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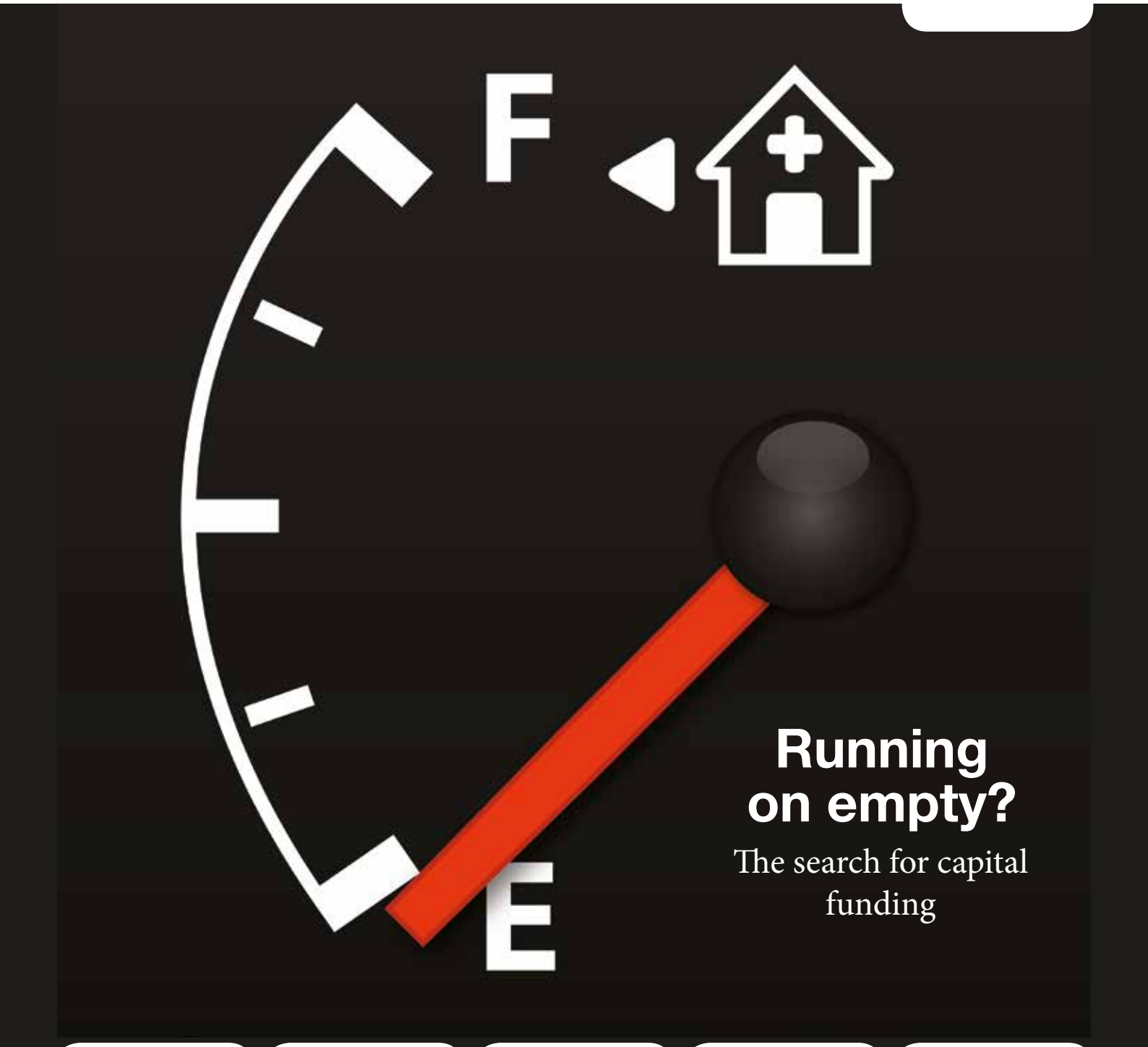

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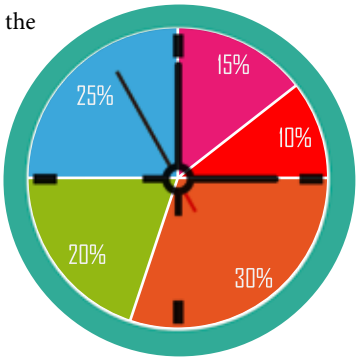

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fleet solutions
by the NHS for the NHS

IT'S BUSINESS AS USUAL FOR SALARY SACRIFICE COMPANY CARS

David Hanson, MD of NHS Fleet Solutions, looks at the new Optional Remuneration Arrangements ('OpRA')

Background

Salary Sacrifice has been with us for many years. Originally popular in connection with pensions, now more widely applied to benefits such as childcare vouchers, cycle-to-work schemes, home technology and company cars.

Following a Consultation by HMRC, it was announced as part of the Autumn Statement in 2016 that several changes would be made to the taxation of benefits provided via salary sacrifice (and other 'Optional Remuneration' Arrangements ("OpRA").

The 2017 Finance Bill and (further) HMRC guidance published on 20 March 2017 now provides some much-needed clarification on how the new Optional Remuneration rules will apply to the treatment of employee benefits from 6 April 2017.

Overview of the new rules

The OpRA apply where an employee in return for a benefit, gives up the right to receive an amount of earnings i.e. salary sacrifice. The new rules mean that instead of being taxed on the benefit received, from 6 April 2017 the tax charge will be on the higher of that figure and the amount foregone. Employer's National Insurance Contributions ('NICs') also apply to this higher figure (but not employee 'NICs').

In terms of company cars provided via a salary sacrifice, the employee will be taxed on the greater of the salary forgone or the company car taxable benefit under the current rules.

For example, if an employee sacrificed £4,000 per annum in exchange for a company car which would have a taxable benefit under the current rules of £3,000, they will now be taxed on a benefit of £4,000.

What the new rules mean

- **Ultra Low Emission Vehicles ("ULEVs")**
  ULEVs with CO2 emissions of 75g/km or less will be excluded from the new rules and will be taxed based on the existing rules. However **all** drivers can continue to choose from hundreds of makes and models with varying savings depending on their own circumstances and the CO2 emissions' rating of their vehicle.
- **Grandfathering**
  Grandfathering applies where the salary sacrifice company car arrangements for an employee were in place before 6 April 2017. In these circumstances, the existing tax and NIC treatment continues until 5 April 2021. This means that there is potential for up to four years' of grandfathering. However, note that transitional protection ceases if and when there is a variation in or renewal of the arrangements, unless it is beyond the control of the parties.
- **Transitional rules**
  Where an agreement to a salary sacrifice is made before 6 April 2017 and the reduced salary/provision of the benefit applies after 6 April 2017, transitional rules will apply. For example, where a variation to terms and conditions of employment is made prior to 6 April 2017 in respect of a company car that is delivered some weeks later due to normal delivery delays transitional rules apply.

  The guidance makes no specific reference to anti-avoidance rules in this context, but HMRC has previously indicated that it will scrutinise 'uncommercial' arrangements, for example where an agreement is made pre 6 April 2017 in respect of the provision of a benefit some distance in the future.

Mixed messages...

There have been mixed messages circulating around the impact of the new rules on salary sacrifice company cars, in particular whether the arrangements will continue and if so whether they will still represent good value?

- **Employee costs may increase**
  Although employee costs may increase (only for new contracts), subject to vehicle choice, the opportunity for employees to make significant savings remains, including NIC, pension contributions (where appropriate) and manufacturer's public sector discounts.

  Fleet Solutions data illustrates that more than three quarters of forecasted 2017 orders would not be affected by the new rules, either because drivers will opt for a ULEV or because they will already be paying more in gross company car benefit than the salary being sacrificed. For the rest, most will see an average increase of less than £10.00 per month. Due to the fact that NHS Fleet Solutions use the Crown Commercial Services (CCS) Framework to source all of their cars, competition drives down prices, resulting in fewer cars being affected by the changes.
- **What about the employer's costs/ savings?**
  Under the NHS Fleet Solutions model and unlike other scheme providers, savings made by all employers will remain the same post OpRA.
- **Are only ultra-low emission vechiles (ULEV) available under salary sacrifice?**
  Employees will still be able to choose any type of car under a salary sacrifice scheme and (with NHS Fleet Solutions) employer savings will be the same regardless of the vehicle chosen.

NHS Fleet Solutions allow customers to access the widest range of cars in production. Unlike some scheme providers, all vehicles and related insurances are procured via the Crown Commercial Services (CCS) framework agreement which gives competitive pricing from 12 suppliers.

If you are a Public Sector Organisation and would like further details on how NHS Fleet Solutions can supply cost effective cars post OpRA and protect your surplus, contact Jason Coleman, National Account Manager on 07976 938497 or jason.coleman@nhct.nhs.uk.

News

Parties jostle for position as election campaign gains pace

By Seamus Ward

The NHS looks set to be a key battleground before the 8 June general election, with Labour setting out early plans and the Conservatives defending their record in government.

Even before the dissolution of Parliament, which was due on 3 May, Labour launched the first part of its long-term plan for the NHS. Focusing on staff issues in England, it said that if it were in government it would scrap the 1% cap on pay rises, reinstate the bursaries for student nurses and legislate for safe staffing levels.

Shadow health secretary Jon Ashworth said the party would ask the pay review bodies to recommend rises that would take account of the cost of living. These would then be implemented.

He added that the removal of nursing student bursaries had led to a 25% drop in applicants for nursing courses. 'Our first step would be investing in staff – giving them a pay rise, investing in training and making the point that safe staffing is important for patient safety,' he said.

Mr Ashworth said the second part of its plan – on NHS finances – would be unveiled in the party's manifesto, which is due to be published in the middle of May.

'We will give the NHS the funding it needs,' he added, confirming that it was the Labour Party's 'ambition' to bring NHS-funded care currently provided by the private sector back into the NHS.

"Our first step would be investing in staff – giving them a pay rise, investing in training"
Jon Ashworth (pictured)

While giving little detail of his party's plans for the future of the health service, health secretary Jeremy Hunt (pictured below) tried to move the debate back to the importance of a good outcome in negotiations with the European Union. He said the Conservatives would deliver the best deal for the UK, which would strengthen the economy and ensure there is more money for the NHS.

'We want to continue increasing funding for the NHS so it is critical we get a good outcome in the Brexit negotiations so we can protect the economy and protect the NHS,' he told the BBC.

Mr Hunt defended his party's record on the NHS, saying around £6.5bn had been invested in the service in the last three years and an additional 12,000 nurses had been recruited. Removing the nursing bursary would allow more nurses to be trained – though applications had decreased this year, he believed they would recover. He added that a returning Conservative government would seek a sustainable solution on social care funding.

There were questions over how Labour would pay for its spending commitments. The party said that it would reverse recent drops in corporation tax, but some economic commentators said other shadow secretaries had earmarked these funds for their spending plans.

Mr Ashworth insisted the Labour manifesto commitments would be fully costed, adding that a Labour government would also look to make savings in health spending – by cutting the amount spent on agency staff, for example.

As *Healthcare Finance* went to press, the Liberal Democrats had not made a statement on health, though it has previously committed to extra funding and increased care standards.

Seventy hospitals given A&E capital

The Department of Health has allocated more than half of the new capital funding for emergency departments announced in this year's Budget.

The announcement came as it emerged NHS Improvement has discussed giving preferential access to capital approvals to providers that outperform their 2016/17 control totals.

Just under £56m of the £100m announced in the Budget will be shared by 70 NHS hospitals. The Department said this would ease pressure on A&E departments by next winter and help the hospitals meet the target of seeing, transferring or discharging 95% of patients within four hours.

The funds seek to ensure patients are seen in the most appropriate setting by using more GPs in A&E. They may be used to triage patients or GP practices could be co-located in A&E departments.

Leeds Teaching Hospitals NHS Trust (pictured), which will receive more than £700,000, said the money would be used to fund a series of improvements at St James's University Hospital and Leeds General Infirmary. The improvements will include changes to reception areas and a dedicated consultation room and waiting area for GPs working in the each of its two A&E departments, a spokesperson added.

Barking, Havering and Redbridge NHS Trust has been allocated £1m and will use the funding to upgrade its waiting area and create spaces to allow emergency consultants and GPs to carry out quick assessments.

• *See Pump priming, page 20*

Election debate on health must be realistic, says Ham

By Seamus Ward

The political parties must face up to the financial challenges in the NHS and not make any pledges on tax and spending that limit their ability to sustain and develop health and social care, the King's Fund said.

With the main party manifestos due to be published in early to mid-May, King's Fund chief executive Chris Ham said during the election campaign debate on the health service would be second only to the UK's exit from the European Union. He set out five tests of the parties' manifesto commitments, which he said they must meet to have a credible policy on health and social care.

They must first ensure funding is sustainable. He said on current spending plans, the Department of Health's budget will rise by about £4.5bn over the spending review period (2015/16 to 2020/21) and this was a long way short of the £10bn increase claimed by the government. Without further funding growth, patients would wait longer for treatment and care would be rationed increasingly.

Pledges to raise spending should include sufficient funds for social care, as well as meet existing commitments on mental health and primary care, he added.

A second test – on workforce – was allied to financial sustainability. Professor Ham said shortages of staff have led trusts to rely increasingly on agency staff and the cost of this was one of the reasons for the current financial pressures. There is concern over staff retention following the bruising junior doctor contract dispute, the more challenging work environments created by rising demand and the number of GPs approaching the end of their careers. Exiting the EU risks losing European healthcare staff, adding to workforce pressures. Manifestos must face up to these issues and set out credible plans to address them, he said.

Though there is a general consensus on moving care out of hospital, Professor Ham said politicians must commit to greater integration of care. However, in his third test, he insisted they must not duck the need to change hospital services, including concentrating A&E and maternity services in fewer hospitals in some areas to improve patient outcomes.

In a blog, he wrote: 'Politicians will be colluding in the continued provision of unsafe services if they make commitments to protect local services that are unable to meet required standards – for example, because of shortages of skilled specialists and nurses.'

