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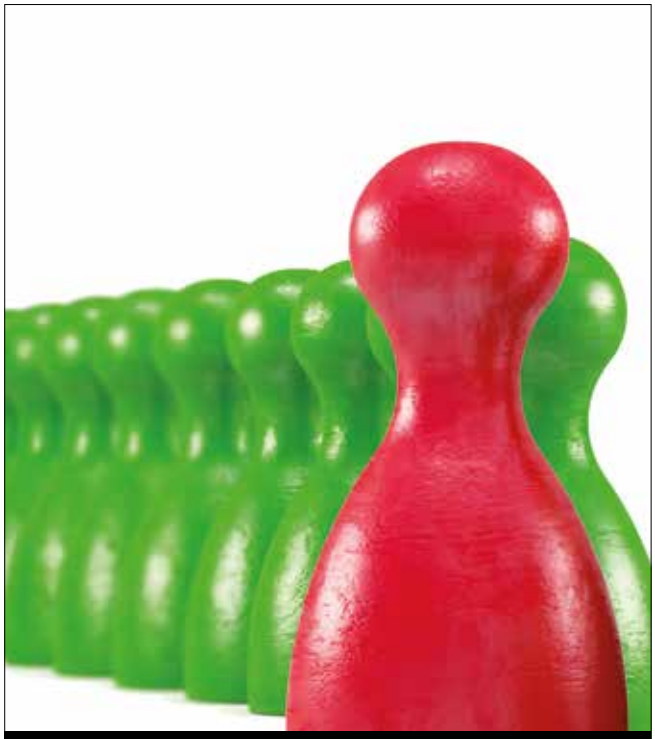

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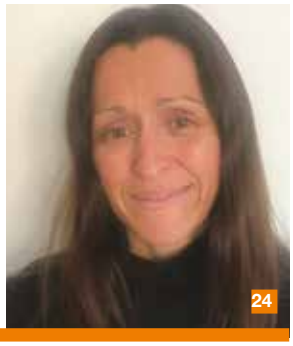

KARL STORZ Partnering Better Healthcare at University Hospital Southampton

Austerity and Growth

Recently, University Hospital Southampton NHS Foundation Trust faced a dilemma familiar to many Healthcare providers; to deliver more effective care, more quickly and with less money.

Nowhere was this felt more acutely than in the theatre suite, where equipment maintenance was difficult to coordinate and outdated theatre technology was undermining the best efforts of staff to realise efficiencies and make cost savings.

The Trust's traditional procurement model, bulk purchasing equipment with capital funds on a periodic cycle, was not satisfactory, because maintenance was often poorly funded or neglected.

Doing Things Differently

With limited capital resources and increasing pressure to invest in new equipment, imaging technology and Integrated Theatres, Jo Hall, Head of Operations and Performance, turned to long-standing supplier KARL STORZ, seeking a solution.

As well as the new equipment, the Trust needed to realise operational improvements, with more efficient service and support.

Partnering Better Healthcare

Working closely with the Trust, KARL STORZ addressed each element of their requirements:

Equipment Upgrade: The Trust now boasts the UK's first 4K, 3D Integrated Theatre with ICG capability in the UK along with first-class instrumentation to ensure a superb working environment for staff enabling better patient-focused care.

Operational Efficiency: KARL STORZ supported the new install with a dedicated On-Site Technician, a trained specialist who can resolve any equipment issues fast. In fact, theatre uptime is guaranteed by a mutually agreed Service Level Agreement.

Financial Predictability: With no initial outlay, predictable payments over a defined term, guaranteed uptime, a rolling replacement programme for equipment and the peace of mind of having a KARL STORZ technician on site, University Hospital Southampton have realised their vision and are delivering better healthcare, without impacting on their capital budgets.

"KARL STORZ helped to improve our theatre facilities and provided surgical equipment in a way that worked for us. We felt we had a good partner in KARL STORZ from the outset. They suggested ways of doing things that have helped us achieve our operational goals and are helping our staff to provide our patients with a better standard of care."

Jo Hall, Head of Operations and Performance, University Hospital Southampton NHS Foundation Trust

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News

Health and care warnings over planned legal changes

By Steve Brown and Seamus Ward

MPs have been warned that the NHS must be wary about the unintended consequences of proposed legal changes. They have also been told that the financial positions of both health service bodies and local authorities are acting as barriers to closer collaboration.

NHS England and NHS Improvement has proposed a number of legal changes to support the implementation of the *NHS long-term plan*. These include: changes to competition rules to bring in a new best value test; giving power to NHS England and NHS Improvement to set annual capital spending limits for foundation trusts; and more flexibility in tariff-setting.

The initial engagement on the proposals ended in April, but, in parallel, the Commons Health and Social Care Committee is also running an inquiry into the planned changes.

With recognition that existing legislation acts as a barrier to collaboration and system working, there was support for many of the proposals. But there were also key objections and concerns about unintended consequences.

A hearing held at the end of April ran out of time before it could discuss one of the more controversial proposals – on capital approvals.

However, in written evidence, the NHS Confederation said it was not convinced by the proposal, arguing it would 'further undermine the autonomy of foundation trusts and confuse governance and accountability arrangements'.

In its written response to the NHS England and NHS Improvement consultation, the HFMA said that there was only a dwindling number of foundation trusts with internal resources available for capital projects. The key constraint for many providers was access to capital funding, not the ability to spend their own resources.

Highlighting the importance of understanding potential consequences of legislative changes, the association pointed out that switching the commissioning of public health services to local authorities under the *Health and Social Care Act 2012* had, presumably in an unintended way, added VAT costs for NHS providers.

The NHS Confederation also raised some concerns about proposals to set the tariff as a formula rather than a fixed price, enabling prices to reflect local factors.

'Where providers and purchasers disagree over the appropriate level of pricing, it will be important to make sure neither side is expected to bear unreasonable levels of risk,' it said.

The proposal to remove competitive procurement of contracts for services was discussed at the committee hearing. NHS Clinical Commissioners chief executive Julie Wood (pictured) said more work was needed to define what the test would look like.

'The key thing for me is that we do not inadvertently end up putting lots of hurdles in the best value test that are as clunky and time-consuming, and expensive in time, as what we are trying to get rid of,' she said.

'We have to make sure that it adds value and that we get the right level of scrutiny needed and the right outcome.'

NHS Providers chief executive Chris Hopson said there might be different approaches in different sectors, depending on their contestability. The NHS would not want to tender for A&E services, for example.

But he added that the current system had led to services being retendered too frequently – particularly in community services – and called for a more streamlined system.

Sarah Pickup, Local Government Association deputy chief executive, said the financial position of individual organisations was acting as a barrier to the ambition of closer working outlined in the long-term plan. But she was optimistic this issue could be overcome.

'If local government is cash strapped and has to cut back its social care services, the health service might worry about bringing it into a formal partnership or pooling,' she said.

'Also, I know that some areas are holding back from formally pooling resources because of deficits in the local health system, so it is a barrier. That does not stop you joint commissioning, but you have to have clear rules.'

The NHS Confederation was also concerned that the lack of movement on social care funding was hampering progress.

• *See Professional lives: technical, page 25; see also Debbie Paterson's blog on the HFMA's website at www.hfma.org.uknews/blogs*

Trust finance plans more realistic

Trusts in England are feeling more positive about their finances in 2019/20, but the situation remains challenging, according to NHS Providers.

In an analysis of the financial challenge for trusts, the provider organisation said changes made to support financial recovery had made the task more realistic.

A February survey of trusts showed 38% were more positive after receiving their control totals for 2019/20 – 13% would not sign up to their control totals, with 28% unsure.

A similar survey for 2018/19 showed that 18% would not agree their control totals, with 29% unsure. Further feedback since February suggests nearly all trusts will now sign up.

The median cost improvement programme saving level is 3.6%, significantly less than the 2018/19 survey average of 5%. While there has been an increase in the number of trusts reporting savings plans of less than 3%, 12% have plans for more than 6%.

Trusts said the variation was due to a number of factors, such as how funding for the Agenda for Change rises interact with staff grades mix.

Providers with local authority contracts – for example, for public health services – have not received funding to pay for AFC pay rises. It is estimated this will cost between £45m and £55m overall, although national negotiations are ongoing.

NHS England confident of financial balance despite CCG deterioration at month 10

By Seamus Ward

The clinical commissioning group financial position deteriorated further at month 10, but, overall, commissioners were forecasting an underspend in 2018/19.

NHS England was confident the year-end underspend, forecast to be £706m at month 10, would be enough to offset deficits in other parts of the health service. The forecast underspend was £441m more than the planned £265m, which was set in-year to help offset deficits in the provider sector.

Overall, CCGs planned for a £48m underspend but were forecasting an aggregate overspend of almost £112m.

A report on the month 10 position tabled at the recent NHS England and NHS Improvement board meeting in common said the deteriorations against plan became apparent following a deep dive into CCG financial positions after month 9. In the month 10 report, 28 CCGs forecast material deteriorations against plan, totalling £248m, with this likely to rise slightly to £250m at year-end.

BCF contributions in focus

Clinical commissioning groups must contribute at least £3.84bn to the Better Care Fund (BCF) in 2019/20. A government document setting out the policy framework in which the fund will operate this year said a further £2.58bn will be allocated to local authorities (for adult social care and disabled facilities), taking the total to £6.42bn in 2019/20.

With a review of the fund under way, 2019/20 will be a year of minimal change for the BCF, it added. Changes following the outcome of the review will take effect from 2020.

The document, published jointly by the Department of Health and Social Care and the Ministry of Housing, Communities and Local Government, said there were positive signs of progress on the BCF and integration. For example, pooled funding from health and local government was at least £1.5bn above the minimum level in each year the BCF had operated. Planned voluntary pooled funding totalled £2.1bn in 2018/19.

NHS England interim chief financial officer Matthew Style (pictured) said up to 35 CCGs could overspend against plan by year end. This was largely due to overperformance against acute contract and under-delivery against QIPP targets, he told the meeting.

While CCGs were forecasting a year-end overspend of £112m, direct commissioning and NHS England running and central programme budgets were forecast to underspend by £267m and £597m, respectively. This is £151m and £495m more than planned. The underspend in central budgets is largely due to vacancies, GP rates rebates and counter fraud receipts not included in the operating plan.

The central underspend also includes the release of contingencies and reserves that are no longer required and £60m in quality premium that is not expected to be earned.

A £45m overspend against plan for technical and other adjustments – due to provision movements and depreciation – completes the

Call for clarity on move to financial balance

Planning guidance for 2020/21 must clarify arrangements and set a timeline for achieving financial balance in commissioners and providers, MPs have insisted.

Expressing concern about the overall health of the NHS in England, the Commons Public Accounts Committee (PAC) said there were warning signs that financial health was getting worse – such as increasing loan amounts, transfers from capital budgets to revenue, the growth in waiting lists and slippage of waiting times.

While the NHS almost achieved balance in 2017/18 this masked 'significant disparities' in the financial performance of individual trusts and clinical commissioning groups.

Trusts and commissioners reported an aggregate deficit of £21m, but it was unclear whether funding was getting to the right parts of the system. While NHS England underspent by £1.2bn, trusts had deficits totalling £991m and CCGs £213m. There was wide variation in trust financial performance. Ten trusts accounted for 69% of trusts' total net deficit and trusts in difficulty were given Department of Health loans totalling £3.2bn, the PAC added.

Although the *NHS long-term plan* said the number of deficit trusts would more than halve by 2019/20 and none would report a deficit by 2023/24, it was not clear how the furthest from break-even would be helped to achieve balance.

The committee said action must be taken to clarify the steps to financial balance in next year's planning guidance, adding that NHS England should write to it by September to give an update on how this guidance is progressing.

PAC chair Meg Hillier (pictured) said: 'No-one should take solace from a top-level financial picture that masks significant local disparities.

'If the long-term plan is to be more than just an aspiration, government must engage fully with the detail and ensure necessary resources are directed to the right places.'

The committee added that staff shortages are a major barrier to NHS financial viability and the delivery of the *NHS long-term plan*.

The NHS would not deliver the plan without addressing staff shortages. It called on the government to outline its staffing plans by July.

picture, producing a forecast year-end underspend of £706m.

'On a risk-adjusted basis we are confident the overall surplus on the commissioner side will be sufficient to balance the NHS group as a whole for the year 2018/19,' Mr Style told the joint board meeting. 'We are also focusing on understanding the underlying causes of those CCG deteriorations in-year in financial performance to ensure we can set sustainable plans in those CCGs and indeed in all commissioners and providers for the year ahead, which is the first year of the long-term plan period.

'Given the decisions we have taken to rebase control totals on a stretching but achievable basis and not hold very material reserves for 2019/20, that work to understand those underlying causes and ensure they are addressed in 2019/20 plans is absolutely crucial.'

NIAO flags up locum cost concerns

The rising costs of locum doctors and settlements for clinical negligence are piling financial pressures on the health and care system in Northern Ireland, according to the nation's audit office.

Locum spending almost trebled between 2011/12 and 2017/18, said the Northern Ireland Audit Office (NIAO). Spending stood at £28.4m in 2011/12 but rose to £83m five years later. This included sharp rises between 2015/16 and 2017/18, with annual costs up by nearly 57%.

