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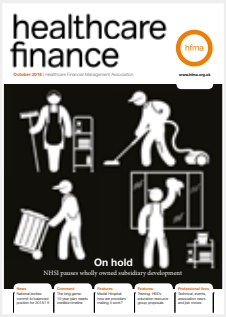

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Contents

October 2018

News

Comment

Professional lives

Page 8 **The long view: Northern Ireland's health and care services cannot make the necessary improvements without a political breakthrough**

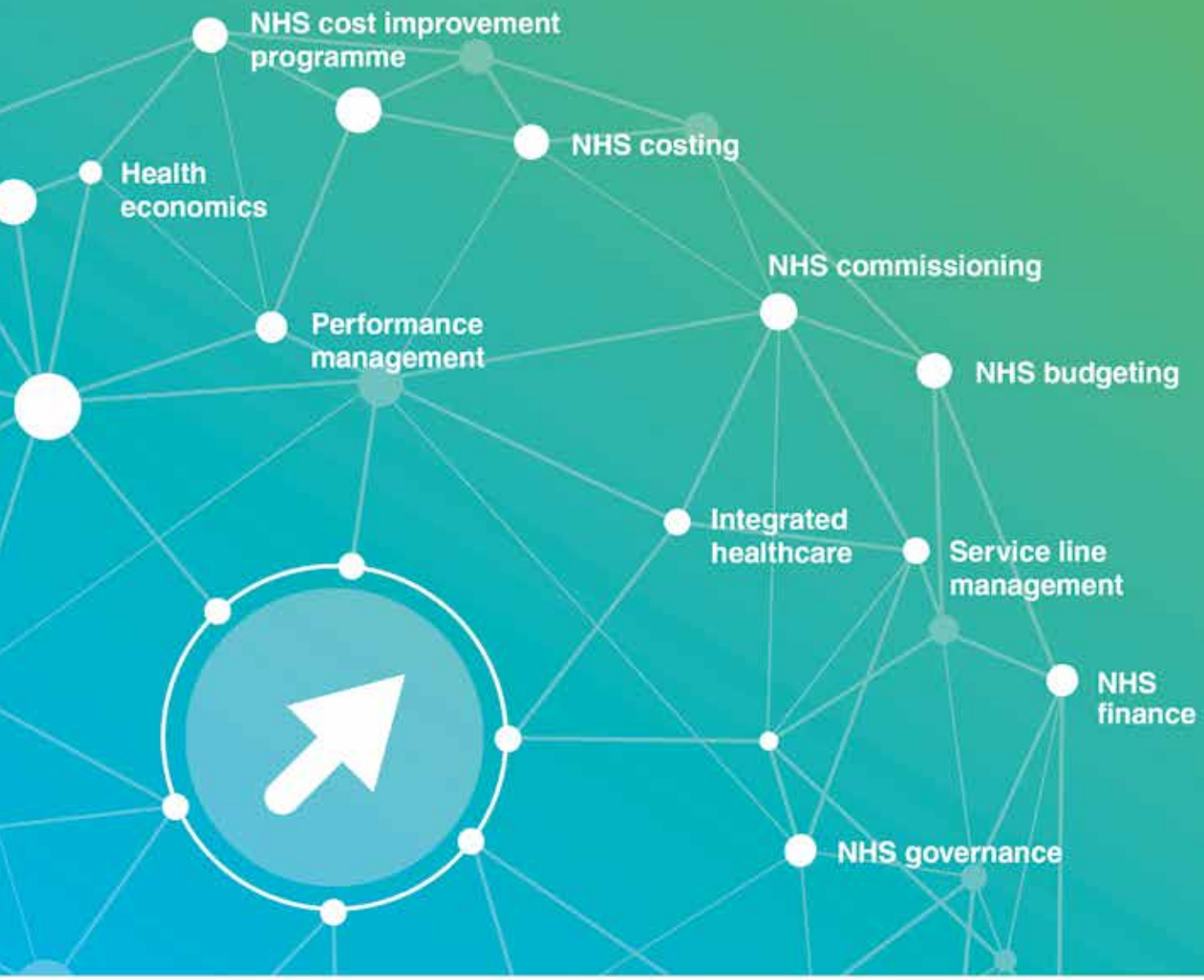
Features

HFMA e-learning
Healthcare finance and business training

hfma

HFMA e-learning

Improving performance through a better understanding of the NHS



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News

Commissioners and providers to contribute to balanced plan

By Seamus Ward

At the end of month four, commissioners and providers were forecasting a combined deficit of £526m, although NHS Improvement and NHS England are both committed to producing a balanced plan before the end of the calendar year.

The national bodies presented the financial picture in commissioner and provider sectors after four months of the financial year in their second joint board meeting at the end of September.

Commissioners had agreed balanced plans for the year, while providers' quarter one report revealed a planned £519m deficit.

The national bodies said a joint programme of action has been agreed to eliminate the £519m deficit in the submitted operating plans in time for quarter two reporting.

Under the plan, the commissioning sector will deliver £265m of planned underspend at month five. NHS Improvement is currently reviewing returns from providers to confirm the level of improvement achievable by providers against a target of £254m.

The national organisations said that actions to improve the financial plans were ongoing and not reflected in the position at month four.

While commissioners forecast an aggregate deficit of £5.8m, the provider sector predicted a combined deficit of £520m, including the provider sustainability fund (PSF). The forecast provider deficit alone, not including uncommitted PSF, stood at £1.5bn against a plan of £1.4bn. At month four, 29 clinical commissioning groups and 100 providers were reporting overspends against plan (including PSF in providers) but, according to forecasts, this will fall to zero and 63, respectively, by the year-end.

Emergency activity is affecting the financial position of commissioners and providers, the board paper said. For commissioners, higher levels of emergency activity is only partially offset by lower elective activity, creating a financial pressure. And in providers, the higher cost of providing unplanned emergency care and the knock-on effect of lower elective income is having an impact on finances.

Commissioners forecast that they would deliver £3.2bn in efficiency savings (94% of plan) by year-end, while providers said they would save £3.4bn (95% of plan).

NHS Improvement chief financial officer Elizabeth O'Mahony (pictured) told the joint board meeting that discussions at system level and with challenged trusts had delivered some progress.

But additional risks had been identified, including unexpectedly high bed occupancy levels and questions over the funding of new Agenda for Change pay scales.

"If we end this year with any financial risk that needs to be carried forward, it will affect our ability to drive change"
Elizabeth O'Mahony (pictured)

More than half of the gap had been closed so far, she said. There was a determination across the service, NHS England and NHS Improvement to close the gap completely and deliver a balanced plan at year-end. 'Most importantly, this is the platform for the long-term plan,' said Ms O'Mahony. 'If we end up in a position this year where we have any financial risk that needs to be carried forward, it will affect our ability to drive change.'

She continued: 'We are broadly on plan, but there's further work to do in terms of closing the financial gap. But we can say it's a positive place to be at this stage of the year in respect of the fact that the board-approved plans that have come forward from all of our providers are, in aggregate, being delivered.'

Although the plans were not without risks, there was a greater clarity on the risks and they were better understood. But there was no longer a risk reserve to offset that risk.

'Between now and the end of the year, we are going to be looking at a number of options – working with systems to ask what the trade-offs are to ensure that we don't forfeit some of the future by making bad decisions this year,' said Ms O'Mahony.

In the Q1 report, NHS Improvement revealed the provider sector entered the year with an underlying deficit of £4.3bn.

This deficit figure ignores the £2.45bn provider sustainability fund for the current year. Though the PSF is non-recurrent, assuming it is deployed in the provider sector the underlying deficit falls to £1.85bn.

ICS progress

Wave one integrated care systems (ICSs) performed better against their financial plans in 2017/18 than non-ICSs, according to a joint board paper on ICS progress.

The paper said six of the 10 first-wave systems delivered a better financial position at year-end than planned, though it acknowledged that selection of this wave was based partly on good financial control. Operational performance on key measures such as cancer and A&E waiting times were above average in most of the first wave.

Eight of the ICSs in wave one are using a new financial framework where they link some or all of their provider sustainability funding to the collective financial performance of the system.

Speaking at the joint board meeting, NHS Improvement executive director of strategy Ben Dyson said ICSs should not be seen as 'an optional extra'. 'Everybody should be doing this,' he added.

Carter points to £500m ambulance savings

By Steve Brown

Reducing avoidable ambulance conveyance and introducing a more efficient operating model across ambulance services could save the NHS up to £500m and help improve performance, Lord Carter's latest report into productivity says.

The new report on the emergency side of ambulance services from Lord Carter (inset), a non-executive director at NHS Improvement and NHS productivity champion, follows his two earlier reports into productivity in acute and mental health/community services.

If paramedics treated more patients at the scene or referred them to services other than A&E, the service could save £300m – mainly from reduced A&E attendance and subsequent admissions. Currently ambulance trusts take on average 58% of patients to A&E, but the range stretches from 52% to 64%.

The report calls for all trusts to target 50%, but recognises that this will require significant improvements in the availability and accessibility of the urgent and emergency care system. It also acknowledges that all trusts have approaches to manage demand in place, but few know if interventions are having an impact.

Implementation of a more efficient operating model could improve productivity and save

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a further £200m by 2021, the report claims. It makes nine recommendations in total covering the need to improve benchmarking, staff planning, fleet management and the performance of control centres.

It highlights challenges with sickness absence rates, with the ambulance service having the highest absence rate in the NHS, losing 20 days per member of staff each year. If reduced by 1%, this could save £15m a year.

A common operating model for ambulance services would include standardising call triaging and processes, delivering best practice protocols for clinical assessment in the control centre and on scene, moving to a common specification for ambulances and converging the technical infrastructure to enable shared call-handling.

Delivery of these goals could be incentivised through the CQUIN system. However, in future safe reduction in avoidable conveyance should be incentivised through the use of the tariff.

The current national currency covers: calls; hear and treat/refer; see and treat/refer; and see, treat and convey. Encouraging greater treatment on scene or referral could require the tariff to reflect the additional time taken by paramedics on scene.

Though there is a national currency, prices are set locally. However, seven of the 10 ambulance trusts are currently on block contracts.

Lord Carter said too many patients were being taken to A&E unnecessarily, putting pressure on hospital services, costing money and providing the wrong response for patients. 'An ambulance is not a taxi to A&E,' he said. 'Modern technology means patients can often be treated at the scene. But an ageing ambulance fleet means this is not always possible.

'It is vital that improvements are made in the infrastructure of the wider NHS to help frontline staff work as efficiently as possible.'

Miriam Deakin, NHS Providers' deputy director of policy and strategy, said there has been impressive progress in treating patients at the scene. 'To be able to realise the levels of savings identified, we must address pressures in other parts of the health and care system,' she said. 'Reducing unnecessary trips to hospitals in ambulances could save money, but it will require investment in other areas.'

Wales pay deal tops England, says minister

Health staff in Wales on Agenda for Change contracts have agreed a new three-year pay deal similar to the agreement struck for colleagues in England.

The Welsh government announced the agreement, saying trade unions had accepted its offer unanimously. It added that the deal matched that offered to staff in England and, in some places, goes further.

As in England, individual staff not at the top of their pay band could receive cumulative increases of up to 29% over three years. Staff at the top of their bands will receive a cumulative 6.5% pay rise over the period.

The uplift is backdated to April and the number of pay points reduced, removing overlapping bands. The latter should lead to faster pay progression. Higher starting pay should aid recruitment and the government has guaranteed to fully fund the pay award over the three years.

Welsh health secretary Vaughan Gething (pictured) said the deal exceeded that in England in a number of areas, including more generous sickness payments.

He added: 'We have committed extra funding beyond the consequential funding we received following the pay rise in England, to offer a deal that is not only fair to staff and taxpayers but will also lead to a better NHS for Wales.'

In Scotland, the government said GPs will receive a 3% pay rise, backdated to April. It said the rise would apply both to salaried doctors who earn less than £80,000 and independent contractors. NHS salaried doctors and dentists who earn more than £80,000 will receive an extra £1,600. The Scottish British Medical Association said the announcement would make little impact on recruitment and retention.

In a further development, the Department of Health and Social Care in England is carrying out a scoping exercise on whether to expand the Senior Salaries Review Board (SSRB) remit to include NHS very senior managers. The pay of around 360 executive senior managers (ESMs) in the Department's arm's length bodies is currently in the SSRB's remit – though they were temporarily removed this year.

The review body said it believed making recommendations on ESM pay, but not on that of very senior managers was 'neither practical nor sensible'.

Trusts making savings from lab networking strategy

Moves towards creating regional pathology networks in England contributed to cost improvements of at least £33m in 2017/18, with savings worth £30m identified for the current financial year, according to NHS Improvement.

In an update on the pathology network strategy, the oversight body said the £33.6m in pathology cost improvements – self-reported by trusts – was thought to be an underestimate of the total in-year efficiency gain.

The strategy aims to create 29 regional hubs by linking pathology departments in 122 acute and specialist NHS hospitals, after analysis showed unwarranted variation in the delivery of these services because of how they were organised. Urgent lab work will still be offered from hospitals.

Launching the strategy a year ago, NHS Improvement said the new system could release £200m by 2020/21, though more advanced networks have found that greater savings are possible.

The report said more than 80% of trusts were making progress on networking pathology. However,

NHS Improvement called for a faster pace of change.

Its executive director of operational productivity, Jeremy Marlow (pictured), said: 'Work to transform NHS pathology services is making excellent progress. However, there is still much to be done by hospitals to ensure the benefits for patients and the NHS are secured.'

