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1. Care Quality Commission. The state of health care and adult social care in England 2015/16 (October 2016). Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561730/State_of_Care_15-16_web.pdf. Accessed November 2017.
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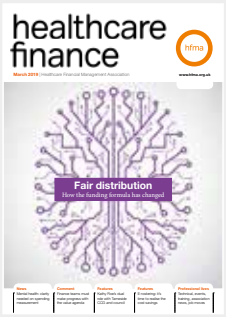

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Practitioners want clarity on mental health investment

By Steve Brown

Commissioners and providers of mental health services have called for greater clarity on how mental health investment should be measured.

The *NHS long-term plan* has promised to increase investment in mental health services faster than the NHS budget overall for each of the next five years, with funding for children and young people's services growing even faster than total mental health spending.

This builds – some argue minimally – on the existing mental health investment standard (MHIS) that requires clinical commissioning groups to invest in mental health services at a faster rate than their overall programme growth. Providers have complained that they haven't seen this increase, with commissioners complying with the investment standard by increased spending on continuing healthcare for mental health and related prescribing and spending with non-NHS providers such as charities or community groups.

New surveys of commissioners and providers by the HFMA and NHS Clinical Commissioners show these concerns continue. While 85% of CCG respondents were confident of hitting the MHIS spending target, 88% of providers had low or no confidence that they would receive this same increase in their own funding. One provider commented that the standard was being achieved by investment in areas not covered by the *Five-year forward view*. And one CCG respondent acknowledged that high demand in mental health continuing healthcare had affected investment elsewhere.

"We need consensus on where mental health money is being spent and where more needs to be done"
Phil Moore, NHS Clinical Commissioners (pictured)

Despite the pessimism from providers, nearly three-quarters of the commissioners taking part in the survey were confident that investment in the sector was being used to meet the targets specified in *Implementing the five-year forward view for mental health*.

Both commissioners and providers agreed that more guidance was needed about what should and shouldn't be included in spending counting towards the investment standard.

There were also concerns that outcomes were not part of the measurement process and that spending on prevention was not acknowledged, despite it being essential to good population mental health.

The contradictory nature of the way the measure works was also highlighted. Increased spending on continuing healthcare may help a CCG meet the necessary levels of investment, but is contrary to other initiatives looking to contain continuing healthcare spending.

And respondents pointed out that the MHIS did not recognise historic levels of under-investment in some areas. While increasing the proportion of overall spend on mental health was welcomed, a metric that looked at spend per head of population was suggested as a more equitable approach.

Phil Moore (pictured) from NHS Clinical Commissioners' Mental Health Commissioners Network said the disparity in confidence between CCGs and providers in meeting the MHIS was worth exploring further. However, he said that CCGs must continue investing in primary and community mental health as well as acute mental health providers – investing in the third sector was a clear commitment in the long-term plan.

'Mental health commissioners welcome the clear steer from NHS England that the money intended for mental health will now be monitored and validated, though there are concerns about the cost of such audits,' said Dr Moore. 'It means we need to build a consensus on where mental health money is being spent and where more needs to be done.'

• ***Survey results: www.hfma.org.uk/publications***

'No deal' having adverse impact on services

NHS managers' ability to focus on transformation work is being hampered by the need to prepare for a possible 'no-deal' Brexit.

By late February, Parliament had still not ratified the government's proposed EU withdrawal agreement, increasing the prospect of the UK leaving the EU without an agreement in place.

A report by the Welsh Audit Office said most public bodies were taking 'no-deal' planning seriously. But public services in general lacked capacity to manage Brexit and this was having an adverse impact on other service areas.

In the NHS, it said, audits had raised concern about the impact on transformation work, with the 'same cadre of management staff' managing the implications of 'no-deal'.

Key risks identified by NHS bodies include medical supplies, food supplies, workforce, and wider wellbeing. But there are also concerns around research and development and reciprocal healthcare arrangements.

A briefing by the Welsh NHS Confederation said EU nationals accounted for 3% of the NHS Wales workforce, rising to 7% for medical and dental professionals. It remains concerned about visa proposals in the immigration white paper and called for a guarantee that the settled status programme be honoured if 'no-deal' proceeds.

In mid-February health and social care secretary Matt Hancock told Parliament the Department of Health and Social Care had so far spent about £11m on 'no-deal' contingency plans. This did not include stockpiled medicines, which were being bought by the pharmaceutical industry.

'I am confident if everyone does what they need to do, the supply of medicines will continue unhindered,' he said, adding that leaving with a deal remained the government's top priority.

Trusts urged to grasp productivity opportunity

By Seamus Ward

Trusts could meet the 18-week referral to treatment (RTT) target by increasing productivity, according to a report for NHS Improvement.

The report said the overall RTT waiting list has been growing since April 2012 and, against a backdrop of rising demand and tightening finances, trusts have tried to tackle this with a range of strategies. Measures included paying for weekend sessions, agency staff and outsourcing to the independent sector.

Alternatively, the report added, trusts could improve theatre productivity by fully using operating list capacity together with the staff and resources already committed for scheduled operations.

The oversight body commissioned Deloitte to analyse theatre productivity across England, which examined data from 92 trusts for the 2017 calendar year. Its report, *Operating theatres: opportunities to reduce waiting lists*, found significant variations both between trusts and different specialties.

The start of a third of operating lists were delayed by at least 30 minutes; 38% finished early by 30 minutes or more. Theatre time that was lost to late starts, early finishes and delays

between operations could have been used to perform up to 291,327 more operations (a 16.8% increase). This included 30,000 more ear, nose and throat operations; an additional 41,000 ophthalmology operations; 27,000 more oral and maxillofacial surgery operations; and 44,000 more urology operations.

The scheduled time allocated to operating lists in the eight highest volume surgical specialties reviewed varied between hospitals and some specialties had consistently higher levels of early finishes, the report said. It added that lists that last the longest appear to offer the greatest productivity opportunities – early finishes are more common for longer lists and the average time between operations on the list is greater.

Tim Briggs (pictured), NHS national director for clinical improvement and council member of the Royal College of Surgeons, said the hard work of surgical staff was ensuring more patients than ever get the care they need. 'While waiting times for surgery are lower than they have been historically, more can be done, so it is important that we work with clinical teams to identify further solutions and share best practice.'

He was encouraged the report found pockets of innovation. 'As the *NHS long-term plan* states, we need to ramp up these efforts where clinically appropriate, so that they become the norm and so that we can address the variation that exists.'

NHS Providers head of policy Amber Jabbal said NHS theatres were among the world's most productive, though there was scope to increase productivity. But elective throughput could not be viewed in isolation – hospitals faced other pressures that affected their use of theatres.

'As a result of financial and workforce challenges the number of patients waiting longer than they should be for routine surgery is growing. Addressing this challenge goes beyond how operations are scheduled,' she said.

'Theatres cannot be viewed in isolation and we have to be realistic about the current resources in place. Often cancellations and downtime for theatres are because of staffing levels, patient needs and the availability of beds.'

NHSI targets use of agency admin staff

NHS Improvement has proposed measures to limit spending on admin and some clinical agency staff, which could limit the use of agency cover in finance and other support functions.

Trusts have reduced overall agency spending by more than £1bn since April 2016, when agency rules were introduced. But the oversight body said the volume of agency shifts had increased since the beginning of this financial year, largely due to rising demand, and despite a significant reduction in agency prices.

The consultation proposes two measures – the first would require trusts to use framework agency workers only when filling non-clinical and unregistered clinical shifts. Non-clinical and unregistered clinical roles include healthcare assistants, estates, admin and some allied health professionals.

In the medium term, restricted use of off-framework agencies for these roles should be part of trusts' strategies to stop using off-framework agencies for all staff groups, the oversight body said. And, though trusts have reduced off-framework shifts by more than 70% since 2016, NHS Improvement believes further savings could be achieved.

Only 37 trusts use off-framework agencies for non-clinical and unregistered clinical cover and NHS Improvement said it would work with these providers to move the spending onto bank or framework agencies by April 2020.

The second measure bears down on agency admin shifts by requiring trusts to use bank, substantive or fixed-term staff instead. This will help providers meet new admin agency expenditure ceilings that will be introduced in

2019/20, NHS Improvement said.

Finance staff account for 14% of admin agency spending, typically used to cover sickness or maternity leave and help with short-term projects. There would be exemptions for the latter – if they last fewer than six months – and for shortage specialties, including clinical coders. Interim very senior managers would still be covered by separate rules.

The consultation closes on 22 March and, subject to responses, agency rule changes will be introduced from April.

Employers ask for detail on pension plan

NHS Employers has called on the Department of Health and Social Care to give greater detail on new funding that aims to cover the increased cost of changes to the NHS Pension Scheme.

In December, the Department opened a consultation on changing the pension scheme regulations. The revisions include a new 20.6% employer contribution rate from 1 April (currently 14.3% plus a 0.08% administration charge). The amendments would also include a confirmation that civil partners and same sex spouses will have the same survivor pension rights as widows.

The current tiered contribution rates of between 5% and 14.5% – calculated according to whole-time equivalent pensionable pay – for scheme members (employees) will remain in place until the completion of a review by the scheme's advisory board.

The consultation closed in January. In its response, NHS Employers welcomed the government's decision to provide £1.25bn a year to cover the higher employer pension contributions, but asked for details of how the money will be distributed. It called for written clarification that the extra funds will cover in full the increased cost of employer pension contributions. It also asked if all pension scheme employers – including non-NHS providers of healthcare and wholly-owned subsidiaries – will be eligible to receive the funding.

Overall underspend rises despite CCG deterioration

By Seamus Ward

There was a sharp rise in year-to-date overspends in clinical commissioning groups between months 6 and 8, but the commissioning sector as a whole remains in balance and is forecasting a larger than planned underspend at year-end.

According to month 8 figures, CCGs had an aggregate year-to-date overspend of almost £144m. At month 6 the combined CCG overspend was £74m. Halfway through the financial year, 36 CCGs had year-to-date overspends, but by month 8 this increased to 48.

Fifteen CCGs predict they will end the financial year with an overspend – four more than at month 6.

NHS England interim chief finance officer Matthew Style (pictured) said the areas with the most significant overspends were Staffordshire (£34.2m), East Kent (£16.9m) and London (£39.3m). But as in previous months, the CCG overspend is offset by underspending in other areas of the commissioning budget – £29m in direct commissioning and £138m in NHS England running and central programme costs. The latter includes income from GP rates rebates and counter fraud receipts not included in the operating plan.

After technical adjustments, the year-to-date aggregate picture for the commissioning sector is a £9.4m underspend.

CCGs forecast a year-end overspend of £45m, but again this is offset by underspends in central budgets (£272.5m) and direct commissioning (£15m). Part of the offset includes the release of £60m from the centrally held quality premium budget, which NHS England does not expect to be earned by CCGs.

When technical adjustments are factored in (forecast to be £54.5m more than planned), the final year-end position is a forecast underspend of almost £188m.

Mr Style said the sector is now projecting over-delivery on its planned position. When this £188m is added to the sector's planned £265m underspend, the forecast year-end underspend is £453m. Initially, the commissioning sector planned for a balanced year-end position but in September NHS England and NHS Improvement agreed a plan to recover planned year-end provider deficits that totalled £519m.

This would give providers a firm financial base for the first year of the *NHS long-term plan.* Commissioners' contribution to offsetting providers' overspend was set at £265m.

'As in previous years, the pattern within [the financial position] is of emerging pressures within the CCG forecasts, particularly around overperformance on some contracts, offset by carefully managed underspends in some central budgets and underperformance against the quality premium,' Mr Style said.

The position will be kept under close review, he said, particularly with a series of deep dives using the month 9 forecast to ensure the commissioning system can play an appropriate part in delivering financial balance.

The risk-adjusted forecast at month 8 was improving – all remaining commissioning risks are expected to be offset by further central mitigations.

Progress at NHS Tayside but risks remain

NHS Tayside has made progress on governance, leadership and sustainability, and is well on the way to delivering its financial targets for 2018/19, according to a report for the Scottish government.

Following the final update from the Assurance and Advisory Group (AAG), commissioned in 2017 to help the health board return to greater financial sustainability, health secretary Jeane Freeman (pictured) accepted improvements have been made. She re-designated Tayside as stage 4 on the performance escalation framework. It had previously been at the highest risk level (5). Stage 4 notes significant risks to delivery, quality, financial performance or safety.

The AAG said the board was on track to deliver its planned £18.7m overspend in 2018/19 (excluding a planned £3.6m repayment) and had made strides in reining in spending. Overspending had fallen from £1.9m a month between April and June 2018 to an average of £1.5m a month from July 2018 to January this year.

It had reduced agency staff use, increased productivity and delivered savings in procurement, medicines, corporate services, estates and facilities. The board is forecasting efficiency savings of £32.2m in 2018/19 against a planned £29.4m.

Ms Freeman paid tribute to the work of the board and the AAG. 'This is just the start of the journey for the new chief executive, Grant

Archibald, in making services the best they can be for patients of NHS Tayside,' she said. 'We will continue to work closely with the board in achieving its aims over the coming months and years.'

News review

Seamus Ward assesses the past month in healthcare finance

With the dust settling on the *NHS long-term plan* and clinical commissioning groups beginning to digest the implications of five-year allocations published in January, February was a relatively quiet month for the NHS. As always at this time of year, winter pressures dominated the headlines, but milder than usual weather and ever-better preparations helped the NHS cope overall – notwithstanding an 'all-time' low in A&E performance, more of which later.

NHS manager-bashing is a popular sport and several governments have considered tighter regulation. Yet given the opportunity to do so, they have largely kicked the can down the road. Similarly, in February the government accepted, in principle, only two of the seven recommendations of a review of the fit and proper persons test for senior NHS managers. The review, led by Tom Kark QC, said new competency standards should be created for directors on NHS boards and where training is needed it should be made available. This was accepted, together with a recommendation that the government should set up a national database of directors' qualifications, previous employment and performance. However, the remaining five recommendations, including a proposal to establish a new organisation to suspend directors that have committed serious misconduct, will be considered as part of the workforce implementation plan that's currently being developed.