Agency doctors accounted for almost 90% (£73.5m) of locum medical expenditure in 2017/18. Most trusts relied increasingly on non-contracted agencies (those without agreed rates). In 2017/18, 29% of total agency spend went to non-contracted agencies.

Comptroller and auditor general Kieran Donnelly (pictured) said the reliance on agencies was becoming unsustainable. 'Efforts to reduce this

dependency have had very limited success,' he said. 'To help ensure that patients' needs are best met and provide better value for money, it is imperative the Department of Health and trusts collectively progress the transformation agenda and formulate strategies for delivering a suitably resourced and sustainable medical workforce.'

The NIAO said clinical negligence costs, including estimated costs of unsettled cases, had risen by 56%.

The overall cost was £252m in the period 2007/08 to 2011/12, but rose to £393.5m in the following five years. Mr Donnelly said steps had been taken to enhance patient safety, but more work was needed.

• *See also Keeping out of the red, page 21*

Compensation for trusts targeted by fraudsters

By Seamus Ward

Three trusts that were targeted by the same group of fraudsters have been awarded more than £1.7m by the courts following a series of convictions.

The criminals used forged letter, emails and faxes to masquerade as legitimate suppliers, allowing them to divert payments to themselves, according to the NHS Counter Fraud Authority. It said 14 fraudsters involved in the criminal group have been convicted, with total prison sentences of more than 50 years handed down.

A police investigation, known as Operation Tarlac, was prompted when a payment of £1.28m from Lincolnshire Partnership NHS Foundation Trust to a building firm for a new mental health unit went missing.

Since 2011, Lincolnshire Police have worked with the NHS Counter Fraud Authority and its predecessors to investigate the fraud and money laundering offences. Their inquiries revealed that other public bodies, including NHS organisations, councils and housing associations, as well as the Guernsey government, had been targeted by the gang.

More than 20 offences were linked, with losses totalling £12.6m. In sentencing, Judge Philip Head, described it as a 'sophisticated and widespread fraud in its conception and execution.'

The counter fraud authority said the Lincolnshire trust has received a payment of £1.2m from a proceeds of crime payment order, while North Essex Partnership NHS Foundation Trust received more than £298,000 and Tees, Esk and Wear Valley NHS Foundation Trust more than £216,000.

NHS Counter Fraud Authority interim chief executive Sue Frith (pictured) said: 'I commend the excellent work by Lincolnshire Police. Close collaboration between the NHSCFA, police forces and other authorities is vital to root out NHS fraud, especially by professional criminals.

'These recoveries for the NHS, and the original investigation, are good examples of how NHS counter fraud work helps to curb crimes against the taxpayer even beyond the NHS. Our Forensic Computing Unit, intelligence, fraud investigation and financial investigation specialists all played important roles in Operation Tarlac.'

Detective sergeant Mike Billam of Lincolnshire Police added: 'Recovering the stolen funds has always been a key objective in this investigation and so I am particularly pleased that Lincolnshire Partnership has now received the full value of its loss, which I know will be used to benefit our communities.'

News review

Seamus Ward assesses the past month in healthcare finance

It will come as no surprise to NHS finance professionals that the service's productivity is growing, with a relentless focus on value for money over the past decade. And, according to a recent independent study, NHS productivity grew two-and-a-half times as fast as in the general UK economy over the last 12 years. The University of York's Centre for Health Economics found that the health service provided 16.5% more care in 2016/17 than it did in 2004/05. Productivity growth in the wider economy stood at 6.7% over the same period. (*For an alternative look at the use of health economics, see Harnessing economics, page 24*).

Reducing inappropriate delays in transfers of care is one way of increasing efficiency and productivity, and these have been falling recently. A further boost may be provided by a new digital portal that allows health and social care staff to see how many vacancies there are in local care homes, potentially saving them hours of time telephoning around to check availability. In 2018 about a quarter of a million hospital bed days in England were taken up by people who were medically fit to be discharged but who could not be placed in an appropriate care home. The NHS and local auhorities reduced the number of lost bed days by 20% last year and the new capacity tracker aims to reduce unnecessary delays leaving hospital still further.

The latest figures from NHS England show that delayed transfers in February were 9.3% lower than 12 months earlier. However, more delays were attributable to the NHS (62.5% compared with 60.2% in February 2018). The figures also showed that A&E attendances were 4.1% higher in 2018/19 than the previous financial year. In March this year, 86.6% of patients were admitted, transferred or discharged within four hours – an increase of 2.4 percentage points since February. In elective care, at the end of February 87% of patients had been waiting fewer than 18 weeks. Although the 92% target was missed, this represents a slight increase since January (86.7%).

A report from NHS Digital showed that out-of-area placements in mental health services cost more than £10m in January. The report presented findings from the out-of-area placements collection for England, and said the average daily cost was £550 and the upper quartile daily cost was £636. According to the report, 20,790 out-of-area placement days were recorded over the month of January. The government has set a target of eliminating inappropriate out-of-area placements in mental health by 2020/21. However, the report found that 645 of the 675 active out-of-area placements at the end of the month were inappropriate. The British Medical Association said the government was not on track to end the practice by 2021.

A new briefing from NHS Providers – *Community services: our time* – calls for primary care networks (PCNs) to be implemented in a collaborative way taking account of what is already in place and working well. Relationships between community services and primary care will become more important as PCNs are rolled out across the country – one of the key proposals of the *NHS long-term plan.* The publication is based on interviews with 10 leaders from across the health and care sector. It added that with PCNs due to recruit 20,000 new community staff, care will be needed to ensure community providers and expanded primary care teams do not end up competing for staff and destabilising some provision.

The month in quotes

'This is a huge tribute to the work of NHS staff, and the intrinsic efficiency of this country's health service. It represents further welcome proof that taxpayers' investment in our health services is money well spent.'
NHS England chief executive Simon Stevens says health service productivity grew at more than double that achieved in the wider UK economy

'Primary care and community services have a vital role to play working together to help change the way people are supported, especially those who are frail and vulnerable. The question of whether community services will receive the national focus they deserve has never been more relevant.'
NHS Providers chief executive Chris Hopson calls for greater attention on community and primary care services

'NHSX is one of the most exciting things happening in the UK. It's cutting edge, it's mission driven and it's about harnessing the best. This is just the beginning of the tech revolution, building on our *NHS long-term plan* to create leading health and care services – for us all.'
Health and social care secretary Matt Hancock on new digital body NHSX

'Heads of internal audit across the whole public sector are working in increasingly high-pressure environments, contending with restricted resources and growing levels of financial risk. While many organisations are already doing a great job in this space, it's crucial that heads of internal audit and their teams are given the tools they need to provide quality assurance to their organisations.'
CIPFA chief executive Rob Whiteman seeks to boost the profile of internal audit

SHUTTERSTOCK

A new digital portal allows health and social care staff to see how many vacancies there are in local care homes

PCNs will be the building blocks of integrated care systems (ICSs), the advent of which could lead to further clinical commissioning group mergers – the *NHS long-term plan* says that, generally, there will be one CCG per ICS. The policy and procedures NHS England and CCGs must follow if the latter want to make changes to their constitution or to dissolve two or more CCGs that wish to merge are set out in a new publication from NHS England and NHS Improvement, updated from a 2016 version.

NHS England and NHS Improvement has announced a new nationally set reference price for adalimumab, which came into effect on 1 April and is distinct from the interim arrangement that has been available to date. The drug is the single medicine on which hospitals spend the most (more than £400m a year) and is used to treat conditions such as rheumatoid arthritis and inflammatory bowel disease. The reference price – alerted in a letter from the two bodies' deputy chief executive, Matthew Swindells – applies to all patients being treated with adalimumab and is intended to support the uptake of the best-value biologics for each regional group. It also ensures that patients are able to access a citrate-free product where clinically required, and that providers are fully reimbursed for their costs.

NHSX, the new NHS technology and data organisation, will seek to use tech to improve cancer and mental health patient experience, the Department of Health and Social Care said. NHSX will work with NHS England's cancer and mental health policy teams to make it easier for patients to access services through smartphones; give clinicians access to patients' medical information; and make it easier to collect and use health data for research. If successful, the programme will be rolled out across the NHS. The new organisation will be launched in July and will be mandated to ensure all computer systems can talk to each other.

The Welsh government has approved three-year plans submitted by seven NHS organisations, health and social services minister Vaughan Gething said. In a written statement, the minister said he had approved seven 'balanced and achievable' plans. He singled out one of the seven – Cardiff and Vale University Health Board – for praise. The board was placed in targeted escalation in July 2016, but had worked 'constructively and maturely' with government officials to address delivery and financial issues. Intervention was de-escalated in January this year. Three organisations were unable to submit board-approved three-year plans and remain in escalation – Abertawe Bro Morgannwg, Hywel Dda and Betsi Cadwaladr university health boards.

Finally, a call to recognise internal auditors in the NHS and across the public sector. According to CIPFA, auditors should be given more recognition, support and encouragement. Its new statement, *The role of the head of internal audit*, sets out five principles outlining the key expectations of heads of internal audit and the conditions that allow them to thrive. The principles are aligned with the UK Public Sector Internal Audit Standards.

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from the hfma

Former NHS finance director Paul Miller takes inspiration from Oscar Wilde as he outlines efforts to bring value to the fore in healthcare. A blog for the HFMA website looks at the work of NHS Future-Focused Finance and the HFMA Healthcare Costing for Value Institute to deliver a best possible value decision framework to help put value into practice. The approach uses 12 standard templates/tools to guide people through a structured process, ending with a three-dimensional scoring system that supports the decision-making process.

There is a new paradigm for NHS leaders, including finance directors, according to Ewan King (pictured), the Social Care Institute for Excellence chief operating officer. He recently presented research at an HFMA masterclass on system leadership in the NHS and found finance leaders open to the new reality of sharing power, working across organisational boundaries and focusing on population outcomes. In a blog, he says new skills will be needed, but he is confident finance staff will rise to the challenge.

In the 12th instalment of his blog series on life as chief financial officer of Bermuda Hospitals Board, Bill Shields outlines the continued focus on change, with payment moving from fee-for-service to a global sum or capped revenue budget for most services. This is reminiscent of the way the NHS worked in the past and he promises to keep readers appraised of any learning points for both the UK and Bermuda.

www.hfma.org.uk/news/blogs

News analysis

Headline issues in the spotlight

Shot in the arm?

The issue of public health is not often at the forefront of debate on the NHS, but there are new calls to give it more prominence – saving lives and money. Seamus Ward reports

Early hopes that the NHS would be so effective in addressing acute ill health that it would quickly become predominantly a wellness service were soon dashed. It became clear that demand for acute and primary care services were higher than expected and the money followed this demand. Although the prevention of ill health has been an important part of NHS services during subsequent years, from vaccination programmes to weight loss and smoking cessation clinics, it has never been given the prominence of acute care.

The five-year funding settlement, which applies only to services purchased by NHS England and clinical commissioning groups – predominantly acute care – did little to dispel the feeling that public health lacked importance. The need to improve the overall health of the population was highlighted in the Wanless review in 2002 and 2014's *NHS forward view*, but Office for National Statistics mortality data published in April show gains in life expectancy have stalled since 2011.

The *NHS long-term plan* did make public health a central plank of its vision for the future health service. Plans for public health include new hospital-based smoking cessation services to complement those commissioned by local authorities (*see Stubbing it out, Healthcare Finance, December 2018*). The new primary care networks will employ social prescribing leads, who could play a key role in preventative care (*see Network solution, Healthcare Finance, April 2019*). And the government is planning to publish a green paper on public health this year.

However, consideration of funding levels for public health, together with education and training and capital funding, will have to wait until the spending review, which is due to take place in the summer.

An announcement will be made in the autumn, when the spending review is expected to report and be published alongside the Budget. However, chancellor Philip Hammond has warned that the timing of the spending review will depend on the UK agreeing a deal to exit the European Union. The EU has agreed to an extension of the leaving date until the end of October. So, with the government cautious about making commitments without knowing how Brexit will affect the economy and its tax income, there is a chance that the political deadlock could muddy the waters over spending decisions.

The British Medical Association believes a squeeze on funding is restricting the impact of public health services – local services to support people in choosing a healthier lifestyle are unaffordable, particularly at a time of rising demand for hospital care.

In a report published in April, *Prevention before cure: prioritising population health*, the BMA said there was a link between public health funding and hospital admissions.

It said there are a number of issues affecting public health, including a continued trend of decreasing funding and, at the same time, increased hospital admissions where smoking, obesity and alcohol abuse are factors.

Since 2013, local authorities have been in

Diabetes cost

Over recent years there has been growing concern over the cost of type 2 diabetes, both in human and financial terms – as reflected in a recent Public Health England (PHE) publication.

It said that in the three years from 2015/16 to 2017/18 there were more than 147,000 hospital stays for diabetic foot disease, one of the major complications associated with type 2 diabetes.

With an average length of stay of eight days, the total number of days spent in hospital for diabetic foot disease was more than 1.8 million. The number of major amputations increased – 7,545 in the three-year period compared with 6,957 in the previous three years.

Overall, diabetes is believed to cost the NHS around £10bn a year. Currently, one in six hospital beds is occupied by someone with type 2 diabetes and 22,000 people die in England each year because of the disease. Its prevalence is set to rise from 3.9 million adults in England to 4.9 million in 2035 (almost 10% of the adult population). Yet type 2 diabetes can be prevented by better lifestyle choices: a balanced diet, maintaining a healthy weight and being physically active.

