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Sharpening the focus

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HOME ELECTRONIC SOLUTIONS

By the NHS

you've got the power

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News

NHS England intervenes to minimise saving risk impact

Paul Baumann: 'CCG risk feels very real'

By Seamus Ward

NHS England is taking the £370m of identified risk in clinical commissioning group savings plans 'very seriously' and is taking steps to minimise its impact, according to chief financial officer Paul Baumann.

NHS England is monitoring financial risks and available mitigations. At month four, it said £370m of net risk was being reported, excluding the benefit of the risk reserve.

'The CCG risk, which is similar to the level of risk we were reporting at this point last year, feels very real to me and last year it proved to be a pretty accurate predictor of what happened to the forecast in the succeeding months. So we are taking it very seriously,' he said.

Mr Baumann explained that the risk reflected two main issues. While activity was substantially below the 3% growth that providers had planned, there has been a significant rise in the cost per case of admitted patients.

The second issue relates to the ambitious savings plans set out by CCGs this year. They are expecting to deliver an aggregate £2.9bn in savings this year, compared with just under £2bn last year, which was unprecedented.

'Much of this increase is in the more transformational programmes related to the *Five-year forward view* rather than more transactional savings,' said Mr Baumann.

'Inevitably, some are struggling to deliver these ambitious plans. On average, the success rate is running at about 91% year-to-date and is currently forecast to rise slightly over the coming months. But the plans are weighted towards the end of the year and carry significant risk, not least because they depend on the full collaboration of providers – who are, in many cases, struggling to deliver the required financial performance.'

"There's a pattern of CCGs forecasting these sort of movements in provision at the start of each year and revising it"

Mr Baumann outlined six steps NHS England was taking to stop the risks leading to a deterioration in the financial position. These included support for CCGs in constructing and strengthening their efficiency plans – particularly for the 70 CCGs with the greatest challenges – and rolling out a menu of opportunities that describe more than 150 of the most successful efficiency programmes.

At month four, the commissioning sector had underspent by £46m (year-to-date) and forecast a £9m underspend at the end of the financial year. The year-end position does not include the £580m uncommitted risk reserve being held by NHS England and clinical commissioning groups.

CCGs had slightly overspent against plan (£58.5m or 0.2%), but were forecasting to all but hit their year-end plan, with an overspend of just over £17m.

However, below the line, there is greater pressure than expected (£71m more than planned in the full year). This is the result of technical and ring-fenced adjustments relating to provision movements and depreciation.

Mr Baumann said: 'There's a pattern of CCGs forecasting these sort of movements in provision at the start of each year and revising it as they get better information towards the end of the year. I would anticipate that particular issue will improve as the year goes by.'

The technical adjustments are more than offset by forecast underspends in NHS England central programme and running costs (£97m) and direct commissioning (£0.3m).

The former is made up largely of almost £89m in programme costs underspends (including £86m of unplanned income) and £8.5m in NHS England running costs.

Pathology restructure to save £200m

A reorganisation of hospital pathology services into 29 networks is expected to save at least £200m by 2020/21, NHS Improvement said.

The restructuring, into a hub and spoke model, will improve efficiency, enhance pathology careers and provide faster, more advanced and accurate results, said NHS Improvement. It is expected to take three years.

Pathology services are provided in 105 hospitals in England, undertaking 1.2 billion tests a year at a cost of £2.2bn. Reviews including the Carter review of productivity and efficiency, have identified unwarranted variation in productivity and cost in pathology services.

While high-volume and more complex tests will be carried out in the new hubs, hospitals will continue to have their own on-site essential pathology services. NHS Improvement said it may also establish cross network arrangements for advanced tests that use genetic or molecular techniques.

Professor Tim Evans, national director for clinical productivity, said there was an urgent need to bring the running of pathology into the 21st century. 'By bringing these services into larger, more efficient networks, patients will have better access to innovative services, and receive test results quicker.

A letter to trusts from NHS Improvement operational productivity director Jeremy Marlow and Professor Evans acknowledged that capital and change management capacity will be 'important enablers'. 'Trusts should prioritise resources already available to them to support delivery of network formation and service consolidation as an investment in recurrent benefits for patients and the NHS's finances,' it said.

Providers call for £350m funding boost to mitigate winter pressure concerns

By Seamus Ward

NHS Providers have called for an immediate funding boost of between £200m and £350m, to support extra capacity to help the health service ensure patients safety this winter.

The providers' body said failure to do so would also increase waiting times in A&E and other services.

A report on the state of readiness for the coming winter at the beginning of September said planning and support were considerably better developed than last year. Emergency care has been given a higher priority, while extra social care funding has increased capacity in around a third of areas.

However, the improvements were outweighed by a number of growing risks. It said NHS trusts are not benefiting consistently from the extra £1bn announced for social care in the spring Budget. Consequently, the government's target of a delayed transfers of care rate of 3.5% in September would be missed.

Demand for emergency care continued to surge, the four-hour standard in A&E has not been met for more than two years, and there were growing staff shortages in key clinical areas. Outside hospitals, primary and community service capacity was under pressure and trusts did not have the financial flexibility to afford the extra resources they need.

The King's Fund highlighted a shortage of beds ahead of the winter period. It said the NHS now had fewer acute beds than any comparable health system. Some sustainability and transformation plans proposed further cuts and were undesirable and unachievable.

NHS Providers chief executive Chris Hopson said trusts were getting better planning support from NHS Improvement and NHS England.

But he added: 'Despite this, the overwhelming view of NHS trusts is that without immediate extra funding they will not have sufficient capacity to manage this winter safely.

'Patients will be put at greater risk as local trusts won't have the extra beds, staff and services they need to meet the extra demand they will face. The only way to mitigate these

Deficit plan on track

NHS providers are forecasting a year-end deficit of £523m – putting them on track to achieve the sector-wide target of a £500m deficit, according to figures from NHS Improvement.

The quarter one figures show provider trusts have cut agency spending by more than a fifth (£169m) compared with the same quarter in 2016/17. NHS Improvement said 88% of providers had agreed their control totals for 2017/18 and 71% (166) had delivered their target for the first quarter.

NHS Improvement chief executive Jim Mackey commented: 'Financially, providers have made a very strong start to the year, and should be applauded for this.

'There are lots of risks ahead in terms of the sector's finances, but the results from the first quarter are very encouraging, and demonstrate that the majority of trusts are sticking to, or ahead of, their financial plans.'

Labour Party promises it would scrap PFI

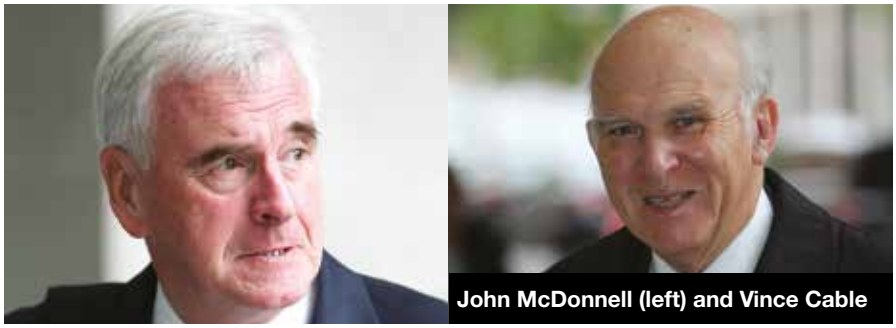
Labour has pledged to bring private finance initiative contracts into public ownership if elected, and called on the government to give the NHS an immediate £500m cash injection to avoid a winter crisis.

Shadow chancellor John McDonnell told his party's annual conference in Brighton that the PFI had led to 'huge, long-term costs for taxpayers'.

