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June 2017 | Healthcare Financial Management Association

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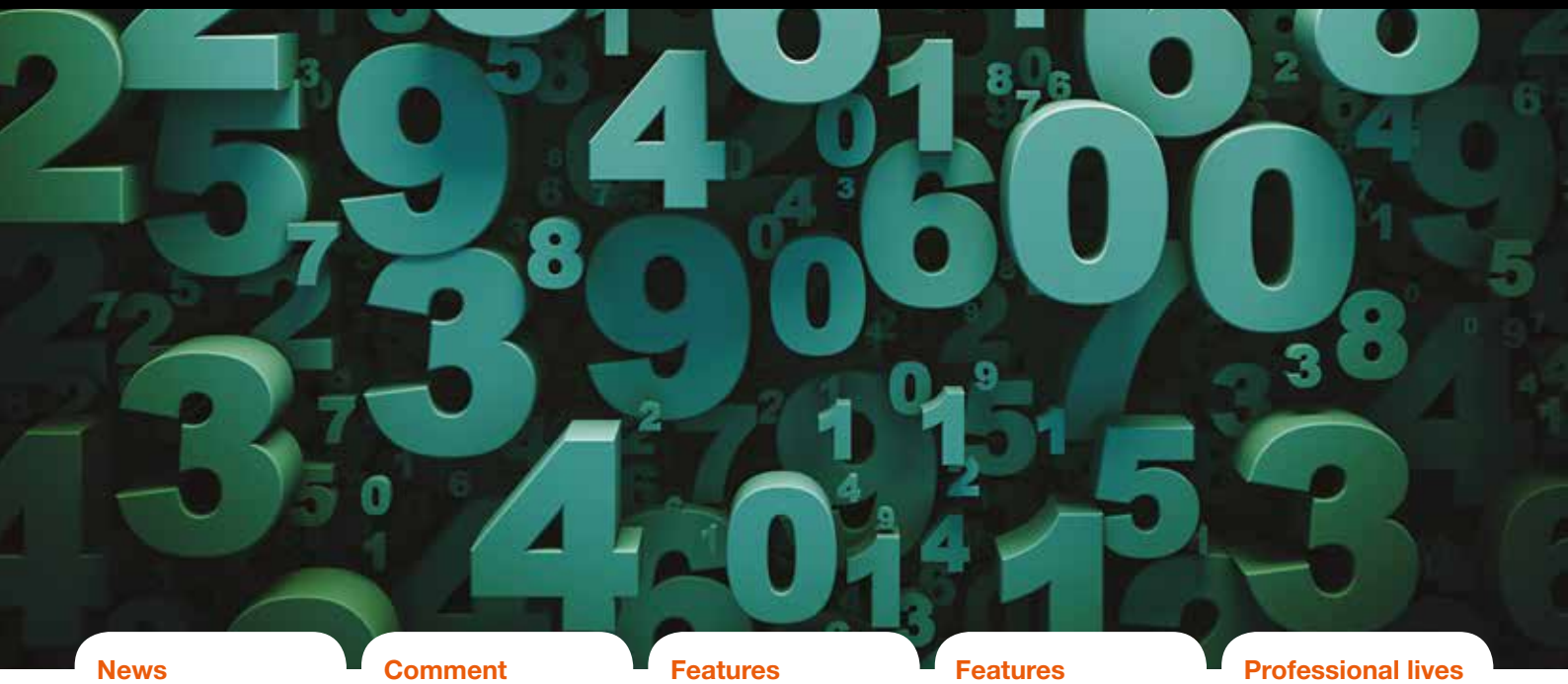

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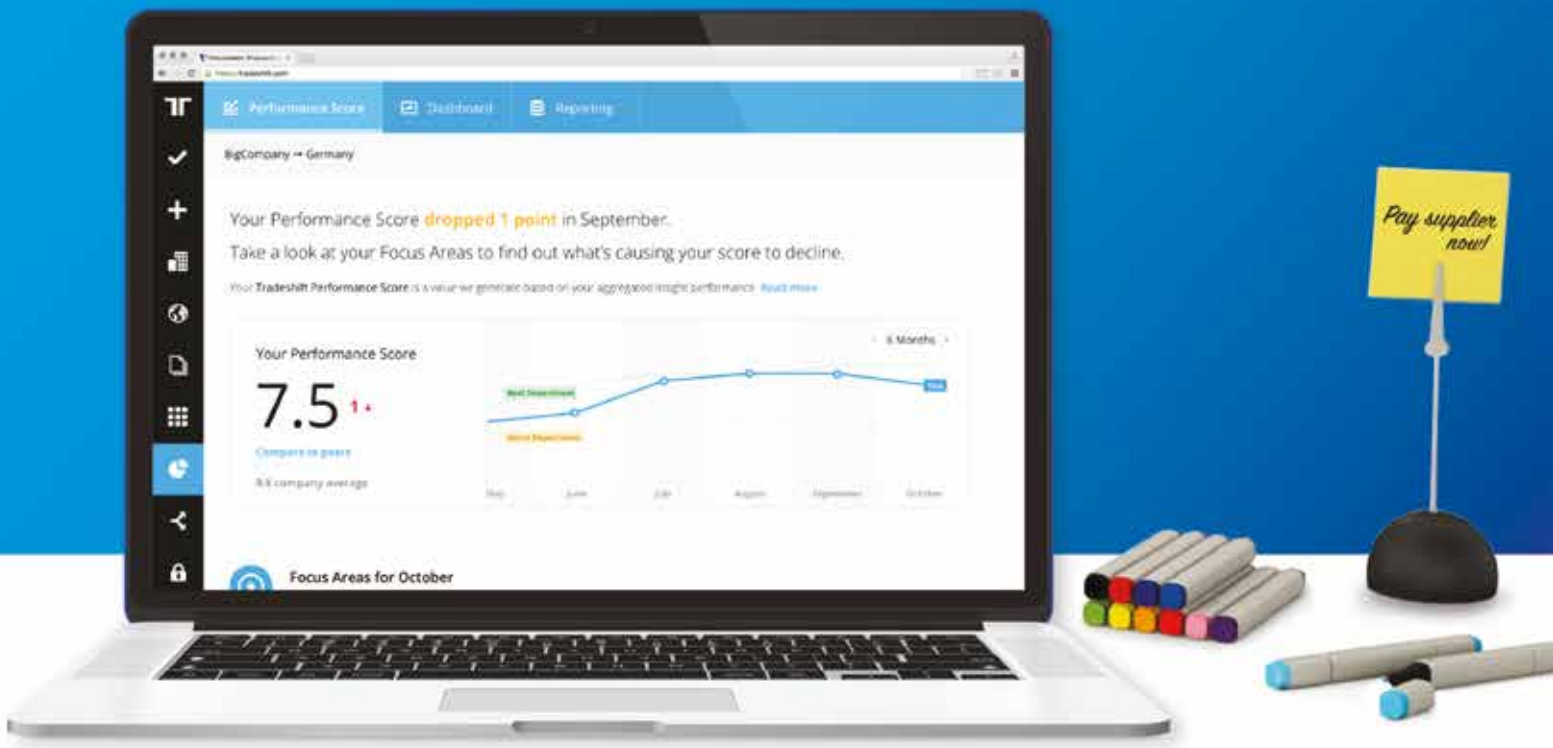

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ISSN 1472-3379

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News

Baumann: reserve will contribute to system balance

By Seamus Ward

The commissioning sector in England met its statutory financial duties in 2016/17 and has made an additional contribution to the overall balance of the system, NHS England chief financial officer Paul Baumann said.

At the start of the financial year, commissioners set aside 1% of their budgets (£800m) that could be used to cover any year-end overspend in providers. As the year progressed, it became increasingly clear that all the reserve would be needed. In February, Mr Baumann confirmed that all the funds would be required to balance the system.

With purdah in operation due to the general election, official year-end figures have not been published by NHS England and NHS Improvement – both were due in May.

However, Mr Baumann told the NHS England May board meeting: 'Subject to audit, we have achieved all of our financial duties in 2016/17 and I can confirm that we have fulfilled our commitment to make an additional contribution to system balance in line with the reserve that we took at the beginning of the year.

'Given the very challenging circumstances we've experienced in 2016/17, this feels like quite a significant achievement,' he added.

"Given the very challenging circumstances in 2016/17, this feels like quite a significant achievement"
Paul Baumann

In the past, Mr Baumann has said that contributing to the reserve had a significant impact on clinical commissioning groups, reflected in a rise in savings requirements from an average of 2.2% in 2015/16 to 3% in 2016/17.

Unofficial figures from NHS Providers estimate that the year-end aggregate provider deficit will be between £700m and £750m. It said a £725m deficit – the mid-point of its estimate range – would be 70% lower than the 2015/16 deficit of £2.45bn.

If NHS Providers' figures are accurate, this will represent a significant turnaround from quarter three, when providers forecast an aggregate deficit of £873m. However, it would still be at least £120m more than the planned £580m deficit.

Despite this, NHS Providers chief executive Chris Hopson said the estimated year-end position was a big achievement. It reflected 'a huge amount of hard work by trusts to control costs, increase productivity and improve efficiency while continuing to provide outstanding patient care'.

Cost improvement had grown, with agency staff savings estimated to have reached £770m, or 20% of the total.

Mr Hopson added: 'A year-end performance

of between -£700m and -£750m would be a particularly good achievement given that trusts reported a £238m deterioration in Q3, due to the immense operational and financial pressures caused by record demand over the winter period.

'Our estimate means that trusts have recovered more than two-thirds of that deterioration in the last three months.'

However, 2017/18 looked difficult, with NHS England funding growth falling to 1.3%, compared with 3.6% in 2016/17.

'Two-thirds of trusts told us at quarter 3 that they were very or fairly reliant on one-off non-recurrent savings to meet their year-end figures. We estimated this accounts for about £1bn of the estimated gain. It's also clear that, with this 2016/17 year-end result, the sector will struggle to eliminate the provider deficit in 2017/18 as originally planned. In our view, given the drop in 2017/18 funding, providers will do exceptionally well to match 2016/17's deficit.'

Mr Baumann expressed his appreciation to CCGs, commissioning support units and NHS England – 'and particularly to the finance teams who work their socks off at this time of year to produce the accounts to the required standards of quality', he added.

Capital transfers to continue for three years

The Department of Health plans to continue transferring NHS capital funding to revenue up to and including 2019/20.

In a letter to the Commons Health Committee, health minister Philip Dunne (pictured) said the transfers would give the Department flexibility to meet its spending priorities, particularly in support of the *Five-year forward view*. He defended the policy of moving capital to revenue, insisting that internally generated cash, retained by providers, funds most capital plans. And for the last 10 years the overall level of capital available has been greater than the amount of internally generated capital spent. The Department was not aware of any capital project that has been cancelled or delayed as a result of capital to revenue switches in 2016/17.

Sent before the election campaign, the letter added that interest-bearing loans and public dividend capital were available from the Department for trusts unable to generate sufficient funds internally and, again, expenditure over the last 10 years has been significantly lower than the budget set.

However, Mr Dunne said the government planned to reduce the level of transfer – eliminating it by the end of 2019/20.

He added that sustainability and transformation partnerships hoping to access new capital – due to be announced in the autumn – must demonstrate they are maximising the generation of their own capital resources through disposal of surplus estate.

Funding shortfall likely despite increases promised in main party manifestos

By Seamus Ward

The NHS in England will face a funding shortfall, no matter which party gains power in the 8 June general election, according to the Nuffield Trust.

In an analysis of the main parties' manifesto spending pledges on health, the trust said that although all of them pledged to increase funding, it would not be enough to close the funding gap, cope with increased demand and sustain high-quality care.

It said the NHS would require £137bn to £155bn a year by 2022/23, based on four scenarios – if the NHS kept pace with: economic growth (£137bn); NHS inflation and predicted demand (£141bn); the long-term spending trend (£150bn); and the projections from the Office for Budget Responsibility (£155bn).

In their manifestos, the parties described funding increases in different ways. The Conservatives promised to increase funding by £8bn over the next five years, Labour talked of a £7.4bn increase and the Liberal Democrats £6bn for health and social care. The trust said that by 2022/23 these pledges would amount to overall spending of £131.7bn (Conservatives), £135.3bn (Labour) and £132.2bn (Lib Dems).

Nuffield Trust chief economist John Appleby said: 'This analysis shows that none of the parties' promises matches even the lowest projections of what funding should be.

'Spending as a proportion of GDP [gross domestic product] looks set to fall whichever party forms the next government, unless additional funds can be found.'

The Health Foundation predicted similar spending – £136bn Labour, £134bn Lib Dems and £132bn Conservatives – and said spending pressures would amount to £153bn by 2022/23. It also agreed that spending as a proportion of GDP would fall under an administration led by any of the main parties.

In a blog, Anita Charlesworth, the foundation's director of research and economics, said: 'This is a stark prospect for the NHS. While extra funding is welcome, none of the parties have found a way of avoiding five more very tough years for the health service. This doesn't seem to be because our politicians want to accept a lower quality healthcare service, but rather reflects the scale of the challenge presented by growing pressures on the service with an economy still feeling the aftershocks of the 2008 recession.'

Though many predicted the election would be fought solely on the UK exit from the European Union, health policy is prominent in all three main party manifestos.

The Conservatives said that, if returned to power, they will review the operation of the internal market. The manifesto said the market can 'fail to act in the interests of patients and creates costly bureaucracy'. Modifications that do not need legislative changes will be made in time for the start of the 2018/19 financial year.

'The pledge to review the internal market is a significant acknowledgement that collaboration rather than competition offers the best way of sustaining and transforming services,' said King's Fund chief executive Chris Ham.

