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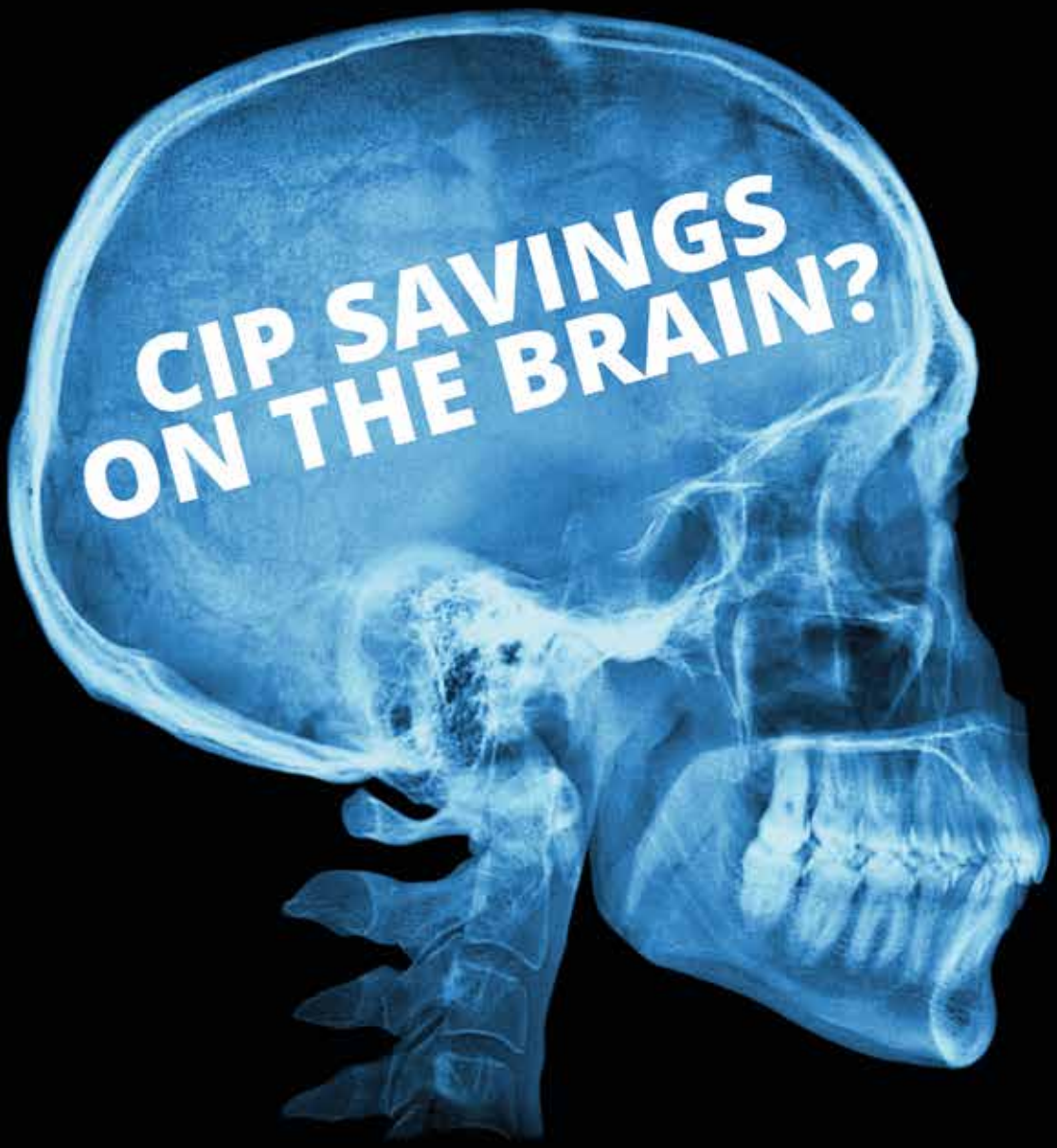

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News

NHS reviews finance framework in 10-year plan development

By Seamus Ward

Working groups shaping the 10-year plan for the NHS in England will consider fundamental aspects of the existing financial architecture, according to NHS Improvement chief financial officer Elizabeth O'Mahony.

Details of the working groups emerged in the summer, and NHS Improvement confirmed it had delayed publication of the tariff engagement document for 2019 and beyond. It said that following the five-year funding settlement announced in July, it was essential that tariff and pricing proposals were aligned with the long-term plan for the NHS.

Further engagement will take place over the coming months, but the tariff proposals will be published later in the year alongside the 10-year plan and 2019/20 planning guidance.

Ms O'Mahony leads two of the working groups – on funding and financial architecture, and capital and infrastructure. She told *Healthcare Finance* the former would look at the tariff, including the marginal rate emergency tariff. It would also consider other elements of funding flows. These included CQUIN, readmissions and material financial aspects of the standard contract, as well as control totals.

There are 17 working groups, including those being led by Ms O'Mahony, but she said they could not work in isolation. A change in one area might have a knock-on effect in another – they must not be rushed, and stakeholders should be involved in considering proposals at the earliest stage possible. 'We have to be careful,' she said. 'A substantial shift in the financial architecture at the same time as the NHS is reforming could destabilise the position.

> **"We need to simplify the financial framework and change some of the levers that are now out of date"**
> **Elizabeth O'Mahony, NHS Improvement**

'We need to simplify the financial framework and change some of the levers that are now out of date. While we do this, however, we need to understand how the changes will impact commissioners, providers and systems.'

NHS Improvement chief executive Ian Dalton said providers would play a key role in the working groups. 'It's a personal intent of mine that we make sure the provider sector that has to deliver the plan is strongly built into this,' he said. 'The workstreams will be the first step in what will need to be a significant engagement process.'

The NHS Confederation welcomed suggestions that the payment regime would be reformed, but it added that any payment changes must encourage place-based care and reward care in the community.

Working groups

Life course programmes
- Prevention and personal responsibility
- Healthy childhood and maternal health
- Integrated and personalised care for people with long-term conditions and the frail elderly (including dementia)

Clinical priorities
- Cancer
- Cardiovascular and respiratory
- Learning disability and autism
- Mental health

Enablers
- Workforce, training and leadership
- Digital and technology
- Primary care
- Research and innovation
- Clinical review of standards
- Engagement
- Funding and financial architecture
- Capital and infrastructure
- Efficiency and productivity
- Local and national system architecture

The Community Network, which has been established by NHS Providers and the NHS Confederation, said the 10-year plan must put community services 'front and centre' of improving care for the public.

In a letter to NHS England and NHS Improvement, Community Network chair Matthew Winn said the acceleration of integration and the spread of a community-based model to manage population health and care must be key priorities.

'Ultimately, we need to do something different,' he said. 'The community-based approach adopted by a number of vanguard projects and wider integration projects across the country has proven to be successful. As the National Audit Office has reported, these models achieved a slower growth rate of hospital emergency admissions.'

• *See Balancing act, page 8; One step back, two steps forward, page 10*

Negligence costs continue to rise

The cost of clinical negligence claims increased again in 2017/18, even though NHS Resolution mediated more claims and saw a plateau in the number of new claims.

In its annual report, NHS Resolution said greater mediation of claims was accompanied by a reduction in claimant legal costs (down almost £32m). The 2017/18 financial year was the first in its five-year strategy that aims to resolve more cases and avoid litigation, while ensuring the NHS learns from clinical mistakes.

The NHS paid more than £1.6bn in clinical negligence damages – an increase of £550m (50%) on 2016/17. This was largely due to a change in the personal injury discount rate, used to calculate compensation. NHS Resolution attributed £404m of the rise in compensation payments to the change in the rate (from +2.5% to -0.75%). Legislation to address this is going through Parliament.

NHS Resolution chief executive Helen Vernon (pictured) said: 'The growing interest from our NHS members and those who act for injured patients in working together to resolve claims for compensation without going to court has been encouraging and we hope to build on this so that mediation is no longer seen as novel in healthcare.

'However, the cost of clinical negligence is at an all-time high. The total provisions for all of our indemnity schemes continue to rise, from £65bn last year to £77bn as of 31 March, which brings a renewed urgency to efforts across government to tackle the drivers of that cost.'

Outpatient improvements must be clinically led

By Steve Brown

There are significant opportunities to improve outpatient services, but clinicians will have to be at the heart of the process, and health systems should not underestimate the time needed to implement new models, the Nuffield Trust has said.

Its report, *Rethinking outpatient services,* draws on a workshop held with NHS Improvement at the end of last year and highlights successful outpatient redesigns from around the country.

It comes amid an increasing focus on modernising outpatient services. NHS England chief executive Simon Stevens recently described the current model as 'an obsolescent mode of specialty long-term support' and an outpatients review has recently been added to the *Getting it right first time* programme.

A number of sustainability and transformation plans have also outlined ambitious proposals to cut costs by reducing outpatient activity

The Nuffield Trust said it was important that redesign work was led by the 'clinicians who are delivering it'. It also warned that administrative referral management models – applying rules to check referrals – did not appear cost-effective, introducing a non-value-adding step and delay into the pathway.

Instead, the thinktank highlighted the transformation of relationships between consultants and GPs and their wider teams as

the foundation of some impressive outpatient redesigns. Two-way conversations had the 'potential to treat more patients in the community and support clinicians in their decision-making', the report said – a change that could reduce referrals.

Child health GP hubs, pioneered by Imperial College Healthcare NHS Trust, have led to big improvements in patient experience and a reduction in hospital activity. In one hub, 39% of new patient hospital appointments were avoided altogether and a further 42% of appointments were relocated from hospitals to GP practices.

Other successful redesigns had introduced virtual clinics and questionnaire-based risk assessment approaches to determine where follow-up appointments were needed.

The report also highlighted the need to change payment systems. The national tariff does not currently have national prices for advice, guidance and remote consultations, though there is ongoing work to develop these. The authors said local prices should be negotiated that took account of overall outcomes and total cost. A price set higher than the tariff for a single professional face-to-face follow-up appointment could actually deliver better value when wider benefits were factored in.

However, the report also warned that there was no one-size-fits-all solution to outpatients redesign. Even within a particular specialty, each clinic was likely to respond differently to interventions and each service would need to experiment with different delivery models.

Workshop attendees emphasised the importance of looking at the patient journey from start to finish and ensuring each member of staff was adding the most value possible.

Sophie Castle-Clarke, a senior fellow in health policy and digital programme lead at the Nuffield Trust, said that with more than 110 million scheduled appointments in England a year and activity on the increase, it was time to rethink outpatient services.

'The good news is that with this significant challenge comes great opportunity to do things differently,' she said.

'A clear thread running through successful changes to outpatient services was allowing clinicians to orchestrate these changes and build strong and productive working relationships. Clinicians and hospital managers should not underestimate the time it takes to achieve this.'

• *A new look?, page 16*

BMA safety and cost fears over no deal Brexit

A no deal Brexit could cost the health service £1bn a year and have catastrophic consequences for patients, the NHS workforce and the nation's health, according to the British Medical Association (BMA).

The UK is due to withdraw from the European Union on 29 March next year, but the deadline for agreeing a final deal is next month. There are fears the UK could fall out of the EU without a deal.

In August, the government issued briefings advising sectors on what to do should that happen – it insisted it was still seeking a deal and the briefings were issued as a precaution.

In the health sector, trusts, GPs and pharmacies were advised against stockpiling medicines, although pharmaceutical companies were asked to hold supplies for six weeks on top of their usual stock levels.

The BMA said without a deal, reciprocal healthcare agreements could end, disrupting patient care and increasing insurance costs.

If 190,000 UK pensioners currently living abroad and signed up to the S1 reciprocal healthcare entitlement scheme returned to the UK, this could cost between £500m and £1bn a year.

The NHS could have to source radioisotopes from outside Euratom, which oversees their import from other European countries. This could delay cancer diagnoses and treatments.

A return to a hard border between Northern Ireland and the Irish Republic could affect patients who currently travel across the border to receive care. And fewer EU doctors could choose to work in the NHS if there is uncertainty over immigration status and confusion over recognition of medical qualifications.

The BMA has backed a public vote on the final deal. Its council chair, Chaand

Nagpaul (pictured), said: 'No deal could have potentially catastrophic consequences for patients, the health workforce, services and the nation's health. Some will say we are scaremongering by warning of the dangers of a no deal Brexit, but this is not the case. We aren't shying away from being honest about what is at stake for health services if the UK and the EU fail to reach a deal.'

NHSI highlights Barking problems

Financial issues at Barking, Havering and Redbridge University Hospitals NHS Trust should not be attributed to the actions of a single individual as they were caused by several factors, according to a report for NHS Improvement.

The Deloitte report was commissioned by NHS Improvement after it placed the trust in financial special measures in February. The report said the trust had 'essentially run out of cash' in October last year and applied for two emergency government loans totalling £20.7m. Board members said they were unaware of the emerging cash crisis.

The report highlighted low levels of transparency in financial reporting; poor escalation of risks; executive director silo working; and weaknesses in board oversight.

NHS Improvement also asked its deputy chair Richard Douglas (pictured) to examine the role played by Jeff Buggle, the trust's former finance director and acting chief executive, who became NHS Improvement's operational regional finance director for London in July 2017.

NHS Improvement chief executive Ian Dalton said the review found there was no evidence that Mr Buggle had 'crossed a professional line' in reporting the trust's financial performance or board briefings.

'I am pleased that he will continue in his role with NHS Improvement,' he said. 'He has our full confidence and support.'

Pay deals must be funded in full, says NHS Providers

By Seamus Ward

The NHS in England will be given an additional £800m this year to cover the costs of the new Agenda for Change pay deal, but trusts have warned that pay rises for doctors and dentists should also be fully funded.