A lot of the news focused on primary care. NHS England announced a five-year GP contract that aims to boost primary care services and establish primary care networks. The deal will see £1.8bn invested in creating the GP-led networks, which will bring a number of healthcare professionals together with family doctors to provide a range of services in primary care. Initially, the networks will hire community pharmacists and social prescribing workers, but in later years they aim to add paramedics, physiotherapists and physician associates.

A long-mooted state-backed insurance scheme for GPs was also launched following the announcement of the new general practice contract. NHS Resolution said the new GP indemnity scheme will open on 1 April and will be known as the Clinical Negligence Scheme for General Practice (CNSGP). The scheme is centrally funded, and NHS England said it will give GPs the same benefits as their hospital-based colleagues.

Following the announcement for GPs in England, Wales health minister Vaughan Gething gave the green light to establishing a state-backed clinical negligence scheme for local GPs. The scheme in Wales will be as closely aligned to English CNSGP as possible. The Welsh programme, to be known as the Future Liability Scheme, will be operated by NHS Shared Services Partnership from 1 April and will cover clinical negligence liabilities arising from the activities of all contractors providing primary care services, including GP staff, salaried GPs and practice nurses.

The indemnity schemes are seen as crucial, not only in attracting new GPs, but also to retain those already practising. In February, the Scottish government moved to address another issue that affects recruitment and retention. It announced that local GPs will be given extra support with the cost of running their practices. Health secretary Jeane Freeman said a further £20m will be invested, bringing the total sum to £50m over the next two years. The money will support the GP premises sustainability loan scheme, which aims to help recruitment and retention by easing the financial burden of owning a practice. The scheme allows GPs who own their premises

The month in quotes

'For patients it should mean fewer trips to hospital and more care in the community, and allows health and care services to work together seamlessly with a greater focus on preventative, proactive and co-ordinated care.'
Reforms to help establish ICPs are crucial to the long-term plan, says health minister Stephen Hammond

'Both the BMA and individual GPs have raised concerns with us about the financial risk of owning premises. So we have responded directly, and this scheme helps to "de-risk" general practice and reduce some of the up-front costs GPs can face when joining a practice.'
Scottish health secretary Jeane Freeman hopes a new premises scheme will make general practice more attractive

'We must not become immune to the reality that behind today's figures are stories of people with urgent medical needs waiting too long to be treated. NHS England's review of performance targets must show how the NHS can get back to delivering the service that patients are entitled to expect and NHS staff want to deliver.'
King's Fund chief analyst Siva Anandaciva says there is a hidden crisis in A&E

'To improve leadership in the NHS we must fire fewer people and attract the best talent. NHS leaders have some of the toughest yet most rewarding jobs in the country. So let's support them to do the job they need to do, and that will encourage more to step up.'
Health secretary Matt Hancock says NHS managers should be supported

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NHS England announced a five-year GP contract that aims to boost primary care services and establish primary care networks

to apply for long-term, interest-free loans worth up to 20% of the practice value.

The government is to change the law to make it easier to establish integrated care providers (ICPs). ICPs will enable primary medical services to be included in the same contract as other health and social care services. The ICP contract, which is due to be available from April, would be held by statutory providers, such as foundation trusts.

NHS screening programmes in England are not meeting standard targets and the proportion of eligible adults receiving screening is inconsistent, according to the National Audit Office. The NAO acknowledged the national bowel screening programme achieved coverage of 59.6% against a standard target of 60% in 2017/18. And all programmes except cervical screening met the lower threshold targets set by the Department of Health and Social Care. Currently, there are 11 national screening programmes in England, but the NAO focused on four that offer screening based on age, rather than a particular condition or pregnancy. The four programmes – abdominal aortic aneurysm, bowel cancer, breast cancer and cervical screening – examined 7.9 million people in 2017/18 and cost the NHS £423m.

NHS accident and emergency departments in England recorded their worst overall performance since the four-hour target was introduced in 2004. The latest figures from NHS England show A&Es continue to see more patients but are failing to meet the 95% four-hour target. In January, 1.78 million patients were admitted, transferred or discharged within four hours (84.4%), although attendances were 5.6% higher than 12 months ago. In January 2018, 1.7 million patients were seen within four hours. The 95% four-hour target was last achieved in July 2015. Delayed transfers of care were 10.8% lower in December 2018 than in December 2017. Most of the delays could be attributed to social care (47%), with 35% due to the NHS and 17% to both.

Integration between health and social care services must advance at a faster rate, according to the Scottish government and local authority body COSLA. A report assessing progress said some good practice had developed, both in the operation of integrated joint boards and how services are being planned and delivered to ensure better outcomes. It set out a number of proposals to bring forward further integration, including ensuring integrated finances and financial planning deliver maximum benefit for every pound spent; introducing more effective strategic improvement planning; and clear governance and accountability arrangements.

Also in Scotland, the government announced a £12m package of measures to transform maternity and neonatal services. A new neonatal care model will be tested at four sites to ensure babies needing more specialist care get the best possible support. There will also be other measures to help mothers and other family members.

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from the hfma

The announcement in the *NHS long-term plan* that hospitals are to provide their own smoking cessation services is a step forward for public health, according to University Hospitals of Leicester NHS Trust consultant Sanjay Agrawal (pictured). In a blog on the HFMA website, he says smokers see their GP over a third more often than non-smokers, while smoking is linked to nearly half a million hospital admissions a year. The HFMA made a major contribution to developing a tariff for treating tobacco dependency (*see Stubbing it out, Healthcare Finance, December 2018*) and he hopes prevention measures will have a lasting impact on patients, the NHS and society.

The HFMA policy team has produced guidance with its CIPFA counterparts on chief finance officers who work across the NHS and local government. Finance directors are performing this dual role in a small number of areas, says Emma Knowles, HFMA policy and research director. There is at least one example of a finance director covering both a clinical commissioning group and local authority (*see Finance frontrunner, page 13*). The guidance will be useful for those already in post to assess their development needs; those considering applying for a dual role post; and those thinking of appointing to a joint role, she adds.

In his latest blog tracing his role as chief financial officer of Bermuda Hospitals Board, Bill Shields says you don't need cold weather to see NHS-style winter pressures. Mr Shields also looks at difficulties for insurance-based healthcare in places with small populations.

www.hfma.org.uk/news/blogs

News analysis

Headline issues in the spotlight

The workforce problem

The *NHS long-term plan* reaffirms proposals to move care out of hospitals and closer to people's homes, but recent trends in staffing levels for priority areas provide a challenging starting point. Steve Brown reports

The *NHS long-term plan* recognises that there is a serious issue with staffing – the service needs to address immediate staff shortages and ensure it has a sustainable supply of appropriately qualified staff to draw on going forward.

However, a new report from the Health Foundation has underlined the extent of the challenge with staff numbers in some of the key areas actually going backwards over the last year.

The Health Foundation's third annual workforce trends report, *A critical moment,* acknowledges that staff numbers are increasing overall. England's 1.07 million staff (full-time equivalent, FTE) – 1.2 million headcount – in place in July 2018 represented an increase of 18,567 (1.8%) compared with 12 months earlier. However, the report stressed that the increase should be seen against a backdrop of more than 100,000 vacancies reported by NHS providers.

Half of the growth is among professionally qualified clinical staff, with ambulance staff, hospital and community health services (HCHS) doctors and scientific, therapeutic and technical staff all growing by around 3%.

However, the number of midwives rose by less than 1%, while the number of nurses and health visitors increased by less than 0.5%.

But of biggest concern is what is happening to staff numbers in the areas being prioritised by the long-term plan. The plan has reiterated the aim to move care out of hospitals and closer to people's homes, with promises to increase funding for primary, community and mental healthcare services.

Against these priorities, the number of nurses and health visitors working in community services continued a long-term decline, falling by 1.2% (540 FTE). Mental health nursing numbers grew by less than 0.5% (just 170 FTEs), while psychiatrists saw the smallest percentage increase (0.6% or 50 FTEs) among all doctors.

Learning disabilities – another priority area, saw numbers of specialist nurses fall by 3.7% over the same period.

While hospital doctor numbers continued to grow, GP numbers fell by 1.6% in terms of FTEs. However, there was a notable increase in the number of general practice-based pharmacists and advanced practice nurses.

'Providing more care outside of hospitals is central to the *NHS long-term plan*, but the health service faces an uphill struggle,' said Anita Charlesworth, the foundation's director of research and economics. 'If it can't recruit and retain more healthcare professionals in primary, mental health and community care, this will continue to be an unrealised aspiration.

'There is unfortunately no sign that the long-term downward trend for key staff groups, most notably GPs, will be reversed.'

Ms Charlesworth said the workforce implementation plan that was currently being worked on would be crucial, but action was needed to address the lack of alignment between staffing and funding, and the damaging impact of wider policy.

'International recruitment remains vital,' she

Staff key to technological future

Digital healthcare technologies – genomics, digital medicine, artificial intelligence (AI) and robotics – will augment healthcare professionals, giving them more time to care for patients. Patient outcomes should improve and patients will be empowered to participate more fully in their own care.

An independent review and report – *Preparing the healthcare workforce to deliver the digital future* – argues that within 20 years, 90% of all jobs in the NHS will require some element of digital skills and all staff will need digital and genomics literacy.

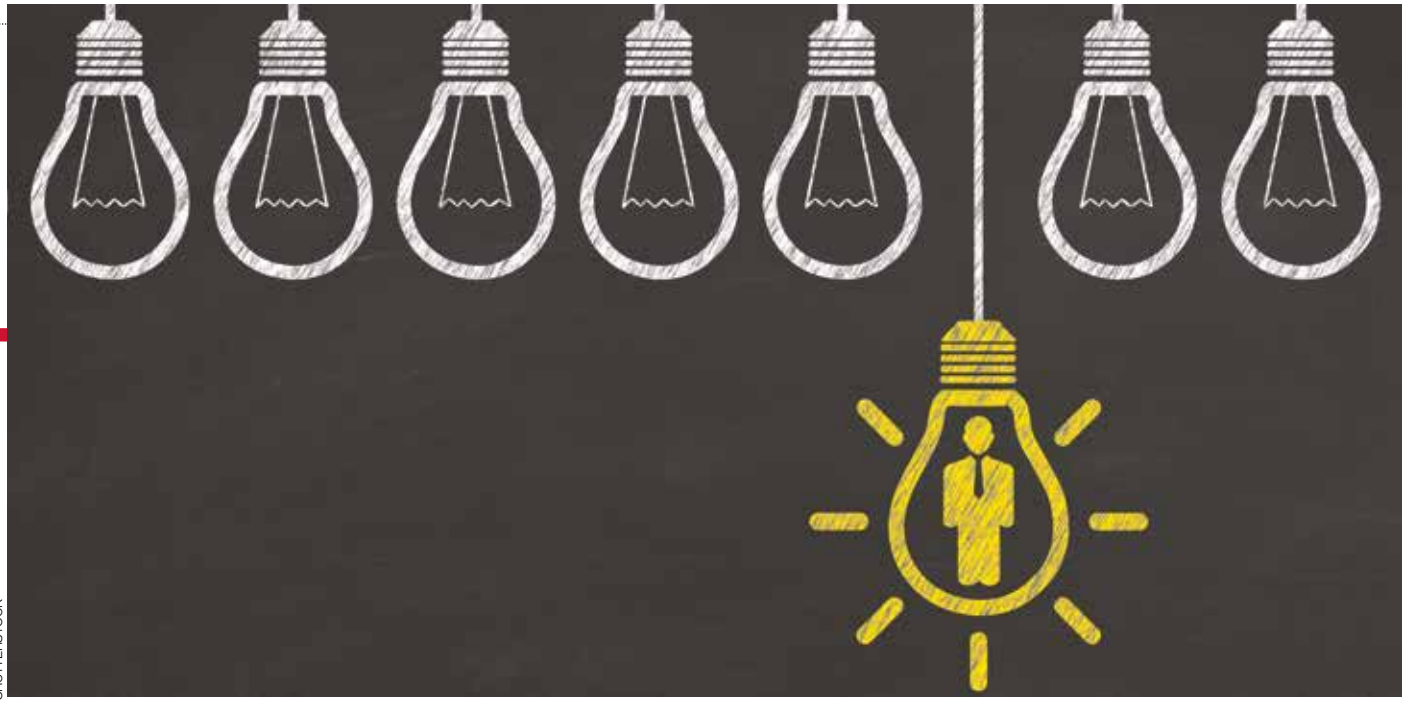
The review, led by cardiologist, geneticist and digital medicine expert Eric Topol, calls on the NHS to tackle differences in the digital literacy of the current workforce linked to age or place of work.

Complex data governance issues should also be addressed and not be used as a reason for inaction. In addition, mechanisms must be put in place to ensure that advanced technology does not dehumanise care.

Genomics will become integral to all medical specialties and the workforce will be key to ensuring it is efficiently and equitably deployed. **Digital medicine** will require leadership with the capability to direct the agenda and new senior roles to advise boards on digital technologies. The NHS will also need to build skills in data provenance, curation and governance.

Artificial intelligence will help to automate mundane repetitive tasks that require little human cognitive power, improve robot-assisted surgery and the optimisation of logistics.

NHS bodies should invest in the existing workforce to develop specialist skills, including the



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said, 'but it is being constrained by migration policies and the uncertainties of Brexit. We urgently need a coherent strategy.'

NHS Providers' deputy chief executive, Saffron Cordery, said the growing gap between demand and supply of critical health and care roles such as GPs and community nurses is a concern. 'We need more immediate actions to ensure staff feel valued and stay within the NHS, and to ensure we can continue to recruit internationally following Brexit.'