'In the NHS alone, £831m in pre-tax profits have been made over the past six years. As early as 2002, this conference regretted the use of PFI,' he said.

'We'll put an end to this scandal and reduce the cost to the taxpayers. We have already pledged that there will be no new PFI deals signed by us. But we will go further. We'll bring existing PFI contracts back in-house.'

Shadow health secretary Jonathan Ashworth added that the NHS needed additional winter funding. 'To avoid another winter like the one we've just had, we would establish a £0.5bn emergency winter fund, so patients and their families never suffer like that again.'



John McDonnell (left) and Vince Cable

The Department of Health has allocated a further £13m to 19 hospitals in capital funding to help trusts improve patient flow in A&E this winter. The funding – initially announced in the spring Budget – will be used for equipment or infrastructure to iron out issues in patient flow.

The Liberal Democrat leader Vince Cable warned that 10,000 European Union workers had quit the NHS in the year after the vote to leave the EU.

He said: 'We are losing thousands of high-quality nurses and doctors from the NHS, driven partly by this government's heartless approach to the Brexit talks.

'Using EU nationals as bargaining chips is not only morally wrong, it is utterly counter-productive and damaging to our NHS.'

• *Healthcare Finance* went to press before the Conservative Party conference began

"The overwhelming view of NHS trusts is that without immediate extra funding they will not have sufficient capacity to manage this winter safely"
Chris Hopson, NHS Providers

risks is through an urgent NHS cash injection.'

Later in the month, in response to the Labour call for a £500m winter bailout, Mr Hopson warned that it was getting 'late in the day' to put in place the extra resources needed.

Trusts in England entered this financial year facing an underlying £5.9bn shortfall in their budgets, according to the Nuffield Trust. In *The bottom line*, the thinktank said this would fall to £4.1bn following the £1.8bn sustainability and transformation fund. This left £3.6bn of savings needed to achieve the target deficit of £500m by year-end – 4.3% in savings. This was 'next to impossible', the report said.

• *See Professional lives, page 27*

STP direction driven by financial pressures

By Seamus Ward

Sustainability and transformation partnerships (STPs) are increasingly driven by measures to tackle financial pressures that are sometimes based on 'heroic' assumptions, according to King's Fund senior fellow Richard Humphries.

At the HFMA/CIPFA integration conference in September, Mr Humphries (pictured) said STPs were based initially on three foundations – working collaboratively to meet the population needs; population-based budgets; and an outcomes-based approach. But the pressure to reduce spending in hospital had shifted the emphasis.

'STPs are being increasingly driven by financial control totals for the NHS, which is not realistic,' he said. 'There are assumptions on how much care can be shifted from hospitals that are heroic and not based on evidence.

'There has been engagement with local authority social care, but there has not been enough.'

Mr Humphries said the government is seeking integration by 2020. 'Given that it's been government policy for more than 40 years, I think that's the triumph of hope over experience.'

A survey of 31 NHS and 25 local authority finance leaders on integration, commissioned by CIPFA, was published at the conference. Finance staff said there was a strong belief that their organisation's sustainability would rely on collaboration across health and social care.

Nine in 10 respondents said it would improve the patient/client experience, 70% said it would lead to better care; and just under two-thirds said it would produce non-cashable productivity improvements.

However, less than a quarter of the respondents said the relationships between local NHS bodies and councils were very strong, though there was a general view that they had improved over the last year.

Almost all respondents (95%) said it was essential or important to invest in prevention in the next three years.

Public Health England chief executive Duncan Selbie highlighted the need for investment in prevention in its widest sense and collaboration between all aspects of the public and voluntary sectors. He said that a number of factors impact on a person's ability to live long and in good health. Of these, only 10% to 20% relate to how much is spent on health services. The rest were due to factors such as inequality, educational level and whether they were employed or unemployed.

• *See Getting back on track, page 13*

NHS Improvement sets out plans for subsidiary oversight

NHS providers' subsidiaries and joint ventures will in future face the same regulatory arrangements as their host organisations and will be subject to the single oversight framework, under proposals from NHS Improvement.

NHS Improvement believes joint ventures and subsidiaries may become more common with the advent of new care models as vehicles to hold accountable care organisation contracts or deliver multispecialty community providers and integrated primary and acute care systems.

Currently, subsidiaries and joint ventures are classed as independent providers, which are subject to a lighter touch regulatory regime.

In a consultation document, the oversight body said that the 'distinction based on legal form does not make sense where NHS care is carried out on behalf of, and ultimately controlled by, NHS providers'.

The proposed new set of licence conditions would require NHS-controlled providers to have effective board and committee structures, reporting lines and performance and risk management systems.

They will be overseen under the single oversight framework and will adhere to other guidance that applies to NHS providers.

According to an impact assessment, the number of providers that would be affected was likely to be low – up to six over five years.

It added that its proposals were unlikely to affect the proportion of services provided by public or private organisations.

The consultation process will close on 12 October.

News review

Seamus Ward assesses the past month in healthcare finance

September was a relatively quiet month as the main political parties geared up for their conferences. As always though, there were a lot of health stories. One that caught the eye was a claim that cyber-chondria – worrying excessively about health and making unnecessary appointments – is a growing problem. Doctors have said the use of the internet to look up symptoms – they call it 'Dr Google' – is a big issue, as they spend more of their time reassuring worried patients. Health anxiety could affect one in five outpatients, the research said.

Commons Public Accounts Committee chair Meg Hillier (right) published her annual report. Though the report may be more of historic interest – it was to be published in the summer, but was delayed due to the general election and summer recess – it said the Department of Health was among those giving the committee most concern. It was worried about the 2015/16 and 2016/17 Department accounts and described bickering over funding between the government and NHS England as unhelpful. Sustainability and transformation plans were at risk of being seen as a cover for cuts, even when good-quality, modern patient services were being planned. Financial and demographic pressures meant the NHS focus is on finance rather than effectiveness and transformation, it added.

The British Medical Association criticised the government for failing to meet in full its pledge to invest in GP services. A BMA report, *Investment in general practice in England*, said that despite some increases, spending on GP services as a proportion of the overall NHS budget was still lower than it was more than 10 years ago. While 9.6% went to GP services in 2005/06, in 2016/17 it was 7.9%. Investing at 2005/06 levels would increase GP service funding by £2bn, the BMA said, and meeting the widely accepted target of 11% of the overall budget would add £3.7bn.

An Education Policy Institute report on access to children and young people's mental health services found that, in 2016/17, just over a quarter of children referred to specialist mental health services were not accepted into those services. This amounted to more than 50,000 children. However, there was considerable variation between providers. NHS Providers said mental health funding must reach frontline services for children and young people. It said the funds would ensure the right level of services is provided where they are most needed.

A&E performance in England held steady in August, according to the latest official figures. NHS England figures showed 90.3% of patients were seen within the four-hour target – the same as in July. Though attendances were down 0.5% on August 2016, a smaller proportion was seen within the standard time in August this year. The 95% standard was last achieved in July 2015.

New deals with suppliers to provide leading edge treatments could save the service up to £350m by 2021, NHS England chief executive Simon Stevens announced. A new oral drug for hepatitis C could save thousands of lives and more than £50m, he said, while plans to accelerate the uptake of biosimilar drugs could save an estimated £300m by 2021. At the Expo conference in Manchester, he called on health leaders to harness the potential of innovation for the benefit of patients and taxpayers.

At the same conference, health secretary

The month in quotes

'GP services are effectively facing a £3.7bn funding shortfall because the government has not reached the goal of allocating 11% of NHS investment to general practice. The rate of extra investment has also noticeably slowed in the past year despite government promises of an acceleration in resources directed to frontline patient care.'