Labour said it would pause all work on sustainability and transformation plans for a review. Professor Ham said: 'The proposal risks holding back essential changes to services. Labour are right that there has so far not been nearly enough engagement with the public and

Manifesto promises

	Conservative	Labour	Liberal Democrat	Other parties
Funding	Minimum of £8bn in real terms over five years	£7.4bn a year, including £2bn for capital	£6bn extra a year. Cross-party convention to review sustainability of finances and workforce	Push for share of £350m for NHS promised by Leave campaign (Plaid Cymru)
Staff	Early agreement to secure future of the 140,000 EU workers in the NHS. New contract for GPs and hospital consultants	Long-term staffing plan, removal of pay cap and reintroduction of nursing training bursary, immediate guarantee on rights of EU staff	Nursing bursaries reintroduced and pay cap abandoned. Guarantee the rights of EU nationals working in health and care. Produce a national workforce strategy	Train and recruit 1,000 doctors and 5,000 nurses (Plaid Cymru)
Internal market	Review to remove barriers to care integration	New community care model. STPs would be paused for review. All services to be returned to NHS control	Move away from funding for activity. Tariffs to encourage joined-up services, better outcomes and prevention introduced	Scrap STPs (Greens)
New bodies	NHS England leaders held to account for delivery of the forward view	Two new bodies – an OBR for health and a new quality and safety regulator, NHS Excellence	Establish an OBR for health	
Social care	Changes to charging structure for domiciliary care. A green paper will outline plans to improve elderly care and consider a cap on cost of care for individuals	£8bn rise in funding over five years and foundations laid for national care service	A long-term objective to integrate health and social care, pooling budgets by 2020. Cap on total individual spending	Single budget for health and social care (Greens). Social care rescue plan (Plaid Cymru)
Other policies	Ensure costs of treating non-EU citizens recouped and increase in immigration health surcharge. *Mental Health Act* reform. Accelerated access review	Free NHS car parking and an end to mixed sex wards. A £250m child health fund would be created. Mental health budgets ring-fenced	Ring-fence mental health funding and roll out mental health waiting times standards	Special status given to NI to maintain services, including cross-border care (Sinn Féin)

Note: not intended to be comprehensive. Some parties published their manifesto after *Healthcare Finance* went to press

"None of the parties' promises matches even the lowest projections of what funding should be"
John Appleby, Nuffield Trust

patients and this needs to happen, but where the case for change has been made politicians should not stand in the way.'

Both Labour and Lib Dems would lift the 1% ceiling on NHS pay rises and establish an Office for Budget Responsibility-style body for health to oversee spending and look at future needs.

The impact of an EU exit on the NHS was acknowledged in the manifestos, with Labour and the Liberal Democrats promising to guarantee the rights of EU citizens working in the health and care services, while the Conservatives said keeping these staff would be a priority in negotiations.

Staffing and funding top election concerns

Funding of health and social care and workforce issues topped the wish lists of NHS pressure groups in the run-up to the election.

The NHS Confederation called for the incoming government to link health spending to GDP (gross domestic product) to ensure spending grows alongside growth in the economy.

Niall Dickson (left), confederation chief executive, said: 'Critically, we need a visible and objective measure of funding as we have seen for overseas aid and the armed forces – the next administration needs to commit to a minimum funding level for health and care linked to GDP. As the economy grows, so should health and care spending.'

He called for an Office for Budget Responsibility-style body for health to assess future funding and workforce needs.

NHS Providers chief executive Chris Hopson said workforce was now the number one priority for the health service.

Recruitment and retention were becoming more difficult in all types of providers and there was uncertainty over the status of EU staff.

'Years of pay restraint and stressful working conditions are taking their toll,' he said. 'Pay is becoming uncompetitive. Significant numbers of trusts say lower paid staff are leaving to stack shelves in supermarkets rather than carry on working in the NHS. And we are getting consistent reports of retention problems because of working pressures in the health service causing stress and burnout.'

• *See Health + wealth, page 21*

Public support tax rises to fund health service

By Seamus Ward

A majority of the public believe that the NHS should be protected from budget cuts and tax should be increased to raise extra funds for the service, according to a Health Foundation poll.

Almost 2,000 people aged over 15 from across Great Britain took part in the Ipsos Mori poll. They were asked if, in the face of rising healthcare costs, they would support raising taxes, reducing spending on other services to fund the NHS, or cutting the level of services provided by the NHS.

Almost two-thirds (64%) chose higher taxes, while 9% backed cutting NHS services. Nearly nine in 10 respondents (88%) told the pollsters that health service funding should be protected. However, half of respondents believed the NHS often wastes money.

There was also concern over the quality of health and social care services, with 44% of people feeling NHS care had declined in the past year and 48% believing it would get worse over the coming year. Half of respondents said social care quality would decline in the next year.

There was support for ending the pay cap – a Lib Dem and Labour manifesto pledge – that has limited overall annual pay rises in the NHS to 1%. Around three-quarters of respondents said the ceiling should be higher.

Ruth Thorlby, Health Foundation assistant policy director, said that, after seven years of austerity, to maintain services the incoming government would have to provide additional funding for health and social care.

'The impact of this austerity – overloaded A&E departments, delays in getting people out of hospital, and longer waiting times for surgery – has been covered widely in the media, and has got through to the public,' she said. 'It is striking that such a significant majority say they are willing to see taxes rise, rather than reduce levels of service or see more cuts to other public services.

'This is not a blank cheque of goodwill though. Half of respondents to this poll also believe there is waste in the NHS, reinforcing the need for NHS services to continue with efforts to be more efficient regardless of any funding settlement, by reducing the use of agency staff for example, or using the best value drugs and equipment.'

Thorlby: 'This is not a blank cheque of goodwill'

News review

Seamus Ward assesses the past month in healthcare finance

Sadly, IT professionals' prediction that the NHS being hit by a major cyber attack was a case of 'when, not if' came true in May. The news focus on the general election was broken on 12 May, when 47 English trusts, 12 Scottish health boards and a number of GP practices were hit by a ransomware attack that encrypted files. IT staff worked all weekend and into the following week to restore files, but appointments and operations had to be postponed. The attackers, who did not specifically target the NHS, demanded £230 for each decryption from health bodies in the UK and private companies round the world.

The virus exploited a vulnerability in Windows operating systems. In the wake of the attack, NHS Improvement chief executive Jim Mackey emailed all trusts to outline the actions that should be taken. These included assessing the scale of the infection across the organisation and the mitigating actions taken. He added that a risk-based decision should be taken on whether unpatched PCs should be disconnected from the network. There were some changes to finance collections, which were due in the week after the attack – changes to performance against organisations' 2016/17 control total, due by 17 May, were collected by NHS Improvement regional finance contacts, while the 2017/18 month one collection was moved from 16 May to 22 May.

The NHS faces the prospect of industrial action over pay by nurses later in the year. Nine out of 10 Royal College of Nursing members told their union that they are willing to take industrial action and 78% would strike, according to an indicative poll by the union. Though 52,000 members took part, the turnout was not high enough to lead to a formal ballot. However, delegates at the RCN annual congress backed a motion for a summer of protest, followed by a ballot on industrial action, should the incoming government not end the pay restraint policy. RCN delegates also called for Scotland, Northern Ireland and England to follow the example set by Wales of enshrining safe staffing levels in law. The RCN said about 40,000 nursing posts were unfilled in England along with 12,000 healthcare support worker vacancies, leading to concerns over patient safety. Mental health and community care providers were hardest hit. The congress also called for a pay banding review.

Meanwhile, the Health Foundation warned the NHS could face a shortfall of 42,000 nurses – 12% of the nursing workforce – by 2020. In an analysis based on the 2016 NHS staff survey, the foundation added that the overall workforce shortfall could get worse as pay for staff on band 5 and above will drop by 12% in real terms between 2010/11 and 2020/21. Its report, *In short supply,* said workforce planning was the service's Achilles heel.

The latest figures for A&E performance in England and Wales showed some improvement in the face of increasing demand, but most targets remained unmet. In Wales, figures for March and April this year show 82.8% of patients were seen within four hours in A&E – 1.8 percentage points higher than March 2016 and 2.5 points higher than April 2016 – but still short of the 95% target. In scheduled care, 88% of patients had waited fewer than 26 weeks – the target is 95% – while 2.8% had waited more than 36 weeks. In both measures, this was the best performance since March 2014. In scheduled care, outpatient referrals had increased 5.6% compared with March 2016, while A&E activity was 5.1% higher than in April 2016.

The March performance figures for England showed that 90% of A&E patients were seen

The month in quotes

'Relentless undermining has pushed us to breaking point. No more. This ends now. We've had the poll, let's have the action.'
Ed Freshwater, a member of the RCN Mental Health Forum, calls for industrial action over pay restraint at the RCN congress

'When it comes to public health, the UK is going backwards. Prevention is better than cure and cuts to public health have a damaging impact on individuals' health and wellbeing, and end up costing the NHS more in the long term.'
BMA council chair Mark Porter urges government action on public health

'The approaches being developed in the vanguards are intended to be a blueprint for the future of the NHS, so mental health needs to be at their core. Getting this right means better quality care, and could also help the NHS to meet the challenge of providing healthcare free at the point of use to an ageing population.'
Vanguards must do more on mental health, says King's Fund chief executive Chris Ham

'Thank you to you and your teams for the work that has been going on over the weekend to recover services following the cyber-attack on Friday. We know that staff have put in many extra hours to address the problems caused by this incident.'
Jim Mackey applauds the efforts of NHS staff to cope with the cyber attack on Friday 12 May

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After the cyber attack, a decision had to be taken on whether unpatched PCs should be disconnected from the network

within four hours. Though A&E attendances were down 3.3% on March 2016, over the 12-month period they were 2.2% higher. Emergency admissions were 3.2% higher than in March 2016 – the highest number of admissions recorded in a single month. As in previous months, the targets for A&E, consultant referral and diagnostic tests were not met in March. However, the NHS continued to meet six of the eight cancer standards.

Scottish health secretary Shona Robison announced a further £9m to reduce A&E waiting times this year. She said the money would help health and integration boards focus on priorities such as daily dynamic discharge to reduce bed blocking; reducing inappropriate hospital stays; maximising discharge before noon; and closer working with integrated joint boards.

The British Medical Association said that public health is a 'ticking time bomb' that must be addressed. It said public health budgets face a cut of £400m between 2015/16 and 2020/21, even though rates of obesity remain high, nearly one in six adults smoke and almost 8 million binge drink. Cuts were a false economy, the doctors' union claimed. It is estimated that, on average, more than £14 is saved for every £1 invested in local and national public health interventions, it said.

A sign of the growing lifestyle-related problems was seen in a BBC story that said ambulance services in England had spent hundreds of thousands of pounds on ambulances specially designed for obese patients. It said this had followed a 10-fold increase in hospital admissions linked to obesity over the last 10 years. NHS obesity statistics suggest nearly 60% of women and 70% of men are overweight, with the service spending £5bn in 2014/15 on treating obesity-related ill health.

Vanguards are not giving mental healthcare sufficiently high priority and have lacked ambition in plans to bring physical and mental healthcare together, according to the King's Fund. A report, *Mental health and new models of care*, written with the Royal College of Psychiatrists, said there was strong evidence that treating mental and physical health needs together is better for patients and more cost effective. Some vanguards had made progress, for example Tower Hamlets in London had reduced by 12.7% the number of bed days for people with dementia, serious mental illness and depression. Lessons learnt in the vanguards should be rolled out across the country and sustainability and transformation plans should offer more mental health support in GP surgeries and hospitals, it said.

Social services in Wales will receive an extra £20m, according to social services and public health minister Rebecca Evans. The funding, which has come as a result of the consequential funding from the UK March Budget, will be invested in three priority areas, she said – £9m to manage workforce costs; £8m to prevent children entering care and improve the outcomes for those leaving care; and £3m to support respite care.

from the hfma

The post-election period could offer the new government an opportunity to revisit planned health spending, according to HFMA research manager Duncan Watson (pictured). In a blog for the HFMA website, he said the new government could conduct a spending review. There's scope to change not only the level of funding, but also what it pays for and how it is distributed across England – although this may be wishful thinking, he said.

He outlined two new HFMA briefings on funding flows, allocations and budget processes, part of the association's *How it works* series. One focuses on the allocation process from the Treasury via the Department of Health to NHS England, while the second focuses on the flow of funding from NHS England to clinical commissioning groups.

Also this month, the HFMA Healthcare Costing for Value Institute issued a briefing on a project it supported at three acute trusts in England. The scheme looked at how easy it is in practice to link costs and outcomes at a patient level.

The HFMA board has paid tribute to Paul Briddock after he stood down from his role as policy and technical director. HFMA chief executive Mark Knight said Mr Briddock had been a passionate advocate for the association and made a major contribution to raising its profile in the past three and half years. Mr Briddock said, with the HFMA refocusing on its development agenda, 'it was the right time to look for fresh challenges'.

News analysis

Headline issues in the spotlight

Campaigning on health

With the general election campaign entering its final days, Seamus Ward looks at how the health service has featured on the stump

Politicians tend to be wary of numbers – detail can blur their message, confuse voters or, to be cynical, be a hostage to fortune. Numbers can be tricky. At the start of the election campaign, shadow health secretary Dianne Abbott tied herself in knots on the cost of Labour's proposed increase in police officers – all of which perhaps demonstrates why representatives from all parties have shied away from the detail.

While Ms Abbott's slip on 2 May was unfortunate, the debate over the future of the health service soon replaced it as lead story in news bulletins. Both the British Medical Association and the NHS Confederation outlined their wish lists for a new government. Both want ministers to set health spending at a fixed proportion of GDP (see page 23).

The official dissolution of Parliament on 3 May energised the election campaign. Labour moved quickly to grab the agenda, with a policy announcement on safe ground – the NHS. On 3 May, shadow health secretary Jon Ashworth said Labour would immediately halt the implementation of sustainability and transformation plans if elected. He said the plans would be paused while they were reviewed by a new arm's length body, NHS Excellence.