While the long-term plan acknowledges the scale of the challenges, the service now needs to see how the NHS and government plan to address these gaps in the short and long term.

On nurse training, the report concluded that the recent changes in funding arrangements in England, combined with a dip in the population of 18-year-olds, had led to a fall in the number of nursing students – not the expected rise. This had been compounded by the attrition rate, with almost a quarter of students across the UK not graduating, or failing to do so within the expected timeframe. There has been no improvement in this attrition rate since 2008 and it was as high as 50% in some universities.

Staff retention must also become a bigger priority as there has been no improvement over the past year. The report says that staff stability – the percentage of staff in a trust at the beginning of a year who remain in their role at the end of it – has decreased substantially between 2010/11 and 2017/18 from 89% to 85%.

The decline may now have halted – in the past year stability rates have been broadly flat.

"There is unfortunately no sign that the long-term downward trend for key staff groups, most notably GPs, will be reversed"
Anita Charlesworth, Health Foundation (pictured)

However, there is a growing gap between the best and worst trusts and across regions. The stability rate is particularly low in areas of London, where almost one in five staff left their post last year.

This may reflect higher career mobility and a younger workforce, but the report says it may also be exacerbated by the movement of EU staff. Again of concern is the fact that community trusts – at the heart of key policy initiatives – appear to have the worst problems with stability, at 79%, while ambulance trusts were the most stable, at 88%.

The report acknowledges that there is some evidence the decline in stability and turnover can be slowed. NHS Improvement's retention programme suggests that if boards engage with the issue and focus on retention, they can improve. Some 71% of 110 trusts in the first cohort on the programme have improved turnover rates – reducing turnover by an average of 1.6%.

There are also hopes that greater flexibility for NHS staff – delivered by more self-service features as part of the wider adoption of e-rostering – will also support greater retention (*see E-rostering: the time is now page 21*).

The report is clear that NHS staffing is failing to keep pace with the level of activity and demand, and in some critical roles such as GPs and community nurses, it is getting worse.

The long-term plan has started to sketch out how some of these issues could be addressed. However, the proposed workforce plan cannot be published soon enough. And the service needs to move beyond simply recognising the issue and start taking actions that increase the retention of existing staff and enable providers to increase recruitment rates.

commissioning of genomics and digital technologies. Future champions will need to be identified early and the service will need to support portfolio careers in academia and industry.

Completing the digitisation and integration of health and social care records is also a necessary foundation if the service wants to realise the full benefits of digital medicine, says the report.

But the overriding message of the review is the need to recognise that successful implementation will require investment in people as well as technology.

Responding to the report, King's Fund researcher Harry Evans said that technology was fundamental to some of the most ambitious targets in the *NHS long-term plan*. Staff will need to be able to use digital tools and understand the data they generate.

'At a time when staff have never been more stretched, technology has an important role to play in making life easier for over-burdened nurses, doctors and other staff, freeing them up to focus on supporting patients,' said Mr Evans.

'As well as training staff to use technology, new systems should be designed to reduce the daily pressures facing NHS workers.'

Comment

March 2019

Business and value

Finance teams are focused on the year-end, but they must also make progress with the value agenda

HFMA president Bill Gregory

The 'business end' of the financial year is now in full swing. That's a well-used phrase by football managers, but nicely sums up how the efforts put in by NHS finance teams up and down the country throughout the year come together at this time of year. In particular, this reflects the process of preparing statutory accounts for the current year and making sure our plans are well developed for next year.

The dust has begun to settle on the planning guidance, particularly as some of the missing parts of the jigsaw puzzle have been published – namely detailed tariff arrangements and control totals. The challenge next year still looks significant for many of us. However, we shouldn't forget that the budget increase for health is relatively generous compared with other public spending budgets.

During the past month, I was able to join the Yorkshire and Humber Branch for its annual conference. It was really pleasing to see such a strong and vibrant branch in action, with a well-supported conference. It was also a great reminder that the HFMA is made up of branches and the devolved nations. I look forward to being able to join many more similar branch events across the country during the year.

While the HFMA's national profile is important for our profession, its core purpose is to serve the interests of its branches and members. This year, we will be revisiting the HFMA strategic aims to make sure they remain relevant to both the branches and its members, with a focus on the membership offer. If you have any views on what the

Costing: it's too important not to…

Mandating patient-level costing for mental health trusts is demanding but the right thing to do

Healthcare Finance editor Steve Brown

The decision to mandate the collection of patient-level costs from mental health service providers from next year is perhaps not surprising, although it will be extremely challenging. However, forcing the pace on the establishment of comprehensive, robust and granular cost data for the NHS is the right decision.

The *NHS long-term plan* may not specifically mention patient-level costing as one of the key delivery tools. But cost data that people can rely on – and that can be interrogated to show where those costs are actually arising and how they compare to the costs of other providers – is essential to many aspects of the plan. It will help people meet the continuing demanding efficiency drive, make business cases for new care models and help organisations to address the unwarranted variation in practice that can add cost to services. And it will support the move to population health management across systems.

There is undeniably a huge amount on the transformation agenda. But the sooner the NHS establishes a robust database of cost information to inform local decision-making, the easier it will be to realise the plan's vision.

Putting it off any longer will simply leave systems without the crucial information that will help them reshape care models. The real question is why it has taken this long to get to a mandatory approach to patient-costing. Before the Costing Transformation Programme was launched, the NHS spent years encouraging the wider adoption of patient-level costing. But these now seem wasted years as, without requiring trusts to follow common guidance and submit the data, progress was patchy.

However, we should also not underestimate the size of the challenge in completing the journey. This year acute providers will submit their first mandatory submission of their 2018/19 data after a few years of growing numbers submitting on a voluntary basis. Ambulance trusts were already due to join them for their 2019/20 submission and now the decision has been taken to bring mental health trusts on board at the same time.

But mental health trusts have in general been pursuing patient-level costing for a lot

"We shouldn't lose sight that health's budget increase is relatively generous compared with other public budgets"

association should be taking into account during this review, please let me or your local branch know.

Last month, I had the opportunity to attend New York State's delivery system reform incentive payment (DSRIP) learning event in Saratoga. This programme has a prime goal of reducing avoidable hospital use by 25% over five years and is about to enter its fifth year in April. The programme is a little bit similar to the new blended payment system for urgent care being introduced in England in 2019/20. However, significantly, it incentivises providers to address issues across the whole care pathway and to consider the impact of wider social issues that affect individual health needs.

The keynote presentation was delivered by Don Berwick, a celebrated healthcare improvement expert and founding chief executive of the Institute for Healthcare Improvement. His work with the NHS has already been acknowledged with an honorary knighthood. Some of you may have been lucky enough to hear Don speak at a number of HFMA events over the last few years.

Don provided us with a salutary reminder of how big an influence social inequality is on life expectancy. He referenced the work of Michael Marmot (*The health gap*), which provided many examples of this relationship.

Perhaps the most striking of these was the progressive reduction in life expectancy as you take a bus from the West End of Glasgow to Easterhouse.

This was also a useful reminder that health value can be improved by using financial and outcome data to critically review how we provide care and prevent illness. These are concepts that our own HFMA Healthcare Costing for Value Institute is looking to explore further as part of its work programme for the year.

In particular, the institute's value summit on 22 May will showcase real-life examples of clinical and financial teams working together to create more sustainable approaches to healthcare and wellness.

I hope to see many of you at the summit or at your own branch conferences during the course of the year.

Contact the president on president@hfma.org.uk

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less time than their acute colleagues. They typically have fewer staff dedicated to the whole costing process – many have had their hands full with the (to date) required reference costs, let alone making substantial progress with the mammoth task of moving costing to the patient level.

About 10 mental health trusts did not have a suitable costing system in place when NHS Improvement undertook its impact assessment to inform the proposal to mandate collection. There are other issues, including concerns that system providers remain preoccupied with supporting their acute customers. And systems still appear to be configured for acute environments rather than recognising the different way that mental health providers work.

Some in mental health suggest that we still haven't bottomed out what the costing unit is – are clusters here to stay? And there are those who continue to argue across all sectors that NHS Improvement's costing approach is too complex – using a sledgehammer to crack a nut.

But the reality is that this information is

"The sooner the NHS establishes a robust database of cost information to inform local decision-making, the easier it will be to realise the plan"

simply vital to the sustainability of the NHS. Without it, how do NHS bodies understand whether they are using resources effectively? How can they understand the financial impact of a new pathway compared with current practice? And how can they make the move to value-based decision-making, weighing up quality and outcomes alongside the cost of provision?

It will not be easy. Providers should rightly point out to NHS Improvement where the obstacles arise and the challenges of doing this on a shoestring – especially with significant continued pressure on back-office costs. But in the end, patient-level costing has to be in the 'too important not to' pile.

- **The HFMA costing conference takes place in London on 10 April. See http://hfma.to/8q for more details**

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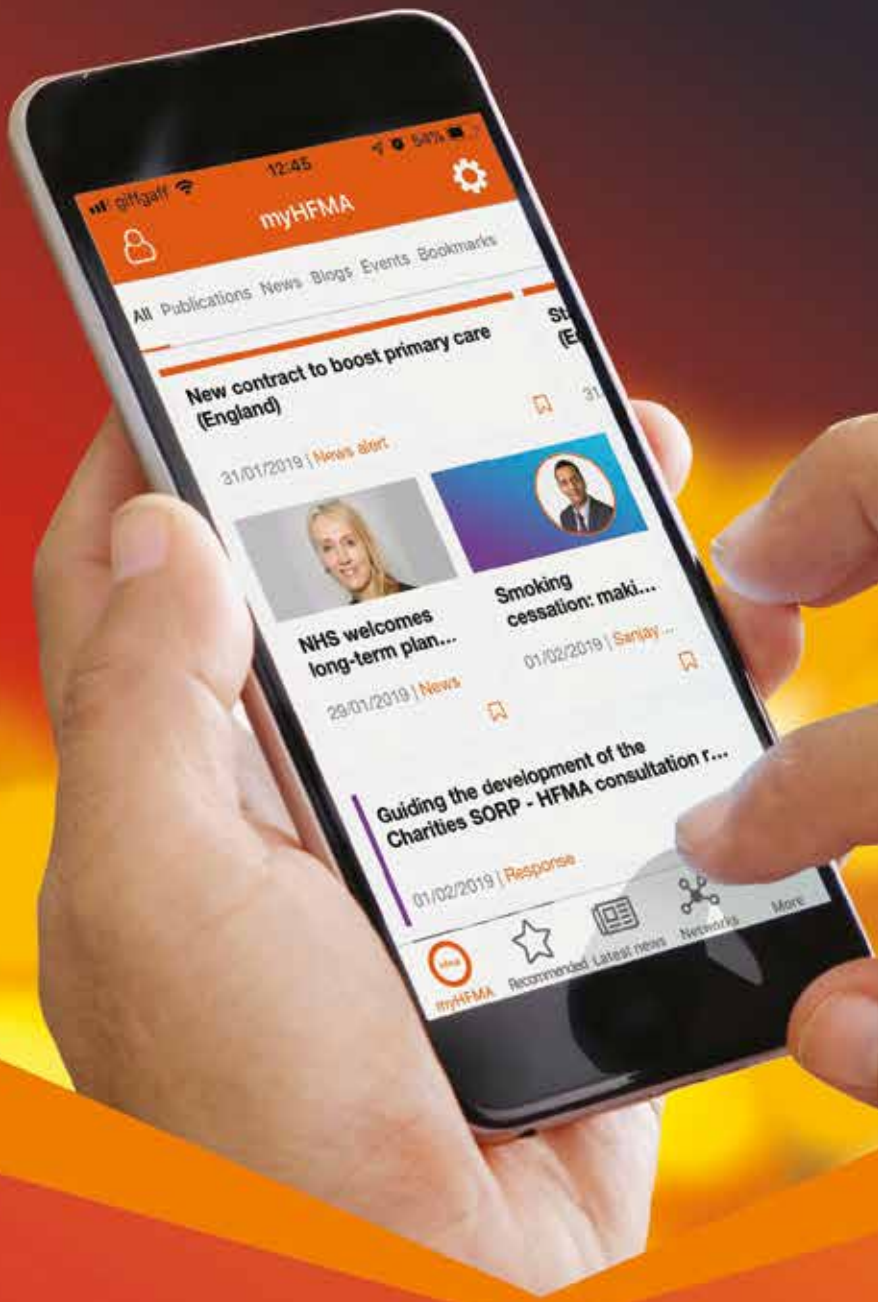

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finance frontrunner

Closer ties between health and social care is the established direction of travel, but what if that is taken a step further? Kathy Roe speaks to Seamus Ward about her pioneering work in Tameside

There are many examples of innovative health and social care in the Greater Manchester devolution area, but Kathy Roe stands out as a true pioneer. For not only is she chief finance officer at Tameside and Glossop Clinical Commissioning Group, but she also fills the same role at the local authority, Tameside Metropolitan Borough Council.

Ms Roe, the 2018 HFMA Finance Director of the Year, is part of a joint management team covering all the council and CCG responsibilities, from commissioning healthcare to ensuring the bins are collected and setting council tax. The decision to take such a radical step sprung from this vision of a new way of working, she explains.

'The council is quite a traditional organisation, steeped in history – the last reorganisation of councils was in 1972. Bringing the council and CCG together is like two oceans coming together, it's challenging but we are finding our way through. We are trying to adapt both organisations – it's not a merger or a takeover, it's creating a new way of working.'

She continues: 'What's the art of the possible? It gives us permission to have a go at something different. We are all looking at system-wide issues and you can't resolve system-wide issues on your own. We

Joined up plans

After years of efficiency savings measures, the Tameside commissioners are taking a new approach – investing in services that improve health and wellbeing to avoid the need for care. 'We want to get in early and switch off the tap where we can,' Ms Roe says. 'We are spending so much money on reactive care, which, if you look at it one way, is spending on failure.'