Providers have been allocated £756m this financial year to cover the additional costs of the Agenda for Change pay deal. The Department of Health and Social Care said commissioners (including NHS England, clinical commissioning groups and commissioning support units) would get a further £20m; other arm's length bodies £12m; and non-NHS organisations £12m.

The funding is being allocated directly – in providers' case this will be calculated using 2018/19 financial plans and electronic staff record (ESR) data on the proportion of staff at different pay spine points.

The Department said the final overall payment matched the national impact of the bottom-up calculation of the cost of the pay award (2.03% over and above the 1% already funded).

Although it believes the method of allocation is equitable, the Department acknowledged there could be circumstances where local costs are not fully met. On the other hand, some providers could be overpaid – NHS Improvement will identify this in month four financial returns.

The pay rise is backdated to April and 1/12 of the annual total was made available to providers in July, with 1/3 paid in August to cover back pay. Trusts will receive 1/12 each month for the rest of the financial year.

For commissioners, £20m will be added to the NHS England mandate funding and the national body will either adjust running costs or make the payment directly to individual organisations.

Most doctors and dentists in England will receive a 2% pay rise – though consultants will get 1.5% plus potentially a further 0.5% in non-consolidated performance pay and specialty doctors 3%. However, unlike the Agenda for Change deal, these rises must be funded from existing budgets.

NHS Providers deputy chief executive Saffron Cordery (pictured) said NHS staff, including doctors, deserved better pay. 'But trusts are already financially overstretched and we have always been clear this increase must be fully funded,' she said.

'If – as seems almost inevitable – the additional costs of this increase are passed on to trusts, it would increase their pay bill substantially. Trusts will have to find other ways of finding the money, with a real risk that that could impact on the quality of care.'

In Scotland, a new pay deal will benefit 147,000 NHS staff on Agenda for Change contracts. Health union members accepted the deal in August, giving those earning up to £80,000 a 9% uplift over three years. Those earning more than £80,000 will be given a flat increase of £1,600 a year. Staff who are not at the top of their pay bands will also receive the incremental pay rise they are due. The pay rise will be backdated to April 2018.

The Welsh government offered local staff a similar deal to that agreed in England.

Public funding pledged to complete PF2 hospital

The government is to provide funding to complete the construction of the Midlands Metropolitan Hospital, which stalled following the collapse of Carillion in January.

The new hospital was scheduled to open in October but this will now be in 2022. It was being funded under a PF2 private finance agreement, but Sandwell and West Birmingham Hospitals NHS Trust had to rethink after the construction firm went into liquidation.

In August, the trust board confirmed it would opt for a publicly funded route, approved by the Department of Health and Social Care and the Treasury.

It has been reported that the government will now provide £300m to complete the building.

In January, before it collapsed, Carillion asked the government for up to £125m to complete the build in exchange for an equity stake, according to the National Audit Office.

Health minister Stephen Barclay (pictured) said: 'By taking this bold step, we are not only giving patients in Sandwell and west Birmingham world-class NHS facilities on their doorstep, but also showing our determination to build an NHS fit for the future.'

Construction at the other NHS part-privately financed building contract held by Carillion – Royal Liverpool and Broadgreen NHS Trust – was also halted in January. The trust said construction was nearer completion than at the Midlands trusts.

Discussions on restarting construction were ongoing and all parties wanted to see the new hospital completed as soon as possible, the trust said.

News review

Seamus Ward assesses the past two months in healthcare

For now, the traditional drop in emergency activity over the summer months in England is a thing of the past, with demand remaining high all-year round. According to NHS England, attendances at A&E in July were 4.9% up on the same month in 2017. As a result, the proportion of patients seen within four hours in emergency departments fell by one percentage point compared with July 2017. The NHS England figures show 89.3% were seen within four hours, compared with 90.3% in July 2017. But more patients were admitted, transferred or discharged within four hours than in July 2017. At the end of June, almost 88% of patients were on the waiting list for fewer than 18 weeks, missing the 92% target.

Staff numbers tend to rise as providers respond to increased demand and, according to NHS Digital, the NHS workforce increased by 1.6% in the year to March 2018. A total of 1.23 million full-time equivalents were employed in health bodies in England, it said – an increase of 19,800 staff. There had been rises in the number of doctors, midwives and clinical support workers, though nurse and health visitor numbers dropped. Manager numbers also rose by 1,220 compared with March 2017.

Though summer may no longer be the time of reduced demand, it is still a time for national bodies' annual reports and accounts. In its 2017/18 report, the Department of Health and Social Care confirmed the NHS broadly delivered financial balance. Though providers reported an aggregate deficit of just under £1bn, NHS England achieved an underspend of almost £1bn – even though clinical commissioning groups overspent by a net £200m. The report added that 15% of trusts are disproportionately driving the aggregate variance to plan. Of these, four have overspends of more than £30m (*see NHS in numbers, page 27*).

NHS providers spent more on capital in 2017/18 than the previous year, according to the 2017/18 consolidated provider accounts from NHS Improvement. Providers spent almost £3.4m compared with £3.1m in 2016/17. Trusts held more cash at the end of 2017/18 (£4.9bn compared with £4.2bn at 31 March 2017). Most of the cash is held by foundations trusts.

Meanwhile, in its annual report, NHS England confirmed the commissioning sector ended 2017/18 with a managed underspend of £970m against a budget of £109.5bn. In the report, chief financial officer Paul Baumann

(pictured) said £640m of the underspend came from the release of the system risk reserve and other contingencies. This £640m reserve has offset provider overspends and was made up of the funding set aside by clinical commissioning groups (£360m), £200m set aside by NHS England and a further £80m (from a category M drugs rebate) added in year. With the creation of the £2.45bn provider sustainability fund in 2018/19, NHS England and CCGs will no longer hold risk reserves beyond normal contingencies. CCGs delivered unprecedented efficiencies of 3.1% of their allocations, Mr Baumann added, but overall, they recorded an overspend of £213m.

Health Education England (HEE) met its statutory financial duties in 2017/18, underspending on its revenue resource limit by almost £37m (0.76% of total). More than 91% of its expenditure was on training the future workforce, according to its annual report. However, it confirmed investment in workforce development was reduced to help balance the overall budget. HEE said it was planning to avoid further reductions as stakeholders are

The summer in quotes

'The public sector is operating in challenging times, so it is more important than ever that we shine a spotlight on what works well and where services need to improve.'
New Wales auditor general Adrian Crompton is looking forward to helping public services improve

'This represents a major effort from them, as well as staff across the trust, but there remains more to do. The trust must now develop a longer term financial plan that reduces its deficit and at the same time remain focused on improving the quality of its services.'
NHS Improvement's Stephen Hay on Brighton and Sussex University Hospitals NHS Trust coming out of financial special measures

'It means receiving the best training and support – the right number of people with the right skills so you are able to provide the safest, highest quality care to patients. I want to ensure training is organised and funded so that everyone can reach their full potential.'
New health secretary Matt Hancock says workforce is one of his early priorities

'NHS England made a complete mess of what could have been a responsible measure to save taxpayers' money. It is clearly unacceptable that poor procurement should put patients at risk of harm and undermine the ability of GPs, dentists, opticians and pharmacists to do their jobs.'

Commons Public Accounts Committee chair Meg Hillier on the fallout from NHS England's outsourcing of primary care support

CREATIVE COMMONS

New health secretary Matt Hancock's early priorities include £500m of funding to support the roll-out of innovative technology

insisting training is needed to transform the skills of the existing workforce.

A new health secretary for England was announced in July as Jeremy Hunt moved to the Foreign Office in a mini reshuffle following the departure of senior Conservative cabinet members. Culture secretary Matt Hancock was named health and social care secretary and spoke of his admiration for NHS staff. He identified workforce, technology and prevention as his early priorities for health and social care and unveiled nearly £500m of funding to support the roll-out of innovative technology. More than £400m will go towards new technology in hospitals to improve safety and access to health services at home, while a further £75m will help trusts put in place 'state-of-the-art electronic systems' that save money, give clinicians more time to spend on patients and reduce medication errors.

There was also change at the Wales Audit Office as Adrian Crompton took over as auditor general for Wales and chief executive of the Wales Audit Office. He has succeeded Huw Vaughan Thomas, who has retired. The role, which carries an eight-year term, is independent of government. Mr Crompton previously held the role of director of Assembly business at the National Assembly for Wales and also worked across the Middle East and North Africa to support the development of political institutions and good governance.

The Department of Health and Social Care continued to take steps to control costs at a national level, opening a consultation on measures to hold down the cost of branded medicines. It said the proposed changes would ensure the overall growth of branded medicines sales would remain sustainable. The consultation seeks views on how the growth in branded medicines is forecast and changes in the method of calculating a payment percentage – this ensures the Department recovers the difference between the allowed growth, which is set by the government, and forecast levels of sales.

NHS Improvement announced that Brighton and Sussex University Hospitals NHS Trust is no longer in special measures for finance. The oversight body said the trust had improved its financial management and performance since it was placed in financial special measures in October 2016. Financial leadership, control over finances and governance had improved and the trust was on track to meet its financial target for this financial year. The trust is now developing a long-term financial plan to further reduce its deficit and, while it completes this, will remain subject to formal regulatory oversight.

The Public Accounts Committee has branded NHS England's outsourcing of primary care support services to Capita Business Services (Capita) as 'a shambles'. In *Supporting primary care services: NHS England's contract with Capita* it said the rush to slash running costs by a third did not take account of the impact it would have on the GPs, dentists, opticians and pharmacists affected. Neither NHS England nor Capita understood the service being outsourced and both misjudged the scale and nature of the risks, ignoring basic rules of contracting, it added.

from the hfma

Partnership working is key to making greater integration a success, and finance professionals have a major role to play, according to Suzanne Robinson (below), director of finance, performance and digital at North Staffordshire Combined Healthcare NHS Trust. In a blog for the HFMA, she said the finance community had already embraced partnership working and had a network of support to encourage the sharing of best practice.

Collaboration was a key theme at the association's Convergence conference in July. In a blog on the conference, *Healthcare Finance* editor Steve Brown said system working will not happen overnight as partnerships and engagement must be built up steadily.

The worrying level of vacancies among senior NHS executives must be addressed, according to Emma Knowles, HFMA head of policy and research in a blog. In 2014 the highest vacancy level was for finance directors (9% vacant), but in 2017 this dropped to a below-average 7%. This was positive, though finance directors were among those most likely to have been appointed in the last three years, she said. More could be done, including health departments making clear they value finance staff.

The HFMA published five blogs in August, highlighting policy area and technical work and reminding members of outputs from that work. The topics covered were: value-based healthcare; new accounting standards due to come into force over the next two years; the future of the national tariff; strengthening system governance; and the development of the finance function.

• See blogs at www.hfma.org.uk/news/blogs or on the HFMA app

News analysis

Headline issues in the spotlight

Balancing act

NHS financial mechanisms are under discussion, but the provider sector must return to financial balance this year to provide a platform for the 10-year plan, NHS Improvement's Elizabeth O'Mahony tells Seamus Ward

NHS providers ended 2017/18 with a £966m deficit and, with operational targets missed and the scars of a difficult winter still fresh, it was a relatively gloomy financial year end. But look behind the headline figures and there is cause for optimism, with extra funds this year, a new five-year funding settlement due to begin in 2019 and a long-term plan in development, according to NHS Improvement's chief financial officer, Elizabeth O'Mahony (pictured).

'Some people might say that a £966m deficit was a poor performance against a planned deficit of £496m. But we saw some of the greatest operational pressures in history. More than two-thirds finished the year on target for finances or better,' she said. 'Boards did their utmost to deliver the financial position. While it was not on plan, it was better than I anticipated at the end of Q3.

'So they turned it around in the last quarter, albeit through non-recurrent measures, which have been a theme of recent years. I have the privilege of working with the finance community, not just at national level, but out at the front line. I sense a strong community that my team and I are proud to be part of.'

Overall, with the provider sustainability fund boosted by £650m to £2.45bn, NHS Improvement is aiming for a balanced financial position in 2018/19. However, Ms O'Mahony, speaking to *Healthcare Finance*, accepted further work was needed to achieve this. 'We expected to start the year with a balanced plan, but it won't be a surprise to hear that we haven't achieved this. At the end of Q1 we will be forecasting that we are on plan, but the plan is not balanced and therefore not affordable.

'NHSI and NHSE teams have during the summer been working with the most challenged systems to identify actions to close the residual gap.

'This work has also identified opportunities for financial improvement in some organisations and systems that are already meeting their control totals.

'We are almost there in closing the planning gap. To achieve this, however, we have developed a number of local incentives and opportunities that will help us move the dial,' she said.

Some of these incentives are being considered by the Quad (NHS Improvement, NHS England, the Treasury and the Department of Health and Social Care). 'Hopefully, we will be able to communicate these more widely shortly.'

While the results at Q1 are not affordable it is important to recognise the intense operational pressure in the service, she added.

'Yet again, we missed the operational targets, but our staff saw more patients in under four hours and treated more patients within 18 weeks than in the same period last year. Once again, the increased demand in emergency admissions is a financial pressure.'

Ms O'Mahony is reasonably positive about the preparations for the coming winter, which have started earlier and build on last year. But she added: 'In Q1, there was a 9% increase in vacancies and, consequently, an overspend in temporary staff. It's still at or around last year's level, but our ambition is to reduce the level of temporary staffing this year further.'

Local systems must continue to bear down on high bed occupancy and delayed discharges and reduce emergency admissions, as it is affecting the sector's ability to admit patients needing planned care. 'Extra beds are not the solution in all places as we simply don't have the additional staff, but there is a lot of scope to use the existing bed base better if we can improve flow.'

The Q1 report (due this month) will also broach the issue of the underlying deficit. This is the level of deficit at the beginning of each financial year due to non-recurrent actions and full-year effects in the previous year. In 2017/18 non-recurrent measures saved £842m, compared with a planned £316m.