Mr Ashworth said the STP process was chaotic and plans to close hospitals, move A&E services and shut children's wards had caused concern and confusion. 'These decisions have been decided behind closed doors, with no genuine involvement of local people. It's a disgrace. The public deserves better,' he said.

Health secretary Jeremy Hunt has kept a pretty low profile since the start of the calendar year, but election campaigns mean politicians have to go out and canvass support. On a visit to St Helier Hospital on 3 May, he was confronted by a local campaigner who accused him of 'demolishing the NHS' and of planning to shut the hospital he had just visited. The hospital may be downgraded or even shut if proposals in the South West London STP are implemented.

After the visit, Mr Hunt said: 'St Helier has made huge strides in recent years and I was delighted to hear more on my visit about progress and plans for the future.'

Labour and the Lib Dems promised to establish an OBR-style body for health. The Conservatives would review the internal market

Next up, the Liberal Democrats focused on another real issue for voters – waiting times for hospital treatment. Responding to a report in *The Times* on a confidential document predicting that within two years more than 5 million patients could be waiting for hospital treatment, health spokesman Norman Lamb said rising waiting lists were 'disgraceful and unacceptable'. The party followed this up on 6 May with a glimpse of its manifesto – promising to raise £6bn a year, ring-fenced for health and social care, by raising income tax by 1p in the pound.

In their first official statement on health during the campaign, on 7 May, the Conservatives pledged to reform mental health laws in England and Wales to end 'unnecessary detention'. Pointing to an additional £1bn for mental health services announced in January, Mr Hunt promised 10,000 more NHS mental health staff by 2020 and to tackle discrimination against those with mental illness. The Tories said mental health funding was at record levels and would be up by £1.4bn in real terms by 2020.

Labour claimed its plans to tackle childhood

The main contenders



On the stump (l to r): Jeremy Corbyn, Theresa May and Tim Farron

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obesity would include a ban on TV junk food ads before 9pm. Currently, adverts for foods high in salt, sugar or fat are banned only on children's TV. Given that childhood obesity cost the NHS £6bn a year, said the party, its strategy would aim to halve the number of overweight kids in 10 years. It would fund a £250m programme in schools by cutting fees for management consultants used by the NHS.

Visitors, patients and staff would get free hospital car parking under a Labour government, the party added. It said the £162m raised by parking charges at England's NHS hospitals would be replaced by increasing insurance premium tax for private health insurance to 20%.

NHS Providers urged the next government to scrap the ceiling on pay rises, which, alongside a number of other factors, was making it more difficult for the service to recruit and retain staff. Both Labour and the Lib Dems picked this up in their manifestos (more of which later). NHS Providers also called for greater funding for health and social care and a concerted effort to ensure parity of esteem for mental health through dedicated funding.

While the leak of a draft version of Labour's manifesto on 11 May was embarrassing for the party, in terms of health it told us that the party planned to raise £6bn a year for the NHS by raising income tax for the top 5% of earners. A further £8bn would be spent on social care over the five years of the Parliament. Bursaries for student nurses would be reinstated and the cap on NHS pay rises – limited in recent years to 1% of the pay bill – would be scrapped. Instead, Labour would take the advice of the independent pay review bodies.

There was some controversy late in May, however, when NHA Improvement confirmed it would not be publishing the final 2016/17 figures for financial performance until after the election.

The parties offered similar funding increases – £7.4bn (Labour), £6bn (Lib Dems) and £8bn (Conservatives) – though the Tories and Liberal Democrats had a focus on mental health

Publication had been scheduled for late May, but Whitehall officials reportedly advised the oversight body not to publish during the period of purdah.

Operational performance figures for March were published in May by NHS England. Although most targets were again not met, there were signs of improvement. For Labour, the figures showed Conservative mismanagement of the health service. Shadow health secretary Mr Ashworth said the winter crisis was stretching into summer and the Conservatives had admitted that waiting times were only going to continue to grow.

'Thousands more people are waiting for A&E care and routine treatment every week because of the failures of this Tory government,' he said. 'Behind every one of these statistics is a patient and their family in pain because of Theresa May's refusal to give the health service the funding it needs.' The Conservatives defended their record, saying A&E performance had greatly improved compared with the same month last year. Elective waiting times had been cut and patient outcomes were better, the party added.

Electioneering on the NHS took, briefly, a back seat as the service in Scotland and England was hit by a cyber attack on Friday 12 May. Though Jeremy Hunt attended a COBRA meeting – the group convened by the government in emergencies – on the Saturday, opposition politicians and some in the media questioned why the health secretary had not made a public statement. He did emerge on 15 May to give an interview to the BBC.

Once the scale of the problem became apparent, opposition parties jumped on the opportunity to blame lack of capital funding and highlighting the movement of capital to revenue in recent years. They claimed trusts did not have sufficient funds to update their IT.

Labour leader Jeremy Corbyn said £2bn of Labour's pledge of an additional £7.4bn a year for the NHS would be ring-fenced for capital, including IT projects. Ministers sought to deflect the blame, claiming the NHS had enough money to protect itself and had been given sufficient warnings of the threat of a cyber attack.

Mid to late May was dominated by the main party manifestos. Broadly speaking, they offered similar funding increases – £7.4bn (Labour), £6bn (Lib Dems) and £8bn (Conservatives). Nuffield Trust analysis suggested that by 2022/23 the pledges equated to spending of £12bn (Labour), £8bn (Conservatives) and £9bn (Lib Dems) higher than 2017/18. The Tories and Liberal Democrats had a focus on mental health. The former promised to ring-fence £1bn of their additional funding for the services, while the Tories said they would reform mental health law.

Labour and the Lib Dems promised to set up an Office for Budget Responsibility-style body for health. The Conservatives would review the internal market and hold NHS England leaders to account for implementing the forward view.

The Conservatives attracted a lot of flak over their plans to pay for social care, which appeared to abandon their policy of capping the amount individuals would pay towards their care. The party manifesto pledged to charge people receiving care in their own homes for the full cost of their care if their home was worth at least £100,000. Currently, assets are not taken into account if someone is receiving care in their own home. Those in residential care must pay the full cost if they have savings and other assets of more than £23,250 and the value of their home may be taken into account.

After a weekend of adverse coverage, with the Conservatives still in a commanding lead but polls showing some gains for Labour, the prime minister promised there would be an 'absolute limit' on the amount people would have to pay. Though denied by the party, opponents quickly labelled this a U-turn by Mrs May. Numbers had got another politician into trouble.

Comment

NHS 70-100: a new hope

Beyond this election, public choices may be needed as part of 30-year forward view

Battle lines have been drawn and all political parties have published their manifesto commitments outlining plans for the next parliamentary period 2017 to 2022. And therein lies the perpetual cyclical challenge for health and social care.

Responding to warnings about mounting pressures, each manifesto pledges more funding for the NHS up to 2022. But nobody is having a meaningful public debate on how we might take steps to ensure that the NHS remains fit for the next generation and the generation beyond that.

HFMA president Mark Orchard

The *Five-year forward view* and associated publications are very welcome and applauded. But as the NHS approaches its 70th anniversary next year, we need to lay the foundations now for its centenary celebration on 5 July 2048.

The alternative is sleepwalking into a forward reality that incrementally assumes, at best, more of the same.

The problem is not simply that real-terms funding may remain broadly flat, nor necessarily the scope to continue to carve out further efficiency. The challenge lies in the assumption that alongside this we will sustain the current NHS 'offer' when official demographic estimates suggest a doubling of the number of us living over 80 years of age and a six-fold increase in the number of centenarians.

Beyond this election, public choices may need to be made as part of a 30-year forward view and that is why the UK would benefit from an independent cross-party review of the future of NHS and social care.

The outcome could either reaffirm Aneurin Bevan's founding principles and offer the NHS a new hope – maybe, based on a set of publically consulted 'conditions' – or, seek public acceptance on a different health offer.

So, what could a set of

It's the how that's important

We need to dig beneath the surface of parties' manifesto claims

Healthcare Finance editor Steve Brown

At one moment, the general election manifestos, looked at from a health perspective, are an exercise in who loves the NHS most. Then in the next paragraph each party is stoking voter fears over whether the service can remain a going concern under their opponents' management.

The NHS and social care have enjoyed a relatively high profile in the election to date – ensuring the campaign isn't solely about the undeniably important Brexit question. Quite right too. The challenges facing the care services as a result of demographic pressures and current financial situation are extreme. We need big, well-thought-through solutions and we need the public engaged in a debate around those solutions and their implications (see Mark Orchard's comment above).

The problem is that, at the high level at which manifestos inevitably operate, it can be hard to argue against any of the proposals. The ambitions set out for better, sustainable services are often common to all parties. The differences are likely to be in how the

different parties would set about trying to achieve those ambitions – and whether voters believe they are actually capable of delivering them in practice. All the main party manifestos, for example, promise additional funding and more integrated services. So

"The UK would benefit from an independent cross-party review of the future of NHS and social care"

'conditions' look like? How could we possibly sustain the NHS founding principles in these circumstances? Here's my starter for ten:

1. A relentless waste avoidance drive. If seeing is believing, taxpayers and the public need to be visibly assured that all services are as efficient as they can be.

2. Fully exploit NHS purchasing power at scale. The Carter report and other interventions such as agency market management are welcome first steps on this journey, but taxpayers expect much more.

3. Decide the best mechanism to deliver integrated health and social care to create a universal service across the whole public journey.

4. Move beyond the internal market – learning from the three UK devolved nations. Embed clinical commissioning, health intelligence and public health at the heart of population planning, and embrace value-based costing within service decision-making.

5. Create a single national IT dataset for patient and public health and care records.

6. Realistic workforce planning based on service design informed by consumerism and modern work/ life preferences.

7. Embrace the best of industry innovation importing skills and competencies to complement and support our health and care leaders.

8. Consult with the public on an honest three-way decision triangle between an outlook where: very significant taxation will be required to meet future need; public funded services are inevitably eroded over time; or, we enter into a public lifestyle 'contract' across a range of healthy-living must dos.

9. A modest national insurance contribution directly linked to health and care – after having taken all other demonstrable action – may be unavoidable, to fund latent demographic projections and poor health choices.

10. Explore devolution of the NHS and social care to a state-sponsored non-governmental body operating on a consumer-driven model outside the day-to-day remit of political intervention.

A debate around these issues has to be healthy in determining the future of our national health service, whichever party gains power on 8 June.

In the meantime, we all have a job to do, and that starts right at the top of this list by demonstrating efficiency beyond public doubt.

Contact the president on president@hfma.org.uk

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how should the person on the street choose between the different offers?

Funding is clearly a fundamental issue. But understanding whether the service needs £8bn extra, £9bn or £12bn is not an easy judgement for a finance director or economist, let alone a general member of the public.

Perhaps that is another argument for creating a link between health (or health and social care) funding and gross domestic product – a link that has been backed by the HFMA and others in the run-up to the election.

There is some sense in linking a country's prosperity to its spending on health – as a country becomes more prosperous, often on the back of growing population, so health spending will need to rise. That would still leave a major job in setting what that proportion should be and understanding exactly what we mean by health spending.

As we explain in our cover feature this month (page 21), economists and politicians bandy around percentages relating to different definitions of health spending. You might hear a figure for health spending that includes public and private spending on health or just government-funded health spending. That might include capital spending and aspects of social care – or it might not. Definitions have also changed over time, so comparing current proportions with those of former years may not be a fair comparison.

That is not an argument against making the link (not promised explicitly by any party, although it might be an outcome of creating an Office of Budget Responsibility-type body). But it is an argument for ensuring you know what people mean when they make references to establishing such a link.

Integration is another common ambition in the manifestos. Again, who would argue against more integrated care? But how should that integration be put into practice? Formal integration and pooled budgets or more partnership working?

"Comparing current GDP funding with former years may not be a fair comparison"

Canterbury District Health Board in New Zealand (see page 16) is one of the more advanced 'integrated' health systems. Allocations there do cover health and social care, but services are delivered across an alliance of in-house and external providers sharing risks and rewards across the system.

We need to explore such approaches in shaping our own path to integration while also learning more closer to home, with UK care systems following different approaches with the same goals. In many ways, there is already a consensus around the need for transformation to meet current challenges. The manifestos don't really paint different pictures for how care services will look in future. But they may well represent real choices in whether, or how quickly, those ambitions can be reached.

Virtual invoicing –

The NHS has moved slowly to embrace e-invoicing, in some cases getting only as far as receiving invoices by email. But a push is now on to make a reality of e-invoicing. Steve Brown reports

Four years ago, when health secretary Jeremy Hunt committed to a paperless NHS, he wasn't primarily thinking about getting rid of paper-based invoices. The focus was more on moving to paperless referrals underpinned by electronic patient records. But with the NHS processing perhaps as many as 15-20 million invoices each year, modernising trading systems was still an important component.

The original 'paperless' target date of 2018 may now have been recognised as 'unachievable'. But turning the NHS onto e-invoicing remains a key goal, albeit one without a specific deadline. Some solid progress has been made, but there is significant potential for improvement. And with all NHS bodies facing pressure to reduce corporate and administration costs or refocus finance department support on more value-added activities, some believe moving to e-invoicing is an obvious step.

Commissioners alone process some 2.8 million invoices each year, received from NHS and other providers, other commissioners and suppliers. This number goes up again when you factor in invoices from GPs, received through the Exeter IT system.

John McLoughlin, senior finance lead for financial accounting and services at NHS England, says using NHS England as an example offers a snapshot of the service's progress in getting its invoicing out of the wastepaper business.

Overall, the percentage of invoices received electronically by NHS England has risen from 2% to 37% in the past two years.

Considering intra-NHS transactions only, of 4,000 invoices received from NHS providers in March, about one in five were from the providers using the finance and accounting service delivered by NHS SBS. With this service provided en masse to all commissioners as part of the integrated single financial environment, these SBS trust invoices are all dealt with 'electronically' within the same system.