A fourth test for manifesto commitments lay in turning rhetoric about preventing ill-health into cross-government action to improve population health. Led by the Department, wider determinants of health and wellbeing had to be addressed, including housing, employment, air quality, exercise and diet and nutrition.

In the final test, Professor Ham said that the manifestos must value people and communities, including the work of third sector organisations, volunteers and families and carers.

"Politicians will be colluding in the continued provision of unsafe services if they make commitments to protect local services that are unable to meet required standards"
Chris Ham, King's Fund, above

Professor Ham said a grown-up debate on the future of health and social care was needed. He acknowledged this would be difficult at a time of pressure on the public finances and uncertainty due to the EU exit.

He added: 'All the more important that the parties do not constrain themselves by making commitments on tax and spending that make it impossible to do what is needed to sustain and improve health and social care.

'The true test of the manifestos will be their willingness to confront these issues and engage the public in a grown-up conversation about the balance between public and private responsibilities in a society in which the needs of all are valued and met fairly.'

MPs deliver stinging criticism of Better Care Fund

The Better Care Fund (BCF) is 'little more than a complicated ruse' to paper over funding pressures in adult social care, according to the Commons Public Accounts Committee.

In a report, the committee said integration must now be delivered through the sustainability and transformation plan process.

Place-based planning will be critical to the success of health and social care, it added.

The report said the BCF had failed to achieve any of its objectives – saving money, reducing emergency care admissions to hospital and lowering delayed transfers of care. Indeed, the committee said emergency admissions and delayed transfers had increased.

The report was one of several published at the end of April, just before Parliament was dissolved for the general election on 8 June.

Another PAC report expressed continued concern over patient access to GPs, which varies between groups of patients and practices.

Despite the target of recruiting 5,000 more GPs, the overall number fell in the last year and retention problems remain, the PAC said.

A further PAC report on ambulance services said there was significant variation in operational and financial performance in ambulance trusts.

Health concerns must be 'front and centre' of the UK negotiations with the remaining European Union members, and the Department of Health must put additional resources into preparing for the UK's exit from the EU, the Commons Health Committee said.

In a report on the Brexit process, MPs' chief concern was the retention of the 60,000 people from the remaining 27 EU countries who work in the NHS, as well as the 90,000 who are providing social care.

Funding instability slows NI transformation

Financial challenges have hampered a programme to move care out of hospital and into the community and primary care, according to the Northern Ireland Audit Office (NIAO).

Its report on the *Transforming your care* (TYC) programme said some gains had been made. Local clinicians and managers have established new models of care, working closely with patients through integrated care partnerships. One project that aims to avoid unnecessary hospital admissions in older people had released £7m to invest in domiciliary care, for example.

However, instability in funding and a reliance on funds becoming available through the in-year monitoring process had lessened the impact of the programme. The lack of stability was compounded by the Department of Health being unsuccessful in some in-year funding bids.

As a result, by March 2016 only £28m of the anticipated £130m of savings had been realised. To mitigate the worst of the financial issues, the Department responded by establishing a ring-fenced £30m transformation fund.

Comptroller and auditor general Kieran Donnelly (pictured) said: '*Transforming your care* was an ambitious shared vision for changing how core elements of health and social care services could be delivered.

'However, in the absence of a precise action plan, backed by necessary finance, the impact has been much more limited than expected and the hoped-for shift of services from hospitals into people's homes has not happened as rapidly as had been intended.'

With the recent Bengoa report recommending a similar direction of travel, Mr Donnelly said the challenge was to build on TYC, creating credible plans, with funding focused on community services.

King's Fund issues warning over HIV

Commissioning and funding arrangements for HIV care are fragmented, hampering progress in meeting patients' needs, according to the King's Fund.

It said NHS England, local NHS organisations and local authorities are responsible for delivering services and this made it more difficult for local areas to make co-ordinated changes.

A report, *The future of HIV services in England*, said the *Health and Social Care Act 2012* had created a fragmented system. The confusion last year over which bodies could fund pre-exposure prophylaxis (PrEP) demonstrated this, it said.

The report added that prevention and social support services were beginning to feel the impact of local government budget cuts.

Alex Baylis, King's Fund assistant director of policy, said: 'Healthcare for people with HIV in England is among the best in the world and that is something we should be proud of.

'However, this report is a warning that the labyrinthine structures created by the *Health and Social Care Act* make it harder to keep the focus on meeting people's needs and represent a real threat to future quality of care,' he added.

SHUTTERSTOCK

Stevens ramps up action on unhealthy food

By Seamus Ward

Hospital food retailers face a total ban on the sale of sugary drinks if they do not reduce sales to 10% or less of their total drinks sales in 2017/18.

The measure, which a number of retailers have accepted and are working towards, builds on the 2017/19 CQUIN scheme that incentivises hospitals to ensure healthier food and drink is sold on their sites.

The 2017/19 CQUIN indicator 1b on healthy food for staff, visitors and patients includes a target of 60% of sweets and confectionery on sale with fewer than 250 calories, with the same percentage of sandwiches and other pre-packed meals containing no more than 400 calories.

NHS England said progress was made on the 2016/17 CQUIN – for example, in cutting price promotions on sugary drinks and foods high in fat, sugar or salt, and ensuring healthy food options are available at all times, including for those working night shifts. The 2017/19 CQUIN calls for these improvements to be maintained. There are further targets for reductions in 2018/19.

However, the threat of a total ban goes beyond the CQUIN measures. NHS England said urgent action is needed. More money is spent each year on the treatment of obesity and diabetes than on the police, fire service and judicial system combined.

Chief executive Simon Stevens said: "A spoonful of sugar may help the medicine go down, but spoonfuls of added sugar day in, day out mean serious health problems.

'It's great that following discussion with NHS England, big-name retailers are agreeing to take decisive action, which helps send a powerful message to the public and NHS staff about the link between sugar and obesity, diabetes and tooth decay.'

NHS England believes limiting sugar in hospitals can make a significant impact. It said that the NHS has 1.3 million employees, with an estimated 700,000 believed to be overweight or obese. Not only does this potentially lead to greater sickness absence, but it also dents the service's credibility when advising patients about their health.

And with more than one million patients going to NHS premises every day, the steps to limit sales of unhealthy food could reduce the damage caused by poor diets.

News review

Seamus Ward assesses the past month in healthcare finance

All NHS news in April was overshadowed by the surprise announcement of a general election on 8 June. Recent announcements must be viewed through the lens of a general election campaign and possible outcome. NHS staff will wonder how the election will affect the service, both over the few weeks of the election period and in the long-term once the new government is formed. With early polls giving Theresa May's Conservative incumbents a convincing lead, will the post-election period turn out to be business as usual? If the Tories are re-elected, will Jeremy Hunt – already one of the longest serving health secretaries – remain in post? What will the election mean for NHS funding, transformation of care and the efficiency programme, including provision of back-office services?

Election pledges on the NHS and political disputes over its services will, doubtless, grab the headlines in the coming weeks, but in April there were continued concerns about the financial position of the service, efficiency and quality. NHS Improvement announced that Northern Lincolnshire and Goole NHS Foundation Trust had been put into special measures after the Care Quality Commission expressed concern over a number of patient services at the trust. The trust was placed in the financial special measures regime in March and the decision has now been taken to put it into the quality special measures programme after the CQC expressed concern over outpatient, emergency care and maternity services. Also, United Lincolnshire Hospitals NHS Trust has been placed back in the quality special measures regime. It was one of the first trusts to enter special measures for quality reasons in 2013 following the Keogh review and was removed from the programme in February 2015. It has now re-entered the regime after the CQC raised concerns over its services, including an increase in waiting times for follow-up appointments.

The current regulation system offers poor value for money, according to more than half of NHS provider trusts. A survey by NHS Providers found that 56% said regulation was poor or very poor value for money. However, the providers' organisation said there were signs that national regulators were improving co-ordination of their requests for information. Just over half of survey respondents felt reporting requirements were not proportionate to the level of risk. More than two-thirds of trusts reported an increase in demands from regulators, while a similar proportion said there had been an increase in ad hoc requests.

Though there have been concerns about NHS productivity recently – including stories of surgeons with nothing to do, despite long waiting lists, because of lack of hospital beds – the University of York said NHS productivity growth has consistently outpaced the economy as a whole since 2008/09. The university's Centre for Health Economics said that over the last decade productivity in the health service has increased by 13.83%. *Productivity of the English NHS: 2014/15 update* said the growth in productivity has been particularly strong since 2009/10, averaging 1.75% year-on-year. Productivity growth was calculated by comparing output and input growth.

Wales health secretary Vaughan Gething allocated funding to 11 projects that aim to improve efficiency through the use of technology. The funding is from a Welsh government technology efficiency fund and the approved projects include: the development of e-forms (a digital version of a paper form) as

The month in quotes

'Children and young people are frequent users of emergency services. While not all emergency hospital admissions can be prevented, our research found that, despite some improvements, many children are still treated in an emergency setting for chronic conditions such as asthma.'
Eilís Keeble, Nuffield Trust research analyst says some emergency admissions for children could be avoided

'This rate of NHS productivity growth since 2004/05 compares favourably with that achieved by the economy as a whole. Annual NHS productivity growth kept pace with that of the economy up to the recession in 2008/09. Since then NHS productivity growth has consistently outpaced that of the economy, which has stagnated.'
University of York has an upbeat message on NHS productivity in recent years

"The consequences of a six-month gap in emergency service communications are unthinkable. The government needs to tackle this now or the result will be a tragedy in waiting."
PAC chair Meg Hillier calls for urgent action to avoid a breakdown of the emergency services communication system

'Trusts appreciate the changes regulators have made to improve how they work together, and to co-ordinate how they oversee and support trusts, particularly given the many changes to the regulatory system. But there is much more to do to reduce the demands from regulators and to improve the value they deliver.'
Regulators must cut costs and demands on staff time, says NHS Providers director of policy and strategy Saffron Cordery

FLICKR/HOME OFFICE

With early polls giving Theresa May a convincing lead, will the post-election period turn out to be business as usual?

part of a digital patient record; an improved pressure ulcer reporting system in care homes; and improvements in the diagnosis of gastrointestinal infections.

The Nuffield Trust and Health Foundation said the number of babies and young children admitted to hospital in an emergency has increased by almost a third over the last 10 years. In a report published as part of their joint *Quality watch* project, they said many children are being hospitalised for conditions such as asthma and tonsillitis. It said these conditions could have been avoided with better care and support in the community.

A spotlight was thrown on ambulance services. First, a Nuffield Trust report said the ambulance service in England is facing significant pressure, with rising demand being a factor in the poor morale and high stress levels of the workforce. Despite these pressures, the briefing says ambulance services have maintained and even improved care quality in a number of key areas – from stroke care to heart attack – and innovations such as 'hear and treat' have enabled them to improve efficiency.

But there was also a warning that ambulance services face the threat of not being able to communicate with staff in the field. The Commons Public Accounts Committee said the existing Airwave system will become inoperable when a key component of its infrastructure is due to be shut down in March 2020. However, in its second report on the replacement of the system used by police, fire and ambulance services, the committee said the new system – Emergency Services Network (ESN) – had been delayed by nine months until September 2020. The committee said this break was potentially catastrophic and urged the government to engage urgently with the Airwave suppliers to resolve the issue.

Public Health England will play a key role in helping deliver the *Five-year forward view* prevention and demand management agenda, the government said. Setting out the public health body's remit for 2017/18, health minister Nicola Blackwood said it would focus particularly on helping to close the health, financial and quality gaps. Public Health England would support the implementation of sustainability and transformation plans; help deliver NHS England's two-year plan to implement preventative interventions at scale; and develop the use of behavioural science to help people take more control over their health.

Seven mental health trusts have been given funds to pioneer new digital services for patients, NHS England said. For the first time, all key health professionals at the trusts will have access to real time health records. And the trusts will develop remote, mobile and assistive technology to enable patients to manage their conditions and help families and carers offer support. Trusts will have up to £70m – £35m from NHS England and £35m in matched funds.

NHS Resolution – the new name for the NHS Litigation Authority – has published its business plan for 2017/18. It said the plan outlines the first stage in its work to address the rising costs of harm in the NHS (see *Healthcare Finance*, December 2016). The body said it intends to use its expertise to resolve issues fairly, share learning and ensure more funding is spent directly on patient care.

hfma

in the media

Before election fever gripped the media, the House of Lords report on the long-term sustainability of the NHS was one of the key stories of early April. The HFMA was keen to get its opinion across on the report, which slammed short-termism in successive governments and called for an Office for Budget Responsibility-style independent body to keep an eye on demographic changes, future workforce needs and changing skills requirements.

HFMA policy director Paul Briddock backed the report's call for longer-term health and social care planning and its recognition that an honest public debate on the future of NHS funding was needed (see news analysis, page 8).

In a blog for National Health Executive, HFMA research manager Lisa Robertson discussed the emerging governance arrangements in sustainability and transformation plan areas. These were explored in the HFMA briefing *Developing sustainability and transformation plan governance arrangements*. While each STP will move at its own pace, they will all need to focus on specific areas of governance – finance directors can use the HFMA's online checklist to ensure they have considered all the key areas, she added.

Last year's HFMA survey with NHS Providers on mental health funding continues to attract interest. It was quoted in an article on parity of esteem in *Mental health today*. The article looks at the Mental Welfare Commission annual report, which concluded that pressures on the NHS made achieving parity of esteem difficult without compromising other services.

News analysis

Headline issues in the spotlight

Question time

With the NHS financial position rarely out of the news – and the service the only real contender to challenge Brexit as the key issue in the upcoming general election – HFMA director of policy Paul Briddock provides the association's view of the key issues

Q Is the *Five-year forward view* achievable?

The *Five-year forward view* set out a vision for how the health service could and should look in future and how it should respond to the pressures of a growing and ageing population with a higher prevalence of long-term conditions in the context of reduced levels of funding growth. There is a significant consensus about how the service needs to respond. We need a greater emphasis on preventing ill-health and improving public health. And we need to transform traditional care pathways so that they are integrated around patient needs and delivered at the right time in the right place.