'We need to transparently consider the underlying position as 2018/19 is the platform for the longer-term plan. It is essential that a balanced plan is prepared and delivered, but we are already playing catch up. A lot of this is

Finance support

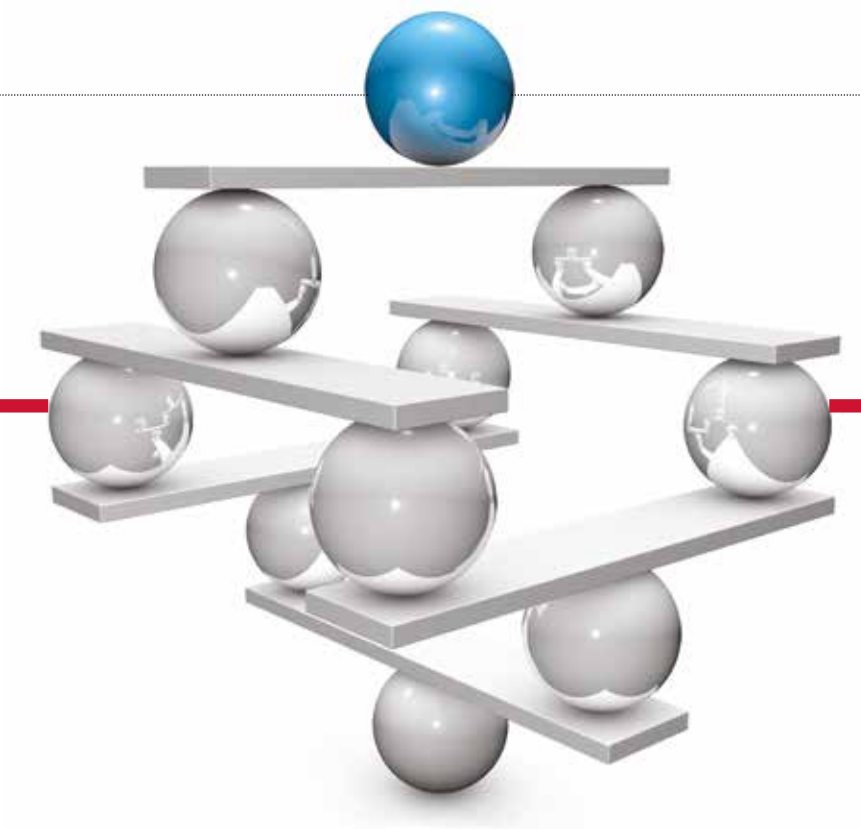
While the NHS is getting on with its day-to-day work, it is also shaping its future to support new delivery models. New skills will be needed and Ms O'Mahony is proud of the work NHS Improvement is doing with Future-Focused Finance and the HFMA.

'It is essential that we all support the next generation of finance directors and ensure they are best placed to succeed,' she said.

She added: 'It would be easy for finance directors to simply stop training as a short-term cost-cutting measure, but we all know that this is a false economy and some targeted investment is important for the future. NHSI and NHSE have provided a bursary to pump prime the HFMA masters-level qualifications and make them more affordable.' (See page 28.)

Diversity is also high on Ms O'Mahony's agenda, though she is frustrated by the lack of meaningful information on this subject. 'We need to better understand the barriers and formulate a clear measurable approach in every finance department in the country. There is a strong appetite in the finance community to respond to issues and promote diversity.

'The FFF launch event for the diversity work programme on 7 November will be a good opportunity to engage, she added.



SHUTTERSTOCK

because last year there was an increased level of non-recurrent savings,' Ms O'Mahony said.

NHS Improvement will provide help. 'It's all very well saying the sector needs to get to a balanced plan, but we need to ensure these issues are widely understood and trust boards are supported to take the necessary actions and manage risk as any shortfall in delivery has implications for next year,' said Ms O'Mahony.

Local organisations are working in partnership and NHS Improvement and NHS England are also moving towards shared structures and leadership with a common set of objectives. She insisted the joint national and regional structures must be set up quickly and not distract from the development of the 10-year plan and making the most of the five-year funding settlement.

'The funding settlement is welcome – it averages 3.4% over five years – but we all know it's not sufficient for us to continue to do everything in the same way.'

Working groups

Seventeen working groups have been set up to shape the 10-year plan. Ms O'Mahony is leading two of them – funding and financial architecture, and capital and infrastructure – but she believes the groups cannot work in isolation as many of the issues under discussion are interdependent. A change in one workstream area is likely to impact another. 'We have to be careful – a substantial shift in the financial architecture at the same time as the NHS is reforming could destabilise the position,' she said.

It is widely agreed that the two-year tariff has built stability in the service and NHS Improvement and NHS England will not want to endanger that stability. This is one reason for the delay in publication of the tariff engagement document. This will now be published alongside the 10-year plan to ensure the tariff and the long-term plan are not contradictory.

"We are considering all aspects of the financial architecture as they have evolved over time and were designed for a different environment"
Elizabeth O'Mahony, NHS Improvement

And with work on the 10-year plan amounting to a game of four-dimensional chess, it is understood that different timescales for the delivery and business plans are being considered – including one year plus four, two plus three or three years plus two. 'It will have wide ramifications and we have to do things the right way around,' Ms O'Mahony said.

The funding and financial architecture working group is also looking at areas such as the future of control totals, CQUIN, MRET, readmissions and material financial aspects of the standard contract.

'The scope of the review is extensive, and we are considering all aspects of the financial architecture as they have evolved over time and were designed for a different environment.

'We need to simplify the financial framework and change some of the levers that are now out of date. While we do this, however, we need to understand how the changes will impact commissioners, providers and systems.

'It is a great opportunity, but equally daunting as there are numerous interdependencies and complexities. I don't want to do something that destabilises the sector because it is rushed. It is therefore essential that we engage with key stakeholders to consider the proposals at the earliest opportunity,' Ms O'Mahony added.

She believes the tariff has a future as it is used in several ways. It has driven improvements in costing, supported pathway redesign and incentivised best practice, she said.

But further reform of the payment system will be necessary if it is to support delivery of the long-term plan and local system collaboration. Ms O'Mahony believes there is much to learn from local approaches in developing the national approach.

She said: 'I think a tariff-based system has its benefits, but I am concerned about the integrity of prices, particularly in urgent and emergency care, as we know that there is a substantial scaling factor, and the tariff baseline has not kept pace with the average cost of delivering care.

'For some providers, the headline efficiency opportunity does not appear to cover their deficit and we need to consider if this is down to structural issues, local system issues or the management hasn't taken all the action it could. But for many organisations the tariff is not covering costs.'

Some finance professionals believe control totals are coming to the end of their usefulness. Asked whether they have a future, Ms O'Mahony said: 'We will not roll forward the 2018/19 control totals a further year as they were based on a 2015/16 baseline. But we have already engaged with stakeholders from across the service and the general sense is that a stretching, but realistic, control regime is helpful in the current environment.

'The trick here is to ensure, by also changing the financial architecture, organisations feel they are structurally better off, and we must have a different approach for those trusts in surplus.'

However, with transformation and addressing underlying deficits, they will become less relevant over time. 'I strongly believe that as we transform in the way we will be describing in the long-term plan, we will phase out control totals and move to an approach around earned autonomy,' said Ms O'Mahony.

It's been a busy summer and it's unlikely this will let up in the autumn, but NHS Improvement and NHS England will hope the work done now will provide a stable platform for the future.

Comment

September 2018

Bring on the planning detail

We need to move quickly to the detail of the 10-year plan

HFMA president Alex Gild

There's a bit of a planning hiatus at the moment. The NHS needs to know soon how the announced five-year revenue uplift will be allocated and managed, beyond addressing the headline priorities such as mental health, cancer and improving provider financial sustainability.

We also need details about the other critical enablers to the NHS's improvement journey. These include: social care funding; health education funding and incentives to address workforce gaps; and addressing capital needs, without which a vision for health and care integration and transformation is unlikely to be delivered.

The current focus is on the development of a 10-year plan underpinned by the five-year settlement set out in June. But we need to move quickly to the detail of what we need to deliver – with specifics on funding flows, integration and workforce – and how we can plan to make that happen.

The first year of that 10-year period will be 2019/20 and we need to head off in the right direction with a good understanding of what we are trying to achieve over the long-term and how we are going to do it.

We have been told that the tariff engagement document, which we might normally have expected before the summer, will now be published alongside the 10-year plan – expected later this year. This does make sense, as the tariff remains fundamental in most areas to how money will move around the system in the

One step back, two steps forward?

We have to wait longer for 2019/20 tariff plans, but we may be edging closer to a new payment system

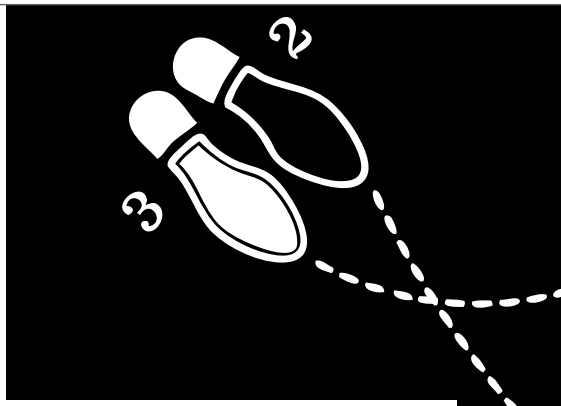
Healthcare Finance editor Steve Brown

NHS Improvement's announcement of a further delay to the publication of the tariff engagement document in August was a blow for local health economies keen to understand the opportunities and financial challenges they will face in 2019/20. But there are also encouraging signs that the NHS is starting to make some progress towards reformed payment systems.

The August announcement said tariff proposals for 2019/20 would now be published alongside the wider 10-year plan later this year. This was already two months beyond the original planned release date. Having extolled the virtues of stability and enhanced planning delivered by the current two-year tariff, delaying plans for the next tariff seems counterintuitive.

The tariff proposals are not an academic exercise, with possible proposals that could make a big difference to how money flows and have an impact on health bodies' ability to meet control totals. Decisions must be made about the specific version of the currency design used – what year's reference costs would tariff prices be based on?

And with reform of outpatients a key priority currently (*A new look, page 16*), it would not be too much of a stretch to anticipate changes around the funding of first and follow-up appointments. Any changes to the marginal rate emergency tariff would also have a massive impact on many providers.



And if there are to be any new best practice tariffs introduced, as much notice as possible would be helpful in ensuring data flows and processes are in place to support their achievement.

But clearly the new five-year settlement is a game changer in terms of the overall quantum of funding that will be delivered via the tariff and other payment

"We can't afford too many delays if we are going to make the most of the opportunity to transform services"

coming years – even though the long-term goal is to move more to capitation-style payment models.

But we can't afford too many delays to the operational planning timetable if we are going to make the most of the opportunity – afforded by the long-term settlement and 10-year plan – to transform services for the benefit of patients. As a finance community, we also need to take full advantage of the promised opportunity to influence the development of this all-important 10-year plan – ensuring it is both ambitious and achievable.

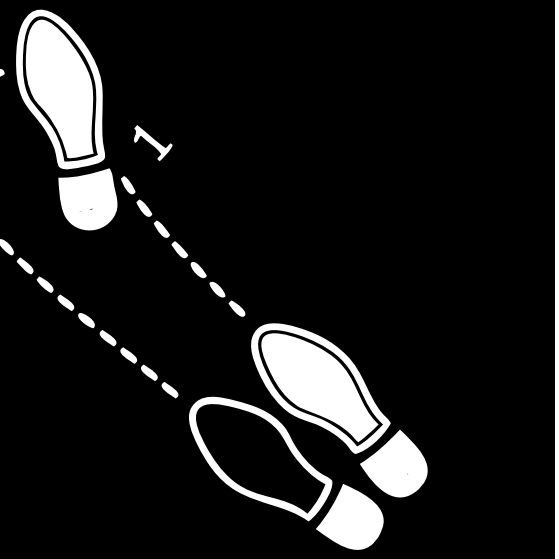
Turning my attention to our finance community, it is worth saying that we are immeasurably lucky to have the HFMA. It has a rich history of providing support to the NHS finance function and we continue to see a bright and relevant future.

This continuing relevance can be seen in the eyes of the grass roots of our vibrant branch membership, in our committee networks, and in our high-quality policy and technical output. But it is also evident in our excellent healthcare business and finance qualification offer, our partnerships and in the high-calibre trustee candidates coming forward to support the work of the HFMA board.

The HFMA continues to provide the glue that holds together finance networks against recent system fragmentation. It is the voice and professional family for thousands of NHS finance staff.

As president for this year, it is a privilege to see the HFMA continue to move from strength to strength, as it helps finance staff and their wider teams shape for the future. This is a future where finance professionals, working alongside clinicians and other professionals, deliver increasing value to the NHS. That value will be seen in clinical services working better together across systems. It will be seen in new technologies being adopted across the service and in further improvements in productivity. And it will be seen in the ultimate measure – better outcomes and better care for patients.

Contact the president on president@hfma.org.uk



mechanisms. And there is sense in ensuring alignment between what the 10-year plan aims to deliver and how one of the key payment mechanisms helps to achieve that.

There is also a sense of greater urgency in messages from NHS England and NHS Improvement about payment reform. Speaking to *Healthcare Finance* in this issue (*page 8*), NHS Improvement's chief financial officer Elizabeth O'Mahony is clear that while the tariff has it place, further reform of the payment system is needed – building on some of the local approaches to support integrated working.

The summer's publication of the proposed contracting arrangements for integrated care providers – now being consulted on – also shows the direction of travel towards the use of integrated budgets. It is clear in identifying capitated payment – or a simplified version of it using whole population budgets – as the way to support moves to integrated care.