Of the other trusts, Mr McLoughlin says, just over 40 are at or close to 100% e-invoicing. But more than half of all providers rely completely on paper and the post.

'The assumption would be that these providers are issuing all their invoices in paper format and probably receiving invoices from their service providers and suppliers as paper documents too,' says Mr McLoughlin.

The direct costs in postage should be enough to persuade them to change their approach, he says. But there are clearly significant other benefits for NHS providers and their suppliers moving to e-invoicing. Some research suggests that e-invoicing could generate savings of more than 50% per transaction for both suppliers and customers.

With a national lower cost quartile cost of £6.75 to process an accounts receivable invoice (according to recent NHS Improvement benchmarking work on corporate services costs) and £2.16 for an accounts payable invoice, this looks like a potential win-win for both providers and commissioners.

'Even saving just £1 per invoice on the 2.8 million invoices received by commissioners would save nearly £3m,' says Mr McLoughlin.

Tradeshift deal

NHS SBS entered a deal with e-invoicing system provider Tradeshift in 2014 and NHS England says providers should at least be thinking about using this system – or an equivalent e-invoicing system – to invoice their NHS commissioners. The NHS standard contract requires providers to 'use all reasonable endeavours' to submit all invoices electronically, either using the Tradeshift system or an alternative PEPPOL-compliant system. (PEPPOL is the messaging standard adopted for procurement in the NHS.) But it stops short of making it compulsory.

Despite this encouragement, according to NHS SBS, just 87 NHS bodies are currently sending invoices using Tradeshift.

Under the deal arranged by NHS SBS, using

the real deal

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the Tradeshift system to invoice commissioners is free for providers and suppliers – they aren't charged per invoice, as with some invoicing systems – and all commissioners have automatically been set up with an account.

Mr McLoughlin says signing up is similar to using social media. An organisation opens an account and then searches for an organisation it wants to send an invoice to and makes a connection request. Once this is accepted, the organisation is good to go.

Under the traditional process, it could take up to 10 days from raising an invoice to it appearing on the payer's system – by the time the invoice has been posted (often second class), sorted and scanned, and allowing for weekends. But an e-invoice is on the commissioner's system the same day and can only be sent if pre-send validation checks are met. Providers can then monitor where the invoice has got to in the payer's process – cutting out the need for 'Have you got my invoice?' calls, the most frequent question asked of finance transaction teams.

Mr McLoughlin believes e-invoicing is a 'no-brainer'. 'Why is someone generating an invoice electronically to convert into paper, when the recipient wants an electronic copy,' he asks. 'All the additional steps of first creating a paper copy and then converting it back to paper incur additional cost and time.'

NHS England has been encouraging clinical commissioning groups to adopt e-invoicing with providers with variable success. The range extends from CCGs where just 7% of invoices are received electronically up to 60%. South Kent Coast CCG is one of the CCGs towards the top of this league table of e-invoicers.

Research suggests that e-invoicing could generate savings of more than 50% per transaction for both suppliers and customers

Edward Andrews, finance manager at the CCG, says the switch has cut 'at least two weeks from processing times' compared with previous paper-based transactions. Following a series of visits by Mr Andrews, all local GP practices have opened accounts and started submitting e-invoices and other local CCGs had also made good progress with GP sign-up.

GP practices range from multi-GP units to single-handed practices, with varying levels of IT and existing invoices raised in a mixture of Word, Excel or accounting packages.

But the effort was deemed a good investment in terms of supporting GPs, ensuring they were paid on time and in a more transparent way. However, the CCG has made less progress with its NHS providers and other suppliers.

West Kent push

West Kent CCG – with 38% of its 25,000 invoices received electronically – is also in a virtual invoicing top five. It has specifically targeted GP practices and continuing healthcare providers, succeeding in getting all its 61 GP practices onto Tradeshift and, with support from its local commissioning support unit, two thirds of its continuing healthcare providers.

A spokeswoman for the finance team agrees that it can be hard work up front in supporting providers to adopt the e-invoicing process. But she says that providers really see the benefits. 'We've had lots of compliments – they see it as more straightforward, they avoid the printing and postage costs and they can see where their invoice is in our organisation,' she says.

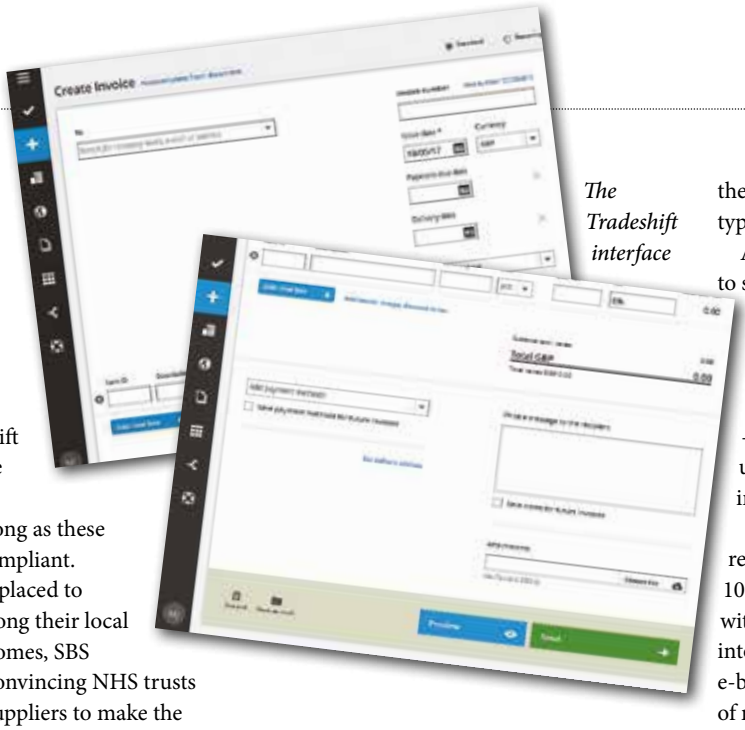
For the CCG, its commissioning support unit and SBS, the pay-off is in a 'total elimination of scanning errors; standard, clear and concise invoices; and fewer queries'.

The CCG has also used the process to encourage more consolidation of invoices, reducing the total number of invoices being submitted each month.

West Kent has also made less progress with its main acute and mental health providers and suggests that it would appreciate more support from NHS SBS and system leaders on this side.

There is a good argument for trusts being encouraged to move to e-invoicing for all their commissioners, rather than changing their process one CCG at a time.

Mr McLoughlin says talks are underway with NHS Improvement on this issue and he implies that the current encouragement in the standard contract could become a requirement in future. This could mean all provider-commissioner invoices having to be submitted electronically by the end of 2018/19 financial year – with a longer term target for all NHS transactions,



The Tradeshift interface

NHS SBS accepts it is well placed to support adoption of e-invoicing. Clearly, its current focus is on promoting use of Tradeshift, but it says that commissioners and providers using Tradeshift should be able to receive invoices from other e-invoicing systems as long as these systems are PEPPOL-compliant.

While CCGs are best placed to encourage adoption among their local GP practices and care homes, SBS accepts it has a role in convincing NHS trusts and the service's main suppliers to make the switch to e-invoicing.

Rather than dealing with individual cases – suppliers to a specific customer, for example – it has looked to maximise its reach. So it has worked with shared systems provider NEP, which has some 40 customers, to support the development of an interface to the Oracle finance system. There are also plans to work with the Capita-supported Integra financial system users.

Supplier target

On the supplier front, NHS SBS has to date targeted its 100 biggest suppliers submitting invoices (by value), succeeding so far with around 70 of them. In total, some 7,500 suppliers are sending invoices to NHS SBS via Tradeshift – about a quarter of all received invoices.

But with about 125,000 suppliers on SBS's list of suppliers, there is a long way to go. And some of the work signing up suppliers will have to come from trusts and CCGs themselves.

Plymouth Hospitals NHS Trust was praised in Lord Carter's report on productivity in acute hospitals for making 'good use of e-ordering and invoicing facilities to reduce staff time in both pharmacy and finance departments'. As a customer of NHS SBS, it uses Tradeshift, which means invoices for commissioners are effectively dealt with in the SBS system.

But it has also looked to move to e-invoicing more broadly. Some 23% of 90,000 invoices a year sent to the trust are now coming through Tradeshift.

Deputy director of finance Alex Keast says this means invoices get to SBS a lot quicker and are much more likely to go to the right place. Validation is also easier. Getting suppliers to use the system has involved encouragement by the trust and SBS – though the trust probably carries more weight given that it is the one directly dealing with suppliers and placing the orders. He also says some suppliers see limitations with the system and how it can integrate with existing invoicing processes.

Moving to true e-invoicing could enable members of the accounts payable team to be redeployed onto more value-adding work

Mr Keast accepts that many of the benefits are for SBS, as the trust's transactional service provider. It sees reduced queries and faster turnaround, although if SBS can reduce costs that should enable it to enhance service levels or reduce costs in future contracts. However, moving to e-invoicing is a key part of its overall strategy for e-procurement, as a pilot site for the Scan4Safety GS1 bar code scanning project.

Leeds Teaching Hospitals NHS Trust runs its accounts receivable and payable functions in-house with systems provided by shared systems provider NEP. Until two years ago, all invoices for commissioners were raised in the Oracle system, printed out and put in envelopes for posting. Switching to Tradeshift in 2015 eliminated the printing part of this process, although invoice details still had to be keyed into the new system. An interface has now been built, enabling the Oracle details to be imported into Tradeshift.

'It's helped us with cash management and cash forecasting,' says David Hay, the trust's head of financial services. 'When we had paper invoices, our treasury people were going into accounts receivable and asking when payments were expected and if we could chase payments. Now we have a report that says with 99% accuracy that an invoice will be paid on a particular date.' (Tradeshift will show an invoice has been approved for payment and the trust knows the dates its commissioners typically pay on.)

At the moment, the trust is using Tradeshift to send invoices to commissioners and any providers that are customers of SBS. The trust is keen to explore the potential for e-invoicing within accounts payable for invoices sent by the trust's suppliers – although Mr Hay says it would need to understand more about the costs it might incur under this approach.

The potential is significant. The trust receives about 220,000 invoices a year. While 100,000 of these are pharmacy related, dealt with by the pharmacy department and brought into the finance system as a pre-approved e-batch, the other 120,000 are for the provision of more general goods and services. Many are submitted as an email attachment, rather than posted. And while an NEP provided system allows these invoices to be dragged into the Oracle system – avoiding rescanning – the details still have to be rekeyed.

Moving to true e-invoicing – with invoice details being taken directly into the Oracle system – could enable members of the accounts payable team to be redeployed onto more value-adding work. For example, with accounts receivable staff spending less time manually raising invoices, they can spend more time on credit control. This has led to significant reductions in 90-day debt in each of the past two years.

Mr Hay thinks that reducing some of the manual activity currently required in accounts payable – rekeying invoices into the system – could enable a similar rebalancing of efforts.

NHS SBS is in fact set to launch a new e-commerce platform called Edge for Health later this year with technology company Virtualstock. Stephen Sutcliffe, NHS SBS director of finance, says this is aimed at revolutionising the way NHS organisations purchase goods and services. 'To ensure the NHS can benefit now from the efficiency savings already available, the immediate priority must be to increase the uptake of e-invoicing by providers and suppliers,' he said. 'Looking further ahead, the Edge for Health will deliver a retail-standard online platform that incorporates e-invoicing as just one part of a fully digitalised procure-to-pay solution.'

It may not mark a major step forward in delivering a paperless NHS, but delivering e-invoicing across the whole NHS would be a solid contribution towards modernising the NHS accounts payable and receivable processes. Given the current pressure to reduce costs and release staff for more value-adding activities, the hope is that the next year will see a further acceleration in uptake.

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lessons in integration

UK health systems have much to learn from a New Zealand health board's experience of delivering integrated care. Steve Brown traces its journey and talks to senior manager Carolyn Gullery about how the board has responded to key challenges

Like health systems across the world including the NHS, Canterbury District Health Board on New Zealand's South Island is looking to integrate care across the boundaries between primary, community, hospital and social care. What marks it out from the crowd is that Canterbury has already been on its integration journey for 10 years. This offers more would-be 'integrators' significant opportunities to learn from its experience.

Structures differ from those in England – although they share similarities with other parts of the UK NHS. New Zealand had experimented with a purchaser-provider split, but brought these two sides together in 2001 within 20 health boards. There are also differences in funding mechanisms. Social care funding in New Zealand is part of health board allocations and there are some elements of co-payments, particularly for its well-organised primary care sector.

Payment for services delivered internally by the board have moved from a tariff-style system, introduced with the purchaser-provider split, to setting budgets built from the bottom up. And, similar to English health systems, services for the 500,000 local population are provided by an alliance of 12 pharmacy and community healthcare provider organisations and primary care networks. Known as the Canterbury Clinical Network, the partnership is built on alliance contracts that try to share risk fairly – with the gains and losses dependent on overall, not individual organisation, performance.

This provides major parallels with moves to primary and acute care systems (PACS) and accountable care systems in England, underpinned in many cases by capitation-based gain-sharing contracts.

Canterbury's journey towards integration began in 2007, driven by pressures and a context that NHS staff will recognise all too well. The health board was already running a deficit (about 1.5% or NZ$17m on a turnover of about $1.2bn) and faced rising admissions, growing

Canterbury Q&A

Carolyn Gullery, general manager planning, funding and decision support at Canterbury District Health Board

Q How have services changed for patients as a result of integration?

There are so many examples, but one is how the system responds to women with heavy menstrual bleeding. Before integration, primary care clinicians would refer a patient to hospital and they'd go on the waiting list for a specialist. The specialist might order a pelvic ultrasound and the patient would go back on the waiting list for the specialist. The specialist would then decide if surgery was needed or some other medical intervention. Under the integrated model, 78% of patients who go to their GP get their entire treatment in the community within 28 days. And the other 22% who need surgical intervention get their procedure much faster. We only see the people in hospital who need to be seen in hospital. It is good for patients and much more cost-effective.

