what treatments there are can last a long time and cause unpleasant side effects.

Pembrolizumab will be available to the NHS in line with the conditions of the managed access agreement with NHS England. As part of this, NHS England and the drug's manufacturer Merck, Sharp & Dohme have a commercial access agreement that makes pembrolizumab available to the NHS at a reduced cost. The financial terms of the agreement are commercial in confidence.

Pembrolizumab acts on the PD-1 protein, which is part of the immune checkpoint pathway. Blocking its activity may promote an anti-tumour immune response. It is seen as appropriate treatment if the patient's tumours express PD-L1 with at least a 50% tumour proportion score with no epidermal growth factor receptor or anaplastic lymphoma kinase-positive tumour mutations.

Treatment is stopped at two years of uninterrupted treatment and no documented disease progression.

The resource impact of pembrolizumab will be covered by the Cancer Drugs Fund budget. The guidance on this technology will be considered for review when the data collection period ends. This is anticipated to

Diary

July

5-6 (N) Annual Commissioning Finance conference, London
6 (I) Value masterclass, part of Convergence conference, London
6-7 (N) Annual Provider Finance conference, London
11/12 (B) Wales: escape event, South and North Wales
12 (B) London: positive psychology to improve wellbeing and resilience, Rochester Row
20 (B) Yorkshire and Humber: annual quiz, Sculpture Park

September

11 (B) Eastern: student conference, Cambridge
14-15 (B) South Central: annual finance event, Reading
14 (B) North West: health sector insight briefings, Liverpool
19 (F) Provider Finance: forum, London
20 (N) CEO forum, London
21 (N) CIPFA/HFMA health and social care conference, London
21-22 (B) Wales: annual conference, Hensol
26 (F) MH Finance: forum and roundtable, Manchester
26 (B) London: introduction to NHS finance, Rochester Row
28 (I) NHS costing – regional networking and training event, Birmingham
28-29 (B) South West: annual conference, Bristol

October

4 (I) International symposium, London
11 (F) Chair, Non-Executive Director and Lay Member: forum, Central Manchester
12 (I) NHS costing – networking
13/14 (B) Kent, Surrey and Sussex: annual conference, Ashford
13 (B) South Central: football tournament, Southampton
17 (F) Chair, Non-executive Director and Lay Member: NHS Operating Game for new non-executives, London
19 (F) Provider Finance: directors' forum, London
20 (B) Eastern: annual conference, Newmarket
26/27 (B) Scotland: annual conference, Clydebank

November

3 (B) East Midlands: annual conference, Loughborough
8 (N) Annual mental health conference, London
10 (B) Northern: annual conference, Durham
14 (N) Audit conference, London
15 (F) Commissioning Finance: forum, London

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

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

be December 2017, when the results of the Keynote-024 trial are available. The aim of the review is to decide whether the drug can be recommended for routine use. More details can be found on NHS England website.

It is estimated that around 1,500 people per year with untreated PD-L1-positive metastatic non-small-cell lung cancer are eligible for treatment with pembrolizumab.

This technology is commissioned by NHS England. Providers are NHS hospital trusts.

Nicola Bodey is senior business analyst at NICE

Events in focus

CEO forum

20 September,110 Rochester Row, London

The HFMA's regular chief executive and accountable officer gathering will look at a range of topics, including the financial outlook, leadership, precision medicine and value-based payment. Jason Helgerson* (pictured), will deliver the keynote address on value-based payment approaches to high-quality, financially sustainable healthcare. He is the Medicaid director for New York State, which serves more than 6 million people and has an annual budget of $63bn (about £50bn). Mr Helgerson will show how, as a result of the recession, the state reshaped services, lowered costs and raised quality – a process he believes can be used in the NHS.

From the UK, Health Foundation research and economics director Anita Charlesworth will examine efficiency and productivity improvements in NHS organisations, while management consultant and author Andrew St George will ask what the health service can learn about leadership from the Royal Navy.

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

* See blog at www.hfma.org.uk/news/blogs

HFMA/ CIPFA health and social care conference

21 September, London

Regulators and those in central government are keen to accelerate integration of health and social services, but some questions remain unanswered, particularly on funding.

While social care will receive £2bn extra over the next three years, the need for a sustainable, long-term funding solution is ever pressing and the new government has promised a consultation on long-term funding options.

This joint HFMA/ CIPFA conference will look at funding and other challenges, such as health and social care integration and place-based governance and planning.

The conference is primarily designed for clinical commissioning group chief finance officers and heads of social care finance, but other finance professionals, including those from providers, policy analysts and general managers in health and social care, will also find the conference useful.

King's Fund senior fellow Richard Humphries, an expert in social care across the NHS and local government, will deliver the conference opening address. More speakers will be confirmed shortly.