BMA GP leader Richard Vautrey attacks the government record on GP funding

'People now go to their GPs with a whole list of things they've looked up on the internet, and the poor GP, five minutes into the consultation, has four pages of reading to do. Dr Google is very informative, but he doesn't put things in the right proportion.'

The internet is causing cyber-chondria, Peter Tyrer, emeritus professor in community psychiatry at Imperial College London, tells the BBC

'This partnership working between government, the NHS and the profession has already achieved some excellent results in unscheduled care – and we are keen to replicate this successful approach.'

Scottish health secretary Shona Robison says the new collaborative programme aims to improve elective access

'If the NHS is going to be the safest, highest quality healthcare system in the world we need to do technology better. So I am setting seven challenges, which, if we achieve them, will make the NHS a world-beater in the care of people with long-term conditions. I do not underestimate the challenge – but if we do, it will be the best possible 70th birthday present from the NHS to its patients.'

Health secretary Jeremy Hunt sets the NHS a cyber challenge

SHUTTERSTOCK

Jeremy Hunt challenged the NHS to ensure patients in England can access seven services via an app by the end of 2018

Jeremy Hunt challenged the NHS to ensure patients in England can access seven services via an app by the end of 2018. With the 70th anniversary of the establishment of the NHS coming up next year, he said they should be able to access NHS 111; see their health record; book a GP appointment; order repeat prescriptions; set organ donor preferences; express data sharing preferences; and access support for managing long-term conditions.

The government must take action to hold down the rising cost of clinical negligence, the National Audit Office said. In *Managing the costs of clinical negligence*, the auditors said clinical negligence costs were rising quickly and adding to the financial pressures faced by trusts. While spending on the clinical negligence scheme for trusts had risen from £0.4bn in 2006/07 to £1.6bn in 2016/17, the number of successful claims had more than doubled. The rising cost was due to higher numbers of claims, increasing damages awarded and claimant legal costs. The latter was up from £77m to £487m over the past decade. A cross-government strategy was needed to tackle this.

NHS Improvement said all providers in England will be required to contribute to the cost of the licence for the national purchase price index and benchmarking (PPIB) tool. The oversight body is taking over the contract with the provider of the PPIB tool (AdviseInc) from the Department of Health. In a letter, it said that it would contribute £200,000 to the cost of the licence and associated services. But it also outlined trusts' contributions to the balance of the cost, which are based on turnover.

With the Labour Party saying it would examine the scope for bringing private finance initiative schemes into public ownership, an independent thinktank said that, over the past six years, private companies have made £831m in pre-tax profits from PFI schemes in the NHS. The Centre for Health and the Public Interest (CHPI) said that further profits from taxpayer funds could amount to £973m over the five years to 2020/21. Its report, *PFI – profiting from infirmaries*, made a number of recommendations, including using public sector loans to buy out PFI contracts; taxing PFI profits; and capping the profit a private company can make from an exclusive contract with the NHS.

The Scottish government has launched an initiative to improve the management of elective care and reduce NHS waiting times. Under its Elective Access Collaborative Programme, the government, NHS Scotland and royal colleges will support health boards to improve the configuration of their elective services. The government said the work would build on the £50m allocated earlier this year to reduce waiting times and health board recovery plans for elective services.

The head of the Northern Ireland civil service has issued an update on the local shared services programme, which is considering options for shared services in HR, payroll, finance and IT across the local public sector. A baseline exercise has been completed, though clarification and benchmarking is ongoing.

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from the hfma

The HFMA published a range of blogs in September. They include

an international perspective on the value of patient-level costing from Alfa D'Amato (left), director of activity-based management at New South Wales Health, Australia. Mr D'Amato, a speaker at the HFMA international costing symposium on 4 October, said costing has a lot in common with gold – it is valuable, but difficult to get at, and once retrieved is often locked away with limited access.

Mr D'Amato's deputy, Julia Heberle, who is also speaking at the symposium, looked at how internal audit can be a key ally in ensuring costing data is sufficiently accurate to inform decision-making.

HFMA head of policy and research Emma Knowles used a blog to launch the association's latest biennial finance staff attitudes survey. She said that a lot of the media attention is on frontline staff, but finance and other key support staff face the same pressures and challenges.

Also online, Bill Shields (right) continued his postcards from Bermuda, while *Healthcare Finance* editor Steve Brown argued that the NHS has to pursue efficiency on multiple fronts if it is to achieve the levels it requires.

The HFMA also published several briefings in September, including a look at the guidance available to the NHS on reforms to off-payroll rules introduced in April, and its latest watching brief on financial reporting.

• To read any of these blogs, visit www.hfma.org.uk/news/blogs

News analysis

Headline issues in the spotlight

Time to pay up?

The government appears to have signalled an end to the cap on public sector pay rises, but what does this mean for the NHS? Seamus Ward reports

Slowly, inexorably, the pressure to lift the 1% cap on public sector pay rises has increased and now, it seems, the pressure has paid off. It may be a sign of a weakened government showing it is in listening mode. It may even be hoping to avoid the worst of the predicted impact of the exit from the European Union on the public sector workforce. Managers will hope that the government also loosens the purse strings and fully fund any award.

At this year's general election, both Labour and Liberal Democrats pledged to remove the cap and, soon after, some of Theresa May's ministers hinted it was under review. In September, nurses marched in Westminster as part of their *Scrap the cap* campaign (pictured). Later in the month, the government lifted the cap for police and prison officers. Police officers were given a 1% pay rise plus a further non-consolidated 1% for 2017/18, while their prison colleagues were handed a 1.7% rise.

However, worryingly for the NHS and other parts of the public sector, both of these increases must be funded from existing budgets. While the percentages sound small, the cost could add millions to the NHS pay bill.

Wage restraint

The public sector pay cap was introduced in 2013 following a two-year pay freeze. In the NHS it is seen as one of the main single contributors to meeting the shortfall between available funds and spending due to demand and other inflationary pressures (£3.3bn of the estimated £22bn gap, according to the Department of Health, NHS England and NHS Improvement). It is frequently claimed that each 1% rise costs the NHS £500m. Without further funding the service faces another significant headache.

The health unions have been campaigning for some time to lift the cap and, on seeing it all but lifted, they responded strongly.

In a letter to chancellor Philip Hammond, 14 unions, including Unison, the Royal College of Nursing and Managers in Partnership, called for a 3.9% rise plus an extra £800 to make up for lost earnings during the years of austerity-driven freezes and caps. The unions' pay demand would match inflation – the September retail price index stood at 3.9%.

Royal College of Nursing chief executive and general secretary Janet Davies said: 'If the government gives nurses the same deal as the police, it would still be a real-terms pay cut. Nursing staff must be given a pay rise that matches inflation, with an additional consolidated lump sum that begins to make up for the years of lost pay.'

> **"If the government gives nurses the same deal as the police, it would still be a real-terms pay cut. Nursing staff must be given a pay rise that matches inflation"**
> **Janet Davies, RCN**

Managers in Partnership chief executive Jon Restell said: 'Managers in the NHS know how the cap has hit their own pay, and that of their staff. They see the damage it's doing to NHS services by making it harder and harder to recruit and keep good staff. Patients need the best staff, and our staff need a fair pay rise.'

Crucially, the unions urged the chancellor to find the money to fund the pay rise in full.

Ms Davies added: 'It must be fully funded and not force the NHS to cut services or jobs to pay for it. When ministers hold pay down, it drives too many nurses out of the NHS. '

Niall Dickson, the NHS Confederation's chief executive, said the unions' demand was not a surprise. 'We have made clear that we do not believe that the 1% pay cap is sustainable and that our members have mounting concern about both recruitment and retention of vital frontline staff. Staff morale is also a serious issue, and while pay is by no means the only or even the critical issue, it is clearly important that those who deliver care feel valued and adequately rewarded,' he said.