Second Carillion PFI deal reverts to public funding

The private finance deal to build a new Royal Liverpool Hospital has been terminated, and public funds will now be used to complete the hospital's construction.

The collapse of Carillion, which was contracted by private consortium The Hospital Company for the new build, meant work was halted in January.

The news follows August's announcement that public funding would be allocated to complete another Carillion PFI contract at the new Midlands Metropolitan Hospital.

Since January, the Liverpool trust has been in discussions with the Department of Health and Social Care, the Treasury, the consortium and funders to restart construction as soon as possible.

However, at the end of September, the trust announced that this could not be achieved within the existing PFI agreement and it intended to terminate the agreement after 30 September.

Subject to government approval and legal agreements being finalised, the consortium will hand over contracts for construction, supply chain and facilities management to the trust.

In a statement, the trust said: 'This is now the fastest way in which we can see construction on the new Royal restarted and means we have outlined a process for doing so.

'This is really positive news for our staff, patients and the people of Liverpool. We now have a solution and can work on moving forward.'

Providers call for realism with five tests for NHS plan

By Seamus Ward

The forthcoming long-term NHS plan for England must be realistic in setting fully-funded, achievable finance and performance recovery trajectories and include a financial architecture that maximises the funds reaching frontline organisations, according to NHS Providers.

In a briefing, *Five tests for the NHS long-term plan,* the provider body said the plan, due to be published in the coming months, should:

- Be centred around patients, service users, carers and families
- Be realistic and deliverable
- Be underpinned by a credible and sustainable workforce strategy
- Lay the groundwork for a sustainable high-performing service
- Support local good governance, autonomy and accountability.

It said the long-term plan must address the realities of frontline health and social care – including the provider deficit of almost £1bn at the end of 2017/18; an ageing infrastructure misaligned with care needs; and an 8% staff vacancy rate. It should recognise increasing demand for health and care and set out how the system will meet this. The plan will work only if the government adequately funds the sector.

Trusts must have a clear implementation plan, with trajectories to recover their financial and operational performance – and performance requirements must be fully funded, it added.

These should be accompanied by realistic assumptions on productivity and efficiency gains, demand management and the speed and scale at which benefits can be released from transformation programmes.

The long-term plan must recognise that further productivity and efficiency gains in the NHS will only be realised through investment in improvement projects rather than non-recurrent sources or by salami-slicing services.

Technology offers the NHS an opportunity to improve patient care and outcomes, and to improve productivity and efficiency. The long-term plan should be ambitious in its plans for technology and ensure they are fully funded.

A new financial architecture should ensure more is spent on care and delivery is sustainable. The framework should also help the NHS make

long-term investment decisions, NHS Providers added.

The briefing said a transformation blueprint should offer sufficient investment and allow for double-running. This would take account of capacity and capability to push on with transformation given the current workforce and operational delivery pressures.

NHS Providers chief executive Chris Hopson (pictured) said the plan offered an opportunity to adapt and improve the NHS, though the scale of the task should not be underestimated.

'The plan must confront the reality of growing demand for treatment as a result of our older, growing, population and the increasing number of people living with long-term conditions,' he said. 'We must have a plan that honestly sets out how we will work together as a health and care system to cope with this demand.

'The plan must also reset what is asked of providers so that the vast majority of trusts, performing well, can return to being successful in delivering the care that patients and the public expect. Assumptions about what can be achieved, and how quickly, must be realistic.'

News review

Seamus Ward assesses the past month in healthcare finance

It's not often this monthly review can begin with a positive story for the health service, but it seems a High Court ruling could save the NHS millions of pounds a year. The court refused a bid to stop 12 clinical commissioning groups in the North of England prescribing Avastin for patients with the common eye condition wet age-related macular degeneration (AMD). The National Institute for Health and Care Excellence has concluded that Avastin is just as safe and clinically effective as the alternatives. The CCGs – based in the North East and North Cumbria – said the drug is about 30 times cheaper than the most expensive alternative and they will save a total of £13.5m a year as a result of the ruling.

New English health and social care secretary Matt Hancock gave his first major speech in September and focused on the power of IT to improve health and the effectiveness of every pound spent. Speaking at NHS Expo 2018, he said poor IT is wasting resources and giving patients sub-optimal care. NHS IT was 'clunky, clunky, clunky', with some workstations needing two monitors – not because the service was at the cutting edge but because two unintegrated systems were running side by side. He gave a commitment to sorting out NHS and social care IT systems as an immediate priority.

As summer turns to autumn, health services across the UK turn their thoughts to the coming winter and the lessons that can be learned from last winter. According to an NHS Improvement report on the 2017/18 winter period, A&Es in England saw 290,000 more attendances than the previous winter. In a review of last winter, the oversight body added that 100,000 more people were admitted to hospital as an emergency. Mitigating steps were taken, including greater capacity and streaming patients into lower acuity settings where appropriate – for example, on arrival at A&E, streaming into primary care was in place across 98.5% of the service; this is now 100%. Winter funding was welcome, but arrived in November, making it difficult for trusts to plan the most cost-effective staffing models.

Taking heed of complaints over the late announcement of extra winter funding last year, in September the Department of Health and Social Care announced that NHS trusts in England will receive a share of £145m to improve emergency services ahead of the winter period. The funding will be spent on 81 schemes to upgrade wards, redevelop A&E departments, improve same-day emergency care, create an additional 900 beds and improve bed management systems.

Winter funding in Scotland was also announced. NHS health boards will receive a further £10m to help them cope with winter pressures, the Scottish government said. The funding will enable boards to plan earlier to increase weekend discharge rates; allow for better staff planning over the festive holidays; and provide more focus on community pharmacies.

Waiting time targets across the UK continue to be missed. In Wales, 80% of patients waited fewer than four hours in August, missing the 95% target. This was 1.4 percentage points lower than July this year and 4.7 percentage points lower than in August 2017. Attendances were 2.4% higher than a year before. In scheduled care, 89% had been waiting fewer than 26 weeks – the target is 95%.

More patients are on the elective surgery waiting list in England and more are waiting longer than the 18-week threshold, according to the latest figures from NHS England. At the end of July 4.1 million people were on the referral to treatment list – an increase of 7% compared with

The month in quotes

'The sooner all NHS trusts implement a policy to offer Avastin as an option for the treatment of wet AMD, the sooner we can start to redirect that money into other resources and equipment, so we can make improvements to care that have life-changing benefits for patients.'
South Tyneside CCG chief officer David Hambleton calls on the NHS to make the most of the High Court ruling on Avastin

'While the attrition rate has remained fairly constant over the last decade, its impact is becoming more severe, bearing in mind the overall shortage of nurses, vacancies in nursing posts and rising demand pressures.'
Ben Gershlick, senior economics analyst at the Health Foundation, says the NHS must retain its student nurses

'It's important that we are well prepared and that's why we are allocating funding earlier than ever before. This investment will ensure boards can put appropriate plans in place – particularly to make sure people are discharged in a timely way when it's safe to do so, and that the right staff are in place throughout the system.'
Scottish health secretary Jeane Freeman says health boards should prepare for winter

'Now is the moment to put the failures of the past behind us and set our sights on the NHS being the most cutting-edge system in the world for use of technology to improve our health, make our lives easier and make money go further, harnessing the amazing explosion of innovation that the connection of billions of minds through digital technology has brought.'
English health and care secretary Matt Hancock sets his sights on improving health service IT

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NHS health boards in Scotland are to receive a further £10m to help them cope with winter pressures

a year earlier. Of those waiting, 87.8% had been waiting fewer than 18 weeks – missing the 92% target. In July 2017 the figure was 89.9%. In August 89.7% of patients were seen within four hours in A&E, compared with 90.3% in August 2017 – over the year there was a 3.2% growth in attendance, while there was a 5.2% increase in the number of patients admitted to hospital as an emergency.

One way of reducing the demand for services in the long term is to promote better health and the British Medical Association called on the health service to prioritise investment in ill health prevention and tackling the causes of preventable long-term conditions. The doctors' representative body said as much as 40% of demand on the NHS could be cut by investing in services to reduce smoking and alcohol consumption and improving physical activity and diet. Preventable ill heath accounts for an estimated 50% of GP appointments, 64% of outpatient appointments and 70% of inpatient bed days, a BMA paper said. Ill-health prevention could help secure the financial sustainability of the NHS, it added.

NHS Improvement has published a guide for trusts on opportunities to secure revenue and capital through the local authority planning process. Funds can be available through section 106 agreements and the Community Infrastructure Levy when new housing places additional pressures on local health services. NHS Improvement advised trusts to work closely with their local planning authority and council members to secure the funding; gain affordable housing for their staff; get planning consent for healthcare projects; and identify surplus land and buildings for sale and development.

The Health Foundation voiced concern as it revealed that a quarter of nursing students drop out of their degrees before graduation. With an estimated 40,000 nursing vacancies in England, it said, the issue of nursing student attrition had never been more pressing. Its research with the *Nursing Standard* found that of the 16,500 students due to complete their three-year degree in 2017, about 4,000 left their courses or suspended their studies (24%). A *Nursing Standard* study from 2006 found a similar attrition rate, suggesting attempts to address the issue had failed, the foundation said.

NHS Improvement said trusts can make further temporary staff savings. Calling for a 'bank first' approach, it said the NHS could free up £480m to reinvest into services and improve patient care. Trusts should fill temporary vacancies with workers from a staff bank instead of using expensive staffing agencies. It added that agencies should be used only as a last resort, and has set all English trusts a target of reducing agency costs by 17% in the current year. The NHS has already cut agency spending by £1.2bn, or a third, since caps were introduced in 2015. And in 2017/18 spending on bank staff was higher than on agency staff for the first time in several years. A toolkit developed by St Helens and Knowsley Teaching Hospitals NHS Trust to grow its own bank has been shared on the NHS Improvement website.

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from the hfma

When introducing value-based healthcare, providers will have to think again about their relationships with patients, professionals and commissioners, according to Yolima Cossio Gil, the clinical data and innovation lead at Barcelona's Vall d'Hebron University Hospital. In a blog for the HFMA website, she says innovation in management is also needed. Value-based healthcare shifts the focus to the health outcomes of individuals, emphasising what matters to them in a financially sustainable manner.

In another blog, Nigel Davies (pictured), head of accountancy services at the Charity Commission, says charities can still improve their annual reports and accounts. Recent commission research has shown a modest improvement in the quality of charity public benefit reporting, but too many are falling short of expectations for this key tool in communicating with the public.

HFMA policy and research manager Lisa Robertson outlines the benefits of a new tool developed by the association to give access to all relevant NHS corporate governance documents from a single source. Keeping track of all the governance requirements is a challenge, she explains in a blog, but the HFMA *NHS corporate governance map* will prove helpful in this task. It has three sections – the strategic framework, enabling good governance and specific areas for assurance.

• www.hfma.org.com/news/blogs

News analysis

Headline issues in the spotlight

The long view

It will be difficult to fully transform Northern Ireland's health and care services, improve care and deliver value without a breakthrough in the political deadlock. Seamus Ward reports

There must be times when senior civil servants – and trust and commissioner leaders – wish they were left to get on with the job of delivering the best possible health and care, with no ministers telling them what – or what not – to do. In Northern Ireland, health and care leaders have the latter, but are increasingly frustrated as their hands are tied when it comes to making major changes to services.

Northern Ireland has been without a ruling power-sharing executive since January 2017, with the two most popular parties (the Democratic Unionist Party and Sinn Féin) in dispute. This has dealt a number of blows to the already struggling integrated health and personal social care system.

Like the three other national health and care services in the UK, transforming delivery and moving more care out of hospital are seen as key to tackling surging demand and long waiting lists. A number of reports and strategies over recent years have backed this approach and there appears to be political consensus behind it.

Without a minister in place, senior civil servants have been running public services at departmental level, making changes where they feel they have a mandate from the previous executive. However, their ability to make decisions was curtailed in the summer when a judicial review determined that a civil servant did not have the power to grant planning permission for a waste incinerator in County Antrim. Only ministers should decide, the ruling said – a verdict widely interpreted as applying to all departments and all major decisions.

Northern Ireland secretary Karen Bradley has promised to bring forward legislation to give departmental secretaries the power to make big decisions in the absence of a government.

Initially, a lack of an executive meant health and care and other public services were without a budget in 2017/18 – the 2016/17 allocations were then rolled on into 2017/18, but extra funding was added in year through the monitoring round system of reprioritising budgets.

With little hope for a deal between the two parties, Ms Bradley intervened in March this year to set departmental budgets for 2018/19. This gave health and care a 2.6% uplift, including an additional £60m for activity pressures and £10m for mental health services, plus a non-recurrent £100m transformation fund (a further £100m will be available in 2019/20). She also consented to the transfer of up to £100m from capital funding to revenue.

While they welcomed the setting of a budget, health leaders remain concerned, as evidenced by witnesses in a Commons Northern Ireland Affairs Committee inquiry in September. The committee is looking into the effects of the absence of a government on health and care funding and heard the service was starting from a difficult position. Witnesses told the committee that cost pressures this year are likely to be between 5% and 6%.

Waiting times were also highlighted. Northern Ireland has some of the longest waiting times in the UK. At the end of the last financial year, almost 31% of patients had been waiting more than 52 weeks for a first consultant-led appointment. And 62% were waiting longer than 13 weeks for inpatient or day case admission – the previous executive set the maximum at 55%.