As well as health and social care, there are services that can contribute to the wider determinants of health and wellbeing. These include education, regeneration and employment, and housing.

Primary school readiness – assessed against emotional and social development, such as ability to listen and socialise with peers – is an area where council and health service could link up. Lack of readiness has been linked to slower academic progress and unemployment later in life – often associated with increased use of health and social services. More than 30% of children in the area are not school-ready. The children often come from 'troubled families', whose situation is known to midwives and health visitors. 'They don't really intervene, but if they did it could lead to a massive improvement for the children.'

can share each other's risks and benefits. All three organisations – the CCG, the council and the hospital – could see that individually they could not manage demand, so they asked how they could work together to do things differently.'

However, collaboration did not happen overnight. A joint vision, *Care together*, set out the strategy four years ago. Initially, *Care together* focused on providers and ensuring services are delivered to patients in a less fragmented way and closer to patients' homes.

'The key things are relationships, trust and leadership. If you can get all three things right, then anything is possible, Ms Roe says. 'When one organisation has a risk, the others try to understand it and on many occasions we have realised that one of the organisations is doing something that is impacting negatively on another.'

An example of this happened when the council cut its spending on provision for the homeless. 'After a few weeks, the hospital chief executive was asking why she suddenly had so many people taking beds overnight who she could not discharge. It was happening because homeless people were ending up in the hospital, as they had nowhere else to go. So, we changed our policy because it's better to spend £20 a night putting people in a bed and breakfast than £200 when they are needlessly in a hospital bed.'

Collaborative effort

The commissioners then realised they should also work more collaboratively. 'We soon concluded we couldn't leave the commissioner side as it was – if the provider side is working together, commissioners should become more joined up also.'

The CCG and council agreed to a joint management structure, with the council chief executive also becoming the CCG's accountable officer and, following her initial role of being responsible for health and social care from January 2016, Ms Roe took up the dual role of finance lead across both the CCG and local authority from October 2017. This puts her in a small group of finance professionals in dual roles.

"Bringing the council and CCG together is like two oceans coming together, it's challenging but we are finding our way through"

Kathy Roe, Tameside and Glossop CCG

The council's section 151 officer – its chief finance officer – had just retired, opening up the opportunity across both roles. 'The council brought in an interim section 151 officer for me to shadow for 12 months because we had to understand if it would work both for myself, the local authority and the CCG. The interim helped to show me the ropes and it was a real help as I don't think you could step into this role without some background. It's a huge job, but very rewarding as you have influence across the system.'

As well as learning the intricacies of local government finance, she learnt about the role of the section 151 officer. 'Councils have to appoint these officers, who have a fiduciary duty to the local taxpayer to safeguard the public purse,' she explains. By law, councils must also set a balanced budget.

'If you think there's any chance of unlawful spending or the budget won't balance you have to issue a formal report to the members of the council. It's a more independent role than in the NHS – a bit like being an auditor – although you are a council employee.'

There are challenges in creating a single management team, including ensuring its governance is right. The council and CCG remain separate statutory bodies, producing their own accounts and operating under their own financial regimes. Their work has been brought together under the umbrella of a strategic commissioning function with a joint board, which can make decisions on pooled section 75 funds. However, other spending decisions can only be taken by the CCG or the council.

This causes frustration and Ms Roe has been involved in talks with government on how to remove these barriers. 'For example, surgical work commissioned by the CCG cannot be included in section 75 budgets – 65% of CCG spending can be on secondary care and a lot of that will be on surgical procedures. Also, other areas such as safeguarding arrangements and emergency ambulance expenditure cannot be included,' she says.

'Overall, the commissioning function has a single integrated commissioning budget, but we have to separate out three pots when we report and make a clear set of decisions around each of the three pots. The first pot is section 75 funds, which make up about 50% of the overall money. The second largest pot is an aligned fund, accounting for around 40% of the budget, which we can take into the commissioning board for an opinion, but any decisions have to be ratified by the executive committees of the CCG or council.

'The third pot is the delegated primary care budget – the remaining 10% – which comes from NHS England. Legally, the CCG can't double delegate to another body, so the strategic commissioning board does have a say, but it's up to the CCG governing body to approve it.'

Her dual role is largely strategic. 'There's no way I could get into all the detail. Obviously, I have a good handle on the health side, and almost every day I learn something new on the council side – it's such a complex and diverse organisation, from bin collection to schools to exchequer services or council tax – each one is so complex and testing.'

But finance staff are well-suited to adopting this higher-level role, says Ms Roe, who is also deputy accounting officer at the CCG. 'All your training in finance, leads you to getting involved in other parts of the business. You are wasted if you are only looking at the numbers – you have to make things stack up and that's the way you apply yourself when looking at a problem, whether numbers are involved or not.'

She would not be able to do the job without her team, she says, especially deputy finance directors Tracey Simpson and Tom Wilkinson, who look after health and local government finance, respectively.

How does she divide her time between council and CCG work? In many ways, she sees it as one, integrated job, though there are times when the local authority or the CCG will have to take precedence. For instance, council budgets must be agreed by the end of February and, when we spoke, she was preparing to present a detailed budget report to the council's executive cabinet. Once the budget has been agreed by the full council, the budgeting focus will turn to the CCG in early March. Once the CCG budget has been signed off, the strategic commissioning board will then agree spending plans by the end of March.

Staff, clinicians and councillors accept that she cannot be in every meeting and has to prioritise, which is again where able deputies step in. 'You need a good support system behind you,' she says.

This fits with her philosophy of licensing staff to take on new responsibilities. 'I want to empower staff. If you want to develop, if you want to learn and you are showing me you are committed, I will empower you. I want everyone to feel empowered and to take on whatever roles they can.'

The strategic commissioning function has a single, integrated and co-located finance team, which covers the CCG and council services. Some groups of staff focus solely on CCG or local authority matters, but others work system-wide, such as on continuing healthcare or the Better Care Fund. The aim, as far as possible, is to identify single budget-holders who currently get two budget statements and try to turn that into a single statement. The team is also pulling together integrated standing orders, scheme of delegation and a risk register.

Currently, council staff are providing back office functions – communications, engagement, payroll and human resources, for both local authority and CCG. Tameside and Glossop Integrated Care NHS Foundation Trust provides IT to the CCG, but there are plans for the trust's IT team to co-locate with their council peers later this year and offer services to all three organisations.

The biggest issue in bringing the finance teams together is that council and CCG are on different finance systems. While CCGs are mandated to use the national ledger system provided by NHS Shared Business Services, councils are free to choose their own. 'I have an ambition to get all our expenditure onto one ledger,' says Ms Roe, 'which would be the council ledger as it has more functionality – the SBS one is more prescriptive.'

The national CCG ledger has set rules for a reason – it ensures consistency in the description of spending across all CCGs and allows NHS England to pull off reports at the touch of a button, for example. Ms Roe's plan would not exclude Tameside from contributing to this – data from the joined-up local ledger could be downloaded into the SBS system every month, she says. 'It will take some doing but I think it's the next natural step we need to get to.'

Many chief finance officers will wonder how Ms Roe fits in all her responsibilities. She admits that, at times, she wonders this too, adding: 'We all work long hours, but I try to take my holidays and also come home to my family at a reasonable hour. You need to switch off. We have tea together and then I often look at my iPad and go through my emails and prepare myself for the next day.'

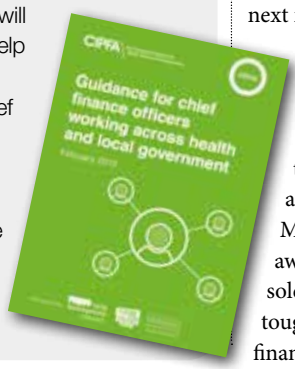
Many finance directors will recognise the need to carve out time away from the office, whether they work in one or two organisations, solely in health or across health and local authority boundaries. It's a tough schedule but perhaps it offers a glimpse into the future for many finance professionals.

Dual focus

The HFMA and CIPFA have joined forces to produce guidance for chief finance officers working across health and local government. With integration intensifying, the bodies said a joint role is being seen increasingly and the guidance aims to consider the implications for these CFOs working across the boundary between health and council services.

The sectors work under different financial, governance and legislative frameworks. *Guidance for chief finance officers working across health and local government* compares the lead finance role in local authorities and the NHS.

CIPFA and the HFMA believe the guidance will be helpful for those already in a dual post to help them assess their development needs or for those considering applying for a joint role. Chief executives may find it useful when appointing to the role and assessing CFO performance subsequently. Colleagues, governors and elected members could also use the guidance to gain a greater understanding of the CFO role and its challenges.



• See http://hfma.to/8p

Fair shares

The revised CCG funding formula will redistribute funds with the aim of tackling health inequalities and unmet need. Seamus Ward unpicks how it will have an impact on local services

By its very nature, the formula used to allocate funding from NHS England to commissioners will always create relative winners and losers. Under long-established policy, areas of greatest need receive the biggest percentage increases. But, with the formula revised, a casual observer of the allocations for the next five years would be forgiven for thinking that even the 'losers' will be winners.

NHS England said every CCG would receive a minimum cash increase of 4.4% in 2019/20 and at least 17% cash over five years. The new allocation formula – which targets health inequalities and areas with higher early deaths – coupled with additional funding, appears generous, even at the lower end. But peel away the layers beneath the headline figures and CCGs will have a lot less flexibility in their spending decisions than it would appear.

NHS England set out five-year allocations overall, with the first three years' funding finalised, and the remaining two issued as indicative figures. Announcing the allocations, the national commissioning body highlighted the 4.4% minimum rise in 2019/20. However, these figures appear to be referring to the total place-based allocations, which include core, primary care and specialised allocations. Generally, when analysing allocations, funding for the core CCG programme is used – the smallest percentage uplift in 2019/20 is 3.6%.

Overall core funding to CCGs will rise in cash terms by 5.65% in 2019/20, falling to 4.14% in 2020/21; 4% in 2021/22; 3.78% in 2022/23; and 3.54% in 2023/24.

Compared with other parts of the public sector, NHS funding remains relatively healthy, though it has to be remembered that large chunks of CCG allocations are already ringfenced. Funding to cover the increases in Agenda for Change pay awards will flow through the tariff for the first time in 2019/20 and £1bn of the Provider Sustainability Fund (PSF) will be transferred to the tariff for urgent and emergency care. Both funding streams are included in the uplifts above.

Once pay and PSF are stripped out, CCG programme growth falls from almost 5.7% in cash terms to 3.4% in 2019/20. In 2019/20, individual CCGs will see increases of 3.6% to 15.25% in their core funding (see tables).

Julie Wood, chief executive of NHS Clinical Commissioners, says funding will flow to those most in need. But she adds: 'There remain considerable challenges in the short term for CCGs, with much of the additional funding already having been allocated nationally, leaving little for CCGs to allocate to local priorities. Over the five years of the increased funding, CCGs will need to find a balance between using this investment for new developments while making sure the NHS remains sustainable for the future.'

NHS England insists the new formula has protected long-term plan commitments to increase spending on cancer, primary care and mental health. And it says the new formula is highly redistributive – it expects £2.2bn to be redistributed within target allocations by the end of the five-year period. A major factor affecting CCG target allocations appears to be a shift to addressing areas with higher premature death levels. This is measured by the standardised mortality ratio in those under 75 (SMR <75), which is used as an indicator of health inequalities and unmet need.

NHS England interim chief finance officer Matthew Style told the commissioning organisation's January board meeting that the additional weight given to the measure has led to little change for most CCGs. However, outliers on the SMR <75 measure, with higher rates of premature deaths, will see bigger rises.

NHS England said this change alone will increase Blackpool CCG's core target allocation by 5.13%, or £16m, and overall it will receive the second biggest percentage uplift in 2019/20 (11.58%).

Bradford benefits

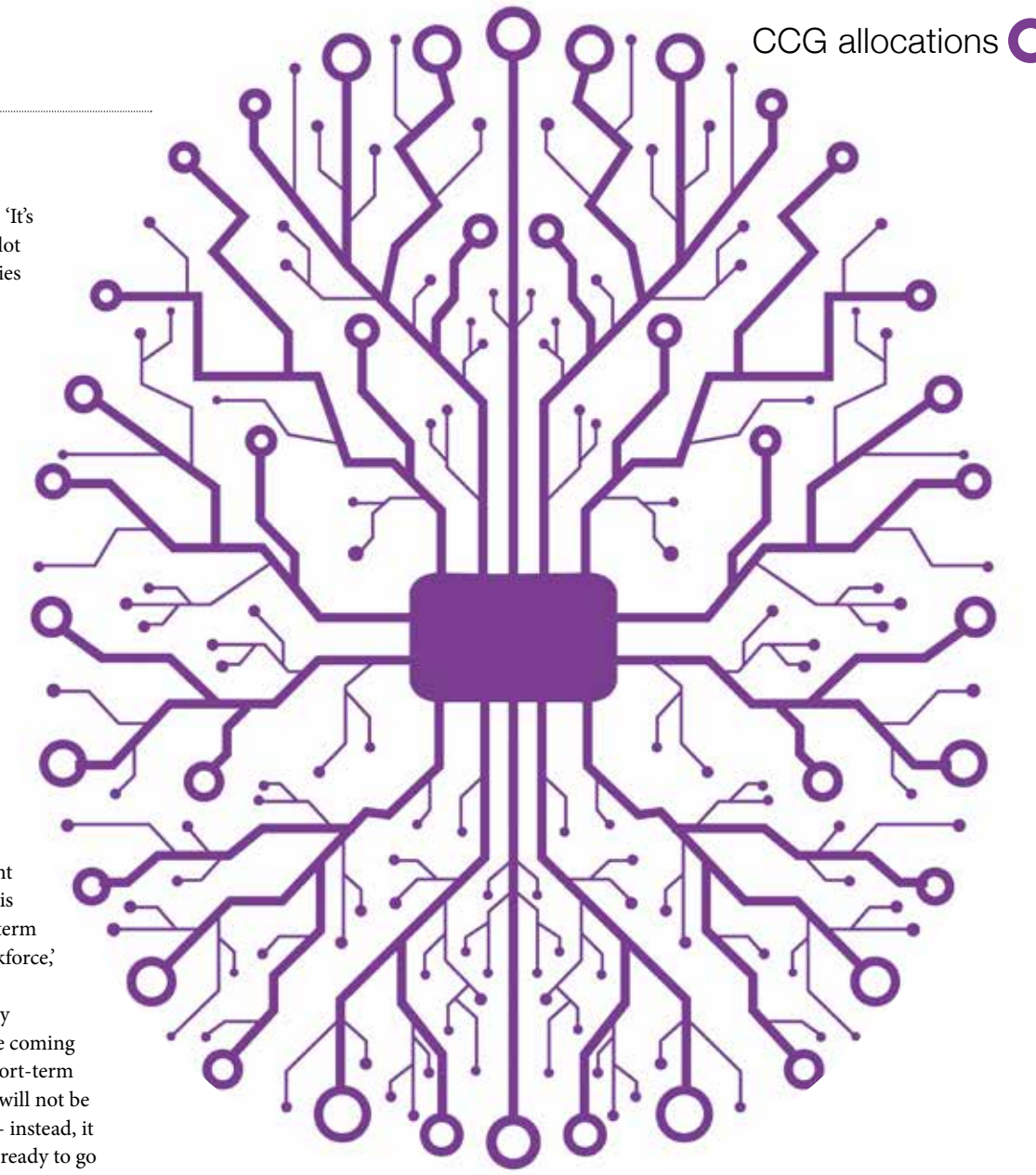
Bradford City Clinical Commissioning Group is another beneficiary, with its allocation increasing by 15.25%, largely due to the change to address high rates of premature deaths. Bradford City chief finance officer and deputy