In the HFMA's recent *NHS financial temperature check*, finance directors expressed anxiety about current and upcoming workforce issues. They noted the difficulty recruiting and retaining clinical staff and were worried about the impact of exiting the EU.

Workforce is now the leading challenge for many organisations, Mr Dickson said. 'We have also made it clear that any attempt by the government to make the service meet the cost of any pay increase would be a disaster – the pressures on NHS organisations are unprecedented and funding has been at historically low levels.'

He added: 'Current plans for funding health and care services over the next two years are already unrealistic and any further cost on the pay bill must be matched with additional funds. We recognise that extra money for healthcare has to come from somewhere, but we believe there would be public support for making this a priority.'

The unions say NHS staff have taken a 15% pay cut in real terms since 2010, but how does public sector pay compare with the private sector?

A recent IFS briefing note said that the lowest paid and 'lower educated' public sector workers have average wages higher than those in the private sector. However, the better paid, 'higher educated' public sector workers have fared worse compared with the private sector.

On average, it argued, there was a better argument for increasing the pay of this higher educated group of public sector staff. But it's not hard to see why increasing higher paid staff salaries would be difficult for politicians.

Jonathan Cribb, a senior research economist at the IFS, and author of the briefing note, said if pay rises in the public sector remained pegged at 1%, these staff would fall increasingly behind their private sector counterparts. The knock-on effect would be to make recruitment and retention more difficult.

'The government is considering lifting the

SHUTTERSTOCK

Nurses marching in Westminster as part of their 'Scrap the cap' campaign

public sector pay cap for at least some workers. If it decides to maintain the 1% cap, we should expect increasing difficulties in recruiting, retaining and motivating high-quality public sector staff, reducing the quality and quantity of public services.

He added: 'But increasing pay for these workers implies substantial extra costs to public sector employers. The Treasury could provide extra funds for this by raising taxes, cutting other spending or borrowing more.

'Asking the NHS, for example, to fund higher pay increases from within existing budgets would be very challenging.'

Complex picture

While 1% may have been the headline figure for pay rises since 2013, the reality is a little more complex than an across-the-board increase. Staff at the top of their pay band have received the 1% rise, but those lower down the band could also have been eligible for increments.

Indeed, in its 2017 report, the NHS Pay Review Body said more than half of NHS staff in England (54%) were due to receive pay increments averaging between 3% and 4% in 2016/17 on top of their 1% pay award.

Incremental pay contributes to pay drift – changes in the cost per full-time employee due to movements in the composition of staff by seniority or group. NHS bodies also face pressure from pension contributions and new costs, such as the apprenticeship levy. Staff and unions would point out that incremental progression under Agenda for Change aims to reward experience and skills and cannot act as a substitute for an annual cost of living pay rise.

In England, the Department of Health told the review body that in recent years pay drift had the effect of bringing down the overall pay bill – due to an increase in less senior staff. In 2015/16 pay drift per full-time equivalent was -0.2%. However, this was more than offset by the headline pay award, which added 0.5% to the overall pay bill and employment of additional staff, which added 2%, producing an aggregate pay bill growth of 2.3%. Employers have argued that the negative figure related to high staff turnover.

These figures do not include the cost of agency staff. The NHS in England is reducing agency spend – in the first quarter of 2017/18 agency spending was £169m (22%) lower than quarter one in 2016/17. For the first time in recent years, providers underspent on their year-to-date plan. While some of this reduction in spending was due to efforts to hold down fees and rates paid for agency staff, some was due to shifting workers to bank and substantive roles.

Additional substantive staff, as noted above, mean the pay bill will grow and was the biggest contributor to the overall pay costs increase in 2014/15 and 2015/16 (2% in each year).

The Department of Health has consistently argued that pay restraint is a key element in ensuring the NHS remains financially sustainable. It had planned to fund an average 1% award up to and including 2019/20.

However, strengthening public opinion about the need to remove the cap on public sector pay, a weakened administration and worries about the NHS workforce are pushing the government away from its established pay policy.

The award for police and prison officers was the first sign of that and all eyes will be on the chancellor to confirm the cap has been removed – perhaps at the Conservative conference at the beginning of October or in the Budget on 22 November. But will he produce the funding to match any pay rise?

Comment

October 2017

Pay attention

Staff are key to current challenges and need to be valued properly

A recent report by the Nuffield Trust provides a sobering analysis of the scale of the challenge facing the NHS.

While providers officially ended 2016/17 with a collective deficit of £791m, the underlying deficit was closer to £3.7bn, it claimed.

To arrive at this figure, the thinktank added back in some £790m of savings achieved non-recurrently – as one-off savings they do not reduce the cost base for the following year and effectively need to be added to savings plans the following year.

It also added back the whole of the £1.8bn sustainability and transformation fund on the basis that this is non-recurrent for providers and should not be counted on beyond 2018/19.

We can argue with the analysis. Expecting all savings to be achieved recurrently each year is unrealistic. Some savings are made non-recurrently as a precursor to them becoming recurrent downstream. However, it also has to be acknowledged that the service is reliant on one-off savings and is falling short of its own targets for recurrent savings.

And we could argue that including the STF in the underlying deficit is a bit 'clever-clever'. These funds are recurrent for the NHS nationally, but not for local providers.

The NHS is pursuing new models of care with the aim of re-providing some care in different settings and at different points in the pathway.

Some may argue that it makes sense not to commit these resources recurrently upfront to one part of the provider sector, when funding will have to flow differently to support these

HFMA president Mark Orchard

No magic solution

We should talk about the funding and time needed to make system working successful

Transformation is probably an overused word. It sometimes just seems like the intangible 'something' that will bridge the financial gap that more traditional efficiency savings can't breach on their own. Easy to say, not so easy to put into cash-releasing practice.

It is about much more than money. It's about the right care and support in the right place. So, patients taking more control of their own conditions. More prevention – avoiding the need for care in the first place. Or more proactive support and earlier intervention, avoiding more serious interventions downstream.

There are real patient benefits in all that. But money is also a huge part of why we need to transform services.

Demand is being driven by an ageing population, rising expectations and growing levels of long-term conditions.

Simply trying to meet that demand in the same way as we have done would require increases in funding that would soon become unaffordable to parties of any political persuasion. The US health system is probably

Healthcare Finance editor Steve Brown

"There appears to be a growing consensus that ending the 1% cap is the right thing to do. All eyes will now be on November's Budget"

new models. And at some point we in any case need to think about refocusing the STF on transformation.

However the report does capture how financially challenging it feels right now in the NHS.

Last month also saw the public sector pay cap lifted for police and prison officers, widely interpreted as an indication that the pay cap may also disappear for NHS staff from 2018/19.

The current financial context suggests that any such move would need to be accompanied by increased funding, particularly as the existing financial settlement assumed continued pay restraint.

NHS health economies would be further challenged if required to absorb an unplanned increase in their single biggest cost pool from within existing resources. Such an ask could undermine the significant progress the service has made.

What is clear is that our staff are absolutely vital to the challenges we face – both in meeting day-to-day operational demands and transforming services. They need to be properly motivated, valued and in sufficient numbers. Pay is not the only issue – having the right number of frontline and support staff to enable them to deliver a high-quality service is also crucial.

Rates of pay – taking account of inflation and economic conditions – are just one indication of how you value your workforce.

However, they also have an influence on how we meet connected staffing challenges such as reducing reliance on agency staffing.

Having pay levels for substantive roles that are appropriate to the labour market is of course fundamental to improving the temporary/permanent staffing balance.

Financially the NHS faces significant challenges that call for a longer term solution for both health and care.

But we should not assume that our staff will personally support this by accepting salary restraint indefinitely and at the same time remain motivated and value-driven. There appears to be a growing consensus that ending the 1% cap is the right thing to do.

