# healthcare finance

October 2016 | Healthcare Financial Management Association

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Dr Steven Allder, Consultant Neurologist, Plymouth Hospitals NHS Trust

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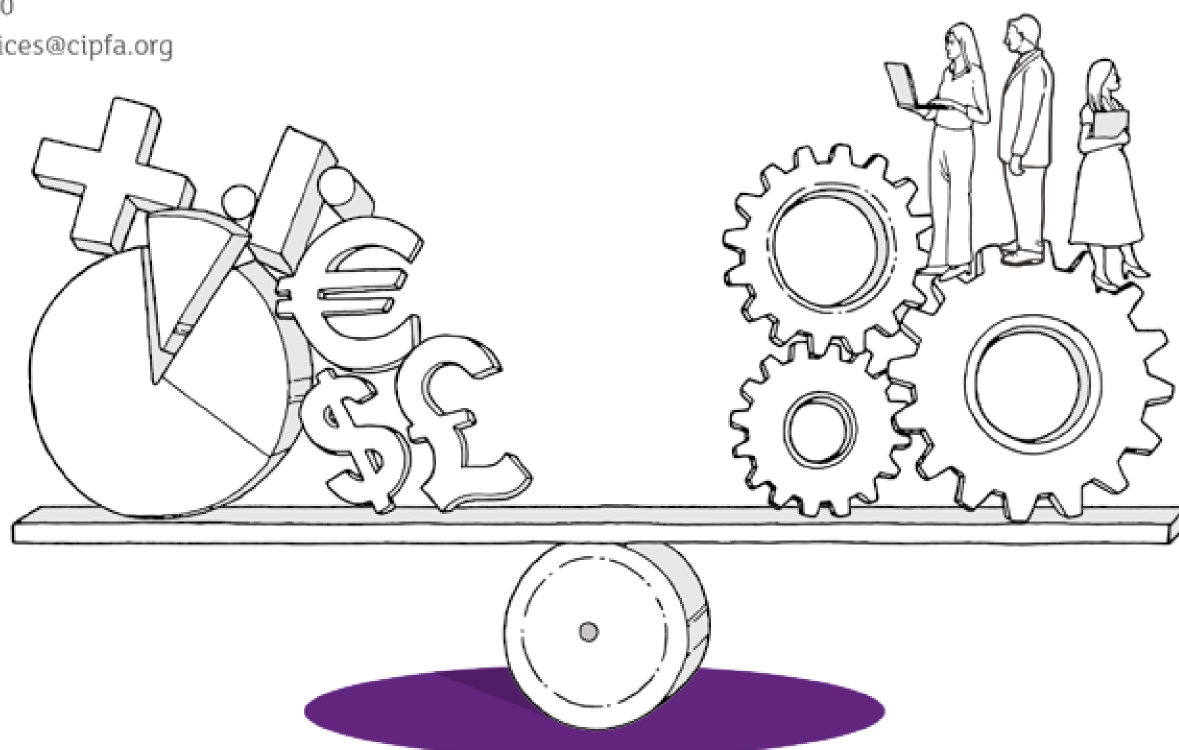


# News

## Baumann: commissioner focus on financial balance

**By Seamus Ward**

No stone is being left unturned in the effort to ensure commissioners deliver a balanced budget this year, NHS England chief financial officer Paul Baumann has said.

Mr Baumann told NHS England's September board meeting that risks to the final position for CCGs and direct commissioners was £444m at month five. This was mostly due to the challenge of delivering efficiency plans, managing activity risks and absorbing the cost of an increase in funded nursing care fees. This could be offset by underspends in central costs (£71m), giving an overall risk position of £373m.

NHS England managers were undertaking a 'deep dive' into commissioners' financial position. The outcome of the review will be included in the month six report to the board.

In his month five report, Mr Baumann said the deep dives would test the robustness of the overall balanced forecast position, to understand the interventions already under way to manage a higher level of risk than seen previously. They would also seek 'to agree any further actions to sustain our 100% track record, so far at least, of living within our means.'

'The report highlights why this is more difficult this year. We have had to increase the level of commissioner efficiencies by nearly 50% overall, and more than that in the CCG sector, to create the headroom for the 1% investment and risk reserve we are holding this year,' he said.

'Work to date indicates that, while recovery actions already under way will ensure not all of the £444m commissioning risk will crystallise, a substantial proportion of it probably will. As well as trying to steer that number down to the lowest possible level by supporting CCGs to take the required action to correct that position, we are redoubling our efforts to find additional mitigations among our central budgets.'

**"We can draw on the financial management approach we have evolved, but there's still a lot to do"**
**Paul Baumann, NHS England**

NHS England remained committed to delivering a balanced budget in the commissioning sector. 'There is no stone being left unturned in the pursuit of that goal,' he said.

Chief executive Simon Stevens said it was important to set the right starting point for the two-year operational plans. 'The financial exit position for CCGs and trusts is obviously a risk – we've got to get it right,' he said. 'If we don't deliver the end-year financial position in CCGs and trusts, 2017/18 will be very difficult.'

The £800m risk reserve has added to commissioners' financial pressure and it was beginning to be seen in deteriorating forecast year-end positions. The funds are currently uncommitted, but will be released to spend on local priorities if they are not required to offset deficits elsewhere in the NHS.

It is understood NHS England is speaking to the Treasury about when this can be released – if this does not happen soon, CCGs could find it difficult to spend the money cost-effectively in the remaining months of the financial year.

As at month three, 39 CCGs were planning for a cumulative deficit at the end of 2016/17 and 29 expect to report an in-year deficit. While the numbers are similar to 2015/16, the overspends are on average 33% lower. At month five, headline expenditure was £95m above plan, with a CCG aggregate overspend of £159m (0.5%). The year-end forecast was an overall commissioning overspend of just under £24m.

The forecast also reflects greater pressure than expected from the impact of the technical and ring-fenced adjustments relating to provision movements and depreciation.

In the year-to-date, 77 CCGs reported an overspend position, of which 40 are greater than 1% of allocation. Most assume they will be able to recover the position by year-end. But 24 forecast a position worse than their annual plan, including four predicting an unplanned deficit.

Mr Baumann said: 'A year that was always going to be exceptionally challenging is living up to our expectations. Across the commissioning sector we can draw on the financial management approach we have evolved over the first three years of operation, but there's still a lot to do.

'And that has to be done in combination with the work on STPs and on gearing up for the operating plan process.'

**Year-to-date and forecast expenditure for NHS England at month 5**

| Net expenditure | Year to date | | | | Forecast outturn | | | |
|---|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Under/overspend £m | Under/overspend % | Plan £m | FOT £m | Under/overspend £m | Under/overspend % |
| CCGs | 31,433.4 | 31,592.1 | (158.7) | (0.5%) | 76,197.6 | 76,285.5 | (87.9) | (0.1%) |
| Direct commissioning | 10,429.7 | 10,450.6 | (20.9) | (0.2%) | 25,782.4 | 25,782.4 | - | - |
| NHSE running and central programme costs (exc depreciation) | 832.1 | 747.2 | 84.9 | 10.2% | 3,729.1 | 3582.7 | 146.4 | 3.9% |
| Other including technical and ringfenced adjustments | | | | | (58.6) | 23.4 | (82.0) | |
| **Total non-ringfenced RDEL under/(over) spend** | **42,695.2** | **42,789.9** | **(94.7)** | **(0.2%)** | **105,650.5** | **105,674.0** | **(23.5)** | **(0.0%)** |

# Increased demand raises alarm over financial sustainability

By Seamus Ward

There is growing concern that the NHS will not be able to meet demand for clinical services within existing funding, even with initiatives designed to increase efficiency and productivity.

The King's Fund said 'relentless demand' was pushing up waiting times and exacerbating financial pressures. And NHS Providers chief executive Chris Hopson said trusts were finding it impossible to provide quality services and meet performance targets with available funding.

The King's Fund quarterly monitoring report said more than 1 million patients were admitted to hospital from A&E in the first quarter of 2016/17, while A&E attendances rose to nearly 6 million. This was more than the same time last year by 14,000 and 54,000, respectively.

Increased activity was affecting waiting times, with 3.8 million patients on waiting lists in June – the highest level since December 2007.

The fund's survey of finance directors showed an improving financial position, in line with NHS Improvement's first quarter report. However, finance directors said the position was fragile, with 47% of trusts forecasting a year-end deficit and a third confident they would meet the control totals agreed with NHS Improvement.

Commissioner chief finance officers' confidence had declined, with twice as many (23%) forecasting a year-end deficit than at the same point last year. In addition, 40% of trust finance directors and 61% of clinical commissioning group CFOs were concerned about meeting cost improvement or QIPP productivity targets.

King's Fund policy director Richard Murray said: 'Winter usually brings a dip in NHS performance, but what is striking now is that key targets are being missed all year round. This reflects the impossible task of continuing to meet rising demand for services and maintain standards of care within current funding constraints.'

While investment and action to curb spending was helping, it would be a mistake to believe financial pressures had eased. 'Unless more is done to tackle rising demand, the ideas emerging

## RCP paints stark NHS picture

Funding earmarked to transform patient services could be 'sucked into a financial black hole', according to the Royal College of Physicians. *Underfunded, underdoctored, overstretched* said demand was increasing by 4% a year, real-terms funding would rise by an average of 0.2% a year to 2020. It insisted the UK does not train enough doctors. Staff were under significant stress and felt 'like collateral damage in the battle between rising demand and squeezed budgets'.

Nuffield Trust policy director Candace Imison said: 'The NHS needs a sustainable funding settlement. Under current plans, trusts are being asked to make savings over the next two years at a rate never before achieved – at a time when they are already visibly struggling after delivering efficiencies through years of financial pressure. We cannot carry on like this.'

# Providers urged to commit to bulk-bought goods

**NHS Improvement has unveiled the first set of 12 core products to be purchased nationally on behalf of non-specialist acute trusts.**

**The move follows submissions by all 136 non-specialist acute providers to the purchasing price index benchmarking tool. NHS Improvement intends to expand the tool to all trusts from the next financial year.**

**The work will help compare prices and standardise catalogues, while the list of 12 core products – which include gloves, bed pans, syringes and needles – aims to use NHS buying power to get the best possible value for money.**

**At the moment, spending on these products amounts to £100m a year and NHS Improvement anticipates savings of up to 25%.**

**A letter from NHS Improvement executive director of operational productivity Jeremy Marlow said NHS Supply Chain and NHS Business Services Authority (BSA) would source the products. But he insisted that for the initiative to produce maximum savings, they must purchase the list items on behalf of all providers.**

Jeremy Marlow: call for a 'coalition of the willing'

**'It is vital that you commit your volumes and don't undermine the initiative by purchasing outside the contracts,' he added.**

**At this stage, NHS Improvement has decided not to mandate compliance through formal contractual or regulatory mechanisms.**

**Mr Marlow said change was more effective when achieved through collaboration. NHS Improvement wanted 'a coalition of the willing' for full compliance across the NHS.**

**Trusts with existing contracts that could delay their switch to the nationally sourced products have been asked to send details to NHS Improvement.**

**The programme started in September and the products are expected to be available from early in the new calendar year.**

**NHS Improvement plans to expand the list up to 2019, when a future operating model being developed at the Department of Health is scheduled to take effect. This will cover most of the estimated £5bn annual spend on goods and supplies.**

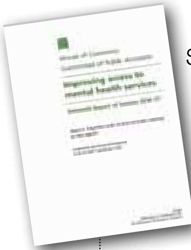
**“What is striking now is that key targets are being missed all year round”**
**Richard Murray, above**

from sustainability and transformation plans about cutting beds and reconfiguring hospitals will look even more unrealistic.’

Writing in *The Observer*, NHS Providers chief executive Chris Hopson said without extra funding the NHS had to make ‘quick, clear choices’ on the services it could afford to provide. ‘We face a stark choice of investing the resources required to keep up with demand or watching the NHS slowly deteriorate,’ he said. ‘Trusts will, of course, do all they can to deliver efficiency savings and productivity improvements. But they are now saying it is impossible to provide the right quality of service and meet performance targets on the funding available.’

• *See Fixing the NHS, page 10*

## PAC calls for open-book update



The Public Accounts Committee has called on NHS England to report by December on progress implementing open-book reporting by clinical commissioning groups.

In particular, the influential Commons committee wants to see how much money CCGs are spending on different mental health services to understand progress towards parity of esteem commitments

Earlier this year, the HFMA and NHS Providers undertook a joint survey of commissioners and providers. Their report, *Funding mental health at local level,* said just half of mental health trusts received the required real-terms increase in their services in 2015/16. This was despite commissioners being told to increase investment in line with their overall allocations.

NHS England chief executive Simon Stevens told the committee’s inquiry that not all increased investment would go through mental health trusts.

‘In some areas, the money is not getting through and in others the money is going to other parts of the mental health system,’ he said.

He added that a move to open-book accounting would provide transparency on where the money was spent. The committee now wants an update on how this move is progressing.

HFMA director of policy Paul Briddock said current budget pressures made parity of esteem harder to achieve. ‘However, it is important that commissioners are open and transparent about how these funding decisions are made and where resources will be focused to reach frontline services,’ he said.

# Oversight scheme change confirmed

**By Seamus Ward**

NHS Improvement introduced a number of changes to the single oversight framework in advance of this month’s launch. Following a consultation over the summer, it decided to introduce a metric on agency staff spending in full from 1 October, rather than in shadow form as previously planned. The metric will assess distance from the agency spending cap, initially introduced last year.

There are other changes to the finance and use of resources score outlined in its consultation. The oversight body also decided not to use EBITDA (earnings before interest, tax, depreciation and amortisation) margin, but to retain income and expenditure margin in line with existing frameworks.