Q How does the financial challenge affect the transformation agenda?

Transformation is more difficult in times of tight finances. But we were in deficit at the start of our transformation work and we saw that the only way out was to change the system. We were about to break even when we were hit by a major natural disaster. We were grateful we'd done all that work or we wouldn't have got through so well.

Where we are now – especially with two very tight years ahead – the risk is that people get distracted by the financial issues and start making the wrong decisions. So we need to manage the financial side of the business in a way that doesn't stop service improvement. Clinicians are now used to change as the natural way of operating, and the leadership team is getting pulled rather than having to push the change agenda. New work has demonstrated that our integrated system has created system efficiencies of around $40m, compared with New Zealand's standardised expenditure – a result of doing so much less in a hospital-based environment and so much more in the primary and community system.

We wouldn't and can't unwind this way of working now. But it does require courage and leadership from the board down.

Q Will integration reduce your requirement for acute beds?

We have a rebuilding programme as a result of the Canterbury earthquakes and

Christchurch Hospital – Canterbury District Health Board's largest hospital

waiting times and a rapidly ageing population – even by comparison to other parts of New Zealand. An analysis – its own mini 'forward view' – calculated that, if nothing changed, by 2020 it would need another hospital nearly as big as its main 500-bed Christchurch facility and an almost doubling of staff working across health and social care.

2020 vision

This was not only unaffordable but, in terms of recruitment, unachievable. Instead a vision was developed for how the service should look in 2020. This involved massive staff engagement and use of quality management techniques such as Lean. At the heart of this vision was a system integrated around patients and a recognition that, despite different funding streams and a range of healthcare partners, there was fundamentally only 'one system, one budget'. This was rapidly adopted as the mantra for the transformation programme, with the key performance metric 'not wasting the patient's time'.

The move to integration has gone hand in hand with engagement of, and investment in, staff and has been underpinned by the new contracting arrangements. In 2013, Carolyn Gullery, general manager planning, funding and decision support at Canterbury Health Board, told the King's Fund – in a detailed briefing on the Canterbury approach – that alliance contracting had moved the board from 'being solely accountable to having a collection of people trying to make the whole system work'. Underperformance by one partner is now met with offers of help from other participants and often further investment. Describing the approach as 'high trust, low bureaucracy', Ms Gullery said: 'We either all fail or all succeed.'

A number of initiatives helped to translate the vision into practice. These include the development of more than 900 HealthPathways, which set out how patients with particular conditions should be managed,

our population is growing extremely fast – up about 53,000 [since before the earthquakes]. When our new acute services block comes on stream in 2019, we will only have 30 more acute beds than we had before the earthquakes. But we've never argued we would see a reduction in beds. We have completely moderated medical growth and our actual bed days are now running 7.7% below the forecast built into the business case for the new hospital.

But we can't slow down surgical beds. It is hard to mitigate growth in surgical beds and counterintuitive when the government wants you to do more and more elective surgery. We also fund long-term care beds. Ten years ago we were remarkably successful at putting people into long-term care beds; now we are remarkably successful at keeping them out.

Q How have clinicians responded to the HealthPathways initiative?

Initially, a few talked about 'cookbook' medicine. But the way we implemented it avoided this. We got primary and secondary care in a room – gynaecologists and GPs, for example – and redesigned the pathway and then talked about how we were going to inform everybody. That's how HealthPathways was born – it was a tool for dissemination.

There were 180 GPs involved in different workgroups for designing pathways – so the whole project was done with them and for them, not to them. As a result, we had no pushback. We also introduced a hospital-facing HealthPathway a year and a half ago. This reinforces the right pathways for patients and gives the opportunity to audit practice against the preferred pathway. For example, in the case of pipelle biopsies (used as a diagnostic in the heavy menstrual bleeding pathway), we can check all biopsies have been followed up.

Q How important is data in general to your work?

We are completely focused on data. One of the great outcomes we've had as a result of our integration work and use of a number of data tools, is that we can do the analysis alongside clinicians and no-one questions the data. We do look at cost data, but our focus is on flow, and patient time is the key metric we use as a proxy for cost. If we can reduce the time a patient is in the system, we'll reduce cost. This makes it easy to grasp if something is the right thing to do.

Focusing on flow helps us to look at the patient journey and identify improvements. For instance, despite our acute admission avoidance system, we noticed we had wards full of chronic obstructive pulmonary disease patients. Analysis of the data showed us that many of these patients were coming in via the ambulance service and bypassing the demand management pathway. As a result, ambulance paramedics have been given criteria for how these patients should be handled and which services are most appropriate. We saw an immediate result, with 30% of these people who called for an ambulance now staying at home.

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Devastation in the city of Christchurch after the 2011 earthquakes put increased pressure on local health services

supporting assessments and referrals by general practitioners. Involving GPs and hospital specialists in the development of the pathways has led to a much higher degree of acceptance and use by GPs, compared with other sets of treatment guidelines and localised versions deployed in more than 30 health systems across Australia and New Zealand (and now in the UK, by South Tyneside Clinical Commissioning Group).

An acute demand management system has also been introduced to directly prevent hospital admissions. This involves general practice teams managing patients in the community with support from community providers, advice from hospital-based specialists and co-ordination from the primary health organisation.

It has evolved over time – for example, enabling ambulance paramedics to access the service – and has more than doubled the number of cases it manages annually from 14,000 to 34,000 per annum.

In a further initiative, a community rehabilitation enablement and support team targets reductions in length of stay once in hospital and aims to avoid readmissions and admission to long-term care with intensive home-based rehabilitation.

Earthquake aftershocks

Part way through implementation of its integration plans, Canterbury was struck by a series of earthquakes and aftershocks in 2010 and 2011. This added significantly to the health board's challenges. It increased the immediate and ongoing demand for services – demand for mental health services, for example, has grown significantly. The board's estate also took a hammering, with some buildings no longer usable and

Canterbury Q&A continued

Q How has your alliance approach helped your integration model?

The alliance is central to delivery and the alliance contracts provide a flexibility that enables providers to meet patient needs. For example, we used to fund district nursing and home support services effectively on a fee per service basis and costs were growing at about 13% per annum, which was unaffordable. It was delivering an old-fashioned model about tasks – cleaning the house – rather than what the patient really needed at that time.

Under the alliance, we selected providers based on quality and use a casemix model where resources are allocated to providers based on complexity. The model allows the provider to flex what is done for a patient each week to meet needs, and it gives the provider the opportunity to become more efficient in how they use their workforce.

Risk is shared across the alliance – and after seven years it's working well. If there are problems – for example, with higher levels of activity than forecast – then we work together to find better ways of doing things. We are constantly innovating. It is about everyone helping and being fairly rewarded. For example, occasionally a provider might struggle to recruit staff or lose a key manager – our response might be to help them with health board staff.

Q What are your key challenges over the next five to 10 years?

We have financial challenges. We have a building programme and will be working on a construction site for at least another five years. Running and rebuilding a hospital at the same time is quite complicated. It's been a long haul since the earthquake and there is a challenge in getting people refreshed and refocused and then seeing where the next opportunity lies. Our government is pushing for its agencies to take more of a preventative and long-term approach, which absolutely suits Canterbury.

The big issue we face is the long-term impact of a very traumatic natural disaster particularly on our children and youth. That is our focus going forward. We're seeing it in our schools. We have a stable system around older people now, but there is now a demand coming at us for services for our children and youth.

In addition, we need to see some change is general practice, where we have an ageing and declining workforce and too much demand. General practice does a fantastic job – for example in helping reduce acute admissions. But the core model hasn't changed, based on 15-minute appointments. How do we move to a more technology-based and flexible model and use other channels and tools to support our patient population?

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Find out more

Carolyn Gullery is speaking at this year's HFMA Convergence conference in July. The London event brings together the annual HFMA commissioner and provider conferences (see page 29)

others needing substantial repairs. This has led to staff having to move regularly as the renovation programme moves across the board's facilities. There was an immediate financial impact. The health board had been on track for an $8m surplus in 2010/11, but that inevitably turned into a deficit as a result of the earthquakes. Since then, the board has relied on revenue deficit funding to support its financial position. For example, in 2015/16 it received $16m in support to help it deliver an overall deficit of just under $0.5m – although this support has now come to an end.

Subsequent earthquakes, including last November's 7.8 magnitude North Canterbury earthquake, have continued to challenge the region and its health services.

The most recent government allocations have just made Canterbury's financial position significantly more challenging. Allocations are based on an age and deprivation weighted capitation formula. And recent census data has led to Canterbury receiving the lowest increase of New Zealand's five biggest health boards – giving it a significant shortfall when inflation and population growth are taken into account.

This is a result of a necessary migration of some 10,000 families out of East Canterbury's most deprived communities following the earthquakes. Levels of deprivation haven't reduced, the health board argues, it has just been dissipated across the wider region. And following an immediate dip in population growth following the earthquakes, it has subsequently been rising rapidly.

Sticking to strategy

The board's large capital programme will certainly continue to drive costs. But the added financial challenges have not changed the board's minds that its integrated health system is the right approach to delivering sustainable services. If anything, it has underlined the urgency of making further progress.

A number of English sustainability and transformation plans are targeting a reduction in inpatient beds on the back of more community services. The King's Fund's 2013 report said that Canterbury had not shrunk its hospital base – nor was that its goal. But it had avoided the growth in bed numbers originally predicted in the 'do nothing' option.

Measuring performance using a core set of agreed measures, including outcome measures, shows positive progress, such as sustained reductions in the number of smokers and acute medical admissions growing at a much lower rate than the New Zealand average. Medical admissions per 100,000 population are 30% lower than the national average.

Acute readmissions have levelled off after several years on the rise and are now in line with the New Zealand average, although with lower than average admissions, admitted patients are likely to be more frail and more at risk of readmission. The number of older people (75+) living in their own homes (88%) is also increasing and fewer are going into aged residential care, with a reduction of 34% in the past five years in the less complex area of rest-home care.

The health board also boasts a lower avoidable admission rate and emergency department (ED) attendance rate that is 25% below the national average, with the credit going to its acute demand management service and other targeted initiatives. More remarkable is the reduction in the rate of ED attendances by over-65s to 260 per 1,000 – well below the national average.

There are still major challenges. In-hospital falls continue to exceed the national averages – though they have decreased slightly recently and the board believes its figures also reflect improved falls coding. A new system-wide falls prevention strategy is now in place.

Canterbury District Health Board is convinced its integration programme has been a success and is the only way to meet ongoing service and financial challenges. It is increasingly recognised as a model showing how integration can deliver better care and help ensure services are sustainable.

The difficult financial challenge facing the board can only make it an even better example for UK health bodies as they attempt to deliver similar goals through more integrated services.

health + wealth

Increasing the proportion of GDP spent on health is a hot topic in the run-up to the election, but what would such a move mean for the health service? Seamus Ward reports

When dealing with heath service funding, the proportion of GDP (gross domestic product) spent on health, compared with other nations, seems to be broadly understood by voters. Yet, despite the prompting of NHS pressures groups and organisations – chiefly the NHS Confederation – during the election campaign the political parties have seemed reluctant to commit to a fixed proportion of the country's wealth to be spent on health.

There are other ways of measuring and comparing health expenditure. Spending per head is traditionally used to compare the four UK nations. Recently, with a rising and ageing population, it is seen as a good way of seeing how well the NHS is funded for demographic pressures.

However, discussion on the percentage of GDP spent on health is not new and is seen by economists as a good indicator of how much is being spent compared with other countries – it was highlighted during the 1987 general election, for example, when spending was around 6%. And, in 2000, Labour prime minister Tony Blair pledged an extra £12bn over six years to bring NHS spending in line with the European Union average. At that time, it meant a 5% a year real-terms rise in funding, bringing spending as a proportion of GDP from 6.7% to 8%.

In April, the Lords Select Committee on the Long-term Sustainability of the NHS said that if spending does not rise as fast as GDP for 10 years after 2020, the quality of and access to care will be 'seriously affected'. It added that NHS funding was growing at a slower rate than GDP, when historically it tended to outstrip growth in the economy.

Though in this election politicians have shied away from linking health spending to GDP, the Conservative mantra of the past few years – that only by creating a strong economy can the country afford to increase spending on health – perhaps implicitly promises that health spending will increase as GDP rises. Despite the lack of political interest, the NHS Confederation believes the service and the public need the assurance of funding linked to GDP. Funding as a proportion of GDP has risen steadily over the years.

Before looking at the figures in detail, a word of warning. The figures bandied around are often accurate but include different spending pots when calculating the health spend as a proportion of national wealth. Generally when comparing countries, Organisation for Economic Co-operation and Development (OECD) figures are used – the UK figures are prepared for the OECD by the Office for National Statistics. However, the OECD calculation of health spending is quite wide and includes some elements of social care (see box) and excludes capital spending (around 0.3% of GDP).

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In 2015, the ONS put UK GDP at £1.8tr and UK health spending at around £185bn, with about 80% from government funding, 15% in out-of-pocket payments, more than 3% from voluntary health insurance and 1.6% in charity-funded care (see pie charts for breakdown).