No room for manoeuvre

One witness, Paul Cummings, finance director of the Health and Social Care Board – the commissioning body – and Public Health Agency, told the inquiry that he had received an extra £207m in this year's allocation. But this left little financial headroom to develop services.

'We went into this year with a significant deficit because we are relying on, and have relied on, increasing mid-year and end-year monitoring rounds,' he said. 'Our system went into this current financial year in deficit because we required £140m of non-recurrent funding last year through the monitoring round just to break even. The £207m [additional income] was set against an opening deficit of £236m.'

Workforce difficulties

Northern Ireland's health and social care service has more than 5,000 vacancies (65,000 total staff) and needs to recruit 1,200 members of staff to deliver its transformation agenda, the witnesses told the inquiry.

A recruitment strategy developed by the Department of Health in Northern Ireland is seeking to attract health staff working in other countries back to Northern Ireland, but there is a significant pay differential to be overcome across most Agenda for Change grades.

Health and Social Care Board finance director Paul Cummings told the Commons Northern Ireland Affairs Committee: 'For a couple of years now our staff have been paid 1% less than those in the rest of the UK, which has been a source of contention for staff. The Barnett consequentials of the recent Agenda for Change announcement, a three-year deal, will pass to Northern Ireland but will not be just given to health, so we have to compete against other departments. That is put into the general Northern Ireland pot and does not go straight to health.'

Even if the health pay uplift is fully funded, the new Agenda for Change deal could bring added pay costs. Local social care staff are also on Agenda for Change contracts and get the same uplift as their health colleagues. But funding for local care workers' pay rises are not included in the Barnett consequentials; money must be found from the total funding given to Northern Ireland.

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Mr Cummings, a former HFMA UK chair, went on: 'We are not in a position to procure extra services in the current financial year. We are just about standing still and meeting inescapable pressures, some demography, a bit of NICE drugs. We are extremely challenged financially, and service development is not something we have been able to pursue in the current year.'

Valerie Watts, chief executive of the Health and Social Care Board and interim chief executive of the Public Health Agency, outlined how the £100m transformation fund would be spent this year.

'Roughly £30m is targeted at stabilising the system by stemming the increase in waiting times for both diagnostic and elective care,' she said. 'Some £15m has been identified for investment in primary care, and that includes £5m for the initial roll-out of an operating model for multidisciplinary teamworking within GP practices. Some £15m has been identified for workforce development right across the whole health and social care system, with up to approximately £30m of investment in reforming hospital and community services. That includes investment in the establishment of new elective care centres.'

Additionally, she told MPs that £5m would be invested in building capacity in communities and in health prevention approaches, and a further £5m in the enablers for transformation, including co-production and quality improvement initiatives.

Health and Social Care Board commissioning director Miriam McCarthy said the £30m being spent on improving elective care this year would help reduce waiting times, but 'it would be unrealistic to think that will sort the problem completely'.

"We are extremely challenged financially, and service development is not something we have been able to pursue in the current year"
Paul Cummings, Health and Social Care Board

Other initiatives will help, particularly with outpatient waits, Dr McCarthy added. Demand management projects were looking at stemming the flow of hospital outpatient appointments by offering alternatives such as virtual clinics or advice to GPs from hospital doctors, for instance.

Cancer specialties had reduced ongoing follow-ups by discharging patients into the care of their GPs and there was room to replicate this across other specialties.

Mrs Watts acknowledged that a lot of the transformation work to date had been preparatory in nature and the MPs wondered if this would be different with a minister in place.

The witnesses reiterated that, at the moment, significant structural transformation could not happen. In terms of closing or reproviding services, the officials' hands are tied – they could not close services as there was no mandate to take such decisions. They could develop services, but funding was tight.

To illustrate the limitations they face, Dr McCarthy said a guidance paper on maximising the cost-effectiveness of varicose vein surgery was being written. Surgery for clinical reasons – bleeding or pain – would be recommended, but not for cosmetic reasons. However, she accepted that once the paper is completed, it could be delayed, as a minister would be needed to consider it before issuing it as a consultation.

Mr Cummings added: 'There are things we want to be doing to bring our service offering in line with some of the changes that have happened in England and Wales that we are not able to take forward or we are not able to pursue.'

He singled out the *Power to people* review – an expert panel review of social care, which made a number of recommendations including making the better-off pay for their care. Mr Cummings said that without a minister, officials could not address the review's recommendations. 'We have no [ministerial] view on charging, which is one of the proposals we may want to examine to come into line with the rest of the UK.'

Care at home

Care at home was one of the areas of focus for the transformation programme and funding, Mr Cummings said. But domiciliary workers should no longer be paid minimum wage – the job required skills that should be paid at a higher level. 'We need to re-examine whether we as a society are prepared to pay and contribute to that, because we are the only part of the UK where domiciliary care is free. The rest of the UK contributes to that cost.'

Longer term budget allocations will help the planning of transformation schemes. Asked about her priorities for an incoming minister, Mrs Watts said three-to-five-year budgets were needed. 'We need to be not limping along from year-to-year, just hearing what we're getting to provide health and social care services sometimes late in the day. We need to be forward planning, and over longer periods of time.'

Even with ministerial direction, the challenge facing Northern Ireland's health and care service is tough. Senior executives hope transformation programmes will reduce demand currently running at up to 6%, but it will be challenging to do so in just two years – they believe sustained transformation over five to 10 years is needed.

Comment

October 2018

Branch power

The strength of the association lies in its branch structure

It has been a real pleasure to get out and meet members and speak at branch conferences. So far, my travels have taken me from the North West event, hosted in Blackpool, via numerous stops to the most recent in Bristol for the South West Branch.

These annual events are a highlight in the branch calendar and celebrate all that is good about the HFMA. It is the hard work of our branch volunteers that make these events a success year after year.

The conferences bring together finance communities to catch up with friends and colleagues, network and learn from each other. Agendas are designed with personal development in mind and create a chance for people to take some well-earned time away from the office to consider the contributions of often thought-provoking and insightful speakers, experts in their field or people sharing personal experiences of using our NHS.

It is high-value personal development time, a time to share between colleagues and continues to strengthen our brilliant association that has branches at its heart.

Each branch usually chooses a theme for its event. The South West theme was *Learning from excellence*, a great choice because we need

The patience deficit

The 10-year plan needs to set credible expectations for how quickly change can be achieved.

The confirmation of providers' underlying deficit was a bit of a surprise last month. Not the size of it, but the fact that it has been publicly acknowledged. There was a time when managers were encouraged to talk about overspends rather than use the D-word – such was the term's potential negative impact.

But we live in different times and the fact that NHS providers are in deficit – forecasting a £519m deficit this year on top of last year's £966m – is no longer news. But the larger underlying deficit is.

The £4.3bn figure revealed in the NHS Improvement Q1 report is the size of the underlying deficit carried into 2018/19 – providers' real recurrent financial position if you strip out one-off and short-term actions.

This figure treats the £2.45bn provider sustainability fund as non-recurrent, whereas if you treat it as funding that will in some form or other be spent in the provider sector in the future, the underlying deficit falls to £1.85bn.

Whichever figure you look at, it helps to capture better the scale of the challenge facing the service – especially when you consider the access and performance figures that accompany this deficit position. It also puts into perspective the £4.1bn real growth that's coming the service's way in 2019/20.

There continues to be talk in some circles about what the new money should be spent on. But the reality is that the additional funds are already being spent on existing services.

"It should be a welcome confidence boost to people in the function to know that our work is valued at every level"

to do more of this across the NHS. The agenda included 'proud moments' segments for colleagues on the patch to take the stage and share just some of the fantastic work finance teams are undertaking in support of services and patients.

I thought it was an inspired and inspiring session, rightly recognising the positive contributions the finance function makes every day across the country.

Elizabeth O'Mahony, chief financial officer at NHS Improvement, spoke openly and supportively to delegates, as she outlined the work to develop the 10-year NHS plan and review the financial architecture to enable it.

National leaders are providing clarity, backed up by a positive and collegiate tone, with work ongoing to strengthen and align the approach of NHS Improvement and NHS England. It is encouraging to hear.

It was also good to hear Elizabeth share her perspective on the 'proud moments' segment that morning. In spite of the challenges the NHS faces, she and her colleagues recognise the widespread pockets of excellence across the NHS, often with the finance function playing a critical supporting role.

It should be a welcome confidence boost to people in the function to know that our work is valued at every level.

We were also encouraged to take the current opportunity to feed our ideas into the development of the 10-year plan.

I look forward to seeing many more of you as the branch conference schedule heats up between now and the HFMA national conference in December – don't forget to book!

Contact the president on president@hfma.org.uk

SHUTTERSTOCK

The challenge remains to keep finances on as even a keel as possible while the service goes through the slow, meticulous process of addressing variation service by service, and transforming the model of care to meet current demand in a more effective and cost-effective way.

There are no short cuts and the service has shown how difficult it can be to take a model that works in one part of the country and apply it to another with a different context and set of conditions.

The NHS is getting better at this. But to be successful, change often needs to be driven locally by clinical teams understanding their own position and making change, rather than having change imposed upon them.

Increasingly, there are tools that will help local health economies. NHS Improvement's Model Hospital – which was given a makeover in September – is starting to help trusts to identify opportunities for improvement (*see Working model, p21*).

This is a good tool that could be great in a few years, once confidence in the data improves – on the back of better collection, improved definitions and the use of more detailed patient-level costs.

But it is not as simple as spotting a variation and fixing it. The Model Hospital certainly provides a starting point and should get conversations going about challenges and solutions. But this needs to become embedded in working practices – with clinical teams using the tool themselves to identify opportunities to improve. And this won't happen overnight.

"The challenge remains to keep finances on as even a keel as possible while the service goes through the slow, meticulous process of addressing variation"

Other changes – and moves towards value-based healthcare – will involve cultural changes. Clinical pathways will need to be redesigned with healthcare professionals taking on different roles to those they have undertaken in the past. Some transformation programmes will involve wholesale changes such as service relocation – with all the consultation and time-consuming political debate that goes with such changes.

The point is that the one thing the NHS needs alongside increased funding is patience. When we finally see the 10-year plan, it needs to be credible in terms of what it wants to be delivered.

The publication of the underlying deficit is helpful in that it provides a more realistic benchmark against which the new plan's proposals can be measured.

ERGs are go

Having taken the first steps to create a more accurate funding mechanism for clinical placements in 2013, Health Education England is now proposing a more granular currency based around education resource groups. Steve Brown reports

SHUTTERSTOCK

The NHS spends about 1% of its revenue budget supporting clinical placements for its future workforce. So, you could be forgiven for not knowing too much about plans to transform the way this particular stream of funding works – unless you are in one of the teams directly involved. After all, the NHS currently has bigger challenges, including a provider side deficit (in 2017/18) that was not far off the whole of the placements budget.

But the changes are challenging and ambitious and could have a significant impact on service providers once fully implemented. They should not alter the overall service's financial position. But, in delivering a more equitable funding mechanism, they could change where deficits and surpluses sit for individual providers.

They should also provide an important mechanism to underpin plans to ensure that the NHS trains the right staff in the right numbers for years to come.

This is not a new initiative. The NHS has long wanted to change the way it pays for training placements for both medical and non-medical staff – a method that has relied on historical arrangements and payments. These arrangements have made it difficult to demonstrate that training providers are being fairly and properly remunerated to cover their legitimate training costs. And they have also hindered attempts to broaden the number of training providers or move training between different settings in line with changing demands for a different skill base.

A national tariff for education and training also allows commissioners (in this case Health Education England, or HEE) and training providers (hospitals and providers in other settings) to focus on the quality of training and the student experience rather than price.

Recent moves towards a new payment approach began in 2013 with the introduction of transitional tariffs setting out three different levels of support for clinical placements. This initially covered non-medical and undergraduate medical placements, with a tariff for postgraduate medical placements added a year later.

While the non-medical and undergraduate tariffs were based on a simple placement fee, the postgraduate posts were supported by a placement fee and salary contribution.

However, the plan was always to produce a more granular currency and appropriate tariff rates – a point underlined in HEE's mandate for 2017/18, requiring the development of education resource groups (ERGs) to support a new tariff system.

After several years of currency development informed by new cost collections for education and training placements, HEE has published its proposals for these ERGs, which could form the basis for new tariffs in the future.

This would involve creating 48 different ERGs for the non-salaried placements (16 of which are currently covered by national tariffs) and 81 ERGs for salaried medical and dental trainee programmes. It has also proposed a further 48 groupings for other salaried training programmes for professions not currently paid under national tariffs.

Balancing act

According to Jenni Field, HEE head of finance strategy, the approach represents a balancing act. 'There are 600 combinations of course and year across all the training programmes,' she told an HEE workshop in September, organised as part of consultation around the proposals. 'The current three tariffs are seen as too blunt, but having 600 would be too many. We wanted enough currencies to fairly reward trusts, but a manageable number to limit the administrative burden.'

This greater granularity would mean that, once tariffs were attached, a provider would receive funding that more closely matched the mix of training that it provided. For example, hospitals providing more consultant input

for later years of specialist training could be compensated for this greater level of support.

Delegates at the workshop – drawn from education and costing teams – seemed broadly happy with the currency proposals, although there were some calls for HEE to improve communication about the changes with education leads in provider organisations.

But it is the next step – attaching tariff prices to the new currencies – that is likely to prove more challenging. The currency could be adopted rapidly – with each new ERG mapped to one of the existing three tariffs. New cost collections could then be based around the new currency. However, there are no firm plans at the moment to introduce tariffs for the new groupings.