The planned shadow metrics on cost per weighted activity unit and capital controls will also be assessed ahead of possible introduction next year.

If a trust has not agreed a control total and is planning for deficit, it can score no higher than 3 (where 1 is the best score and 4 the worst). Those planning a surplus without an agreed control total can score no more than 2 for use of resources.

NHS Improvement has also removed six planned quality metrics.

The single oversight framework will replace the Monitor risk assessment framework and the NHS Trust Development Authority accountability framework. Assessment will take place across five areas – finance, quality of care, operational performance, strategic change and leadership and improvement capability.

NHS Providers head of policy Miriam Deakin (pictured) was pleased NHS Improvement had taken account of feedback from the service. But she added: ‘It isn’t possible to separate the introduction of the single oversight framework from the context in which providers and their partners are operating. ‘While the framework better co-ordinates NHS Improvement and the Care Quality Commission’s regulatory regimes, trusts are facing increased financial and operational pressure alongside a greater sense of “grip” from the national bodies. Improved clarity and less regulatory duplication are welcome in these challenging times, but providers would still like to see the national bodies take further strides to integrate and align their approaches.’

• *See Technical review, page 28*

## New HFMA corporate partner

**The HFMA has announced a new corporate partner, Genesis Automation. The company provides innovative healthcare value-chain solutions that improve patient safety, cut costs and eliminate waste for healthcare providers and suppliers.**

# News review

## Seamus Ward assesses the past month in healthcare finance

**Even in a month that saw the publication of two-year planning guidance and draft tariffs, questions over NHS financial and operational sustainability and confirmation of a new oversight framework, junior doctors managed to grab the spotlight.**

Having announced in August a series of five-day strikes over several months, the British Medical Association abandoned the first in September, before going on to suspend the remaining action due in October, November and December. The decisions were taken for reasons of patient safety, the BMA said, and there had been growing disquiet among the medical royal colleges, the General Medical Council and some juniors about the impact on patients.

So where are we now on the lengthy dispute? The BMA still opposes the new contract for junior doctors, though the government remains committed to introducing it from this month. The Department of Health won a judicial review of the contract, brought by the group Justice for Health, at the end of last month. The group had questioned the legality of the imposition of the contract; whether the health secretary had properly informed the public and Parliament; and the evidence behind the proposed changes.

Department of Health permanent secretary Chris Wormald defended the actions taken to balance the accounts in 2015/16. At a hearing of the Commons Public Accounts Committee on the Department accounts, he said they were within normal professional standards and had been signed off by the National Audit Office. He recognised many of the measures were one-off and unsustainable and this had prompted the financial reset over the summer. He was also pressed on the Department's receipt of an additional £417m from the National Insurance Fund in 2015/16. Without the funding the Department would have exceeded its revenue budget voted by Parliament. Mr Wormald insisted it was due to a mistake and steps were being taken to ensure it would not happen again.

Nuffield Trust chief economist John Appleby said the NHS would still be affordable through general taxation by 2030. He was commenting on long-term projections from the Office for Budget Responsibility on how NHS spending could grow, based on population and other factors. Mr Appleby said the UK currently spends 7.4% of GDP (£140bn) on healthcare each year. The OBR projections show that by 2020 this will have fallen to 6.9%, but could rise to 8.8% (£234bn at today's prices) by 2030. This was an average annual real terms increase of 3.5%, which was less than the historic UK average of 4%, he said.

The Nuffield Trust and the King's Fund highlighted the projected funding gap in adult social care. They said it would rise to at least £2.8bn by 2019/20. A joint report, *Social care for older people: home truths*, said public sector adult social care spending would shrink to less than 1% of GDP by the end of the decade and called for a new public debate on how to fund social care. Additional pressure on hospital beds have been in part attributed to recent cuts in adult social care spending.

Problems with patient discharge were highlighted further in a report by the Commons Public Administration and Constitutional Affairs Committee. It said pressure on resources and capacity in hospitals were leading to 'worrying and unsafe discharge practices'. It called on health and social care leaders to ensure staff worked in an environment where patient-centred care was the undisputed

## The month in quotes

'I discussed this with the comptroller and auditor general in quite a lot of detail and we agree that the kind of one-off measures that were necessary [in 2015/16] to bring us within the Parliamentary control total is not a sustainable way forward.'
**Department of Health permanent secretary Chris Wormald tells the PAC that the NHS must look for sustainable solutions**

'We still oppose the imposition of the contract and are now planning a range of other actions in order to resist it, but patient safety is doctors' primary concern and so it is right that we listen and respond to concerns about the ability of the NHS to maintain a safe service.'
**BMA junior doctor leader Ellen McCourt explains why planned strikes have been suspended**

'A failing system leaves older people, their families and carers to pick up the pieces. Putting this right will be a key test of the prime minister's promise of a more equal country.'
**Richard Humphries, King's Fund assistant director of policy, calls for action on social care**

"We want to fast track existing digital excellence, as well as nurture the new skills and expertise we need to deliver a new breed of digitised services. This means on the one hand giving pioneering NHS organisations the financial backing to unleash their potential, while also making sure that we can build a digitally-confident workforce across the whole NHS.'
**Health secretary Jeremy Hunt launches the 'global exemplars' for digital health**

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priority. It considered the split between health and social care, which meant they were managed and funded separately, to be political maladministration.

More information on health service organisations' vulnerability to cyber attack emerged in September. The National Audit Office said there was a sharp spike in cyber attacks in the health sector in the second quarter of 2015/16. Previously health was not thought to be a high-threat sector, according to *Protecting information across government.* While health had consistently the highest number of data breaches, this may be due to the Department of Health's insistence that all personal data breaches must be reported. This stance has not been adopted across all Whitehall departments, the NAO said. The report noted the efforts the sector has made to secure its data, including the establishment of the national CareCERT programme (*Healthcare Finance* September 2016, page 20). Wales health secretary Vaughan Gething announced an £11m investment in IT to improve cyber security in local health boards and trusts.

**The National Audit Office said there was a sharp spike in cyber attacks in the health sector in the second quarter of 2015/16**

The government and NHS leaders must set out a credible plan for expanding the use of digital technology and quickly clarify when funding will become available, the King's Fund said. Frontline staff backing for digital plans could be lost because of changing priorities, the introduction of new initiatives and slipping timescales. It also said holding back funding until later in the Parliament would slow progress. In the meantime, the Department of Health announced 12 NHS organisations would receive up to £10m to deliver pioneering digital services and help other health service organisations learn from their experiences. The 'global exemplars' include trusts in Salford, London, Bristol and Sunderland. The digital services will include new smartphone apps, instant access to personal health records, an online NHS 111 triage service and a relaunch of NHS Choices.

Health is a key element of the Welsh government plans for the next five years. Its new programme focuses on improving patient access, increasing clinical staff numbers and bolstering mental health and older people's services. Announcing the government's five-year plan, first minister Carwyn Jones committed to introducing a new treatment fund to provide quicker access to innovative treatments and also to prioritising mental healthcare support, prevention and de-escalation.

The Scottish government was also looking at access, but in the shorter term – announcing that health boards are to share £9m to help emergency departments, hospitals and primary and social care teams prepare for the coming winter. The Scottish government said the funding would support dedicated multi-disciplinary teams that will improve patient flow in A&E, across the hospital and in the community. It said that by enhancing staff numbers, providing the same level of discharging at weekends as in the week and offering community treatment, patients would be seen in the most appropriate setting. This would prevent unnecessary admissions and free up beds for those who needed them most.

## in the media

**As well as responding to last month's operational planning guidance (News analysis, page 8), the HFMA also commented on the Royal College of Physicians' gloomy picture of the NHS. Its report, *Underfunded, underdoctored and overstretched,* said the UK did not train enough doctors, transformation funds could be 'sucked into a financial black hole' and staff were increasingly stressed.**

Commenting in *Hospital Doctor* and other NHS press, HFMA policy director Paul Briddock said the association supported much of the report. 'Although the financial position in the first quarter of this year was better than planned, this was largely down to additional STF funding being used to plug provider deficits. Overall, the underlying financial position for the NHS still hasn't much improved on last year. 'The report calls for an increase in NHS funding, however, given this may not be feasible, the dialogue needs to focus on what the NHS can and cannot afford to deliver,' he added.

**The HFMA also issued statements on the Commons Public Accounts Committee report on improving access to mental health services and the King's Fund/Nuffield Trust report on social care. On the former, he highlighted a joint survey by the HFMA and NHS Providers in May, which showed a lack of clarity from commissioners on how extra MH funding was being handled.**

• For HFMA press statements, see www.hfma.org.uk/news/media-centre

## Highlighting the longer view

**The NHS has shown its support for changes that demonstrate the centre is listening to practitioners about what they need to extend planning horizons. Steve Brown reports**

NHS national bodies appear to be in listening mode. The publication of two-year planning guidance, with two-year prices and the beginnings of a system-focus, delivers a number of changes that the NHS – and finance practitioners in particular – have been calling for for years.

There are significant complications in raising the planning horizon beyond the traditional single year – less confidence around inflationary pressures for year two and the inability to change the package based on the performance in year one, for example. But system leaders have listened to the service and responded.

There was widespread recognition of this move. HFMA director of policy Paul Briddock described it as a step in the right direction. 'It supports the need for the NHS to work more widely as a system, but with clear visibility of organisational control totals and requirements within that,' he said.

And Chris Hopson, chief executive of NHS Providers agreed. 'A two-year planning and contracting period will help make the best use of resources,' he said. 'The clarity on key elements of the NHS landscape – the tariff, CQUINs, business rules and the standard contract – will all help and are to be welcomed. We recognise the hard work of NHS England and NHS Improvement, which have worked at high speed to get us here.'

All sides are equally clear that the changes are helpful but won't of themselves solve the major financial challenges facing the NHS over the next two years. 'Our members have been calling for longer term funding settlements, more realistic efficiency requirements and an earlier timescale for agreement on financial plans for the year ahead,' said Mr Briddock. '[But] we must not underestimate the scale of the challenge ahead or the strain this will put on NHS finance staff, partially given the planning timescales outlined.'

The big news was the two-year coverage and the fact that the planning guidance is out three months earlier than usual. Across just 23 pages, the guidance confirmed nine 'must-dos' for 2017/19:

1. **Sustainability and transformation plans**
2. **Finance**
3. **Primary care**
4. **Urgent and emergency care**
5. **Referral to treatment times and elective care**
6. **Cancer**
7. **Mental health**
8. **People with learning disabilities**
9. **Improving quality in organisations**

Detailed operational plans by both commissioners and providers will need to demonstrate how they deliver this list and support delivery of the local sustainability and transformation plan (STP), with finance and activity numbers agreed in both sets of plans and drawn from the STP.

The planning guidance was published alongside technical guidance, commissioner finance templates, a draft two-year NHS standard contract, CQUIN incentive scheme guidance and tariff prices for both years. Provider control totals and sustainability and transformation fund (STF) allocations were due to be published just after *Healthcare Finance* went to press, with commissioner allocations due out in mid-October.

Full draft operational plans for both years are due towards the end of November and contracts must be signed by 23 December. All in all, it is a huge ask for finance and contracting teams.

The beginning of a switch of focus away from organisations and towards whole systems comes with the setting of system control totals. These, in fact, are simple sums of the corresponding individual organisation control totals within each footprint. And in truth there is limited flexibility.

Organisations will be able to adjust individual organisation control totals 'by application' as long as the system control total is not breached. But there is a parallel requirement that, perhaps rather ambitiously, requires the provider sector to achieve financial balance in 2017/18 and 2018/19 and for commissioners collectively to live within their statutory resource limits.

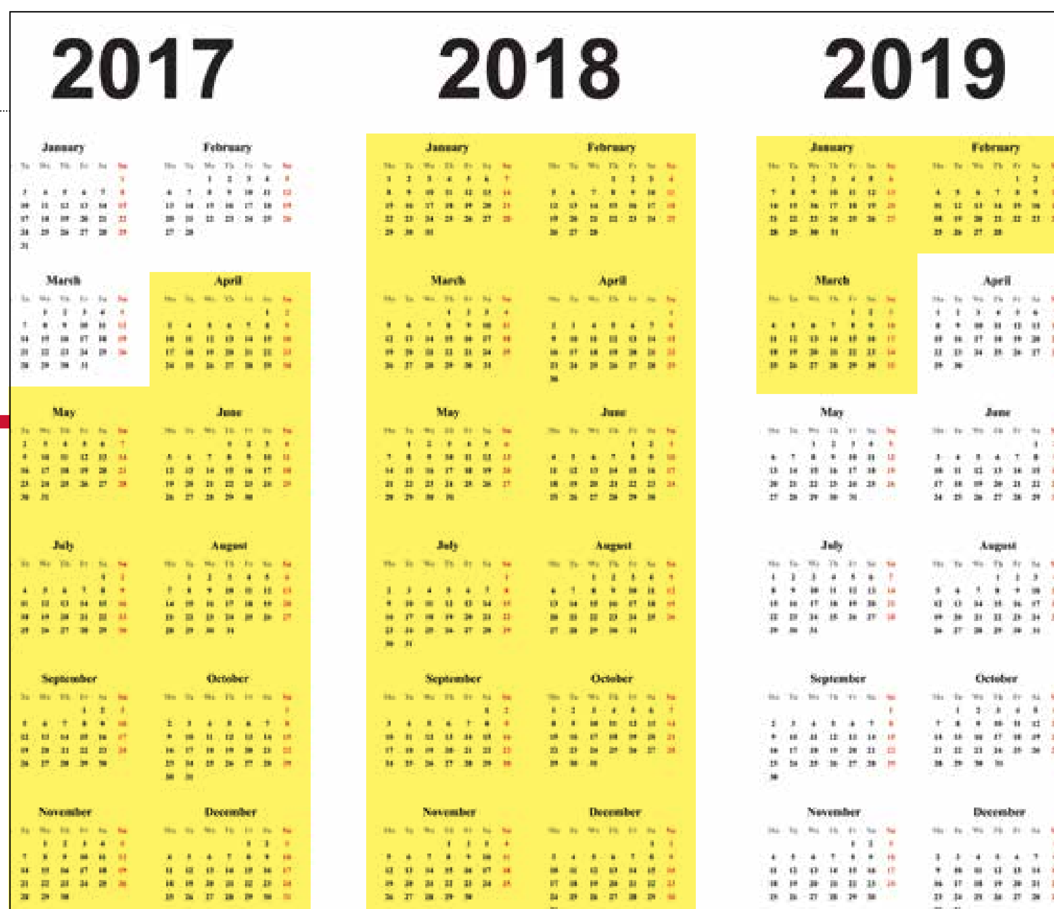
### Education and training tariffs

There will be no changes to the education and training tariff currency design before 1 April 2019, with three possible exceptions:

- **Non-medical placement tariff** The Department of Health consultation on education funding reforms could lead to structural changes from September 2018. Health Education England will continue to fund the non-medical placement tariff on the same basis as 2016/17, provided there are no material changes to placement numbers.
- **Dental undergraduate tariff** The Department has put forward proposals for structural changes from April 2018.
- **Primary care tariff** There may be an expansion of the standardised education and training tariff for primary care placements.