The recent refresh – *Next steps on the NHS five-year forward view* – summarises progress and focuses on what can be delivered in the two years from April 2017. It remains ambitious, but provides a welcome recognition of the continuing severe pressures facing the NHS. In clarifying the immediate priorities – accident and emergency, GP services, cancer and mental health – and accepting that elective waiting times will grow, NHS England is demonstrating a pragmatic approach. But, even with this change, the plan amounts to an unprecedented challenge for the service.

What has become clear is that we need to regularly review what is achievable over what timescale. The environment we operate in – the general economy, funding of other services such as social care, demand, availability of staff – has a direct impact on our ability to meet the targets set out in the *Forward view*. It sets the right direction of travel and the right level of ambition. However, we need to acknowledge that the context has changed and will continue to change.

Q Does the NHS need additional resources?

Overall funding of the health service is a political issue. Clinicians and managers have to deliver the highest possible quality services within the set funding envelope. However, the consistent message we hear back from finance directors through our regular *NHS financial temperature* check is that the service is under extreme pressure. The provider side in particular is clearly living beyond its means, and has been doing so for a number of years. This simply cannot continue.

Three-quarters of the way through the year, providers were forecasting a year-end deficit of £873m. While this was a significant improvement compared with their overall £2.5bn deficit in 2015/16, it relies on £1.8bn of sustainability and transformation funding. It was some £293m worse than plan and, with three months of the year left, it was by no means a done deal that it would be achieved.

Delivering this position or close to it would be a significant achievement in the current climate. Time will tell.

There continues to be a major focus on the £30bn funding gap identified in the original *Forward view*. This was the gap assuming demand trends continued, the NHS received flat real terms funding and no further efficiencies were delivered. The subsequent spending review settlement, giving the NHS an £8bn real terms increase over five years, left the NHS with an ambitious £22bn efficiency requirement. But even this assumed a 'radical upgrade' of prevention and support for wider public health measures, continued availability of capital and that social care would not add further pressures.

The £30bn and £22bn were never actual sums of money to be released. If demand can be reduced – or met in better and more cost-effective ways – the trend lines bend downwards and the cost gap narrows. But the figures remain useful illustrations of the size of the challenge the service faces. The key issue is around timing. How quickly can the service transform patient pathways, improve productivity and address clinical variation – especially while continuing to deliver existing services to meet demand?

And there is still uncertainty about the financial impacts of some transformation programmes. Moving services to support patients in the community and avoid conditions worsening to the point of needing inpatient treatment is the right thing to do, and could lead to lower overall costs. But we need to understand more about the financial impact of these changes.

The NHS spends less on health as a proportion of gross domestic product than many major European countries including Germany and France. However, despite this, there is still a significant opportunity to improve value. The Carter review highlighted a number of areas where productivity could be improved. However addressing unwarranted clinical variation arguably offers the greatest potential. Initiatives such as RightCare, *Getting it right first time*, the Model Hospital and patient-level costing are a good start in using data and evidence to drive this agenda. We need to prioritise the collection of robust data and start to use this information in earnest to drive improvement.

Q Can the sustainability and transformation plans deliver?

The NHS will only meet its current challenges if it faces them as systems. In our *Temperature check*, finance directors give us a clear message that STPs are a good idea and provide a valuable platform for discussing ideas. Many say that they have been instrumental in improving relations between providers and commissioners. But they are not without their challenges. We absolutely need to improve long-term planning – at a national level (a point made recently in the report from the Lords Select Committee on the

Long-term Sustainability of the NHS) and at a local health system level. But STP plans will need capital and political support where the right solution involves major changes to how services are delivered locally.

STP governance is an area where finance directors have particular concerns. They highlight a lack of clarity around the authority of the STP and how this relates to the statutory duties of NHS boards and how financial control totals work in an STP context. As a result, nearly two-thirds of finance directors say they would continue to prioritise their own organisations' objectives above those of the STP.

In everything the NHS does, there has to be a focus on value (measured in terms of quality and costs) rather than simply costs. This value increasingly has to be viewed across whole systems. STPs provide an opportunity to take this agenda forward. Providers may need to give up some services and their income, if services would be better provided elsewhere or provided in a different way earlier in the pathway.

Similarly, commissioners need to understand the impact of commissioning decisions on providers and on the overall value delivered by the system.

Q What is finance's role in transformation?

Finance staff have a huge role to play in meeting the service's current challenges. While all staff have a duty to be aware of the financial implications of their actions, finance staff clearly have a central role in achieving control totals and producing accurate financial reports that reflect performance.

But finance staff will also be key to the success of transformation activities, which will benefit from their analytical and project management skills and evidence-based approach.

"The *Forward view* sets the right direction of travel and the right level of ambition. However, we need to acknowledge that the context has changed and will continue to change"
Paul Briddock, HFMA

Finance staff will also have a specific role in collecting and analysing much of the data needed to drive initiatives such as the Model Hospital. Robust costing data in particular will be needed to identify opportunities for improving value. The Costing Transformation Programme is ambitious but will give the NHS in England a sound foundation of cost and patient-level activity data on which to take informed decisions.

But it will need greater investment in the costing function and feeder systems at a time when the service is under extreme financial pressure. Finance practitioners will also need to sit alongside clinicians helping them to interpret this financial and patient-level data alongside outcome information.

We will also need sound business cases for proposed new pathways so that the service understands the financial implications of new approaches.

The finance function should not be immune to improvement work. It needs to challenge its own working practices and ensure it is offering the best value for money possible. However, there are concerns about pressure to reduce corporate costs. The focus, as in other areas, needs to be on value. If higher than average finance function costs lead to better productivity and effectiveness overall, that should be a good result.

Q What impact will June's general election have on the NHS?

Clearly in the short-term, the election has the potential to hamper progress with the transformation agenda as it distracts current ministers' attention away from the NHS. It may also postpone local consultation on plans for changing services. History suggests that decisions tend to get delayed and momentum to get lost.

However, the HFMA has been consistent in calling for a wider debate about how the health and social care systems meet their current financial challenges and address long-term sustainability issues.

June's election may provide an opportunity for this debate. There's a consensus around the need for transformation and the potential for productivity improvement. But if this can't close the estimated funding gap in the time available, we need an open discussion with the public and patients about the options.

Increased funding would need to come from higher taxation, reprioritisation of existing government programmes or by introducing some form of co-payments, although finance directors are clear they do not support this co-payment approach.

The Lords sustainability committee's call for an Office of Budget Responsibility type body has a lot of appeal in taking a more balanced view on how we match funding and demand.

If increased funding is not an option, we need to explore the appetite for restricting the range of services on offer. The recent delays in elective treatment are effectively a form of unplanned service rationing. The election campaign may offer an opportunity for issues around NHS sustainability to be discussed more openly.

Comment

Ker-Plunk!

Guardians of the money need to become gladiators of change

Until 18 April, most of us would not have imagined a UK general election before 2020, certainly not before the Brexit pathway was clearer. In the near term, this would have meant continuing to plan for macro NHS funding in line with the 'funding U-bend' settlement. And it would have meant planning for operational service priorities and access targets clarified by the recent *Next steps* on the *NHS five-year forward view* publication.

HFMA president Mark Orchard

In that context, the outlook for next three to four years was clear enough, albeit challenging locally to continue to sustain high-quality services alongside transformation programmes at varying degrees of infancy.

The uncertainty we accepted was not knowing what the next Parliamentary term looked like in terms of funding plans and priorities for the medium term beyond 2020. With a general election now on 8 June, that void of uncertainty has narrowed.

Early indications suggest that, putting aside political manifesto commitments expected over the next few weeks, we will probably still have to wait for the longer term direction of health and care to be confirmed.

In any election outcome scenario, it is hard to see how the country could avoid a future choice between increased health and social care funding or changing the services currently delivered free at the point of need for all. Commitment to an early cross-party review of NHS and social care needs would be a good place to start.

Reaffirmation of the NHS founding principles in the first 392 days of office – and ahead of its 70th anniversary – would be

Health warning

Don't believe all the claims, but let's use the election to get talking

Healthcare Finance editor Steve Brown

The promises made around political campaigns – in general and maybe even those particularly relating to health – should be taken with a pinch of salt. Remember 2010's coalition government pledge to 'stop the top-down reorganisations of the NHS'? This may have been post-election, but it was a strange way to warm up for the upheaval involved with 2012's *Health and Social Care Act*.

Perhaps a more obvious example was last year's bus-delivered claim by the Leave campaign that it could take the £350m spent on the European Union and redirect it to the NHS. Even leading Brexiteers found that amusing… at least once the vote was in the bag.

Elsewhere, we've seen the new leader of the free world's promise to 'quickly' repeal Obamacare meet the harsh reality of the political real world of government – to say nothing about his wall.

We need to read everything, but be careful what we believe. However, there are early signs that the general election campaign could actually provide a platform to get the public thinking about key issues relating to health and social care.

Okay, perhaps I'm being naïve, but when the snap election was announced in April, there was a feeling that the election would be a one-issue debate: Europe. This time it would not be about if we leave but how we leave, and who we want in charge of the all-important negotiations. Some suggested the election was effectively all over bar the shouting, given the

"Being serious means organising ourselves on an industrial scale to underscore the 'national' in NHS"

cause for celebration. If this comes with a commitment to move our health spend as a proportion of gross domestic product in line with some of our European neighbours, I'll bring the cake on 5 July 2018 and you can eat it. And that's a promise.

But back to the election announcement: where does it leave us? The 2016/17 consolidated financial position will be known soon. Organisational performance has been declared and is now with the individual auditors for verification. 2017/18 is under way and, setting aside the £325m capital distribution for well-developed sustainability and transformation plans, closing out residual financial gaps is at the top of the 'to-do' list for most. Managing down system demand to within broadly flat funded activity assumptions isn't far behind.

Achieving both these while also reducing A&E waiting times is important not only for patient experience, but also for (STF) cash balance assumptions.

From my vantage point – looking out from a health and care system that is broadly doing what it said it would do across a broad performance scorecard – two things are clear. First, if we are serious about reducing unwarranted variation at scale, we can probably iron out the remaining efficiency wrinkles to sustain services for another year at current levels. Being serious, however, means organising ourselves on an industrial scale to underscore the 'national' in NHS. Waiting for this to happen organically may be too late.

So there's the other thing. Doing the same thing that we have always done in the same way we've always done it, and continuing to take out efficiencies of 4% a year, well, that would be like playing Ker-Plunk in the dark and against the clock.

The NHS is worth more than that. Patients, service users, carers and families deserve better.

Everyone counts. Our job is to keep going. But our responsibility is to be true to the services we support and to demonstrate efficiency beyond public doubt.

As the UK's best loved institution, let's not rest on our laurels. Guardians of the money need to become gladiators of change.

Contact the president on president@hfma.org.uk

SHUTTERSTOCK

Conservatives' apparent domination of polls and the media's portrayal of a divided main opposition party.

But as the month drew to a close, there were signs that the Brexit debate might need to give up a little air time for other important issues. And the NHS is without a doubt at the top of the 'other issues' list.

The HFMA and others have long called for a debate about the challenges facing the NHS. Yes, we need to transform services and redesign pathways so that patients are treated in the most clinically and cost-effective way. But if this doesn't enable the service to close the famous £22bn efficiency gap, we need to look at other options – more funding (which can only come from taxation or unpopular co-payment approaches) or restricting the services offered.

It really is wishful thinking that any of the parties might actively address different funding options or service rationing as part of an election campaign – other than accusing their opponents of such unthinkable ideas. But just getting the NHS on the stage alongside Brexit would be a good start.

Labour's opening gambit – ending the pay cap, safe staffing legislation and reinstating nursing student bursaries – is interesting. On safe staffing, the suggestion is that the National Institute for Health and Care Excellence would restart its guidance initiative. It is not clear what difference a legislative approach would make. The NICE guidance published for acute adult wards did not set minimum staffing ratios, but required trusts to use a structured approach to setting establishments and monitoring actual staffing levels day to day.

"There are early signs that the election campaign could actually provide a platform to get the public thinking about key issues relating to health and social care"

But while having high-level public appeal, it should force all parties to address some of the detail of current issues – with pressure groups and thinktanks able to then keep the discussion going. And, of course, in setting out or questioning how these measures would be funded, it puts the overarching NHS funding question front and centre.

Depending on who you choose to believe, these policies were uncosted or would be funded by other simple and populist changes. But at least the NHS funding question is up and running. And with manifestos due shortly, May should prove an interesting month.

HFMA introductory guide
Fourth edition

hfma

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Hitting refresh

SHUTTERSTOCK

Circumstances have changed since the *Five-year forward view* was published, and the plan has been refreshed to reflect the financial realities and demands on the service. Seamus Ward reports

It was no surprise that the NHS in England chose to refresh its five-year plan recently. Compared with earlier periods, there has been relative stability. We have not had a change in health secretary, for example. But in the past two and a half years since the publication of the *Five-year forward view* there have been significant increases in demand, rising cost pressures and an unforeseen crisis in social care that has impacted on capacity in the NHS.

As the refresh, known as *Next steps on the five-year forward view*, was published, the House of Lords Committee on the Long-term Sustainability of the NHS called for an Office for Budget Responsibility-style organisation to be set up for the health service (see box overleaf). The proposed new body would advise governments on health and social care needs in the long term, looking at changing demography, workforce, skills gaps and the funding of health and social care compared with demand.

The Lords believe a more proactive NHS could prevent problems such as shortages of key staff or rises in demand. Certainly, as the next steps document points out, increased demand has been a feature of the NHS in recent years.

Next steps on the five-year forward view looks forward to next year's 70th anniversary of the establishment of the NHS, with its sights firmly set on this financial year and next. It leaves out 2019/20 and 2020/21 – years that were included in the original plan and the subsequent spending review settlement.

NHS England chief executive Simon Stevens (pictured) says the document sets out 'practical care improvements for the next few years. We do not underestimate the challenges but, get these right, and patients, staff and the tax-paying public will notice the benefits.'