These proposals – initially setting the budget based on current commissioner spend, top-slicing an element to provide an outcome-based incentive scheme and developing gain/loss sharing mechanisms to share risk – are not new. They are built on earlier published guidance. But while the whole ACO contract has been caught up in judicial reviews, debate on reforming payment approaches has also been relatively stifled.

"There are real examples now of transformed services not being further rolled out because of payment system difficulties"

Payment reform will not deliver the transformation that the NHS needs to see. But there are real examples now of transformed services – delivering patient and system-wide cost benefits – not being further rolled out because of payment system difficulties.

The delay to the 2019/20 tariff engagement document may produce headaches for local finance managers trying to navigate next year's financial challenge. But if it means that we will see faster moves to a more appropriate payment system to support modernisation, it will be a price worth paying.

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the power of four

NHS Wales has adopted value-based healthcare underpinned by the quadruple aim. Its finance director Alan Brace tells Seamus Ward how this will impact on services

Across the developed world, healthcare systems have adopted the triple aim to deliver value-based healthcare – better health, better care at lower cost. Wales is one such system, but now it aims to take a step further by implementing a quadruple aim and putting a greater focus on the outcomes patients want.

The triple aim seeks to improve services by focusing on three dimensions of health and care:

- Developing population health and wellbeing
- Increasing the quality of services
- Producing high-value, lower cost health and social care.

The quadruple aim takes these three dimensions and adds the aim of developing a motivated, well-trained and sustainable workforce.

The quadruple aim and the new focus on outcomes were outlined in *A healthier Wales*, a long-term plan for health and social care published at the beginning of the summer. The new strategy is the government's response to a Parliamentary review on the future of health and social care in Wales, carried out by a panel of health and care experts. Both call for a seamless health and care system underpinned by the quadruple aim.

Alan Brace, Welsh government health and social services group finance director, says services must now focus on implementation. Wales has taken a number of ground-breaking steps in recent years, he says, including legislation such as the *Wellbeing of Future Generations Act*. This obliges public bodies to work together, focus on prevention and look to the long term.

Integrated university health boards – covering both planning and provision of care – and the moves the local NHS has made to integrate with social care have given the nation a framework that is right for the future, he adds.

'We created a population health-focused organisational model in 2009, moving away from a market system, and organised ourselves around aspects of the triple aim.'

The new strategy, with its quadruple aim focus, addresses how the service will improve its population-based healthcare at the necessary scale and pace, he adds. 'We have a good overarching framework for the future and the population health focus was right, as was the cross-public sector approach. The regional partnership boards bringing together health and social care was also right and a good foundation to build on. But, for me, the telling point made by the Parliamentary review was: if the case for change was so compelling, why hadn't it compelled?

'The review concluded this wasn't a problem of strategy, policy or direction – the real issue was about execution. The review helped us focus on what needs to be done.'

Previously, all seven university health boards were required to develop plans to meet the needs of their populations. Different models were proposed, and Mr Brace says the centre is looking at measures that can be taken on an all-Wales basis and that can be done locally. Changes will be supported by a £100m transformation fund over two years.

While Mr Brace insists this does not mean changes will be driven on a command and control basis, he adds that the central capacity and capability must be increased to support transformation.

'We have to strengthen our approach to planning, performance management and delivery. Planning and monitoring have operated in silos in local government and health. But regional partnership boards are the vehicle for how we expect planning and delivery for health and social care to work in the future.

'We are trying to build a foundation that people will be comfortable with, to plan and execute in an integrated way. There's also some work here for me on how we allocate resources in a seamless way; how we plan our resources; and how we execute the transformation

"If the case for change was so compelling, why hadn't it compelled? The review concluded this wasn't a problem of strategy, policy or direction – the real issue was about execution"
Alan Brace

programme and target the transformation fund.'

He has been leading a commission looking at future spending requirements in social care. This is due to report early in the new year.

A study by the Health Foundation in 2016 led to more funding being allocated to healthcare. The same review suggested social care required an additional 4% a year.

Mr Brace is also developing a framework to allocate resources across the system, to support a seamless model of care with integrated pathways and pooled budgets. 'We must think about how we measure and track resources in a different way, and infrastructure, capital and estates investment is linked to that.' This work is due to be completed in 2019.

With its addition to the triple aim, workforce is a key element of the new plan. Like other parts of the UK, Wales has experienced issues with recruitment and retention. But as care shifts to new models, many of which are out-of-hospital, new skills will be needed.

The strategy says the government will invest in the skills needed in the future, including those required as technology advances, but it also commits to rethinking how staff can be used best. This includes team-working and using those best equipped to deliver the care needed.

'Workforce is a real challenge for us and a real opportunity,' Mr Brace says. 'We talk about multidisciplinary working in health and social care, but our approach to training is still uni-professional. We need to think in a radically different way about the workforce of the future and start developing it now. We have set up a national body, Health Education and Improvement Wales, to bring all this together.'

As well as workforce development, research and development will be expanded, centring on innovation and improvement. Regional innovation and improvement hubs are being created.

Outcomes framework

A new outcomes framework and clinical plan will be produced as part of the strategy. In 2013, a Commonwealth Fund report comparing international healthcare systems ranked the UK first or second across its categories in all but healthy lifestyles (where the UK was 10th out of 11). However, in its 2017 report, the fund introduced a measure on outcomes and the UK came 10th (with the US 11th).

Mr Brace says: 'This tells us we have created a system that is great at process and dealing with volume, is low cost and with access free at the point of delivery. But we haven't created an effective system because when you introduce outcomes, you can see there's a danger that we may be doing the wrong things more efficiently.

'We have a technically efficient system where we manage inputs and outputs really well, but it is not allocatively efficient or effective.'

Allocative efficiency may sound more like economics than NHS finance, but it is becoming increasingly important as countries seek better care from the funding allocated.

'We need to be more geared to effectiveness rather than efficiency and productivity. Clearly, it's about measuring outcomes, but we need to think about the best outcomes we can deliver and how we allocate money in a more balanced way, rather than just making hospitals more efficient,' Mr Brace says.

This does not mean an end to cost improvement plans and Lean programmes – the focus on technical efficiency will remain. 'Two things must be on finance directors' agendas,' he says. 'Every health system will still have to be technically efficient. The push on productivity and efficiency is not going away. But alongside that technical efficiency we need to be allocatively efficient. We must ask: "How do we allocate scarce people and financial resources? And how do we allocate to get the best outcomes?"'.

This could mean alternative care pathways. Some researchers have suggested that 30% of knee replacement surgery is unnecessary – a technically efficient system is concerned only with getting high volumes of patients through their procedures at lowest cost, regardless of outcomes. An allocatively efficient system would adjust the patient pathway according to the individual's needs – avoiding surgery where appropriate.

'We must ask where we need to be technically efficient and productive and where we should link to outcomes and the value-based agenda,' Mr Brace says.

Rather than use outcome measures in silos such as the numerous clinical and technical outcomes, patient-reported outcome measures (PROMs) or patient-reported experience measures (PREMs) – which Mr Brace believes are too narrowly focused – Wales will continue to work with the International Consortium for Health Outcome Measurement (ICHOM) to pull all of this together. Its outcomes set allows internal and international comparisons, and Welsh health boards will look to learn from their counterparts in Sweden, for example.

Design principles

The implementation of the quadruple aim will be underpinned by 10 design principles. These are:

- **Prevention and early intervention – anticipating and acting on poor health and wellbeing**
- **Safety – focusing not only on delivering healthcare that does no harm, but also improves safety in families and communities**
- **Independence – supporting self-management of an individual's health and wellbeing**
- **Voice – empowering individuals to manage their health together with transparent engagement on change**
- **Personalised – tailoring health and care services to individual needs**
- **Seamless – ensuring there is integration and joint working to provide a less complex, better co-ordinated service**
- **Higher value – delivering better outcomes and experience, based on what matters to patients, at lower cost**
- **Evidence driven – using research and innovation to develop and evaluate service improvement**
- **Scalable – spreading good practice to other teams and organisations**
- **Transformative – making sure new models are affordable and sustainable and replace existing services**

"Our approach will use internationally validated data to benchmark both outcomes and costs – that's a key thing we are trying to achieve"
Alan Brace

Sweden was ranked second for outcomes in the latest Commonwealth Fund report and, while Mr Brace acknowledges some of this is because Sweden has a healthier population, he adds that it is also due to a more rounded approach to outcomes. While clinicians examine outcome data to improve their practice, they also bring in patient representatives to pinpoint improvements.

'The culture is to look at outcomes in the round. Our approach will use internationally validated data to benchmark both outcomes and costs – that's a key thing we are trying to achieve.'

As part of its transformation programme, NHS Wales is working with strategic partners to measure outcomes, using the ICHOM dataset. Measurement will be made before and after outcomes-based intervention that changes the patient pathway. 'If there is no improvement, we will be prepared to ditch an intervention and then rethink it,' says Mr Brace. 'This will ensure we make the most of our innovation and transformation money this year and next year.'

Prevention of ill-health could reduce costs and is an important feature of the new strategy. 'Everybody agrees prevention is the thing to concentrate on – if you can get that right, it will make a big difference. But seeing the benefits is hard when money is tight. We must ask: "How do we get serious about prevention? What is the business case for prevention and how do we get the prevention focus right?"', he says. 'At a practical level, we may find that, as we go into some outcomes, it is better to invest in social care than health, for example.'

Value-based care also lends itself well to procurement of goods and supplies, he continues. NHS organisations tend to trade with suppliers over the long term, with the period punctuated by contracts being re-tendered and renewed and the focus on aggregating volume to drive down cost.

'Suppliers or manufacturers often have expertise about optimising the use of their products within pathways to produce better outcomes. What if we contracted and reimbursed on outcomes achieved and delivered? That would change the risk/reward conversation hugely.

'If 20 years ago somebody said to me that we would still be doing business with the same suppliers, by now we would have a different relationship. In short-term relationships, we are probably having the wrong conversation and some of the research on this found that suppliers have realised this as well.

'I am keen to go down the route of value-based procurement. The conversation should be about added value. Most of the finance directors in Wales are also directors of procurement, so this is a big challenge for the finance profession here.'

Clinical engagement is a priority for all finance professionals in most healthcare systems and Mr Brace believes outcomes will help.

'The typical clinician doesn't go to work to implement system change or transformation. They go to work to improve outcomes for their patients. It's an easier way to engage.'

He says the finance professional of the future should be well versed in value-based care. 'Be a business partner and work with others to drive better outcomes for patients. It could also help us recruit more people to work in finance but requires different skills.'

Mr Brace says NHS Wales will move quickly to implement and evaluate the strategy to ensure it is not committed to a plan that has become obsolete.

Technology is driving rapid change in health and care, making long-term planning difficult, he says. 'There is a notion that you can plan for 10 years and then do it, but most of the evidence shows that doesn't work any more. Evidence shows you should do as much planning as you need, then execute the plan in the real world, with the flexibility to adapt, re-plan and redo.

'Our strategy deliberately has a lot of front-ended tasks. We will implement quickly and then it's about evaluation, learning and adapting,' adds Mr Brace.

Clearly, the strategy seeks to create a seamless system with a focus on the outcomes patients want, but also one where change is evidence-based and, where necessary, continually evolving.

• ***The HFMA Wales annual conference will be held on 27-28 September. For more details, visit the branch page on the HFMA website***

International symposium

Defining and measuring outcomes will be one of four major themes discussed at the HFMA Healthcare Costing for Value Institute's third International Symposium next month.

The event, *Making value-based healthcare a reality*, will also discuss how to make the most of data to drive value; increasing value at the system level; and making value-based healthcare a reality. Speakers from England, Wales, Sweden, Holland and Spain will make short presentations, followed by interactive discussions with delegates.

The event, to be held in London on 3 October, is open to senior finance professionals and clinical colleagues. Subject to availability, Institute members will receive a free place for a finance professional and clinician.

• For more details or to book, email **charlie.dolan@hfma.org.uk**

outpatients

Outpatient activity has soared in the past 10 years and there is now increasing pressure to reform a model that has barely changed since the NHS began. Steve Brown reports

A new look?

The NHS outpatients model is obsolete. So said NHS England chief executive Simon Stevens, addressing the NHS Confederation conference in June. The periodic trip to outpatients for five minutes with the consultant was unlikely to be delivering great value for anybody, he said. 'Think of it from the patient's point of view, think of it from the clinical team's. Have the conversation of what redesign looks like,' he said.

There certainly seems to be a growing consensus that this is an area ripe for reform, delivering more value by improving services and convenience for patients and potentially reducing costs or freeing up scarce resources. Elsewhere, the *Getting it right first time* initiative has launched a review of outpatient services under the lead of consultant ENT surgeon John Hadley.

Reforming the outpatients model is not a new idea. NHS Improvement chief executive Ian Dalton told the same NHS Confederation conference that the service had 'been talking about modernising outpatients for a long time'.

Single visit approach

Sheffield Teaching Hospital NHS Trust has transformed its outpatient services for elderly patients, slashing weeks off the traditional pathway for patients. What used to take 18 weeks from referral to receipt of a management plan now takes days – with all patient assessments and tests in a single, one-day visit.

Natalie Vethanayagam, consultant physician and geriatrician at the trust, says the concept has been in place for several years, but it is only in the past two that the trust has been able to turn it into a reality.

'There was an unmet need in the community with patients and GPs really wanting quick access to comprehensive, geriatric assessment from a geriatrician and the whole multidisciplinary team – with all the tests, diagnosis and management plan given in a single day rather than the typical 18-week pathway,' she says.

Frail patients requiring urgent comprehensive geriatric assessment are assessed within two working days. This means any required treatment or support can be started before a patient deteriorates further, potentially avoiding the need for more costly interventions or admissions downstream.

In effect, the trust has brought together emergency and outpatient assessment services, with both streams of patients now seen in the same frailty assessment unit, which opened at the end of 2017.