The guidance said that the spending review settlement meant there would be no increase to the education and training tariffs in both 2017/18 and 2018/19.

NHS training providers have been on a transition path to the education tariff prices. This has limited provider gains and losses and will continue as planned. The cap on annual losses will remain at £2m or 0.25% of income.




move all follow-up outpatient activity to a single block payment. They acknowledged this was not widely supported. The HFMA had suggested it was a backwards step to a 'crude currency' and that the measures would mean organisations facing financial disadvantages when follow-ups were clinically appropriate.

However, both commissioners and providers will from next April contribute to a risk reserve to cover potential system overspends. A similar risk reserve was created for the current year – worth around £800m. This not only required commissioners to plan for 1% of allocations to be spent non-recurrently (as in previous years) but also to start the year with this sum uncommitted.

The difference this year is that providers will also contribute to local reserves. A total reserve of £830m will see commissioners set aside half of their 1% non-recurrent spending requirement – worth about £360m. NHS England will add £200m. Finally 0.5 percentage points of the CQUIN payments paid to providers (worth a total of 2.5% of contract value) will also be held within the reserve – adding a further £270m.

## CQUIN release

If a provider delivers its 2016/17 control total it will be paid this CQUIN at the beginning of 2017/18, although it will have to hold this as a reserve until release is authorised once it is demonstrated that the system in question is delivering its control total.

Some 1.5 percentage points of the 2.5% CQUIN is tied to the delivery of national indicators – with different sets for different sectors. The 'local' CQUIN will see 0.5% of contract value handed to providers if they engage fully with the STP process, with the final 0.5% forming the risk reserve.

The £1.8bn sustainability and transformation fund will again be used to help the provider sector hit its aggregate financial balance target. Some £1.5bn will be allocated on the basis of emergency care, £0.1bn will be allocated to non-acute providers and £0.2bn will be used in a targeted way. The guidance said: 'Sustainability funding must deliver at least a pound-for-pound improvement in the aggregate financial position.'

> **"The national bodies must align regulation and policies that would help organisations to work closer together"**
> **Phil McCarvill, NHS Confederation**

Clinical commissioning groups, in addition to their 1% non-recurrent spend requirement, must again plan for a 0.5% contingency to manage in-year pressures and risks. Drawdown worth £0.4bn will be used to fund the £200m contribution to the risk reserve and to cover in-year CCG deficits. However, CCGs that have built up cumulative underspends above 1% in previous years will also get access to drawdown.

The two-year tariff will increase prices by 0.1% - the net impact of cost uplifts worth 2.1% in each year offset by the previously announced 2% efficiency requirement. Some healthcare resource group-specific uplifts are on top of this to reflect cost increases related to the Clinical Negligence Scheme for Trusts (CNST).

It is difficult to see a straight 0.1% increase even between years one and two of the new prices as the picture is complicated by manual adjustments, smoothing and scaling, as well as the CNST uplifts.

Again, showing a willingness to listen, NHS England and NHS Improvement said they had decided against earlier proposed changes to

Instead the guidance now proposes to increase the percentage of follow-up costs bundled into first attendances – 30% adult surgery and diabetes, cardiology and general paediatric medicine; 20% other medical specialties; and no change (10%) in other areas.

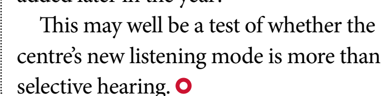
Mr Briddock welcomed the about turn. 'It is right to get the payment system aligned with the aim of reducing follow-up attendances where this is clinically appropriate. We don't think the earlier proposals would have achieved this and the revised approach makes more sense.'

The consensus is that the two-year guidance is helpful. But representative bodies have been quick to point out that the core financial challenges facing the service remain.

Phil McCarvill, deputy director of policy at the NHS Confederation, while describing the guidance as 'clear and useful', warned that the proof would be in the delivery and alignment of both organisational and local STPs. 'Local commissioners and providers are being asked to achieve something that is longer term and wider reaching than ever before,' he said. 'The national bodies must continue to work together and align regulation and policies that would help organisations to work closer together.'

NHS Providers Chris Hopson also underlined that 'the gap between what the NHS is being asked to deliver and the funding available remains'. He said it was important that 'numbers of small but unfunded commitments are not added later in the year'.

This may well be a test of whether the centre's new listening mode is more than selective hearing.



# Comment

October 2016

## Club vs country

**A greater system focus also requires a pragmatic approach to regulation**

**The two-year planning** guidance is exactly what we professionals wanted. NHS finance practitioners have long called for early guidance, more time to plan and the ability to plan for the longer term – giving us the opportunity for greater stability. So we should be grateful NHS Improvement and NHS England have listened and given us what we called for.

HFMA president Shahana Khan

The themes in the planning guidance – two-year contracts, earlier planning and a move to a system focus – were the key messages delivered by the national planning workshops facilitated by the HFMA and Future-Focused Finance on behalf of system leaders over the summer. Those messages have been taken on board. So we should acknowledge that this is a major step forward.

But we also need to understand these changes do not provide a magic solution to the extreme financial challenges facing the service. And some aspects, while desirable in terms of the bigger picture, will create big headaches for finance teams in the short term.

The point of 'contracts signed and finalised plans' by 23 December is that, as of January, the service should be focused on delivery. But getting there almost certainly means heroically long hours and weeks for our departments and changing some of our approaches.

Major issues still need to

## Fixing the NHS

**Addressing current financial problems needs action on several fronts. But it may also be time to admit the NHS needs more money**

Healthcare Finance editor Steve Brown

**The move to two-year planning guidance** with two-year tariffs and system control totals is a good step forward. For a service that has been asked to plan for the longer term (or sustainability as the current fashion would have it), one-year contracts and annual price changes have looked out of place.

Too often in the past, organisational targets and must-dos have not been aligned across a system. What has been best for the broader health economy – and patients and populations in general – has not always been best for individual organisations. Calling for organisations to make decisions in the interests of broader populations or system finances, and then criticising the organisation if it makes a deficit as a result, simply doesn't make sense.

But on its own this longer term focus won't fix the financial problems facing the NHS.

New models of care are the right thing to do. Some of the ideas emerging from the various vanguards – early recognition of illness, sharing of best practice, more community support – are brilliant. There is little doubt they will lead to better outcomes and better patient experiences. But the financial outcomes are less clear.

There is plenty of theory around how better community support for patients with

> "How do we marry up organisational sovereignty with system governance?"

be worked through. While there are moves in the planning guidance towards system regulation, how can this work in practice?

We now have system-wide control totals as well as organisation totals. And movement away from organisational control totals is 'by application' only. At the same time, providers must balance in aggregate in both years and the commissioning sector must live within its resource limit. So it is not clear how much flexibility this delivers in practice.

But how do we marry up organisational sovereignty with system governance? When push comes to shove, how do we avoid forcing organisations to choose between club and country?

The planning guidance forces the issue by creating system-wide risk reserves. Commissioners may be familiar with the requirement to set aside uncommitted funds to support the overall position, but providers will also see 0.5% of local CQUIN funds linked to the achievement of the system control total.

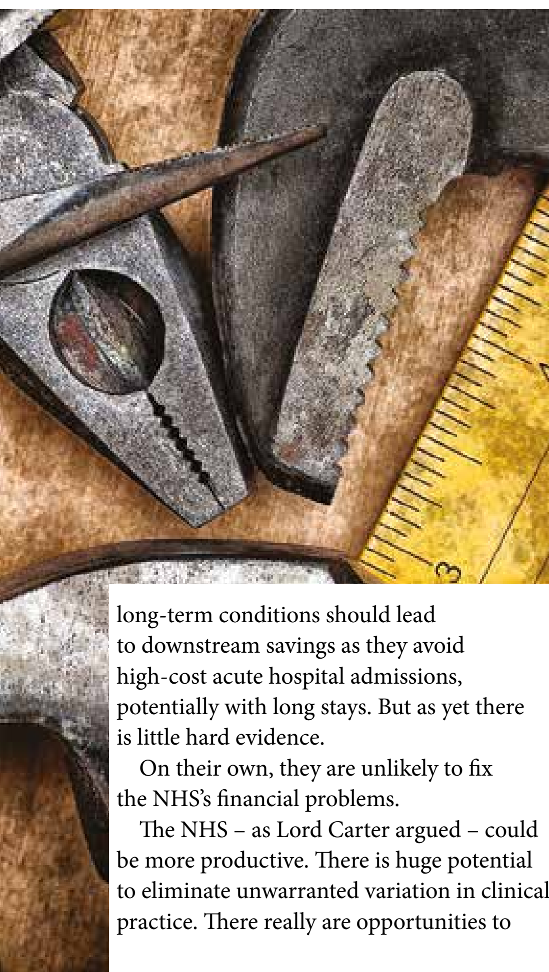
There's an expectation that all organisations planning sustainability and transformation will act to achieve system goals, not just organisational ones.

There is a huge challenge for the finance function here. The contract deadlines are tight, but the main task is for us to become real system leaders. This will mean changing some adversarial behaviours the regulatory system has required of us.

We must be pragmatic, leaning on contracts only when there are problems. We must be experts in the greater good and system thinking, helping boards make the right decisions.

But central bodies must take the same pragmatic approach to regulation. If organisations are to put the best interests of the system ahead of the organisation, system context must be fully recognised when holding organisations to account.

*Contact the president on president@hfma.org.uk*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long-term conditions should lead to downstream savings as they avoid high-cost acute hospital admissions, potentially with long stays. But as yet there is little hard evidence.

On their own, they are unlikely to fix the NHS's financial problems.

The NHS – as Lord Carter argued – could be more productive. There is huge potential to eliminate unwarranted variation in clinical practice. There really are opportunities to improve services for patients and cut costs. Many organisations are doing this at a local level using Lean management techniques to examine theatre efficiency or ward practices. Increasingly providers are using patient-level costs to help them explore these opportunities and there is significant potential to ramp up benchmarking.

But much of this improvement work is at very small levels – in fact that is how it works best, ensuring clinical ownership. The service improvements are great and often the savings are real, but they must be pursued on a much grander scale and that will take time.

Back-office functions and procurement could also be more cost-effective. But there are concerns that some of the savings could be at the expense of having the necessary support available to pursue some of the initiatives mentioned above.

In short, better productivity on its own won't be enough to fix the financial problems facing the NHS – at least not within the timescales required.

To deliver a sustainable NHS for the future, what is needed is for all the above to be pursued simultaneously and with enthusiasm. Of course this needs to be done while also managing day-to-day services and delivering this year's financial totals.

> "Better productivity on its own won't be enough to fix the financial problems facing the NHS"

It is a matter of opinion how achievable this is. Extra NHS funding has always been a favourite cry for opposition politicians. But we are seeing an increasing clamour building around this view.

Liberal Democrat leader Tim Farron (filling the void left by Labour's internal squabbles) last month called on the country to face the 'hard truth that the NHS needs more money', putting the Liberal Democrats firmly behind raising taxes to fund health services.

In the absence of additional funding, the HFMA has consistently called for a debate on what the NHS can and cannot afford to deliver within existing funding levels. And last month NHS Providers reinforced the point, calling for 'national health chiefs and political leaders to acknowledge publicly that the NHS can no longer deliver what is being asked of it for the funding available'.

Even with extra funding, all the above improvement work would still be needed. However, it may allow for more realistic timescales.

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# heads up

**NHS Improvement has outlined the progress of a programme that creates spare management capacity to deliver savings in-year. Seamus Ward reports**

It's common in any job – the daily grind of getting everything done means there's no time to take a step back to identify and implement tweaks to how you do things; changes that will make you more efficient, get better outcomes and maybe save a few pounds along the way. The NHS, of course, needs to save more than a few pounds over the coming years, but in many trusts there simply isn't the time and capacity. External help is needed.

Last year, NHS Improvement's predecessor, Monitor, set up the financial improvement programme (FIP) as a means to helping some trusts get that support from management consultants. The emphasis is on quick wins to improve the 2016/17 income and expenditure and cash positions, rather than longer term transformational projects.

This means there's a focus on what many finance managers will feel are well-trodden paths, such as vacancy controls, temporary staffing, operating theatre efficiency and procurement. In NHS Improvement's words, this is not rocket science.