The document points out that new treatments for a growing and ageing population mean the pressures on the service are greater than ever. Even so, treatment outcomes are better and patient satisfaction is higher than a decade or two ago, it adds.

Waiting times are still low compared with the past, though they are growing, and the budget is increasing slowly, so it was the right time to take stock and look at how the current challenging environment impacted on the service, it says.

While the next steps document sets out many of the objectives for the NHS in the next two years, it does not seek to be comprehensive. Its task is to outline the main improvement priorities over the next two years within the constraints needed to achieve financial balance. Indeed, finance and efficiency play a key role in the refresh – as we reported last month, *Next steps* includes a 10-point mandatory efficiency plan – though it does not mention the £30bn funding gap or the £22bn efficiency target set out in the original *Five-year forward view.*

It is also pragmatic – pointing out there must be trade-offs to reach financial balance. At least in the short term this means an acceptance that A&E performance against the four-hour target is hard to achieve in the current climate.

Emergency services are struggling to cope with rising demand – as can be seen by monthly statistics showing the NHS overall has missed the A&E four-hour performance target. But, as the refresh points out, up to three million A&E visits could have been better provided elsewhere in the system. There are difficulties admitting sicker patients into hospital, often because of delayed discharge of patients medically well enough to leave hospital but without adequate support in the community.

A&E relief

The refresh promises action to relieve the pressure on A&E over the next two years. This includes freeing up 2,000 to 3,000 hospital beds by working closely with community services and councils. Patients with less severe conditions will be offered alternatives to traditional A&E – a new network of around 150 urgent treatment centres, GP appointments and more clinicians taking calls on NHS 111.

As announced in the recent Budget, hospitals will be given £100m in capital funding to establish clinical streaming in A&E by October. Last month, the Department of Health announced more than £55m of the fund would go to 70 hospitals.

Mapping a return to achievement of the four-hour target, A&Es have been told to treat, admit or transfer at least 90% of patients within four hours before September this year. The majority should then meet the 95% target by the end of the current financial year. The whole service should return to the 95% standard during 2018.

GPs will be important not only in seeing patients that are diverted away from A&E, but also by offering more appointments in the evening and at weekends to stop patients going to A&E in the first place. Additional appointments should be available across half of the country by March 2018 (this is a stretching target, going beyond the NHS England Mandate of 40%) and the whole country by 2019.

This will require an increase in primary care clinicians and the report says in the next two years the NHS is on course to recruit 1,300 clinical pharmacists and 1,500 more mental health therapists to work with an additional 3,250 GPs.

Cancer remains a priority and there will be a renewed emphasis on early diagnosis, which is so often vital to the success of treatment. The refresh document says new rapid assessment and diagnosis centres will be opened and cutting edge linear accelerators will be used throughout the country to help at least an extra 5,000 people survive cancer over the next two years.

Next steps reiterates many of the recent announcements on mental health services, including the expansion of the availability for talking therapies for common mental health conditions, extra support to new mothers and greater emphasis on addressing the physical health needs of people with severe mental illnesses.

The numbers of frail, older people needing care is a key pressure on hospital beds and A&E. The refresh document says integrated care vanguards have seen some success in slowing the growth in emergency hospitalisations and reducing the amount of time this group of patients spend in hospital. This is particularly noticeable for those aged over 75.

However, it stresses the need not to over interpret the figures. It compares the most recent 12 months for which complete data is available (the 2016 calendar year) with the 12 months prior to the vanguards commencing (the year to September 2015). While growth in emergency hospital admissions and emergency inpatient bed days in non-vanguard areas across England was 3.2%, in primary and acute systems vanguards (where GP, hospital, community and mental health services are joined together) it was 1.1%. In multispecialty community providers – where community services are better integrated and specialist care is moved out of hospital – it was 1.9%.

The refresh document calls for an acceleration of the integration work and says a number of STPs are ready to fully integrate their funding and services through accountable care systems (ACSs). The centre will back this move and the ACSs will gain new powers and freedoms, including a devolved transformation funding package from 2018, potentially

"The five-year plan reinforces a stark truth: you get what you pay for"
Chis Hopson, NHS Providers

Reaction

While the original five-year plan was met with almost unanimous praise, reaction to the *Next steps* document was a little more mixed.

NHS Providers chief executive Chris Hopson said the report was pragmatic, though it would mean more patients will have to wait longer in A&E and for routine surgery than they should. He said two pressing issues were not addressed in the report – how the NHS will close the estimated £1bn gap in 2017/18 and the need to work out what can be delivered in 2018/19, when headline growth slows even further.

'The plan reinforces a stark truth: you get what you pay for. Trusts will do all they can to transform and realise efficiencies as quickly as possible. But if NHS funding increases fall way behind demand and cost increases, NHS services inevitably deteriorate. That is clearly now happening,' he concluded.

King's Fund chief executive Chris Ham welcomed the clear course set for the NHS over the next two years. He added: ''Hospitals are now under pressure all year round and so the ambition to improve A&E performance and other key services within the current budget is extremely ambitious. Putting the onus on the NHS and local authorities to work together to improve social care and free up hospital beds is the right approach. But with growing pressures on both services, expecting 2,000 to 3,000 hospital beds to be freed up is optimistic.'

NHS Confederation chief executive Niall Dickson said the public must be clear about what to expect from the NHS.

'We have to acknowledge there are significant risks and in some respects it is a leap in the dark. We have no alternative but to embark upon such fundamental change but to do so when services are under enormous pressure and money is so tight is without precedent.'

The document confirmed a move away from competition,

Nuffield Trust chief executive Nigel Edwards said. 'But the legal framework under which the NHS is operating pushes against this, promoting competition and discouraging team working. This is therefore a heroic attempt to work around laws that are not fit for purpose. While nobody wants another top down reorganisation, legislative change of some kind in the future is a certainty,' he added.

bundling together national funding for the *General practice forward view*, mental health and cancer.

ACSs will manage funding for their populations and have shared performance goals and a control total across providers and commissioners – this will mean moving beyond what the document describes as 'click of the turnstile' tariff payments where appropriate, and effectively abolishing the annual contracting negotiations.

There will be moves to boost frontline staff numbers, including at least 6,000 more nurses by 2020. There will be an increased emphasis on e-rostering and job planning to ensure the NHS has the right staff and at the right time. While staff numbers have increased, they are under more pressure. The NHS will also use technology to help people take a more active role in their health.

HFMA members have expressed concern over the governance and support mechanism in STPs and from April all NHS organisations have become part of Sustainability and Transformation Partnerships – conveniently using the same acronym – that will include a board drawn from its constituent organisations. Decision-making mechanisms will be established and, if an organisation is standing in the way of necessary local change, NHS England or NHS Improvement could take action to ensure the change goes ahead. Metrics that align with the NHS Improvement single oversight framework and NHS England's annual clinical commissioning group improvement and assessment framework will be used to judge the success of STPs. These are due to be published in July.

Next steps attempts to reflect the changes in the NHS since the FYFV was published. But the elephant in the room is the £30bn efficiency gap and £22bn target

The *Next steps* document is clearly more than a tweak of the original *Five-year forward view* as it attempts to reflect the changes in the NHS since the latter was published. But the elephant in the room is the £30bn efficiency gap and £22bn target – for so long now the focus of all national-level discussions.

Of course, the figures were always indicative and subject to changes in circumstances so their omission may make no difference – as *Next steps* clearly states, the efficiency drive (through the mandatory 10-point plan) and financial and clinical sustainability are still paramount.

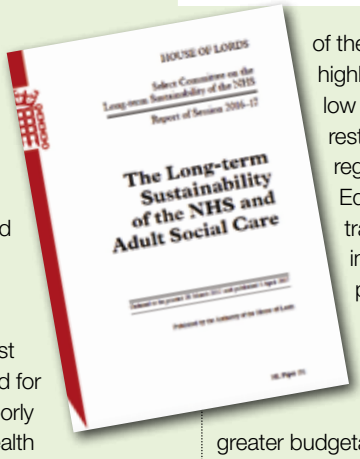
Lords leap into sustainability debate

The *Five-year forward view* is well supported as a basis for making the NHS more sustainable, but is the only example of long-term strategic planning, according to a House of Lords committee. The peers concluded this was 'clearly short-sighted', *writes Steve Brown.* 'Without a longer-term strategy for service transformation, which goes beyond 2020, any short-term progress achieved through the *Five-year forward view* will be put at risk,' it said.

The report from the Lords Select Committee on the Long-term Sustainability of the NHS said this short-sightedness spanned successive governments. It called for a new independent Office for Health and Care Sustainability to be established to examine health and care needs over the next 15-20 years – a health version of the Office for Budget Responsibility. The body would report to Parliament on 'the impact of changing demographic needs, the workforce and skills mix in the NHS and the stability of health and social care funding relative to demand'.

There was a lot of support for the proposed new body. In a blog, HFMA director of policy Paul Briddock said it was 'hard not to see the attraction' of a body that could help keep everybody 'focused much more on the long term direction of travel as well as the short term operational necessities'. Chris Ham, chief executive of the King's Fund said that 'regular independent assessments of funding needs – like the Wanless reports during the early 2000s – could play a key role' in a move to longer term planning.

The committee insisted a tax-funded, free-at-the-point-of-use NHS remained the 'most appropriate model'. However, it added that, in coming years, this 'will require a shift in government priorities or increases in taxation'. Past funding was also criticised for being 'too volatile and poorly co-ordinated between health and social care' resulting in poor value for money and resources allocated in ways that don't meet patient needs. Future funding should increase 'at least in line with growth in GDP'.



The committee highlighted social care pressures as a big threat to the NHS's stability, to the extent that it broadened the scope of its review. 'The funding crisis in adult social care is worsening to the point of imminent breakdown,' it said.

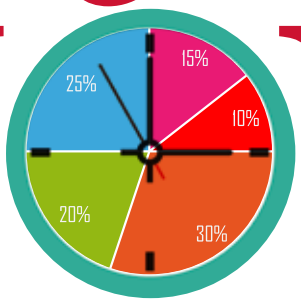
Although it acknowledged additional funds announced in the spring Budget, it said this was 'clearly insufficient to make up for many years of underfunding and the rapid rise in pressures on the system'. More funding was needed between now and 2020 and beyond that funding increases should 'as a minimum' be aligned with the rate of increase in NHS funding.

The lack of a comprehensive, long-term strategy for workforce was described as the 'biggest internal threat to the sustainability of the NHS' – with the report highlighting problems such as low morale, prolonged pay restraint and over-burdensome regulation. It called for Health Education England to be transformed into a 'new single, integrated strategic workforce planning body for health and social care', looking 10-years ahead on a rolling basis. It should be supported by a protected budget and given greater budgetary freedom.

Too little attention had been paid to training the existing workforce and a 'radical reform' of many training courses for medical recruits was 'desperately needed'. Danny Mortimer, chief executive of NHS Employers agreed the need to retain a strong, skilled workforce in the health and care system was of 'paramount importance'. 'Managing pay costs remains a key part of meeting the financial and service challenges,' he said. 'Employers understand that a continuation of pay restraint over the longer term is of growing concern to our workforce.'

The committee's 34 recommendations for change included examining alternatives to the current 'small business' model for GP services, the integration of NHS England and NHS Improvement, a review of the impact of pay on morale and retention and more incentives to adopt new technology and innovation. It also called for a ringfence around national and local public health budgets for at least the next 10 years.

Costing's time is NOW



Changing clinical behaviour is the key to addressing the value gap – and robust, easy to understand costing data has a crucial part to play. Steve Brown reports

'We are in a really important time, when the costs really matter. The work you are doing really counts.'

Costing practitioners have probably heard statements like this before from various sources – NHS Improvement, their finance director or the HFMA would all be likely. But what made this comment refreshing on this particular occasion was that it came from a leading medical director.

Paul Buss, medical director and deputy chief executive at Aneurin Bevan University Health Board, led the cheerleading for the costing function at the HFMA's annual costing conference in April.

But he also warned that data needed to be in the right format and used as the basis for engagement with clinicians, not just produced to meet a central requirement. 'The work is really important, provided it doesn't just sit on a balance sheet, but is used somewhere in a discussion with clinicians,' he said.

Dr Buss suggested that cost data was vital for individual clinicians, who had to break away from simple demands for more resources and engage properly in the value agenda.

It was vital for teams – in his experience, discussion informed by meaningful cost data almost always led to redesign. And it was vital for organisations, whose financial health depended on economic literacy.

'[The information you provide] won't solve all issues relating to the economy, but it will blunt the trajectory of spend going forward,' said Dr Buss. His repeated message was for 'costing to be brought into the conversation', although he recognised that getting clinical engagement could be challenging.

"[The information you provide] won't solve all issues relating to the economy, but it will blunt the trajectory of spend going forward"

Paul Buss, Aneurin Bevan UHB

Rising costs were often an early warning of a potential service failure or incident, he added. Organisations, managers and clinicians had to get better at getting the data out in a timely way so that these warnings could be acted on.

Dr Buss said that a significant proportion of the value gap – the gap between projected health spending and whatever version of likely actual funding was used – could be addressed by making changes to clinical behaviour where different habits and styles had led to variation in practice.

'I can often tell where, and in what areas, people have trained by their style of practice and the investigations they use,' he said. '[Addressing the] gap needs to be informed by costing and put alongside outcomes to

understand the value we deliver. We have to influence clinical behaviour by getting costing into the discussion.'

He acknowledged that some clinicians would resist this initially, but that if done properly it could bring simplicity to the analysis of an otherwise complicated set of circumstances – leading to questions of 'how, why and what are we doing'.