Five CCGs with the lowest growth in 2019/20

CCG	2019/20 growth (%)	Closing distance from target (%)
West London	3.6	19.61
Central London (Westminster)	4.65	7.0
Hammersmith and Fulham	4.76	-3.42
South Sefton	4.83	4.42
Sunderland	4.83	6.7

Five CCGs with the highest growth in 2019/20

CCG	2019/20 growth (%)	Closing distance from target (%)
Bradford City	15.25	-3.9
Blackpool	11.58	-4.99
South Worcestershire	8.17	-4.99
Wyre Forest	8.06	-4.99
Sandwell and West Birmingham	7.04	-4.99



chief officer Julie Lawreniuk said: 'It's really welcome, though I think a lot of people miss the huge inequalities we have in Bradford City. Our hospital usage is low, and we want to see it rise as we increase the awareness of the healthcare and prevention services that are available.'

Upping the population's use of hospital services may seem to be going against the direction of travel – the long-term plan for the NHS in England instructs local health services to provide more care out-of-hospital. However, increasing hospital usage in Bradford City will be about earlier cancer diagnosis or intervention to limit the effects of other major killers, such as heart disease.

'We've had bits of non-recurrent funding in the past, but we see this as an opportunity to invest long-term in services and a permanent workforce,' Ms Lawreniuk adds.

It's early days and Bradford City CCG is reviewing its plans for the coming financial year. However, in the short-term Ms Lawreniuk believes the CCG will not be looking to develop new services – instead, it has evidence-based programmes ready to go or that can be scaled up quickly. These include *Bradford beating diabetes*, which helps those with type 2 diabetes stay healthy, and *Bradford's healthy hearts,* which targets prevention of heart attacks and strokes.

Its cancer screening programme will play a big role as it looks to tackle the rate of premature deaths in the city. There is also a wealth of information from the *Born in Bradford* programme about pre-conceptual care that has already been evidenced through *Better start Bradford* – a range of programmes to support pregnant women and families with children under four.

'I don't think there will be a problem spending the money in 2019/20 and then recurrently. The challenge for us will be to ensure it makes a difference to the level of inequality in the city,' says Ms Lawreniuk.

Other CCGs say their flexibility to spend their increased budgets has been limited by national spending commitments on pay, urgent and emergency care tariffs, mental health and primary care. However, due to the relatively large increase in its allocation, Bradford City will still have a good deal of flexibility to shape its spending plans, Ms Lawreniuk says.

Other changes in the funding formula are the introduction of a measure of need for community services; use of the annual average of GP registered lists, ensuring allocations are better able to pick up cyclical patterns in population movement; and improvements in age and gender information.

Blackpool CCG has one of the highest percentage increases for 2019/20 (11.58% in core allocation, leaving the CCG 4.99% under target). A spokesperson for the CCG says a significant proportion of the increase relates to addressing unmet need and the CCG is working through the detail.

'Workforce remains a challenge in respect of a number of aspects of local capacity. The CCG and ICP [integrated care provider] is already engaged on work to redesign pathways and service delivery models including workforce elements. Commissioning approaches and options to address unmet need and long-term plan requirements are being developed.'

The Blackpool CCG spokesperson adds that mental health need forms a key driver in the CCG's allocation growth for 2019/20. 'The CCG has identified the resource to invest in respect of areas included in the *Mental health forward view* and delivery plans are being developed, but workforce remains a challenge.'

South Worcestershire CCG and Wyre Forest CCG will also receive relatively high uplifts for 2019/20 (8.17% and 8.06%, respectively, in core allocations, leaving both CCGs 4.99% under target). The CCGs, which have a joint management team together with Redditch

"The challenge for us will be to ensure we make a difference to the level of inequality in the city"

Julie Lawreniuk, Bradford City CCG

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and Bromsgrove CCG, say the increases give them the opportunity to look at local service provision and what service developments are required. A number of options are being examined in community and mental health services. However, capacity could also be an issue. 'Local capacity continues to remain challenged, so any service developments will require new ways of working and recruitment of new staff,' they say.

'A significant proportion of the CCGs' uplift will be consumed within the increased tariff prices to acute providers,' they add.

Some CCGs will have less growth money. Sunderland CCG, for example, will receive a 4.83% uplift in cash terms, leaving it 6.7% above its new target allocation.

David Chandler, the CCG's chief finance officer, says: 'Sunderland CCG is pleased to receive our share of the additional allocation growth for the next five years. Coupled with our existing allocation funding, we are confident we can, working with partners, improve the quality of services and health outcomes for our population in a sustainable way and play our part delivering the NHS long-term plan. We expect to be able to meet all our key financial duties including the mental health investment standard and reductions in running costs.'

Big step forward

NHS England's Mr Style said the new allocation formula had taken 'a big step forward' in the estimation of relative need for community services. It has not been included in the formula previously due to lack of data.

The formula for relative need for community health services has been developed using early returns from the community services dataset together with more detailed patient-level data from a handful of local areas.

Mr Style told NHS England board members: 'This, in particular, reflects higher need for community services in areas with a higher proportion of people aged over 85, particularly in rural and coastal CCGs, but also importantly in some deprived populations in the Midlands and the North. The formula will be refined as data quality improves.'

There have also been improvements to the mental health formula, enabled by better data, particularly through IAPT activity collections. This has resulted in higher need indices for some coastal areas and areas with older populations due to better diagnosis and recording of dementia now coming through in the national data.

As previously trailed, CCGs must continue to bear down on their running costs, with a 20% real terms reduction on their 2017/18 allowances required by 2020/21.

One CCG points to a potential merger and vacancy freezes as a way of delivering most of its running cost savings target, which amounts to more than £2m. While the CCG is keen to see how automation and IT can deliver savings, it feels there is a lack of clarity about what it means. This point is echoed by other CCGs.

Julie Wood of NHS Clinical Commissioners says the reduction in administrative spending will put CCGs under more pressure. 'Commissioners will still need effective teams and expertise to enact their crucial functions of assuring quality and driving effective integration. It will be critical that these cuts to running costs don't undermine the efforts happening across the system to transform health and care services for the better.'

As with previous allocations, NHS England has adopted a pace of change policy, moving CCGs to their target allocation gradually. If CCGs received their target allocations immediately it would risk destabilising those over target. At the same time, under-target CCGs may find it hard to get best value from a large overnight increase in their funding.

The policy for the next five years will mean that no CCG will be more than 3.5% below their core target allocation by 2023/24. However, in 2023/24 13 CCGs, mostly in Greater London, are still due to be more than 5% above target.

NHS England chief executive Simon Stevens told fellow board members that no part of the country will be more than 5% below their target allocation in 2019/20.

'In all honesty, we can say that since the approach to trying to allocate funding based on need began in the national health service in 1976, this will be the fairest and most precise allocation of the growing resources that the NHS has ever seen.'

He added that local areas will have to show in their plans how they will use the funding to narrow health inequalities.

Clearly, the allocations have been made in support of the NHS long-term plan. There is money to protect provider finances and help resolve deficits, but CCGs will be expected to use their additional spending power to commission services that address health inequalities and boost primary, community and mental healthcare, with the ultimate aim of tackling the major causes of deaths.

Rural boost

The new formula appears to direct more funding to rural areas in the long-term, according to Nuffield Trust research director and chief economist John Appleby (pictured).

Professor Appleby and colleagues recently wrote a paper for the National Centre for Rural Health and Care that said rural areas were disadvantaged by the old funding formula.

Subsequently, he has analysed the impact of the revised formula. He says that between 2018/19 and 2023/24, total funding relating to core CCG allocations for predominantly rural areas will increase by 24.2% compared with 22.9% for predominantly urban areas.

This equates to an annual average increase of 4.2% to urban areas compared with 4.4% for rural. He adds: 'In absolute terms, the 32 predominantly rural CCGs will be getting around £120m more than if there was just an equal uplift.'

The new formula includes an adjustment for unavoidably small hospital provision in remote areas – this is unchanged from the previous formula. Professor Appleby says: 'It is fair to say that the current adjustment for unavoidable smallness was a first step in trying to address cost pressures in rural areas, focusing, for example, just on acute providers. As such, further work will be needed to calibrate the most appropriate level of funding and coverage of such adjustments.'

He understands that the Advisory Committee on Resource Allocation (ACRA), which recommends changes to the funding formula, will be asked to look again at the adjustments for rurality. The Nuffield Trust report makes a number of recommendations on further work. These include:

- Greater transparency about the nature and scale of mechanisms for compensating for rural costs
- NHS Improvement must be more transparent around the calculations of, and decision-making to approve or reject, local modifications
- ACRA should continue revisiting evidence on costs in consultation with rural trusts, including non-acute providers, and commissioning further research if required
- National bodies should also be providing non-financial support to rural commissioners and providers to overcome the challenges they face.

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e-rostering: the time is now

E-rostering is not new – or at least it shouldn't be. But its adoption has been encouraged for over a decade and there is a feeling that trusts are still not realising its full potential. Steve Brown reports

E-rostering has long been seen as a useful tool to ensure the optimum use of NHS staff in the delivery of healthcare, while supporting flexible working and minimising temporary staff costs. But the long-term plan has finally put a deadline – 2021 – by which time all clinical staff should be being deployed using an electronic roster or e-job plan.

This has been a long-time coming. The National Audit Office first called on trusts to explore the use of e-rostering systems in its *Improving the use of temporary nursing staff in NHS acute and foundation trusts* report in 2006. And encouragement to do more and better in this area has been pretty regular since then. In his work on productivity in acute trusts, Lord Carter said there was still significant variation in the use of digital systems such as e-rostering.

E-rostering and job planning technology allows trusts to improve their advance planning of their workforce, improving leave and rota management, and can also support daily decision-making about staff deployment to meet patient demand, while minimising the need for additional temporary staffing.

But Lord Carter found that even where trusts had invested in the technology, many 'were not getting full meaningful use of it'. The message was the same when he turned his attention to mental health and community providers – make better use of e-rostering.

In response to the Carter recommendations, NHS Improvement last year updated its nursing e-rostering good practice guidance and unveiled a new system for trusts to measure their progress in adopting e-rostering software. These five 'levels of attainment' – stretching from level 0 (no attainment) to level 4 (organisational e-rostering) – are underpinned by meaningful use standards describing the processes and systems trusts need to meet each level of attainment.

NHS Improvement's initial survey to assess e-rostering usage across acute and community trusts reinforced the Carter findings. It found 43% of trusts at attainment level 0 with just 59% of the clinical workforce deployed via an e-rostering system. It concluded there was a 'significant opportunity to improve'.

This overall gloomy snapshot may reflect the fact that most trusts initially focused on their nurse staffing in taking forward e-rostering and are only more recently applying the same approach to their medical and allied health professional workforces. Level 1 requires at least 90% of clinical employees to be registered on an e-roster.

Simon Courage is director of product management at Allocate, which says 200 NHS bodies use its HealthRoster system for nurse staffing. 'There is a huge variety from a staff group perspective,' he says. 'A huge amount of trusts are at a level 3 or 4 for nursing, but a level 0 or 1 for medics.'

In fact, he suggests there have been some great success stories in

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Nursing leads the way

Liz Rix (pictured), chief nurse at University Hospitals of North Midlands NHS Trust, believes that rostering and the intelligence derived from rostering systems has helped the trust reduce vacancy rates, almost eliminate its nurse agency costs, revise pathways and improve patient outcomes.

An early implementer of workforce deployment software, the trust first worked with Allocate to introduce its e-rostering software for its nursing staff some 10 years ago. While this delivered benefits for staff and the trust, the real value has come with the further acquisition of the company's SafeCare and Insight modules.

With SafeCare, nursing staff now input patient acuity scores three times a day. And Insight enables the analysis and comparison of this data alongside other key metrics. 'This means we can plot acuity and dependency of patients over time,' she says. 'Then in discussions with matrons, ward sisters and charge nurses, we can look back over 12 months to see where we are meeting the needs of patients and where we aren't. Is the workforce sufficient or is there too much resource in some areas? Intelligent information has dramatically changed the debate around staffing.'