Progress was outlined at an HFMA Provider Finance Faculty forum in September. NHS Improvement director Jason Dorsett said about 90 trusts expressed an interest in being involved in the scheme, with 16 chosen. 'It will cost around £25m in fees and we expect to get multiples of that as payback,' he said. 'These multiples of £25m are a helpful contribution to the 2016/17 figures, but they are not a silver bullet.'

The 16 trusts in the programme have a combined CIP target of in excess of £250m and, by the end of July, 17% of this had been delivered. NHS Improvement says that FIP aims to deliver savings of at least £50m in this financial year alone.

Mr Dorsett acknowledged that the quick wins targeted by the programme are generally cost control measures that will be familiar to finance managers. 'The intention is that the measures will pay back in 2016/17,' he said. 'We were not looking for the sort of interventions that would pay back over three years or five years. There are a lot of opportunities over the medium term and we should be looking at these too, but we were focused on the short term.'

## Quick payback

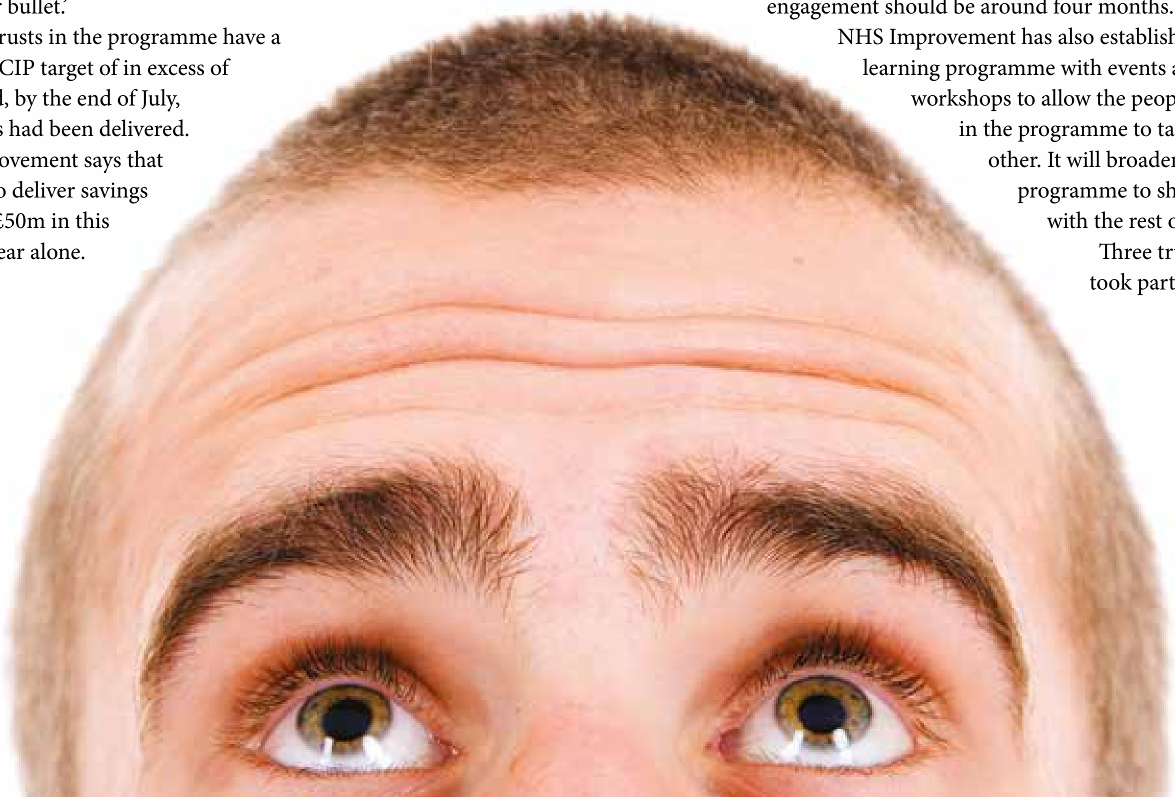
Quick wins are important for another reason. 'If we were going to encourage providers to write out large cheques to management consultants, we needed to protect ourselves and the trusts by working on schemes with quick paybacks,' said Mr Dorsett. 'We wanted them to have some skin in the game. If we wrote the cheques, the trust management team wouldn't have as big an incentive to make this work.'

'Quick' was important for another reason – the period of engagement of the management consultants was deliberately short to encourage them and the trust management to focus on moving quickly to identify and deliver savings speedily.

There are two phases. In phase 1 the management consultants and the trusts look for quick wins and scope out the opportunities that will be delivered, with the consultants' support, in phase 2. Overall, consultant engagement should be around four months.

NHS Improvement has also established a learning programme with events and workshops to allow the people involved in the programme to talk to each other. It will broaden this programme to share lessons with the rest of the NHS.

Three trusts that took part in the



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scheme outlined how it had helped them. Feroz Patel, finance director at Stockport NHS Foundation Trust, said he joined the trust in August 2015. While the trust had a history of strong finances, delivering surpluses in each of the previous five years, it recorded a £13m deficit in 2015/16. It had delivered its CIPs in previous years, but much of this was through non-recurrent measures. In this financial year, the trust has a CIP of almost £26m.

FIP means getting a better grip on the trust finances through a range of measures, he said. Short-term, this meant making cash savings and protecting its cash position. Some of the biggest savings opportunities have been identified in the pay bill and the trust has set up establishment controls and renewed its focus on sickness absence and temporary staffing. It has been able to cut the latter by 21% this year, while sick leave, including long term, has dropped.

NHS Improvement's transformation and turnaround team senior manager Caroline Atkinson, who worked closely with the Stockport trust, said the trusts had to look beyond the short-term intervention of the management consultants. While the additional resources were important, it was vital to consider the handover process from day one and how the programme would be taken forward once the consultants' time was up. This means gaps in skills can be identified and recruitment set in train early.

Full executive sponsorship and communication with staff make a difference, she added. 'We've been particularly successful where the board has been engaged with the programme and we have sent out a message that the trust needs to change and why.

## Areas for improvement

Mr Dorsett said several common areas for improvement were outlined in the phase 1 reports:

- Strengthening project management offices (PMOs)
- Clarifying committee roles
- Improving communications
- Making CIPs more robust.

Much of this would not be a great revelation for trusts. 'We pretty much know all of the themes,' said Mr Dorsett. 'You have to work on your PMO structure, you need the bandwidth to deliver change and you need the technical skills to put together a programme and manage the risks. Most places needed to strengthen their PMOs or even create them from scratch.'

Imperial College Healthcare NHS Trust was in the latter category. Siobhan Peters, the trust's deputy chief finance officer, said FIP presented it with an opportunity to strengthen its CIPs, provide assurance of delivery, identify further in-year savings and strengthen financial management.

Last November it realised that a planned 2015/16 deficit of £18.5m would move to a forecast £30m deficit. And planning for 2016/17 identified a CIP programme of just under £54m to deliver a planned deficit of £52m. 'To deliver a programme of that size, we needed a PMO and we didn't have one. FIP was a good way to get that support quickly. We've called it the "project support office" and it's building financial control and management capacity, improving cash controls and working capital management processes.'

Imperial has introduced 'cost control trios' across all directorates – so called because a manager and clinician from the directorate, plus a critical friend from another directorate, meet to review and reduce directorate spending.

**"Most places needed to strengthen their PMOs or even create them from scratch"**
**Jason Dorsett, NHS Improvement**

Mr Dorsett said trusts had to get into the detail of CIP governance, ensuring, for example, there are responsible individuals for all schemes and embedding a rolling approach to developing CIPs, rather than treating this as a once-a-year exercise.

In phase 1, management consultants identified savings opportunities, including £21m in procurement controls, £13m in theatre productivity and £5.5m in more productive outpatient departments.

Ms Atkinson said the FIP provided an external challenge to organisations that often knew where they could make savings but had not been able to take action. In procurement, for example, they identified savings from rationalising the number of suppliers, focusing on those that provided best value for money, and renegotiating contracts. Together with other measures such as refusing off-catalogue orders, savings potentially ranged from 0.1% to 0.5% of cost base.

The role of committees had to be addressed. Mr Dorsett said: 'Do people go into a room to make a decision or do they go there to find out what's going on? One trust not in the FIP scheme, but which is in special measures, saved 300 hours a month of executive time by slimming down the number of executives going to each meeting.'

He 'could not oversell' the importance of communication with staff and wider stakeholders to ensure they were engaged with the FIP goal of delivering savings.

Culture was also important. Dawn Jarvis, turnaround director at Doncaster and Bassetlaw Hospitals NHS Foundation Trust, said it took part in the FIP following the discovery of a significant deficit. A restatement of the 2015/16 position in January put the forecast deficit at £38m, but measures to get a grip on its finances slowed the run rate down by about £2m, producing an outturn deficit of £36m. The trust agreed a £27m deficit control total for 2016/17, but following the FIP, it is now forecasting a £16m deficit.

She added that the trust is seeking to balance financial recovery with the protection of its 'hard won' clinical service quality.

Each quarter, she and her team go through spending, line by line, with budget holders to ensure their finances are on track. It's important to set the tone, she said – no matter how senior the budget holder, if their figures are out, they are asked to rethink their plans.

The FIP is not a 'big bang' initiative with a single measure producing significant savings, It could be seen as a refocusing of traditional CIPs – albeit with external support – back to basic cost control measures. These can be worth a little individually, but add up to a greater whole.

## FIP savings tips

**NHS Improvement FIP director David Hill outlines the top 10 areas trusts should examine when seeking savings in a blog on the HFMA website. He says many areas identified dovetail with those in the Carter report on acute trust efficiency and productivity. The largest potential savings have been in using facilities better – by reducing cancellations and 'did not attends' in theatre, for example.**
**• See www.hfma.org,uk/news/blogs**

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# combined forces

**NHS Improvement wants trusts to consolidate their back-office services, including much of the finance function, as part of the STP process. But what can be achieved and will it be cheaper? Seamus Ward reports**

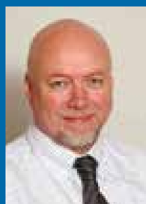
Shared services are not a new idea in the private sector or in the NHS. There are significant NHS shared services operations in Scotland, Wales and Northern Ireland, while clinical commissioning groups in England have used shared services from their inception through commissioning support units and the NHS Shared Business Services-run integrated single financial environment.

In English provider trusts, the movement towards shared services has been much more glacial, but it was given a push this summer by NHS Improvement. Keen to help providers tackle their aggregate deficit, the watchdog wrote to the 44 sustainability and transformation plan (STP) areas in August, asking them to review and consolidate back-office services. Priority areas were finance, HR, IM&T, procurement, payroll, governance and risk, estates and facilities and legal services.

The finance function included seven areas for review – financial accounts, management accounts, accounts payable, accounts receivable, income planning, commercial teams and internal audit.

The letter raised eyebrows in the finance community – management accounts, income planning and commercial teams are generally not deemed ripe for outside provision. *Healthcare Finance* spoke to a number of finance directors who were incredulous about the inclusion of these functions.

Although this may have ruffled a few feathers, some believe there is no option but to share or outsource most of the seven financial services listed. Others are more relaxed, believing they must review – or be seen to be reviewing – provision without necessarily changing who provides the services.



**"We are committed to helping and supporting STPs to look at this area and put together more robust plans"**

**John Warrington, NHS Improvement**

## Patchy performance

NHS Improvement's John Warrington acknowledges that the approach from STPs so far has been somewhat of a mixed bag.

'Some are looking at it well, some have already done it and done it well, and in others it is not even on their radar,' he says. 'We are committed to helping and supporting STPs to look at this area and put together more robust plans by the end of October so we can embed the plans in the next iteration of STPs in November.'

He adds that trusts should be aware that the push for back-office consolidation is coming right from the top of NHS Improvement. 'Jim Mackey's view is that they should be getting on with it. STPs have a lot of priorities and the back-office consolidation could drop off the scale, but he is adamant this needs to be done.'

Mr Warrington insists opportunities exist to make savings in the back office through consolidation. For example, only 60% of trust payroll and 35% of their accounts payable has been consolidated.

NHS Improvement takes the view that while trusts cannot control some costs – demand for clinical services, for example – they can bear down on back-office spending. It is also looking at how much consolidation can save, asking trusts for information on back-office service costs to see if savings are reflected in the costs of NHS organisations that have consolidated.

*Healthcare Finance* conducted a small survey of trusts' attitudes to the move to consolidate financial services (see box page 18). Although the snap survey attracted only 33 respondents, it gives some insight into how STPs are

approaching back-office consolidation.

Finance managers are almost evenly split over whether sharing or outsourcing financial services can deliver the same or better quality as in-house providers (47% think they can, 53% said no).

However, a clear majority (61%) said sharing or outsourcing would deliver savings compared with in-house provision.

In comments, finance managers said the payback could take two to three years and business cases had to be realistic. Where they could be provided at scale, sharing transactional services made economic sense, they said. Others said the savings would be marginal as there were costs in managing any external solution and in making redundancies.

While 18% of respondents said costs would increase and 15% said they would stay the same, more than 42% said the savings would be less than 5% of current costs. A further 18% believed savings would be between 5% and 10% of current costs, while 15% thought savings would be greater than 10%. This included one respondent who said savings would be more than 20%.

Survey respondents were almost equally divided on the timing of the NHS Improvement move to consolidation, with 52% saying it was not the right time. Typically, these respondents believed trusts needed a stable finance team in the face of the other challenges, including Carter and transformation.