When the three existing tariffs were introduced, they were accompanied by a transition mechanism to limit the gains and losses for providers in any one year. It is likely that a similar damping system would be needed again if new tariffs were brought in.

However, there are other issues that need to be dealt with in setting tariffs.

Perhaps the biggest issue that people have struggled with for years is around the quantum of funding provided for training. There have long been suspicions that the funds provided for placements do not match the real costs of delivering that training.

Tariffs for healthcare services have been set on the basis of reference costs. But the reference costs have been compiled having netted off the income for training – effectively assuming that the income received equals the cost of delivery.

The service has now undertaken four specific cost collections for its education and training activities – two of them integrated with reference costs, to avoid doubt that costs are being double counted.

What these collections have revealed is an apparent significant underfunding of education and training placements. Full costs – according to these cost returns – amount to nearly £1.9bn – while HEE funding is just over £1.2bn for areas currently covered by the national tariff.

This underfunding is not across the board. Undergraduate medical training is in fact over funded compared to reported costs. However, this is more than offset by significant shortfalls on non-medical and postgraduate medical.

A consultation paper on the proposed new currency, published by HEE in September, acknowledged the gap.

'It was initially hoped that having robust data on the cost to deliver education and training activities might provide the evidence to support a rebasing between education and training and service,' it said. However, this rebasing – effectively taking resources out of tariff and other healthcare funding streams and redirecting them into training budgets – is not currently 'considered appropriate'.

While shifting resources from service funding to training would not alter the overall financial position within the NHS, it would potentially change the surplus/deficit position of individual trusts. There may be presentational difficulties in taking money out of service budgets at a time when providers are in overall deficit and struggling with access targets and there are also concerns about creating financial instability. But there are other reasons behind the reluctance to rebalance funding in favour of training.

Costing concerns

Fundamentally, there is still a concern over the accuracy of the costing data.

As one delegate at the workshop pointed out, 'education and training costs are much more subjective than other patient-level costs'. This is because they rely on subjective judgements. On the teaching side, an estimate has to be made for how much time consultants spend on teaching activities and how much they spend on delivering care.

That may be easy if the training is being undertaken in a classroom setting. But often training is delivered on the job – at the bedside or in a clinic – making the time split much less clear. While this should be informed by surveys and clinician-specific questionnaires, it opens up a larger margin for error. (And any error on calculating education and training costs means there is a balancing error being made on service costings.)

"We wanted enough currencies to fairly reward trusts, but a manageable number to limit the administrative burden"

Jenni Field, HEE

With postgraduate students who are delivering care being taught, and providing some of the teaching and supervision of more junior doctors, a similar split needs to be made to correctly assign costs to the delivery of patient care.

HEE points to improving cost returns since the first training cost return covering 2013/14 costs. There is now a normal distribution around the average cost position – although some practitioners suggest this is in part driven by providers using nationally suggested time splits and ranges, rather than rigorously calculated local costs.

While the full gap between HEE funding and education and training costs is close to £700m, there is a much smaller gap to reach the direct costs of providing training placements – less than £200m, according to the latest costs.

Workshop delegates suggested this should be a first target for any future funding adjustment – although patient care tariffs have traditionally been set using fully absorbed costs.

Another issue concerns undergraduate placements in primary care. These are not currently on the national tariff. Funding is negotiated locally, is lower than provided to secondary care-based training providers and varies from area-to-area.

A costing exercise has recently suggested that placement costs in primary care are similar to those in secondary care providers and so the consultation paper proposes bringing primary care into the scope of tariff.

However, if this involves an increase in funding for primary care, then it is not clear where this would come from.

There were also concern about funding for promised increases in training places for pre-registered nurses, midwives and undergraduate medics.

Ian Newton, senior policy manager for HEE sponsorship, funding and tariffs at the Department of Health and Social Care, said funding would be provided. 'You won't be expected to fund these increases from existing funding,' he said. He encouraged anyone hearing a different message locally to contact their regional or national HEE teams.

The changes around education and training currencies and tariffs may seem trivial compared with the broader financial challenges facing the NHS. However, it is an exercise that needed to be undertaken. Once set up, placement funding should more accurately match the costs of delivery and there should be a more flexible system that underpins plans to right size and 'right skill' the workforce.

• ***The HEE consultation runs until 5 October***

With a national tariff document not expected until the new year, Andrew Monahan outlines the main areas currently being discussed and what further engagement the sector can expect

Price reset?

At an HFMA National Payment Systems and Specialised Services committee meeting in September, the NHS Improvement (NHSI) pricing team confirmed that the statutory national tariff consultation is unlikely to be released this calendar year. Mid-January 2019 now appears a more likely time for publication.

With the move towards integrated care systems, setting a national payment mechanism is a difficult task. On one hand, it needs to deliver stability for those still negotiating what their integrated system looks like. On the other, the more advanced economies need their innovation and long-term ambitions to be unconstrained by payment mechanisms.

However, commissioners and providers cannot avoid planning for 2019/20 and the delay in the statutory consultation is a frustrating one. To address this, NHS Improvement is expected to publish an indicative set of tariffs before Christmas.

Procurement The Department of Health and Social Care is changing the funding mechanism for NHS Supply Chain (now Intelligent Client Co-ordinator). Funding will come from NHS England, with the funds most likely sourced using a top-slice from the tariff quantum. As a result, NHS customers will not face the mark-up in prices currently applied by NHS Supply Chain to cover operating costs. After regional engagement events for chief executives and finance directors in September, feedback will be factored into the proposal in the statutory consultation.

Market forces factor NHS Improvement is considering a refresh of data and methodology used in calculating the market forces factor. They were last refreshed in 2010. If updated, implementation is likely to be phased in over four years. A stand-alone document is expected to be published before the statutory consultation.

Maternity pathway One likely change with the maternity pathway tariff would be to put it on a non-mandatory footing. This is because the provision of screening services – provided as part of the pathway – is a public health responsibility, so the NHS cannot set a tariff for it. This is unlikely to lead to substantive changes in practice. Other aspects are also being reviewed, including:

- Moving the funding of specialist foetal medicine to NHS England specialised commissioning to reduce the administrative burden of provider-to-provider recharges
- Whether to increase maternity delivery phases from two to either six or 36 prices, and then mitigating the impact on home births and midwife-led delivery units
- Updating the factors for post-natal complexities.

A webinar in October will enable the sector to hear proposals, ask questions and offer feedback to NHS Improvement.

Outpatients Two episodic-based options are being considered:

- Mandated prices for consultant-led face-to-face appointments, non-mandated prices for non-consultant led face-to-face, and non-mandated prices for non-face-to-face follow ups (including those that are consultant-led)
- One price for first appointment, and one price for follow-up, irrespective of who or how delivered.

Prices for both options would be set per specialty and vary depending on the involvement of multiple or a single profession. The decision will be based on which option makes sense in all clinical specialties and importantly doesn't stifle innovation.

The HFMA understands that further engagement on this issue is unlikely although NHS Improvement and NHS England will continue to consider feedback already received at earlier workshops. A decision regarding the preferred option will be based on discussions with the tariff advisory group.

Urgent and emergency care funding (UEC) Two options are being considered in this area including potential changes to the marginal rate emergency tariff (MRET) and how the tariff can further support the provision of ambulatory care.

Payment approach The two national bodies responsible for the tariff are continuing to review whether to stick with episodic-based payment or move to a more blended approach involving some activity payments alongside a block payment and with built-in risk share arrangements. Even if a blended approach were to be adopted, key questions remain over where it might be used – emergency, ambulatory, outpatients or even non-elective? A webinar highlighting current proposals is expected to be announced shortly.

Tariff length This is tied up with the decision on blended payment:

- Remaining with the current payment system may see a return to a one-year tariff, buying time to introduce the blended approach the following year
- If the blended approach is applied in selected settings (such as accident and emergency attendances and ambulatory care), then a two-year tariff may be more likely
- A fully blended approach (also including non-elective and outpatients) could see a two- or even three-year tariff for elective inpatient care.

The HFMA understands that the NHS Improvement pricing team is in support of the Provider Sustainability Fund being included in the tariff quantum. If agreed, this may enable the blended approach to be developed further and introduced in time for 2020/21.

No further engagement is expected as this decision is largely dependent on other factors including the default payment approach and strategic policy in line with the long-term funding settlement.

Andrew Monahan is HFMA policy and research manager

Moving on?

Until last month, many trusts in England were planning to create wholly owned subsidiary companies for their support functions. But with the plans now on hold, what are the benefits of NHS companies and why are they so strongly opposed? Seamus Ward reports

Claims of NHS privatisation and tax avoidance are a heady cocktail – politically difficult for any government and guaranteed to grab the headlines. So, with growing discomfort in the Department of Health and Social Care about the 'noise' from trusts creating wholly owned subsidiaries, it was unsurprising that NHS Improvement stepped in last month to order a pause in plans to create new subsidiaries or alter existing ones.

NHS Improvement will consult on a new regulatory approach to NHS wholly owned subsidiaries this month, and new guidance will follow. The Department has already announced that it intends to alter its transaction guidance during this financial year to make the proposed creation of subsidiaries a reportable transaction to NHS Improvement. It says this will make all subsidiaries visible to the regulator and allow it to seek assurances that risks had been identified and assessed.

The unions are delighted with the moratorium. Unite national officer Colenzo Jarrett-Thorpe says: 'We believe this is in the best interests of patient safety and our members who wish to remain employed by the NHS and not outsourced to an outfit where their pay and employment conditions could be seriously eroded.'

Under local opposition, some trusts had already abandoned their plans for wholly owned subsidiaries. They include University Hospital of Leicester NHS Trust, which dropped its plan to create a subsidiary for its estates, facilities, procurement and supplies services after reportedly being told that the move would not be accepted by the health and social care secretary.

Wrightington, Wigan and Leigh NHS Foundation Trust ended its estates, facilities and procurement subsidiary plan, which was due to save £2m a year, after the local council stepped in with a promise to bridge the financial gap.

Leeds Teaching Hospitals NHS Trust had proposed to set up a subsidiary for estates and facilities. However, in July, chief executive Julian Hartley told a board meeting that it would not transfer any staff into a wholly owned subsidiary during this financial year. 'We will continue to explore alternative models to help us meet the significant financial challenges we face,' he said.

Despite the recent controversy, NHS subsidiary companies are not new – some have been around for more than a decade. Both foundation and NHS trusts can establish wholly owned subsidiaries, though it is more complicated for the latter as they must first secure the agreement of the regulator NHS Improvement and the Department of Health and Social Care.

Though wholly owned by the NHS, they are registered at Companies House and are governed by a board that includes senior executives from their owner trust or trusts.

Wholly owned subsidiaries are primarily used for back-office services such as estates and laundry, as well as outpatient pharmacy. The companies sell the services back to the trust. Sometimes they are set up to exploit the commercial worth of research and innovation in trusts – a new type of prosthesis or skin creams, for example.

> **"For some trusts the low-hanging fruit is gone and now they have to look at how they run some of these services to provide best value"**
> **Adam Wright, NHS Providers**

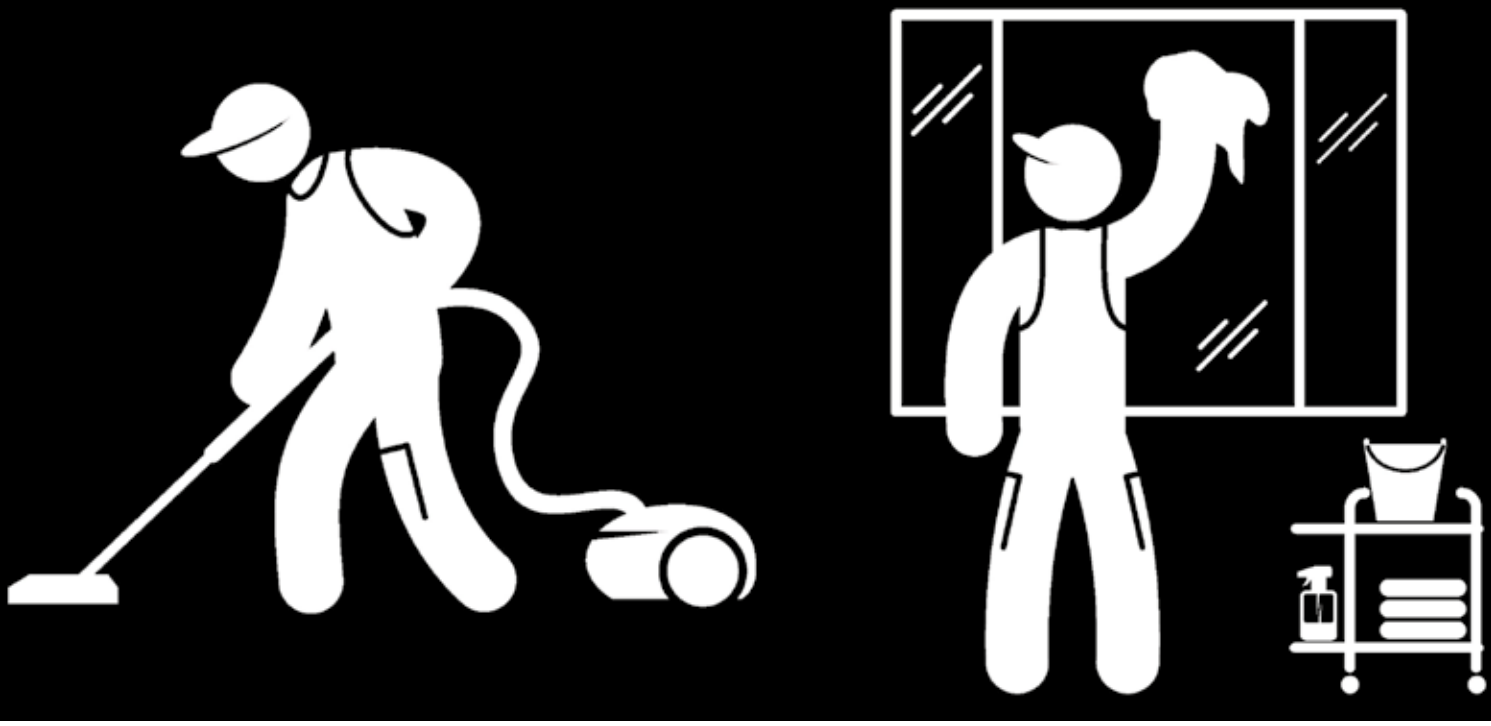
Generally, they are 100% owned by a single trust. There are other types of companies – including joint ventures with non-NHS public sector bodies and commercial organisations – but these are not wholly owned by the NHS.