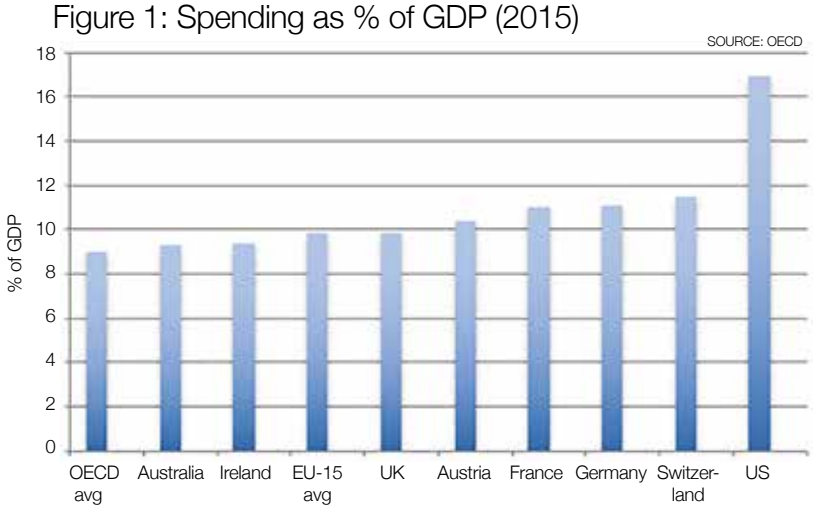
But other bodies use different definitions. The Treasury, for example, uses a measure known as UK public health spending. That means public spending on health, rather than spending on public health, and includes all taxpayer spending including capital (though not some administrative costs). Other expenditure areas included are medical research, devolved administration health spending and local government spending on health. In 2015/16, public health spending, using this definition, stood at £140bn and accounts for 7.3% of GDP.

Assessing the main party election manifestos and using the Treasury definition, the Nuffield Trust said that health spending pledges by all parties would see the proportion of GDP spent on health fall in the next few years. Under Labour's plans it would fall to 7.2%, while under the Liberal Democrats it would drop to 7.1% of GDP by the end of the Parliament. While it was unclear if the Conservative promise of an additional £8bn applied to NHS England or the wider Department of Health, the trust said that even under the most generous interpretation, spending would shrink to 7% of GDP.

International comparisons

But how does the UK compare with other countries? According to the OECD figures (see figure 1), in 2015 the UK spent a little more than the Republic of Ireland and Australia (9.8% compared with 9.4% and 9.3% respectively). UK spending was the same as the average for the EU-15

Figure 1: Spending as % of GDP (2015)



countries – the members of the European Union prior to the 2004 enlargement that brought in seven former Eastern Bloc countries. The United States is an outlier worldwide at 16.9%.

Neighbouring countries in Europe spend more of their wealth on health, including the economic strongholds of Germany and France, which are often the benchmarks when assessing the strength of the UK economy.

NHS Confederation chief executive Niall Dickson argues that there is a precedent for linking spending to GDP, with defence spending set at 2% and international development 0.7%. 'It would recognise there is a special place for health and care, as with the military and international development. As these two have demonstrated, setting a proportion holds politicians' feet to the fire and makes them more accountable.'

The confederation has set no target for the proportion of GDP to be spent on health – that, it says, is for an incoming government. But it has looked at two scenarios and how they could affect health spending – maintaining the current 10% (it is around 9.8%) or being more ambitious and seeking to match the 11% spent in France and Germany.

The former would require an additional £16bn a year by 2022, and it assumes £12bn of this would come from the Exchequer – this was calculated using the proportion to government-funded care found in the ONS figures above (79.9%). The remaining £4bn would come from a variety of sources, such as out-of-pocket spending, private health insurance and charity funds.

Matching the French and German spending as a proportion of GDP would cost £20bn a year, the confederation says. Again, using the proportions in the ONS figures, £16bn would come from the government and £4bn from private sources.

The proportion of GDP spent on health is not just about the headline figure, but the balance of funding from the government, private sources, including insurance, and charities. If increasing the proportion of GDP, the country may have to decide where the balance should lie.

In most other countries, the bulk of the spending comes from national government. Nevertheless, in higher spending countries a greater proportion of overall health spending comes from private sources. According to the Institute for Fiscal Studies, while 79% of UK health spending in 2015 was publicly funded, the average in other EU-15 and G7 (world's strongest economies) countries was 75%.

The US spends around the same as the UK on publicly funded healthcare as a proportion of GDP, but this accounts for less than 50% of the country's total spend on health.

These international comparisons have led some commentators to suggest that the UK could increase its spending as a proportion of GDP by upping private funding, specifically through increasing co-payments.

Clearly, both scenarios considered by the NHS Confederation factor in an increase of £4bn in non-government funding, but could this mean more co-payments, such as for GP appointments?

Mr Dickson says: 'At the moment, healthcare is nationally funded and free at the point of delivery and there seems to be a genuine consensus that that will remain. Social care has long been means tested and funded locally and again I don't think we envisage any particular change in that.'

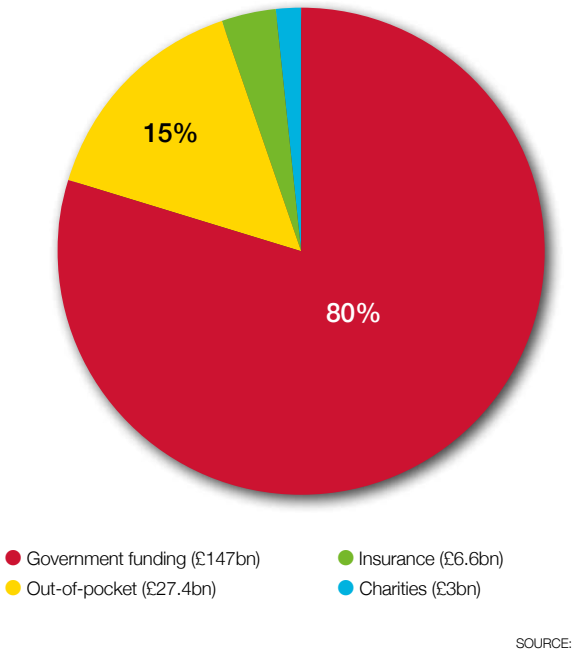
He adds that the Conservatives' planned green paper on social care, should they win the election, could change the balance of public and private funding.

Proportional argument

John Appleby, Nuffield Trust director of research and chief economist, says in principle he does not see a problem setting NHS spending as a proportion of GDP at its current level. 'It represents real growth of around 2% a year which is half the long-run [since the 1950s] average annual real growth and assumes we are content to remain about average with regard to other countries,' he says.

'It wouldn't mean more co-payments – it would just mean keeping the NHS growing in line with growth in the economy. This assumes tax

Figure 2: UK health spending 2015



SOURCE: ONS

Proportional spending

UK spending on health as a proportion of GDP has risen gradually over the years (see graph). In 1970, for example, it was about 4%, hitting 5% a decade later.

While in the 1980s spending stagnated at around 5%, the initial years of the 1990s saw a rapid climb as the purchaser-provider split was introduced. It had climbed to 6% by 1993 before plateauing again and being maintained during Tony Blair's first administration.

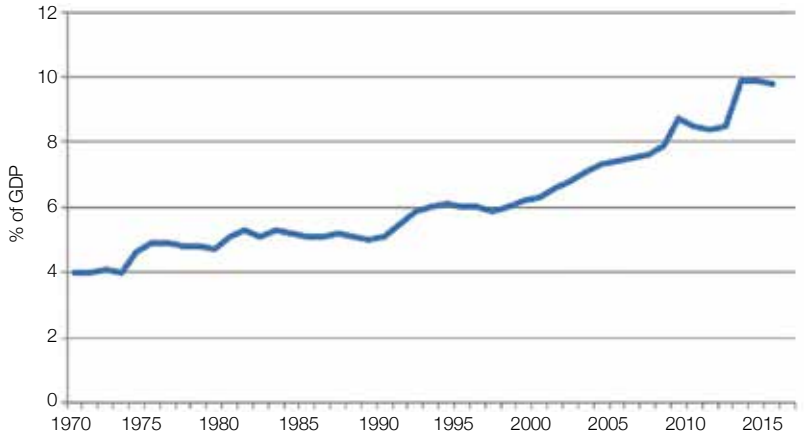
But with Tony Blair's promise in 2000 to increase health spending to the average level for the European Union, spending began to rise again. It increased from 6.3% of GDP in 2000, rising rapidly through the Blair/Brown years to 8.9% by 2009.

The Conservative/Lib Dem coalition government elected in 2010 imposed austerity on public services. Though the NHS was protected more than other parts of the public sector, it began to feel the effect of the squeeze on public spending. Health spending fell as a proportion of GDP during the early years of the coalition to 8.5%, but jumped to around 9.9% in 2013 and 2014. This is not due to an unnoticed multibillion-pound increase in actual spending, but changes in the way the figure is calculated.

The adoption of new definitions (known as the *System of health accounts*) developed by the OECD, has meant a reclassification of spending. In 2014, just under £9bn previously counted as health spending was no longer included, while more than £29bn that was attributed to other categories is now part of the calculation of health spending.

Out went capital spending and some out-of-pocket expenditure, but into the calculation came the carer's allowance (£2.4bn in 2014), privately funded spending on long-term care (£9.5bn) and taxpayer-funded health-related social care (£13.5bn). Under the new rules, local authority nursing and residential care are now within the ambit of health spending.

Figure 4: UK health spending as % of GDP



revenues et cetera also grow in line with GDP growth. But what happens when GDP doesn't grow very much or falls in times of recession?'

GDP tends to rise, even if only by small amounts, though it contracts during recession – in this case, would health spending fall as the economy shrinks? Mr Dickson again: 'It's a legitimate point to make, but our argument is that when there is a recession, it is inevitable that a government will look at public spending.

'We, and others, would make a strong case for protecting the most vulnerable in health and care. Historically, recessions have been short and it is unlikely during that time we would see big issues with health and care budgets. If a recession was prolonged, we could have a debate as a society about how much we want to spend on health and care.'

As we've seen, nailing down just how much the UK spends on health and how this compares internationally can be difficult. To bring some clarity, the confederation proposes setting up an Office for Budget Responsibility for health.

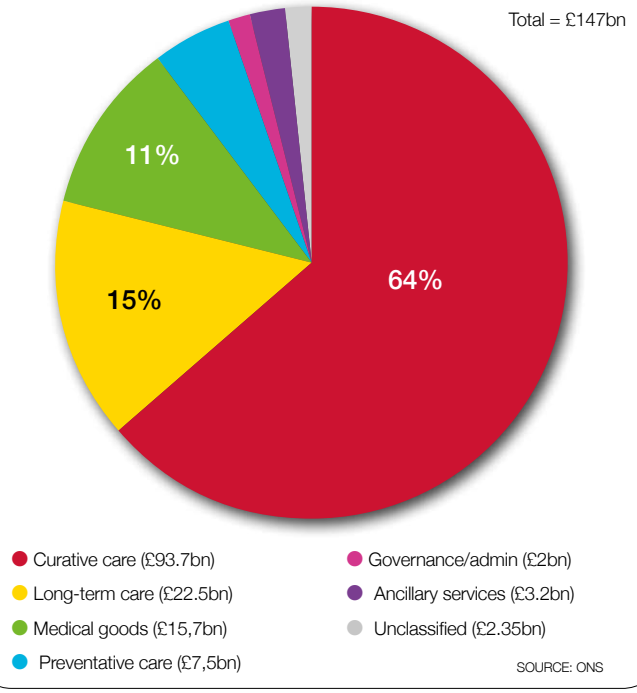
This has also been floated by the Lords Select Committee on the Long-term Sustainability of the NHS and promised in both the Labour and Liberal Democrat manifestos.

Mr Dickson says the independent body would strengthen the evidence base on which decisions are made.

'I would like to see an objective assessment of funding needs as a one-off and then in future it could go through an OBR for health. This could project the future needs of health and care, be independent of government and provide indicative data on the proportion of GDP that's appropriate. It could report on whether the government has done what it said it would do and whether the system is providing good value for money, which is an obligation on the system.'

Health spending as a proportion of GDP seems a straightforward measure, but it can be a minefield, with different elements of health and care spending included or excluded from calculations. However it is calculated, this election campaign has seen NHS bodies push for its use to assure the public that health services have the money they need to provide the care the public wants.

Figure 3: UK government health spending 2015



Into the future

With the NHS facing major financial challenges, the role of the HFMA in supporting finance practitioners is ever more important. Mark Knight sets out its new strategy

The NHS is in a very different place to where it was three years ago. In 2014, austerity was already the government's established economic policy, and the NHS was feeling the pressure with a small provider side deficit in 2013/14. The HFMA's first *NHS financial temperature check* highlighted growing finance director pessimism about their organisation's ability to meet financial targets.

Three years on and finance directors' concerns have materialised into perhaps the biggest financial challenge the NHS has faced. There is a broad consensus around how the service needs to progress – transforming care models and integrating all health and care services around patients – but there are also clear concerns about whether current funding levels are sufficient to allow a realistic timeframe to be set for this transformation.

This new environment provides a different context for the HFMA to operate within and will have a direct impact on some of its activities. Our new strategy – covering 2017 to 2020 – sets out the board's key aims for the association over the next three years. We are keen to hear any comments and views from members on this strategy.

The HFMA is the only professional body in the UK dedicated to setting and promoting the highest standards in financial management and governance in healthcare. We possess a unique space in the healthcare sector – our members and what we say is important and the network we provide is vital for a healthy and effective finance function.

The difficult financial position within the NHS and the challenges faced by all NHS staff make the role of the association – particularly in delivering professional development (CPD) and technical support to finance practitioners – even more important.

Since the last strategy document was published in 2014, the HFMA has run more than 750 events and provided some 300,000 hours of CPD. Its wider membership has grown to more than 13,000 and it constantly performs at 95% good/excellent satisfaction ratings for its events.

The association remains committed to ensuring the content of all its education and development activities meets the changing needs of the membership and that these activities are delivered in the most appropriate way to fit the busy working lives of members.

In setting our objectives, the strategy is governed by a number of overriding themes including to make greater use of smart technology as the HFMA establishes itself as a 'one-stop shop' resource for members (see box). To help us achieve our vision of supporting 'better quality health and social care through effective use of resources', we have set four objectives:

1. Provide excellent member networks and services
2. Develop and disseminate leading edge policy and technical work
3. Create relevant and affordable development and qualification opportunities
4. Manage ourselves effectively as a business.

Members and services

Our members remain the central focus for the HFMA. We will continue to support members,

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ensuring content is absolutely relevant and improving how they can access this support.