- **For further information, email: jonathan.richards@hfma.org.uk**

Changing at pace

Association view from Mark Knight, HFMA chief executive

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

SHUTTERSTOCK

My HFMA

I'm delighted our first 16 students for the HFMA qualification began studying in May. The qualification represents a new chapter for us as an organisation and is the culmination of a two-year development project that the association has invested substantial sums in.

This has had an impact on the association's finances, but the board believes it is an important step forward. Our next development will be the creation of further qualifications to cater for other groups within the service.

Our new qualification is at level seven – in other words, it is a postgraduate qualification. The further opportunities we are looking at would be at levels three and possibly four.

All these initiatives are only going to succeed if senior finance professionals want them to and, while the qualification isn't cheap, it is still hugely competitive compared with what else is in the market. And at the lower levels, there is the added incentive that we may be able to tap into the apprenticeship levy.

I also want to thank you for the comments I received on our new strategy document. The revised strategy will now be presented to the board in July for adoption and a first budget has already been crafted around it. We are also reorganising ourselves internally to prepare ourselves for the next phase of our development.

The introduction of a new app will offer you better access to our content and we are improving other ways of communication with you. We hope these will be in place by the end of the year. Our association is changing, but we're not moving away from one of our core principles – influencing the agenda. That remains a key role for HFMA alongside our education and technical work.

I've just returned from the US HFMA conference, which as usual was staggering in size and scale. One of the key features of the trip was a great two-day session we held with colleagues from the US and Australia. Australia represents a kind of bridge between the free market system of the US and our system. It was useful to share experiences of our different systems and hear also what's going on in South America.

HFMA chief executive Mark Knight

Since the demise of our UK/US Exchange programme in 2009, we have kept in touch by visiting each other's conferences. However, I have always felt that the three 'HFMAs' could do a lot more to connect members across the associations. We are looking at how we can realise this ambition using online technology.

We face many of the same challenges around addressing clinical variation and managing cost growth in the face of rising demand, ageing populations and increasing levels of chronic conditions.

Moves to accountable care systems, better costing, payment approaches that encourage collaboration and integration, and managing services to maximise value (measured in outcomes and cost) are areas where we are all trying to learn more about what works.

Back in the UK, as we gather together for our first summer Convergence conference, supporting system solutions to current challenges, I can only reflect that the association is changing fast. I need your help to continue to develop these many new initiatives and I know you will give that help willingly.

Member news

The West Midlands annual awards ceremony took place at the branch's annual conference in June. This year the judges gave awards in four categories:

- **Student** Reena Mehta-Jagatia, University Hospitals Coventry and Warwickshire NHS Trust
- **Lifetime contribution** Paul Taylor, director of finance at Dudley Group NHS FT
- **Finance team of the year** Telford and Wrekin Clinical Commissioning Group
- **Great place to work award** Birmingham South Central CCG and North Staffordshire Combined Healthcare NHS Trust

The East Midlands and Kent, Surrey and Sussex branches held networking events in June. Seven teams took part in various activities at a team-building day organised by the East Midlands branch (pictured), including constructing a vehicle from basic equipment to carry team members around a course.

In addition to the Poole to Paris Pedal in July, Stuart Wayment (pictured), finance skills development manager at NHS South (South East), has plunged into another fundraiser, in support of the Planets (pancreatic, liver and neuroendocrine tumours) cancer charity. He's competing in the men's 2k wetsuit category at the Seahorse swim in Dorset. Last year he came sixth in just under 43 minutes – eight minutes off a medal.

- To support him visit www.justgiving.com/fundraising/Stuart-WaymentSeahorse

hfma

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

Integration finance

The HFMA and CIPFA have responded to calls from finance professionals to support health and local government staff working on closer collaboration by launching the Integration Finance Network.

'It quickly became apparent that our work with the two sectors was complementary and that there is much to be gained by joining forces on the integration agenda,' says Jane Payling, head of heath and integration at CIPFA and an HFMA member. 'For example, people who are on CIPFA's Health and Integration Board are also often members of the HFMA faculties, so it was natural to practise as we preach and integrate the resources of the two organisations.'

The first piece of work from the Integration Finance Network is the *Glossary for NHS and local government finance and governance* (pictured), which clarified definitions and terms used in the NHS and in local government, promoting closer working.

Recently the two organisations brought together representatives from local authorities, the NHS and the Department of Health to explore how local government and the NHS can collaborate on capital schemes. The workshop identified opportunities available to promote joint working. But to progress, schemes must not breach the constrained NHS capital expenditure limit and must fit with local political priorities – each project needs to be viewed case by case at local level.

The outcomes of the research were revealed in the briefing *Capital collaborations between the NHS and local authorities* (page 28), now on HFMA's website.