Set up in 2005, Salisbury NHS Foundation Trust's Odstock Medical, which supplies devices to support rehabilitation in patients who have lost limb movement, is widely regarded as being the first NHS wholly owned subsidiary. The trust now has two wholly owned subsidiaries. Until recently the number of NHS wholly owned subsidiaries was growing relatively slowly. According to the government, there were 42 in March 2017.

However, in the past year interest has swelled. With this there has been a rising tide of opposition from unions – a factor in the pause ordered by NHS Improvement.

But why do trusts wish to set up wholly

SHUTTERSTOCK



owned subsidiaries and why have they become so controversial? *Healthcare Finance* spoke to a number of finance directors – who do not wish to be named – of trusts that have established wholly owned subsidiaries or are hoping to do so. All say their interest in creating subsidiary companies is at least in part the result of austerity and the need to deliver recurrent cost improvement plan (CIP) savings.

Adam Wright, senior policy officer at NHS Providers, says there are several reasons for trusts to explore the potential benefits of wholly owned subsidiaries. For many trusts, there is little alternative.

'For some, but not all, this represents a cost saving opportunity as well as potential income generation. The low hanging fruit is gone and now they have to look at how they run some of these services to provide best value.'

But while a wholly owned subsidiary means a cost improvement programme for some trusts, for others it is one solution to workforce challenges. This is particularly true of those outside the capital and other large urban areas, he says. 'A lot of wholly owned subsidiaries, particularly for estates functions, are being set up because the NHS needs to compete with non-NHS companies for staff in these areas.'

Existing staff are transferred to the subsidiary under TUPE rules and retain their Agenda for Change contracts and NHS pension rights. However, flexibility in terms and conditions has allowed subsidiaries to offer existing and new staff higher pay in return for a non-NHS pension with lower employer contributions. In the case of existing staff, accepting such an offer would mean moving off Agenda for Change pay scales.

'A wholly owned subsidiary has more flexibility over staff incentives, pension benefits and overall remuneration package,' Mr Wright says. 'Finance directors in trusts outside London will say that Agenda for Change is good for staff overall. But for graduates in non-healthcare roles – for example building surveyors – it's not as attractive as the private sector can flex its terms and conditions unlike Agenda for Change.'

One finance director says Agenda for Change does not recognise the true local cost of living, including buying a house. 'The reality is you cannot recruit staff for love nor money. A wholly owned subsidiary will allow us to offer different packages that attract people – it's not about destabilising or eroding existing terms and conditions; it's about doing something to address the gap.

'Some younger people need more money now, but I believe NHS subsidiaries have a moral obligation, as well as a legal obligation, to provide a good pension scheme.'

In a few cases, trusts can turn to wholly owned subsidiaries to help facilitate new models of care, Mr Wright says. 'Some trusts we have spoken to are considering using the wholly owned subsidiary model to collaborate with external partners to run services differently. This could include working with GPs who wish to become part of the trust but do not want to become salaried employees on Agenda for Change terms.'

VAT issues

Flexibility on pay is one of the key commercial benefits named by trusts in their business cases, potential VAT savings another.

VAT is a difficult and complex area. Generally, much of the healthcare activity trusts carry out is exempt from VAT under a general exemption. This means VAT incurred on expenditure related to those services, including outpatient pharmaceuticals, is also not recoverable. On the face of it, NHS bodies therefore pay 20% more for those goods than VAT-registered commercial providers. The Treasury argues that the NHS is funded to pay these taxes, which are paid to the Exchequer and then back to the NHS in a circular flow.

NHS bodies can recover VAT in some circumstances through the contracted-out services mechanism, which is worth around £2bn a year to the NHS, according to the Department of Health and Social Care. However, wholly owned subsidiaries are not subject to the contracted-out rules and would therefore be able to recover VAT in a wider range of circumstances.

Unions believe wholly owned subsidiaries seek to circumvent the rules on contracted-out services. A wholly owned subsidiary dedicated to providing outpatient pharmacy would be able to reclaim the VAT on drugs and devices dispensed, for example, which an NHS run outpatient pharmacy would not. A trust could also save on VAT if capital projects are carried out by a wholly owned subsidiary – potentially a significant sum.

With concern rising over tax avoidance, the Department intervened a year ago. A letter to provider finance directors asked 'careful consideration' be given to any contractual arrangements that give rise to tax advantages. No scheme should be considered if it is solely to gain a tax advantage as this would amount to tax avoidance, contrary to the requirements of HM Treasury's *Managing public money.*

This was welcomed by opponents of wholly owned subsidiaries, but they remain concerned due to one sentence in the letter: 'If there are genuine commercial reasons for entering into

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contracts which, as a by-product, have a tax benefit this is considered acceptable.'

Critics believe this leaves the door open for trusts to target VAT savings. However, finance directors say wholly owned subsidiaries are chiefly about implementing new, more efficient delivery models that are in line with the mood for greater collaboration.

Even so, they acknowledge that tax savings can be a factor. One says: 'There's no doubt VAT is a big driver for a lot of people, but there are other benefits. Finding savings in the CIP is getting ever more difficult, but we found that giving our estates function the opportunity to run their own services gave them the incentive to get rid of some bureaucracy. They are also able to go and win business outside the trust to generate a financial return.

Another adds: 'We would be doing this even if we couldn't get the VAT benefit. Many trusts are looking at wholly owned subsidiaries to address the issue of skilled workforce shortages and this issue won't go away.'

A further criticism is that creating wholly owned subsidiaries is privatisation by another name and with that comes concerns about a two-tier workforce, pension rights and erosion of other employment terms.

Unison says: 'There is a consensus across the NHS that a two-tier workforce is not in anyone's interests. The national pay system under Agenda for Change is a strength that should not be bypassed by trusts that feel unable to use the flexibilities it provides.

'Unison believes that strong management will always work in partnership and consult properly with staff to find better solutions, rather than attacking workforce terms and conditions as a counterproductive shortcut.'

Any alternatives?

But could the benefits of wholly owned subsidiaries be gained without creating these companies? Finance directors say subsidiaries can give fresh impetus to savings plans. 'It's a legitimate question,' says one. 'We know we aren't doing anything we couldn't do previously – but in reality it was getting more and more difficult to find savings under the old structure.'

Subsidiaries do not have to adhere to NHS mandatory training, but give training only as appropriate, add the directors. 'If you are a porter do you need to do everything, including information governance training, when our porters don't use computers?'

A further benefit is that more management time can be devoted to the services provided by the wholly owned subsidiary. One finance director who sits on a subsidiary board, says: 'A senior estates and facilities manager will sit through a board meeting for two hours a month and, if they are lucky, 1% of the time will be devoted to the services they manage. If you have a wholly owned company that talks only about estates and facilities, it might make different and better decisions.'

Some trust finance leads are incredulous at union opposition to their trust plans, as a wholly owned subsidiary is a more palatable alternative to outsourcing or job losses.

Far from being a step towards privatisation of NHS services, NHS Providers' Mr Wright agrees that wholly owned subsidiaries are a way of keeping staff in the health service.

'The alternative is to outsource to the private sector because of the way the VAT rules are structured, which make it cheaper for non-NHS providers. Some have argued it is a form of privatisation, but it's the complete opposite. The options are: a wholly owned subsidiary, outsourcing or a risk to jobs.'

Wholly owned subsidiaries also offer an opportunity to move staff inside the health service rather than seeking an outsourced deal at the end of contracts, he adds.

The scope of NHS Improvement's review of its regulatory framework remains to be seen and critics will hope it makes wholly owned subsidiaries less attractive. But with trusts under pressure to make more recurrent savings, they will be pressing for little change – or an alternative.

One finance director says: 'I think the centre is nervous about wholly owned subsidiaries, but we need to make savings and I don't see anyone coming up with a better idea.'

• *An HFMA briefing on wholly owned subsidiaries highlights issues for trusts that have set up the companies, and examines governance and financial issues. See www.hfma.org.uk*

York to press ahead

Despite the pause announced by NHS Improvement, York Teaching Hospital NHS Foundation Trust is due to go ahead with its new wholly owned subsidiary this month.

A spokesperson for the trust said the moratorium did not affect the company. With a small number of exceptions, all the services provided by the estates and facilities directorate will transfer to a limited liability partnership on 1 October, a spokesperson said.

Unite members at the trust took industrial action in the week before the transfer. Chris Daly, Unite lead officer for health in Yorkshire, says: 'This is an act of arrogance considering the direction given by NHS Improvement that a pause needs to be instituted in setting up such subsidiaries, while a review takes place in October.

'This is a snub to NHS Improvement with its influential national remit. There is still time for the trust to row back from its ill-considered proposal to transfer staff out of the NHS family.'

However, the trust says the move will be beneficial and avoid the need to outsource.

'The way the trust operates estates and facilities has not changed for many years and with the continued financial pressure across the NHS, both nationally and locally, it is becoming increasingly difficult to maintain the standards that we aspire to for these essential services,' the spokesperson says.

'If we do nothing, the pressure to reduce budgets further will inevitably continue and there will be the very real risk that the trust will need to put estates and facilities services out to tender. By creating an LLP, we can access the commercial benefits enjoyed by the private sector while keeping these services under the ownership of the NHS.'

Potentially, the subsidiary will generate additional income by attracting further contracts from outside of the trust.

The spokesperson adds: 'As part of our cost improvement plan, this arrangement will allow more flexibility to negotiate on a local basis and therefore achieve efficiencies and cost effectiveness.'

working model

The idea behind the Model Hospital was to demonstrate what good looks like and enable trusts to identify opportunities for improvement. Steve Brown talks to providers putting the model to work

It has been over two years since a prototype of NHS Improvement's Model Hospital was first released to the acute provider community. It was grown from the seed of an idea in the Carter review of productivity to show what good looks like. But it is slowly becoming an established tool as providers look to address wide-ranging variation in the performance and costs of their services.

The digital information service (see box overleaf) now includes more than 7,000 metrics spread across different compartments covering clinical service lines, support services and people. It is subject to some of the same criticisms of benchmarking solutions that have gone before – principally concerns about data quality and comparability.

But there is increasing evidence that it is overcoming this issue – even driving improvements in data quality – and establishing itself as a valuable and increasingly used tool. The national profile given to the programme – and the ministerial backing given to the Carter recommendations – goes some way to explaining it. Some 21 of the Model Hospital's headline metrics now inform the Care Quality Commission's use of resources assessment for trusts. This puts metrics such as pay cost per weighted activity unit (WAU), pre-procedure elective bed days, estates cost per square metre and finance cost per WAU right alongside the more established finance metrics that make up the single oversight framework.

There is a concern that this will lead to a narrow focus on this subset of metrics, but in general trusts say the use of resources link has made executive teams sit up and pay attention to the Model Hospital. A number of trusts are now actively using Model Hospital data to inform efficiency and improvement programmes, although they warn that individual indicators don't always give an absolute indication of performance.

High pay costs per weighted activity unit (WAU) could mean exactly that – a trust is spending more than its peers on staff for the same output of healthcare. Or it could mean that some support services (catering,

"We can see how the improvement productivity programmes are starting to have an impact on our cost per WAU metrics"
Laura Langsford, University Hospitals Plymouth NHST

cleaning and portering for example) have been outsourced through commercial service arrangements with those costs then contributing instead to the non-pay costs per WAU. This would artificially lower a trust's costs for its own staff, although the overall cost per WAU for a trust would stay the same.

Plymouth progress

Laura Langsford is the model hospital and *Getting it right first time* (GIRFT) programme manager at University Hospitals Plymouth NHS Trust. She says the tool really comes into its own at clinical service line level and in particular when looking across different care settings – elective, non-elective, day case, outpatients and other (outpatient imaging). The trust has been using the data to track trust-wide improvement programmes, particularly in theatres and outpatients. This builds upon its established service line reporting approach but provides a different dynamic and measure of financial efficiency and effectiveness.

'I identify anything in the quartile 3 or 4 red position for both elective and day cases by service line and I do the same for outpatients,' says Ms Langsford. 'I map their position on theatre utilisation and outpatient clinic utilisation pre-commencement of these projects and using the latest data. So, we can see how our improvement productivity programmes are starting to have an impact on our cost per WAU metrics.'