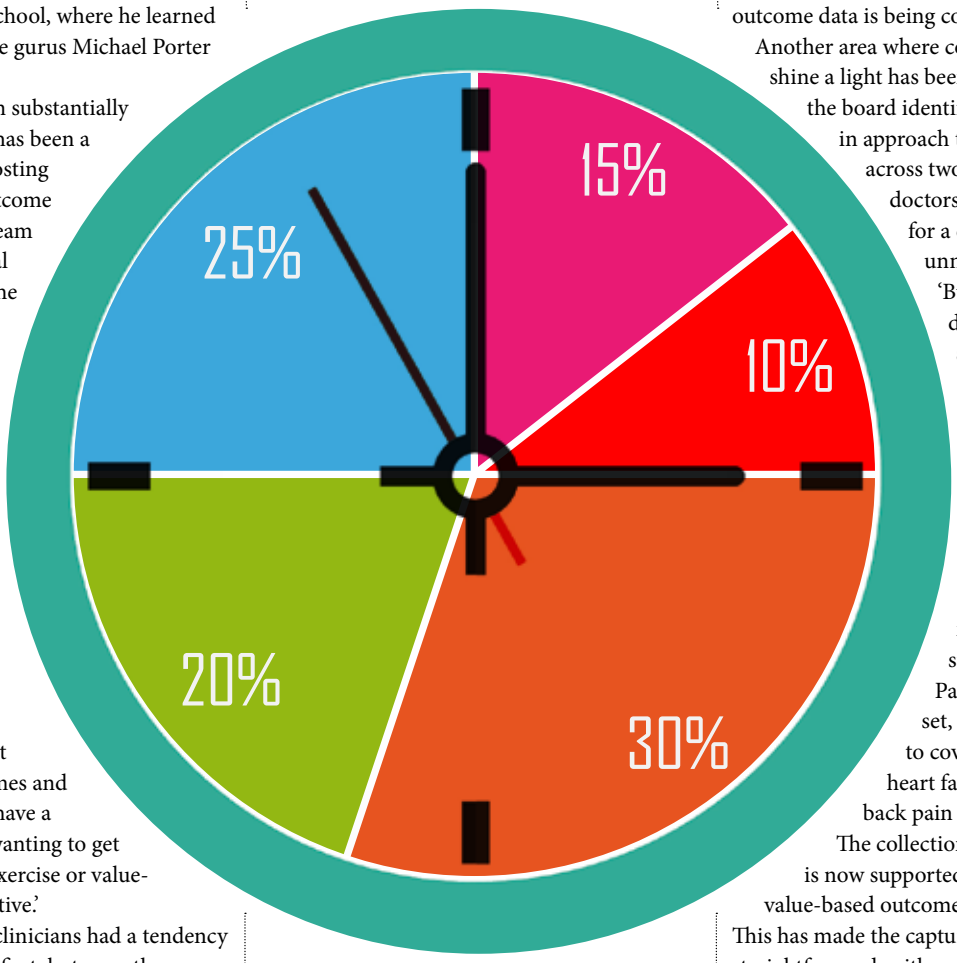
Value agenda

Aneurin Bevan has been pursuing a value agenda for a number of years. Its former finance director Alan Brace, the HFMA's Finance Director of the Year in 2014, has had a significant role in this, following a study visit to Harvard Business School, where he learned about the work of value gurus Michael Porter and Robert Kaplan.

This work has grown substantially in recent years. There has been a focus on developing costing data and collecting outcome metrics, with a value team led by assistant medical director Sally Lewis. The board has also entered into a strategic alliance with the International Consortium for Health Outcomes Measurement.

And Dr Buss said clinical attitudes have changed from disinterested to enthusiastic. 'At the start doctors wanted to know what value was and now they want information on outcomes and costs,' he said. 'I don't have a week without a team wanting to get involved in a costing exercise or value-based healthcare initiative.'

"I don't have a week without a team wanting to get involved in a costing exercise or value-based healthcare initiative"



He recognised that clinicians had a tendency to 'rubbish the data' at first, but once they overcame that reaction, clinical directors could really start to influence behaviour.

And while cost data needed to be meaningful, it was similar to medicine in involving an iterative process of improvement.

'The work you do has to get better and better,' he said, with each iteration more accurately portraying clinical behaviour.

One area explored in Aneurin Bevan has been within its dementia services. Dr Buss said there was huge variation in referrals from primary care to start with, but once within the system, there were major pathway differences across the five boroughs covered by the board. These involved 'different pre-assessments, different diagnostics and different follow-ups'.

Combining the different pathway analysis with costing data revealed a 1.7 times difference between the cheapest and most expensive aspects of the service, before outcomes were even factored in. He said that costs were the key to helping the board 'focus our minds on why we were doing what we were doing' and to highlighting the differences in the styles of practice and their financial consequences. The teams have started to implement changes and more standardised approaches, even while more meaningful outcome data is being collected.

Another area where costing has helped to shine a light has been cardiology, where the board identified major differences in approach to cardiac pacing across two hospital sites. 'Some doctors admitted patients for a day, others saw this as unnecessary,' said Dr Buss. 'But we also noticed differences in nurse staffing levels and the kit procured.' This could all be discussed and addressed by the clinical teams involved.

The health board has also done a lot of work on outcome measurement. This started with ICHOM's Parkinson outcome data set, but has expanded to cover cataracts, stroke, heart failure, dementia, lower back pain and lung cancer.

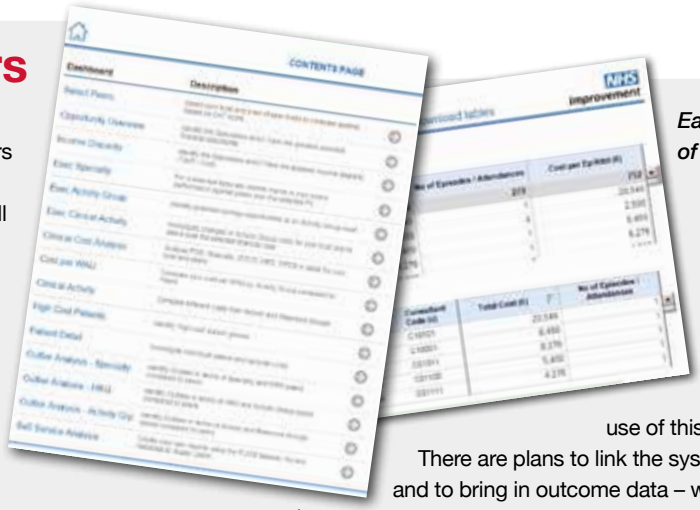
The collection of outcome data is now supported by a dedicated value-based outcome capture platform. This has made the capture of data much more straightforward, with patients being able to input some measures directly themselves.

Whole system costs

He said the board was on a value journey with costing and cost data central to its success. 'In future, we need to be looking at whole system costs – that will be a real challenge but we must rise to it,' he said.

Dr Buss added that the Welsh integrated structure offered some benefits in looking across whole pathways, but that England's approach to costing – with the Costing

The transformers



Early screenshots of the portal

This summer's patient-level cost collection – involving some 86 providers implementing new costing standards ahead of mandatory requirements – will be a 'massive' milestone, according to Richard Ford*, NHS Improvement's costing improvement director and head of the oversight body's Costing Transformation Programme.

'We'll have some tangible information that we can play back and all the people interested in costing will be able to see it and make comparisons,' he told April's HFMA costing conference. 'We'll move from selling off a plan to selling from something that is real.'

There is already a lot of excitement about the potential for robust, patient-level cost data to drive improvement. The Model Hospital team, also at NHS Improvement, talks about the move to patient-level cost data rather than reference costs as having the potential to 'revolutionise' its work. And the *Getting it right first time* programme, which has now broadened its focus beyond variation in orthopaedic surgery, is also reported to be enthusiastic to access data that can accurately reflect how different activities contribute to total costs and how costs vary from patient to patient.

A new patient-level information and costing portal – developed by NHS Improvement – also clearly demonstrates the potential power of the data once delivered back to providers. This detailed cost benchmarking system – fed by providers' patient cost data – will provide executive overviews of providers' costs compared to selected peers and then enable users to drill right down to patient level for their own activity, exploring high-cost procedures and healthcare resource groups or tracking patients – and their costs – across the whole pathway. Access will be restricted to trusts submitting data.

Introducing the portal, Paul Howells, collection and analysis costing lead at NHS Improvement, highlighted the power of the data to help improve services inside organisations and across whole health systems. For example, the data enabled a single patient to be tracked across four separate providers over a year, involving more than 20 outpatient appointments, an accident and emergency visit and a couple of inpatient episodes, incurring total costs of nearly £48,000.

NHS Improvement is convinced this 'operational intelligence' – scaled up across all acute providers – could be used to identify opportunities to provide better care and reduce overall costs. 'And when we can bring in mental health, ambulance and community services, we'll be able to track across all settings,' said Mr Howells. 'This is really good information for us nationally and you [locally] – and we need to find ways to make use of this information.'

There are plans to link the system to the Model Hospital and to bring in outcome data – with an aim to include patient reported outcome measures, patient experience metrics and friends and family test scores.

As clever as the system appears, its value will be judged on the quality of data that it is populated with. This is where the CTP is crucial as it aims to ensure all providers use a consistent methodology in compiling patient costs – so providers use the same definitions of, for example, theatre costs and then allocate them to patients using the same methodology.

Following an acceleration of the programme announced at the end of last year, NHS Improvement is now supporting the 86 acute early implementers in preparing for their first cost submission using the new costing standards and approach. It is also working towards pilot cost collections with roadmap partners in mental health and ambulance services (towards the end of the year) and community services in autumn 2018.

Work is ongoing to finalise standards in these non-acute sectors, with developmental versions only published earlier this year. There have also been changes to the costing audit process. While this will focus on early implementers this year to maximise the learning, it will be based more on validation gateways and quality metrics.

Mr Ford said NHS Improvement, which also oversees the ongoing reference cost programme, recognised this year's combined national cost collection was a major burden on costing teams. This will see collections of education and training (E&T) costs, reference costs net of E&T income and reference costs net of E&T costs all submitted at the same time in a single workbook.

The timetable, which was already different for early implementers and non-early implementers, has been further challenged by delays in releasing the new reference cost grouper. Non-early implementers who felt they would struggle to meet their July deadline were encouraged to talk to NHS Improvement.

**Richard Ford was due to leave NHS Improvement at the end of April*

Transformation Programme (see box) and the finance systems being developed – was also a major asset.

He ended with three specific challenges for organisations and systems serious about taking value-based management forward. 'Are your medical director, finance director and you [the costing lead] meeting regularly to discuss what value-based systems look like? You have to have that co-ordinated approach,' Dr Buss said. Clinical cost leadership was another key issue. 'We have to have a fundamental shift in the training of medical and clinical directors to bring in their responsibility to understand more about costing frameworks,' he said. 'We need more joint learning.'

And finally, and most important, he believed the service had to get much more involved with value analysis.

Over the next year, Aneurin Bevan would be 'marrying up seriously informed cost data with internationally validated outcome data.'

'We have to start asking questions of this merged data,' he said. And over time that should lead to establishing the characteristics of the service the NHS wants to provide – in particular the balance between health maintenance and intensive treatment activities. Costing data needed to be at the heart of this 'optimising value' discussion,' he said.

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pump priming

STPs need capital, but there is little public funding available, forcing the NHS to rethink how it can find the money, says Seamus Ward

In the NHS, capital funding can sometimes feel less important than revenue spending. Capital budgets are often underspent, while in recent years capital funds have been transferred to revenue budgets to shore up providers' financial positions. However, the health service across the UK is integrating and transforming, moving more care out of hospital – and this will require capital to fund new or upgraded buildings and equipment. A change in attitude towards capital funding, as well as a plan for how to find the money, is needed.

Acknowledging the funding need, England's sustainability and transformation plan (STP) areas have been asked to assess their capital requirements. A British Medical Association freedom of information request – to which 36 of the 44 STPs responded – put the total requirement at £9.5bn. The recent Naylor review of NHS estates put the figure at £10bn, a figure that seems to have been accepted by NHS Improvement. But with access to capital constricted, where will the funds come from?

In England, the spending review settlement set NHS capital spending at £4.8bn a year until 2020/21. In this year's Budget the capital allocation has been revised upwards to around £6bn a year between 2017/18 and 2019/20. The Treasury says this is due to the additional funding for A&E and STPs announced in the Budget and the reclassification of research and development spending as capital. But the value of capital budgets has been eroded by capital to revenue transfers, which have been needed to reduce provider deficits and keep the NHS in overall financial balance. In 2016/17 this amounted to £950m – £640m in 2015/16.

Other parts of the UK have seen a reduction in capital budgets – in

Scotland, for example, revenue spending increased by 8.6% between 2008/09 and 2015/16. But over the same period capital spending fell by almost 65%, according to Audit Scotland. Even so, NHS Scotland's capital budget more than doubled to around £500m in 2016/17, mostly to fund four new facilities.

With growing calls for increased capital funding in England, chancellor Philip Hammond relaxed his grip, albeit in a small way. In the March Budget, he announced £325m over three years for STPs sufficiently advanced in planning, and promised further sums for all STPs would be allocated in his autumn Budget. He also allocated £100m to allow hospitals to build facilities to extend the use of GP triage in emergency departments.

Golden opportunity

It seems unlikely that all of STPs' capital requirements will be funded directly by the Exchequer. Certainly, this is a view taken by NHS Improvement chief executive Jim Mackey, who has held discussions with private financiers. He told *Healthcare Finance* that even though public finances are tight, historically low interest rates offer the NHS a golden opportunity to access the capital it needs.

NHS Improvement believes an increase in the capital available to the NHS could secure better A&E performance by building extra hospital capacity and modernising facilities, and technological innovations could be scaled up to increase efficiency and productivity. Overall, an injection of capital could provide greater stability for NHS finances, it adds.

Mr Mackey says radical new ways of raising funds for STP capital plans is needed. 'We have to be realistic because we aren't going to get a £10bn cheque to pay for all the transformation under way and the massive maintenance backlog, so we need to think long and hard about another way of doing things,' he says.

'Historically low interest rates are a golden opportunity for the NHS but we are constrained by rigid rules around borrowing that prevent us from taking action. An NHS Fund could power the improvement needed to sort out problems at our hospitals and to drive the change required to get the NHS ready for future challenges. If we are open to new ideas then we could really be in business.'

NHS Improvement also wants NHS bodies and local authorities to work together to secure investment that stays off the NHS balance sheet.