Joint learning is another pillar of the new network. The HFMA and CIPFA are holding a joint health and social care conference, merging the annual CIPFA health and social care conference with September's HFMA Commissioning Finance Faculty forum. HFMA and CIPFA teams are working together on the conference programme.

The event, to be held in London, promises to bring together over 100 professionals involved in the integration agenda.

Bookings can now be made – Commissioning Faculty member chief finance officers qualify for a free place.

- For more information, contact **jonathan.richards@hfma.org.uk**

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Appointments

The winner of HFMA's Finance Director of the Year Award 2016, **Annette Walker** (pictured), has been named finance director at Bolton NHS Foundation Trust, taking over from 2015 Finance Director of the Year **Simon Worthington**. Ms Walker was chief finance officer at Bolton Clinical Commissioning Group. She has been working closely with Mr Worthington and the trust, including on the development of aligned incentives contracting, which is being rolled out to other parts of the country. Ms Walker has been a member of the HFMA North West Branch for nearly 25 years and is an active member of the Commissioning Finance Faculty Technical Issues Group. Mr Worthington is now director of finance at Leeds Teaching Hospitals NHS Trust.

Deputy director of finance **Pete Papworth** (pictured) has stepped up to be acting director of finance at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. He has spent the past five years as deputy and has 14 years' experience across the public sector in Dorset, having joined the Audit Commission's graduate training scheme in 2003. He takes over from **Stuart Hunter**, who is now chief finance officer at Dorset Clinical Commissioning Group, where he succeeds **Paul Vater**. **Ian Metcalfe** is the current interim deputy director of finance at the Royal Bournemouth trust.

Shropshire Clinical Commissioning Group has appointed **Claire Skidmore** chief finance officer. She was chief finance and operating officer at Wolverhampton Clinical Commissioning Group. **Tony Gallagher** is now chief finance officer for Walsall Clinical Commissioning Group and Wolverhampton CCG. Ms Skidmore succeeds interim **Deborah Hayman**, who is now interim director of finance at NHS England (North Midlands).

Carolyn Wood has been appointed director of finance at Pennine Acute Hospitals NHS Trust's Oldham Care Organisation, one of four organisations in a new site-based operational management model. Previously, she was deputy director of finance at Wrightington, Wigan and Leigh NHS Foundation Trust.

Northern, Eastern and Western Devon Clinical Commissioning Group has promoted NHS national graduate **Sian McPhee** to senior finance manager.

Nick Kenton (pictured), former director of finance at NHS Highland, has become director of finance and corporate services at development agency Highlands and Islands Enterprise.

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

"The here and now challenge is to keep tackling the financial position so we get room to breathe to carry out our plans. With a new team coming in, that has probably led to more breathing space"
Simon Goodwin

Goodwin siezes capital opportunity

On the move

There are many big jobs in NHS finance, particularly with the current pressure on finances and to find the resources to deliver a long-term transformation of services. But few can be bigger than that in North Central London, where Simon Goodwin has just become chief finance officer for five clinical commissioning groups and the sustainability and transformation partnership.

Mr Goodwin is part of a new executive team at Barnet, Camden, Enfield, Haringey and Islington CCGs, which also manages North Central London STP.

The area, which also includes eight NHS provider trusts and five councils, is beset with financial difficulties. In health, its 'do nothing' projection is an aggregate deficit of more than £800m, with a further £247m in local authorities (social care and public health).

His interest in the post came as he added up a number of factors. 'This is my fourth director of finance job in the NHS, and after 16 years at this level it felt to me like the right stage of my career to take on something a bit more challenging.

'I know North Central London really well and have lived here most of my adult life. I have worked in health bodies in the area off and on for 20 years and I worked with Helen Pettersen, the chief officer and accountable officer, for a long time in Islington. I know she is good to work with and for.'

It's easy to see why he describes the post as challenging. 'It's a big task. The cumulative do-nothing deficit is approaching nine figures and virtually every NHS organisation in North Central London has financial issues. Obviously both NHS England and NHS Improvement are keen for us to close the gap.'

Despite this, though, he believes that the collaboration and integration seen in STPs is the right direction of travel for the NHS.

'I like being at the start of things. It's early days, but in the system there's a commitment to the integration needed. For me, it's good to be able to help set that up.

'The here and now challenge is to keep tackling the financial position so we get room to breathe to carry out our plans. With a new team coming in, that has probably led to more breathing space.

'But we are in the capped expenditure programme so we are involved in a high level of assurance anyway.'

Mr Goodwin is a staunch supporter of the HFMA and has served on two national groups – the PCT Steering Group and, most recently, the Mental Health Steering Group.

'I have been in and around the HFMA national bodies for 10 years,' he says, 'and it is something I am keen to support.'

He moves to the post from Barnet, Enfield and Haringey Mental Health NHS Trust, which he joined in 2010 as chief finance and investment officer. Prior to that, he spent six years as director of finance at NHS Islington.