And having identified outliers by service line and setting, the trust has something solid to challenge performance. It first investigates any reasons that might explain the apparent high costs – under-recording of activity and higher level of complexity than other providers, for example. However, it would also start to explore the amount of programmed clinical time in job plans compared with the direct clinical care being delivered.

It would also look at efficiency performance – for example, in terms of clinic utilisation and did-not-attend rates within outpatients.

Service lines' cost per WAU positions are also being factored into decisions around business cases looking to expand services. 'If a service is more expensive than the national and peer median, Ms Langsford says it is reasonable to expect them to be able to explain their cost position before increasing the size of the workforce.

One area where Model Hospital data has contributed to major service change is ophthalmology day cases where the service was an outlier with its cost per WAU metric.

GIRFT also signposted this through the cost per procedure for cataracts. The trust was higher than the national average cost of £893 and considerably higher than some of the costs of peer organisations following some supporting patient cost benchmarking where some trusts were cheaper by £200 per procedure.

A key difference identified by the ophthalmology clinical lead was the trust's continued use of a separate anaesthetist. This was despite some other trusts not using this approach for less complex cases and the 'no anaesthetist' approach being an established model in the delivery of work in a private setting. This led to a unanimous agreement from all 10 consultants within the trust to deliver one list a month in this way as part of a pilot.

This pilot is now live, but it is estimated that the change of approach will reduce the unit cost per procedure by £110 (12% of total procedure cost). This will save £66,000 in a full year at pilot volumes. If scaled up to 50% of cases, the saving would be £155,000 and the trust believes that eventually 60% or more of activity could be undertaken this way – with no impact on productivity, outcomes or safety.

'This sounds transformational, says Ms Langsford. 'But it is actually what is done in the private sector, and clinicians are familiar with the practice. This will neatly reduce the cost per WAU for day cases within ophthalmology and our benchmarking will improve.'

She adds that the next step is to 'work the outputs' of this through with the service and identify the releasing benefits for the trust as a whole. This could mean redeploying the clinical workforce to make most effective use of resources, which may also translate into offsetting waiting list initiative payments.

Model Hospital metrics are increasingly helping trusts to reinforce business cases for transformation. For example, they helped Guy's and St Thomas' NHS Foundation Trust, Lewisham and Greenwich NHS Trust and Dartford and Gravesham NHS Trust make the case for their SmartTogether shared procurement service.

Model hospital refresh

The Model Hospital brings together some 7,000 metrics across 57 compartments to help NHS providers spot opportunities to improve efficiency. In most cases, it relies on information that is already collected from providers – specific service returns, annual accounts and reference costs – although it has led to some additional data collections in a number of areas.

The idea is that anyone in a provider can register to use it. The system offers quantified savings opportunities – based on matching median or lowest costs. This enables users to drill down into detailed data to understand their own performance and costs and compare with the national average or self-selected peer organisations.

A new design (see opposite), which was unveiled at the end of September, brings these productivity opportunities to the fore on a reformatted home page.

A change to the system also enables the opportunities to be presented in terms of the increase in activity that could be achieved at the same cost – recognising that this can often be a better way to engage clinicians.

Users should also notice more prominent information about the metrics and data itself – as well as the Model Hospital now being more

David Lawson, chief procurement officer at Guy's and St Thomas', which hosts the service, said the Model Hospital and Carter metrics had crystallised the potential for improvement. Lewisham did not have any catalogues in place before the services came together and was paying 4.5% above average prices according to the purchase price index benchmarking tool within the Model Hospital. And there were recruitment challenges across the trusts' procurement teams.

But he thinks the Model Hospital has done more than make the case for the shared service, which has reduced the procurement overhead by 10% and already seen Lewisham's variance from average price fall to 2.9%. 'The Model Hospital forces accountability on performance,' he says. 'For us it was helpful as a catalyst to recognise our own performance [across the different trusts].' He says it has also helped to raise the profile of procurement in the trusts. 'With previous benchmarking tools, procurement wasn't really visible,' he says.

He adds that the increased transparency works both ways. It creates a 'healthy pressure' on procurement departments to improve, but it also enables them to demonstrate any improvement that they do make. Some of the Model Hospital metrics now feature as part of a balanced scorecard that helps all three organisations to monitor performance.

Maidstone milestones

Maidstone and Tunbridge Wells NHS Trust is another trust that is starting to embed the Model Hospital in its way of working. Patrick McGinley, head of costing and service line reporting, believes he has noticed a difference between presenting Model Hospital data and earlier attempts to encourage teams to focus on improvement on the back of local cost data.

'There is a real power in the fact that everyone can see the data,' Mr McGinley says. People either want to improve performance or improve the data being recorded – both of which are good results.

More than 120 people across the trust now have access to the Model Hospital, including an increasing number of consultants. At the moment, getting teams to use the data to challenge performance involves Mr McGinley and a 12-strong project management office. But the trust hopes teams will slowly start to use the data themselves.

There have been some early wins. Following the Carter review of productivity, the trust was told it had a £44m saving opportunity if it brought high-cost areas in line with the national averages – and cardiology was one of 10 services making up the bulk of this figure. As part of a deep dive into the service, Model Hospital data has helped inform a change in cardiology outpatients.

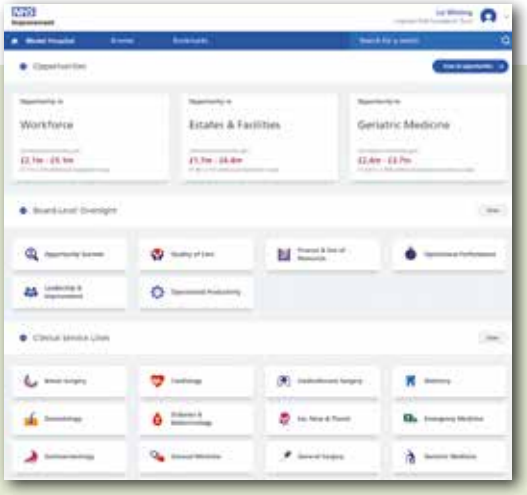
With medical staff costs in the upper quartile and productivity below the median, cardiologists pointed out that part of the problem was the escalated admission of non-cardiology patients to angio wards.

A new model – already in operation on the Tunbridge Wells site and due to be rolled out – now sees nurse specialists leading outpatient clinics for steady state follow-up patients. This frees up consultants to spend more time on wards and support the emergency department, reducing the level of inappropriate admissions.

The change hasn't reduced direct costs, but it has avoided the need to recruit further cardiologists, which had been proposed in a business case to cope with increased demand.

Model Hospital and GIRFT data has also been important in making the case for frailty and ambulatory care units – both of which are also aimed at getting patients the right treatment and avoiding inappropriate admissions.

'It is too soon to see the impact in the Model Hospital – as data needs to be refreshed – but we used the Model Hospital to see the cost of operating an inefficient model,' says Mr McGinley.



tablet and mobile friendly.

Some 12,000 users across the provider sector have registered to use the system – but it is not clear how many trusts are actively using the model to really identify opportunities and drive improvement.

'We know of several regional network groups that have been established for peer trusts to learn from one another, says David Ashby, NHS Improvement's director of model hospital and analytics.

He says trusts are actively using the information to stimulate conversations and learn good practice from one another. Executives are also tracking improvement, which helps to embed the tool, and there have been 60 sign-ups to its relaunched model hospital ambassador programme.

He says metrics tracking trusts' use of a selected top 10 medicines – expensive biological medicines and high-cost drugs where generic drugs were available – helped to save the NHS more than £324m last year.

But Mr Ashby wants more. 'We would like to drive a revolution in the strategic data available to the NHS to drive productivity,' he says.

Talking to finance managers, there remain concerns about data quality and the need to ensure you are comparing like-with-like. Others say the data can be helpful in reinforcing a business case, supplementing other evidence or getting consensus around the need to change.

There are still concerns about variation being about differences in cost apportionment rather than differences in process or efficiency.

But many agree that in some cases the variations are big enough to indicate that there is genuine potential for improvement and well worth exploration.

It may take a number of years – with better data being submitted to better definitions – before the Model Hospital realises its full value as a system that can help managers identify what good looks like and how they measure up against it. But most agree that the Model Hospital is a good and necessary step towards that ultimate goal.

Our NHS, your HFMA

Brighter Together

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HFMA annual conference 2018

5-7 December, Hilton London Metropole

The theme for this year's conference is 'Brighter Together' which is reflected in the programme with a strong emphasis on integration, equality, diversity, and leadership. We'll have two opportunities during the event to come together and celebrate successes in healthcare finance, with the HFMA Qualification graduation ceremony at the President's welcome dinner and the HFMA National Healthcare Finance Awards at the gala dinner.

Confirmed speakers for this year's conference include:

- **Elizabeth O'Mahony**, Chief Financial Officer, NHS Improvement
- **Ian Dalton CBE**, Chief Executive, NHS Improvement
- **Matthew Swindells**, National Director of Operations and Information, NHS England
- **Claire Murdoch**, CEO, Central & North West London NHS FT and National Mental Health Director for NHS England
- **Rt Hon Norman Lamb MP**
- **Anita Charlesworth**, Director of Research and Economics, The Health Foundation
- **Dr Michael Dixon**, National Clinical Champion for Social Prescribing, NHS England
- **René Carayol MBE**
- **Jon Rouse**, Chief Officer, Greater Manchester Health & Social Care Partnership

...and many more

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Accounting for democracy: changes called for in departmental reports

Technical

How many of you are aware of the accounting for democracy movement? Perhaps disappointingly, this does not involve thousands of accountants protesting in Westminster waving banners declaring everybody's basic right to double-entry book-keeping, *writes Steve Brown.* But it does involve pressure being brought on government to revamp departmental annual reports and accounts and turn them into the democratic scrutiny tools they are intended to be.

There's a bit of a story to tell here for those not up to speed. In 2017, the Public Administration and Constitutional Affairs Committee (PACAC) published a report on the back of an inquiry into government accounts. Its report – *Accounting for democracy: making sure Parliament, the people and ministers know how and why public money is spent* – made a number of bold claims. But, in essence, it said that current government annual reports and accounts were not meeting the needs of the public or Parliament.

The committee said many departmental government reports were badly written and difficult to follow – despite being prepared to a high technical standard. Even organisations like the King's Fund and TaxPayers' Alliance found them difficult to use and academics said the format had not been designed for the purpose of democratic scrutiny. The Plain English Campaign's written submission said one extract from a departmental annual report was 'truly terrible' and that 'the full documents are not always as bad as these excerpts suggest, but are consistently badly written and in serious need of a rewrite'. Damning stuff.

The report made several recommendations. For example, accounts should enable Parliament to scrutinise 'how actual spending and activity compared to financial commitments announced to Parliament in press releases or through the media to spend on or cut particular programmes or policy priorities'. Audits were suggested for performance data to improve trust in these announcements. There should be more plain English, named contacts to explain accounts' contents and the inclusion of public sector unit costs for key services.

SHUTTERSTOCK

The committee was kept waiting a year for a response. Even making some allowance for last year's general election and the dissolution of Parliament, this goes some way beyond the usual expectation that the government will respond to committee reports within two months.

And it is a disappointing response too, according to the PACAC, which published an update over the summer, as it fails to respond to individual recommendations.

Instead, the committee said, it addresses just some of the points in a narrative response, although it does propose a Treasury review of annual reports and accounts. The committee is treating the response as interim and is holding out for a formal response to the original report that addresses all recommendations.

While the government has offered support for the overall aims of the report, it does not acknowledge that accounts' objectives are not being met and has highlighted areas where it disagrees with the report. In particular, it does not believe that annual accounts are the place to track ministerial commitments.

The committee, however, is adamant this should be considered by the Treasury's further review of accounts – claiming that in 198 of 209 government announcements in 2017, it was unclear what year money would be spent in. And too often it was unclear when new money was being offered or existing money reallocated.

So what are the implications of this democratic movement? If the PACAC gets its way – following the Treasury review – a bigger burden could be placed on departments to include more detail in their annual report and accounts as well as improve the clarity of contents.

It is also possible this could have an impact on local public bodies. If the Department of Health and Social Care has to justify money was spent on an intended purpose – not just handed out with that aim – that could place new reporting requirements on NHS providers and commissioners.

And it may even lead to increased scrutiny and more onerous requirements on local bodies when bidding for central funds for specific initiatives. Watch this space.