The long-term plan pledged to double the NHS diabetes prevention programme over the next five years with the aim of reaching more people at risk of developing type 2. The programme, delivered by PHE, NHS England and Diabetes UK, will support 200,000 people each year to reduce their risks.

Jenifer Smith, PHE programme director for the NHS diabetes prevention programme said: 'The NHS Diabetes Prevention Programme has been hugely successful in providing help and support to those at risk of developing the condition, which is why it's now being doubled in size.

'It's important that those providing the service work closely with their local public health teams who know their community, to ensure that they are reaching and meeting the needs of those who are at greatest risk.

'Type 2 diabetes remains the greatest health challenge in this country and many adults are in danger of developing this deadly but preventable disease.'

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charge of commissioning the bulk of public health services, including weight management programmes, smoking cessation and sexual health clinics. The Department of Health and Social Care provides grants directly to local authorities.

However, the BMA said grants have been cut by £550m in real terms since 2015/16, adding that the alcohol and obesity service budgets have been reduced by 10% over the past three years, while smoking cessation budgets shrunk by more than 20%.

Meanwhile, there has been a tenfold increase in obesity-related hospital admissions since 2006/07. Admissions associated with alcohol had more than doubled in the same period, while smoking-related admissions had also increased.

The BMA called for the spending review to reverse the £550m cuts in public health spending since 2015/16. However, it believes that while funding is important, it is not the only issue that must be addressed.

It said there must be a cross-government approach to addressing societal factors that influence health. This would recognise the importance of health in all policy-making.

More regulation is also needed to tackle lifestyle issues such as excessive drinking, smoking and poor diet – for example, by introducing minimum alcohol unit pricing across the whole of the UK.

The NHS could do more to place public health as a priority – for example, by ensuring all vehicles it uses minimise air pollution or by enforcing smoke-free hospitals and grounds.

"It is clear that failure to adequately fund public health teams may fatally undermine any increased spending on prevention in the NHS"
Toby Green, Royal Society for Public Health

The BMA believes the case for action is compelling. Its public health medicine committee chair, Peter English, said prevention can save the NHS 'substantial sums' in the long term by ensuring patients avoid conditions such as alcoholism and obesity.

Preventable ill-health accounts for an estimated 50% of all GP appointments, 64% of outpatient appointments and 70% of all inpatient bed days, according to the BMA. And 40% of the uptake of health services could be prevented through action on smoking, alcohol, physical inactivity and poor diet, it added.

Dr English said: 'Unfortunately, we have seen a systematic pattern in the past decade of all parts of the public health sector being subjected to a funding squeeze that has left preventive healthcare in crisis. A lack of joined-up thinking and national standards has led to widening health inequalities.

'These cuts come at a time when inequalities in life expectancy are widening. In England, males living in the most deprived areas are now expected to die 10 years earlier than those living in the least deprived, while for females the gap is seven and a half years.

'We need to see the upcoming green paper as an opportunity to address these failures and put in place a well-funded, co-ordinated plan that provides patients with a preventive health system that meets their needs.'

Royal Society for Public Health senior policy and research executive Toby Green agreed that funding was a significant issue for public health services.

'It is true that local authority funding is not the only vehicle for boosting the public's health – and indeed we welcome the extra focus on secondary prevention outlined in the long-term plan earlier this year – however, it is clear that failure to adequately fund public health teams may fatally undermine any increased spending on prevention in the NHS.

'As just one example, local authority spending on smoking cessation services has fallen by a third over the past five years, and they are now a universal offering in only half of council areas in England. This flies in the face of good evidence that tobacco control services provide an astonishing return on investment when it comes to the wider healthcare sector, returning an estimated £11.20 for every £1 spent.

'The future sustainability of the NHS depends on rejecting false economies and pursuing a sensible allocation of funds to local public health interventions – a strategy countless studies have shown to be highly cost-saving in the long term.'

Few would argue against the need for preventative care. Practitioners are hoping that the long-term plan and the forthcoming green paper will give public health a much-needed shot in the arm.

Comment

May 2019

Systems: beyond the theory

Every organisation will need to play its part in delivering system control totals

HFMA president Bill Gregory

The beginning of May finds the NHS well into the audit season – and auditors and final accounts will soon be long forgotten. But before we move on, we shouldn't forget the professionalism of NHS finance teams, which largely produce their statutory accounts within three weeks of the year end. I doubt there are many £150bn concerns that can do that.

In recent weeks, the control total system, and some of its perverse incentives, has rightly come in for a bit of criticism.

However, it doesn't take a genius to work out that the control system is flawed in the long term. It was merely an expedient short-term measure that is now being phased out. The move to system-based control totals – sitting across sustainability and transformation partnerships or integrated care systems – is a more useful concept. But, of course, a number in a spreadsheet does not itself change behaviours.

Successful management of system finances will need to be accompanied by effective mechanisms to ensure all parts of the system play their part in solving problems and improving care for our patients.

The escalating borrowing requirement of many

Getting engaged

Clinical collaboration remains the key to using costing data to drive improvement

Healthcare Finance editor Steve Brown

Calls for clinical engagement in costing are hardly new. A *Healthcare Finance* report from an HFMA costing conference in 2006 focused on the need to involve clinicians in compiling and checking costing data.

Thirteen years on and the importance of clinical involvement was still a core message at April's annual costing conference, organised by the HFMA Healthcare Costing for Value Institute.

Back in 2006, costing was all about reference costs and a key focus was supporting the compilation of tariff prices as part of the fledgling payment by results system. There were people using reference cost data in a high-level way to identify variations between services and organisations.

But the 'average' nature of the costs and major concerns over data quality and comparability stopped many organisations from using the data to inform decisions.

Clinical involvement was seen as an essential way of addressing some of these data quality issues – helping to improve allocation approaches and ensure that costs made sense (at least at that average level) to those practitioners actually delivering the care.

The context for costing has changed dramatically. After spending some years encouraging NHS bodies to start costing at the patient-level, the NHS in England is now

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"Successful management of system finances will need to be accompanied by effective mechanisms"

providers is a by-product of the challenging financial environment they have operated in over the last five years. The idea of trusts borrowing money to pay interest and balance sheets with negative net assets are difficult for our profession to comprehend never mind the public. Tackling these issues will need to form part of the financial architecture as we move forward.

The HFMA has been similarly busy supporting us during a busy time of year, with accounts planning sessions and a costing conference helping prepare practitioners for the upcoming cost collection.

We have the Healthcare Costing for Value Institute's value summit during May, which will focus on showcasing examples of collaboration between clinicians and finance teams across the country.

You may have also seen the announcement of plans to launch HFMA apprenticeships that combine the first stages of a professional accountancy qualification with our health sector-tailored HFMA education material.

Look out for more information shortly about this exciting development, which will allow our finance teams to access the apprenticeship levy for personal development.

My comments last month about the timing of Brexit were a bit tongue in cheek, but we are not much clearer on when or if Brexit will happen.

I suspect that there will be a big push to avoid the need for European elections with yet another Parliamentary vote on the deal.

But I wouldn't be surprised if there is more mileage in this saga yet that will keep us entertained over the summer months ahead.

Contact the president on president@hfma.org.uk

well into a journey that will see the whole service required to cost at this more granular level using detailed common standards.

Acute trusts will make their first mandatory submission this year, closely followed by ambulance trusts and mental health trusts next year. Providers of community services are likely to join them in 2021. But the message about the importance of clinical engagement remains a constant – though really we need to talk about collaboration, as engagement perhaps sounds a little like something done to the clinical workforce rather than with it.

This continued importance is not because people ignored the calls first time around, but because clinical engagement is a continual process. As one speaker urged costing practitioners at the April costing conference: spend more time on engagement and less on fine-tuning the costing model.

Now engagement is less about correcting allocations and apportionments – although a more detailed understanding of how clinicians spend their time is always helpful. Instead, it is about helping clinicians to understand what the data can tell them and take ownership of the data, trusting it so they can make decisions about patient pathways.

The data is increasingly meaningful and comparable – thanks to everyone following the same methodology. And it is at the patient level – so clinicians can relate costs to specific cases (especially if the data is delivered in a timely way), helping them to understand the reasons for outlying costs, for example.

Clinical collaboration is so vital because clinicians using costing data to inform service redesign is the point of costing. Accurate costs that reflect real clinical practice might be something for a costing team to be proud of. But if it doesn't get used to inform clinical decision-making, it becomes a hollow exercise. Information is only useful if it changes behaviour – as one speaker told the conference.

Some still argue that the introduction of patient-level costing is using a mallet to crack a nut. Similar outcomes could be achieved by comparing variations in length of stay, time in theatre or number of tests. You don't need to attach money to them, they say.

"The costing programme is broadly about bringing patient-level information of all types into one place"

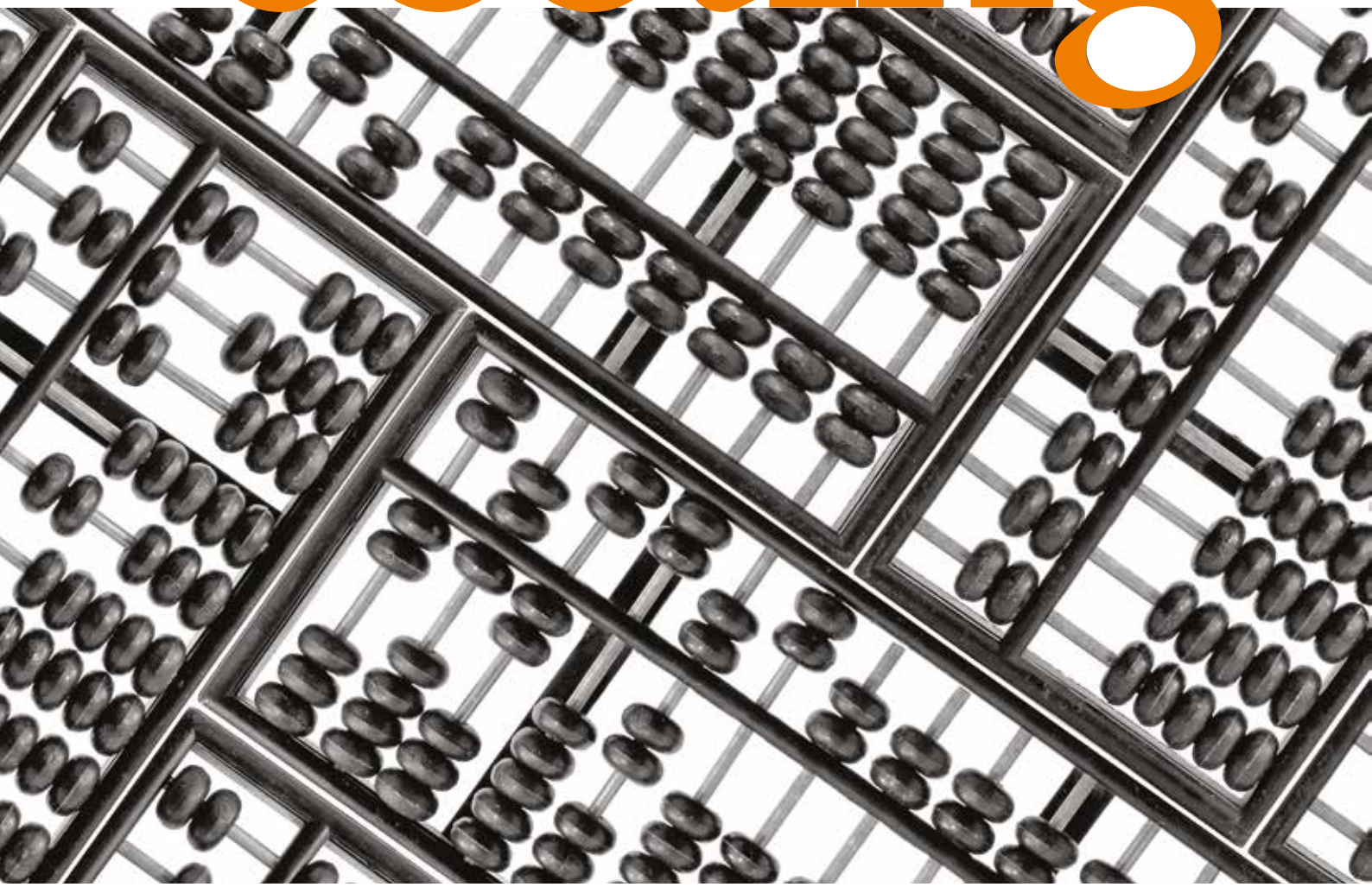
But attaching costs to these activities helps clinicians, supported by their costing practitioners, to focus on the best place to start looking – the areas that will deliver the greatest value. And the costing programme is more broadly about bringing patient-level information of all types into one place. The simple fact is that the exploration of variation simply hasn't happened to any great degree in the absence of patient-level cost data.

Costing practitioners also point out that many clinicians love the detail of cost data once they get their heads into it, and find it incredibly useful in helping them see how resources are used along patient pathways.

Even finding just one clinical champion can make a huge difference to how costing data is viewed across a trust and – more importantly – how it is used to improve services and value.