The change in practice for nurses – recording acuity scores – has not been straightforward, but the trust has worked hard to develop prompts for staff to enable a consistent approach to scoring. However, once in place, the intelligence is powerful and vital for understanding how best services can meet patient needs.

Ms Rix says nursing's earlier start puts it ahead of other staff groups, such as allied health professions, and other service areas. But the benefits of properly understanding how capacity and demand change in predictable ways over time should not be underestimated.

She believes the intelligence regularly provided – including sickness rates, temporary staff usage, vacancies, used hours and unavailable hours – can inform service transformation. For example, when the trust was struggling to fill nursing positions on its stroke and rehabilitation wards, the data helped the trust to rethink the team make-up – replacing some nursing posts with therapists. Vacancy rates and temporary staff usage fell and patient experience measures went up.

In fact, patient experience scores in general, measured through the friends and family metric, now put the trust at the top of its peer group. And nurse and midwife agency costs represent just 0.3% of the total nursing staff costs – a level many trusts would be envious of.

These improvements cannot all be laid at the door of e-rostering. The trust has worked hard to grow its own staff, working closely with local further education colleges and universities and introducing nursing and nursing associate apprenticeships. But information has played a crucial part.

'When you have more understanding of patient need and your staff, you can respond better and sooner,' says Ms Rix.

moving much of the nursing community onto e-rostering from a more or less standing start 12 years ago. This progress has seen rostering move beyond the electronic timetabling of nurses onto shifts and into areas such as ensuring safe staffing levels and supporting the flexing of staffing levels in real-time.

This was accelerated by the Francis report on failures in care at Mid-Staffordshire NHS Foundation Trust, which led to the development of guidance and tools to help trusts ensure there were enough staff to deliver safe care on a day-to-day basis, taking account of patient acuity. Mr Courage estimates that 70% of Allocate's customers now also use its SafeCare rostering module, which enables trusts to take acuity into account when setting, monitoring and managing staff levels.

According to Mr Courage, this live managing of demand and staff capacity effectively equates to level 3 on the attainment scale and by level 4, e-rostering should be fully embedded across the organisation. This means having board-level accountability and using data from the rostering system to inform each department's budget.

Staffing is recognised as one of the major challenges facing the NHS in the recent long-term plan. Significant new recruits are needed over the long-term to ensure the service can meet projected demand in a sustainable way. But in the short run, the NHS also needs to ensure it can retain its existing workforce and use this workforce in the most effective and efficient way to meet patient needs.

'While investment is clearly needed to bolster staff numbers, employers accept there is more to do to make sure the talents of the people and teams who make up the NHS are properly utilised and retained,' says Danny Mortimer, chief executive of NHS Employers, which last year collaborated on work to promote the uptake of e-rostering (see **www.beyondtheroster.co.uk**). Others have called for greater flexibility and predictability of working patterns to address high levels of staff turnover – both of which can be improved by the use of e-rostering.

If many providers are well along the road with rostering for their acute nursing workforce, Mr Courage says community nursing presents different challenges, particularly where nurses are making home visits. Sophisticated use of e-rostering software can help acute trusts to match staffing levels to demand, taking account of patient need and acuity.

Community considerations

'In the community, you also have to consider what visits you have to make and who is being sent out,' he says. 'That's a very different problem and it is only just starting to be solved.' Scheduling solutions can help providers to optimise this – ensuring that, if a patient needs an insulin injection, you don't send someone out who is not able to administer it.

Medical staff and AHPs are arguably the main focus right now for many providers in improving their use of rostering and other workforce software. The environment has changed from five years ago, when rostering for doctors was simply not talked about, to today where it is widely recognised as providing benefits for patients, staff and employers. The BMA is now a key proponent of its use to ensure junior doctors work compliant shifts, and has even produced rostering guidance.

The medical community can be looked at in terms of the consultant workforce and junior doctors. For consultants, there is an important first step in ensuring all consultants have an e-job plan, setting out the direct clinical care, on-call work and supporting professional activities that each consultant agrees to undertake.

A number of organisations have set out with intentions to move consultants onto an e-rostering solution, only to realise that existing job

There's a better way to engage and manage the workforce

The demand for quality healthcare is constantly growing - and with a shrinking pool of healthcare workers, organisations struggle to create an engaged, compliant culture, retain top talent, and provide the quality care that patients count on. In order to thrive, providers need to modernise their workforce management strategies and technology as part of their plans to deliver exceptional patient care and deliver better clinical outcomes.

Providing quality, consistent care for every patient across an increasingly complex continuum makes accurate staffing more important than ever. Outdated, inadequate staffing practices can have serious consequences - think inaccurate scheduling, overworked employees, non-compliance, low morale and poor patient outcomes - making it imperative to accurately align staff with workload demand to create a culture of consistent quality care.

With modern workforce management technology, you can automate manual tasks and processes such as time and attendance, scheduling, absence management and labour analytics. Freeing up care providers of time-consuming administrative tasks, to spend more time with patients – as well as improving accuracy, which helps mitigate risks of non-compliance of wage awards and enterprise agreement conditions. Optimising schedules, so skilled professionals are in the right place at the right time, while accommodating employees' preferences and managing absence, while still delivering exceptional care.

Workforce Dimensions modernises critical workforce management processes so healthcare professionals can better align the care that they're giving with the rising patient demand. Care workers feel more involved, engaged and empowered via modern, consumer-grade technology that features self-service functionality to better managed their working life with their personal life.

Managers spend less time dealing with staffing needs and administrative tasks, and more time delivering better patient care and being on the floor with their staff proving valuable on-the-job coaching and bonding.

Workforce Dimensions ensures people are always there to meet demand and challenges – and keep you ahead of the competition.

Deliver more quality care
Eliminate time-sinks by generating accurate, best-fit schedules for nurses and caregivers based on staff qualifications and predicted patient volume.

Control labour costs
Managers then gain the visibility they need to take corrective action before extraneous payroll costs accrue.

Increase employee engagement
Easy-to-use tools with mobile access and self-service options empower employees to manage their own schedules.

Minimise compliance risk
Consistent enforcement and proper staffing translates into reduced employee grievances, claims, lawsuits, and fines - and less time and money spent monitoring compliance.

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plans did not reflect what consultants were doing closely enough.

For junior doctors, many trusts have focused on ensuring rotas are compliant with European Working Time Directive and junior doctor contract requirements. A lot of trusts have used the DRS (Doctors' Rostering System) to achieve this, but the system's provider – Skills for Health – says a number of its 100-plus trusts/health boards have taken the next step by also using its Realtime Rostering system.

Working patterns for both consultants and junior doctors can be entered into Realtime, enabling rosters to be produced from existing rotas. These take into account annual leave, study leave, shift swaps and unexpected absences.

According to Ben Marchini, product manager at Skills for Health, the benefits for the trust are clear. Clinicians can use smart phones to see at a glance where they need to be and when, and can submit their leave and swap requests anytime, anywhere.

As well as reducing the administrative burden in compiling rosters, the system has helped trusts to reduce spend on locums and to reduce theatre and clinic cancellations by avoiding typical paper-roster mistakes such as double bookings. It also supports trusts in compiling management information on how often a roster breaches the agreed safe staffing levels, meaning that understaffed areas have metrics to quantify the challenges they face.

Sherwood Forest Hospitals NHS Foundation Trust started working with Allocate in 2015 to improve the visibility of medical workforce issues. This started with implementing a three-stage job planning process that led to nearly the whole consultant community signing off job plans linked to annual activity.

Andy Haynes, the trust's medical director, says: 'Job planning is a fairly blunt tool really, because it's all about time, not activity. But by agreeing annualised activity, you can start to agree variation between consultants that is acceptable. And you can standardise things like annual leave – generally medical leave is not as tight in most trusts as it is for other members of staff. By doing all this first, we could really understand where consultants should be.'

"With the right information, you can start to see trends quickly. You need to be able to see it, report on it and act on it"
Peter Harte, Kronos

The trust followed this up with the introduction of e-rostering for junior doctors using an app. 'We linked bank onto a weekly payroll so people were paid straight away for any bank work and this was all very positive,' says Dr Haynes. 'But again, on any given day we could see which juniors were in and which area of the trust they were based in and look at safe staffing ratios – something we hadn't been able to do before.'

Job planning and rostering consultants, together with rostering juniors, have had significant benefits. The trust is filling more of its medical vacancies using its bank – up from 0% in 2017 to about 8% now, compared with a national average of about 5.5%. The process also helped identify where consultants were being under or overpaid – perhaps because their on-call supplement reflected old working arrangements. And making better use of all consultants' available time has contributed to a reduction in the trust's agency spend on medics from £350,000 per week to £140,000. It has also helped the trust to be better prepared for the contracting round.

With the job planning process undertaken in September, by February the trust is clear what capacity it has in each team to inform discussions about the activity it can deliver.

The new deadlines set for e-rostering in the long-term plan do not come out of the blue. Most trusts already have e-rostering systems. The real challenge will come with making more use of these systems, getting more information out of them to help optimise the use of staff and provide them with greater flexibility and convenience. Further support from NHS Improvement is expected in the near future.

New solutions

A new workforce management system has just been launched by Kronos for the healthcare market. Kronos is no stranger to the NHS, supporting the SMART Rosterpro system in about 30 NHS trusts. But its new system – Workforce Dimensions for Healthcare – promises a 'next-generation' cloud-based solution that harnesses machine learning to enhance efficiency in workforce management. And while it is new to the NHS in the UK, the system was launched worldwide 15 months ago and has 300-plus customers across healthcare and other sectors.

Kronos vice president for Europe Peter Harte says the focus is on accessibility – with the cloud basis meaning the system can be accessed from any phone, tablet or computer – and powerful analytics that will help trusts to optimise the use of their workforces. These analytics need to take account of acuity in understanding staffing levels and provide much greater visibility to boards on issues such as agency spend – increasingly helping people to manage in real-time.

'For example, we need to understand issues such as absenteeism, which usually has something else at its root,' he says. 'With the right information, you can start to see trends quickly. In one hospital we worked with, by looking at the attendance record you could predict if staff would leave within a month. You need to be able to see it, report on it and act on it – otherwise you can't change behaviour.'

Automating processes will also be key to driving efficiency. You've got to take the administration out of the process as much as possible,' says Neil Pickering, the company's customer insights manager.

'If someone wants to swap a shift, let the system figure out if they are qualified enough and if it will affect patient care or budgets. And then give an immediate response. If they want to book a holiday, let them do that without it sitting in a manager's inbox. It is all about automating processes that were previously very difficult to automate.'

More sophisticated rostering will also be vital to supporting retention. In Australia, where Mr Harte has spent the past 20 years supporting the healthcare market, he says nurses decide where they want to work based on how technologically efficient they are.

'The ability to see rosters ahead of time and be able to bid on them and change shifts at their convenience is key,' he says.

The company is talking to a number of hospital sites about implementing the system across their full workforces.

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professional lives
Events, people and support for finance practitioners

Pre-accounts briefings: practical impact of new accounting standards

Technical

For the first time in many years, 2018/19 will see the adoption of two new accounting standards. While neither is expected to have a material impact on the financial position of any NHS body, there is still a lot of work to do to demonstrate that fact and to embed these new standards into daily working practices, *writes Debbie Paterson.*

Both the provider and commissioner month 9 submissions included disclosures for the new standards. Feedback from NHS Improvement and NHS England was that there is room for improvement in the quality of the completion of these returns. During the recent HFMA pre-accounts planning conferences, NHS Improvement indicated that around 40% of providers had not yet determined the impact of the new standards. Clearly, there is work to do before the year-end submission.

As income-generating organisations, the implementation of IFRS 15 – *Revenue from contracts with customers* – is expected to affect provider bodies more than commissioners. The pre-accounts planning conferences focused on what the implementation of the standard will mean in practical terms. The key messages were:

- Auditors will expect providers to have analysed all their income streams against the five-step process set out in the new standard.
- The Department of Health and Social Care and NHS Improvement have reviewed the standard NHS contract against the accounting standard. The resulting paper should be reviewed by each NHS body to ensure that any local amendments to the standard contract have been taken into account.
- It was suggested that this review also sets out a sensible approach for NHS providers to take to all of their other income streams.
- Research income is a particular concern as there are a number of different arrangements in the NHS and it is not yet clear whether any of these will affect the amount of income recognised each year.

Unsurprisingly, the work done to date on the new standards has focused on year one adoption and whether there will be an impact on the financial position in 2018/19.

At the conferences, NHS bodies were challenged to consider whether they have done enough work on embedding these new standards into their systems. Any new income streams or contracts need to be considered against the five-stage process – this means early engagement and training for staff who will be negotiating and agreeing those contracts.

The main impact of IFRS 9 – *Financial instruments* – is likely to be in relation to expected credit losses. In the NHS, the standard will be applied using a simplified model. This considers lifetime expected credit losses, rather than using the three-stage process set out in the accounting standard.

It is suggested that a provision matrix is used to determine whether there should be any provisions for expected credit losses – again, both NHS Improvement and NHS England reported room for improvement in submissions.

The most difficult area in the NHS will be the impact of these two new standards on agreement of balances. There has always been a tension between the amount of income recognised and the amount that has been provided for as a 'bad debt'.

The new standards provide a much clearer framework for assessing what can be recognised as income and what should be recognised as an expected credit loss. But, as always, there is a grey area between the two. For NHS bodies, the guidance from the DHSC remains clear – it is not expected that there will be impairments of intra-NHS balances as these balances are not expected to be irrecoverable.

This is because it is assumed that as part of the IFRS 15 income recognition assessment, only income to which the entity is expected to be entitled will be reflected in the accounts. Year-end negotiations mean that sometimes the amount to which the entity considers it is entitled and the amount it actually expects to receive may be different amounts. It is expected that this tension will be an area for judgement, which will be of interest to most auditors at the year end.