Consolidation would prove to be a major distraction. However, the opposing view was that the financial squeeze made consolidation unavoidable. Others felt the organisational reconfiguration that could take effect under the STPs made sharing back-office services a natural next step. But, as Mr Warrington says: 'When is the right time? We believe there is £350m on the table [across all back-office services] – we need to get on with it.'

## STP support

NHS Improvement emphasises that trusts are not alone and it will provide support. At the moment, only a small amount of Mr Warrington's time is spent on back-office consolidation, but NHS Improvement plans to build a team to support STPs.

He says NHS Improvement's approach is based on the Carter methods – generate information, produce benchmarks and identify good practice. Recently, it has commissioned PA Consulting to help begin the work in earnest. 'Its job is primarily to look at STP plans, identify good practice and benchmarks to help and support the development of these plans and to challenge them where necessary.'

The consultants will also look at the supplier side of the market. But what capacity is there in the market?

Jordon Beevers, NHS Shared Business Services (NHS SBS) development director for STPs, detects a renewed determination among NHS leaders to push it forward.

'With the introduction of STPs, we feel NHS SBS can contribute towards making this happen. With the emergence of STPs, NHS SBS has a strong and reliable offering to support trusts with back-office consolidation while delivering benefits and efficiencies,' he says.

There have been a variety of responses to the NHS Improvement initiative, with about 10 STPs proactively approaching SBS 'to see how we can support and develop their plans', says Mr Beevers.

'We are contacting each of the 44 STP senior responsible officers and finance leads to understand their current thinking and provide additional support to help them develop the plans to submit by the end of October. We are engaged with about a quarter of STPs but we have an ambition to engage with all of them.'

He believes NHS SBS could provide a 'good proportion' of the areas listed for review by NHS Improvement, not just in finance. The joint venture has experience in implementing and running a large cross-boundary NHS financial shared service, he says. An example is the integrated single financial environment now used by all clinical commissioning groups.

Mr Beevers adds: 'We will be led by our

## Shared landscape

The HFMA survey in September received 33 responses, three-quarters of which came from acute or integrated acute/ community trusts. Some were unable to give details of plans for financial services, as the direction of travel had not yet been decided.

All had income planning, management accounts and commercial teams in house. The other services listed for review by NHS Improvement were shared to varying degrees:

- **Financial accounts** – the vast majority have this in-house (85%). One trust shared with other NHS providers, while four outsourced to a non-NHS provider
- **Accounts payable** – five shared with an NHS provider, six with a non-NHS service and 22 (66%) provided it in-house
- **Accounts receivable** – 72% of trusts provided this in-house; five (16%) shared within the NHS and four (12%) with a non-NHS provider
- **Internal audit** – was most likely to be shared with only one provider having the service in-house; 30% was shared within the NHS, while 67% had outsourced the work
- **Payroll** – almost half of the respondents have an in-house provider, while 36% share with other NHS bodies and 15% have outsourced payroll.

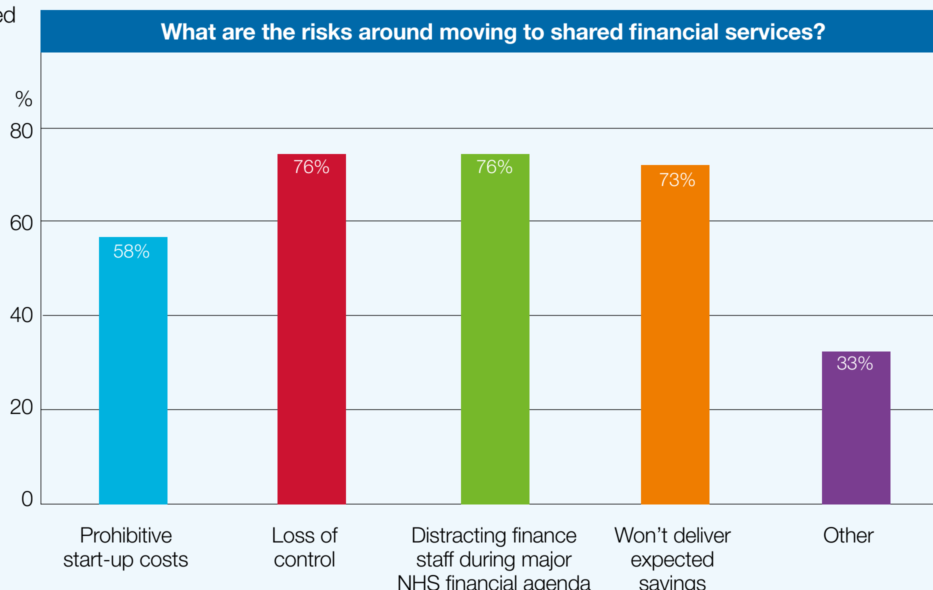
Unsurprisingly, the biggest changes are envisaged in the more transactional services. About 40% of trusts plan to move to shared services with other NHS providers in accounts payable and receivable, while one trust (3%) intends to outsource the services to a non-NHS provider.

The next biggest change is in payroll, with 27% intending to move to shared NHS provision and 6% (two trusts) outsourcing to a non-NHS provider. With most internal audit services provided outside the organisation, most trusts envisaged no change, though the one trust that has an in-house provider is planning to move to a shared NHS provider.

While most arrangements for financial accounts will stay the same, six trusts (19%) will move to share with other NHS bodies. There is also little movement in commercial teams and income planning, with three trusts (9%) looking to NHS shared arrangements in both categories. Most (94%) see no change in management accounts provision, though two trusts plan to share with other NHS bodies.

While some see changes taking place by the end of the financial year, most anticipate that changes will happen by April 2018.

The potential to distract finance staff and a loss of control were seen as the greatest risks of a move to shared financial services, closely followed by the risk of expected savings not being delivered. Some 58% voiced concerns over prohibitive start-up costs.




customers and are supportive of reaching into areas that haven't traditionally been associated with the NHS SBS portfolio of services.

'We have our own future services programme that is working to improve and enhance services that will support STPs over the next five years. We will do this in partnership with our clients to meet their future service needs.'

Many NHS organisations already share financial services within the health service. with some large trusts providing payroll and other transactional services to neighbours. And a number of consortia, initially established to serve a local area, have become national concerns.

> **"When shared services are delivered well, the provider can be a major asset to an NHS organisation"**
> Graham Gornall, ELFS

### Joined up working

Originally established in the North East of England, NEP Shared System Group (formerly North East Patches) provides a single, Oracle-based system for finance and procurement. It is an NHS consortium hosted by Northumbria Healthcare NHS Foundation Trust and serves 38 NHS organisations across the North East, North West, South West and London.

Christine Hall, associate programme director for the consortium, says most of its members operate financial services in-house using the single system. However, the host trust provides transactional processing for two NEP members.

'This works quite well as it reduces the need for software licences and, with the same data sets, it does help drive through best practice in its processes. Other members of our consortium are looking at how we can expand this offering, which will bring in additional savings locally,' she says.

'In other geographical areas, there are opportunities to work collaboratively with other service providers who offer the same software solution. Discussions are taking place to see how we can support this.'

Ms Hall adds that, working with its host trust, it can support all the financial services listed by NHS Improvement for review, in

terms of both providing services and systems needed. 'NEP is in a strong position and has the ability to share services with other NHS bodies, purely because we are offering a single platform and single data set.

'We accept it becomes increasingly difficult to offer shared services when NHS organisations are using stand-alone, disparate systems that don't have any standard approach. However, the NEP solution is flexible enough to support the needs of individual organisations' requirements, either through a shared system or shared service option.'

NEP is committed to further enhancing its ability to support back-office services, adds Ms Hall. It has recently added e-invoicing, budgeting and forecasting to its services.

'In addition, we have partners who, again through the use of technology, can help to minimise the effort from our client organisations to streamline their processes at a minimum cost,' she says.

ELFS is an NHS-hosted, shared services provider that has 30 health service clients for its finance and payroll services. Managing director Graham Gornall says: 'When shared services are delivered well, the provider can be a major asset to an NHS organisation, offering a high-quality and efficient operating solution.'

ELFS has more than 14 years' experience in the NHS, he says, and has grown steadily over that period providing a personal service that has seen it attract net promoter scores that are upper quartile for the shared service sector.

To date, ELFS has agreed with its clients that management accounts, budgetary control and business decision support are best managed locally, though Mr Gornall adds: 'Things could be different in the future if clients want to take shared services to another level.'

## Scaling issues

He believes the big challenge in the short term is scaling up the shared service sector quickly. 'Growing the shared service sector will require investment in technology and capacity,' he says, 'which potentially needs to be ready to be able to take on multiple organisations at the same time.'

Some areas of the finance function traditionally seen as sacrosanct in-house services, such as management accounting, were included in NHS Improvement's list of services for review.

Mr Warrington admits there was some debate about whether to include management accounting, given its importance in supporting frontline staff to deliver efficient services, for example. But he adds: 'Looking around the world, we knew that we could probably do better in terms of quality and efficiency. It

**"NEP can share services with other NHS bodies because we offer a single platform and data set"**

**Christine Hall, NEP Shared System Group**

should be looked at, though it might be that it comes a little later. We'll have a better view by the end of October and will look at it carefully.'

The *Healthcare Finance* survey shows little appetite to share or outsource management accounts, income planning and commercial teams. All trusts currently provide these services in-house and only two say they plan to share management accounts with other NHS bodies. Three expect to move income planning and commercial teams to a shared NHS provider, but none of them plan to outsource these services to a non-NHS provider.

'Income planning, management accounts and commercial teams do not lend themselves to outsourcing,' one finance director says.

Even where change is anticipated, it's striking how few trusts are expecting to outsource financial services to non-NHS providers, even in well-established transactional areas such as accounts payable/receivable and payroll.

One finance manager said: 'We've explored using shared services on a number of occasions but in-house remains a less expensive option.'

However, private sector provision has not been ruled out altogether. 'We are currently reviewing the transactional processing elements – initially we would look to share back office with other NHS organisations but if the most efficient way of providing this going forward is non-NHS, that would be explored,' one finance director commented.

Finance managers believe prohibitive start-up costs are a major risk in the move to shared services. One finance director told *Healthcare Finance* that local trusts had been talking about buying a new finance system but payback would take many years. 'We have been consulting on moving to one ledger but the barrier is the cost of the IT. If there was IT transformation money earmarked for back-office consolidation, we would probably do it.'

Mr Warrington acknowledges start-up costs would have to be taken into account when putting together a business case. But NHS Improvement is keen to build on existing shared services, using their infrastructure to minimise start-up costs. 'We already have solutions in place and it makes sense to use these to avoid start-up costs. There are questions about whether they are fit for purpose and we need to look at that.'

## Technology input

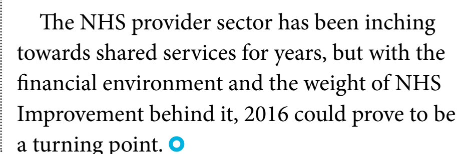
NHS SBS provides the tech as part of its service. 'We make the investment on behalf of our clients, but in-house services will have that consideration [start-up costs] to make, Mr Beevers says. 'There is a significant push from the centre to ensure there is lower spending in capital and back office because of the requirement to invest further in clinical services. It is an opportunity for NHS SBS to work with STPs to put plans in place, but also to draw out a road map across the next five years for continuous improvement in technological quality and efficiency.'

NEP's Christine Hall says her consortium is a not-for-profit organisation, with costs shared across the consortium members, keeping NHS funds within the NHS. NEP is exploring options to make it easier for organisations to join without the capital investment.

'At this time, if an organisation wishes to take advantage of our full solution and join NEP, we would need to purchase additional software licences, unless they already had access to a licence in their own right,' she says.

Almost three-quarters of the survey respondents said non-delivery of expected savings was a major risk in moving to shared services. There is a degree of scepticism over the savings produced by shared services, but Mr Beevers says the NHS SBS record speaks for itself.

'Part of our five-year strategy is to produce £1bn in savings for the NHS by 2020,' he says. 'We have currently delivered circa £400m. For us to deliver the 2020 challenge, it will have to be across all areas. It's a significant challenge and we are investing in our organisation and our services to achieve that.'



The NHS provider sector has been inching towards shared services for years, but with the financial environment and the weight of NHS Improvement behind it, 2016 could prove to be a turning point.

Ambulance service providers are making their own rapid response to calls to introduce patient-level costing across the NHS. Steve Brown reports

# blue light

The move to patient-level costing in the NHS has largely left the ambulance sector behind. This is perhaps not surprising given that total spending on ambulance services represents only around 2% of total NHS spending in England. There are only 10 dedicated ambulance trusts (plus a combined service trust in the Isle of Wight) across the whole country. And their finance departments do not stretch to dedicated costing teams, with costing often being just a small part of an accountant's responsibilities.

But NHS Improvement is determined its costing transformation programme will cover all NHS services – opening up the possibility of seeing patient costs across a whole pathway. And that means ambulance service costing is finally getting a bit of attention and support.

The sector may be making something of a standing start in terms of patient-level costing, but the proposed timetable is in fact quite challenging for all parties concerned.

The initial plans to push ambulance trusts through the programme alongside acute trusts were relaxed by a year. But that still leaves ambulance trusts working towards complying with yet-to-be published standards for costing in 2019/20, based on feedback from the ambulance sector, with a first mandatory cost collection in the summer of 2020.

## Bumpy road ahead

Those standards are now halfway through their first year of development and NHS Improvement recognises there are major challenges. 'There is a lack of experience with patient-level information and costing systems (PLICS),' says Julia Gray, costing standards lead at the oversight body. 'Until recently none of the ambulance trusts had done patient-level costing before and the majority have not implemented a costing system. There is a clear lack of costing resources and a lack of patient information – the emergency nature of ambulance care means it is simply not captured in many cases.'