• *See Counting on costing, page 12. For more on the Healthcare Costing for Value Institute, see hfma.to/costingforvalue*

counting on costing



New changes to payment models and moves towards system working do not reduce the need for robust patient-level cost data – they increase it. Steve Brown reports from the HFMA costing conference

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Key changes set out in the long-term plan and moves away from activity-based payment do not reduce the need for better cost data in the NHS. In fact, they make the current programme to get all NHS providers compiling and submitting patient-level costs even more important, according to the now joint pricing and costing team at NHS England and NHS Improvement.

Chris Walters, the combined body's director of pricing and costing, told the HFMA Healthcare Costing for Value Institute costing conference in April that good-quality costing underpinned all six of the themes in the long-term plan – from the development of new service models through to the delivery of value.

And despite the significant five-year settlement alongside the plan, improved efficiency would remain a major priority, especially in the light of rising demand, with cost data fundamental to identifying opportunities to drive this efficiency.

The direction of travel spelt out in the operational planning guidance also means a big role for costing, with changes under way to support system working and the introduction of a blended payment model for emergency care services.

Blended payment models – with a fixed payment linked to expected levels of activity and a volume-related element reflecting actual activity – are expected to be used more widely in the coming years for different areas of activity, moving the service away from strict payment by activity approaches.

Pictured, top to bottom: costing conference delegates Steven Wainwright, Naomi Simpson, Chris Walters and Michael Harrison

Increased focus

Over the years, costing has become linked in some people's minds with the activity-based payment system, because cost data is used to set tariff prices. 'But this [move to blended payment and system working] doesn't reduce the need for costing,' Mr Walters said. 'It increases it, as the NHS will need to assess the true cost of care and understand any variation.'

Existing initiatives, such as *Getting it right first time*, NHS RightCare and the Model Hospital, are all keen to replace the existing reference cost data in their models and improvement tools with the more granular patient-level cost data.

Mr Walters said patient-level cost data had already informed work looking at the drivers of performance against the two-week cancer referral target. It was also being used in work around currency redesign, with same-day emergency care tariffs being a priority.

Mr Walters shared a platform with Model Hospital modelling lead Chris Rye and costing lead Jack Hardman. The team acknowledged that being able to look at outcome data alongside patient cost data was 'high on the priority list' and that the cost per weighted activity unit should ultimately be weighted on outcomes.

But even getting patient activity and cost data into one place across the whole patient pathway would be a step towards this.

'Patient-level costing means we can see more of what happened to patients,' said Mr Walters. 'So, we could see things such as a patient coming back in the next day. That gives us a step towards outcomes.'

If current plans with the costing transformation programme – newly renamed simply as National Cost Collections – proceed as planned, in two years the whole of the English NHS could be making a costing submission at patient level, covering all services. Acute trusts face their first mandatory collection this summer, although 80 trusts last year took part in a voluntary submission. Mental health and ambulance trusts will also be required to submit their patient-level costs in 2020, covering 2019/20 costs. And although not yet mandated, it is expected that community providers will join the submission in 2021.

This will give a powerful data source to inform decision-making across integrated care systems as it will enable patient costs to be seen across whole patient journeys, not simply within specific organisations or sectors. Trusts delivering community services perhaps face the biggest challenges in meeting the likely 2021 deadline for submitting costs. For some organisations, these challenges are around incomplete activity data needed to correctly allocate costs to individual patients and the systems to support this – although there are also concerns about whether organisations have the right IT infrastructure in place to support the costing process (see box overleaf).

Gloucestershire Care Services NHS Trust is one of the trusts most advanced in this sector – one of NHS Improvement's roadmap partners helping to test out the costing process. It has made significant progress helped by relatively recent acquisitions of a new clinical and costing system and mobile devices for clinical staff.

Steven Wainwright, trust commercial manager, said the motivation for community trusts was just as strong as for other sectors. 'We want more granularity for our in-house reports and to understand episodes of care,' he said, adding that the lowest cost contacts were not necessarily delivering the best value. Understanding these costs by team and locality was also important.

He said executive level sponsorship was crucial – in Gloucestershire's case, coming from the finance director. But he offered other lessons for trusts embarking on their own programmes. 'Have a strong relationship with your software supplier. Familiarise yourself with the technical documents – there is a lot to get your head around. And identify some quick wins to demonstrate the potential,' he said.

He also warned against looking for perfection. 'If you can get up to 70% right, it is enough to start the cycle of improvement,' he said. He encouraged community providers to get on with the finance ledger to cost ledger mapping, which was a 'lot of work' but was broadly a one-off exercise and crucial to getting accurate cost data.

'Engage stakeholders and share the results early,' he said. 'And it is an iterative process, so the sooner you start the better.'

Collective effort

Getting to the position where all providers are collecting and submitting patient-level costs is a major undertaking. But the point of costing is to use the information to improve decision-making.

Wrightington, Wigan and Leigh NHS Foundation Trust is relatively well advanced in using patient-level data. Its work was recognised last year, when it won the HFMA Costing Award. And the trust's costing team talked the conference through its patient-level costing journey.

Although this started back in 2009 – and the trust has won plaudits in its costing audits – it knew there was room for improvement and in particular targeted better engagement with clinical teams.

Faced with a raft of typical responses – including complaints that

the data was too complicated and concerns about the allocation of overheads – the trust embarked on a major education and awareness-raising exercise.

Gaining executive buy-in to a *Maximising contribution* programme, the team demonstrated how service line reporting, costing and Model Hospital data could be used to identify opportunities for service improvement. Divisional leads were involved in validating the data and this has led to better acceptance of the data and to changes in process – for example, in terms of how theatre time is allocated and the costs used for different prostheses. Checks have also been built into the system to ensure input errors do not lead to meaningless results.

The programme has identified big savings and the cost data has been used in local tariffs to support a joint venture business case and as the basis for challenge on trauma and orthopaedic complex revision prices.

'Engagement is a continual process,' Naomi Simpson, the trust's cost accountant told the conference. 'It is about getting and then keeping people interested.' A recent initiative to support this has seen the creation of a costing club for clinicians and managers to discuss costing.

"If you get even one person in a key role outside costing, that can raise the profile and open doors"
Michael Harrison, Wrightington, Wigan and Leigh NHS Foundation Trust

Michael Harrison, SLR accountant at Wrightington, Wigan and Leigh, added that getting champions for costing can make a difference. 'If you get even one person in a key role outside costing, that can raise the profile and open doors,' he said, urging colleagues to spend more time on engagement and less on fine-tuning the costing model. 'It is about finding the right people who understand the importance of working with the costing team,' he said. 'Persevere until you find them.'

The programme to introduce comprehensive patient-level costing across the English NHS has already been a long slog. And there's still plenty to do before robust costing data exists covering the whole patient pathway. But with the first mandatory collection for acute trusts in 2019, the programme has reached a milestone.

Big challenges still lie ahead in producing comprehensive data that is comparable across organisations and across systems. But the biggest is starting to use the data to inform clinical decision-making and getting this embedded in practice across the service.

The right hardware

NHS England and NHS Improvement (the new, single-organisation name for the formerly separate bodies) is reminding NHS trusts of the importance to review their IT hardware infrastructure to ensure it can meet the requirements placed on it by the new patient-level costing standards.

This year, acute trusts will make their first mandatory submission of patient-level cost data for National Cost Collections, using the national NHS's consistent, centrally set methodology.

An increasing number of trusts have been making voluntary submissions in recent years, but this year's submission – based on 2018/19 cost data for admitted patient care, outpatients and A&E services – will be the first time that all acute trusts have submitted patient-level costs during a mandated submission window. They will be joined by mental health trusts and ambulance trusts next year (for 2019/20 data).

As for community trusts, there is a consultation currently being undertaken with the aim that they will be mandated to make their first submissions in 2021.

In getting to this stage, much of the focus has been on revising local costing processes to align with the new methodology and on the software needed to support these processes.

However, the sheer scale of the new collection process puts a much greater demand on the IT infrastructure, which has traditionally been required by finance teams to prepare and submit reference costs.

'We have six million records for the collection of reference costs across the whole sector,' says Jack Hardman (pictured), costing lead at NHS England and NHS Improvement.

'But now we have a more than ten-fold increase in the data set. For instance, for just 80 acute trusts submitting patient-level cost data last year as part of the voluntary scheme, we have three billion records.'

'There is a significant quantity of data and an increase in the volume of validations we need providers to do to ensure we get the right data quality,' adds fellow costing lead Candice Goold. 'If trusts have not allocated the right hardware to their costing practitioners, it significantly slows down the costing process.'

In some cases, the process of allocating overheads to patient-facing or support cost centres and then on to patients has been taking up to 17 hours.

There have also been reports of costing teams borrowing more powerful computers, or running on multiple computers, to enable the process to be run.

The problems are perceived to be with both computers and servers.

NHS England and NHS Improvement appreciates that capital funds are currently in short supply and that this makes it challenging to invest in the necessary IT infrastructure to be able to meet the mandatory submission requirements.

However, Mr Hardman says that trusts can expect a good return on their investment.

'I'm working with one organisation currently that has invested less than £1m and has found £4m of recurrent savings,' he says. 'Organisations need to consider the opportunities to invest to save.'

These savings come from the ability to embed the use of patient-level cost data across the organisation. 'If you can't run the costing processes quickly and accurately – for example the 17-hour model – then an organisation is not going to ask you to run the data monthly,' Mr Hardman adds.

This might leave organisations looking at patient cost data on a yearly basis, long after it has lost its patient-specific meaning to clinicians who can use up-to-date granular data to optimise pathways.

Mrs Goold believes that the biggest concern now is the community sector. 'Many community trusts may not have the hardware available to collect the data,' she says. 'The need to comply with – and to benefit from – costing requirements is likely to be coming down the road really quickly.'

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Track and trace

With its demonstrator programme officially wrapping up last year, the government is keen that Scan4Safety is adopted by all trusts in England. Seamus Ward reports

Barcodes are so common that they tend to go unnoticed. But step into some hospitals in England and you might see a piece of laminated paper with a barcode stuck to a wall, MRI scanner or tray of surgical instruments.

Staff IDs, and even patients' wristbands, may include a barcode. Originally conceived as a procurement project that would help track supplies – and when they should be reordered – the introduction of simple barcodes promises to deliver much more for the NHS. It could prove to be a rich vein of information about all that happens in a hospital.

Since 2016, this programme – Scan4Safety (S4S) – has enabled six demonstrator trusts to aim for benefits ranging from reduced procurement costs to increased patient safety.

Heart of the system

At its heart is a relatively simple, procurement-only system. A clinician will read the barcode on a product using a hand-held scanner, automatically informing the trust's inventory management system, which records the product's use and checks stock levels. If stock is below a set threshold, the item can be automatically reordered. Mandated e-procurement standards, based on the GS1 barcode system and PEPPOL messaging standards, will mean ordering will be online, reducing transaction costs.

Automating the whole purchase-to-pay process would further reduce costs. But greater potential benefits have been explored by the demonstrator sites. If the clinician also scanned the barcode on their name tag, the one on the patient's wristband and the GLN (global location number) on the wall, the trust would know the clinician, patient and location of the treatment, and the products used.

Some of the demonstrator sites have also introduced barcodes linked to OPCS codes, recording the procedure that has taken place. This data can, in turn, flow through to informatics and finance systems as the basis for patient-level costing.

Given these benefits, health and social care secretary Matt Hancock believes S4S is a key element in expanding the use of technology to deliver a more efficient health service.

In February, Mr Hancock backed S4S in a speech to the Royal Society of Medicine. 'I want to see this taken up by the entire acute sector. We can have the most advanced tech, but we won't see the benefits unless we have real interoperability.

'So, staff have to make scanning a routine part of their working day. It takes seconds, but saves hours. If adopted across the NHS, the time saved would equate to almost 400 extra nurses.'

NHSX, the Department of Health and Social Care's new unit overseeing the health secretary's tech vision – setting common standards, reforming the procurement of technology and developing best practice – takes responsibility for S4S from 1 May.

"I want to see S4S taken up by the entire acute sector... Staff have to make scanning a routine part of their working day. It takes seconds, but saves hours"
Matt Hancock, health secretary

Demonstrator sites

- North Tees and Hartlepool NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- University Hospitals of Derby and Burton NHS Foundation Trust
- Salisbury NHS Foundation Trust
- University Hospitals Plymouth NHS Trust
- Royal Cornwall Hospitals NHS Trust

The S4S demonstrator programme formally ended last summer, but the Department says the six demonstrator sites have continued to build on their work. Examples of this include:

- The development of an app that uses barcode location identifiers to navigate around a hospital
- Blood transfusion tracking
- RFID tracking of medical records and mobile medical equipment
- Safety alerts from ophthalmology systems
- Standardised and automated data fed into registries such as the National Joint Registry.

Much of the safety focus to date has been on giving the NHS the means to trace a prosthesis, for example, that has been found faulty.

There is a drive to use barcode scanned data to prevent never events. Last year, a Healthcare Safety Investigation Branch report on the use of an incorrect prosthesis recommended barcode scanning as a way of reducing risk. The Department has accepted this.

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Glen Hodgson, GS1 UK's head of healthcare, says barcodes can contribute to removing unwarranted variations, improving patient safety and generating efficiencies. 'We now have senior level support that gives cover to directors of finance to get on and do this. Two or three years ago everyone thought it was a good idea, but wanted to see the clinical benefits. Not unreasonably, they wanted evidence. The evidence shows error rates in the dispensing of medicines were reduced.'