Technical review

The past two months' key technical developments

Technical

With **NHS charities** just completing their annual reports and accounts for 2017/18, the HFMA last month published an updated example annual report and accounts. The example set of accounts will also cover 2018/19, with there being no new guidance applicable to either of the two years. The example report and accounts were first published in January 2016 to help members with the preparation of their first accounts prepared in accordance with the SORP FRS102. While this guidance has not been amended, the revised example takes account of the Charity Commission's *Information note 1*, issued in April 2017, intended to add clarification on some of the requirements. (See *NHS charities: still room for improvement* blog at www.hfma.org.uk/news/blogs.) http://hfma.to/7z

NHS Digital has called for trusts to be involved in field trials of ICD-11, the latest revision of the **international disease classification** list. It has run two rounds of trials and the third round is open until 30 November. Though it has around 250 participants who have volunteered to take part, NHS Digital called for more. Participants are provided with ICD-11 familiarisation and training prior to starting the trial cases, it said. The latest version of the classification was released by the World Health Organisation in June as an 'advanced preview' to enable countries to start transition plans. Current plans are for it to come into effect in 2022 – although actual implementation dates for different countries will vary. http://hfma.to/80

NHS England has issued a call for applications for the innovation and technology payment (ITP) for 2019/20. It said in 2019/20 the payment would build on the 2018/19 ITP and innovation and technology tariff, which incentivise the uptake of 12 innovations. ITP 2019/20 will be a competitive process, designed to scale up adoption of clinically proven **innovations and technologies**. As well as financial and procurement support, successful applicants will have access to support from academic health science networks. http://hfma.to/81

Health Education England has proposed a new currency based on education resource groups to replace three transitional tariffs used to fund **clinical placements and training posts**. *Proposed changes to currencies for education and training placements* recommends the creation of 48 different education resource groups (ERGs) for the non-salaried placements (16 of which are currently covered by national tariffs) and 81 ERGs for salaried medical and dental trainee programmes. It has also proposed a further 48 groupings for other salaried training programmes for professions not currently paid under national tariffs. There is a gap between the quantum of costs reported in education and training cost returns and HEE's (lower) expenditure. However, there are no current plans to rebase funding between education and training and service, partly because of continuing concerns around the accuracy of cost data. The consultation runs until early October (*see ERGs are go, page 12*). http://hfma.to/82

A new case study from the HFMA Healthcare Costing for Value Institute aims to give trusts in all sectors practical ideas on how to meet the challenges of implementing **patient-level costing**. *PLICS – the Leeds way* is based on Leeds Teaching Hospitals NHS Trust's implementation of the IQVIA PLICS system. Within three years the trust had successfully installed the system, was running routine monthly PLICS reports and had achieved significant success in engaging clinicians in the use of costing and informatics data. The trust's efforts were recognised last year, when it was named the HFMA Costing Team of the Year for 2017. http://hfma.to/83

Cardiac rehab push for heart failure

Technical: NICE

Following the busy summer, September has been a little quieter in terms of the volume of guidance published by NICE, *writes Gary Shield*. However, three important guidelines have been published, as well as two technology appraisals (TAs).

TA540 *Pembrolizumab for treating relapsed or refractory classical Hodgkin lymphoma* recommends pembrolizumab for use within the cancer drugs fund as an option for treating relapsed or refractory classical Hodgkin lymphoma. TA541 *Inotuzumab ozogamicin for treating relapsed or refractory acute lymphoblastic leukaemia* recommends inotuzumab ozogamicin as an option for treating relapsed or refractory CD22-positive B-cell precursor acute lymphoblastic leukaemia in adults.

An updated guideline on chronic heart failure in adults recommends offering people with heart failure a personalised, exercise-based cardiac rehabilitation programme (unless their condition is unstable). The associated resource impact tools highlight the significant potential savings for CCGs as a result of cardiac rehabilitation.

Although investment in services may need to happen before savings can be achieved, by providing cardiac rehabilitation for people with heart failure the number of readmissions for these people is expected to reduce. By 2023/24, savings of £7.7m for England are estimated, equivalent to savings of around £14,000 per 100,000 population.

The final guideline on preventing suicide in community and custodial settings advises local businesses, community services and prisons on the support people considering suicide require. The guideline highlights the need for multi-agency partnership working to effectively implement the guideline.

A resource impact statement highlights that the impact should be considered locally. This will vary according to progress towards implementing existing policies and strategies.

Gary Shield is resource impact assessment manager at NICE

NHS in numbers

A closer look at the data behind NHS finance

Capital spending

Technical

Collectively in 2017/18, bodies in the Department group spent a net £5.2bn on capital, £360m short of the £5.6bn capital departmental expenditure limit (CDEL) – a 6.4% underspend. The budget had already been reduced by £1bn after a Parliament-authorised transfer to the revenue DEL. Gross capital spending – before netting off £300m of income from disposals – was £5.5bn. Providers accounted for £3.1bn, or nearly 60% of total spend, and three-quarters of providers' capital expenditure was financed from depreciation, cash reserves and loans. More than half this spending was on land and buildings, just under a third on plant, transport and equipment and the remainder on IT and software.

Despite a consensus that capital funding is in short supply, providers underspent their DEL allocation by £267m. According to NHS Improvement, this underspend emerged at month 11, after previous forecasts had suggested an overspend. It said there was no mechanism to return this funding in 2018/19, which would increase pressure on the 2018/19 CDEL budget. The Department of Health and Social Care is working with NHS Improvement to review the capital regime to minimise future underspends.

Further details from the Department about financial assistance show NHS providers had £2.8bn of outstanding capital loans at the end of the year, and paid back more of these loans during the year than the money they drew down.

Some £551m of provider capital spending was financed by non-repayable public dividend capital. This included spending on a range of Department-led initiatives, including A&E reconfigurations (£98m), provider digitalisation (£94m), cyber security (£61m) and the upgrade of linear accelerators (£46m). In the case of the A&E programme, 110 trusts received funds to allow for better assessment of patients when they arrive and to increase the provision of on-site primary care facilities.

The 2017 Naylor review of the NHS estate showed capital investment had been about £4bn per year over the term of the previous Parliament (excluding primary care estate) – higher than the long-term average. (Subsequent to the Naylor report, CDEL has been redefined to include research and development funding. This increased CDEL by £1bn in 2017/18.)

However, the NHS had still experienced rising backlog maintenance and capital as a percentage of total DEL was declining.

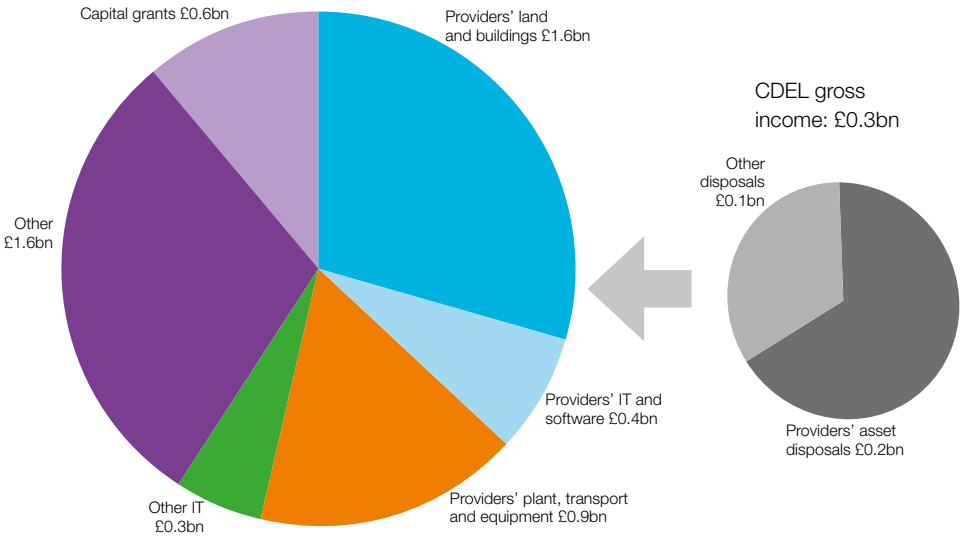
The 2015 spending review settlement held the CDEL flat in cash terms, meaning a real-terms cut over the course of the Parliament. It also suggested £2bn of assets would be sold, releasing land for 26,000 homes and freeing up investment.

The Naylor review estimated sustainability and transformation partnership (STP) capital requirements were about £10bn in the medium term – with £5bn of backlog maintenance and a similar figure needed to deliver *Five-year forward view* proposals. This would be met from property disposals, private capital (for primary care) and the Treasury. A step to close this gap came with the November 2017 Budget announcement of an extra £3.5bn over five years, with £2.6bn to be delivered through STPs. However, STP capital plans continue to outstrip the available resources.

Figure 1: Capital DEL – gross expenditure £5.5bn

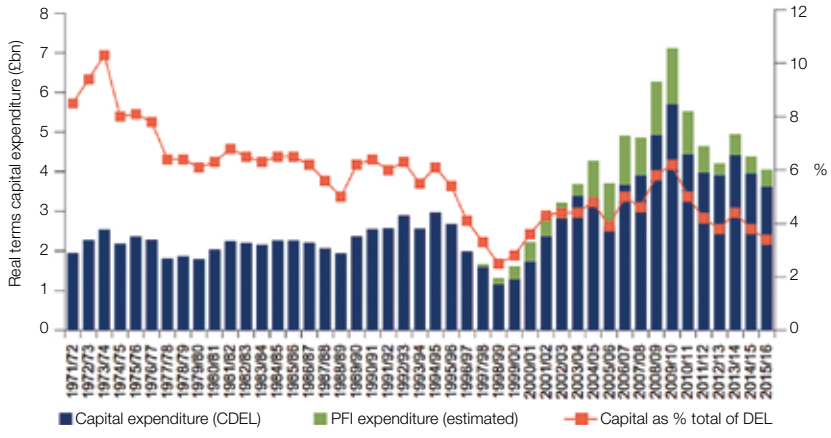
CDEL gross expenditure: £5.5bn

Gross capex	£5.5bn
Gross income	£0.3bn
Net CDEL	£5.2bn



Source: DHSC annual report and accounts 2017/18

Figure 2: Historical trends in capital investment



Source: NHS property and estates (Sir Robert Naylor report)
Note: CDEL was subsequently redefined to include research and development spending

Levelling up

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

Training

The HFMA's masters-level qualifications are quickly establishing themselves as a popular way for qualified accountants and others to further their postgraduate studies (see *Healthcare Finance* September 2018, page 28). But the HFMA is about to launch a further set of qualifications – this time aimed at those wanting to take some earlier steps towards a qualification in healthcare business and finance.

The intermediate diploma – a level 4 qualification that is similar to the first year of undergraduate study – addresses a growing demand for a qualification in healthcare business and finance from a range of staff working in healthcare – and potentially even some currently working in other sectors.

The association is confident that there will be significant interest in this from within the finance function itself – particularly among staff in existing Agenda for Change bands 4-6 – with the qualification complementing technical accounting studies and graduate training schemes.

But it is also anticipating interest from non-finance and clinical staff including procurement officers, information officers, first line managers, budget holders, team leaders, nurses, practice managers, junior doctors and allied health professionals.

Developing an awareness and understanding of how finance works is increasingly a basic requirement for all staff. If we are really going to take strides towards a value-based health system – covered in one of the optional modules within the intermediate diploma – then we need staff across the professional spectrum to get to grips with the fundamentals of finance – how we pay for services, how we cost activities and how we manage finances to deliver the best possible outcomes for patients.

Moreover, when non-finance staff engage with the finance agenda, we find they enjoy the topic and it can really help them in their day jobs and careers.

Learners need to earn 40 credits to achieve the qualification. They do this by all undertaking the mandatory *How finance works in the NHS* module, which is worth 20 credits, and then choose two optional 10 credit modules. Participants can also choose to study individual modules on a stand-alone basis.

There are currently four optional modules:

- Healthcare costing for adding value
- Management skills
- Governance and risk management in the NHS
- Tools for transforming services in the NHS.

> "We believe the intermediate diploma will meet a real demand and provide a valued qualification and a good grounding for furthering careers"

The HFMA Academy-delivered qualification is now open for applications and is due to start with its first intake in January. The first 20 learners – who should have at least a year's experience in the NHS in most cases – are being offered a discount in return for providing more feedback on the course than would be expected from full fee paying learners.

It is a detailed course with an estimated 200 hours overall study and learning time for the mandatory module (100 hours for the optional modules). No exams need to be taken to achieve the qualification.

Instead, assessment is based on assignments and may include case studies, reports, presentations or integrated work activities. The compulsory module starts with a face-to-face session – likely to be held in London at the HFMA Rochester Row conference centre. However, all subsequent tutor-led sessions are delivered online.

We believe the intermediate diploma will meet a real demand and provide successful learners with a valued qualification and a good grounding for furthering their careers. They provide an excellent step-up for anyone looking for an accredited healthcare finance and business qualification, perhaps having dipped their toes in the water with our more introductory e-learning offerings.

And once achieved, possible progression routes could include an HFMA level 7 advanced diploma in healthcare business and finance or a chartered manager degree apprenticeship.

South-east coast signs up to be positive

Future focused finance

The south-east coast region is to pilot a new engagement model with the Future-Focused Finance (FFF) *Engagement and development delivery* theme.

Thirty-eight finance skills development enthusiasts from across the region met Simon Worthington, SRO for the *Engagement and development* theme, to work out a plan to do this.

They heard from value makers and clinical educators; finance directors who have signed up to the FFF finance director declaration; staff who support FSD in the region; and an organisation that has recently submitted its level one accreditation.

This provoked lots of discussion about the benefits of a positive and engaging approach to getting more and more people involved in development across the patch. Key actions coming out of the event were:

- Encouraging every finance director in the patch to sign the Future-Focused Finance FD declaration
- Promoting a massive increase in the number of value makers and finance and clinical educators in the patch, with every organisation having at least one of each
- Further developing the existing Skills Development Network (SDN) in the patch
- Every organisation to achieve level one accreditation over the next year
- Organising a survey of all finance staff in the region to find out how they feel about access to SDN and how FFF can help.

'People who attended are taking responsibility for pushing this forward and getting as many of their colleagues involved as possible,' Mr Worthington said.