'The patients being assessed in the rapid access clinic often have similar needs to patients admitted as an emergency,' says Dr Vethanayagam. 'The inpatient/outpatient divide didn't make sense. Thinking about this from a patient perspective, why would you wait months for assessment and treatment when you know you could be seen in days?

'From a finance perspective, a further benefit of developing a single frailty assessment interface is the ability to use our staff flexibly and synergistically – rather than having to have separate inpatient and outpatient multidisciplinary teams.'

The unit has one consultant on site for 12 hours a day except on Fridays when nine hours onsite cover is provided. A second consultant provides support every day and together they manage the inpatient/outpatient work.

As the service beds in, the aim is to increase the number of assessments, including all required diagnostics.

Dr Vethanayagam says the service is already providing a better patient experience, with excellent feedback from GPs and commissioners. She believes this will be backed up with improved outcomes and reduced admissions.

The service is anticipated to use fewer resources than before due to more timely care and transportation costs, but a formal review will assess the impact on activity, outcomes and costs, she adds.

Other departments, including surgical specialties, are already showing an interest in providing quicker, more comprehensive assessments and diagnoses.

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But it has clearly been stuck in the too difficult pile. And there now seems to be a real push to prioritise this particular modernisation.

It is a significant area of expenditure – Mr Stevens said spend was close to £10bn – and it is also a rapidly expanding activity.

According to national statistics, there were nearly 119 million outpatient appointments in 2016/17, of which 94 million were attended by patients. This attendance figure is up from 52 million in 2006/07. Patients aged 60-79 accounted for over 30% of all attendances and 31% (of all attendances) were first appointments, with GPs the source of referral for these in just over half of cases.

The sharp rise in outpatient attendances – rising faster than other types of healthcare activity – has lifted outpatient services up the transformation priority list. But while the model has stayed largely unchanged since the start of the NHS, there have been attempts to stem the rising activity.

However, Sophie Castle-Clarke, senior fellow in health policy and digital programme lead at the Nuffield Trust, says these have not always been helpful.

'One activity that's been used to reduce activity is to change GP referral behaviour – reviewing the appropriateness of referrals through referral management centres,' she says.

This has involved either an administrative person or a clinician reviewing referral decisions against a set of guidelines before firming up the need to see a consultant.

'This has been adopted quite rapidly, but there is limited published evidence to suggest it is effective at saving money or cutting inappropriate referrals,' she says. 'It often simply adds a delay to the process because of the additional review.'

She says such centres typically carry a large overhead that can outweigh any savings from reduced referrals. And she points at BMJ research that found just 10 out of 72 clinical commissioning groups with referral

management schemes could demonstrate savings. Other initiatives have sought to transfer activities traditionally undertaken in outpatient departments to GPs.

But Ms Castle-Clarke says that, with primary care so massively stretched, asking GPs to do more is unlikely to be effective. Instead, she says, referral practice can be improved significantly by strengthening relationships and communication between GPs and consultants. 'We need to remove the barriers preventing GPs asking consultants for advice – potentially in the presence of patients,' she says.

One model already having success in this area has been pioneered by Imperial College Healthcare NHS Trust, where general practice-based child health hubs have been established as the central point for child health. The model was one of a number of new approaches spotlighted in a Nuffield Trust/NHS Improvement workshop at the end of 2017.

A hub typically brings together three or four GP practices covering a population of 20,000, with about 4,000 registered children. They are built around monthly multidisciplinary team meetings attended by hospital consultants to discuss paediatric cases. The consultants also hold outreach clinics with a hub GP.

The response has been positive, with

"We need to remove the barriers preventing GPs asking consultants for advice – potentially in the presence of patients"

Sophie Castle-Clarke, Nuffield Trust

patients feeling better supported and health practitioners also benefiting. GPs talk about learning from the joint clinics and meetings and being able to apply that learning in general consultations. They also have more confidence in talking to and contacting paediatricians.

With this collaborative approach, there has also been a reduction in traditional hospital activity. In one hub – comprising three GP practices – 39% of new patient appointments were avoided through the multidisciplinary team and improved care co-ordination. A further 42% of appointments were relocated from hospital to GP practices. There was also a 19% drop in subspecialty new patient appointments, with paediatric admissions down 17% and A&E attendees down 10%.

Imperial's consultant paediatrician, Mando Watson, says the changes – part of a *Connecting care for children* programme – represent more of an adjustment to existing practice than a revolution. With a first hub in place five years ago, Imperial now supports seven hubs across its patch, covering a third of its resident population. Further hubs have been established across North West London and some areas outside London are in the early stages of establishing similar arrangements.

But while she is keen to expand the model further – within child health across the Imperial patch and beyond and more broadly where the model is relevant to other services – Dr Watson says a revised payment system would help. The current tariff system, with payments for first and follow-up outpatient attendances, does not fit well with the new community-based model.

A capitation model would be more appropriate, she says, admitting to frustration at the slow pace of change in payment reform nationally. 'I'd love this to be scaled up quickly,' she says. 'In a cash-strapped NHS, when you have something that delivers this type of efficiency, we have a moral obligation to do it.'

Another key principle is to concentrate consultants' time – the service's most expensive

resource – where it is most needed. In some examples, this has involved consultants supporting other practitioners in assessing or reviewing general patients, leaving consultants to see the most complex cases.

A new musculoskeletal service in Nottinghamshire (*Healthcare Finance, July/August 2017, page 16*) relies on a consultant-supported but physiotherapy-led triage service.

This is not a referral management centre – simply reviewing GP referrals – but recognises that nearly half of first outpatient appointments had resulted in no treatment or a referral for physiotherapy. For many patients it means faster treatment, while the most complex cases are still handled directly by consultants.

In Sheffield, redesign of geriatric care has been based around the delivery of value overall, with changes leading to faster assessment of patients in a new dedicated elderly frailty unit (see box, page 17).

Follow-up appointments are another key area, with many scheduled routinely regardless of need or risk. Ms Castle-Clarke highlights an orthopaedic surgery service at Central Manchester NHS Foundation Trust that uses patient reported outcome measures (PROMs) to help indicate whether a follow-up appointment is needed.

Glaucoma focus

A glaucoma service at the Manchester Royal Eye Hospital also takes a risk-based approach to the use of consultant-led clinics. Glaucoma is a chronic condition and all patients are assessed in optometric-led clinics. Lowest risk patients are then supported using virtual clinics, while moderate risk patients are offered follow-ups with the same clinics. Consultant clinics are then reserved for complex/high-risk patients or those requiring surgery.

Ms Castle-Clarke stresses that there is no one-size fits all for outpatient services. 'It's not one thing, it is so complex, even within a single specialty. For example, just because you redesign glaucoma clinics in a certain way doesn't mean you can use the same model for all ophthalmology clinics.'

There are lots of factors. What is the type of problem trying to be addressed? Is it progressive? Does it follow a predictable course? Is it acute or time sensitive? All of these issues could demand a different approach, with changes clinically-led.

This means outpatient transformation cannot be a single project – a point recognised by the Berkshire West Integrated Care System (see box, above), where outpatient modernisation is spread across 20 workstreams and a diverse range of specialties.

Ms Castle-Clarke adds that technology has a role to play. 'But just focusing on moving to remote consultations is the wrong starting point,' she says. 'The aims have to be to use consultants' time appropriately and not to keep patients waiting.' Where technology can help meet these aims, it should be used.

Transformation of services in general is a long-term project and is likely to see a blurring of boundaries between primary/community services and hospital services. As the interface between the two, outpatient services are fundamental to this overall reform.

And with system leaders now making outpatient reform a clear priority, the rapid spreading of effective new models and sharing of best practice will be vital.

Multiple opportunities

Transforming outpatient care is a priority for Berkshire West Integrated Care System (ICS) and Raghuv Bhasin (pictured), deputy director of ICS delivery for the ICS and Royal Berkshire NHS Foundation Trust, is the person charged with delivering it.

'At the moment, we are providing services that do not always meet the needs of patients or use resources in the most effective way,' he says. 'Outpatients has historically received less attention than other areas. It doesn't have any big national targets associated with it, is diffuse in nature and the model of delivery has undergone little change since the inception of the NHS.'

There has been work on modernising the model across the patch for the past couple of years, but the area's selection as one of the first-wave ICSs is an opportunity for system-wide solutions, building services around the patient, not organisations, and making most effective use of the Berkshire West pound.

This approach sidesteps some of the barriers to change presented by tariff-based payment and organisational silos.

A further driver has been the need to create space to meet growing demand for non-elective activity on the Royal Berkshire site. Reducing outpatient activity or reproviding it closer to people's homes will help to future-proof the site.

The ICS recognises there is no single solution to modernising outpatients and that many changes will need to be taken forward service-by-service. But there are some common challenges and common solutions, together with good practice, that can be shared across specialties and learned from other systems.

Examples include moving activity traditionally done in the acute hospital into primary or community care – for example, the follow-up injection of an osteoporosis drug administered by injection twice a year.

Pathways are also being developed for chronic cough, which has seen a large growth in referrals in recent years, to offer more treatment options in the community and avoid unnecessary referrals.

Even when patients are stable or have no problems, many routine appointments are often undertaken based on historical practice, rather than clinical need.

To tackle this, drawing on successful models from hospitals such as University Hospitals of Morecambe Bay, patient-initiated follow-ups are being explored as a solution. 'We are also looking at remote monitoring of things like regular blood tests using automated technology that looks for variation or where people are outside limits of what might be expected,' says Mr Bhasin.

'This might indicate the need for a follow-up and removes the need for manual monitoring of these tests. This is currently working well in haematology and rheumatology and we are expanding that out to other specialties.'

Technology is also being investigated to improve how services are delivered. For example, virtual clinics between consultants and patients, and connecting GPs and consultants to offer specialist expertise and enable patients to be managed in the community.

The system has ambitious targets. There were nearly 500,000 outpatient appointments last year at Royal Berkshire NHS Foundation Trust and the trust's strategy commits it to halving this by 2025. This will involve a mix of using satellite sites, virtual consultations, shifting work into the community and stopping clinically unnecessary attendances.

'There is a significant structural and cultural change needed in the way the system operates and it will take time,' admits Mr Bhasin. 'But there is so much opportunity out there.'

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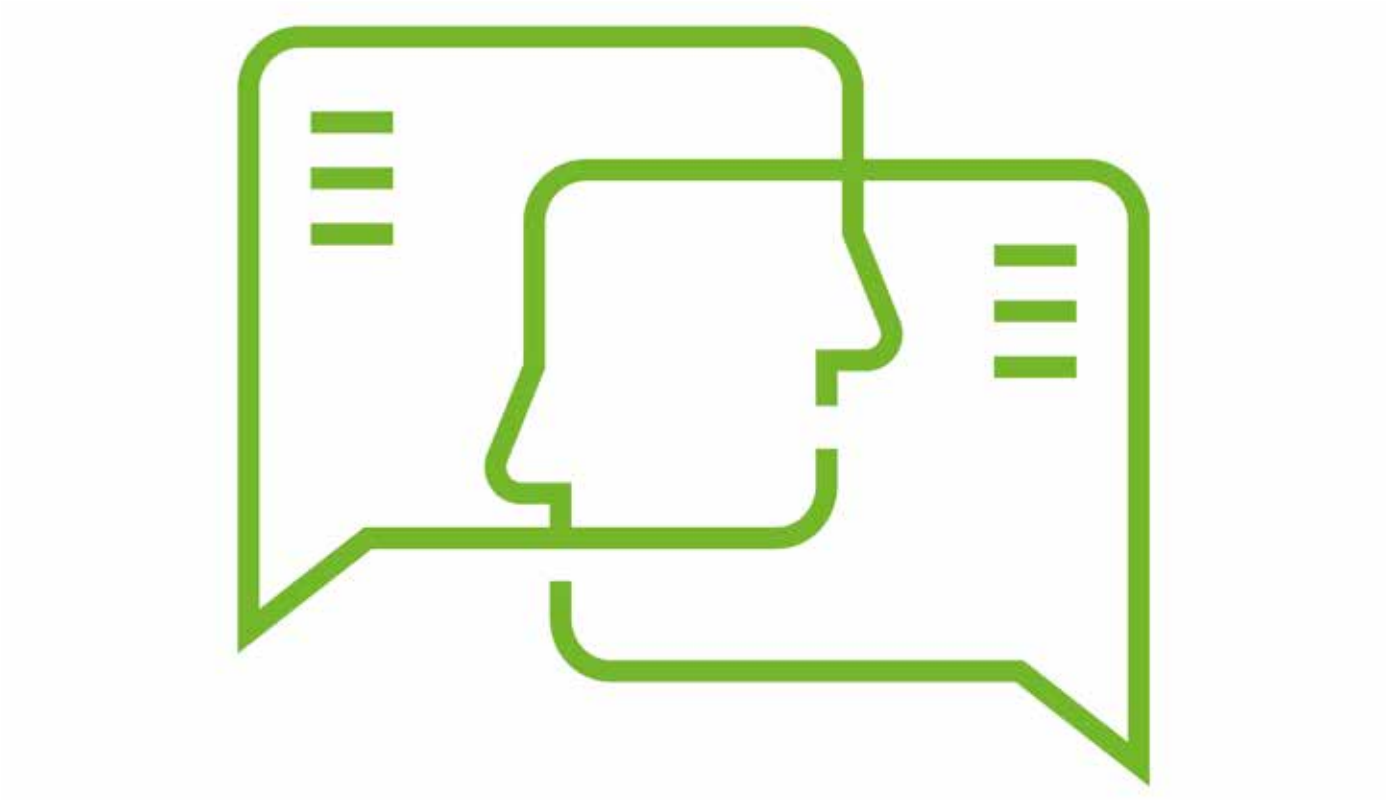

SHUTTERSTOCK

Like all trusts, University Hospitals of Leicester is bearing down on its procurement costs, but it also believes that improving engagement is key to greater savings. Seamus Ward reports

Engage and save

Despite the additional funding promised to the NHS in England over the next five years, the government has made it clear that the service must continue to increase its efficiency. It must continue to bear down on costs – and with spending on goods and services second only to pay costs, the focus will remain on procurement.