In one Dutch study, use of GS1 barcodes and other technologies led to a 76% fall in dispensing errors. Closer to home, some trusts are combining barcode scanning and clinical decision software to reduce the incidence of misplaced gastronasal tubes (where they are accidentally placed in the trachea rather than the oesophagus).

From April, GS1 has a new five-year contract with the NHS, allowing trusts to use the GS1 barcodes and access the global GLN registry. Mr Hodgson adds: 'GS1 standards support identification of people, products and place – the person includes patients and staff; the products are assets employed,

Alternative approach

Inspired by the use of GS1 technology at pioneers such as the Royal Derby Hospital and the level of automation at the Jaguar Land Rover factory in Solihull, Hull University Teaching Hospitals NHS Trust chief financial officer Lee Bond (pictured) has championed implementation at his trust.

'Whenever I go into a supermarket or factory, I see automation that far surpasses anything in the NHS. The technology underpinning this is heavily based on the use of barcodes and therefore GS1,' he says.

With no central funding available for non-demonstrator sites, Hull decided to fund its own GS1-based programme, spending £300,000 a year on a programme and full-time programme director.

'We put in a small amount of money and bought the Genesis inventory management system. We're doing it on a bit of a shoestring, but progressing well,' he says.

The trust approached implementation in a different way to other pioneers. Instead of placing the initial focus on theatres, in the first instance it introduced barcodes into a single patient pathway – cardiothoracic care. 'We've implemented not just in theatres, but in everything, including intensive care, central sterile services, anaesthetics, perfusion, even the mortuary,' Mr Bond says.

The implementation has included the roll-out of patient wristbands, staff barcodes, procedural barcodes (which incorporates the OPCS national coding) and GLNs, giving the trust information on location and total resources involved in that patient's episode of care.

'It gives us such a rich mine of information. We can follow the patient pathway through the hospital. It's early days, but people are asking what we can use it for beyond giving us information that's credible.

'As well as the potential quality and safety improvements, there could be significant financial implications in terms of efficiency as it's enabling me to have a conversation with clinicians that I've never had before concerning variation.'

He has a 'long shopping list' of ideas – nurses are asking if it could be used to measure activity, with the information then being used to redesign the skill mix on a ward.

The trust has an 18-month road map to implement the barcode technology beyond cardiothoracic services, starting with cardiology. Central funding would allow Mr Bond to roll out the programme further and more quickly.

'My only regret is that I can't do it quicker. The centre keeps saying there are huge benefits from the introduction of this technology – and intuitively I feel that this will be the case. However, it is frustrating that no central funding has been made available other than that which went to the original demonstrator trusts.'

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including medical devices, pharmaceuticals and IV pumps; and place records where the care happens,' he adds. 'I was shocked by how few trusts have proper inventory management systems. Apart from the reduction in wastage, the savings from reducing stock to 19 or 20 days are phenomenal.'

S4S is expected to generate more than £1bn in efficiency savings in seven years. But how do these savings break down?

A Department spokesperson says the benefits are best understood in three categories: patient safety, clinical productivity and supply chain efficiency. The six demonstrator sites are realising and/or forecasting a number of benefits.

These include: near real-time track, trace and recall of faulty products and affected patients; one-off reductions of inventory levels; and recurring efficiency benefits, including return of time equivalent to 392 nurses to patient care. In addition, accurate analysis of patient level costing is helping to reduce variation.

'The anticipated financial benefits of Scan4Safety are a mixture of efficiency and cash-releasing benefits,' the spokesperson says. 'The bulk of the cash-releasing benefits are due to a reduction of inventory levels in trusts. The savings are a combination of efficiency and cash releasing savings. It is expected that the benefits will be retained within each hospital to support improvement in patient care.'

PEPPOL key to success

The adoption of PEPPOL (pan European public procurement online) standards is key to the success of S4S and the wider ambition to automate core transactional services, such as invoice processing and payment. Essentially, PEPPOL acts as a go-between, ensuring different computer systems can share information – between trusts, a trust and supplier or a national registry, for example.

The Department says: 'The implementation of PEPPOL was initially mandated by the publication of the NHS e-procurement strategy in 2014. Scan4Safety is the programme of work to implement the standards mandated in the NHS e-procurement strategy, including PEPPOL. So, S4S has played a leading role to date in driving PEPPOL adoption in the NHS.'

The Department's assessment of the impact of the S4S programme is expected to be published soon. While the Department may use its report to urge trusts to roll out the programme across England, there could be one major barrier – funding.

The Department has told *Healthcare Finance* that trusts will have to find their own money to fund S4S implementation.

'The model employed for roll-out of Scan4Safety will be different from the demonstrator phase and trusts will be expected to self-fund this activity. The proven financial and efficiency benefits of Scan4Safety deliver a return on investment for trusts implementing the programme,' its spokesperson says.

Some trusts are self-funding their implementation (*see Alternative approach, previous page*), while others have secured finance through the global digital exemplars scheme and sustainability and transformation partnership-wide IT funding from NHS England.

Mr Hodgson believes trusts will take the lead in paying for systems. 'It will be a pull rather than a push,' he says. 'We have the mandate written into the standard contract for providers and suppliers to be GS1-compliant by 2020/21.

'It's fair to say that many trusts will be waiting to see what happens, but if I were a senior trust manager, I'd introduce wristband identification for patients. It's a minimal cost.'

Trusts are mandated to implement e-procurement. In most cases it will not be subsidised, but the Department believes the potential benefits not only in efficient procurement but also from wider uses of the data – including safety, quality and a richer picture of the patient journey – outweigh the costs to individual trusts.

Cornwall's journey

The Royal Cornwall Hospitals NHS Trust is starting to see the benefits of its Scan4Safety (S4S) programme. The trust is one of the six demonstrator sites chosen in 2016 and has introduced the programme in a number of clinical areas across the trust.

Its procurement inventory manager, Stavros Ballas (pictured), says the first step after being chosen for S4S was to get control of its inventory. 'We found we were over-stocked and not really looking at waste. Everything was hand-written, so accessing records was time-consuming and it was difficult to know what we had. Clinicians, ward and theatre managers were spending time managing and ordering stock.'

The trust invested in a catalogue management system and PEPPOL exchange from GHX, together with the Ingenica inventory management system, which introduced GS1 barcodes for supplies.

'We can now track our stock from the point of ordering to the point of use,' says Mr Ballas.

Trust chief procurement officer James Leaver says good inventory management is key. 'You couldn't do Scan4Safety without knowing your inventory. People in the NHS didn't understand the benefits of having a good inventory management system. However, Scan4Safety is the lever that's enabled us to show inventory management is a strategic programme of work.'

Mr Ballas says the trust has seen a 15% reduction in expenditure for the areas using the system and is aiming to reduce waste by 50% over three years.

The project is also freeing up clinical time and can trace a recalled implant in seconds. The system has other safety features, including alerting a clinician that a product has expired.

Future developments could include steps to prevent never events.

Patient-level costing is more accurate – clinicians can scan the patient, the location and 80% of the products used (a value is assigned to the other 20%, which are mostly commonly used, lower value items).

Barcodes for the OPCS code and consultant are also logged, giving a fuller picture.

Mr Leaver adds that S4S began as a safety initiative, but has produced many beneficial spin-offs. And while it is tempting to push on to gain these additional benefits, he says it is important to get the basics in place first.

For example, the trust is beginning to see the benefits of end-to-end automated procurement. But first it had to agree stock levels and establish clear schemes of delegation. Agreed stock levels allow automatic reordering, while new schemes of delegation ensure a relatively seamless procurement process with little human intervention.

Previously, an order would have gone through a cumbersome approval process before being sent to the supplier. Mr Leaver says: 'It is now a full, end-to-end e-procurement system and it frees up my staff to perform more value-added work, such as negotiating with suppliers.

'We are seeing some of the benefits of S4S, though we won't see it fully until the system is implemented in full. We are still on that journey, but we can see the benefits it will bring.'

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keeping out of the red

The most recent figures suggest that NHS providers were on course to overspend on agency staff in 2018/19 compared with their collective ceiling. Are there still more costs that can be taken out of this temporary staffing budget? Steve Brown reports

The NHS in England has undeniably made huge strides forward in reducing its spending on expensive agency staff over recent years. When work began in 2015/16, costs were at an unhealthy 7.2% of overall pay costs and peaked shortly after at 8.2%. Since April 2017, agency costs have been below 5%.

But with the recent forecasts suggesting providers were on course to overspend their centrally set agency ceiling by up to £300m in 2018/19, has the service reached the end of the road in terms of temporary staff cost reductions?

NHS Improvement's quarter three report showed that actual spending on agency staff was £1.8bn over the first nine months of the year – £139m ahead of the ceiling set by the oversight body. Providers collectively forecast an outturn expenditure of £2.37bn against the full year ceiling of £2.2bn.

In fact, the Q3 report warned that the overspend would be between £200m and £300m by year end. At that level, spending would match the 2017/18 outturn and the overspend would be close to the amount by which the ceiling was lowered.

More than 130 trusts were spending above their ceiling at Q3, according to ratings in the single oversight framework, with 32 trusts overspending by 50% or more.

So, was NHS Improvement too optimistic in lowering the 2018/19 ceiling? Dominic Raymont, deputy director of agency intelligence at NHS England and NHS Improvement, says not.

'2019/20 will be the fourth year of ceilings. In years one and two, the ceilings were identical and it took until year two to hit the frozen ceiling. Having lowered the ceiling for year three, we've frozen it again in year four and we will work with trusts to achieve the ceiling this year.'

Mr Raymont also stresses that the overspend in 2018/19 is down to volume, not rates. Trusts have booked 6%-7% more agency shifts despite plans to reduce them compared with 2017/18. But average prices per shift have fallen by 6%.

The Q3 report provides ample evidence of the pressures driving this volume – A&E attendances up 4.3%, non-elective admissions up 5.4%, elective admissions up 0.7% and first outpatient attendances up 2.1%.

Agenda for Change has contributed to the increase in spending too as agency rates have seen a parallel increase in price caps, although agency commission and framework fees were frozen.

In the face of such pressures, Mr Raymont, says trusts continue to do well in bearing down on agency costs.

Compared with that 8% high a few years ago, agency costs for the first three quarters stood at 4.4% of total pay costs and were forecast to end the year at 4.3% of total pay costs.

And Mr Raymont is confident that variation between trusts means that agency spending can be reduced further. Compared with that average of 4.4%, agency costs as a proportion of total pay range from

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practically zero to 14% – with about 10% of trusts being around double the national average or more.

NHS Improvement says there are still some national issues that need to be tackled – including spend on the lower profile use of administrative and non-clinical temporary staff. But beyond that it is about helping some trusts to fix entrenched local factors.

In some ways, he says the big global changes have been put in place – framework rules and rate and price caps. But now there is 'different work to be done'. This could mean helping trusts with geographical challenges – difficulty to recruit to some positions in some areas not only increases demand for temporary staff, it also suggests it may be difficult to find temporary staff for those positions at a sustainable price.

Another issue for some trusts is dealing with long-term temporary staff. There are still lots of trusts with long-serving agency staff, says Mr Raymont – in the most extreme cases these have been in place for years. 'A lot of trusts have used our list of the top 10 highest rates paid each week to negotiate different rates or even move them onto bank or to substantive roles,' he says.

There is now a rich data set in most trusts to support such work and Mr Raymont wants all temporary workforce teams to use this data more proactively. Consultancy Liaison's *Taking the temperature* reports track the NHS's use of locum doctors. The latest puts the projected annual cost of the top 10 highest earning locums in Q3 – working time equal to 16 whole-time equivalents – at £3.7m. Used differently, this could pay the salaries of 42 full-time substantive consultants. Reflecting NHS Improvement's point, all of these locums had worked consecutively for six months or more and eight had been in post for more than a year.

Some areas still need help establishing or expanding their staff banks too and could learn from good practice across the NHS. At Q3, bank spending was forecast to hit £3.3bn for the full year, £486m (17.5%) over plan and £291m (10%) ahead of last year's outturn spend. The rise in bank spending in recent years is seen as a success story – its growth avoids the more expensive use of agency staff.

The best way to avoid temporary staff costs overall would be to fill the 100,000-plus vacancies in the service. But while longer term solutions are put in place to improve the availability of appropriately qualified staff to fill substantive positions, banks will continue to play a major role.

The focus for the past two years has been primarily on medical staff banks – fewer trusts had medical staff banks compared with nursing banks. However, by January 2018, 94% of trusts had a medical bank in place or under development and the attention has turned to increasing the effectiveness of these banks.

There has already been some noticeable improvement. On average in 2018/19, 38% of medical temporary staffing shifts went through bank rather than agency – an increase from around one in four shifts in 2017 to more than one in three in the latest year. NHS England and NHS Improvement hope to make more progress on this in 2019/20, informed by a series of pilots – a report on which is due shortly.

Key lessons

Some key messages have already emerged from organisations running successful medical banks. For example, they should be set up on the principle that medical banks are primarily a quality initiative, not a cost-reduction one – with employed staff likely to be delivering a more consistent, better quality service than agency staff. It can be useful to give bank staff first pick of available shifts ahead of agency staff and to accommodate deployment preferences.

Weekly pay and pay commensurate with the agency offer once benefits-in-kind are taken into account can also be important. And enabling doctors to book shifts via smartphones is another key factor.