All eyes will now be on November's Budget to see how the government plans to take this forward.

Contact the president on president@hfma.org.uk

the closest to being in that position of unaffordability already.

So transformation of the sort set out in the *Five-year forward view* involving new models of care is absolutely the right direction of travel – the only viable direction of travel.

But there is a danger that it becomes viewed as an almost magic solution that will fill the affordability gap, no matter what size that gap becomes.

The real debate should be around timing. How quickly can we realistically expect new models of care to be having an impact at scale? Is current funding sufficient to see the service through the transition period – allowing health economies to meet existing demand while developing new pathways in parallel?

It has been three years this month since the *Forward view* was published. And soon after that, 50 national vanguards started to be selected to test out new models in five areas – integrated primary and acute care systems; multispecialty community providers; enhanced health in care homes; urgent and emergency care; and acute care collaborations.

Other systems are pursuing similar change programmes and the whole transformation agenda has become wrapped up with sensible attempts to take a system-wide approach to transformation through sustainability and transformation partnerships and moves to accountable care systems.

There are some early signs that new models are already delivering improvements – moving care into the community, being more proactive and reducing costs. But it is a slow process. Even where areas are borrowing ideas from elsewhere, there is no quick fix. Transformation needs to be from the bottom up, clinically driven and taking account of local infrastructure and context.

Some aspects of transformation will need communities to understand why the changes are necessary.

Consolidating some services in regional locations rather than in every community can be as much about safety and quality – needing sufficient numbers of appropriately qualified staff seeing enough cases to keep their skills honed – as it is about financial affordability, although that should be a legitimate factor as well.

"The real debate should be around timing. How quickly can we realistically expect new models of care to be having an impact at scale?"

So, three years on from setting out on the vanguard movement, let's not expect too much too soon. Yes, keep the pressure on to drive reform as quickly as sensibly possible. But it is the right approach and localities need to be given time and sufficient resources to make a success of system working. This then needs to be underpinned by the right payment mechanisms.

The choice is not between more funds or transformation. Instead we should be talking about how much funding is needed to enable the NHS to achieve transformation over a realistic timeframe.

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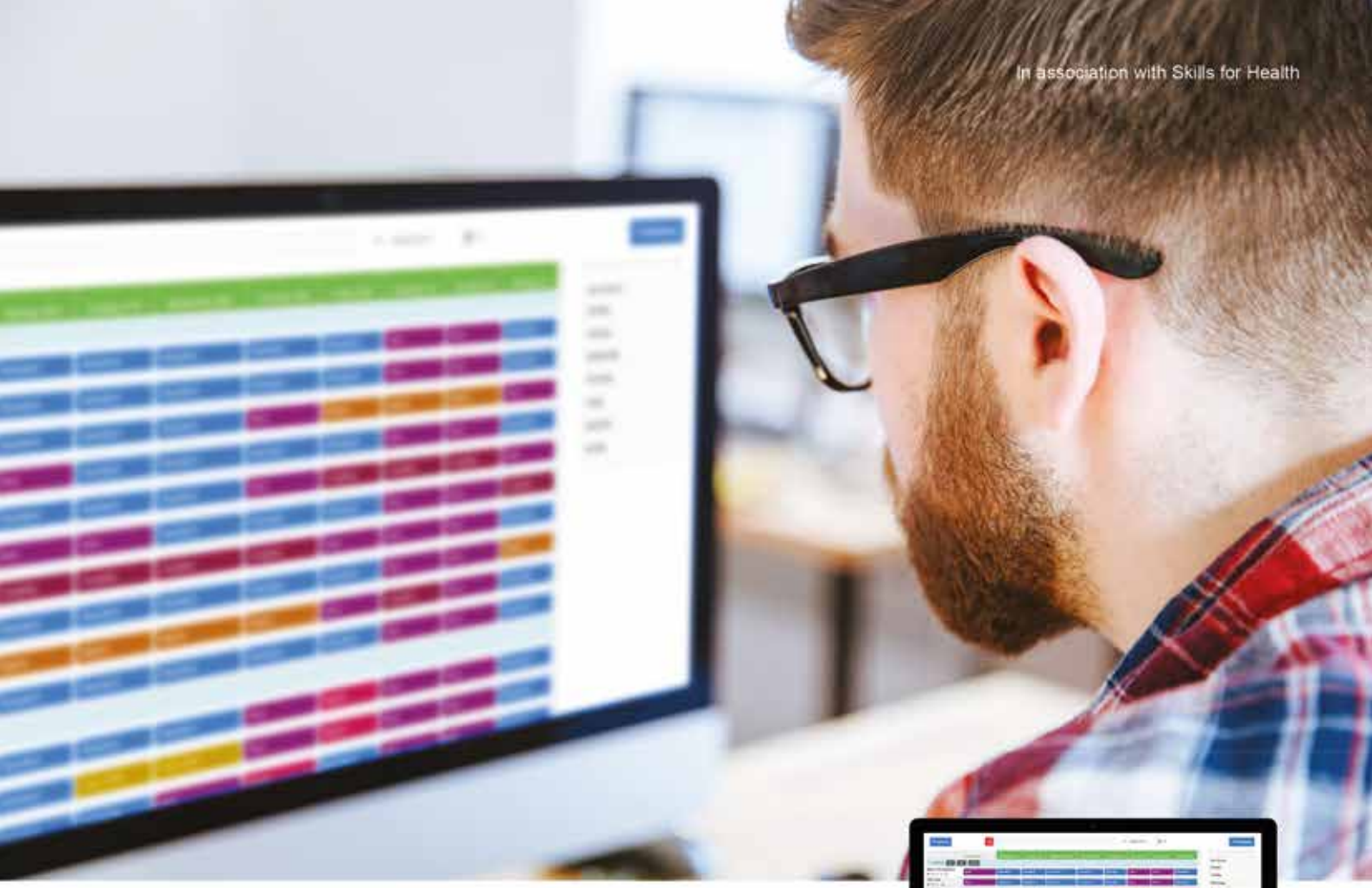

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Getting back on track

Have sustainability and transformation partnerships – set up to deliver value based on quality, health and wellbeing, and finance – become too focused on costs? Paul Assinder suggests Michael Porter's value work offers pointers for getting back on track

Sustainability and transformation partnerships (STPs) were established in 2015 with noble motives: to improve taxpayer value over a five-year planning horizon by bringing together commissioners, providers, social services and the third sector within a defined region. But have they lost their way?

Together STPs were meant to articulate a local vision of a better integrated health and social care future – a vision built on the three inter-related pillars of finance, quality and health and well-being. In economic terms, STPs represented a value proposition.

This non-negotiable process, set out for the 44 local STPs by NHS England, required them to extrapolate a dystopian future where demographic and epidemiological trends continued unabated and were overlaid with negative real-terms growth. This would both make the case for essential change and encourage a fresh joined-up approach to planning and delivering a better future state.

Two years on from their launch, what progress has been made? The STPs have certainly underlined the worst case scenarios that would emerge by 2020 if no action were taken. Reports suggest that STPs collectively are targeting £26bn in 'savings' to remain within funding constraints. The concern is that the plans have led to an almost exclusive focus on reducing NHS spending or future NHS cost avoidance, sidelining the original triple aims (and arguably local authorities and the third sector).

This narrowing of the STP task runs counter to work by Michael Porter on delivering value-based healthcare. Professor Porter would admire much in the original triple aims of the STP approach, but is unlikely to have been impressed with the progress to date in delivering 'do something' solutions. For Professor Porter, value is the interaction of health and social care outcomes delivered and resources deployed.