For example, a new member app will provide a simple way for members to keep up to date with what the association is doing, what it is publishing, and the webinars and events that are most relevant to their working lives.

But we'll also continue to target an increase in membership, both in terms of our core finance practitioner members and our growing affiliate membership – a broader group of stakeholders who rightly have an interest in healthcare finance.

We will continue to develop our faculty system with new networks in social care and for clinicians – underlining the importance of engagement and working as whole systems to deliver sustainable services.

Policy and technical

Over the past three years, the HFMA has made significant investments in its policy and technical team. Our approach has always been to make comment on the basis of evidence and to publish informed and practical guidance. Our expanded policy and technical team has enabled us to expand these activities, while retaining our commitment to depth and detail, and to enhance the support to our range of groups and forums. Over the next three years, we aim to continue this development with an increased focus on ensuring our members are always aware of the wide ranging work being taken forward across the association.

Education and training

The HFMA is the leading provider of finance-related CPD and will continue to ensure its programme of conferences, forums, workshops, webinars and e-learning remains relevant to members and other stakeholders. In helping branches to develop their work and events, we will co-ordinate more sharing and developing of common programmes that can be rolled out in different areas.

The masters-level qualification, which formally started in May 2017, marks a significant milestone for the association. This is an exciting development and our clear objective is to establish this qualification as the 'gold standard of healthcare finance' attracting more students and adding a wider range of modules.

A new HFMA Academy will oversee the qualification training. We will also continue to support the Future-Focused Finance initiative in our role as prime partner.

Manage ourselves effectively

In the past 15 years, the HFMA has become a successful medium-sized business with a turnover of more than £8m. While in 2000, we had one employee, we now have more than 70 staff (45 whole-time equivalents). The HFMA's asset base has increased significantly in the same period, with our London conference centre the biggest single asset in our portfolio.

The association recognises that 2017-2020 will be a difficult period for the health and social care sector. Budgets for the work in which the HFMA is engaged are likely to remain tight and we recognise that affordability and value for money will be more important than ever.

The HFMA board will continue to consider investments of its cash reserves, with any revenue used to reduce costs of services.

We do not anticipate increasing reserves during the coming three years, but will aim for balanced budgets. We will also continue with our long-term goal of becoming a chartered organisation.

The new strategy walks a fine line between the association wanting to develop, but also recognising that the current NHS landscape is very tough.

Equally, the move to deliver more services digitally, to provide new educational offerings and a drive to be more member focused are all areas where the board feels there is real scope for development.

Strategy: overriding themes

1. The HFMA will remain relevant and financially stable so it can support an NHS facing a continued period of funding constraint.
2. It will draw upon reserves, where appropriate, to maintain affordable and accessible programmes.
3. It will invest in services and look for opportunities for new areas of growth and support for its members.
4. It will look to take advantage of new opportunities in education, launch an academy to deliver educational offerings and aim to become an awarding body.
5. It will target becoming a more digital organisation via the use of smarter technology.
6. It will further establish itself as a learning and sharing organisation and a true 'one stop shop' resource for members

Have your say about the new strategy by emailing chiefexec@hfma.org.uk

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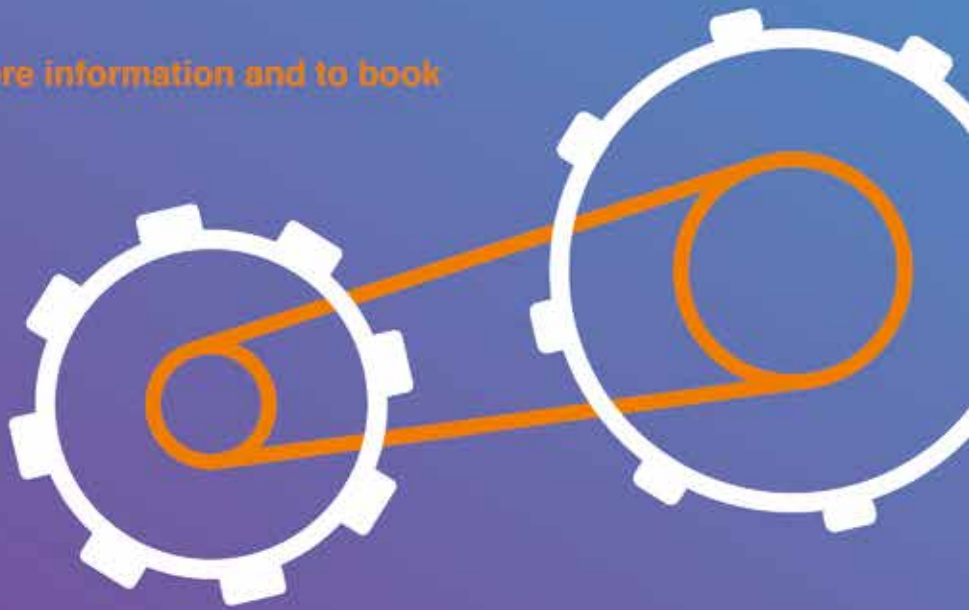

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Finance teams should prepare for changes to lease accounting

Technical update

Changing how we account for leases may seem like a technical and insignificant change. It isn't up there with the big NHS financial challenges – deficits, sustainability and transformation. But it does need to be on financial accounting teams' radars, *writes Debbie Paterson.*

The impact – uncertain in many respects – could be wide-ranging, leading to an increased workload for finance teams, changes to key metrics, different phasing of reported leasing costs and a possible influence on how much investment the NHS can make in capital assets.

The new accounting standard – *IFRS 16: leases* – is not due to apply in the public sector until at least April 2019 (and hoops must still be jumped through in terms of European and Treasury adoption). So you could be forgiven for thinking that you don't have to even think about it yet.

But NHS bodies cannot afford to wait until everything is certain and the new requirements are built into the 2019/20 *Financial reporting manual.* In simple terms, the new accounting standard (replacing IAS 17) will end the distinction between finance leases and operating leases for lessees. Under IAS17, if a lease was judged to be similar to purchasing the asset being leased, it was a finance lease. As such, it was reported on a company's balance sheet at the net present value of future lease payments and the asset would be depreciated in the revenue account. But operating leases were treated in the same way as service contracts – off-balance sheet and only reported as revenue costs.

In future, leases will require a slightly different treatment. 'So what?' many people might wonder. Well, the new approach is likely to be more time-consuming and burdensome for finance teams, at least initially. This is simply because all leases will need to be identified and

the accounting entries worked out for the new approach. It is also likely to change how the costs of leasing hit an organisation over time. The total costs won't change, the same amount will be paid to the lessor, but costs will be higher in earlier years – depreciation may be on a straight-line basis but interest will start high and reduce.

An early briefing from the HFMA last year demonstrated this in a simple worked example. That may not be a deal-breaker, but organisations need to be aware of the change in phasing of costs, both for existing leases and any new ones being considered.

Metrics will change too. Earnings before interest, depreciation and amortisation (EBITDA) is the most obvious example. Lease payments made under traditional operating cost leases are currently recorded above the line, but once on balance sheet, their depreciation and interest costs will move below it. EBITDA will increase.

Costs and performance won't change, but managers and regulators will need to view such metrics in light of the new accounting treatment.

Perhaps the greatest uncertainty is around how this might impact on capital funding in the NHS. Moving all leased assets on balance sheet will mean they count against the capital departmental expenditure limit – already under significant pressure, facing huge demands to support sustainability and transformation plans and being tapped to support current revenue overspending.

It is such a big issue that the Office of National Statistics is leading a project on the impact of IFRS 16 on the national accounts.

This is being run in parallel with the Treasury's work on how this standard will affect its *Financial reporting manual.* The national accounts, which are used to measure performance against the CDEL, are prepared using the *European system of accounts 10* (ESA 10), which retains the finance/operating lease distinction. One solution to this problem could be dual accounting – where the accounts are prepared under IFRS but then the ESA10 information is also maintained and submitted to consolidating bodies. This currently works for private finance initiative schemes. But is it practical for the many hundreds if not thousands of lease agreements NHS bodies are party to?

The HFMA's Accounting and Standards Committee is starting work on a briefing setting out the practical steps NHS bodies should take now. It will also include questions on NHS bodies' preparedness for the new standard in its year-end survey of all NHS bodies in early June.

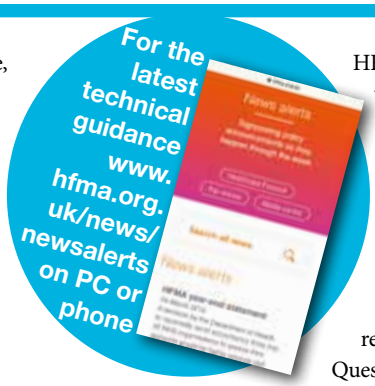
• ***Debbie Paterson is an HFMA technical editor***

Technical review

The past month's key technical developments

Technical roundup

The **apprenticeship levy** scheme, which started in April, requires all employers with a paybill of more than £3m a year to contribute at a rate of 0.5% of their paybill minus a £15,000 allowance. Payments go into each employer's own digital apprenticeship account along with a government top-up. Employers can then access these funds for up to two years to support approved vocational training.



It has been unclear how employers account for payments into and withdrawals from their accounts – with the HFMA's Accounting and Standards Committee last year identifying three possible approaches. The major accountancy firms are understood to have reached a consensus – Deloitte has published a proposal, with others expected to follow suit.

The Deloitte guidance suggests different treatments depending on whether employers plan to enter into eligible apprenticeships or not. When paying into accounts, those expecting to use funds should recognise a prepayment for training services expected to be received. These payments are recognised as an asset until the receipt of service. When the service is received, an appropriate expense should be recognised. Employers not intending to offer apprenticeships within the 24-month life of the funds should treat the payments as an expense. Payments relating to staff in Wales, Scotland and Northern Ireland must also be expensed. Deloitte adds that government top-ups (10% as standard and a 90% co-investment in set conditions) should be recognised as grant income at the same time that an associated expense for training services is recognised.

The approach has not been officially confirmed yet and NHS bodies will have to follow whatever guidance is issued by the Department of Health, NHS Improvement and NHS England. NHS Improvement guidance on filling in the planning forms should be followed until it says otherwise.

NHS England has also set up codes to allow clinical commissioning groups to deal with the payment of the levy. The HFMA's Accounting and Standards Committee is in discussion with all of these bodies and will develop a briefing that is expected to include worked examples.

New HFMA guidance offers help to **governing body and audit committee members** when reviewing financial reports during the year and at the year end. The guidance is organised as a series of questions non-executives and lay members might ask about annual accounts and periodic reports, also explaining the underlying reason for asking it. Questions are grouped under six headings:

- Overall performance
- Accounts preparation
- Statements of comprehensive income/net expenditure
- Statement of changes in taxpayer equity
- Statement of financial position
- Statement of cash flows.

For example, in terms of expenditure it directs non-executives to ask about meaningful changes in depreciation figures. It explains that changes in the useful economic lives of assets may reduce in-year expenditure without a corresponding improvement in cash.

NHS Improvement has provided a summary of messages emerging from this year's **acute costing assurance** programme. Using a dashboard, the oversight body has provided feedback from 20 of 49 reports and highlighted 209 recommendations, including 40 improvement opportunities and 27 high-risk themes.

One high-risk area was where auditors found insufficient programme management of costing submissions with no clear accountability. Of the 20 bodies audited, four were rated as having substantial assurance, 10 moderate and six limited assurance.

Chromoendoscopy enables real-time polyp assessment

NICE update

NICE has recommended the use of virtual chromoendoscopy using narrow band imaging (NBI), flexible spectral imaging colour enhancement (FICE) or iscan to assess polyps of 5mm or less during colonoscopy under set conditions, *writes Nicola Bodey*. This can be used to determine whether they are adenomatous or hyperplastic.

Colorectal polyps are small growths on the inner lining of the colon that carry a small risk of becoming cancerous. They affect 15% to 20% of the UK population. Colorectal cancer is the second most common cause of cancer death in the UK – there are about 40,000 new cases registered each year.

Current clinical practice is to remove all polyps found during colonoscopy investigations and send them to laboratory services for histopathology assessment. Polyps are examined to determine whether they are adenomatous (and so at high risk of cancer) or hyperplastic (at low risk).

Virtual chromoendoscopy technologies allow colour-enhanced visualisation of blood vessels and surface pattern. They may allow real-time differentiation of adenomas and hyperplastic colorectal polyps during colonoscopy. This could lead to fewer unnecessary resections of low-risk polyps, quicker results and management decisions, and reduce use of histopathology examinations.

It is estimated that 410 people per 100,000 population are eligible for assessment with virtual chromoendoscopy each year. From year five, it is estimated that 330 people for every 100,000 population will have an assessment with virtual chromoendoscopy each year once uptake has reached 80%.

The guidance is expected to lead to a cost saving for the NHS and may improve patient

Diary

June

12 B London: annual conference, London
13 B Kent Surrey and Sussex: prestige event, Lingfield
15 B South Central: employment tax changes, Southampton
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
23 B Northern Ireland: co-production/outcomes-based accountability conference, Newtownabbey
26 B Eastern: positive psychology to improve wellbeing and resilience, Rowley Mile Racecourse
28 N Workforce, Rochester Row
28 B Wales: business etiquette, Cardiff
29-30 B North West: annual conference, Blackpool

July

5-6 N Annual Commissioning Finance conference, London
6 I Value masterclass, part of Convergence conference, London
6-7 N Annual Provider Finance conference, London
11/12 B Escape event, South Wales
12 B London: positive psychology to improve wellbeing and resilience, Rochester Row
20 B Yorkshire and Humber: annual quiz, 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 I NHS costing – regional networking and training event, Birmingham
28-29 B South West: annual conference, Bristol

October

4 I International symposium, London
11 F Chair, Non-Executive Director and Lay Member: forum, Central Manchester
12 I NHS costing – networking and training event, London

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

key B Branch N National F Faculty I Institute

experience. The saving depends on avoiding unnecessary histopathology assessments when assessing colorectal polyps. The annual saving associated with implementing the guidance for every 100,000 population is estimated to be £3,800 in year one, increasing to £18,800 from year five. This equates to a £10.3m saving in England from year five.