At national level, there are developments in this area. The new NHS Supply Chain operating model (previously known as the future operating model) aims to deliver savings of £2.4bn over five years using the collective buying power of the health service (see box overleaf).

Locally, there may be a feeling that the major savings opportunities have either been taken or are now tied up in the national operating model. But how can a trust keep identifying new savings?

University Hospitals of Leicester NHS Trust (UHL) believes the answer lies in greater engagement with clinicians, widening the influence of its procurement specialists, making procurement an integral part of its cost improvement programme (CIP) and measuring the performance of its procurement department and clinical directorates, known as clinical management groups (CMGs).

In 2017/18, the trust spent almost £184m on goods and services, but its procurement team also has some influence over a further £50m spent on purchased healthcare, agency, managed equipment services and capital equipment.

The trust's vision is to achieve upper quartile productivity across all areas, including procurement, to ensure it provides the best care possible. In doing this, it is striving to clear its deficit, which was £34.5m in 2017/18, by 2021.

Its core CIP this financial year is a saving of £51m, including £8m of cash-releasing savings targeted in procurement.

Trust director of efficiency and CIP Ben Shaw says the savings target allocated to procurement has more than doubled over the past few years and the procurement team is currently working towards a stretch target of more than £10m, when non-cash releasing savings are included.

The Model Hospital cost per weighted activity unit (WAU) shows productivity is generally good, but the trust's finances are unsustainable. However, there are still significant efficiency opportunities – an average of 6% across the trust based on 2015/16 reference costs. Some specialties lose money, and national productivity data shows potential productivity improvements in some areas of 30% or more.

Mr Shaw says: 'Trusts should have procurement as a core part of their CIPs, but care needs to be taken to ensure that CIP reporting for

procurement is aligned to the trust-wide process.'

Both must be recorded in the same way, he says. 'If you aren't careful, there can end up being a mismatch between what procurement claims as their total CIP contribution and what's reported centrally by a trust.

'We don't have that problem here – over the years we have developed a really well run CIP process and tracker, which makes sure the figures reported by the procurement department are exactly what we report nationally to NHS Improvement.

'A key part of this is that the budget-holding teams within UHL are held accountable for reporting their CIP and teams like procurement are allocated what we call 'enabling targets', which helps hold them to account for their contribution to the overall trust programme.

'This has worked very well and has certainly improved the way our teams work together – rather than competing to record CIPs as their own.'

"Teams are allocated what we call 'enabling targets', which helps hold them to account for their contribution to the overall trust programme"
Ben Shaw, UHL NHS Trust

Name change

The trust has also changed the formal name of its programme from a CIPs programme to an efficiency and productivity improvement programme, Mr Shaw adds. 'In the past, we only reported to the board our progress against our CIP target. But now, as well the financial cost improvement measure, we also focus on those measures that contribute to our wider productivity improvement. This is a range of 15 key measures – from attendees on our Lean programme, logins to Model Hospital, to procurement engagement.'

David Streets, the trust's head of procurement and supplies, says: 'We didn't know how we were performing, but our vision is to be the best procurement team in the NHS. We also want to increase our engagement, so we have recently added metrics around our engagement across the organisation.'

Engagement between procurement and each of the trust's clinical management groups is measured in four categories. The categories include ratings on:

- The regularity of meetings with the procurement department to discuss progress on CIPs
- Attendance at the clinical procurement group
- Best value consumables group.

In the fourth category, the trust measures the volume of 'free text' transactions that the procurement team believes could be ordered via a catalogue. The ratings are 0-5, with 5 being the best, and are added together to produce an overall score. This is translated into a RAG rating, which is reported to the trust's performance board, allowing senior managers to see at a glance which directorate requires more attention, for example.

Mr Shaw continues: 'To understand what is happening, we hold meetings with CMGs. The chief finance officer, medical director and I will challenge them on why they haven't engaged, and the actions needed to rectify that.'

But meetings are not just about how a CMG can improve performance against its procurement CIP – better engagement means clinicians can help design incentives into a tender or contract, as happened recently over the retendering of an orthopaedic supplies contact.

This approach has led to improvements, not just in procurement but other elements of the trust's CIP, Mr Shaw says. 'The expectation is that if you engage more with procurement you will see greater benefits. We have taken the same approach with coding with a PLICS engagement measure, and our Lean programme. People are competitive – they don't want to be seen as the bottom performers.'

As a result of its partnership working and engagement with its

Bulk benefits

Successive reports and strategies over the past few years have pointed out the potential for the NHS to save on its supply costs by bulk buying. There have been a number of initiatives, from informal collaborations between trusts to formal purchasing programmes, to get the best value from procurement.

A national scheme operated by NHS Supply Chain – a partnership between DHL and the Department of Health and Social Care – was set up in 2006 and recently announced it had achieved its target of £300m in cash-releasing savings. Under the Department's Procurement Transformation Programme, NHS Supply Chain has now moved to a new operating model (previously known as the future operating model).

Most elements of the new system are already up and running. In April, the management function of the new operating model – known as Supply

Chain Co-ordination Limited (SCCL) – was launched. This is operating as a limited company wholly owned by the Department of Health and Social Care.

SCCL will be responsible for delivering savings of £2.4bn – net of running costs – in the procurement of goods and supplies over the five years from April 2019. The savings will be made through aggregating purchasing and bulk buying.

To this end, more goods will have to be purchased via the new operating model – DHL/Supply Chain had 40% of the market, but the aim is to double this to 80% under the new model.

'We will achieve this only by working collaboratively with trusts and suppliers,' says Stephen Foulser, SCCL customer director (pictured).

The work of the former NHS Supply Chain has been disaggregated, broken up into 14 contracts. There are 11 category towers, with buying teams focusing on products from specific categories, plus three enabling services – logistics; IT; and transactional services. All products will be brought together in a single catalogue.

In July, the 11 category towers were launched, covering medical (equipment and consumables), capital (diagnostic equipment, including large purchases); and non-medical products (food, office and hotel supplies). The contract winners are incentivised to get the best deals for the NHS and to make their processes as streamlined as possible – making savings for trusts.

"We want to ensure we are at the table when every efficiency decision is taken. We want to see what else we can do to improve services and get better value"
David Streets, UHL NHS Trust

staff, the trust achieved level 2 accreditation in the NHS Standards of Procurement last November – the first in the East Midlands – and is aiming to reach the highest level (3).

The standards, which were launched by the then Department of Health in 2012, are a tool to support trusts to develop their procurement function and spread best practice.

Mr Streets says the trust procurement team is also trying to increase its influence nationally. He sits on the Procurement Skills Transformation Programme working group, which is part of the Skills Development Network.

National benchmarking work is also having an influence on the trust's procurement processes. 'We are getting involved in the Model Hospital and *Getting it right first time* work at the trust,' Mr Streets says. 'We want to ensure we are at the table when every efficiency decision is taken. We want to see what else we can do to improve services and get better value.'

The national GIRFT work on orthopaedics highlighted a good example of the progress the Leicester trust has made on procurement, Mr Shaw adds.

'Working with local partner trusts, Leicester has driven down costs and increased standardisation by procuring 70%-80% of hip and knee prostheses from a single supplier.

'Working with local trusts and our partners at NHS Supply Chain in the new operating model, we will produce further savings as a consequence of working better,' he adds.

Mr Streets says the trust has good contacts with NHS Supply Chain and hopes even closer working will realise further savings. Individually, savings may look small or relatively insignificant, but they can soon add up.

'There will be lots of little successes, but that's what we need to do now,' Mr Shaw says. 'All the big opportunities have gone years ago, but in orthopaedics, for example, the small savings can add up to big numbers.'

Mr Streets adds: 'We have a lot of supplies that go through Supply Chain and lots of things that would have come through procurement hubs historically that will now be procured through the new NHS Supply Chain category towers (see box).

'It's good for us as we will be able to use national buying power and it will allow us to start focusing on other areas that are not included in the category towers. We can, for example, get more involved in contract management to ensure we get better value.'

The remaining big opportunities to make savings in the procurement of goods and supplies will probably lie mostly at national level, with the NHS using its buying clout to cut costs. However, opportunities will remain at trust level, and the Leicester trust hopes that engaging its clinicians and measuring its progress will help it continue to chip away at its procurement costs.

DHL has retained three of the category towers – infection control and wound care; ward-based consumables; and large diagnostic capital equipment.

The four NHS procurement hubs, working together as the Collaborative Procurement Partnership, have been awarded three of the clinical category towers – sterile intervention equipment and consumables; orthopaedics, trauma and spine, and ophthalmology; and rehabilitation, disabled health, women's health and consumables.

In addition, one of the hubs – the North of England Commercial Procurement Collaborative – has picked up the hotel services category tower.

Procurement hub framework agreements deemed to be competing with the new Supply Chain model will be novated to the appropriate tower category provider.

'Trusts should be working with their NHS Supply Chain account managers to look at their current savings and risk profile and highlighting potential savings opportunities specific to each trust,' Mr Foulser says. 'We are encouraging finance staff to talk to their procurement specialists to find out about the new NHS Supply Chain.'

'Other benefits include a bigger accounts team to give dedicated support and consolidation of invoicing for trusts. Products will be clinically assured so that there's no need for trusts to do their own clinical evaluation.'

DHL will continue to provide transactional services, IT and logistics until at least the end of 2018. The Department of Health and Social Care has decided transactional services, including accounts payable and receivable, will be brought in-house.

IT firm DXC Technology will provide the supporting information technology to underpin the new operating model – a contract due to begin in January.

The Department awarded the logistics contract to Unipart Logistics, but has faced a legal challenge from DHL Supply Chain. However, the DHL Supply Chain case was rejected and Unipart is expected to commence delivery services early in 2019.

The price of goods will be passed on to trusts with no margin. Trusts will have paid for the new operating model running costs through a new funding model – a top slice on the tariff that is a further incentive to use the new model.

Details of the top slice are scarce – the overall tariff engagement document for 2019/20 and beyond has been delayed to align the tariff to the new 10-year NHS plan. However, it has been reported that NHS Improvement has proposed the top slice to be 0.4% for acute trusts; 0.2% for community; and 0.1% for mental health and ambulance trusts. This would be used to cover running costs of £250m in 2019/20 and £260m in 2020/21.

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Companies' corporate governance code shows way ahead for NHS

Technical

In July, the Financial Reporting Council (FRC) issued two publications which, although not directly applicable to NHS bodies, show the direction of travel in the corporate world in relation to engagement with and reporting to stakeholders, *writes Debbie Paterson.*

The 2018 *Corporate governance code* (http://hfma.to/7n) – subsequently referred to as the code – is applicable to listed companies from 1 January 2019. NHS Improvement's *Code of governance* http://hfma.to/7o) for NHS foundation trusts is based on the previous versions of the code, so is also likely to be updated to reflect the new requirements.

In any case, the code represents best practice, so NHS bodies should, at least, consider whether any of the changes are applicable to them.

The key changes to the code include new requirements for boards to:

- Engage with their workforce to understand their views. The code suggests three ways of doing this: appointing a director from the workforce; establishing a workforce advisory panel; or designating a non-executive director to lead on workforce matters
- Describe how they have considered the interests of stakeholders when performing their duty under section 172 of the *Companies Act* to promote the success of their organisation. This duty is considered by the government and investors to be of increasing interest as it is important to a company's long-term success and the contribution it makes to wider society. It is worth noting that this duty is applicable to all company directors and will therefore apply to the directors of any subsidiary companies established by NHS bodies.
- Create a culture that aligns organisational values and purpose with its strategy and assess how those values are maintained over the long term
- Ensure that boards have the right mix of skills and experience, provide constructive challenge and promote diversity. There is a new emphasis on the need to refresh boards and undertake succession planning
- Consider how workforce remuneration policies are taken into account when setting director remuneration.

The new code is supported by *Guidance on board effectiveness* (http://hfma.to/7w), which is intended to stimulate boards' thinking on how their carry out their role and how they can improve their effectiveness.

It sets out questions that boards can ask themselves in relation to their leadership and the purpose of the organisation, division of responsibilities, the composition of the board, the audit committee and internal controls and the remuneration committee.

The FRC's *Guidance on the strategic report* (http://hfma.to/7p) is aligned with the new requirements of the code and takes into account a new requirement for large companies to report on executive pay and how directors have regard to their section 172 responsibilities. The guidance is intended to enable companies to produce a clear and concise strategic report that is fair, balanced and understandable.

NHS bodies are not required to produce a strategic report in accordance with the *Companies Act*, but all of its requirements are included in the performance report that NHS bodies include in their annual report.

So, this guidance is not immediately applicable, but is a useful source of best practice. The FRC guidance sets out the legal requirements (which are not directly applicable to NHS bodies but are the basis for the performance report contents), practical examples and linkage examples. The linkage examples illustrate how the relationships between different parts of the annual report can be presented to make it more understandable for the reader.

The revised guidance includes more guidance on non-financial information and how it can be used to better 'tell an organisation's story'. A company's main stakeholders are its shareholders, but the new code requires companies to look at stakeholders more widely to include employees and other parties.