Importantly, outcomes should not only be defined by health status measures (such as survival ratios and outputs). They should also include individual patient experiences (measured, for example, by satisfaction surveys, patient reported outcome measures and pain scores) and longer term impacts on population health (such as mobility, mental well-being and return to work numbers).

In many cases, STPs have largely shrunk their scope to major on resources to the near exclusion of outcomes. Where outcomes are logged, these are often limited to a restricted range of RightCare or *Getting it right first time* commissioner or provider metrics.

Destined to fail?

In their game-changing paper – *The strategy that will fix healthcare* – Professor Porter and co-author Thomas Lee start from the standpoint that in seeking to frame reduced funding with rising costs and uneven quality as an 'efficiency problem', the NHS and countless other systems worldwide are starting from the wrong perspective. As such, they are inevitably developing strategies that are destined to fail.

So what does the Porter playbook recommend that could help get STPs back on track to secure their noble 'triple objective' version of taxpayer value?

The first imperative is to measure the important stuff, because only through measurement will progress be made. In this instance, this means measuring what is important to patients and taxpayers – namely, outcomes and costs.

More specifically, we must cost and budget on

"In many cases, STPs have largely shrunk their scope to major on resources to the near exclusion of outcomes"

outcomes and costs by medical condition and by patients. Currently, we collect information largely at input or output level only and that is institution-specific rather than patient-centred.

Professor Porter has recommended the routine collection of three tiers of patient specific data-sets:

- Tier one data is concerned with resulting health status such as five-year survival rates.
- Tier two data measures compliance with the pathway or cycle of care, including measures on readmissions and waiting times.
- Tier three data relates to longer term sustainability of the treatment cycle and might include long-term increases in mobility or freedom from pain.

Capturing this data – and doing so at individual patient level – implies a quantum leap in the NHS data capture and processing capability and a new data sharing compact between the NHS and the patient.

On the cost side of the value equation, Professor Porter is clear that universally available patient-level information and costing systems (PLICS) are long overdue and must cover the full cycle of care for a single patient with a specific clinical condition.

Professor Porter and colleague Robert Kaplan have promoted a time-driven activity-based costing (TDABC) approach to healthcare system planning and control. Such an approach builds a cost profile by patient from the base upwards and has the advantage of relating most closely to clinical practice.

Genuine shifts in value can only be achieved through changes in clinical practice. The English STP model goes some way towards laying the foundations for common informatics approaches and a genuine recasting of clinical practice across organisational boundaries. And there are promising moves towards a comprehensive system of patient-level costing, using common and mandated standards. But in general, STPs remain some distance from the overall vision.

Healthcare provision

Professor Porter is similarly directive about how healthcare provision should be structured across health economies. First, he advocates the reorganisation of services into 'integrated practice units' (IPUs). These are similar, perhaps, to existing NHS care networks, but are a significant distance from existing siloed NHS providers.

An STP-level IPU could be organised around a set of closely related patient conditions such as diabetes or renal care. It would draw together all the relevant clinical staff, employed in different local organisations, to provide direct patient care as well as patient education and carer support. Putting a relentless focus on the different costs and contributions of individuals within an IPU supply chain is how improved value will be delivered.

Ideally within an STP, clinicians and support staff operating within a single IPU would be co-located. Notwithstanding this, however, IPUs would require a significant volume of rich common patient and population data, shared across the STP. This would demand sophisticated IT infrastructure and advanced secure communications to operate effectively.

The technical and logistic challenges cannot be underestimated. However, economists are persuaded that the resulting identification of duplication and waste is massive. Professor Porter and Dr Lee, for example, point to the significant savings made at Virginia Mason Medical Center in Seattle (average hospital visits for spinal care reduced from eight to four, for instance).

Professor Porter is also an advocate of economies of scale in healthcare delivery. His argument for a fundamental four-stage reorganisation of provision could guide STP development:

- Define the scope of services (some existing services may be uneconomic or best provided super-regionally for example).
- Concentrate volume in a few locations to exploit scale for cost and quality reasons
- Match such locations with services within IPUs
- Build IPUs across locations.

Again, the delivery challenge for STPs here is immense. This approach would entail removing some staunchly defended trust facilities and challenge accepted medical architecture. But it might also be at odds with the government's 'care closer to home' mantra.

"A broader focus on value and not cost has to yield a more sustainable and enduring solution in even the most challenged STP"
Paul Assinder

For economists, pushing for economies of scale in times of financial austerity feels instinctively right. And in England, the widely supported consolidation of hyper-acute stroke care provides a blueprint for other services.

Again, for Professor Porter, the most successful providers would lead the development of IPUs and a hub and spoke provider model will emerge. This is likely to lead to the highest value providers swallowing up more remote hubs to form new regional networks. This chimes well with the NHS's commitment to clinical networks with their well-established national hierarchies, and with provider chain experiments.

In terms of contracting models, the NHS in England is clearly moving away from payment by results activity-based payment approaches towards capitation or period of care funding models. For Professor Porter, such polar extremes are equally flawed. He advocates instead bundled payment covering a full care cycle for a patient condition. This, he says, encourages cross-silo working to deliver budgets and promote value, with IPU providers incentivised to reduce duplication and cost. Applying this to an STP model would still allow local commissioners and providers to debate the standard reimbursement tariff for a particular cycle of care. But it would be on a basis that is more meaningful in terms of individual patients' experience and informed by meaningful data.

Michael Porter's work sets out some fundamental truths. First, organising services around the patient is not only intuitively right but is shown to offer greatest value. Second, in a period of financial retrenchment, aiming for increased economies of scale is a tried and tested response and so is perhaps not a bad mantra for STPs. Third, there is no denying the need for a quantum improvement in information flows between the key pathway players in a locality.

And finally, a broader focus on value and not cost has to yield a more sustainable and enduring solution in even the most challenged STP.

• *Paul Assinder is a management consultant working in the NHS. An experienced NHS finance director and former HFMA national president, he also lectures on health economics and delivers the health economics module within the HFMA qualifications set.*

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A sharper focus

With numbers of people receiving continuing healthcare funding on the increase, along with the costs of this care, there is a major push to understand significant variation across the country and to address this where it is unwarranted. Steve Brown reports

Continuing healthcare costs are a major pressure for the NHS and clinical commissioning groups. The increase in costs in recent years has outstripped the growth in NHS spending overall. And with an ageing population, if no action is taken, costs are expected to keep on rising. Against this backdrop – and with significant variation across the country in spending and eligibility rates – NHS England has set ambitious targets to slow down the rate of increase.

Continuing healthcare (CHC) is a package of care for adults with ongoing healthcare needs that can be provided in a nursing home or at an individual's own home. Once an individual is assessed as being eligible for CHC, defined as having a primary health need (assessed under a fast-track or standard process), the NHS pays for a package of care for all healthcare and associated social care needs.

Individuals not eligible for CHC funding may still be entitled to NHS-funded nursing care or local authority (means-tested) social care services. For someone living in a nursing home, this would mean a flat weekly rate paid to the care home.

A report from the National Audit Office over the summer said that spending on CHC rose from £2,647m in 2013/14 to £3,062m in 2015/16. This £415m difference represents a 16% increase, well ahead of the overall growth in NHS spending over the same period of just 6%. The costs of NHS-funded nursing care stayed relatively static during this period (at just under £500m).

Factors at play

There are a number of factors in play. The number of people receiving or being assessed as eligible for CHC funding increased by 12% over the three years to 2015/16, says the NAO. However, snapshot data suggests a fall in the numbers on CHC at the ends of 2015 and 2016, perhaps indicating people are receiving CHC funding for shorter periods. The average annualised cost of CHC per person has also risen over the same period by 9% – from £45,850 to £50,000.