There are also opportunities to develop staff banks for non-clinical and administrative staff. Medical secretaries and ward clerks have long been provided through banks, but NHS Improvement thinks this could be widened – perhaps particularly for estates staff, where shift work is more likely to be a feature of services such as cleaning and portering.

Reducing agency costs for these non-clinical roles has become the

Controlling costs in the face of rising demand

Nottingham University Hospitals NHS Trust, like many acute providers, has had a difficult year in 2018/19, with significant financial pressure linked to higher than anticipated demand. A March board paper forecast the trust would deliver a deficit of £40m, £48m the wrong side of its £8m post-provider sustainability surplus control total.

The deficit has been driven by overspends on pay and non-pay, which have resulted in the trust missing its control total and so not receiving PSF income. But regardless of this difficult financial climate and, in particular, significant demand on its emergency department, the trust has continued to keep a check on its agency costs.

After 11 months of the year, the trust's spending on agency was £1.6m under its agency spending cap. An agency to total pay ratio of 2.6% is lower than the previous year (3%) and well below the national average of more than 4%. At the same time, the trust recently received an 'outstanding' rating for caring as part of its overall 'good' rating from the Care Quality Commission.

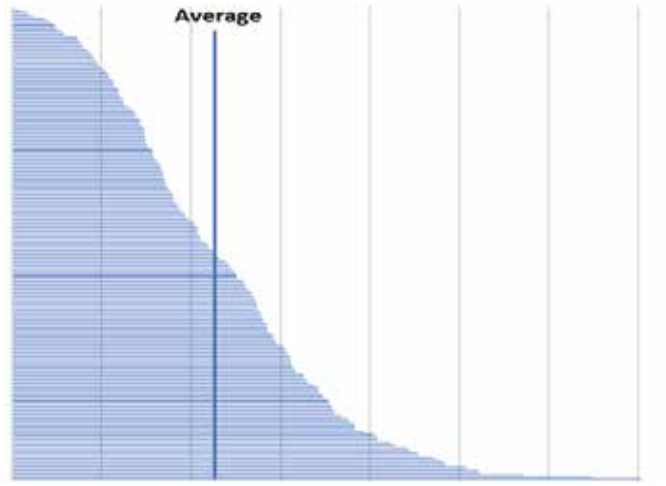
Duncan Orme (left), the trust's operational finance director, singles out two initiatives that have helped. 'We've tiered our suppliers of agency staff to try to manage them to be within the rates cap,' he says. 'We've adopted a win-win approach – if they come in line we give them line of sight of the shifts that need filling. Second is the effective elimination of agencies for healthcare assistants. We promote the use of our internal bank and have taken a proactive approach to developing clinical support workers and recruiting locally.'

The vast majority of general nursing shifts are now within the capped rates. 'We used to report hundreds of [non-compliant] shifts, but we are now down to 20 per week or so,' says Lissa Anderson, finance manager providing support to the chief nurse Mandie Sunderland's team. The few occasions when the trust does have to 'break glass' to exceed the rates tend to be for specialist paediatric or critical care nurses. 'We don't break glass for general registered nursing use any more,' she says.

With an outsourced bank service, provided by NHS Professionals, bank staff can book and manage shifts via their smartphones and the trust has introduced a weekly payroll option for its most pressured areas – including junior doctors and emergency department nurses. Can the trust continue to control its agency staff costs in the current climate? 'Our main focus going forward is how we can afford safer staffing models of care within a tariff set on lower staffing levels,' says Mr Orme.

There needs to be complete transparency on what is needed to deliver safer staffing levels and then the trust must focus on its average length of stay and optimising flow.

Month 9 2018/19: Percentage of agency spend to total paybill (one line per trust)



SOURCE: NHS IMPROVEMENT

latest focus for NHS Improvement. Agency workers in non-clinical and unregistered clinical roles – including healthcare assistants, administration, estates and some allied health professionals – currently consume around one-quarter of the total agency spend by trusts.

New proposals, which were consulted on in February and March, look to bring these costs down, by introducing specific restrictions over and above the existing rules set for all agency staff. These are seen by NHS Improvement as the last piece in the jigsaw of national measures to reduce agency spending. If the proposals go ahead, trusts would be required to use only on-framework agencies for shifts involving these staff. Most already do this – but about 37 trusts have been going off-framework in these areas and are responsible collectively for about £7m or 5% of total off-framework spend. (A typical off-framework nursing shift costs nearly 14% more than an average on-framework one.)

'For nursing, trusts can go off-framework using break-glass procedures if it is a safety issue,' says Cathy Cawston, head of temporary staffing policy at NHS England and NHS Improvement. 'But you can't make that argument as much for admin roles. We've seen finance staff bought off-framework. Is that what the break-glass proposals are for? We don't think so.'

It is more of a change of emphasis than a new rule, she says. 'The rule has always existed, but we will be monitoring and enforcing it much more closely than we've done in the past.'

A second proposal would restrict the use of admin and estates agency staff – currently £223m or 9% of total agency spend. Specific admin agency ceilings are being introduced in 2019/20, alongside proposals requiring trusts to use bank or substantive/fixed-term contracts to fill admin shifts, with exceptions for special projects and clinical coding, for instance.

The message is clear. Reducing agency staff spending is getting harder now that price caps are embedded and more widely adhered to. And volume and activity increases have made the challenge even harder, with safe services being the overriding priority.

Even so, more can be done both in maintaining and improving on existing performance and governance arrangements and in addressing the wide variation that still exists across the country.

Harnessing economics

Despite a recent promised £20bn boost, the NHS continues to face significant financial challenges. The need to maximise the impact of every penny has contributed to a rise in the demand for specialist input from health economists to directly support commissioning.

Health economists use advanced forecasting and modelling techniques with NHS data sets to explore cause-and-effect relationships, predict future demand and account for uncertainty in business proposals.

The convergence with finance is clear; delivering the best outcomes for patients in an environment of conflicting priorities and finite resource is the business of health economists and finance experts working collaboratively.

Most NHS business cases will make the case for change by contrasting a modelled 'do nothing scenario' with the monetary effect resulting from an intervention.

Baseline data is projected over time, using a set of assumptions to determine expected outputs in a number of scenarios. In other words, no randomness is incorporated.

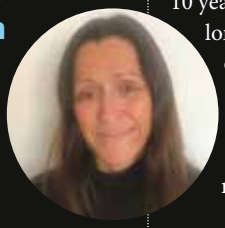
Health economics expertise can strengthen a business case by incorporating estimates from critically appraised health literature and making the models randomly generated.

A probability curve showing outcomes and their likelihood can be plotted to account for expected outputs under multiple scenarios. These enhanced financial models will reflect a truer picture of plausible outcomes derived from implementing a new initiative or model of care. And, once the initiative is in place, health economists can use advanced modelling to isolate its effects and assess its impact.

The health economist's toolbox is broad; they use advanced analytics techniques, such as econometric modelling, accounting for factors that aren't traditionally incorporated into business planning within the NHS. Clinical engagement also plays a significant role, particularly when planning new services.

For example, Arden and Greater East Midlands Commissioning Support Unit supported the development of a business case to fund a clinic for cascade testing to detect familial hypercholesterolaemia, a rare genetic disorder. By working closely with clinicians using multiple data flows, and reviewing health economic literature to incorporate likely estimates into the model assumptions, we were able to compute expected patient outcomes.

The ongoing need to maximise value from limited resources and moves towards population health management mean a bigger role for health economists, argues Ana Ohde (pictured)



This enabled us to confidently identify that nine lives would be saved within five years and 116 adverse events (angina, stroke and so on) would be avoided if the clinic were set up.

Contract analysis

Health economics has multiple applications. We are often asked to produce impartial evidence during contractual disputes or clarify whether sudden changes fall within tolerance limits. Our methods follow scientific enquiry principles, and results are framed as such.

We recently conducted econometric modelling using NHS observational data to examine the effect of health, demography and other relevant factors on the A&E conversion rates in a sustainability and transformation partnership. We computed the marginal effects of having an attendance in a particular acute trust and found that high levels of deprivation alone did not account for higher A&E attendances than neighbouring trusts, as had been suggested.

We use intervention analysis to assess the effect of an unexpected or sudden external factor (such as a change in coding practices pushing up prices) to assess if observed changes are within expectation in trends based on a single attribute. Although often perceived as complex, this mathematically driven analysis gives precise results and is very effective.

Preventative care

The *NHS long-term plan* sets out ambitions to use population health analytics to develop more targeted, preventative health interventions, which will be vital to the sustainability of the NHS.

Realistically, commissioners must accept they are unlikely to see the true value of preventative healthcare for at least five to 10 years – and often much later in terms of long-term outcomes, such as healthy life expectancy. This means it is even more important that decisions are robust and that clear expectations are set out for when return on investment can realistically be delivered.

Population health management brings imperatives into commissioning: moving towards value-based commissioning; understanding how the determinants of health impact on health outcomes with the aim of reducing health inequalities; and using integrated data sets that capture the care continuum for planning purposes.

The measurement and interpretation of health outcomes and their association with the determinants of health, the analysis of healthcare consumption by different populations and its complex association all are topics studied by health economists.

Commissioning organisations increasingly realise health economics need no longer be confined to academia and has practical applications in the planning process. As economists, we have a role in bridging the gap between research and commissioning, deploying an analytic toolkit to support some of the NHS's most ambitious programmes.

The interest in health economics is growing, with integrated care systems requiring the analysis of much broader data sets, so we can start to segment the population, planning services around groups with similar needs. As the challenges become more complex and demand grows, the benefits of a more scientific approach to analysing data and modelling potential outcomes will become clear.

Ana Ohde is senior health economist at NHS Arden and Greater East Midlands Commissioning Support Unit

hfma
professional lives
Events, people and support for finance practitioners

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Association unconvinced by need for new capital spending limits for FTs

Technical

The HFMA is not convinced that setting spending limits for foundation trusts is the solution to managing scarce capital resources across the healthcare system in England.

The association disagreed with the proposal as part of its response to the NHS England and NHS Improvement consultation on possible legislative changes to support the *NHS long-term plan*. The system leaders' argument for the change is that a more co-ordinated and collaborative approach is needed to planning capital investment.

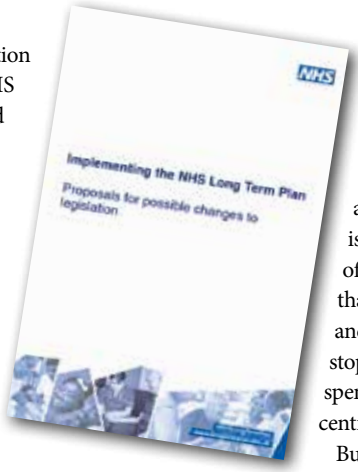
There are currently no mechanisms to set capital spending for foundation trusts – they are free to use their internally generated resources or borrow to fund capital programmes.

As the Department of Health and Social Care (DHSC) pointed out in its annual report and accounts for 2017/18, the £0.4bn underspend against the capital departmental expenditure limit 'arose predominantly due to NHS providers' capital spend being significantly lower than they planned and forecast'.

However, according to the consultation document, the lack of foundation trust limits 'leads to situations where, because of uncertainty or unpredictability associated with capital spending by foundation trusts, it becomes necessary to constrain or delay capital spending by non-foundation trusts that may be more urgent or address higher priority needs'.

It added that this limits the centre's ability to work with health systems to improve capital planning and it increases the risk that the DHSC and the NHS collectively could exceed the limits prescribed by Parliament.

NHS England and NHS Improvement acknowledged that the ability to build up reserves for capital projects is viewed as a 'helpful freedom'. But they said that the power to set annual spending limits for foundation trusts – which already exist for NHS trusts – would need to be exercised carefully. And foundation trusts would not ultimately be prevented from using reserves to support capital investment; rather, it would just be the timing of such investments that could be affected.



The HFMA's response to the consultation disagreed with the proposed change on the grounds that spending limits only addressed one part of the problem and may not necessarily avoid the underspend incurred against CDEL in 2017/18, which resulted in much-needed resource lost to the NHS.

The association acknowledged that there is 'a dwindling number of NHS foundation trusts that have internal resources' and spending limits would stop these providers from spending them without central approval.

But it stated that the key constraint for many provider bodies was simply access to resources to support capital projects.

'We would be more supportive of the extension of NHS Improvement's powers if it was linked to the availability of funding so that capital programmes can be delivered on a timely basis,' its response said.

The association also queried whether a change in legislation was even needed to develop agreed annual capital spending limits for foundation trusts. The current control total arrangements operate alongside the existing legislative regime and neither NHS trusts nor foundation trusts have a revenue resource limit, it pointed out.

The HFMA did not comment on incentive schemes used in the last two years encouraging surplus trusts to commit to increased surplus levels in return for additional bonuses from unallocated sustainability funds at year end.

However, there have been comments elsewhere about the tension between one policy initiative that enables trusts to increase surpluses that could be used for capital programmes in subsequent years and a separate policy initiative that seeks to limit the flexibility of when these reserves can be used.

HFMA on legislation

- The HFMA backed proposals to remove the **Competition and Market Authority** function to review mergers involving foundation trusts. It said the introduction of integrated care systems meant that competition was no longer the mechanism used to drive improvements in care.
- The association agreed with proposals to relax procurement requirements when commissioners are putting services in place. However it raised concerns about the proposed new **best value test** that commissioners would be subject to. More details were needed about how this might operate.
- The association also strongly supported proposals to enable **adjustments to tariff** provisions to be made within a tariff period (subject to consultation). This would be particularly important when a multi-year tariff is set.