Debbie Paterson is HFMA policy and technical manager

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Technical review

The past two months' key technical developments

Technical

NHS Improvement has published an updated ***NHS foundation trust annual reporting manual 2018/19 (ARM)***. There are a number of changes, including some relating to the General Data Protection Regulation (GDPR) covering the disclosure of personal information about senior managers in the remuneration report. NHS bodies must inform individuals in advance of the intention to disclose information about them, invite them to see what is intended to be published, and notify them that they can object. The manual also sets out the disclosure requirements for off-payroll engagements and gives details of an updated model annual governance statement that makes specific reference to UK climate projections. http://hfma.to/8f

The HFMA has published its response to a consultation on the development of the **charities statement of recommended practice** (SORP). The association has backed the use of an advisory SORP committee as the 'only practical way' to engage at a detailed level with stakeholders. However, it has called for consideration to be given to developing special interest sub-committees to enable wider engagement with stakeholders that have a particular interest. The association's Charitable Funds Special Interest Group also said it would welcome the opportunity to submit suggested amendments at the start of the revision process, as well as during any final consultation. http://hfma.to/8m

NHS Improvement is calling on trusts to volunteer to pilot new pricing approaches and methods for **outpatients**. To date, there have been separate prices for consultant-led first and follow-up attendances. Since 2012/13, there has also been a practice of 'frontloading' overall outpatient payments into first appointments to discourage unnecessary follow-ups. The 2019/20 tariff consultation set out non mandatory prices for non-face-to-face follow-ups and for non-consultant-led first and follow-up attendances. A number of areas are already testing new outpatient approaches (*See Outpatients: a new look?, Healthcare Finance September 2018 page 16*). http://hfma.to/8n

The Royal Institution of Chartered Surveyors (RICS) has issued a UK supplement to its ***Global red book for valuations***. The update clarifies the approach that should be taken to componentisation of assets when calculating depreciation. This is where a major asset is broken down into its major components, so that these separate components can be depreciated over their distinct useful lives rather than depreciating the whole asset cost over the same useful life. The guidance says that each significant component should be depreciated separately. Significant parts with similar remaining useful lives can be grouped together. The remaining parts should then be grouped together with approximation techniques used to calculate a single overall estimate of appropriate useful life for those components. http://hfma.to/8o

Guideline seeks to reduce antibiotic resistance

Technical: NICE

NICE published its latest antimicrobial prescribing guideline in February. The guidelines focus on bacterial infections and appropriate antibiotic use, *writes Gary Shield*. Each features a visual summary of the recommendations, a guideline and an evidence review.

The *Cough (acute)* guideline (NG120) sets out an antimicrobial prescribing strategy for acute cough associated with an upper respiratory tract infection or acute bronchitis in adults, young people and children. It aims to limit antibiotic use and reduce antibiotic resistance. There is potential for resource savings if a no antibiotic or back-up antibiotic prescription strategy is used in this area.

This guideline follows about 20 technologies or guidelines published over the previous two months.

Among the technology appraisals, NICE recommended a pioneering cancer treatment, CART-cell therapy, for people under the age of 25 with leukaemia. The therapy, which involves taking a person's own immune cells and modifying them to fight their cancer cells, has the potential to be a cure. Under TA554 *Tisagenlecleucel for treating relapsed or refractory B-cell acute lymphoblastic leukaemia in people aged up to 25 years*, 25 to 30 people will be eligible for tisagenlecleucel each year in England. A specialised NHS service is being developed to manage access to the therapy.

Several guidelines were also published, including an update to the *Chronic obstructive pulmonary disease in over 16s: diagnosis and management* guideline (NG115). A new guideline – *Renal and ureteric stones: assessment and management* (NG118) – aims to improve the detection, clearance and prevention of stones, so reducing pain and anxiety, and improving quality of life. The supporting resource impact tools also show how savings of over £2.8m a year for England may be made by implementing the guideline.

In addition, NICE published diagnostic guidance – *Tumour profiling tests to guide adjuvant chemotherapy decisions in early breast cancer* (DG34). This replaced the NICE diagnostic guidance on gene expression profiling and expanded immunohistochemistry tests for guiding adjuvant chemotherapy decisions in early breast cancer management.

Because there is uncertainty around future uptake of the recommended tumour profiling tests, three scenarios have been created for completion at a local level in the resource impact template that supports the guidance.

Gary Shield is resource impact assessment manager at NICE

NHS in numbers

A closer look at the data behind NHS finance

Deficits

Technical

The *NHS long-term plan* commits the NHS to returning to financial balance. It says that the service will continue to achieve financial balance across providers and commissioners as a whole. However, within this, it commits to achieving balance across the provider sector in 2020/21, with all NHS organisations individually in balance by 2023/24.

This is no simple task, even with funding expected to rise by £20.5m in real terms over this time frame.

The NHS ended 2017/18 with an almost balanced position across providers and commissioners, with providers' net deficit of £991m almost balanced by a combined underspend across all commissioners of £970m – leaving a small £21m deficit.

Achieving balance has been increasingly difficult in recent years and its continued achievement remains the minimum requirement.

Achieving financial balance across the provider sector looks altogether a more difficult challenge. Collectively providers' nearly £1bn deficit in 2017/18 was £500m over plan and included the benefit of a £1.8bn sustainability and transformation fund (STF). Their underlying deficit is even higher at £1.85bn.

Of 234 providers in 2017/18, 105 had planned to make a collective deficit of £1.6bn, which should have been offset by the 129 providers making a surplus of £703m (plus £404m of uncommitted STF).

In fact, the outturn position showed an improvement in the number of providers reporting deficits. But the 101 deficit trusts reported a significantly increased deficit of £2.4bn, albeit offset by an improved collective surplus of £1.3bn across the 133 surplus providers (with a further £105m of adjustments delivering the overall net provider deficit).

The National Audit Office's financial sustainability report in January underlined how a small number of providers are responsible for most of the problem. Just 10 of the worst-performing trusts reported a combined deficit of £758m – 69% of the net trust deficit (before central adjustments). However, this only represents just over 30% of the gross deficit shared by all deficit trusts.

According to NHS Improvement's Q2 report for the current year, there were 155 deficit providers at the halfway point in the year, with 111 forecasting to be in deficit by the year-end. Eleven of the most financially challenged trusts remain in financial special measures.

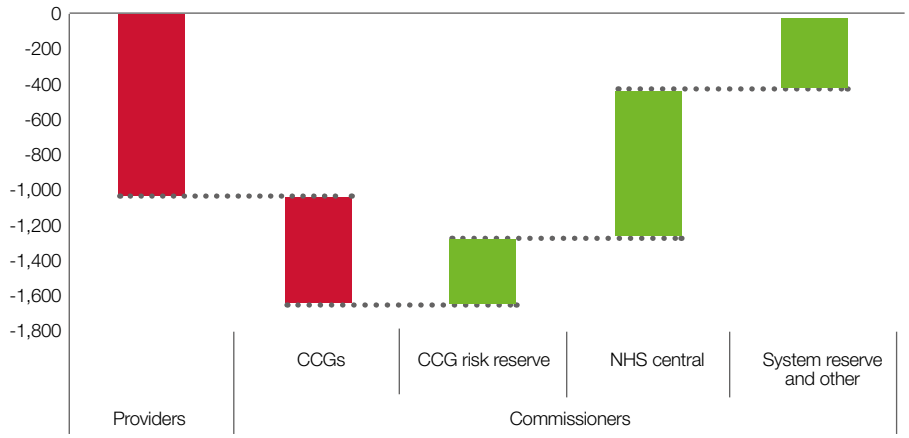
Achieving balance at the individual commissioner level might seem an easier prospect given their overall collective balanced starting point, but this will also be challenging.

Within NHS England's overall underspend of £1bn for 2017/18, the Department of Health and Social Care's annual accounts demonstrate that clinical commissioning groups overspent by a total of £0.6bn, reducing to £0.2bn following the release of the CCG risk reserve.

The NAO's analysis shows that this £213m overspend was after underspends on the quality premium programme and technical adjustments. The actual collective overspend on locally commissioned services was £321m, made up of an overspend of £568m by 75 CCGs and an underspend of £247m by 132 CCGs.

This year, even with a £400m commissioner sustainability fund specifically targeted at those CCGs unable to live within their means, some 48 CCGs were reporting year-to-date overspends after eight months, with 15 forecasting to remain overspent at the year-end.

Net NHS financial balance 2017/18



Source: DHSC annual report and accounts 2017/18

NHS Providers' surplus (deficit) 2017/18 outturn

	Deficit		Surplus		Net	
	Number	£m	Number	£m	Number	£m
Equal to or better than control totals	29	(519)	122	1,297	151	778
Worse than control totals	52	(1,213)	9	40	61	(1,173)
Others	20	(702)	2	0	22	(702)
Adjustments						105
Net	**101**	**(2,433)**	**133**	**1,337**	**234**	**(991)**
Variance from plan	-4	(832)	4	634	0	(496)

Source: DHSC annual report and accounts 2017/18

Direct relevance

Alison Myles, HFMA director of education
News and views from the HFMA Academy

Training

The HFMA postgraduate qualifications are not simply academic exercises in broadening students' general understanding of healthcare business and finance. Their content is directly relevant to the challenges the NHS faces in delivering the *NHS long-term plan*, published at the start of the year.

Feedback from students has already indicated that they are able to apply what they are learning in their day-to-day roles within the NHS. And there are specific areas of content that have a direct read-across to the long-term plan.

For example, the plan says that delivery of its vision will rely on local health systems having the capability to implement change effectively. This, it suggests, will demand that the service develops its quality improvement skills and data analytics. There is also a big focus on delivering value and moving to population health management.

The *Tools to support decision-making* module – one of six optional modules that underpin the HFMA's advanced and advanced higher diplomas – clearly supports the aim to improve data literacy and the use of data. It will help those providing information to inform the decision-making of others to think about the usefulness of the data being provided and whether it is presented in the best format. And it will help decision-makers to think more about the information they are being provided.

It covers the different types of information tools that people might come across and also discusses the importance of patient-level cost data. Increasingly, patient-level cost data is being used to help understand variation and address it where it is unwarranted.

Cost data – currently extracted from healthcare resource group level reference costs – already underpins the growing Model Hospital system (soon to be the Model Health System, according to the long-term plan) and the aim is for this to be refreshed with much more granular patient-level cost data.

In line with this, all functions within the NHS need a better appreciation of the importance of accurate cost data and how it can inform improvement – and the *Tools to support decision-making* module helps to deliver this (with a separate module available for those wanting a much deeper understanding of the costing process and using cost data).

The module also goes on to talk about the investment/disinvestment process, business planning, ethical and professional considerations and negotiation.

The level 7 qualification's *Creating and delivering value in healthcare* module is also on-message for the direction of travel laid out in the long-term plan. The plan puts a major emphasis on improving outcomes, while also addressing variation and efficiency.

> "Students, if successful, will not only enhance their own academic credentials but learn skills that will increase the service's ability to deliver the long-term plan"

In a nutshell, this equates to delivering value-based healthcare – ensuring all decisions deliver the optimum value taking account of outcomes (in terms of clinical effectiveness, patient experience and safety) and costs.

The plan's push towards integrated care systems taking collective responsibility for population health also requires value-based decision-making at the system level. For example, changes in service delivery and pathways need to be considered in terms of the outcomes and costs delivered across the whole local population, not just at the level of organisations.

To date, the advanced qualifications have attracted some 150 students, whether to take an individual module or a diploma – with a handful of people now studying for the full MBA. Finance professionals are in a slight majority within these students, but there are significant numbers of clinicians and non-finance managers also studying. A better understanding of decision-making tools and value are relevant across the board.

We believe these students, if successful, will not only enhance their own academic credentials but learn skills that will increase the service's ability to deliver the long-term plan.

Finance teams going for gold

Future focused finance

At the Finance Leadership Council meeting on 31 January a further 15 organisations were awarded Future-Focused Finance accreditation, *writes FFF programme director David Ellcock.*

This brings the total to 68, with 36 of these at level 1, 23 at level 2 and nine at the 'gold standard', level 3. Our accreditation scheme for finance skills development is now gaining traction across the country, and we are delighted there is at least one accredited organisation in each of the 10 skills development network areas. Organisations from Sunderland to Plymouth and Lancaster to Crawley have taken part in the process.

We asked, Paul Simpson, chief finance officer at Surrey and Sussex Healthcare NHS Trust (pictured), to tell us why he'd sought FFF accreditation for his organisation. He said: 'At Surrey and Sussex Healthcare the finance team (as a unit, led by the deputy finance director) is passionate about ensuring it is actively and strongly supporting our trust's services. FFF level 1 accreditation provides a visible measure that clinical and operational colleagues, and patients, can understand and really appreciate.

'That helps people in the finance team feel more confident in themselves. And, because it's about what the people in the team do, we think it will help our internal talent planning, as well as entice others to come and join us. It also gives us another goal… which is all about striving for the next level.'

• For more on FFF accreditation, contact **futurefocusedfinance@nhs.net**

Diary

March
1 (B) Eastern: accounting standards and VAT update, Fulbourn
14 (N) Brighter together: leadership masterclass, Rochester Row
14 (B) Northern: better business case development, Durham
26 (B) Eastern: Brexit and STPs, PwC Cambridge
26 (B) North-West: can a wholly-owned subsidiary work for you in the NHS? Liverpool

April
10 (I) Institute: costing conference

May
9 (B) South Central and South-West: developing talent (with SDN), Reading
16 (F) Chair, Non-executive Director and Lay Member: forum
22 (F) Commissioning Finance: forum
22 (I) Institute: the value summit, London

June
5 (F) Provider Finance: forum, Rochester Row (am)
5 (F) Mental Health Finance: forum, Rochester Row (pm)
13 (B) West Midlands: annual conference, Birmingham
21 (B) Northern: Keep stepping, Durham
27-28 (B) North-West: annual conference, Blackpool

July
4-5 (N) HFMA summer conference, Bristol

September
12 (B) South Central: annual conference
23-24 (N) CEO forum and dinner

October
16 (N) Charitable funds, London
17 (N) Mental health finance conferemce, Rochester Row

December
4-6 (N) HFMA annual conference, London

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

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

Accredited CPD

The HFMA's e-learning modules and its NHS operating games have recently been awarded full continuing professional development (CPD) accreditation by the CPD Standards Office.