To date, the more or less complete focus for costing in ambulance trusts has been the annual reference costs return. This is typically done as a project, with staff returning to their 'day job' after submission. A largely top-down process, it provides only average costs. Costs are allocated on the basis of time, but only to produce costs for the average response times for different incidents. It also only covers the 999 work, ignoring trusts' patient transport and non-emergency 111 work – which together can typically be 25% of a trust's income.

So moving to more detailed costing for all activities as a year-long process would be a massive step change. NHS Improvement

SHUTTERSTOCK

is working with all the ambulance trusts to develop the new standards for the sector – a participative approach that aims to get upfront buy-in for solutions to the key challenges.

One of the most fundamental issues is reflected in the name – patient-level costing. Obviously ambulance trusts' work is centred around advising, treating and conveying patients. But their operational focus is the incident, not the patient. That is how their activity is counted, how they are paid and how they manage themselves. From a costing perspective, it is also pragmatic. In some incidents, they don't know the patient they are helping (at least not until later, and sometimes never) – so the cost object would be missing.

Mathew Norman, head of strategic finance at Yorkshire Ambulance Service NHS Trust (YAS), which has recently led the ambulance sector into use of incident-based costing and is one of NHS Improvement's roadmap partners, says this it is an important distinction.

'We see huge benefits in more granular costing – but at an incident level rather than at patient-level,' he says. 'We get paid per incident and our costs are driven by incidents – for example, we still incur costs if we send a response and there is no patient at the scene.'

While he says the trust does obtain 'quite a proportion' of NHS numbers for patients treated or conveyed, this is not comprehensive and some of it requires manual compilation.

NHS Improvement remains committed to being able to see the whole pathway costs for a specific patient. But it recognises the practical difficulties in capturing patient details in all cases. Its solution is to allocate costs to 'a patient' not 'the patient'. So, an incident involving multiple patients only counts as one incident in the currency used to contract for ambulance services (see box overleaf).

But in these cases, trusts would need to record (and make accessible to their costing systems) the number of patients involved. NHS Improvement says this would allow costs to be split among the patients without requiring patient specific information – a good step in the right direction.

NHS Improvement is also aware that 'time is crucial' for ambulance services. Their performance management regime has been

approach

**"There is a clear lack of costing resources and patient information – the emergency nature of ambulance care means it is simply not captured in many cases"**
**Julia Gray, NHS Improvement**

built principally around response times with associated ambulance quality indicators. 'Collecting information for costing purposes can never interfere with the processes on the phone or at the scene,' it says.

Instead, 'compromise needs to be made to work with the information available,' says Mrs Gray. Work to date has involved the National Ambulance Information Group to ensure any information collected is used in an appropriate way and, where information is not collected, a work-around can be provided to address this.

## Response times

Mr Norman agrees that time is a crucial issue for ambulance services and it is a key driver of its main costs. In some ways, YAS is data rich in this area as it already collects much more detailed time information than the high-level response times set as national targets. For a 'see, treat and convey' patient it would collect the times taken for the following:

1. Call
2. Despatch
3. From vehicle start to arrival at scene
4. Time at scene
5. From scene to destination
6. Destination to handover
7. Handover to clear.

According to Mr Norman, service line management is a strategic priority for YAS, and PLICS is a key component of this. Having a detailed breakdown of how its human and physical assets are used opens up major potential to identify improvement opportunities. 'We can look at operational

## Tangible benefits from PLICS

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*Source: Patient Level Costing: Case for Change April 2016 (NHS Improvement)*

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information in specific areas, for example, and look at how that impacts variances in average cost, or we could break this down by chief complaint or patient symptoms,' he says. 'That enables us to understand the potential benefits of reducing that variation. It might also highlight where to look for examples of good practice.'

The trust is also thinking beyond simple cost analysis. 'We are starting to look at time spent on scene against patient outcomes,' he says, adding that specified clinical outcome data is already collected by all ambulance trusts.

'If we are on scene for just five minutes and then transport the patient to hospital, it may be quicker and cheaper for us, enabling us to get to the next job sooner,' he says. 'And it is arguably cheaper for commissioners, bringing down the cost of those journeys. But it may not necessarily be the best thing for the patient or the wider healthcare system.'

Spending more time on the scene could in some circumstances produce a better outcome for the patient and also reduce the pressure elsewhere in the system.

## In the detail

Detailed understanding of costs could also help identify the value of different practices and inform redesign across health economies. For example, putting more senior clinicians in vehicles might mean different responses – leaving a patient at home or referring to an alternative service rather than transporting to hospital.

Again, the cost data will enable ambulance trusts to consider the return on investment for the healthcare system when comparing the cost of the senior clinician against the saving in hospital by reduced conveyance. This is of fundamental importance given the current challenges and fits well with the aims of the sustainability and transformation plans.

YAS started introducing its PLICS system in November last year, having selected Bellis-Jones Hill as its provider using the Prodacapo system. Mr Norman says the implementation was planned to last 12 weeks but proved more complex than expected due to the 'sheer scale of activity and data points in ambulance trusts'.

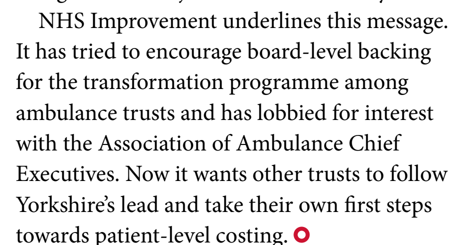
Yorkshire deals with more than three million incidents a year – up to 900,000 of these are 999 incidents – generating some 4.5 million data points in PLICS. It was a steep learning curve for everyone – the trust, NHS Improvement and the supplier.

Sebastian Kerr, associate director for Bellis-Jones Hill, says the cost model is 'very different to the one used for acute hospitals and mental health organisations'. Ambulance trusts may only have to allocate costs across four currencies, compared to the thousands of different healthcare resource groups that cover acute activity, but data volumes are still large.

'In many ways, the data is a lot richer, which makes for a more dynamic understanding of costs because the model can largely be driven by time,' says Mr Kerr. Or, put another way, high volumes of data but a slightly simpler cost make-up than acute providers.

The trust, supported by its system supplier, is now in an iterative process of refining the process and data. 'To date, ambulance trusts in general haven't taken as sophisticated an approach to costing as acutes – mostly because they have not had the staff. But YAS has some very capable people, strong data and good informatics support,' says Mr Kerr. However, while other trusts may have a similar vision, not all have started to put it into action yet.

Mr Norman believes other ambulance trusts should follow YAS's lead. 'I can't overstate the benefits of a PLICS system for ambulance trusts, he says. 'It increases understanding of the link between performance, resource and finance.'



He is clear it needs commitment from the organisation and support from finance and business intelligence teams – ideally with a dedicated resource internally with previous experience of PLICS. End-users should also be involved at all stages, to avoid the systems being labelled as 'just another finance system'.

NHS Improvement underlines this message. It has tried to encourage board-level backing for the transformation programme among ambulance trusts and has lobbied for interest with the Association of Ambulance Chief Executives. Now it wants other trusts to follow Yorkshire's lead and take their own first steps towards patient-level costing.

## Ambulance service currency

New national currencies for ambulance services were introduced in April 2012 after several years' development. These form the basis for ambulance trusts' reference costs submission. While use of the currencies is mandated in tariff guidance, prices are set locally. There are four activities described by the current currency:

**Urgent and emergency calls answered** The unit for payment is per call and all calls to the emergency operations centre are included, including hoax and multiple calls about the same incident. Calls abandoned before being answered are excluded, as are patient transport services requests and NHS

111 calls (both are separately contracted).

**Hear and treat/refer** The unit of payment is per incident and covers incidents where the call is resolved by providing advice and an ambulance practitioner does not arrive on the scene. Incidents are included where a vehicle is despatched but called off from attending the scene before arrival. An assumption is that each 'hear and treat' involves one patient, so is therefore costed at patient level.

**See and treat/refer** The unit for payment is per incident. The patient is treated and discharged from ambulance responsibility on the scene without conveying the patient to a healthcare provider. It also includes incidents where the ambulance professionals are unable to locate a patient or incident.

**See treat and convey** The unit of payment is per incident and an incident is counted when at least one patient is conveyed to an alternative healthcare provider. Patient transport services and contracts with non-NHS providers are excluded.

**Ambulance service reference costs 2014/15**

| Currency description | Activity | National average unit cost | Lower quartile unit cost | Upper quartile unit cost | Number of submissions |
|---|---|---|---|---|---|
| Calls | 9,491,159 | £7 | £6 | £8 | 11 |
| Hear and treat or refer | 575,168 | £35 | £26 | £43 | 11 |
| See and treat or refer | 2,270,229 | £180 | £148 | £198 | 11 |
| See and treat and convey | 5,107,902 | £233 | £203 | £256 | 11 |

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# Pay attention

**A number of staff-related changes are due to come in next April and finance and human resource teams need to be ready for them. Steve Brown reports**

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NHS Improvement's analysis of providers' quarter one financial performance made for interesting reading. The £461m year-to-date deficit was £5m ahead of plan and total pay bill costs were £10m better than planned. But make no mistake: pay remains undoubtedly the key financial pressure facing the NHS. And a raft of seemingly small and technical changes for 2017 could be about to add to the burden – not all will lead to an increase in direct costs, but they may well make the achievement of cost improvement programmes harder.

The detail of NHS Improvement's analysis in fact revealed a continued overspend on agency and contract staff, in part driven by an inability to recruit to permanent positions. Cost improvement programmes were also £45m below plan and 80% of this shortfall related to under-delivery against planned pay savings.

Three changes due to kick in from April 2017 – relating to salary sacrifice schemes for staff, new apprenticeship arrangements and rules around off-payroll employment – could well add to these challenges.

## Salary sacrifice

Revenue and Customs is currently consulting on changes to salary sacrifice arrangements that would reduce the associated tax and national insurance benefits for employees and employers. With salary sacrifice, an employee agrees to give up cash remuneration in return from some form of non-cash benefit in kind. The element of given-up salary is not chargeable to income tax nor is it liable for employee or employer national insurance contributions. (It also reduces pensionable pay.)

The government plans to change tax legislation so that where a benefit in kind is provided through salary sacrifice, it is chargeable to tax and (employer) national insurance. A few key areas – where the government wants to encourage uptake – would be excluded. These are:

- Pension contributions (not relevant to NHS pension scheme)
- Employer-supported childcare
- Bicycles/cycle to work.

However, employers have also used salary sacrifice to provide employees with cars, mobile phones, IT and even workplace parking. Under the proposals, they would still be able to do this, but the tax and national insurance advantages would be removed. From an employer perspective, they would continue to pay any associated administration costs for the schemes, but not save on national insurance contributions.

The HFMA will respond to the consultation, which closes in the middle of October, but has already called on NHS bodies to start thinking through the implications as the consultation suggests a start date of April 2017. Letting staff know about the changes involved in such arrangements would be the first consideration. The HFMA has particular concerns about the fairness of changing rules for staff who are effectively locked into existing arrangements. However, it has broader potential concerns too. The unwinding of existing schemes could exert an additional cost pressure (for employers and employees) – even if relatively small compared with overall spend.

One trust spoken to by *Healthcare Finance* saves about £300,000 a year overall on various car, IT and car parking schemes. It has not yet calculated the potential impact of the proposed changes on this saving, but says different schemes would be affected in different ways and to greater and lesser extents.

However, it said the administrative burden could be more significant. Car parking schemes may affect a large part of the workforce, for example, and there could be an impact on the perceived attractiveness of working for the organisation – which may be unhelpful, given the current push on improving recruitment and retention.

## Apprenticeships

There will also be changes to the way the government funds apprenticeships next April, with some employers required to contribute to a new apprenticeship levy and changes to funding paid to employers to support apprenticeship training. Employers throughout the UK with

**"The numbers we need to make the maximum use of the levy is quite a big shift on where we are now"**

**Ruth Warden, NHS Employers**

a paybill of more than £3m a year will contribute to the levy at a rate of 0.5% of their annual pay bill minus a £15,000 allowance. Most NHS bodies will face the charge and the NHS collectively will be the single biggest contributor to the levy.

It is not a one-way street. NHS bodies in England will be able to access their funds from the levy – plus a small top-up – to support apprentice training. This will be accessed via a digital account set up for each organisation, with levy contributions added on a monthly basis (based on the previous month's pay bill) and topped up by central government.

However, there are clear concerns that the NHS will be unable to get as much out of the scheme as it puts in, which means that it will end up a net contributor. Health Education England estimates the NHS will contribute £200m to the levy in gross terms. There has been no estimate to date of what the NHS could hope to claw back, but NHS Employers argued from the outset that it would be 'very challenging for the NHS to get back what it puts in'.

The problem is that the levy contribution has been based on total employee earnings. According to NHS Employers assistant director for development and employment Ruth Warden, the NHS workforce includes large numbers of people for whom apprenticeship qualifications would not be sufficient to deliver the required skills – doctors and nurses are the prime examples.

'The numbers we need to make the maximum use of the levy is quite a big shift on where we are now,' says Ms Warden. In 2015/16, there were nearly 20,000 apprenticeship starts in the NHS. The target for public sector organisations is for apprenticeships (measured in starts) to account for 2.3% of total workforce each year. Across the whole English NHS, this has been estimated at around 28,000 apprenticeship starts.

This looks even harder to achieve when you take into account that many existing apprenticeships in GP practices and dental surgeries don't contribute to the set target. Stripping these out, the NHS starting position is more like 12,000 apprenticeships – meaning it would need to more than double its current activity.