Technical review

The past month's key technical developments

Technical

NHS England and NHS Improvement have published patient-level **cost collection guidance for ambulance trusts** covering 2018/19. The guidance is for ambulance trusts that have volunteered to implement the patient-level costing standards this year. Next year – in 2020, covering cost data for the 2019/20 year – all ambulance trusts will be required to make a submission. All ambulance trusts will also continue to submit reference costs in 2019 as part of the National Cost Collections. A data validation tool update is due to be released in May and the collection window will open in August, with collection feedback and lessons learned shared from the autumn. Activity and financial data should be submitted for all incidents going through 999 call centres or dispatch centres. The collection will include activity by: third party providers; hazard area response teams; medical emergency response incident teams; healthcare professionals; and air ambulance responses (staff only). http://hfma.to/94

NHS finance staff with an NHS email address have been offered free access to the EY Atlas portal, procured through the Technical Accounting Centre of Excellence for the next two years The tool allows access to **technical accounting guidance**, thought leadership, reference materials and tools from EY's assurance, tax, transaction and advisory service lines, and accounting standards. The *Financial reporting manual* and *Group accounting manual* will remain the main sources of guidance, but the hub provides useful supporting material. To access, email DFinStrat-TechnicalAccountingCOE@mod.gov.uk, copying in other colleagues who would value access, and the hub will arrange access with EY.

The local t**ariff variations template** has been simplified for 2019/20. NHS Improvement said the updated template concentrates on the key information needed to guide future price development and understand how providers and commissioners are working together.

Local variations are adjustments to a national price or currency for a nationally priced service agreed by commissioners and providers. Variations could include payments based on agreed activity with a gain and loss share mechanism or a whole population budget. Commissioners should complete the template by 30 June. http://hfma.to/95

The Department of Health and Social Care has issued guidance on the administration of **overseas patient debt** and data sharing. The document includes information on reasons for supplying debtor information to the Home Office; the information that should be shared and how it will be used; how to inform the patient; and repayment plans. The Department also published guidance on the information patients are entitled to receive under the *General Data Protection Regulation 2016* and the *Data Protection Act 2018*. http://hfma.to/96

A reference guide setting out the definitions of different types of fraud has been launched by the NHS Counter Fraud Agency. The classifications in the document are already used by the **counter fraud** agency. The agency said the guide will be expanded during this financial year, including providing fraud prevention advice and awareness resources. http://hfma.to/97

Trusts' 2017/18 **reference cost benchmarking tool** and associated guidance are now available on the trust planning portal. The tool uses the latest reference cost data and highlights areas of potential financial efficiency opportunities. NHS Improvement added that the tool will also allow trusts to evaluate their reference costs to improve costing in future collections.

Relapsed multiple myeloma treatment

Technical: NICE

As NICE celebrates its 20th anniversary, April saw the publication of five technology appraisals, bringing the cumulative total of technology appraisals published to 577.

TA573 recommends daratumumab with bortezomib and dexamethasone for use within the cancer drugs fund (CDF) as an option for treating relapsed multiple myeloma in people who have had one previous treatment. It is estimated that around 2,700 people per year with multiple myeloma who have received at least one prior therapy are eligible for treatment. Costs for this technology will be funded from the CDF.

TA574 and TA575 recommend two further technologies (certolizumab pegol and tildrakizumab respectively) for treating moderate to severe plaque psoriasis. Around 17,500 people are thought to be eligible for treatment with these drugs. Costs associated with these two technologies are not expected to be significant.

TA577 recommends brentuximab vedotin as an option for treating CD30-positive cutaneous T-cell lymphoma (CTCL) after at least one systemic therapy in adults. It is estimated that 90 people with CTCL are eligible for treatment with brentuximab vedotin and that 80 people will have this technology from year 2020/21 onwards once uptake has reached 90%.

Four guidelines were also published in April. Of these, only one is expected to lead to significant costs or savings as a result of implementation. NG123 *Urinary incontinence and pelvic organ prolapse in women: management* recommends offering an annual review for women using absorbent containment products. This could potentially lead to a significant resource impact and a template has been published to help organisations assess the potential resource impact at a local level.

Gary Shield is resource impact assessment manager at NICE

NHS in numbers

A closer look at the data behind NHS finance

Healthcare across the UK

Technical

Since 1999, devolution to Scotland, Wales and Northern Ireland means that decisions about health services in the four UK nations are taken by the respective governments.

Scotland, Wales and Northern Ireland receive block grants from the UK government to fund spending on public services.

Year-to-year changes to these block grants are largely determined by the Barnett formula, which was originally devised in the late 1970s as a short-term measure to support budget negotiations.

However, the starting point for these block grants was the historical level of spending on public services.

The Barnett formula calculates the changes to these block grants so that they reflect increases in spending on relevant services in England proportional to the size of population, and taking account of whether the spending is all on services that are devolved.

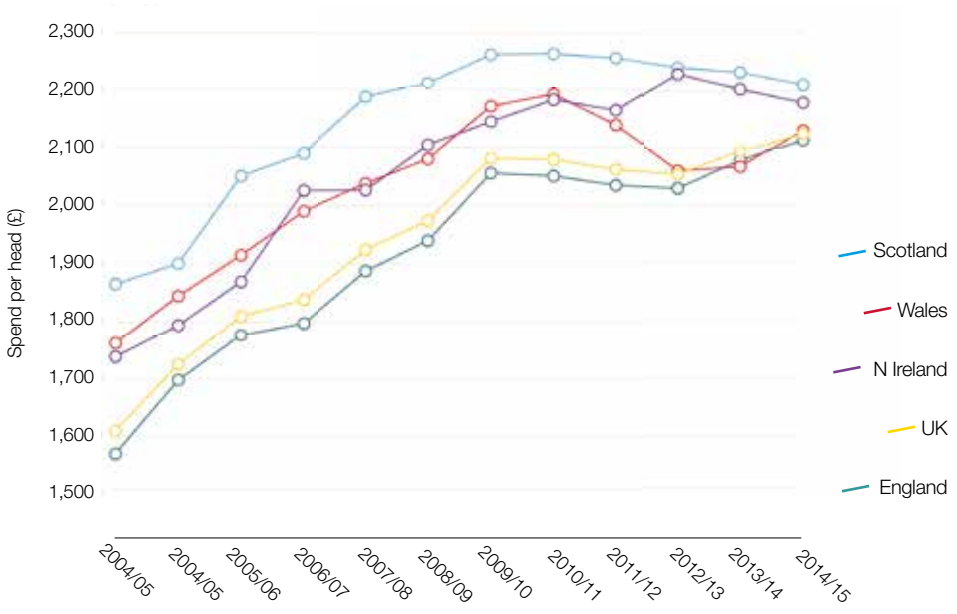
An Institute for Fiscal Studies paper gives the following example: 'If the UK government announces a £100m increase in Department of Health spending, if 99% of that department's budget is spending in England on responsibilities that are devolved to Scotland, and if Scotland's population is 10% of England's, then the Scottish government's budget would increase by £9.9m.'

While original block contracts may have been set on the basis of need, annual increases are based on unweighted headcount.

> The National Audit Office concluded in 2012 that no single system in the UK has been consistently more economic, efficient or effective

Identifiable spending on health

Spending in the four countries of the UK per head, 2003/04 to 2014/15



Source: Health Foundation, health.org.uk/fundingexplained

So, over time, in theory, the formula should lead to convergence in spending per head. However, there are other factors at play, including the fact that if Scotland's population relative to England declines, then its overall spending per capita will increase.

While the Barnett formula matches increases in the block grant with increases in spending on relevant services in England, devolved governments can then choose to split their block grant between different spending programmes however they want.

Despite this, a report from the National Audit Office in 2012 – *Healthcare across the UK* – said that since 2005/06, the proportion spent on health by each nation had remained relatively constant at between 18% and 22% of all public spending.

Figures from the Health Foundation (see chart) for 2014/15, illustrate that health spending per head remains highest in Scotland (£2,208) and lowest in England (£2,112).

Clear differences have emerged since devolution in the structures within the devolved nations, with Scotland and Wales ditching all vestiges of the internal market in favour of boards that both plan and deliver services.

There have also been differences in how the different services spend their money. For example, Scotland, Wales and Northern Ireland all have a policy of free prescriptions, although the vast majority of prescribed items in England are exempt from charges. Car parking in Scotland and Wales is also free.

The NAO concluded in 2012 that – looking across a number of indicators including life expectancy, spending, length of stay and emergency admissions – no single system in the UK has been consistently more economic, efficient or effective. And a report by the Nuffield Trust and the Health Foundation in 2014 – *The four health systems of the United Kingdom: how do they compare?* – also concluded that the increasing divergence of policies since devolution was not associated with a matching divergence of performance.

• Relative spending across the UK health systems is extensively covered in the HFMA's level 7 advanced certificate qualification (*Comparative healthcare systems* module).

Flexible benefits

Letsie Tilley, HFMA masters-level tutor
News and views from the HFMA Academy

Training

After working for almost 30 years in NHS senior finance management roles (including 20 as a board-level finance director), I followed my dreams and came to live in the Loire valley of France with my husband. Having retired early, I wanted to work part-time, preferably in a role that would draw on my experience in the NHS.

I have always enthusiastically promoted NHS finance leadership and personal development, including strongly supporting the HFMA. After moving to France, I was fortunate in having been able to continue as an HFMA executive coach by using a combination of face-to-face sessions (during brief visits to the UK), phone calls, emails and Skype conversations.

In April 2016, I was delighted to be given the opportunity to help develop the new HFMA Academy masters-level qualifications. Initially, this began by writing some of the course content and then I went on to become a tutor and module leader on three different modules, which I have really enjoyed doing.

The HFMA qualifications are attractive to a wide range of managers and clinicians at different stages of their careers. They present challenges to learners in different ways, which is partly what makes them so worthwhile.

Those at an earlier stage of their careers may be used to studying, having just finished a professional qualification or degree; but have less knowledge and experience to draw on. Those further along their career pathway may not have studied for a while, so can initially find studying a big step up, but often they have much more knowledge and experience to fall back on.

Studying at masters level tends to be more intense and requires a greater amount of independent study than a first degree or professional accountancy qualification does. It also requires discipline to be able to study regularly each week, while juggling the demands of busy work and home lives.

However, as tutors, we are here to support you, to try and enable you to get the most out of the course. Being able to study online, provides you with greater flexibility around how you approach your studies by enabling you to:

- Avoid having to take time off work or travel long distances to participate
- Study the course material and prepare for discussions at times to suit you
- Participate in academy live sessions (often held in the evening) from the comfort of your own home (wearing what you want, while eating your supper!)
- Watch the academy live sessions again or catch up any time if you miss one, as they are recorded.

> "The qualifications not only support learners in their current roles but also help to prepare them to take advantage of future career opportunities"

Most learners ultimately find that the hard work they put in more than pays off in terms of their own personal development and the opportunities it can bring.

The qualification provides a broader perspective on various aspects of the management and delivery of healthcare and it also challenges preconceived assumptions about healthcare systems by discussing and understanding other points of view.

It builds on and develops existing skills in areas such as critical thinking to improve problem-solving and decision-making abilities. Undertaking relevant independent research extends existing knowledge of business theories, which can be put into practice to enhance effectiveness at work.

Networking with colleagues from different backgrounds and professions and sharing different experiences is also a significant bonus – a benefit that many students have commented favourably on.

All in all, the qualifications not only support learners in their current roles but also help to prepare them to take advantage of future career opportunities. I do hope this encourages you to find out more about the HFMA qualifications and to come and join us on one of our online modules very soon.

• **http://hfma.to/qualification**

Our year in review

Future focused finance

Like everyone in the NHS, we at FFF have spent some time reviewing 2018/19 over the past few weeks, *writes David Ellcock*.

While we haven't had to hit control controls or clear suspense accounts, we have been crunching numbers. We now have over 3,800 subscribers to our newsletter and had 880 new sign-ups to our website during the year. We published 150 blogs and received 69 new finance director declarations. At 31 March, we had 639 value makers and 362 FACEs (finance and clinical educators) committed to helping us achieve our aims. We held 37 events, attended by 1,300 delegates, and ended the year with 68 FFF-accredited organisations.

Thanks to the Finance Leadership Council (FLC), our senior responsible officers and our programme leads, each of whom gives up a great deal of their time to support our work. We'd also like to thank everyone who has contributed to FFF's success in any way whatsoever. Whether you're one of our value makers with a national profile or someone who has quietly pushed our work within your organisation and encouraged others to get involved: thank you.

Finally, we would like to give our thanks to Bob Alexander and Paul Bauman, our two longest serving FLC members, both of whom moved on to new roles during the year. Without their leadership and unstinting efforts since our launch we would not have made the progress we have made.

We will publish our annual report soon. Please keep an eye out for it on our website.