Diary

October

9 I Institute: costing together (South)
10 F Chair, Non-executive and Lay Member: forum, London, Rochester Row
12 B West Midlands: HPMA/ HFMA joint event, Birmingham
12 B South Central: football tournament
12/13 B Kent, Surrey and Sussex: annual conference, Crawley
16 F Chair, Non-executive and Lay Member: operating game for new non-executives, London, Rochester Row
17 N Provider Finance: directors' forum, London, Rochester Row
18 N Charitable funds, London, Rochester Row
19 B Eastern: annual conference, Newmarket
25/26 B Scotland: annual conference, Glasgow

November

7 I Institute: costing together (North)
8 B West Midlands: AGM, Birmingham
9 B East Midlands: annual conference, Loughborough
13 N Brighter together: estates forum, London, Rochester Row
14 F Chair, Non-executive and Lay Member: audit committee conference 2018, London, Rochester Row
15 F Commissioning Finance: forum, London, Rochester Row
16 B Northern: annual conference, Durham
17 B South Central: Brighter together theme event
22 F Mental Health Finance: site visit, Nottinghamshire Healthcare NHS FT
23 B Northern Ireland: annual conference, Belfast
27 I Institute: technical update, Leeds
27 B West Midlands: collegial conversations workshop, Birmingham

December

5-7 N HFMA annual conference, London
14 B Northern Ireland: Christmas cracker and AGM, Belfast

January

15 F Chair, Non-executive and Lay Member: annual chairs' conference, London
16 I Institute: introduction to costing (North)
30/31 N Pre-accounts planning, Birmingham/London
31 B Yorkshire and Humber: annual conference, Broughton

February

27 I Institute: value masterclass

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

key B Branch N National F Faculty I Institute

Events in focus

Brighter together: estates forum
13 November, London

This event for finance staff and their estates colleagues will examine the constraints on capital funding; how finance and estates teams can work together; and how sustainability and transformation partnerships (STPs) are accessing capital. The NHS must transform its services and it is likely a rethink of estates provision will be needed. Last year the British Medical Association estimated that STPs would require around £10bn to meet their estates plans – a figure the government appears to have accepted in its capital funding plans. Speakers include Chris Cale, NHS Improvement's assistant director of finance, and Helen Davis (pictured), programme director for the new regional health infrastructure companies. This event is being held as part of HFMA president Alex Gild's *Brighter together* presidential theme. It is the last of a series of free one-day events for members. Members are encouraged to bring along an estates colleague (charged at £99 for non-members).

- **For further details or to book a place, email josie.baskerville@hfma.org.uk**

Annual conference 2018 – Brighter together
5-7 December, London

The annual conference is the culmination of HFMA 2018 president Alex Gild's theme for the year – *Brighter together,* encouraging collaboration between NHS staff and with other stakeholders to improve patient services. This year's conference will include workshops and a chance to network with colleagues. With further details of the five-year funding plan and 10-year strategy for the NHS in England due to be published later in the year, the future shape of services and how money flows around the system are sure to be hot topics for discussion. Speakers include former Liberal Democrat health minister Norman Lamb (pictured) as well as Elizabeth O'Mahony and Ian Dalton – respectively NHS Improvement chief financial officer and chief executive, and Jon Rouse, the chief officer of Greater Manchester Health and Social Care Partnership. The 2018 HFMA Awards will also be presented during the gala dinner on 6 December.

- **For further details or to book a place, email josie.baskerville@hfma.org.uk**

Self-assessment

SHUTTERSTOCK

Association view from Mark Knight, HFMA chief executive

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

My HFMA

We are well into the swing of the HFMA autumn programme and, as the president says, it's been great to see so many of you at local and national events. The service is moving at a frenetic pace so it's gratifying so many of you can spare the time to look after your development.

Over the past year, the HFMA has been looking at itself to ensure it is in the best shape to serve you, our members. Thanks to the efforts of our former chair, Chris Calkin, we were able to do a lot of work on the internal structure earlier in the year, with his review looking at how the organisation develops into a bigger operation.

This involved thinking through how we can communicate better and establish our own internal management structure. Our vice president Bill Gregory, who becomes president in December, led a commercial review to identify growth areas for the association. This looked at areas where we could develop our services.

We've done quite a bit of work on communications and how we can get our message out. We recently held a workshop with eminent journalist David Walker to discuss the best ways to promote our policy and technical work. Our social media presence has been ramped up considerably and our member app and events app are both key to our strategy to become a more paperless organisation.

Don't expect the association to start being very active in the media. We value the influence you have 'inside the tent' to promote HFMA messages. We believe our voice is being heard and our policy work is having a big impact.

The final bit of work we've been doing is on our own governance, run by HFMA fellow and former head of internal audit at the Houses of Parliament Paul Dillon Robinson. At the time of writing, his review had not yet been published, but the general view was that the organisation is well run with proper checks and balances.

We are, however, committed to being the best we can be, so we'll be taking his advice to make any changes we need to make.


HFMA chief executive Mark Knight

So it has been a busy year but we are not interested in marking time. The qualification continues to grow from strength to strength and I'm looking forward to our graduation celebration on the Wednesday night of the annual conference. We have 30 or so diplomas to give out and well over 100 currently studying. Interest in the qualification is high and there are still opportunities to access the NHS Improvement/NHS England bursary fund, which reduces the cost of the diploma and the higher diploma.

You may have seen the finalised programme for the annual conference, which we published towards the end of September. I believe it is one of the more eye-catching programmes of recent years and we'll be announcing our punchy closing speaker soon. But don't leave it too late to book – numbers are high as usual, but let us know you're coming in good time so we can allocate you a room and plan your attendance.

If you're a finance director, this is *the* event. But it is also the stand out event for all NHS finance professionals, giving unrivalled opportunities for networking and sharing ideas.

Member news

Northern Health and Social Care Trust director of finance Owen Harkin (pictured) will become HFMA president in 2020/21. He will be a vice-president of the association for two years, starting at the annual general meeting in December, working alongside current vice president Caroline Clarke to support 2018/19 president Bill Gregory. The HFMA has also appointed four new trustees, who will take up their posts at the AGM – Rachel Hardy, Claire Wilson, Lee Bond and Sandra Easton.

The North West Branch awards ceremony took place at its recent annual conference in Blackpool. The winners in the three categories were:

- Finance Team: Tameside and Glossop Clinical Commissioning Group
- Innovation: The Walton Centre NHS Foundation Trust
- Great Place to Work: Lancashire Care NHS Foundation Trust (highly commended: Wrightington, Wigan and Leigh NHS Foundation Trust).

The North West branch also hosted a raffle that raised £800 for North West Blood Bikes.

The finance team of Norfolk Community Health and Care NHS Trust, made the most out of the trust's updated volunteering policy and combined a team-building day with gardening at one site. Ten team members, ranging from the deputy finance director to an apprentice, weeded flower beds, pruned hedges and tidied the gardens near the patient areas. Their efforts were greatly appreciated by patients and staff at Kelling Hospital. 'Norfolk Community Health and Care NHS Trust recently became the first community trust in the country to be rated outstanding by the Care Quality Commission and the spirit of staff to pull together is a huge part of this,' said the trust's head of finance Steven Dewing.

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Member benefits

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

Network focus

My HFMA

Commissioning Finance Faculty

Care closer to the community that allows people to be treated more effectively and efficiently is one of the key principles of the current NHS transformation. And commissioners have a key role to play in making it a reality.

'We have to be prepared to invest in out-of-hospital services,' says Sarah James, chief financial officer at Bath and North East Somerset Clinical Commissioning Group. 'Most people who go to hospital need some type of care, so if you're going to say hospital isn't the right place for that individual to receive care, you need to put in the right care provision in the right setting.'

As an example of a programme in which her organisation has invested, she says people with painful hips were given physiotherapy, dietary and exercise advice and information on the difference an operation would make. By the end of the programme the number of patients who had an operation fell by about 40%.

'The biggest challenge facing commissioners is learning to move to a different way of working with providers,' Mrs James says. 'For many years the whole system had a particular way of working with providers that could be very contractual and confrontational at times. The way we need to work now is much more collaborative and is about co-designing the process and the things we're going to do; managing risk and money together.'

Mrs James is part of the HFMA Commissioning Finance Faculty's Technical Issues Group and helped put together the programme for the faculty's next technical forum, which will take place in November.

The event will provide local examples of successful transformation, as well as a report on the implementation of the national *Building the right support* policy and an update from NHS Property Services.

'Good commissioners have the skills and vision to take the data, evidence and examples of what other people are doing, look at what they have locally and come up with an idea for how it could be done differently; get all the right people behind it, design what it's going to look like and then actually see it through as a programme of work,' says Mrs James.

• For more on the Commissioning Finance Faculty go to **http://hfma.to/commissioning**

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Appointments

Alan Brace, the Welsh government health and social services group finance director, has been made an honorary professor at Swansea University School of Management. He will be working with the school on a range of developments and will be supporting some of its work around value-based healthcare.

Loretta Outhwaite (pictured), who was deputy chief officer/chief finance officer and at Isle of Wight Clinical Commissioning Group and one of the senior responsible officers for NHS Future-Focused Finance, is now a tutor at the HFMA Academy and director at Turn the Tide Solutions Limited. Ms Outhwaite has 30 years NHS and public sector experience and has worked at board level for the past 10 years.

Rupert Davies (pictured left), interim director of finance at Dudley and Walsall Mental Health Partnership NHS Trust, has retired after more than 35 years working in healthcare finance. **Rob Pickup** (right) succeeds him as interim director of finance at the organisation. He previously held the position of deputy director of finance at Birmingham and Solihull Mental Health NHS Foundation Trust.

John McLuckie is now acting chief finance officer at North West Boroughs Healthcare NHS Foundation Trust. He has been working at the organisation since 2004 and was most recently deputy director of finance. Mr McLuckie joined the NHS as a graduate trainee in 1988 and has since worked in the NHS provider sector. He takes over from **Sam Proffitt**, who is on a secondment as director of finance at Cheshire and Merseyside Health and Care Partnership.

Bedfordshire, Luton and Milton Keynes Integrated Care System has appointed **Chris Ford** chief finance officer for its three clinical commissioning groups. He was previously NHS England's director of finance for the central Midlands area.

John Goulston (pictured) has retired after more than six years spent as chief executive at Croydon Health Services NHS Trust. Before taking up his first CEO position in 2008, Mr Goulston was director of finance at Barts and the London NHS Trust. **Matthew Kershaw**, former chief executive at East Kent Hospitals NHS Foundation Trust, will succeed him.

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

"It can be difficult to attract clinicians to these localities, so community hospitals find it difficult to attract the workforce they need."
Clare Bryan, Kernow Clinical Commissioning Group

Bryan takes first CFO role in Cornwall move

On the move

Clare Bryan does not deny that a chance to live in Cornwall – a beautiful area and a great place to bring up a young family – was a significant factor in applying to become Kernow Clinical Commissioning Group's chief finance officer. But she says the role, which she takes up this month, is also a chance for career progression and to prove herself in a top commissioning finance job.

Ms Bryan was previously in the NHS England Wessex office as head of finance and succeeds Simon Bell, who has joined Vale of York Clinical Commissioning Group as chief finance officer.

'It's a step up to the CFO role and there aren't a huge number of those around at the moment,' she says. 'It's a significant career step and I wanted to do it in an environment where I wouldn't be biting off more than I could chew. The system is a good size and there is a nice balance in terms of complexity.'

She continues: 'There is also the nature of Kernow, not least its geography – it's a beautiful part of the world – but also the challenges facing the local NHS.'

Those challenges, particularly in finance, are significant, but it has made great progress to stabilise that and is now on the road to recovery, Ms Bryant says. There's still plenty to do, but local organisations have made a difference working together as a system.

'There is an historical deficit, so some debt needs to be repaid and this is a financial burden the system needs to address. The underlying deficit of the CCG is now around £20m, so I can't speak highly enough of the turnaround.'

An illustration of the turnaround can be seen in the CCG's 2017/18 annual report. Having saved £7m (1%) in 2015/16 and a further £21m (3%) in 2016/17, it planned to save 4% or almost £30m in 2017/18.

Even if this target were met, the CCG would still have recorded a deficit of £37.6m.

However, at year-end, releasing the CCG's 0.5% uncommitted reserve to the bottom line led to an improvement in the financial position, giving it an overspend of around £33m.

'Being in NHS England previously, in a CCG assurance role, I got to see a number of CCG financial positions.

'Kernow is one that stood out for the right reasons – it was severely challenged but it has made such a positive turnaround, not least because of the local leadership, including Simon Bell. I have big boots to fill in living up to his legacy. I want to continue that momentum.'

"Kernow is one that stood out for the right reasons – it was severely challenged but it has made such a positive turnaround, not least because of the leadership"

The financial issues are, in part, due to the county's higher proportion of older people, who often have greater health needs, and the smaller number of working age people.

'The workforce pool is smaller, but more people are needed to provide services,' says Ms Bryant. 'I'm reluctant to say it, as other areas have the same issue, but I don't think the rurality of Cornwall and the older population is totally reflected in the allocation framework. This is a particular challenge when it comes to financial sustainability of the health service.'

There are also challenges on the quality of services. As with the financial issues, some of this is driven by the geography and demography of the county.

'It's a big area with a small population,' she says. 'We also cover the Isles of Scilly. It can be difficult to attract clinicians to these localities, so community hospitals find it difficult to attract the workforce they need.'

In response to the issues, the local system – councils, NHS England and the CCG – are considering creating an integrated care system.

Ms Bryan is well-versed in commissioning, having worked in primary care trusts and clinical commissioning groups, and, latterly, NHS England. It is also an area of finance she enjoys.

'I've spent most of my finance career in commissioners,' she says, 'and although I have worked in providers and I accept that not everyone likes it, I prefer the outlook.'

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