Healthcare Finance spoke to one trust in advanced talks with its local authority over a loan for a retail development that would benefit patients and visitors and aid recruitment and retention. But it was halted by NHS Improvement over concerns that the liability would end up on the public sector balance sheet. The trust is nonplussed – the deal would have delivered a higher rate of return than a privately financed alternative – but is exploring other avenues.

CIPFA and the HFMA are working to bring local authorities and health organisations together. Jane Payling, CIPFA's head of health and integration, says clear themes emerged from a recent roundtable, chaired by CIPFA director of local government and policing Sean Nolan and attended by county and district councils, NHS provider bodies, NHS Improvement, the Department of Health and the HFMA.

'The key message was that, whatever we do, if it results in an asset that's on the NHS balance sheet then we are not solving the problem,' she says. 'Capital is constrained at a national level in the NHS, and creation of any further NHS assets, however funded, is likely to count against the CDEL [capital departmental expenditure limit].'

"The message was that, whatever we do, if it results in an asset that's on the NHS balance sheet then we are not solving the problem"
Jane Payling, CIPFA

Some councils have reserves potentially available for investment, and all have the ability to borrow within the guidelines of CIPFA's prudential code. Local authority capital could be invested in the NHS for tactical reasons – for example, rates of return may be better than the amounts available on the markets – or to meet strategic goals such as improving services for older people. A scheme to help the local NHS could be a vote winner, it could generate a commercial return, or council services such as social care could benefit from co-location with NHS services.

There are opportunities for local authorities and the NHS to work together, she insists, but those putting together the projects must be careful about where an asset sits.

Joint ventures between councils and the NHS – potentially with private funding – could sit on the local government or joint venture balance sheet rather than in the NHS. Such an approach might work for an intermediate care facility, which would allow trusts to discharge patients medically fit to leave hospital but who do not have the family support or care availability they need to live at home.

The NHS and local authorities could work together to identify land for joint use or to sell off housing, for example – particularly when they can bundle packages of land together to provide more attractive sites for developers. The value of this land could be much higher with planning permissions in place, a system governed largely by local authorities.

The planning system, with its potential for contributions from developers through section 106 agreements and the community infrastructure levy (CIL), could also offer the NHS an alternative source of capital. *Healthcare Finance* knows of at least one trust that has explored the potential of CIL with its local authorities.

There are opportunities to be brought about by closer working on capital between the NHS and local authorities; and where working relations are strong and incentives are shared there is potential for successful ventures, Ms Payling says.

Local authorities, on the other hand, have a wide range of competing calls on their cash, Mr Nolan adds. So, any projects must first meet the council's commercial or policy agenda. Once this is met, a combination of good relationships and local political backing will be required to navigate obstacles such as the constraints of the NHS CDEL, he says.

Property review

The sale of surplus NHS estate and its potential to raise large amounts of capital, are central elements of the recent review of property and estates by Department of Health property adviser Sir Robert Naylor.

The review says the NHS needed capital. Provider trusts are on 1,200 sites and cover 6,500 hectares, but despite significant hospital building programmes over the past 15 years, 18% of the provider estate predates the formation of the NHS and 43% is more than 30 years old. While the report acknowledges that refurbishment programmes mean this is not always a problem, it insists too much of the NHS still has inadequate facilities – as the maintenance backlog proves. This was put at £5bn in 2015/16, but the report believes this to be an underestimate as there is no incentive for trusts to report their situation accurately.

Sir Robert does not see an argument for reducing hospital bed numbers, except where NHS England reconfiguration criteria are met. Indeed, even if new models of care are successful, demand fed by the growing and ageing population will mean current bed numbers will have to be more or less maintained, he says.

However, his report argues that the acute sector can make efficiencies without reducing bed numbers. Over time, it has treated more patients

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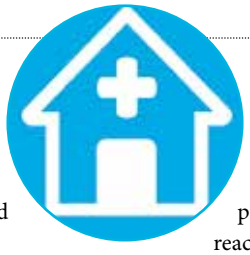

with fewer beds, though at the same time the size of its estate has grown – so there must be surplus estate. External analysis of the acute estate and research by the Naylor team on non-acute property identified potential gross risk-adjusted capital receipts of £2.7bn from disposing of inefficiently used land and property – more with planning permission. This includes £1.8bn from the acute sector. Though service reconfiguration was needed to maximise value, the disposals could lead to revenue savings of £0.5bn a year.

Chris Hopson, the chief executive of NHS Providers, believes the targets for trusts to raise money from the sale of assets for reinvestment and to deliver land for new homes are stretching. 'Trust leaders recognise their important responsibilities in this area but, as the report points out, trusts currently lack the leadership bandwidth and expertise to deliver this target. We will want to consider, with members, whether these targets are realistic and deliverable given the constraints,' he adds.

In 2015/16 and 2016/17, there have been significant capital to revenue transfers and the Naylor report says the NHS will face significant challenges in maintaining patient care and delivering the *Five-year forward view* if the transfers continue. It estimates the need for significant capital investment of about £10bn, funded through property sales, private capital for primary care developments and exchequer funds. Primary care capital grant funding is small and will not be sufficient to deliver the forward view vision of more out-of-hospital care.

BMA council chair Mark Porter says the £10bn capital requirement is even higher than the figure in its analysis earlier this year. 'The NHS simply doesn't have this kind of money available and these plans are fast becoming unworkable. The figures are especially concerning given that everyone can see that the NHS is at breaking point. We urgently need an honest look at the pressures facing the NHS and how to give the investment needed to match the promises made.'

While the disposal of surplus estate could recover £2.7bn, the Naylor report says business cases will have to take a long-term view – in most cases, more than a decade – as the time period over which the receipts from sales can be realised will be longer than the current spending review period. Sir Robert insists providers must be given incentives if these figures are to be reached. Providers have tended to hold onto land until they need funds to build facilities – encouraged by the rapid property price rises.

The report says that, at a minimum, the Department should allow STPs to keep receipts from the sale of locally owned assets, provided the disposal is in agreement with the STP plan. But it adds that the Treasury should offer incentives to dispose of land through a '2 for 1' offer, with public funds matching sales receipts, given in addition to those receipts. This should be offered, initially for a five-year period, on a first come, first served basis, to encourage STPs and providers to act quickly.

The allocation of other national capital funds should take the '2 for 1' incentive into account so STPs with lower potential sales values are not disadvantaged.

Sir Robert considers incentivising disposal of surplus land by increasing capital charges from the current 3.5%, introducing higher charges for surplus land, or having different charges for land and buildings. While he believes these would have positive effects, alone they would not sufficiently influence behaviour to meet the forward view's ambitions. Land should be prioritised for residential homes for NHS staff, where needed, either in partnership with housing associations or through a national NHS housing association. Urgent action should be taken to deliver a large number of small-scale and low-risk housing developments, the report adds.

The report produced 17 recommendations (see box), including the creation of a national property board to improve capability and capacity in estates and support action at a local level.

Overall, it suggests all national bodies should work together to produce a capital investment plan by this summer, which maximises value for money and makes a strong case for securing public and private funding. With STPs also developing their estates plans, capital funding – and where it can be sourced – will be a key issue for the NHS.

Estates expertise

Eight of the Naylor recommendations relate to establishing a new arm's length NHS Property Board, bringing together some of the functions of NHS Property Services (NHS PS) and Community Health Partnerships (CHP).

While both invest in new properties, NHS PS provides estates management and facilities support for properties inherited from primary care trusts and strategic health authorities. CHP oversees the 49 LIFT companies – joint ventures with private partners to develop integrated health and social care centres.

Naylor recommends the new organisation be set up immediately in shadow form, substantively from April 2018. The new NHS Property Board should consider divesting back to providers the functions and residual assets given to NHS PS following the abolition of PCTs and SHAs.

With many primary care surgeries not set up for the expansion of services envisaged by the *Five-year forward view*, the report suggests GPs should be incentivised to move to more appropriate premises by linking reimbursements for estates to the quality of facilities.

A financing facility – possibly funded from sales receipts – could lend up-front development costs where no other sources of finance could be secured.

The new property board should support STPs to develop affordable estates and infrastructure plans, to deliver the forward view and address backlog maintenance.

Benchmarks developed for the review should be used to assess these STP estates plans and access to capital – through grants, private finance or loans – should be denied if plans do not meet quality standards. Plans should align with clinical strategies, provide value for money and include land disposals.

In a joint statement to *Healthcare Finance*, NHS PS chief executive Elaine Hewitt and CHP chief executive Sue O'Connell backed the creation of a national property organisation. They are already working to support STPs.

'Our collective expertise and success in reducing costs and developing new facilities for healthcare will form a strong foundation for the new organisation. Our work releasing surplus land is not only generating valuable cash for the NHS, it is also supporting government housing targets,' they say.

NHS Property Services says it has generated nearly £200m for reinvestment in the NHS through sales of surplus assets since 2014/15 and invested £60m in capital developments in 2016/17. More than 3,000 new homes have been built since 2014/15 through the release of surplus land.

Integrated thinking and reporting

As Welsh public bodies publish their first wellbeing objectives, can integrated reporting help embed sustainable development principles for Wales and the UK, asks Lisa Robertson

There is widespread recognition that the NHS is not sustainable in its current configuration. The population is expected to increase to 74 million by 2039 with nearly one in eight of us predicted to be 75 or over and one in 12 aged 80 or older.

With increased life expectancy, the health system increasingly needs to support more people living with illness. The challenges faced by the NHS cannot be addressed in isolation with clear interconnections between services such as health, housing, social care and education. If we are going to target holistic improvements, we need to think in whole systems. It is clear we all need to be doing this, yet how do we move this ideal forward?

We are already seeing signs of looking beyond working as an isolated NHS and engaging with all contributors. Emerging examples include health and wellbeing boards and sustainable transformation footprint areas in England, fully integrated health and social care in Northern Ireland and Scotland's integrated joint boards and community planning partnerships. Yet, arguably Wales is further down the line in thinking this through, with the *Well-being of Future Generations Act (Wales) 2015* challenging all public bodies to individually and collectively work towards a legally-binding common purpose.

Wales does not come at this initiative from a standing start. Value-based healthcare – considering outcomes relative to costs – is being pursued in some areas and provides a good mechanism for thinking through and setting objectives, particularly in terms of outcomes, to meet the requirements of the act.

Guidance on the act also suggests that integrated reporting – an approach pioneered in the commercial sector and being explored by the Welsh government – could offer a way of reporting on progress. This proposal has prompted the HFMA to take a closer look at the reporting tool with the aim of publishing a briefing towards the summer.

Wellbeing act

The Welsh act aims to improve social, economic, environmental and cultural wellbeing in Wales. The challenges faced by Wales now and in the future are not unique. However, Wales is different in using explicit legislation as a framework to address them.

The act recognises that no one body can address these challenges alone. Its intention is to make public bodies think about the long term, work better together and look to prevent problems.

According to Sophie Howe, the future generations commissioner for Wales, the act provides 'the encouragement, the permission and statutory obligation to make these changes'. It establishes seven wellbeing goals to create a shared vision (see figure 1). Public bodies are then required by a statutory duty to set wellbeing objectives to maximise the contribution to these goals. In taking reasonable steps to meet these objectives, they must also apply the sustainable development principle in what they do.

In the context of the act, sustainable development is about ensuring the needs of the present are met without compromising the ability of future generations to meet their own needs. More specifically it means:

- Looking to the long term so that we do not compromise the ability of future generations to meet their own needs
- Taking an integrated approach so that public bodies look at all the wellbeing goals in deciding on their wellbeing objectives
- Involving a diversity of the population in the decisions that affect them
- Working with others in a collaborative way to find shared sustainable solutions
- Understanding the root causes of issues to prevent them from occurring
- Public bodies had to produce wellbeing objectives by the end of March and will need to review progress annually. Public service boards (PSB), created by the act and made up of a range of specified public bodies, are also required to undertake a wellbeing assessment by this May, with a further year to produce a wellbeing plan.

Rather than creating additional requirements,

Figure 1: Overview of the approach SOURCE: SHARED PURPOSE, SHARED FUTURE

the act aims to provide a different context within which priorities can be reviewed and rethought. Early signs are that public bodies have reviewed their existing strategies through the lens of the act and produced wellbeing objectives, agreed by their boards.

Organisations will need mechanisms to assess, achieve and report against their objectives. Future planning processes will also need to be aligned with the act. This will apply to a number of processes including budget planning, communication and engagement, risk management, data gathering and monitoring, decision-making and reporting.

There are major links between this wellbeing agenda and value-based healthcare. Value-based healthcare aims to look at outcomes in the round, focusing on the outcomes that matter to patients rather than activity-based outputs.

It pushes organisations to look across the whole care cycle – considering the impacts of changes in secondary care on community services, for example. And it also overtly takes account of the costs of providing services. It is an evidence and data-driven approach and offers a robust way of establishing objectives to meet the wellbeing goals.

In Wales, a strategic alliance with the International Consortium on Health Outcome Measurement (ICHOM) is looking to establish an agreed set of standard outcome sets for several conditions, potentially providing a foundation for wellbeing objective setting.

Once objectives have been set based on delivery of the right outcomes that maximise the contribution to the wellbeing goals, public bodies are required to report annually on progress. Guidance on the act – *Shared purpose, shared future* – suggests integrated reporting could help organisations discharge this communication duty.

Integrated reporting

Integrated reporting or IR has been developed primarily in the commercial sector and is now being explored by the Welsh government. NHS bodies already report annually on performance. Integrated reporting would push them to report on how they manage their resources and relationships (referred to as 'capitals') to create value over the short, medium and long term.

There is an explicit recognition that not all aspects of the value of an organisation can be accounted for in financial statements. In taking this holistic view, it fits well with the aims of the act and value-based healthcare.

A published IR framework defines the 'capitals' that should be considered as: financial; manufactured (which might be translated as 'infrastructure' in the public sector); intellectual; human; social and relationship; and natural – although only those that are material should be included in an integrated report (see figure 2 overleaf).