These pressures are digging deep into commissioning budgets. CCGs are already averaging 4% of their total spending in 2015/16 on CHC. In addition, NHS England is meeting costs for previously unassessed periods of care (PUPOC), relating to periods before April 2013, when primary care trusts were responsible for CHC.

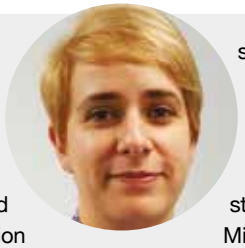
But NHS England estimates CCG spending on CHC and NHS-funded nursing care and assessment costs will increase by a further £1.64bn from £3.607bn in 2015/16 to £5.247bn in 2020/21 if things are left as they are and current trends continue. This would represent a huge 45% increase – well above general NHS growth. To counter this, it plans to deliver £855m of savings compared with this 'no action' forecast.

According to the NAO, it plans to do this by 'increasing standardisation, reducing variation between CCGs and adopting best practice, including in conducting assessments and in procurement'. If successful, this would leave spending in 2020/21 at £4.392bn. However, the NAO pointed out that NHS England does not have a costed breakdown and CCGs do not have spending plans to achieve this.

NHS England says that 'draft plans are now in place' and these are currently being reviewed at CCG level. And it insists the £855m figure has been modelled taking account of the need to provide fair access to CHC.

With no plans to change the eligibility for CHC, as this is mandated in legislation, the broad thrust of the plan is to improve consistency, ensure more patients are assessed after being discharged from hospital and improve the commissioning of care packages. NHS England's assumption is that these

Local action



Sunderland CCG deputy chief finance officer Tarryn Lake (pictured) says detailed plans are being developed to identify where savings will come from locally. The CCG – targeting the delivery of more services in the community as part of its multi-specialty community provider vanguard – has seen a rise in CHC numbers and costs. This may be as a result of some of its transformation work. 'As you try to help more people in the community, inevitably more of the frail elderly population may become eligible for CHC and the packages of care that go with it,' she says.

She adds that with people living longer, there are increased challenges with bed capacity in care homes too, as numbers rise. And care homes face some significant cost pressures themselves. Some homes across the country claim that public sector rates cover only 75% of the cost of care, leaving private payers cross-subsidising taxpayer-funded residents. Those homes in more deprived areas have fewer self-funders and so less ability to compensate for the shortfall in income from public funding. And recent increases in the national living wage – which is paid to many care home staff – have also created pressures in this sector.

Mirroring the NHS, care homes also have their own struggles recruiting nursing staff and are also having to use more expensive agencies to fill vacancies. Nationally there have been reports of care homes closing their doors to NHS and local authority residents unless there is a top-up to basic rates.

The flat national rate for funded nursing care is in many cases added to locally agreed residential care rates in setting standard CHC rates. Enhancements for more complex cases, perhaps requiring one-to-one care, can then be negotiated.

measures will temper the predicted growth in eligibility and cost in coming years.

In April, it launched a two-year CHC Strategic Improvement Programme. This is about more than costs. It also aims to improve outcomes and patient experience – but better use of resources is very much on the agenda.

Understanding variation and addressing this where it is unwarranted are high on its 'to do' list. And there is a lot of it for the programme to get its teeth into. According to the NAO, the numbers of people receiving or eligible for funding in 2015/16 ranged from 28 to 356 per 50,000 population. The proportion of people assessed as eligible, having been referred for a fast-track assessment or identified as needing a full assessment, ranged from 41% to 86%. And

Ms Lake says the process is difficult, with a lack of a national price structure and little transparency about the cost structure and profitability of different homes.

She wonders whether different contracting arrangements – perhaps offering homes block contract arrangements, giving greater stability on income – might offer opportunities for homes to reduce costs and improve sustainability.

There are other issues with direct costs. For example, providing care in someone's own home can be more expensive than provision in a nursing home – particularly for complex cases.

Sunderland is developing a policy around CHC – balancing patient choice with a desire to maximise the number of people it can support. This will involve making an offer to a client and their family that provides the best quality service and gets the best outcomes, while still being cost-effective. This will not set a cap on cost and will allow opportunities to appeal against the offer.

This is not new, but the policy aims to improve the consistency of approach and staff are currently being trained to support them in discussions with patients and their families in what are often sensitive circumstances.

'There may also be opportunities for new care models to get a grip on this,' says Ms Lake. 'Special purpose vehicles within foundation trusts could perhaps own homes and run care. I don't think this has been explored enough yet.'

In terms of the process, Ms Lake believes Sunderland has some challenges meeting the requirement to review CHC cases three months after the initial eligibility decision to reassess care needs and eligibility. She suggests that, recognising people's care needs change as they recover more from any acute incidents, improving performance in this area could lead to some efficiencies.

CCGs are spending 2%-7% of total spending on CHC (excluding the 5% of CCGs with the highest and lowest percentages).

There is also a question mark over the number of screenings being undertaken. Although the process sets out to ensure anyone who might be eligible for CHC is properly assessed, just 18% of screenings actually lead to someone being assessed as eligible for full CHC. This means multidisciplinary teams spend most of their time carrying out assessments that do not lead to people being assessed as eligible. The low thresholds between screening and full assessment can also raise people's expectations about eligibility.

Alison Henley-Jones, NHS England's finance lead for the Strategic Improvement Programme, says analysis to date suggests that demographics only go so far in explaining the variation. 'We are doing further work to understand the age drivers in CHC, but we've also been sense checking what we've done and our assumptions at a national level out in the system. The lack of correlation could be telling us: we're missing a key driver we haven't considered; our data isn't as good as we'd like; or variation is driven by so many local level factors that we can't identify correlations at a national level.'

Alternatively, it could represent different local interpretations of existing guidance in the national framework for CHC.

Savings interventions

A number of interventions are seen as key to delivering savings over the next four years:

- Increase regular case management for existing care packages
- Improve CHC processes and invest in CHC workforce
- Encourage active market management and implement e-procurement
- Encourage the uptake of personalised health budgets.

With a number of work streams in place, some measures are already in operation to improve processes – using the quality premium mechanisms to incentivise timely assessments and more assessments outside of hospital, for example. While this latter measure should support a reduction in delayed transfers of care and increase acute capacity, by cutting the numbers of patients waiting in hospital until an assessment can be undertaken, it could also have an impact on CHC costs.

NHS England reminded CCGs of the required standards in an August letter and identified the poorest performers, which need to take action to get back on track.

Ensuring less than 15% of all full assessments take place in an acute setting is about allowing individuals more time to recover before their assessment. This can often provide a far better indication of long-term care needs.

One CCG *Healthcare Finance* spoke to commissions discharge-to-assess beds specifically for this purpose, enabling patients to recover more before screening using a checklist to indicate if someone is entitled to

Applying the framework

Much greater rigour in the application of the primary health need test at Telford and Wrekin Clinical Commissioning Group has led to a significant drop in both the numbers of people assessed as eligible for continuing healthcare and the associated costs.

Back in 2009, the CCG's predecessor primary care trust had more than 100 CHC clients per 50,000 population – well above the national average at the time. This fell to about a quarter of that figure before increasing a small amount again in recent years. Compared with expenditure of more than £12m on all continuing care in 2009, it is now closer to £5m.

According to head of complex care Colin Evans (pictured with members of his team), the big difference relates to two issues: a bar set too low pre-2009 with a poor review process; and subsequent rigorous understanding and adherence to the national framework alongside good housekeeping of ongoing cases and costs.

'We have a clear understanding of what CHC looks like,' he says. 'All our nurse assessors are clear on the threshold, backed up with training, and we ensure a consistent application of the assessment criteria to ensure equity to all across all client groups.'