Mr Goodwin began his career as an audit supervisor at accountancy firm Touche Ross, and has worked in the NHS since 1994 – first at North Middlesex Hospital, followed by three years at Oxford City Primary Care Trust, where he was director of finance.

He says that although North Central London probably started collaboration later than health services in other parts of the capital, the organisations are determined to succeed.

'We have a bit more to do on forming relationships and learning to trust each other. That takes time and must be done before we can come together to collectively shape and agree to do something that is radically different,' he says.

'My priority is to improve the system numbers in-year and create a bit of headroom so we can work on a longer-term solution.'

Briddock targets new challenge

Paul Briddock has stepped down as the HFMA's policy and technical director. Mr Briddock joined the association at the beginning of 2014, bringing with him 20 years' experience in NHS finance – 15 of them as a finance director.

Mr Briddock has been central to improving engagement with the media and raising the profile of the association's wide ranging policy and technical work. However, he said that with the association deciding to refocus on its development agenda and spend less time on media activities 'it was the right time to look for fresh challenges'.

A key highlight of his time at the association has been working with an expanded policy team to establish the *NHS financial temperature check*. Alongside a higher volume of technical and policy briefings, this twice-a-year report now provides a regular, authoritative analysis of current NHS finances and reports finance directors' views of current challenges.

He has also played a major role in establishing the HFMA Costing for Value Institute, which is leading calls for greater value-based decision making across the service.

Mr Briddock said he'd enjoyed working at the HFMA. 'The NHS continues to face significant financial and service pressures as it looks to transform delivery models,' he added. 'My focus will now be to use my skills to support NHS organisations in meeting this agenda.'

The HFMA board praised Mr Briddock's work at the association, describing him as a 'passionate advocate for the HFMA – both in his role as policy director and previously during his time as an NHS finance director'. HFMA chief executive Mark Knight said the association had 'benefited enormously from his experience and hard work'. 'I wish him well in his future endeavours,' he said.

Children & Young People's Services: A Case Study

BACKGROUND

This NHS Foundation Trust, based in the North East of England, was formed in 2006 and serves a population of 1.4 million. It employs approximately 6000 staff over 60 sites covering 2200 square miles. The project was the fourth programme undertaken with the Trust following successful initiatives in Allied Health Professionals (AHP) and Psychology Forensic Inpatient Teams, Acute Mental Health Inpatient Ward Management and the Call Handling Teams.

The Children and Young People's Service (CYPS) consisted of approximately 320 WTE staff with a budget of circa £14.8m and provided specialist community mental health and learning disability services for 0 to 18 year olds across three localities. The Trust engaged in an analysis with Meridian to identify opportunities to redesign CYPS's community services and ultimately increase productivity through a reduction in agency, bank and overtime spend.

IMPLEMENTATION PROGRAMME

Meridian's engagement with the Service's management team was essential to deliver the overall goals of the project. Workshops were conducted to develop and agree the required systems and behavioural changes with staff having opportunity for discussion, critique and contribution. During interactive sessions, new clinical pathways were designed to maximise the capacity of staff to deliver quality and productive levels of work. In addition, a new robust management control system was designed to ensure effective running of CYPS.

This control system is now owned by all managers involved.

The key focus was to facilitate the service redesign and implement management controls enabling a reduction in overspend and large scale behaviour change. Integral to this was that all levels of management fully understood the planned and actual performance of their service against the target, taking the appropriate corrective action where necessary.

The installation included:

- Visibility of the achieved contacts and associated measures to establish variance against the plan
- A weekly review attended by all key stakeholders to provide authoritative decision making along with the option for each level of staff and management to escalate issues/concerns
- A weekly management report containing Service KPIs with actuals against plan and target, which aided the follow up process for senior clinical management and team managers
- A monthly caseload cleanse in order to control and manage the service demand and minimise the required capacity
- Controls to reduce unwarranted variation in practice
- Bank, agency and overtime caps and controls to minimise the overspend

RESULTS

The redesigned service including the installed management control system and new clinical pathways better equipped CYPS managers with the necessary systems and processes to manage the demand with reduced capacity through increased care hours per patient day. Ultimately this resulted in a significant reduction in bank, agency and overtime usage.

PRODUCTIVITY

An overall productivity improvement of 45% represented as an increase in direct patient facing time

SAVINGS

Cashed savings of £18,500 per week by week 2 of the programme

£1.4 million saved during the lifetime of the project (£3.6 million full-year effect)

R.O.I.

An overall return on investment of programme costs of 10 to 1

SYSTEM

Redesigned services and new clinical pathways equipped managers with systems and processes to manage the same demand with reduced capacity, resulting in a significant reduction in bank, agency & overtime usage