Accountancy body CIPFA and the International Integrated Reporting Council have published a guide to how integrated reporting might work in the public sector. It suggests an integrated report should use 'quantitative and qualitative information to look at how the activities and capabilities of an organisation transform the relevant capitals

into outcomes for the organisation and others'.

IR is not intended to be just another reporting initiative. Many organisations will already have existing information and processes in place, but IR could help focus on what matters most.

CIPFA's guide suggests it could be 'an umbrella that can encompass other standards and frameworks to help provide a more complete and coherent picture of value creation by an organisation'.

Early experiences suggest that the following steps are needed in making a move to IR:

- Identify/communicate the potential of IR
- Identify stakeholders, understand their needs and engage with them over what you are trying to achieve
- Get senior-level commitment to the approach
- Identify champions from across the organisation
- Involve all parts of the organisation in simply defining and understanding the strategy
- Understand and manage the risks
- Identify relevant capital and inputs/outputs
- Identify what information is required, how it can be measured and what you already have
- Set a realistic timetable and clarity over inputs, resources and outputs
- Allow time to reflect on year one of IR

The HFMA's briefing will be looking at the practical insights from those already using the approach. Early signs are that those using IR have seen benefits internally and externally, yet the approach requires time to evolve and improve for each organisation.

IR has the potential to support organisations as they pull together the number of jigsaw pieces across complex organisations and systems. It offers an opportunity for public bodes to demonstrate how they are creating long term stability, restore trust and demonstrate different sources of value spanning borders, cultures and generations. As such its potential application reaches well beyond the Welsh borders.

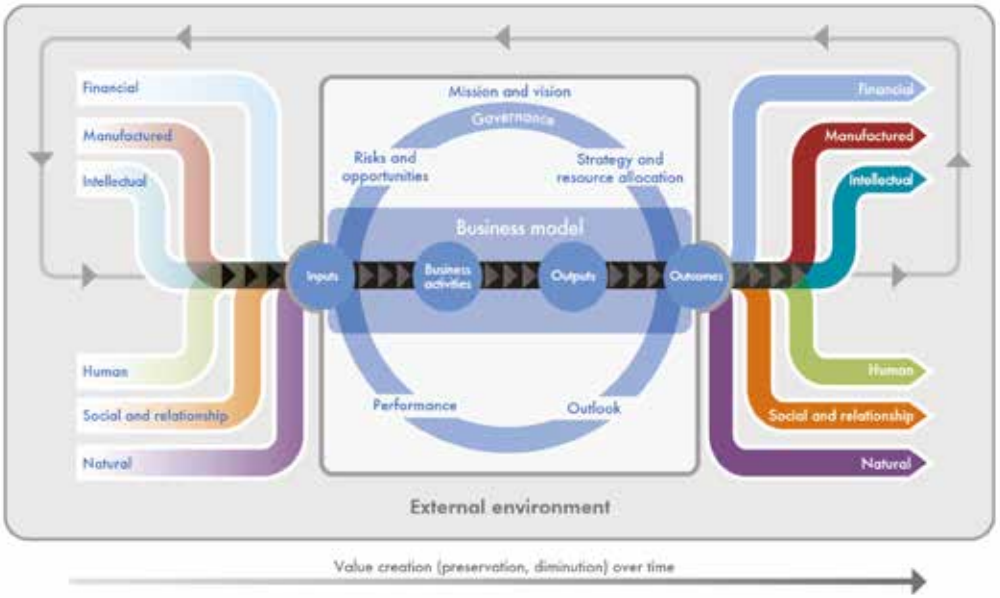

Figure 2: The value creation process

SOURCE: IR FRAMEWORK

Lisa Robertson is a research manager at the HFMA

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Events, people and support for finance practitioners

Accounting guidance brings first year of STF to a complex close

Technical update

The 2016/17 year is relatively quiet in accounting terms – there are no big changes to accounting standards or public sector reporting requirements, *writes Debbie Paterson*.

At the HFMA's pre-accounts planning conference, the one issue that was flagged as a potential difficulty was accounting for the sustainability and transformation fund (STF).

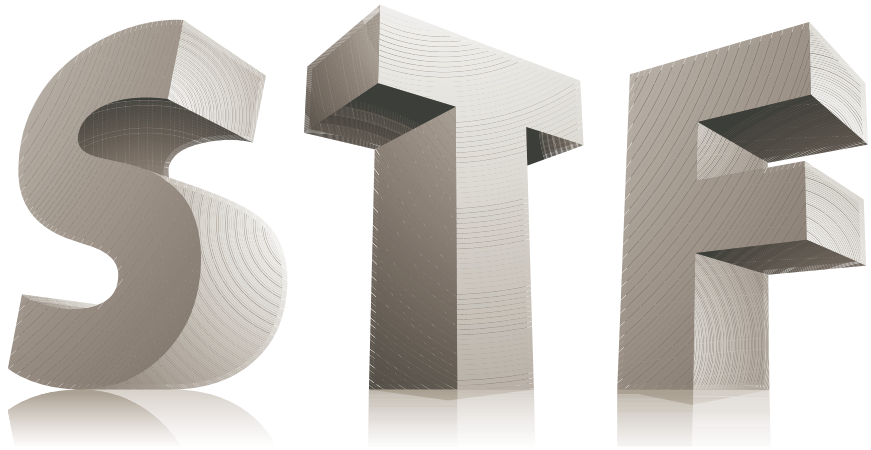
This certainly appears to be an accurate forecast, if the timing of the guidance is anything to go by. The final guidance on accounting for Q4 STF payments was issued on the Department of Health's website on 3 April, although we understand that NHS provider bodies received the guidance slightly ahead of the year-end.

Then on 18 April, additional guidance was issued to set out how to manage the circular impact the STF receivable was having on public dividend capital dividend calculations.

In July 2016, every provider body was informed of their allocation from the STF. Receiving this allocation – paid in quarterly instalments – was conditional on meeting set conditions. Some 70% of the fund was paid for achieving financial control totals with the remaining 30% additionally requiring organisations to meet agreed performance trajectories.

Some of the STF was unallocated from the outset – with some providers not agreeing control totals; some was not earned as the conditions were not met. At Q3, some £424m of the total £1.8bn was being held centrally.

However, the policy aim has been to make the full fund available to providers to offset deficits and not to hold as a central contingency. And so the STF central balance (or at least the 70% linked to control totals) is being made available to providers via a finance incentive scheme and a bonus scheme.



The incentive fund is available to all bodies that have achieved their control total on a pound for pound basis. A provider with a control total deficit of £100m that achieved a deficit of £90m would receive an additional £10m incentive payment and would therefore report a final deficit of £80m.

The bonus element is to be shared among providers that achieve their control total, but with a weighting towards those who committed to the improvement earlier in the year.

The calculations of the allocations from the various parts of the fund have been made centrally by NHS Improvement. These calculations were made all the more complicated by the fact that no-one could know the size of the unallocated and unearned pot until Q4 performance was reported in a near final form.

NHS bodies are well used to including information produced by a third party in their accounts. HFMA members often report that this is fine, as long as they receive that information on a timely basis. In the case of the STF, this could never happen.

To allow them to calculate provider bodies' share of the STF, NHS Improvement requested a 'pre-submission' data collection. It then had two working days (and a weekend) to make the calculations and provide the necessary information back to providers to allow them another two working days to complete their draft accounts ready for submission.

As NHS Improvement has pledged to allocate the whole £1.8bn of the STF to provider bodies in 2016/17, the actual final allocations won't be known until the accounts are audited and finalised. Any audit adjustments that adversely affect performance against control total could result in bodies losing STF.

It is not clear whether any audit adjustments that improve performance against control totals will result in additional funding. Given that the STF 'pot' is fixed, any late adjustments must have an equal and opposite affect elsewhere.

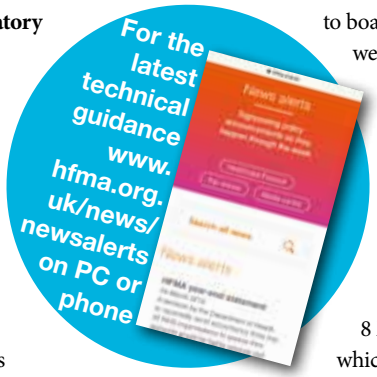
One test of whether NHS Improvement's plans work will be if the income recorded as STF funding in 'other operating income' of provider bodies matches the expenditure recorded by NHS England against its central code. If there is a mismatch, then questions will no doubt be asked and adjustments will have to be made.

Technical review

The past month's key technical developments

Technical roundup

Changes are needed to the way **ambulatory emergency care** is recorded to support payment approaches that incentivise treatment options that do not require patients to be admitted to hospital and stay overnight. This was one of the key conclusions of a survey by the HFMA's National Payment Systems Group. A best practice tariff is currently in place to incentivise ambulatory care for a number of specified clinical scenarios. However, the survey revealed a range of different ways for recording these contacts – including non-elective emergency admissions and outpatient appointments – with national and local price payment mechanisms in place. Respondents suggested a third category of patient care – other than admitted or outpatient – was needed. They also called for greater clarity over recording and collecting data.



The Northern Ireland Department of Health has published healthcare resource group (HRG) **cost schedules for 2015/16**. The schedules cover acute hospital activity covering elective, non-elective long stay, non-elective short stay and day cases, while also listing excess bed days. They give information on activity and average cost information, alongside minimum and maximum spend across all health and social care trusts.

NHS Improvement made changes to its **Model Hospital** information portal during April. New compartments have been added for pathology and doctor productivity, while data has been refreshed in four other compartments: pharmacy; nursing and midwifery; allied health professionals; and visitor cost recovery. A number of clinical services compartments – helping to align with the *Getting it right first time* programme – have also been populated with a standard set of productivity and efficiency metrics. In addition, the oversight body has been adding key performance metrics from the single oversight framework to board-level oversight compartments. These compartments were set to go live at the end of April.

The HFMA is currently planning its **policy, research and technical work** for 2017/18. Each year, it aims to produce a range of outputs, from those that have a very technical focus to those that are more strategic and position the HFMA as a thought leader. To help it prioritise activities, members have been asked to complete a survey (deadline Monday 8 May). The survey contains a list of potential topics, which would be in addition to regular outputs such as the introductory guides series, the suite of e-learning modules, work on costing and value and responding to consultation papers. The final work programme will be published in July.

The HFMA Healthcare Costing for Value Institute has published *Patient-level information and costing system toolkit for mental health services*. Adding to the previously published acute services version, the **new toolkit**, which includes a briefing and Powerpoint presentation, aims to support costing and finance practitioners and others in selling the benefits of PLICS to boards, clinicians and other staff. It also supports organisations in turning the data generated by PLICS into useful information to support decision making. A 'top tips' section sets out lessons from organisations that have successfully developed PLICS reports and rolled them out across their organisations. The kit includes a series of charts that can be used to demonstrate the power of the data. These are based on examples provided by mental health trusts and focus on both individual service users and teams/localities. The toolkit is freely available to institute members. Non-members can see a summary of the contents on the HFMA website.

New multiple sclerosis treatment

NICE update

New technology appraisal guidance from NICE (TA441) recommends daclizumab as an option for treating relapsing forms of multiple sclerosis in certain cases. The recommendation covers people with active relapsing-remitting multiple sclerosis previously treated with disease-modifying therapy and those with rapidly evolving severe relapsing-remitting multiple sclerosis for whom alemtuzumab is contra-indicated or otherwise unsuitable.

Multiple sclerosis is a chronic, disabling neurological disease. It occurs when the body's immune system destroys myelin, a protective sheath around nerve cells in the brain and spinal cord. Around 86,200 adults are estimated to have multiple sclerosis in England.

NICE has previously recommended several treatments for multiple sclerosis including natalizumab, fingolimod, teriflunomide, alemztuzumab and dimethyl fumarate.

In relapsing remitting multiple sclerosis, people have distinct attacks of symptoms, which then fade away either partially or completely.

It is estimated that 3,700 people would be eligible for treatment with daclizumab as set out in the recommendations. By 2021/22 some 1,100 people are expected to be following this treatment option.

Commissioners indicate that people with previously treated active relapsing–remitting multiple sclerosis are currently likely to receive fingolimod or alemtuzumab and people with rapidly evolving severe relapsing–remitting multiple sclerosis currently receive natalizumab.

These assumptions have been included in the resource impact calculations.

The Department of Health and Biogen Idec

Diary

May

11 (F) Commissioning Finance: continuing healthcare forum, London
11 (B) South Central and South West: developing talent conference, Bristol
17 (F) Chair, Non-Executive Director and Lay Member: forum, London
18 (N) Procurement forum, London, followed by …
18 (F) Provider Finance: directors' forum, London
19 (F) Mental Health Finance: directors' forum
23 (B) London: VAT, Rochester Row, London

June

12 (B) London: annual conference, London
13 (B) Kent Surrey and Sussex: prestige event, Lingfield
19 (B) East Midlands: team building event, Loughborough
22 (B) West Midlands: annual conference, Wolverhampton
22 (B) Kent Surrey and Sussex: maximise your impact/boost your team's resilience, Crawley
29-30 (B) North West: annual conference, Blackpool

July

5-6 (N) Annual Commissioning Finance conference, London
6 (I) Value masterclass, part of …
6 (N) Convergence conference, London
6-7 (N) Annual Provider Finance conference, London
12 (B) London: positive psychology to improve wellbeing and resilience, Rochester Row
20 (B) Yorkshire and Humber: annual quiz, Yorkshire Sculpture Park

September

11 (B) Eastern: student conference, Cambridge
14-15 (B) South Central: annual finance event, Reading
19 (F) Provider Finance: forum, London
20 (N) CEO forum, London
21 (N) CIPFA/HFMA health and social care conference, London
21-22 (B) Wales: annual conference, Hensol
28-29 (B) South West: annual conference, Bristol

October

11 (F) Chair, Non-Executive Director and Lay Member: forum, Central Manchester
19 (F) Provider Finance: directors' forum

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

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

have agreed that daclizumab will be available to the NHS with a patient access scheme that makes it available with a discount. The size of the discount is commercial in confidence.