This means e-learning students and participants in the operating game can now be issued with a CPD certificate confirming that the development activity counts towards accredited hours.

While completion of an e-learning module or participation in the operating game would previously have counted towards CPD, these would have been 'unaccredited hours'.

A number of professional bodies are now insisting that up to 50% of CPD should be accredited hours – where members are taking part in accredited activities.

As of January, the association is now a registered provider with the CPD Standards Office – see the listing at http://hfma.to/8l. The accreditation covers 38 e-learning modules and five versions of the operating game.

Events in focus

Brighter together: leadership masterclass
14 March, Rochester Row, London

This one-day event is aimed at senior finance professionals who are keen to develop their leadership skills in integrated working. It will be chaired by HFMA immediate past-president Alex Gild (pictured) and is part of the *Brighter together* programme, his presidential theme. The programme aims to increase the mutual understanding between health and social care professionals by exploring system-wide issues, applying practical approaches to analysing problems and promoting inspirational leadership.

The move to system working in the NHS in England has been reinforced by the long-term plan and presents challenges and opportunities for health and care leaders.

Ewan King from the Social Care Institute of Excellence, will facilitate a workshop for delegates, who will also hear from Kathy Roe, who was awarded HFMA Finance Director of the Year in December. She is a trailblazing finance leader and is both the chief finance officer of Tameside and Glossop Clinical Commissioning Group and Tameside Metropolitan Borough Council (see p13).

• For more details, email emily.simmonds@hfma.org.uk

HFMA summer conference
4 July, Ashton Gate stadium, Bristol

Bringing together the association's commissioning and provider finance network conferences, the annual summer conference is now in its 15th year. The integrated nature of the conference reflects the move to system working in the NHS. The event, *Connected thinking for the future*, will focus on integration, ill-health prevention and the use of technology in the health service.

The conference is aimed at senior finance professionals from acute, community and mental health providers, and commissioning organisations, as well as those from arm's length bodies.

Speakers include King's Fund chief analyst Siva Anandaciva (pictured), Tim Kendall, national clinical director of mental health at NHS Improvement, and, from Public Health England, finance and commercial director Michael Brodie and Gregor Henderson, national lead for wellbeing and mental health. NHS Digital finance director Pete Thomas will look at the role of digital technology in implementing the long-term plan.

• Members of the HFMA partner programme can receive discounted rates for this event. To book your place at the conference, please contact josie.baskerville@hfma.org.uk

Targeting apprenticeships

SHUTTERSTOCK

Association view from Mark Knight, HFMA chief executive

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

My HFMA

I'm delighted Caroline Clarke is now the chief executive of The Royal Free Group. Its turnover is way over £1bn and, although it has financial challenges, it is a model we could see more of moving forward. In the heart of London, it is one of the most influential roles in the country.

Caroline will be our 70th president commencing her term at the annual general meeting in December. She will be the third in my time to be a chief executive while holding the office of HFMA president following Sue Jacques in 2011/12 and Andy Hardy in 2013/14. Others subsequently became chief executives, such as Mark Millar, Keith Ford and Suzanne Tracey to name a few. It's a well trodden career path.

In part, that is why we created our CEO Forum, which runs twice a year, to allow finance CEOs to continue to network via the HFMA and for us, in turn, to reach those not in finance. This is just one of the events we run for 'non-core' groups and we believe it is important to reach out to other parts of the NHS.

You may have noticed the booking rates for the annual conference are out. The closing date for the initial offer is 18 April. We're open to special arrangements when you book five or more for the event as we'd like to see more executive teams there as well as deserving finance staff. So, it's worth calling us if you get more than five in your group to see what's available. We will be announcing key speakers throughout the year to whet your appetite.

The HFMA board got together at the start of last month for its first meeting of the year. We are indebted to our retiring trustees, Sue Jacques, Keely Firth, Huw Thomas and Ros Preen. And, of course, Tony Whitfield who sadly passed away at Christmas. However, we welcome an infusion of new talent into our ranks and they have made an immediate impact.

There were the usual discussions around our finances and current operations, all of which are pretty much on track, although nothing's certain. One of the main items of business was apprenticeships. The association has applied to be a training provider and hopes to be offering accountancy level 4 and business administration level 3 apprenticeships this year. The board agreed to set up a working group to take this forward, led by new vice president Owen Harkin.


HFMA chief executive Mark Knight

We believe we have something to offer in this space that is unique and tailored to the health market. In the case of the accountancy level 4 apprenticeship standard, we can, for example, offer the ACCA diploma qualification (the first three exams of the full ACCA qualification) with extra specialist content from HFMA to contextualise it for health.

This is just one example of an apprenticeship we hope to be offering in September. For more details, email me at **chiefexec@hfma.org.uk** and I'll pass on your enquiry to our team.

As we move forward, it's clear we are changing as an organisation. We want to remain relevant and vibrant, offering members the best technical and educational content.

Often that comes from the skills and knowledge of the members themselves and for that I offer a hearty thanks.

Member news

Susan Rollason (pictured), chief finance officer at University Hospitals Coventry and Warwickshire NHS Trust, has been appointed chair of the Healthcare Costing for Value Institute. Ms Rollason has been involved in the institute since its launch in 2015. In her new role she will chair the institute Council, as well as support institute events.

Alongside their main programme of training sessions, conferences and other events, the HFMA branches also host social events. The West Midlands Branch recently spent an evening locked in several

escape rooms in Birmingham. Some 22 people, from a wide range of NHS finance jobs, attended the event. Working together in several teams, they had to find clues to unlock the doors, but they had only 60 minutes to escape. One group was blindfolded and locked in separate cells. They had to break out of their cells before attempting to escape. Luckily, all but one of the teams managed to free themselves in time. To find out more about the upcoming events in your region, please visit **www.hfma.org.uk/our-networks/branches**

The HFMA is on social media – follow us on twitter at **@HFMA_UK**, on Facebook at **www.facebook.com/HFMAUK** and LinkedIn at **www.linkedin.com/company/hfma_2** and interact with colleagues across the country.

The HFMA's e-learning modules and NHS Operating Game have achieved full accredited status with the CPD Standards Office, following a rigorous assessment process focusing on the development and delivery of the training.

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

Chair, Non-Executive Director & Lay Member Faculty

The *NHS long-term plan* sets out the direction of travel for the next 10 years, providing a framework for organisations to develop local plans. The changes in each plan will reinforce the role of chairs, non-executive directors and lay members in ensuring innovation happens in a safe and secure way, and that governance systems are maintained and enhanced.

'The plan provides us with direction and gives us the authority to pursue change in a slightly different way,' says Phil Taylor (pictured), deputy chair of Sheffield Clinical Commissioning Group and outgoing chair of the HFMA Chair, Non-executive Director and Lay Member (CNL) Faculty. A former HFMA chairman, Mr Taylor is stepping down from the faculty after two years in the post.

'The faculty is unique because it creates the opportunity for all NHS organisations to come together – commissioners, providers and arms-length bodies,' he says. 'Its aim is to ensure strong leadership, robust challenge and wise counsel. To do this, you need to understand what's happening across the system and this is why the faculty is so helpful.'

The faculty holds several events a year and kicked off the 2019 programme with its annual chairs' conference. Delegates heard from high-profile speakers, including Tony Young, national clinical lead for innovation at NHS England, who spoke about the past, present and future of innovation in the NHS.

'Non-execs and lay members have a key role not only in encouraging innovation, but also in ensuring the governance structures are in place to support innovation,' says Mr Taylor.

'Part of the real innovation in the NHS at the moment is the move to work together more closely across organisations so we can allow for more innovative things to happen. In this way, we can implement innovation that benefits the whole system, instead of looking at it from the perspective of the individual organisation.'

He says some of the speakers at the faculty events over the past few years have talked about the governance innovation in the NHS, covering the devolution in Greater Manchester, GP vertical integration, system leadership and more.

The CNL faculty is hosting its next forum on 16 May in London. Find out more at **http://hfma.to/cnl**

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Appointments

Adam Sewell-Jones (pictured) is now regional director South West for NHS Improvement and NHS England. He will be in post until Elizabeth O'Mahony, currently chief financial officer for NHS Improvement, takes over later this year. Mr Sewell-Jones was previously director of improvement at NHS Improvement. He has over 23 years' experience in the NHS, including as deputy chief executive and director of finance and continuous improvement at Basildon and Thurrock University Hospitals NHS Foundation Trust.

Helen Cobb has become director of finance, clinical scientific services, at Manchester University NHS Foundation Trust. She was previously director of transformation at Lancashire Teaching Hospitals NHS Foundation Trust and won the HFMA Governance Award with her team in 2006.

Kent and Medway NHS and Social Care Partnership Trust has named **Victoria French** deputy director of finance. She joined the trust as an associate director of finance in 2016.

Neil Kemsley will join University Hospitals Bristol NHS Foundation Trust as director of finance and information this summer. Currently director of finance at University Hospitals Plymouth NHS Trust, he will succeed **Paul Mapson**, who will retire after nearly 17 years in the trust. Mr Kemsley joined the NHS in 1994 as part of the NHS South West finance training scheme. He has over 25 years of experience in the sector, including as a regional finance director in NHS England.

Peter Axon is now chief executive of North Staffordshire Combined Healthcare NHS Trust. He takes over from **Caroline Donovan**. who becomes chief executive at Lancashire Care NHS Foundation Trust. Mr Axon is currently deputy chief executive and chief finance officer at Birmingham Community Healthcare NHS Foundation Trust. He joined the board of directors of the foundation trust in 2009 and has broad experience in the NHS and private sector.

Caroline Clarke (pictured) has been named group chief executive officer at Royal Free London NHS Foundation Trust. She recently became deputy group chief executive at the organisation after serving as chief finance officer for seven years. She takes over from **Sir David Sloman**, who is the new joint NHS England and Improvement London regional director. Ms Clarke is an HFMA trustee and next in line to be president for 2019/20. She has worked within the NHS for more than 25 years, as well as spending two years as an associate partner at KPMG.

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

"Bedfordshire has the biggest financial problem but it's pretty much on target and we have some good news on control totals"
Chris Ford, Bedfordshire, Luton and Milton Keynes CCGs

Ford takes CCG reins in first-wave ICS

On the move

System working is not a new concept for the NHS, but it is the right path to take, according to Chris Ford, who recently became chief finance officer for the three clinical commissioning groups serving Bedfordshire, Luton and Milton Keynes.

The CCGs are part of a first-wave integrated care system (ICS), known locally as BLMK. 'We were in the first batch of ICSs and it's one of the things that attracted me to the role. Being at the front is a good opportunity to set the agenda,' he says. 'On a personal level, I'm at the point of my career where I'm mature enough to have the conversation about how we work together as a system rather than how we work as individual organisations.'

He adds: 'I think we are big enough to be strategic, but small enough to be relevant to our population – I'm confident we will never forget about Luton, for example, when we are talking about BLMK.'

The BLMK ICS was established three years ago, initially as a sustainability and transformation partnership (STP), and has a population of just under a million. It had a 'do nothing' deficit of £200m. In addition, two of the CCGs – Luton and Bedfordshire – had historic debt, which requires repayment. To do so, the CCGs were given surplus control totals of circa £5m and £10m respectively in 2018/19.

Mr Ford says a lot of the historic debt is related to underfunding due to the two CCGs receiving less than their target allocations (with gaps of more than 5%). He acknowledges that there were also failures in governance, which have been addressed.

The CCGs are gradually reducing the historic debt, but he would like the NHS to take a more 'mature' attitude to repayment, with historic debt being set aside.

Under the new formula for 2019/20 onwards Luton and Milton Keynes CCGs remain underfunded by 2%-3%. 'Bedfordshire has the biggest financial problem but it's pretty much on target and we have some good news on control totals, with the 2018/19 repayment target of £15m having been reduced to £9m.'

He has worked in the NHS for 35 years, across the spectrum of NHS organisations, including providers in and around London and community and mental health services. In 2010 he became finance director of Luton Primary Care Trust, one of the predecessors to the BLMK system. In 2012 he joined NHS England as director of finance for Central Midlands.

'In many respects system working is not a new thing. Going back to my days as a regulator, a large part of many of the conversations with systems in difficulty was about reaching agreement. We were disappointed when systems couldn't work together.

"The ICS concept is about people working together, where we aren't referring to third parties to sort out issues

'The ICS concept is about people working together, where we aren't referring to third parties to sort out issues because it is in the nature of system working to resolve health and social care-related problems across the patch.'

He continues: 'The difficulty is conceptualising what it means in practice. An awful lot has been written about ICSs, but no-one has said, "Here's a standard structure". That can cause issues for the system as we work through dealing with the practicalities of working in an integrated way.'

The BLMK ICS involves 15 organisations, but there is no suggestion of setting up a single body to run all of them. 'It's easy to fall into the trap of reorganisation. Certainly, benefits can flow from a merger, but a merger is not enough in itself.' BLMK is focusing on evidence-based change.

CCGs are required to take 20% out of their administration costs by 2020/21 and system-wide working across a larger footprint could help realise some of those savings. Mr Ford says: 'We are trying to identify opportunities to become more efficient. There are things that we are doing three times or maybe even more. We are looking at this across all our functions – back office support as well as our clinical commissioning functions – to not only become more efficient but also more effective.'

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