Even if it makes the 28,000 target, there is no guarantee it would see the return of its £200m contribution to the levy. There are preset amounts that can be drawn down to fund the training of recognised apprentices. Many existing apprenticeships would currently be in bands 1-4 (typically healthcare assistant, catering or administrative roles) that might attract as little as £1,500 funding over 12 months.

To start getting a better return on its contribution, the NHS would need to ensure that it had significant numbers of higher level apprenticeships. These typically attract higher levels of funding, but they also often last several years and would only count towards the 'starts' target in the first year.

There is a lot of work going on centrally and locally to understand where apprenticeships could be used more to deliver required training and meet staffing needs. For example, an apprenticeship model is being explored for nursing.

While the rules relating to the levy contribution have basically been fixed, NHS Employers is hoping to influence some of the detail around how the scheme will work. For example, it is proposed that funds will expire 18 months after being placed in an organisation's digital account. 'We want the expiry to last three years, not 18 months, to allow the NHS to develop its apprenticeship frameworks,' says Ms Warden.

It would also like to see a broader approach taken to the definition of apprenticeship training – so that funds could be used to support mentorship, for example. But at this point, there is a significant danger that the new arrangements will provide an additional cost pressure on NHS providers in particular. One trust told *Healthcare Finance* that it had built in £750,000 as an additional cost pressure for next year, based on the full 0.5% of its payroll.

## Off payroll

The government announced in the Budget earlier this year that it was planning to reform intermediaries rules for public sector workers. These earlier rules aimed to ensure that people doing the same job – whether employed directly or through a personal services company – pay broadly similar amounts of income tax and national insurance.

With the government perceiving widespread non-compliance, it wants to improve effectiveness of the rules in the public sector (currently known as IR35 rules). It consulted on its plans over the summer.

Under existing rules, the personal services company is required to assess whether the rules apply to a specific contract and, if so, work out any tax liability. The proposal is to move this responsibility to the public sector body, which, depending on its assessment of the case using an online tool, might then pay the worker through payroll having deducted tax and national insurance.

The HFMA says it is 'broadly supportive' of the proposals as members have been concerned about the complexity of the existing requirements for some time. It has called for greater clarity on the distinction between compliance with employment and tax law and reporting of off-payroll arrangements – thresholds apply for reporting but not for compliance, which can trigger penalties.

The association also wants more specific guidance on how GPs should be treated given their special status as independent contractors and the potential to support new models of care.

Finance practitioners suggest the proposals could increase the administrative burden on HR and finance teams. It doesn't necessarily help organisations identify cases in the first place. But if the tool works as promised – then it should at least provide a definitive answer on the appropriate payment approach for cases that have been spotted.

However, there is a concern that some contractors may withdraw from the NHS market if they cannot provide their services through a personal services company – making it harder for organisations to fill senior interim positions or source services from its preferred suppliers.

The NHS faces a huge agenda as it looks to hit challenging short-term financial targets while also addressing long-term sustainability issues. But all the changes discussed – salary sacrifice, appreniceships and off-payroll contractors – demand early attention from NHS bodies.

The clear message is to think thorough the implications now, rather than wait until new rules are implemented in April next year. And that means involving all the relevant departments, including finance, human resources and any payroll or accounts payable providers.

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# professional lives

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## Department brings FTs back into fold with group accounting manual

Technical update

The Department of Health issued the *Group accounting manual 2016/17* (GAM) early in September, with only minor changes compared with the version it consulted on at the beginning of the summer.

The manual sets the accounting rules for all bodies within the Department's group accounting boundary, which includes more than 450 bodies. For the first time, NHS trusts, foundation trusts and clinical commissioning groups will all refer to this manual for guidance – previously foundation trusts followed separate guidance issued by the (then) regulator Monitor.

There is one exception to the 'one manual to rule them all' approach – the second chapter on the requirements for the annual report. This is not applicable to foundation trusts, which will refer instead to an annual reporting manual that will be published by NHS Improvement later this year.

The manual covers all organisations in the Department group, but some guidance is specific to organisation types.

In its response to the consultation, the HFMA had suggested this was not always clear. The Department has taken this on board and made this much clearer in its final version, while also using consistent terminology to refer to the different types of NHS entities.

All the main changes (compared with the 2015/16 requirements) broadly remain as they were proposed in the consultation draft. Some of these aim to align reporting requirements for foundation trusts with the rest of the NHS. For example, the previous requirement for foundation trusts to make separate disclosures in relation to director benefits under s412 of the *Companies Act 2006* has been removed. The requirement to use the market discount rate when using future cashflows to calculate the fair value of financial instruments has also gone.  Neither of these changes are likely to have a significant effect.

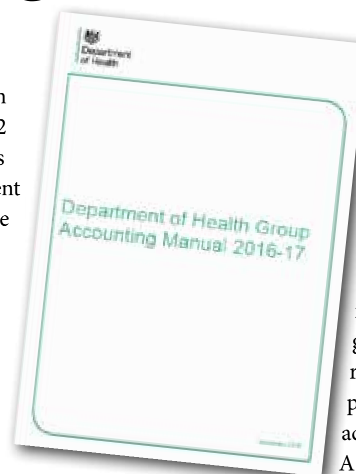
However, one change will have an impact on a small number of foundation trusts – the requirement that all NHS bodies use £5,000 as their de minimis limit for capitalising individual or grouped assets.

While this has previously been the case for NHS trusts and CCGs, foundation trusts have previously been allowed to apply a different de minimis. Some had set the threshold at up to £15,000. For those foundation trusts, this seemingly small change may require a lot of work to implement.

The HFMA had asked for confirmation of whether this should be treated as a change in estimation technique or accounting policy – the latter potentially requiring prior year restatements, which would be difficult for some bodies. However, the Department has not provided a definitive view.

**For the first time, NHS trusts, foundation trusts and clinical commissioning groups will all refer to this manual for guidance**

'Any foundation trusts for whom adoption of the [lower] threshold would be a change in accounting policy should consider whether the impact is sufficiently material to require prior year restatement in line with IAS 8,' the manual says.




The HFMA has encouraged NHS foundation trusts in this position to have early discussions with auditors.

For non-foundations, chapter 2 covering the annual report now provides clearer guidance on which bodies are required to produce which parts of the Parliamentary accountability and audit report. A useful table summarises the parts of this report that are mandatory, not applicable or optional for each type of NHS entity.

Detailed information on staff numbers and detailed staff cost analysis – previously reported in the accounts – will now move to the annual report, with just a single column reported in the accounts.

Finally, chapter 2 now reflects the requirement (already included in *Managing public money*) to report the total value of gifts made if they total more than £300,000 and provide details of individual gifts over this amount.

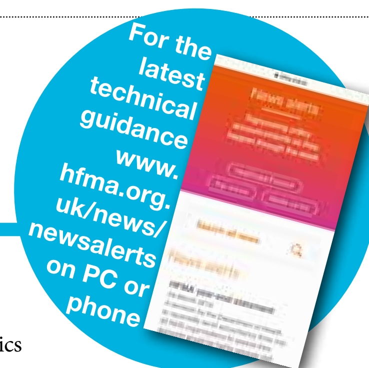
The two main changes that will have an impact on all entities are:

- Clarification about the valuation of loans from the Department – to be held as the historic cost of the principle outstanding, with any unpaid interest held as a separate accrual
- A reminder that in some circumstances it is appropriate to value PFI assets net of VAT. This can only be done where the VAT is recoverable and the approach has been agreed with both valuers and external auditors.

*Debbie Paterson is a technical editor with the HFMA*

# Technical review

## The past month's key technical developments




**Technical roundup**

Difficulties producing the annual report and accounts for 2015/16 related to one-off events in what was otherwise a 'business as usual' year, according to an HFMA survey of finance practitioners. The survey, which drew 84 responses from commissioning, commissioning support and provider bodies, follows surveys of just the commissioning sector in the previous two years. Other than one-off events, such as mid-year mergers, the difficult issues tended to be dealing with new initiatives such as the better care fund and primary care co-commissioning. The financial pressure in the year led to additional auditor scrutiny, with a focus on prudence following communications from the centre. The agreement of balances exercise again consumed a lot of time and resource. Detailed feedback from the survey has been shared with the Department of Health, NHS Improvement, NHS England and the National Audit Office and the association will use the findings to inform its work programme and next year's pre-accounts planning conferences.

An agency spend metric has been added to the four finance metrics proposed by NHS Improvement for its finance and use of resources assessment as part of the new single oversight framework (see table). The final framework was published in September following consultation over the summer (*Healthcare Finance* September 2016, p27). The consultation had proposed to operate the agency spend metric, which looks at distance from a provider's cap, in shadow form for the rest of 2016/17. Two further metrics – change in cost per weighted activity unit and distance from capital control total – will stay in shadow operation as proposed. But the oversight body has removed the specific score thresholds set for these metrics while further work is done and the metrics are better understood. NHS Improvement has also decided to return to measuring income and expenditure margin rather than EBITDA margin. It had proposed switching to the earnings margin as part of its consultation. All five metrics will have equal weighting in the overall finance rating. There has also been a change in the language used, describing the framework in terms of providing support rather than identifying concern.

A busy work programme for the HFMA will see it continuing to support the transformation agenda with reports on sustainability and transformation plans and what the NHS can learn about integration from across the UK. The programme, approved by trustees over the summer, sets out plans for briefings, guides and other outputs in five policy areas:

- Transforming service provision
- Building a sustainable financial future
- Knowing the business
- Getting the basics right
- Giving a national perspective.

The association will continue to take financial soundings from directors with its biannual NHS financial temperature check. It aims to supplement this with an examination of the NHS finance function following Lord Carter's work on productivity and it will explore the impact on the NHS of the vote to leave the European Union. At a more detailed level, there will be briefings that look at accounting for joint working and maintaining good governance in challenging times. The complete work programme can be found on the HFMA website.

**New sustainability and financial performance risk rating**

| | Weighting | Metric | Score | | | |
|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 |
| Financial sustainability | 0.2 | Capital service capacity | >2.5x | 1.75-2.5x | 1.25-1.75x | <1.25x |
| | 0.2 | Liquidity (days) | >0 | (7)-0 | (14)-(7) | <(14) |
| Financial efficiency | 0.2 | I&E margin | >1% | 1-0% | 0-(1)% | ≤(1)% |
| Financial controls | 0.2 | Distance from financial plan | ≥0% | (1)-0% | (2)-(1)% | ≤(2)% |
| | 0.2 | Agency spend | ≤0% | 0-25% | 25-50% | >50% |

## NICE learning disability guideline

**NICE update**

NICE has produced a guideline (NG54) offering best practice advice on the prevention, assessment and management of mental health problems in people with learning disabilities in all settings, *writes Nicola Bodey.*

Mental health problems in people with learning disabilities are more common than in the general population, with a point prevalence of about 30%. They are also under-recognised in people with learning disabilities, and professionals are increasingly aware that mental or physical health problems can be incorrectly attributed to the person's learning disabilities.

Recommendations include cognitive behavioural therapy, adapted for people with learning disability, to treat depression in people with milder and more severe learning disabilities and using graded exposure techniques to treat anxiety or phobias.

Experts suggest there is variation in services across England. Implementing the guideline may have a resource impact for the NHS and local authorities in several areas:

- Staffing
- Staff training
- Psychological interventions
- Annual health checks.

Implementing the guideline may result in the following benefits and savings:

- Improved recognition of the symptoms and signs of mental health problems in people with learning disabilities, leading to effective treatment
- Prevention of mental health problems in people with learning disabilities, leading to reduced costs
- Reduction in the costs of treating mental health problems in people with learning disabilities

# Diary

## October

**7-8** B Kent, Surrey and Sussex Branch: annual conference
**12** I HC4V: international symposium, London
**12** B South Central Branch: technical update, Southampton
**13** B East Midlands Branch: annual conference, Leicester
**14** B Eastern Branch: annual conference, Newmarket
**15** B Northern Branch: treasure hunt, Newcastle
**19** N Charitable Funds, London
**20** F Provider Finance Faculty: directors' forum, London
**21** B Northern Ireland Branch: annual conference, Belfast
**21** B North West Branch: implications of changes in procurement law, Liverpool
**25** F Chair, Non-executive and Lay Member Faculty: NHS operating simulation, London
**26** B London Branch: AGM, Rochester Row
**27-28** B Scotland Branch: annual conference, Glasgow

## November

**10** I HC4V: technical costing update, London
**11** B Northern Branch: annual conference, Durham
**14** B Eastern Branch: national tariff, Newmarket
**15** F Provider Finance Faculty: directors forum, London
**17** B West Midlands Branch: AGM, Birmingham
**21** B North West Branch: AGM, Liverpool
**23** F MH Finance: directors' forum, Grant Thornton UK
**24** F Audit conference, London
**24** B South Central Branch: technical update, Newbury
**29** B Eastern Branch: accounting standards, Newmarket

## December

**7-9** N HFMA annual conference: *Step up*, London Hilton

## January

**17** F Annual chairs conference, London
**25** N Pre-accounts planning, Leeds
**26-27** B Yorkshire and Humber Branch conference, Broughton
**26** N Pre-accounts planning, London
**27** B Kent, Surrey and Sussex Branch: student conference, Maidstone
**30** B Eastern Branch: introduction to NHS finance, Fulbourn

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

key: B Branch N National F Faculty C Committee/

- Reduction in associated support and social care costs.

These mental health services are commissioned by clinical commissioning groups (CCGs) and NHS England. Providers are NHS hospital trusts, primary care services. independent hospitals and secure care services (usually through specialist commissioning). Commissioners will need to work with providers of mental health services to ensure that local services for people with learning disabilities follow the recommendations.

**Nicola Bodey, NICE senior business analyst**

# Events in focus

## Provider Finance Faculty, directors' forum
**15 November, London**

Initiatives such as the Carter efficiency plans, paperless NHS and costing transformation programme point to a much greater role for IT and digital technology in the health service.