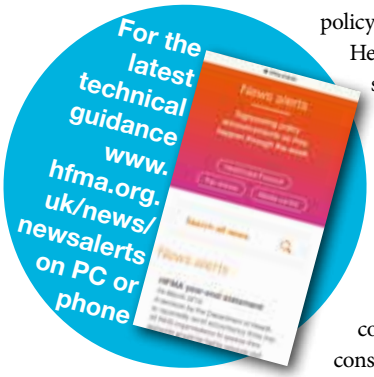
Debbie Paterson is HFMA policy and technical manager

Technical review

The past two months' key technical developments

Technical

NHS Improvement is consulting on making it a mandatory requirement for **ambulance services to record and report patient-level costs**. If agreed, this would require costs to be calculated for 999 activity in line with the *Healthcare costing standards for England* starting from the financial year 2019/20. Under the preferred option, there would be no dual running of reference costs, with ambulance trusts' final reference costs collection covering 2018/19. Submission of patient-level costs has already been mandated for acute trusts starting from 2018/19 cost data. Seven out of 10 ambulance trusts are voluntarily submitting data for 2017/18. Most have patient-level cost and information systems (PLICS) in place and two are currently implementing. An impact assessment looked in detail at three options, including the status quo, but concluded that the mandatory approach with no dual running of reference costs represented the best value for money. http://hfma.to/7q



The HFMA has produced an NHS corporate governance map to bring together the key guidance and models to support **effective corporate governance** in the NHS. The map is aimed at NHS boards, governing bodies, audit committees and all staff with an interest in governance. It follows a similar structure to the earlier *NHS efficiency map* published by the HFMA and NHS Improvement, dividing content into three sections: strategic framework; enabling good governance; and specific areas for assurance. The map will be updated regularly. http://hfma.to/2t

HMRC has confirmed that **income from the non-elective treatment of overseas visitors** is exempt from VAT. In a letter, it said urgent care is provided under a duty to treat and charged under restrictions that the NHS is legally obliged to enforce. As a result, it is non-business activity that is outside the scope of VAT. HMRC said it did not consider this a change of policy. Some providers will have interpreted Department of Health and Social Care guidance as indicating this income stream is exempt and accounted for it accordingly. However, others can seek a refund, subject to time limits, the letter added.

NHS England is consulting on proposed contracting arrangements for integrated care providers (formerly accountable care organisations) and has published documents to support the consultation. Depending on the outcome of the consultation, the new **ICP contract** would join existing contract forms, including the NHS standard contract and primary medical services contracts, as options for commissioning care to meet local needs. In particular, it would provide a single contract through which general practice, wider NHS and, in some cases, local authority services could be commissioned from a lead provider responsible for delivering integrated services. The contract envisages commissioners using an integrated budget – a whole population annual payment paid in monthly instalments. This will initially be set based on existing spend on the in-scope services. A proportion of the contract value would be paid to the ICP on achieving certain goals. http://hfma.to/7t

An HFMA survey of NHS bodies about their experience of the **2017/18 year-end process** has highlighted what went well and where there were problems. With no major accounting changes, most issues related to particular circumstances at individual NHS bodies. There were concerns about the audit process with bodies complaining about auditors raising last minute issues and sometimes not seeming to be prepared. In terms of third party information, a number of bodies reported problems with pensions data for senior managers and asset valuation was a significant issue raised by auditors. However, respondents reported that the agreement of balances exercise was as smooth or better than previous years. http://hfma.to/7s

Tumour dye to be rolled out

Technical: NICE

It's been a busy summer at NICE with 17 pieces of guidance published, *writes Gary Shield*. Ten technology appraisals were recommended while new guidelines on *Brain tumours (primary) and brain metastases in adults (NG99)* and *Community pharmacies: promoting health and wellbeing (NG102)* were also published.

In the final guidance on brain tumours, a chemical dye that can help neurosurgeons remove a brain tumour should be used in initial surgery, NICE has said. It is recommended patients take 5-amino levulinic acid (5-ALA) – or 'pink drink' – before surgery. As a result, tumour cells glow pink under ultraviolet light, allowing a surgeon using a fluorescence-detecting microscope to identify which areas of the brain are cancerous.

The late Dame Tessa Jowell urged the government to make 5-ALA available across the NHS in one of her final speeches to the House of Lords. Prime minister Theresa May announced in May £40m of funding, topped up by £25m from Cancer Research UK, for the Tessa Jowell Brain Cancer Mission to stimulate innovative new research and clinical practice to boost outcomes of people diagnosed with brain tumours.

Implementing this new guideline is set to benefit hundreds of patients a year and is set to cost £2.5m per year from 2019/20. Further details on the potential costs, savings and benefits of implementing the guideline can be found in the resource impact tools published alongside the guideline.

The new guideline makes recommendations about diagnosis, monitoring and treatment as well as the information and support that should be offered to patients.The recommendations are not only for people with malignant brain tumours, gliomas and metastases, but also for those with more long-term problematic tumours such as meningiomas.

Gary Shield is resource impact assessment manager at NICE

NHS in numbers

A closer look at the data behind NHS finance

Revenue spending

Technical

The Department of Health and Social Care's revenue departmental expenditure limit (RDEL) sets its budget for revenue spending by all bodies within the departmental group. It is not its only revenue budget. There is also the revenue annually managed expenditure budget (RAME), which is set outside the spending review, is demand-led and relates purely to impairments and provisions that do not need taxes raised to cover spending. Staying within the RDEL is the Department's key revenue measure and it is set net of income. So it can only exceed the RDEL figure if it has additional income to cover the excess.

In 2017, the RDEL was £121.3bn. Actual gross spending was £130.5bn, but there was £9.8bn of gross income to be netted off, meaning that actual net spending came in at £120.7bn – an underspend of £692m.

About £76bn of revenue expenditure is within the provider sector and nearly 70% of this relates to staff costs. Provider staff costs (£52bn) in fact make up 40% of gross spending overall, while procurement (£22.4bn), non-NHS healthcare (£14.2bn) and primary care (£11.6bn) are the next biggest items of expenditure.

Of the £121.3bn RDEL budget, £109.7bn was allocated directly to NHS commissioners, with the remainder (£11.6bn) funding arm's-length bodies and the department's central budgets.

Providers reported an aggregate deficit of just under £1bn, balanced out by a similar underspend by NHS England (£970m) – meaning that financial balance was broadly delivered for the sector as a whole. Within this, clinical commissioning groups overspent by £600m, reducing to £213m – according to NHS England accounts – after the release of their proportion of a £640m risk reserve.

This risk reserve was set aside in the NHS England allocation to balance out overspends elsewhere in the systems if – as proved to be the case – they were needed. Some £360m of this was set aside by CCGs (based on 0.5% of their allocations).

A further £200m was contributed by NHS England and the final £80m was added to the reserve from other sources during the year. NHS England's accounts said all three elements were released at the end of the year to offset provider overspends.

However, the CCG element was in fact needed to reduce local commissioner overspends. No risk reserve exists in 2018/19 with the expansion of the provider sustainability fund and the creation of a new commissioner sustainability fund, which will support CCGs in deficit to return to financial balance.

Figure 1: Revenue DEL – spending breakdown

RDEL gross expenditure: £130.5bn

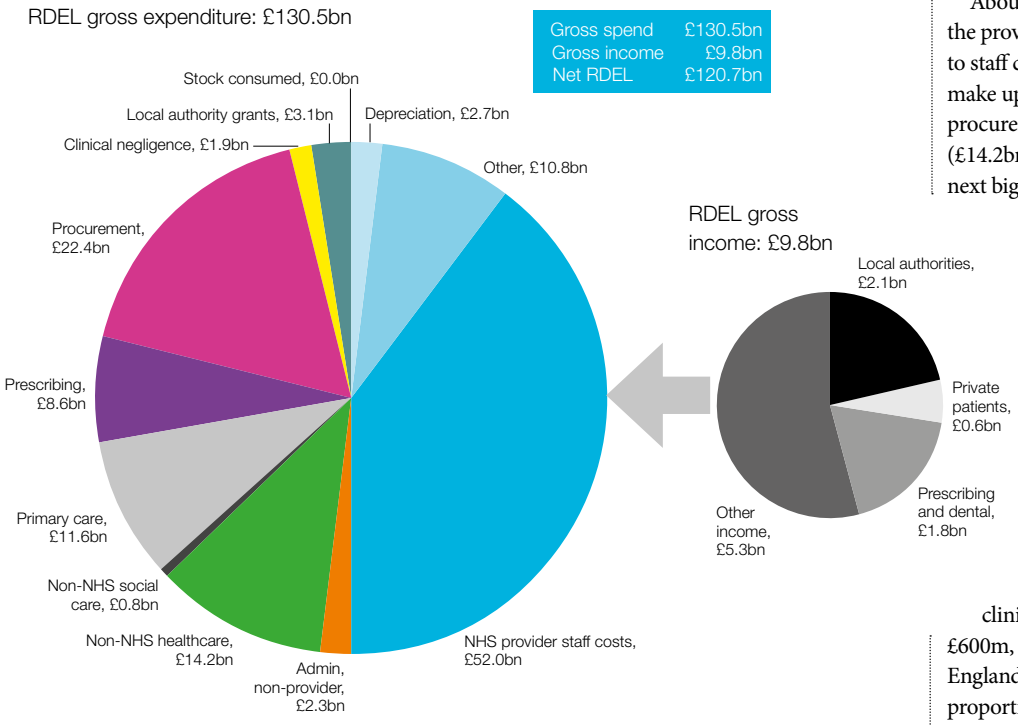
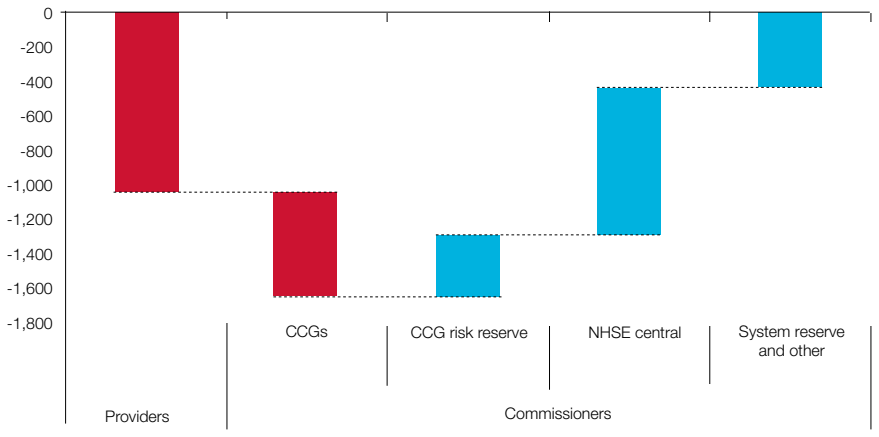


Figure 2: Net NHS financial balance 2017/18

Pressures and savings across providers and commissioners (£m)



Source (both charts): DHSC annual report and accounts

Starting a new term

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

Training

Now may not seem like the time to add to your workload by taking on further studies. But that's exactly what finance professionals and the broader healthcare community are doing with the HFMA's masters-level qualifications.

The feedback from students is positive. Some say they need to re-adjust to the studying habit, but they enjoy the content and are applying what they are learning to their work environment.

The benefits are two-fold. The student gains a qualification – which is quickly establishing a reputation as valuable and well-regarded; the NHS gets a workforce with an enhanced skillset. Paul Baumann, chief financial officer at NHS England, says the health service needs people at the 'top of their game' given the challenges it faces. While a finance qualification is essential for many of the financial leadership roles, he says the HFMA masters-level qualifications fill an important gap by focusing attention on the specific NHS context.

Outside finance, Mr Baumann says clinicians and non-finance staff do not need to become accountants, but be 'value literate'. This involves understanding the financial and value aspects of the decisions they take and recognising the importance of optimising quality and efficiency.

Both NHS England and NHS Improvement have backed this support for the qualifications with funding in the form of bursaries that cover up to half of the costs of the advanced certificate, diploma or higher diploma.

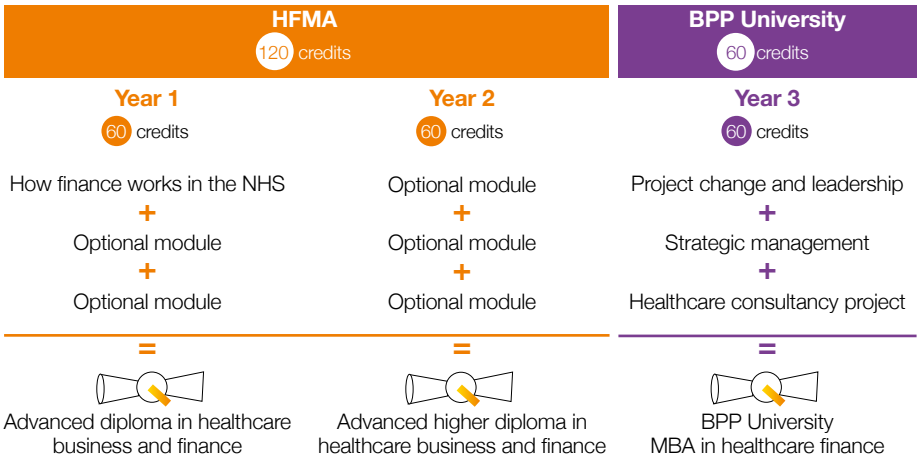
The qualifications were launched in 2017 and there have been four intakes to date plus an initial pilot intake. Learning is delivered online through the HFMA Academy using tutor-led 'live online' sessions, interactive discussion forums, e-books and a resource library.

More than 100 students have already undertaken some aspect of the qualification – whether one or multiple modules. Completion of three modules makes up both the postgraduate diploma and higher diploma in healthcare business and finance. In September, over 90 students will start modules with the academy, approximately 40 of these taking their first module, while the rest are continuing studies.

To date students have had six modules to choose from – with one module (*How finance works in the NHS*) compulsory for diploma students. But from this month, they also have the option of a new patient-level costing module. As an extra incentive, the HFMA is offering further discounts for people signing up to a diploma or higher diploma including this module, in return for students providing regular feedback on the content and format.

A handful of students have now completed their higher diploma, making them eligible to access the final third of a new MBA programme in healthcare finance, developed by BPP University, which will be running from October.