There may be savings resulting from reduced administration costs associated with daclizumab compared with natalizumab, which needs infusion inpatient visits.

This technology is commissioned by NHS England. providers are NHS hospital trusts.

A resource impact template is available at www.nice.org.uk to help organisations plan for implementation of the guidance.

Nicola Bodey, senior business analyst, NICE

Events in focus

Provider Finance Faculty procurement forum
18 May, London

Lord Carter's review of productivity in the NHS suggested that providers could save £700m from better procurement. The procurement forum is an opportunity to understand how improvement is being driven nationally and how local providers are progressing in turning potential savings into real improvements.

Programme director for NHS procurement transformation at the Department of Health Howard Blackith, and NHS Improvement's new director of procurement and corporate services, Paul West, will provide an update on central policy including a new future operating model and national procurement forum.

A series of workshops will highlight how improvements are being driven in local organisations such as Guy's and St Thomas', Cambridge University Hospitals and Scan4Safety demonstrator site Derby Hospitals, where Arthur Stephens, consultant orthopaedic surgeon, will share details of the organisation's theatre-kitting programme.

Other sessions will include opportunities to discuss use of the Model Hospital and spend analytics plus procurement law considerations for NHS organisations working together collaboratively.

- For details contact clare.macleod@hfma.org.uk

Convergence: HFMA annual commissioning finance conference 5-6 July HFMA annual provider finance conference 6-7 July, Novotel London West

To reflect moves towards integration and closer partnerships across the health service, the 13th annual HFMA provider and commissioner conferences will overlap on Thursday 6 July with the aim of facilitating networking and shared learning.

A range of plenary and interactive sub-plenary sessions will address key finance issues for providers and commissioners, including: collaborative working; multi-agency governance and contracting issues; new models of care; the development of accountable care organisations; and learning from the Virginia Mason programme.

Confirmed speakers include: Bob Alexander (pictured), NHS Improvement deputy chief executive and executive director of resources; Steve Wilson, executive lead (finance and investment), Greater Manchester Health and Social Care Partnership; Caroline Clarke, chief finance officer and deputy chief executive of Royal Free London NHS Foundation Trust; and Ben Collins, project director at the King's Fund.

- To book your place at the commissioning conferences, visit hfma.to/converge or email emily.bowers@hfma.org.uk

Showing the way

Association view from Mark Knight, HFMA chief executive

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

SHUTTERSTOCK

My HFMA

The HFMA board met at the end of last month. For this meeting it was the turn of the president's own facility at Poole to host us. We had a short tour round the hospital and reflected on the challenges faced by a trust of that size and local context. NHS staff are brilliant, dedicated people and that shone through at Poole.

The agenda was dominated by the current pressures HFMA is facing as we continue providing our usual services while looking to bed in new ones. We're very pleased that our first group of students will commence studying for the HFMA qualification programme in May. The books are now open for September applications and we have a few in already.

There are significant opportunities arising from the qualification, not least that the current e-learning could provide the basis for new NVQ level 3 and 4 programmes. The significance of that is organisations may be able to access the apprenticeship levy to support them. This development is at a very early stage so look out for more in the coming months and years.

There was quite a lot of discussion at the board about the continuing high level of support for all of our programmes from the service – including the time given up by individuals. However, there were concerns about how long the NHS could invest in what we do. I'm grateful for all your support in whatever way you give it because I know there are many tough decisions being made at this time. We have seen a small contraction in what we do, which, together with our investments in the qualification, have led to a tightening financial picture in the run-up to our own financial year-end in June.

The board agreed a new strategy around personal awards. This starts with the key contributor awards, which are awarded to individuals who are core to the operation of a branch or committee. Now we will award 'bronze' for a first key contributor. Five years later, we can award a silver and finally a gold. Following that, we can award an honorary fellowship, helping us to create a clear ladder recognising the hard work and effort of all those involved. Other awards will be announced later in the year.

HFMA chief executive Mark Knight

The board also approved the association's next step in tendering for our new app and we discussed our media and communications policy. Over the last three years, we have sought to provide comment in a wide range of journals and on the radio and television. And here, I must pay tribute to my colleague and policy director Paul Briddock, who has worked tirelessly to put across our message. After discussing with members, we have now agreed to refocus our communications approach much more on telling you about our developments first before broadcasting to the wider world.

And finally, we talked extensively about our new strategy that we want to share with you in full next month. Just like the NHS, the HFMA is working with tightening budgets and cash constraints, and inspired by you we aim to continue to develop our services so that you, our members, are front and centre of our thinking. In the next edition of *Healthcare Finance* I will be sharing more about our plans for the next three years. Please be a big part of them – we need every one of you.

Member news

Bob Baker (far left), long-time member of the Kent, Surrey and Sussex Branch committee, is helping raise £5,000 for the Motor Neurone Disease Association and Alzheimer's Society. He is part of a team that will play 80 holes of golf in five countries in less than 40 hours, starting in England at 6am on 25 June and ending in Germany the following day. To donate go to http://uk.virginmoneygiving.com/team/IcklesshamCasualsFootballClub

There have been several changes to administrative contacts for the HFMA:

- **Emily Bowers** (emily.bowers@hfma.org.uk), who takes over the Mental Health Finance Faculty while Lay Hine is on maternity leave
- **Jonathan Richards** (jonathan.richards@hfma.org.uk), who was previously working with the Healthcare Costing For Value Institute, is now leading on the Commissioning Finance Faculty.
- **Clare MacLeod** (clare.macleod@hfma.org.uk) will be managing the Provider Finance Faculty. She was West Midlands finance skills development co-ordinator
- In addition, **Grace Lovelady** has been promoted to lead on key projects such as HFMA roundtables, surveys and site visits. Please email grace.lovelady@hfma.org.uk if you are interested in a topic or want to get involved.

This month new members can join the HFMA for just £1 to have a 60-day trial of full membership. Find out more on our website and tell friends so they can receive benefits such as *Healthcare Finance*, weekly news alerts, briefings and webinars.

hfma

Member benefits

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

Network focus

My HFMA

Mental Health Finance Faculty

While accountable care systems (ACSs) could receive funding for the *GP forward view,* mental health and cancer services, practitioners will ask whether this will help the NHS achieve its objective of delivering parity of esteem in mental health.

'I'd hope that ACSs, if they're set up correctly, will be able to acknowledge the link between good mental health and physical health and develop services accordingly,' says Paul Stefanoski (pictured), chair of the HFMA Mental Health Finance Faculty and director of finance and business at West London Mental Health NHS Trust. 'I always worry, however, that setting up new systems requires time and investment, when many health economies are struggling to cope with current demands,' he adds.

Mr Stefanoski believes there is a danger if specialist mental health provision is less visible in an ACS, funding could continue to go predominantly to acute services. 'Despite the welcome increased media focus in recent years, mental health still has an issue with getting its voice heard when competing for scarce resource,' he says.

To support mental health finance professionals' argument to get more funding, the Mental Health Finance Faculty regularly hosts events that focus on topics that have impact on the whole healthcare system. 'This is a way to face the fact that unless you can make the case for the wider system benefits, it's going to be more difficult to secure investment for mental health,' he says.

The faculty is also involved in the second Carter review that will help develop a model mental health hospital. It will extract early learning from the analysis to share with network members. 'We're keen to ensure that the experiences in the acute sector are replicated in mental health,' says Mr Stefanoski.

Implementing the Carter recommendations in mental health is one topic that will be discussed at the faculty's directors' forum on 19 May. In November, it will host the annual mental health conference, which is open for bookings.

'Through the HFMA, the value of discussing the issues you are facing in your organisation with colleagues from across the country is enormous. Sometimes this gives you strength and confidence to hold your line at a local level,' he adds.

- To find out more, visit the HFMA website or contact Emily Bowers at emily.bowers@hfma.org.uk

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Yorkshire and Humber laura.hill@hdft.nhs.uk

Appointments

Ian Woodall is now director of finance at Birmingham Community Healthcare NHS Foundation Trust. Mr Woodall is reporting to Peter Axon, who remains chief finance officer and deputy chief executive. Mr Woodall was previously chief finance officer at Solihull Clinical Commissioning Group, which has appointed its head of finance **Dan Gilks** (pictured) as its acting chief finance officer.

Jonny Gamble has been named deputy director of finance at Kettering General Hospital NHS Foundation Trust. He is joining from University Hospitals Coventry and Warwickshire NHS Trust, where he is head of financial management and financial planning. Mr Gamble sits on the HFMA West Midlands Branch committee and is also a Future-Focused Finance value maker.

Jonathan Rowell (pictured) is acting chief finance officer at Cambridge University Hospitals NHS Foundation Trust, taking over from interim CFO Bill Boa. Mr Rowell has been at the trust since May 2013, working as deputy chief finance officer. He has spent his entire career in the NHS, having started as a graduate trainee in the East of England in 1998.

Essex Partnership University NHS Foundation Trust has appointed **Mark Madden** executive chief finance officer. The organisation formed after a merger between North Essex Partnership University NHS Foundation Trust and South Essex NHS Foundation Trust. Mr Madden has worked in a variety of NHS and non-NHS financial roles, latterly in the role of director of finance at South Essex NHS Foundation Trust.

Sandra Betney is now deputy chief executive and director of finance at Gloucester Care Services NHS Trust. She was previously executive director of resources at Birmingham and Solihull Mental Health NHS Foundation Trust and has 24 years' experience working in the NHS. Ms Betney succeeds Glyn Howells.

Rotherham, Doncaster and South Humber NHS Foundation Trust has appointed **Steve Hackett** (pictured) as its new director of finance. Previously, he was director of finance and contracting at Chesterfield Royal Hospital NHS Foundation Trust.

His NHS career started in 1990 and included work for NHS England and primary care trusts. Mr Hackett, who is due to join the trust this month, succeeds Paul Wilkin who retired at the end of March.

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

"Salisbury staff go the extra mile and I am proud to be part of a board that has encouraged a focus on the most important thing – patients"
Malcolm Cassells

Long-server steps down

On the move

For a relatively small trust, Salisbury NHS Foundation Trust punches above its weight . It has wide commercial interests; it is well advanced on efficient procurement measures and the implementation of barcode technology; and it is one of the original Carter trusts. And it has possibly the longest serving director of finance – Malcolm Cassells, who is to retire in August.

Mr Cassells has been at Salisbury for more than 30 years, broken only by a six-month secondment to help set up the Central Police Training and Development Authority.

He joined initially as finance director of the Salisbury Health Authority in 1986 – at age 31, he was one of, if not the, youngest finance directors in the country at the time. Following the introduction of the internal market in the early 1990s, he moved into the new provider trust, which gained foundation status in 2006.

'I've not been at the same organisation all this time, but the location has been really good – my family is well settled, which does affect your career aspirations. But over 20 years ago I was seriously ill on two occasions and the support and care I was given was amazing, and that made me even more committed to this organisation.'

Though he jokes that he should have moved on 27 years ago for the sake of his career, he is clearly proud of his achievements at the trust.

'The thing I am most pleased about is how we, as a trust, care well for patients. Staff go the extra mile and I am proud to be part of a board that has encouraged a focus on the most important thing – patients.'

He is also proud of the work to rationalise the trust from three acute sites to one, although there is some regret over the disaggregation of what was an integrated trust.

'In 2001 we went through a seven-way disaggregation to make us just an acute trust. We previously ran mental health services – which I think should be in a specialised organisation – but we also ran community services and hospitals. That probably gave us more control and allowed us to move patients into alternative accommodation where appropriate. I regret we lost that.'

Mr Cassells welcomes innovation. He established the trust's commercial developments, setting up what was the first NHS-owned company in England, Odstock Medical.

Other companies followed and the trust now sells services such as laundry and payroll to other trusts. It also launched the My Trusty skincare range, which is now on the shelves of supermarkets such as Tesco and Superdrug.

The trust is involved in a range of Carter workstreams and is one of the leaders for nursing and procurement. It is one of six Scan4Safety pilots appointed by the Department of Health, implementing GS1 barcodes to map the patient journey.

'Carter has made every trust look in detail at how they are spending their money, what value they are getting and the potential to do things better,' says Mr Cassells.

Carter's value lies in these principles, he adds. 'I think the savings targets in the Carter reports are probably optimistic and were driven politically by the need to identify as much as possible to bridge the £30bn gap. However, Carter will add enormous value, especially through the Model Hospital, provided the numbers are not taken as absolutes.'

Lisa Thomas, currently deputy director of finance at the Royal United Hospitals Bath NHS Foundation Trust, will succeed Mr Cassells. She is due to join the trust in July.

On retirement, he plans a holiday to the US, but will not stop working completely – he plans to work with charities and organisations inside and outside the NHS. 'I am not desperate to leave the NHS, but it is the right time to go. I think my team make a real contribution to patient care. It's something to be proud of and I am glad to have been involved in it.'

FFF gets three-year extension

Future focused finance

The Financial Leadership Council (FLC) has extended the lifespan of NHS Future-Focused Finance (FFF) by three years to March 2022 – which FFF programme director David Ellcock (pictured) says will allow for a review and refresh of its work.

'Subject to FLC sign-off, we are planning to ask, "How much of what we set out to do three years ago have we delivered? Are there new priorities that we now need to address?" Priorities can change for good reason,' he says.

Senior responsible officers will identify if there is still work to do in their workstreams. 'We don't want to assume just because something was valid three years ago that it is still valid now,' Mr Ellcock says.

FFF also plans to ask if there are other areas that it has not examined and should incorporate into its work.

'We want to see if the landscape has shifted considerably since we first set out our work on FFF. We will also be seeking views on what we should focus on and I would encourage finance staff to respond to that,' adds Mr Ellcock.

FFF foundation meetings will become more focused. And, working with Finance Skills Development and the HFMA, the foundation will deliver the national strategy for skills development, which will be set by the FLC.

The extension will give FFF more time to ensure its tools and guidance become part of the fabric of NHS finance – for example, through the HFMA, specialists will be engaged to show finance staff how to use the 'Best possible value' decision toolkit.

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