This will be the focus of the Provider Finance Faculty's next forum. As well as looking at the broader digital landscape for health, the forum will examine the Carter recommendations for improving the use of digital technology.

It will be an opportunity to understand the term 'meaningful use', a concept used by Lord Carter and a key part of the NHS digital maturity index.

The HFMA has confirmed the first keynote speaker for the event – Tom Denwood (pictured), NHS Digital's director of provider support and integration.

There will be other plenary sessions, plus sub-plenary workshops, which will explore case studies. This is a new date for the forum, which was initially scheduled for 20 October.

• For further details, contact grace.lovelady@hfma.org.uk

## Step up programme
**November**

Two national one-day events are to be held in November as part of the HFMA *Step up* programme. The events, facilitated by Steve Head (pictured), will focus on leading change, managing teams and developing management skills. Though primarily aimed at finance directors and deputy directors, the events would be suitable for other senior finance professionals.

The day will be split into two parts – the first on self-awareness, the second on building and leading world-class teams. The interactive first part will give delegates a greater understanding of how their actions can affect their teams and how to be more consistent in their behaviours. The second part will look at building trust and inspiring team members, as well as helping cope with stress.

• The events will be held in London on 1 November and Leeds on 16 November. To book a place or for more information, email charlie.dolan@hfma.org.uk

# Making introductions

**Association view from Mark Knight, HFMA chief executive**

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

**My HFMA**

The new *NHS finance introductory guide* has just been released and is available now from the HFMA online shop. I know many of you regard this as the unofficial bible of NHS finance. However, unlike the holy book, the guide changes frequently and this edition is no different. It's a great resource to give to your various managers, board colleagues and staff to supplement the e-learning and other resources HFMA provides.

We are now in the thick of our autumn programme, with summer a dimming memory and conferences going on everywhere from the South West right up to Scotland.

Our president has had a very successful year encouraging our members to *Step up* and there are still places available on our wide range of programmes to support her year. Mentoring is a key theme, with more than 50 booked onto these programmes. And look out for the various different development sessions being planned and funded at branch level.

The 2016 annual conference programme looks very good – please keep your eyes peeled for announcements regarding important speakers. It's still the number one gathering for NHS finance professionals and I'm grateful for everyone's support in making it the event it has become.

We are fortunate to have some strong speakers from a whole range of areas, alongside the usual panel of system leaders.

The annual dinner, at which our industry awards are presented, is still a highlight. At the time of writing, the indications are that we will have a strong group of entries for these awards, with the powerhouse of the North West region hoping to cling onto their title of unofficial kings and queens of the medals table.

Of course for members working in the service, you have precious little time to think as the deadlines come in thick and fast – particularly in England, where the sustainability and transformation planning process is in full swing. That's why I'm so grateful for all those who can attend the networking and committee meetings we hold. HFMA policy director Paul Briddock and his team have a heavy schedule of work, not just in the high-profile areas but in vital, more 'under the radar' areas such as costing, financial accounting and governance.

**HFMA chief executive Mark Knight**

My colleague Alison Myles, HFMA director of education, is working hard with her team of staff and consultants to develop the HFMA qualification. We were bowled over by the response to the invitation to pilot the initial modules and a few dozen brave souls will be starting that from November onwards.

We are slightly later than planned because of various technical challenges that have arisen. However, we are going to open for registrations for the diploma and the higher diploma on the Thursday of the annual conference.

The first students will start studying for the first modules in May 2017 – the end of one journey for us and the start of another that will see the association heading to new places.

I would like to thank all of those who have helped get the qualification this far, it's been a significant undertaking.

Finally, a reminder that new members can pay by monthly direct debit from October onwards. If you can spare a minute to help persuade one of your colleagues, it would be most appreciated, and at £6 per month it's a small price to pay to receive all that HFMA offers. It might be the best decision you and they make that day!

## Member news

In September the HFMA welcomed 10 graduates and four apprentices to the NHS Finance Management Training Scheme in South Central, South West and West Midlands. On day one the trainees met second and third years to hear their experiences; on day two they played the NHS Operating Game led by Chris Calkin.

The British seven-a-side football team, including HFMA head of skills development James Blackwell (pictured in Brazil), finished fifth in the Rio Paralympics – the best result of a British football team in the games. Mr Blackwell scored a goal against Ireland. 'It's been the most amazing, surreal, funny and inspiring experience of my life,' he said. 'Thank you for the support and kind messages.'

Nadine Gore is now branch administrator for the London Branch, taking over from Taryn Nicolson in September.

Stuart Lindsay, an associate director in the public sector advisory team at BDO, is HFMA East Midlands Branch's newest committee member.

Two teams from Mersey Care NHS FT's finance unit (pictured) competed in a local 'wipeout' activity day. Activities included quad boats, kayaking, stand-up paddle boarding and raft building, as well as problem solving and orienteering. The teams were fundraising for the Stroke Association, Alzheimer's Society, Cancer Research and MIND. To donate go to **http://linkis.com/www.justgiving.com/c/fiYqo**

## Member benefits

**Membership benefits include copies of *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**

## Faculty focus

### Chair, Non-executive and Lay Member

The lack of adequate housing or social services to support patients after they are discharged from acute or mental health hospitals, means they often need to stay longer. This has proved to be a major challenge for the health system. The Carter report on NHS productivity identified it as a significant problem, meaning patients were not being cared for in the most appropriate setting and adding unnecessary cost.

The report called on trusts to co-operate more with other health and social care partners and for the system to put the right incentives in place for this to happen.

Appropriate and cost-effective provision for elderly and vulnerable people through system integration was one of the topics discussed in a recent Chair, Non-executive Director and Lay Member Faculty forum.

'One of the key points that came up during the session was the need to look at the whole situation,' said Heather Strawbridge OBE, chair of the faculty and chair at South Western Ambulance Service NHS Foundation Trust. 'It became clear once again how important it is that the health service works together with social care and housing providers.

'The faculty provides good opportunities for people from across the health communities to come together to network – commissioners, providers and ALBs. We can talk to each other about the issues that we are all facing; share areas where we've made good progress and areas where we've learnt that things didn't work,' Ms Strawbridge added.

The faculty not only encourages the sharing of best practice between different organisations within the NHS, but gives a critical perspective to different issues around governance. The keynote speech for the upcoming audit conference (London, 24 November) will do just that. Former national NHS finance director Richard Douglas (above), now non-executive director and chair of the audit committee at NHS Improvement, will be talking about NHS governance – personalities, policy and politics.

The faculty team is already working on the programme for the chair's conference in January, where delegates will have the opportunity to hear from Jim Mackey, Care Quality Commission chair Peter Wyman and NHS Confederation chair Stephen Dorrell.

**• To find out more about the faculty contact aimee.church@hfma.org.uk or go to: hfma.to/cnl**

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# Appointments

**Stephanie Watson**, who was previously director of finance on interim basis at Mid Essex Hospital Services NHS Trust, is now financial lead for the Essex 'Success regime', which includes hospitals in Mid Essex, Basildon and Thurrock and Southend. Ms Watson is succeeded by **David Miekle** (pictured), who was previously director of finance at Medway NHS Foundation Trust. Mr Miekle has more than 25 years of experience working in healthcare finance.

**Andy Robinson** (pictured), previously director of finance and performance at Northern Devon Healthcare NHS Trust, has been appointed system lead director of finance at the North, East and West (NEW) Devon 'Success regime'. Mr Robinson qualified in 1996 as a management accountant and was appointed to his first director of finance post in 2001 at the Robert Jones and Agnes Hunt Orthopaedic and District Hospital. He is succeeded at Northern Devon Healthcare NHS Trust by **Colin Dart**, who is acting up as a director of finance from his substantive position as deputy director of finance.

**David Shannon** has been named director of finance at Taunton and Somerset NHS Foundation Trust. He was previously director of operational finance at North Bristol NHS Trust, which he joined in June 2014. Before that he spent six years at Nottingham University Hospitals NHS Trust as assistant director of finance. He succeeds **Peter Lewis**, who was acting as director of finance from his substantive position as deputy chief executive officer.

**Steve Perkins** is acting chief finance officer at Wiltshire Clinical Commissioning Group following **Simon Truelove**'s move to Avon and Wiltshire Mental Health Partnership NHS Trust (see page 32). Mr Perkins joined NHS Wiltshire CCG in February 2013, when he was appointed deputy chief financial officer.

Homerton University Hospital has named **Jonathan Wilson** (pictured) as finance director. He was previously director of finance at Royal National Orthopaedic Hospital NHS Trust. Mr Wilson's career in the NHS started in 1998 when he joined the NHS national financial management training scheme as a graduate trainee and worked at West Hertfordshire Hospitals NHS Trust. He succeeds interim finance director **John Yarnold**.

**"I want to generate an environment of accountability and make sure good information is being provided"**
**Simon Truelove, Avon and Wiltshire Mental Health Partnership NHS Trust**

# Truelove makes move to mental health sector

**On the move**

Balancing family commitments with a career in NHS finance is not straightforward, and for Simon Truelove getting this balance right has meant waiting for the right opportunity to come along. He has been appointed director of finance at Avon and Wiltshire Mental Health Partnership NHS Trust (AWP), joining from Wiltshire Clinical Commissioning Group, where he has held the post of chief finance officer for the last four years.

'I have been in the NHS for 26 years, in a range of organisations, from providers to commissioners and across health and social care. The opportunity to get back into the provider landscape as a finance director was something I desired and I'm glad the opportunity came up at AWP,' he says.

'I believe in maintaining a balance between work and family life. I have three children and never wanted to up sticks and move them. The opportunity at AWP came up at the right time.'

This was not just the right opportunity, but also the right job, he says.

'I have always been passionate about mental health services and it has always felt like a second-class service compared with some mainstream acute hospitals. But mental health is a rising challenge for the NHS because it touches so many people. I wanted to be part of an organisation trying to respond to that challenge.'

He brings with him an extensive knowledge of commissioning, both locally and nationally – he was one of the national finance leads for the development of medium secure units.

'I feel my knowledge of commissioning is a strength. I know what's going on in commissioning with respect to parity of esteem, and I can challenge commissioners about the investment they are putting in, to make sure it's having the desired impact.'

AWP has a block contract with commissioners for its services. But with demand rising he says he will be working with commissioners to ensure services are sustainable. 'I am conscious of the fact that we need to move mental health services to a tariff-based approach. If an organisation is doing more or can deliver more, it needs to be at least getting some financial contribution towards it, even if it's at marginal cost.

'But I am mindful that CCGs are in a difficult place and funds are restricted. I hope as a system we can get sign-off on where we want investment to go. Clients with mental health issues are turning up in A&E more often, which is challenging for these services.'

He believes a tariff approach is one way of ensuring these patients are seen in a more appropriate setting – in mental health services.

Having started the job at the end of September, and having spent a few days at the trust prior to joining permanently, Mr Truelove has already picked out some priorities.

'I want to generate an environment of accountability and make sure good information is being provided to the organisation to allow it to make informed decisions.'

He also wants to create a supportive culture within the finance department. 'AWP has gone through some tough times and I want to try to create a supportive environment for the people working for me. You are only as good as the team working around you.'

He says it's important for finance professionals to work across the service – from commissioning to the range of providers, including primary care, community, mental health and acute.

'I believe it is really important for finance directors to understand what's happening in the wider system because acute or mental health providers cannot deliver the whole agenda by themselves. Commissioning finance directors get a wider view of what's happening and I can bring that to AWP.'

## Common appraisal framework

**Future focused finance**

NHS Future-Focused Finance (FFF) has launched a framework outlining the attributes needed by NHS finance staff, which can be used for formal and informal appraisal. FFF said the 'Four strengths' framework would give finance departments a common set of standards. Finance staff in different types of organisation – commissioner or provider, for example – could be appraised using the same standards.

The strengths have been expressed as challenging personal statements: I'm a finance expert; I'm a team player; I drive value; and I make change happen.

The strengths, and the descriptions that support them, have been developed in consultation with NHS finance professionals.

Finance staff gave a positive reaction to the statements in an FFF survey. Of 350 respondents, 71% agreed the framework was a good idea and the new, consistent language an advantage. Finance staff saw themselves as strong team players, but being able to 'make change happen' was seen as an area for improvement, with an average score of 3.5 out of 5.

FFF skills and strengths programme senior responsible officer Richard Alexander, who is also chief finance officer at Imperial College Healthcare NHS Trust, said: 'Most of the staff we spoke to conceded that the existing finance competency frameworks for NHS finance professionals are good, but the materials spend most of the time on office shelves.

'The framework can be used all year round, formally and informally. It also emphasises that the essential technical expertise in finance, for which there is much development support, is only one of the strengths we actually will need.'

# Digital health and technology forum

**15 November, London**
HFMA Provider Finance Faculty

**This session will examine the current digital landscape in health and will showcase the benefits of using digital technologies in trusts and across STP footprints. How can these tools be used to improve efficiency, quality, and contribute towards the financial savings target highlighted in the Carter Report?**

Join us to get involved in the discussion, hear from industry thought-leaders and network with colleagues.

The event will include both keynote speakers as well as an opportunity to share learning through smaller, focused case-study sessions. The day will give you an opportunity to:

- take a look at the current digital landscape for Health
- examine the Carter recommendations for improving the use of digital technologies
- outline the key policy and programmes available to support trusts
- get an understanding of the concept of 'meaningful use'
- focus on benefits of, and ways in which digital tools can improve efficiency, quality, and contribute towards the financial savings target

Book now by visiting **hfma.to/digitalhealth**

For more information contact **grace.lovelday@hfma.org.uk**

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