These are exciting times for the HFMA and for those working in the NHS who want to take their understanding of healthcare business and finance to a new level. If you would like to join in, visit www.hfma.org.uk/education-events/qualifications or contact the HFMA on qualification.enquiry@hfma .org.uk.



Robinson to lead value maker programme

Future focused finance

NHS Future-Focused Finance (FFF) is delighted to welcome Suzanne Robinson, director of finance at North Staffordshire Combined Healthcare NHS Trust, as the new senior responsible officer for value makers.

Ms Robinson and her team have been implementing some innovative projects at the Staffordshire trust, including the launch of its own *Combined value makers* programme, an interactive website where people can submit ideas for efficiency, cost improvement or adding value.

On being appointed to the role, she said: 'I'm hugely passionate about the value makers here at the trust, so I am excited about how we link this to FFF nationally.'

Ms Robinson will chair the value maker annual conference on 28 September in London. The event will hear from a range of high-level speakers, as well as giving attendees an opportunity to network and share ideas with more than 120 delegates from numerous NHS organisations.

There will be a number of best practice 'market stalls' where delegates can hear about FFF's latest and upcoming work, as well as innovative ideas and projects from different NHS organisations.

These sessions will be interactive, giving delegates a chance to ask questions and take ideas back to their organisations.

The conference is open to all value makers, as well as those wanting to find out more, whom FFF hopes will be inspired to join the network.

• If you would like more information on the conference, please get in touch at futurefocusedfinance@nhs.net

Diary

September

7 B Northern Ireland: patient/client focus, venue tbc
13/14 B South Central: annual conference, Reading
14 B West Midlands: STP briefing, Staffordshire/Stoke-on-Trent
18 I Institute: introduction to costing (South)
19 B Eastern: student conference, Cambridge
19 N CIPFA/HFMA health and social care conference, London, Rochester Row
20 F Provider Finance: technical forum, Model Hospital, London, Rochester Row
20/21 B South West: annual conference, Bristol
25 N CEO forum, Rochester Row
27/28 B Wales: annual conference, Hensol
27 F Mental Health Finance: annual conference, London, Rochester Row

October

3 I Institute: international symposium
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: president theme event
23 B Northern Ireland: annual conference, Belfast
22 F Mental Health Finance: site visit, Nottinghamshire Healthcare NHS FT
27 I Institute: technical update, Leeds
27 B West Midlands: collegial conversations workshop, Birmingham

December

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

Mental Health Finance annual conference
27 September, London

This one-day event is aimed at finance staff in mental healthcare providers, together with their commissioning colleagues and clinicians. Governments have been giving greater priority to mental healthcare – insisting on parity of esteem with physical healthcare and implementing the mental health funding standard. In England, the government has made mental healthcare one of the key areas of the new 10-year plan. This annual event, now in its 15th year, will examine how mental health services fit into the new era of integration. This conference, titled *Integrating mental health in new models of care*, will look at issues such as prevention of mental illness, improving quality and the role of digital technology in increasing efficiency. Keynote speakers include campaigner Lisa Rodrigues (pictured), Tim Kendall, NHS England and NHS Improvement national clinical director for mental health, and former health minister Paul Burstow.

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

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

The highlight of the NHS finance calendar – the HFMA annual conference – will take place on 5-7 December. Taking HFMA 2018 president Alex Gild's theme, *Brighter together,* the event 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 in the autumn, delegates will have a lot to discuss. Speakers include Elizabeth O'Mahony (pictured) and Ian Dalton from NHS Improvement, and Jon Rouse (pictured), the chief officer of Greater Manchester Health and Social Care Partnership. And 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**

Higher education


SHUTTERSTOCK

Association view from Mark Knight, HFMA chief executive

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

My HFMA

I hope you were able to get some time off during the summer holidays. The weather in the UK was a bit of a lottery, with the first half of summer evoking memories of 1976, and the second half turning a little bit more damp.

We've not been resting on our laurels at the HFMA. Preparations are afoot for the annual conference in December, and plenty of other events in the meantime, with eight of the branches hosting their own annual conferences during this autumn.

In addition, we've been gearing ourselves up for another intake on our advanced qualifications, where once again we've seen a healthy number of applicants. If you turn to page 28, you will find a new monthly column dedicated to our qualifications and news from our HFMA Academy.

The new qualifications are a major development for the association and, we believe, for the NHS. So we make no apology for raising their profile in this way.

Over coming months, you can expect to hear from our education director, Alison Myles, and other key staff, as well as from tutors and students, as we attempt to give you a range of perspectives of the qualifications and highlight new and upcoming developments.

The first 20 places on our new *Supporting patient care with patient-level costing* module were snapped up quickly and we have seen a good uptake on the other modules as well.

In addition, we have the first cohort of students ready to take the MBA top-up year with our partners at BPP University. There are just a handful at the moment, but in future years we will see this grow.

The HFMA advanced diploma and higher diploma programmes are set at Level 7, which is masters level. This is deliberately pitched to follow on from the professional accountancy qualification, and designed to be a prestigious programme. However, this is part of a whole series of educational offerings the association wants to develop and take forward.


HFMA chief executive Mark Knight

Keep reading the new academy column for further developments, including the launch of our level 4 intermediate diploma programme later in the year.

Those of you who can't wait can contact my colleague Natalija Elphick (natalija.elphick@hfma.org.uk), who can also talk you through the availability of discounts for the first 20 places to be booked.

Many members ask me if we have programmes that could be funded using the apprenticeship levy. The answer is not quite yet. However, we are hoping to have some additional information about that later this year or early next year.

In the meantime, we're excited about our educational programmes and want to develop more to meet the needs of the finance community.

We're also always on the look-out for tutors, so if you think you've got something to offer, please do not hesitate to contact my colleague Emily Osgood (emily.osgood@hfma.org.uk) – it's an excellent way to give back.

Member news

The HFMA awarded its key contributors awards in July. At the ceremony, which took place in the Ashmolean Museum in Oxford, John Andrews received a silver key contribution award, and the following won bronze:

- Alasdair Pinkerton
- Craig Marriott
- Laura Bateman
- John Graham
- Matt Clarke
- Andy Ray
- Marjorie Crilly
- Suzanne Robinson

Claire Wright (pictured), Derbyshire Healthcare NHS Foundation Trust deputy chief executive and director

of finance, opened the first conference of the trust's new LGBT+ network. Ms Wright is the network's board champion and is supporting and promoting the initiative. The aim is to create a supportive and inclusive network for the benefit of LGBT+ staff across the trust and to participate in the development of organisational policies and inform service design and delivery. 'From day one of working with us, our new starters hear in their induction about how equality, diversity and inclusion is really important to us,' Ms Wright said. 'We want everyone to be happy to be themselves and respect each other. At the end of the day, who wants to work in a place where you can't be yourself?'

Kent and Medway NHS and Social Care Partnership Trust has taken on the hosting of NHS Skills Development on behalf of the South East area. The change will lead to Finance Skills Development manager Stuart Wayment and the function relocating to the trust's headquarters in Maidstone.

- For further information, contact Mr Wayment at stuartwayment@nhs.net

hfma

Member benefits

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

Branch focus

My HFMA **South Central**

With four sustainability and transformation partnerships and three integrated care systems, the South Central region has been on a journey towards integrated care for a number of years. Collaborative working and developing relationships are centre stage.

'Different areas of the South Central patch are at different stages of this journey, but we are all on a very similar path,' says Sam Dukes (pictured), head of finance business planning and development at North East Hampshire and Farnham Clinical Commissioning Group and chair of the South Central Branch.

'The first step of this journey has been about understanding what the picture looks like across the system and not just looking into the organisational financial performance,' he adds. 'The next step is to understand how we change things: how do we change how we move money around the system to make things work better?'

This year's South Central Branch annual conference – *Collaboration in action* – will assist with this change in mindset. During the two-day event (beginning on 13 September), delegates will hear from Fiona Wise, executive chair, Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Partnership, and Rebecca Clegg, chief finance officer, Berkshire West CCGs. Ms Clegg will share insights from the Berkshire West Integrated Care System.

'We spend a lot of time talking about integration, a lot of time thinking about how we use our new relationships and what it means to the services we offer to local people,' says Mr Dukes, the youngest ever HFMA branch chair.

He emphasises that the HFMA has an invaluable role in helping build these relationships and providing platforms where finance professionals can meet and interact outside of the office.

'There's no financial model you can build that will solve all your problems for you,' he says. 'You have to solve the problems collaboratively and you need to have the right relationships for this.'

The branch also runs the Finance Skills Development scheme for the region and provides more than 1,500 hours of CPD annually.

'FSD is really well established and is seen as the way finance professionals can ensure their skills are relevant,' says Mr Dukes.

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West Midlands rosie.gregory@hfma.org.uk
Yorkshire and Humber laura.hill@hdft.nhs.uk

Appointments

Rebecca Monck is now head of finance across the Greater Nottingham Clinical Commissioning Partnership – Nottingham City Clinical Commissioning Group, Nottingham North and East Clinical Commissioning Group, Nottingham West Clinical Commissioning Group and Rushcliffe Clinical Commissioning Group. Ms Monck was previously senior finance manager (planning and strategy) at South Nottinghamshire CCGs. She is also student lead at the HFMA East Midlands Branch.

The newly formed East Suffolk and North Essex NHS Foundation Trust has appointed **Dawn Scrafield** (pictured) director of finance. She previously held the role of director of finance at Colchester Hospital University NHS Foundation Trust, which has merged with Ipswich Hospital NHS Trust to form the new foundation trust. Prior to that Ms Scrafield spent two years at NHS England's Essex Area Team as director of finance and deputy area director.

Dinah McLannahan (pictured) has been named acting director of finance at Sandwell and West Birmingham Hospitals NHS Trust. She had been appointed deputy director of finance at the organisation last year, following a three-year period working as head of business and finance (West Midlands) at NHS Improvement.

Tom Taylor has been appointed chair of the NHS Counter Fraud Authority. He has more than 25 years' experience working at board level across the public, private and third sectors. Mr Taylor is a qualified accountant and an honorary HFMA fellow, and has chaired the HFMA West Midlands branch. His last NHS position was chief executive at Shrewsbury and Telford Hospital NHS Trust. He is currently the Wales chair for the Consumer Council for Water, a non-executive board member for Northern Ireland's Department of Finance, and an independent member of HMRC's audit committee.

Vale of York Clinical Commissioning Group has appointed **Simon Bell** (pictured) chief finance officer. Mr Bell spent the past three years as chief finance officer of Kernow Clinical Commissioning Group and is a graduate of the NHS Finance Management Training Scheme. He has worked in the NHS for over 20 years in provider and commissioning organisations. Mr Bell takes over from **Tracey Preece**, who is now finance director at the Joseph Rowntree Foundation – an independent social change organisation working to solve UK poverty.

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's not about moving from payment by results to block, or block to PBR. It's got to be more sophisticated than that"
Sam Simpson, Tameside and Glossop Integrated Care NHS Foundation Trust

Simpson takes on Tameside challenge

On the move

It is often said that NHS finance professionals need a range of experience in different organisations, particularly now that there's a greater emphasis on collaboration and integration of services. Sam Simpson, the new director of finance at Tameside and Glossop Integrated Care NHS Foundation Trust, is someone who has gained broad experience and is putting it into practice.

She has worked in acute, community, mental health and commissioning sectors, as well as at system level in a strategic health authority and, most recently, as Cheshire and Merseyside Sustainability and Transformation Partnership director of finance. She also spent two years within Greater Manchester Police and has worked for a local authority.

Ms Simpson says: 'Having that range of experience gives me a real understanding of every element of the system. I have the opportunity to take all that learning into a trust that is trying to do something innovative and transformational.'

She believes it is important for NHS finance professionals to gain broad experience, both inside and outside the health service, either through secondments or permanent moves.

While a number of organisations are moving towards integrating acute and community services and bringing in social care, Tameside and Glossop is taking a further step. It is working with its single commissioner – a combined local authority and clinical commissioning group – to address the wider determinants of health across the whole population. This includes economic growth, the availability of good housing and employment opportunities.

Ms Simpson says the innovative nature of the whole population focus on the wider determinants of health is one of the most exciting elements of her new job.

However, this is not without its challenges. While Tameside is a local authority area within Greater Manchester, Glossop is part of Derbyshire. And innovation will mean moving away from traditional payment mechanisms.

'It's not about moving from payment by results to block, or block to PBR,' says Ms Simpson. 'It's got to be more sophisticated than that.

'You have to use your cost base differently; identifying where there are opportunities to reduce costs and where growth in demand can be absorbed within the existing cost base.'

Tameside and Glossop was in special measures until 2015, having been one of the trusts identified in the 2013 Keogh review. However, Ms Simpson says its clinical care has been through a remarkable transformation and is now rated good by the Care Quality Commission.

'The CQC rating represents a significant improvement as clinical aspects can be much harder to change than the financial ones. It can have an impact on your ability to recruit.

'We have an excellent executive team who are respected as individuals and as a team, and many people have come here to work for them.'

However, like many providers, the trust faces a significant financial challenge. Having signed up to its 2018/19 control total, Ms Simpson says it is focused on delivering its financial plan – a £23m year-end deficit, not including the provider sustainability fund.

The trust is focusing on delivering its financial plan and looking to take the efficiency opportunities indicated by the Model Hospital and *Getting it right first time* programmes.

The devolution deal taken by Greater Manchester also offers a chance to get involved in system-wide changes.

'There is a real opportunity to do things differently and be part of the discussions on how to solve the challenges facing the health and social care system,' says Ms Simpson.

'If you're doing it right as a finance director, you will not just focus on your organisation, you will also be proactively engaged with the wider system.'

> While organisations are moving to integrate services, Tameside and Glossop is working to address the wider determinants of health across the population

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