David Ellcock is FFF's programme director

Diary

May
9 (B) South Central and South-West: developing talent (with SDN), Reading
15 (N) Embracing digital technology, London
16 (F) Chair, Non-executive Director and Lay Member: forum, London
21 (N) Webinar: reimagining outpatient services at Homerton (12.30 start)
22 (F) Commissioning Finance: forum, London
22 (I) Institute: the value summit, London
22 (B) Eastern: positive psychology

June
5 (F) Provider Finance: forum, Rochester Row (am)
5 (F) Mental Health Finance: forum, Rochester Row (pm)
5 (N) Webinar: workforce management and the future of nursing (12.30)
13 (B) West Midlands: annual conference, Birmingham
21 (B) Northern: keep stepping, Durham
25 (B) London: annual conference
27-28 (B) North-West: annual conference, Blackpool

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

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

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

November
7 (N) Estates forum, Rochester Row
7-8 (B) Northern: conference
13 (F) Audit conference, London
14-15 (B) East Midlands: conference
14 (F) Commissioning Finance: forum
21-22 (B) Northern Ireland: conference
28 (I) Institute: technical costing update

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

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

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

Events in focus

HFMA summer conference
4 July, Ashton Gate stadium, Bristol

Integration is at the heart of the HFMA summer conference. Reflecting the move to system working in the NHS, it brings together the association's commissioning and provider finance network conferences.

Now in its 15th year, this year's conference, *Connected thinking for the future*, will focus on integration, ill-health prevention and the use of technology in the health service. It 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 Julian Kelly, the joint chief finance officer of NHS England and NHS Improvement, and King's Fund chief analyst Siva Anandaciva (pictured). Others include Tim Kendall, national clinical director of mental health at NHS England and 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 delivering the ambitions of the long-term plan.

Members of the HFMA partner programme can receive discounted rates for this event.

• **To book a place, email josie.baskerville@hfma.org.uk**

CEO Forum
24 September, 110 Rochester Row

The regular HFMA CEO forum offers chief executives and chief accountable officers an opportunity to meet with colleagues and discuss the latest developments in the NHS.

In September, delegates will hear from Dorset Clinical Commissioning Group chief officer Tim Goodson (pictured) about Dorset's journey to becoming an integrated care system. Rob Walsh, North East Lincolnshire Council and North East Lincolnshire Clinical Commissioning Group chief executive, and CCG chair Mark Webb will discuss the move to integration, partnership working and a learning culture. And Natasha Curry, acting deputy director of policy at the Nuffield Trust, will provide an international perspective – looking at what the NHS can learn from the long-term care systems in Japan and Germany. Delegates are also invited to a networking dinner on 23 September.

The forum is free to the chief officers of NHS organisations that have a subscription to any of the HFMA's services.

• **To book a place or check your eligibility, email josie.baskerville@hfma.org.uk**

Putting value centre stage

Association view from Mark Knight, HFMA chief executive

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

My HFMA

The reorganisation of NHS England and NHS Improvement to act as one body brings the NHS one step closer to having a system where real integration can happen. The HFMA is looking forward to working with the new management teams across the country, especially new chief financial officer Julian Kelly.

Constant change has been a feature of my 19 years in and around the service and it hasn't always been welcome. But the new structure will make a lot more sense once accompanied by primary legislation, which should remove some of the structural obstacles to system working.

As healthcare finance professionals, we need to take a leading role in creating real value for the NHS following the financial settlement. Investment falls short of where many people argue it needs to be and yet we need to view the settlement in the context of wider spending decisions across the public services. Many continue to face significant reductions.

It is against this backdrop that the HFMA Healthcare Costing for Value Institute's work comes into sharp focus. We recently held our largest costing conference, with over 240 'costers' in the room; in May we turn to the value side of the equation with a first 'value summit'.

Value the opportunity is our president Bill Gregory's theme this year, so it should be no surprise that he will chair the event. The institute is also involved in other initiatives, such as Future-Focused Finance's best possible value decision-making framework. I hope you've seen something about this – if not, your organisation may not have signed up for membership. I encourage them to do that – it's extraordinarily good value (to coin a phrase).

Our qualification work continues and once again a healthy cohort of students have passed their assignments. We had planned to become an Ofqual awarding body but we've decided our current assessment strategy is suitable at level 7 to enable students to move to an MBA.

HFMA chief executive Mark Knight

Our overriding goal is to become an apprenticeship provider and we hope our level 7 qualification will be supportable using the levy, probably following the senior leaders' standard.

From January 2020 we will offer AAT, ACCA and CIMA level 4 apprenticeships, with the added value of some tailored level 4 content. If you are interested or want to know more, please contact me at **chiefexec@hfma.org.uk**.

Our summer conference will feature a session with author and former Labour government spokesman Alastair Campbell (pictured), and we should also hear from Mr Kelly.

For our annual conference in December, BBC Europe editor Katya Adler will be speaking. Even if Brexit has progressed by then, she should give a fascinating insight into European politics. New NHS chief people officer Prerana Issar has also agreed to speak on the Friday and Lord Carter will talk all things value. With our usual set of 'short talks' and networking, it promises to be a superb event.

Now that the year end is largely out of the way, we can look forward to meeting more often and doing what we do best in this association – associate!

Member news

As a fundraiser for mental health charity Mind, HFMA staff will climb the three highest peaks in the UK in 24 hours in October. The team (pictured l-r) – Steph Zahorodnyj, Georgina Callaghan, Rebecca Aslett, Fleur Sylvester, Carly Price, Richard Sawyer, Jonathan Richards and Alex Chapman (not pictured) – are aiming to raise £5,500. 'We're excited and nervous about the challenge. Knowing that we're doing it for such a good cause will be a great motivator though. Every penny counts towards our target and we'd be grateful for any support our members can give,' said Ms Aslett. To support the team, head to **hfma.to/3peaks**

Nearly all HFMA branches have submitted their business plans and are now looking at their events programmes for the upcoming year. Keep an eye on the HFMA website to find out more: **hfma.to/branches**

Stuart Wayment, skills development network manager at NHS South East, continues his fundraising efforts for Planets Cancer Charity, which

helps patients with pancreatic, liver, colorectal, oesophageal, stomach and neuroendocrine cancer, and funds patient support groups, treatments and research. In April, Mr Wayment undertook a 14km paddle that was expected to start at Totnes and reach the sea via the river Dart, but due to bad weather had to change course – so they went halfway to Duncannon and back. To support him go to **uk.virginmoneygiving.com** and search for 'Stuart Wayment'

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Member benefits

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

Network focus

My HFMA

System Finance Special Interest Group

'We've spent 20 to 30 years building absolutely perfect organisational silos and a culture of competition between NHS organisations. Now if we want to be effective, and provide the best possible care within the resources available, we need to take all these barriers down and think about one system and one budget for that system.'

These are the views of Nigel Foster (pictured), director of finance at Frimley Health NHS Foundation Trust and East Berkshire Clinical Commissioning Group, and member of the HFMA System Finance Special Interest Group.

Mr Foster was keen to get involved with the group to share best practice. 'The group aims to be the expert voice for the HFMA on system finance matters; to support members working in system roles; and advise on system finance matters,' he says.

In March, Mr Foster chaired the *Brighter together* leadership masterclass, which reminded delegates why health and social care systems should work in a more joined up way. 'We're not doing this because working in a system is the next big thing, we are doing it because we can only deliver better care for our patients if we work together. As a finance community, we're part of supporting that change,' adds Mr Foster.

To achieve 'one system, one budget', finance teams need the right tools. And hearing examples from across the country is a good way to develop them. One of the next opportunities to hear more about these issues will be at the HFMA summer conference. In past years, the event has brought different parts of NHS finance – commissioners and providers – together to think about system working. And Mr Foster suggests it is a good place to network with colleagues and share best practice.

'As leaders in the finance community, we sometimes need to make hard choices for the whole system, rather than concentrating on the individual organisation.

'Yes, you can get good governance in place within your system; yes, you can get the right tools, but if you don't have trust between organisations and leaders within the system, you are not going to make great progress on the integration agenda,' he concludes.

- **HFMA summer conference details are at hfma.to/summer**
- **To enquire about joining the System Finance SIG, email emily.simmonds@hfma.org.uk**

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Appointments

Julia Gray (pictured), former costing lead for the national Costing Transformation Programme at NHS Improvement, has become business transformation lead for West Midlands NHS Leadership Academy. Her career in healthcare finance started in 2002 at the Royal Orthopaedic Hospital NHS Foundation Trust. She succeeds **Lucille Legiewicz**.

Paul Bradshaw (pictured left) is now interim director of finance at Royal Liverpool and Broadgreen University Hospitals NHS Trust. He was deputy director of finance at the trust and takes over from **John Graham**.

The trust has also appointed **Michael Wright** (pictured below) as turnaround director. Mr Wright moves from Barnsley Hospital NHS Foundation Trust, where he was director of finance and also has experience working at the Department of Work and Pensions.

Helen Ashley has been named director of strategy and performance at University Hospitals of North Midlands NHS Trust, having been its chief officer finance and performance.

Wrightington, Wigan and Leigh NHS Foundation Trust has appointed **Debbi Wallis** directorate manager – radiology and cancer services. She was deputy head of strategic financial planning at Bolton Clinical Commissioning Group.

Bob Alexander (pictured) has been appointed independent (non-executive) chair of Sussex and East Surrey Sustainability Transformation Partnership. He was executive chair at the STP, having previously been director of resources and deputy chief executive at NHS Improvement. The change in leadership arrangements meets *NHS long-term plan* requirements for all integrated care systems to have a non-executive chair.

Birmingham Community Healthcare NHS Foundation Trust has named **Ian Woodall** chief finance officer. Previously director of finance and procurement at the trust, he takes over from **Peter Axon** who is now chief executive at North Staffordshire Combined Healthcare NHS Trust (*see page 32*).

Janet Meek is now regional director of commissioning at NHS England and NHS Improvement South East. Ms Meek has held a variety of senior finance roles, including regional director of finance (south) and chief finance officer for four clinical commissioning groups in Berkshire West.

We are sad to report that former chairman of the association **Ian Dyson** died recently. Mr Dyson was treasurer of Barnsley Health Authority when he became chair of the Association of Health Service Treasurers – the HFMA's predecessor body – in 1983/84.

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

"Mental health has some good opportunities ... But there is a risk these could be hampered by system-level deficits across the country that range from very small to very large"
Peter Axon, North Staffordshire Combined Healthcare NHS Trust

Axon makes switch to lead Staffordshire

On the move

Peter Axon took up his new role as chief executive of mental health provider North Staffordshire Combined Healthcare NHS Trust in April. He moved from Birmingham Community Healthcare NHS Foundation Trust, where he was finance director and deputy chief executive. In nearly 10 years in Birmingham, the organisation moved from being the provider arm of South Birmingham Primary Care Trust to a freestanding NHS trust, gaining foundation trust status in 2016.

More recently, as the Birmingham trust explored a merger with two local providers, he was also chief finance officer at one of the other participant bodies – Black Country Partnership NHS Foundation Trust – as part of a shared executive team. While the merger did not proceed, during the preparation period Mr Axon also spent four months as acting chief executive across the two organisations.

He says this experience in part motivated his decision to look for a chief executive role as his next career move. 'I became a chief finance officer relatively early – in my mid 30s – and spent a few years developing into that executive role,' he says. His 10 years in post were punctuated by some key landmarks including the successful FT application and completion of the £50m Birmingham Dental Hospital.

He also pays tribute to his longstanding chief executive, Tracy Taylor, for creating 'the right environment' for the executive team to operate.

After Ms Taylor's departure from the trust, Mr Axon started to reflect on his next steps. He says his exposure to general management as deputy chief executive at Birmingham, and the short period as acting chief executive, convinced him that a more permanent switch into a chief executive role was the right move.

He comes into an organisation that appears on top form. It recently received an overall outstanding rating from the Care Quality Commission – one of only two specialist mental health trusts to receive the top rating. And it has been in surplus or breakeven for the last 20 years.

'Finance and quality can go hand-in-glove and a lot is about embedding quality improvement methodology in the culture of the organisation – that's been critical to success,' he says.

However, he says the trust and mental health sector do face significant challenges. 'Mental health superficially has some good opportunities to evolve to do more of the same services and new innovative services,' he says. As an example, he points to the trust's selection as a wave one child and adolescent mental health services trailblazer pilot site, embedding support teams in schools to address growing demand, particularly in secondary education.

'But there is a risk these opportunities could be hampered by system-level deficits across the country that range from very small to very large,' he adds. Staffordshire is in the large deficit group and half way through April negotiations were still ongoing about funding for 2019/20.

'It is very tough,' says Mr Axon. 'The reality is that the system in Staffordshire is spending more than the allocation provided and all organisations are aware that we have a balanced responsibility – on the one hand to maximise support for our services users and deliver organisational balance, while at the same time acknowledging the system's financial challenges.'

He adds that the system is also discussing quite radical changes to contracting mechanisms that in part support a more transformational system approach.

'However, elements of the proposals, such as the redistribution of deficits based on turnover rather than historical performance or patient need, have brought with them significant disruption and a real concern that systems are being dominated by spreadsheets rather than population need,' he says.

He believes the system needs to do two things. 'It needs to get on with the detailed service line analysis to eradicate waste while moving services up to upper quartile performance where possible – across all organisations and sectors,' he says. 'But there is also a macro-level analysis. Based on the £2bn the system has available to spend, what is the appropriate allocation to various services using national benchmark and programme budget data?'

Mr Axon suggests this twin approach can help the health economy find the right balance of funding, recognising the interdependencies between different services.

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