The use of virtual chromoendoscopy technologies is commissioned by clinical commissioning groups (CCGs). Providers are NHS hospital trusts.

Nicola Bodey is senior business analyst at NICE

Events in focus

Convergence: annual commissioning finance conference 5-6 July

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

Speakers have been added to the HFMA's Convergence conference, which brings together its annual commissioning and provider conferences for the first time. They include King's Fund chief executive Chris Ham, on the challenges of setting up accountable care organisations. And Carolyn Gullery, general manager planning, funding and decision support at Canterbury District Health Board in New Zealand (see page 16), will give an international perspective on integration. Two trusts involved in the partnership programme with the Virginia Mason Institute will also share their experiences so far. And a range of plenary and sub-plenary sessions will include: Bob Alexander, 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 (pictured), chief finance officer and deputy chief executive of Royal Free London NHS FT; and Ben Collins, project director at the King's Fund.

• To book your place, visit hfma.to/converge or email emily.bowers@hfma.org.uk

Workforce 2017: improving efficiency and value 28 June, Rochester Row

Managing the workforce is one of the greatest challenges facing the NHS – from recruitment and retention to safe staffing and efficiency. This one-day event, organised by the HFMA and Healthcare People Management Association (HPMA), will examine these and a number of other hot topics, such as the apprenticeship levy and leadership development. Speakers include NHS Employers chief executive Danny Mortimer and Health Education England chief executive Ian Cumming.

Aimed at finance, HR and clinical professionals, workshops will include a case study on how the London Ambulance Service NHS Trust developed a sustainable staffing model, which won the trust the HFMA Havelock Training Award in 2016. Another workshop will examine how the NHS can save on its medical locum bill by achieving Model Hospital levels of best practice.

• To book places and receive a free place please email camilla.godfrey@hfma.org.uk

Real choices

Association view from Mark Knight, HFMA chief executive

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

My HFMA

By the time you read this, the election will nearly be upon us. It's such an unusual period to be living in. Brexit supposed to be the all-encompassing issue, but for those of us working in the caring services (and many others), health and social care is as important if not more so.

Understanding the funding pledges from the different parties is not straightforward given the different ways they use to describe their offers. Respected thinktank the Nuffield Trust, based on a number of assumptions, says the additional spending promises amount to, by 2022/23: £8bn (Conservatives); £12bn (Labour); and £9bn (Liberal Democrats).

It adds that the three main parties' proposals for health would all see NHS spending fall as a proportion of gross domestic product.

This falling proportion – even with the proposed investment plans – perhaps highlights why the HFMA and others have been calling for health spending to command a set percentage of GDP to provide some protection against rising demand and activity (see page 23).

Healthcare funding is such an important issue. Getting the balance right between proper funding and realistic productivity improvements is difficult and election campaigns have a tendency to encourage simple slogans and overblown claims rather than evidence-based arguments. It is not all about funding. But getting the right financial framework in place will provide the right context for the other essential changes in clinical and support service pathways.

We have been spared the often overt NHS manager bashing seen in previous campaigns. But, depending on who you believe and what you read this time, different party proposals would contribute to either bankrupting the country or be a forerunner to open privatisation of the NHS. The reality is always more nuanced.

Of course there are opportunities to improve outcomes and productivity in the NHS. But we should rightly be proud of a service where ability to pay is simply not an issue. I have recently returned from the US and, while there are aspects of their system that are laudable, their insurance-based funding approach leads to some inequitable situations that I'd suggest are incompatible with 'British values'..

HFMA chief executive Mark Knight

HFMA members will have their own views on who to vote for, influenced to differing extents by the parties' proposals for health and social care. It may not be the wide-ranging, detailed debate that the HFMA and others have been calling for. But there do appear to be some very different proposals on which to base our decision.

Working in the service means we can sense-check the claims of the parties and how they will affect services. We are best placed to understand whether health and social care proposals are realistic and practical or just populist hot air.

All I can say is … please do vote. There has been some suggestion that the country has election fatigue – with Brenda from Bristol becoming the spokeswoman for many when she declared: 'Not another one'.

The reality is that there are major issues at stake on 8 June and the right to vote is a privilege our ancestors have fought hard for – universal suffrage sadly still remains only an ambition in some parts of the world.

See you in the polling booth.

Member news

Alison Myles, HFMA director of education, is to take part in two charity runs as part of the Cancer Research initiative Race for Life. She will run 5km at Cheltenham Racecourse in June and a further 10km in Salisbury in July. Funds raised will support vital research into preventing, diagnosing and treating cancer. Donate: http://bit.ly/2rHIGUF

Andy Ray, chair of the HFMA Eastern branch and deputy director of finance at Basildon and Thurrock University Hospital NHS FT (pictured), received the manager of the year award at the trust's annual excellence awards evening. The award

has so far been given mostly to clinicians. He was nominated for empowering staff from all grades to continue their personal and professional development; his dedication to the wellbeing of staff; and continuous support of other teams in the organisation.

Rosie Gregory is now co-ordinator of the West Midlands Branch. She joins the HFMA from University Hospital Bristol NHS Foundation Trust, where she was a rota co-ordinator.

Charlie Dolan, previously membership and event co-ordinator at the association, is now part of the Healthcare Costing for Value team, as Institute co-ordinator.

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Branch focus

My HFMA

South West Branch

In the last decade, three HFMA presidents have been members of the South West Branch. Bill Shields, Suzanne Tracey and current president Mark Orchard are, or have been, based in the region.

Across the area covered by the branch, financial challenges in the commissioning sector are a key issue and the committee is keen to provide plenty of training and development opportunities to help members cope with the difficulties.

'If your commissioners are financially challenged, this is a challenge for everyone,' says branch chair Neil Kemsley (pictured). 'In the face of such adversity, there is an even greater need for professionals to come together and commissioners and providers need to work ever closer.'

The branch responds to this with events that encourage networking at different levels and geographical areas of the branch, which covers Penzance in the south, Gloucester in the north and Poole in the east.

As part of an accreditation scheme unique to the branch, organisations that fulfil certain agreed criteria can get a bursary to run a local 'Connect' event of their choice. Following the successful pilot in Dorset, the latest event was in Devon, where more than 150 finance professionals, contracting and performance staff attended.

The South West is one of the four areas where the HFMA provides the Finance Skills Development programme. FSD supports finance skills development across the NHS and the branch ensures the events it runs complement the FSD programme.

The branch is also running more events with the neighbouring South Central and Wales branches. 'It's always a good practice to bring ideas from slightly further afield,' adds Mr Kemsley.

The biggest event of the year is the branch annual conference that will take place on 28 and 29 September. The conference this year is entitled 'Relentless optimism', a phrase taken from Bristol's renowned street art culture. The intention is to highlight the need for resilience and a positive attitude towards the challenges the NHS faces. For the first time, a focus on personal wellbeing will be included in the programme.

'Working in NHS finance is getting tougher,' says Mr Kemsley. 'We're trying to create greater awareness of managing stress and developing successful coping strategies.'

• **Visit** www.hfma.org.uk/our-networks/branches/south-west

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Appointments

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has confirmed **Craig Macbeth** (pictured) director of finance. He joined the trust in 2008 as deputy director of finance and then moved on to be associate director of finance. Mr Macbeth succeeds **John Grinnell**, who is now director of finance and deputy chief executive at Alder Hey Children's NHS Foundation Trust. Mr Grinnell's NHS career began on the national finance graduate training scheme, and he has worked in a variety of roles across the NHS. **Claire Liddy**, who had been acting director of finance, has returned to her substantive role as deputy director of finance.

Karen Brown is now interim director of finance at United Lincolnshire Hospitals NHS Trust, succeeding interim Peter Hollinshead. Ms Brown was previously director of finance and information at Lincolnshire Partnership NHS Foundation Trust. She is succeeded by interim **Sarah Connery**, who was previously deputy director of finance at the trust.

Paul Simpson (pictured) has been appointed interim accountable officer at three clinical commissioning groups – Cannock Chase; South East Staffordshire and Seisdon Peninsula; and Stafford and Surrounds CCGs. He was previously director of finance and deputy accountable officer at the organisations. **Vicky Hilpert** has been named interim executive director of finance. She was previously deputy director of finance at the three clinical commissioning groups. Mr Simpson is also chair of the HFMA West Midlands branch.

Chris Macklin has been appointed lay member for audit and chair of the audit committee at Sunderland Clinical Commissioning Group. Mr Macklin retired as director of finance at the organisation in May 2015, having spent 42 years working for the NHS and more than 20 as a finance director. Prior to his new appointment as lay member for audit, he was the lay member responsible for primary care commissioning. He was chair of the HFMA Accounting and Standards Committee between 2000 and 2009.

Yarlini Roberts (pictured) has been appointed director of finance at Richmond Clinical Commissioning Group. She is also director of finance at Kingston Clinical Commissioning Group and will continue in that role alongside her new position at Richmond CCG. She has 24 years of experience in the NHS across the provider and commissioner sectors. **Richard Thomas**, former chief finance officer at Richmond CCG, has now moved to South West London Alliance, a group of six CCGs commissioning collaboratively.

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

"At Bolton, we wanted to become the best finance team in the country. At Leeds, we could aim beyond that and look to be recognised internationally"
Simon Worthington

Worthington heads back to Leeds as director

On the move

Bolton NHS Foundation Trust deputy chief executive and director of finance Simon Worthington is heading back to Leeds, where he began his career as a trainee accountant nearly 30 years ago.

Mr Worthington, recently appointed Leeds Teaching Hospitals NHS Trust director of finance – started his career at Leeds General Infirmary (LGI), now part of the teaching trust, in 1988 and lives in the city. 'I'm really excited by the move,' he says, 'because it's my local hospital and, as a large teaching hospital, it's one of the biggest finance jobs in the country.'

Professionally, it's the next step up from the Bolton trust – Leeds has an annual income of £1.2bn. He also feels a debt of gratitude to the Leeds trust, which treated him for a detached retina a few years ago. 'I was going blind in my right eye, so the trust saved my sight in that eye. I want to help make it the best it can be.'

The chief executive Julian Hartley has fostered greater staff engagement, Mr Worthington says. 'The board is excellent and there's a strong improvement focus – the trust was rated as requiring improvement by the CQC, but is now rated good.'

Finances are difficult, as they are right across the NHS, but the trust delivered its control total in 2016/17 – broadly a balanced financial position. Although he accepts that the trust had to take a number of non-recurrent measures to reach this position, Mr Worthington says it's important to look at the longer-term position.

'When [predecessor] Tony Whitfield came to the trust, he had to tackle some significant problems, but through his work and the work of the rest of the finance team and all the staff, it is getting better. I'm looking forward to continuing that work.'

Plans to redevelop part of the LGI site are high on his agenda. This will be a significant capital investment (£300m). The trust has agreed its control total for 2017/18 – a £65m cost improvement is required to deliver this, but Mr Worthington says: 'I have been talking about having a sustainable surplus. The size of that surplus will be dictated by how much we need to make to service the planned capital investment.'

When he joined the Bolton trust, it was heading for a £14m deficit, but in 2016/17 it has made a surplus of more than £15m – or £4m without the benefit of sustainability and transformation funding.

'It is a big wrench to leave Bolton, and the staff there have done amazing things, such as day one reporting. When this opportunity came up I couldn't ignore it, but I feel I am leaving it in a strong position and have learnt a lot over the past four years.'

Mr Worthington was named HFMA Finance Director of the Year in 2015, and received recognition, along with other parts of the Bolton health economy, for the local aligned incentives contract. Will he bring some of his pioneering work to Leeds?

'I need to take time and see what will work best. Lots of places around the country are taking up the aligned incentives contract. In Bolton, we had a set of circumstances and we needed to do something. There will be specific issues in Leeds and we will do something to respond to that.'

He has been spending a day a week at the trust in the run-up to taking the job full-time at the end of this month.

Mr Worthington has talked to finance staff and clinicians and has been impressed by the trust's commitment to world-renowned research and teaching. 'This sets a benchmark for us to aim for as finance professionals. At Bolton, we wanted to become the best finance team in the country. At Leeds, we could aim beyond that and look to be recognised internationally.'

He adds: 'The people working in the organisation have achieved some great things and I am delighted to be able to join them and to make my contribution.'

FFF focus on diversity

Future focused finance

NHS Future-Focused Finance (FFF) will launch programmes in 2017/18 to help boost the career prospects of female and black, Asian and minority ethnic (BAME) finance colleagues. A launch event for the first of these is scheduled for 14 June.

The FFF sponsorship programme is targeted at women and BAME finance professionals working at band 8a or above who are ready to progress their NHS finance career. It offers tools and resources for a sponsorship relationship to be developed in the organisation of the individual, and is based on the sponsorship programme at EY.

The second programme, to be launched later in the year, is a springboard programme for women working in more junior grades.

The programmes, delivered by the FFF 'Great place to work' action area, will support the Finance Leadership Council's aim to develop a diverse pipeline of talent.

A narrative has been developed for the overall diversity scheme. It says a diverse and inclusive finance function can help drive value and that finance teams face barriers to progress in this area. These include ineffective policies, bias, perceptions of high workload and the lack of flexible working opportunities at the more senior levels.

'Great place to work' senior responsible officer Loretta Outhwaite said: 'The narrative highlights what we are doing to achieve this and, as senior finance professionals, what you can do to help.

'NHS finance can lead the way and be a catalyst for change, but this requires strong leadership. To make long-term, sustainable progress, diversity and inclusivity need to move away from being an issue that is owned by HR and to sit firmly on the agenda of senior leaders in every team.'


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