Countering suggestions that the CCG's assessment process is overly robust, he says that local work suggests it is getting the right results. Reviews in 2012 and 2016, undertaken to reassure the local authority that eligibility was being correctly assessed, resulted in just one case being changed from ineligible to eligible out of 86 cases that had been assessed as 'not eligible'.

Consistency and clarity are key to the whole process – which is run by an in-house complex care team – along with proactive case management. All cases are reviewed at least annually and whenever there is any indication of a change of need.

The team also keeps track of changes to the caseload each month, looking at the numbers and the costs of new CHC clients (standard and fast-tracks), joint funded clients and those eligible for funded nursing care. These are looked at alongside cases no longer eligible for the various forms of continuing care support. We ensure the team know the financial position,' says Mr Evans. 'It doesn't change clinical decisions, but they can't work in a vacuum.'

Good housekeeping at team level is mirrored at board meetings, with detailed statistics covering referrals, eligibility assessments and outstanding reviews all reported monthly.

Mr Evans says the provider market is closely managed. It is moving towards a benchmarked cost for all 'typical' cases and challenges every cost that is different to expectations. Requests for additional money are reviewed, and the homes all know that the CCG could drop in at any point to ensure care delivered matches what is being paid for – for example, in one-to-one care cases.

There is less control over fast-track cases, where numbers are rising annually. However, these cases are subject to ongoing review in the early weeks, with a full assessment undertaken by week 12.

The CCG also undertakes no standard assessments in an acute setting. Instead, potential patients who are medically fit for discharge are subject to a pre-checklist fact-finding assessment to understand rehabilitation needs. This matches the patient to one of four discharge-to-assess pathways. This could involve being discharged to their own home (48% of cases), a residential care home (29%), nursing home (23%) or requiring a checklist screening on the ward.

In the first three pathways, patients are given enablement support involving occupational therapy, physiotherapy and district nursing. This is provided by the community healthcare trust and funded using the Better Care Fund. Mr Evans says this means that when the checklist or CHC assessment is undertaken, it has a much better chance of identifying the ongoing care needs from the outset.

'Overall the process needs rigorous application in a consistent and equitable way,' he says. 'Everyone needs to understand the eligibility criteria and be supported in their decision-making. And there needs to be a high level of challenge.'

be considered for CHC eligibility. It suggests it has led to more accurate assessment of real ongoing care needs and is considering expanding the model to enable discharge for assessment at home.

The quality premium also links to getting decisions on CHC eligibility within 28 days of a positive checklist in 80% of cases. NHS England's newly appointed national director for the CHC Strategic Improvement Programme, Jim Connolly, believes this will have multiple benefits. 'Delivering a decision for CHC eligibility within 28 days is good practice and will benefit the person, their family and the NHS as a whole,' he says.

Some CCGs have looked at direct ways to balance patient choice with overall cost-effectiveness – looking at whether there should be any limits on meeting individual patient requests, perhaps involving being cared for at home however complex the condition. While many CCGs currently have no official policy in this area, the Disability United charity earlier this year highlighted growing numbers of CCGs operating caps some set as low as 10% and up to 40% above the most cost-effective package of care. In some areas, proposals to change this cap – from a pre-existing 25% to 10% in one case – have met stiff local resistance and, for some of the CCGs involved, a postponement of the decision.

> **"Delivering a decision for CHC eligibility within 28 days is good practice"**
> **Jim Connolly, NHS England**

CCGs would like to see central guidance on how to balance out these pressures, clarifying what patients should expect at a national level for example.

Asked about the issue, NHS England says only that 'decisions on buying appropriate care are for CCGs. This has to be balanced on the needs of an individual and requirements for CCGs to balance their budgets'.

The national framework, which is overseen by the Department of Health and sets out the process for establishing eligibility for CHC and the dispute process, is currently being reviewed.

It is not completely clear what the scope of this review is although the NAO report said that the 'Department has been working with NHS England, local authority representatives and charity groups to understand the impact of the national framework on delivery of CHC and where there might be scope for improvements'.

Market management is another area where NHS England sees opportunities for spreading best practice. This could look at the benefits of different types of contract but also look at how contracts are subsequently managed. 'If a CCG is paying for a high level of nursing care for a patient – one-to-one care, for example – it needs to have assurance that that care is being delivered,' says Ms Henley-Jones.

It is clear that NHS England is serious about getting a more consistent and equitable approach to CHC assessment and funding across the country. Having set it as a national improvement priority, CCGs should expect both more support and more scrutiny of local provision and costs over the next two years.

Quick save

Halfway through the financial year, trusts in Northern Ireland are consulting on a range of cost-cutting measures. But, asks Seamus Ward, how have they got to this point? And how will it affect services?

Local politics in Northern Ireland is never far away from the running of its health and social care services. But while the internecine war of words will be lost on most outside the region, finance professionals are well aware of the difficulty of being asked to find extra cash-releasing savings mid-year – as the local health and social care service has been asked to do.

With the local political process frozen since the March local Assembly elections – due to the main parties failing to agree a new power-sharing executive – 2017/18 spending was not confirmed until July.

As September ended, the Irish government said the Assembly and executive could be up and running within weeks. But in the absence of a minister, officials at the Department of Health in Belfast are running local health and social care and have been working with trusts and commissioners to develop a balanced financial plan. As part of this process, trusts have been required to bring forward proposals to address a shortfall of £70m.

In August, the five local health and social care trusts launched consultations on savings plans to close the £70m gap (the total budget for health and social care is £5bn a year, about half of the devolved government's budget). The consultation ends on 5 October, giving the local service five months to implement their plans – assuming they can push them forward following the consultations.

Funding stalemate

The failure to form a local Assembly government has consequences for the local public services. It appears that the additional £1bn for Northern Ireland from the deal struck between the Democratic Unionist Party and the Conservative government in Westminster – including £250m for health – will not be released until the power-sharing executive is restored. Despite this, with financial storm clouds looming over health and social care, in July an additional £60m was found. So how has the service reached the point where it needs to make additional savings in-year?

A Northern Ireland Department of Health spokesperson gives some clues. 'The indicative resource allocation for the Department of Health is £5,095.4m, which provides an additional £224.8m for health, when compared against the allocated budget at the start of the 2016/17 financial year,' they say.

'This indicative allocation includes the additional one-off allocation of £60.1m in July. Despite this, the financial challenge for health remains significant due to inflation [widely recognised as 6% per annum], an increasing and ageing population and the cost of new treatments. HSC trusts have been tasked by the Department with developing draft savings plans to deliver a total of £70m of savings in 2017/18, which must be achieved as part of the financial plan for this year.'

There are several points to make about the in-year savings. The Department insists the actions that are proposed to make the savings are temporary and are required only to meet the statutory duty of breaking even in 2017/18. If the proposals are implemented and subsequently need to be extended beyond the current financial year, there would be another public consultation.

Inflation running at 6% means there was a shortfall of around £300m at the beginning of the financial year. This year's uplift leaves the service around £70m short.

John Compton, the former chief executive of the Health and Social Care Board (HSCB, which commissions care across Northern

SHUTTERSTOCK

Ireland), says: 'We've got here because we have become overly dependent on non-recurrent funding. In the past, when in-year monitoring funding was awarded, it was to bring things on, to run new services. The service needs around £300m a year to take account of rising demand. You can't get that 6% – you'll maybe get 2% to 3% from government, the service can make 1% to 1.5% from its own resources, but you're still 2% short and that shortfall is getting bigger.'

There are several unanswered questions, he adds. Will the in-year savings lead to a balanced financial position at year-end? If it was known that further action was needed to balance the books, why did the Department wait until August to set the ball rolling? Will next year's shortfall be £370m or more? And is this year's pay award, yet to be announced, included in the calculations that led to the £70m savings requirement? Even an overall pay rise of 1% could add more than £20m to the pay bill.

In recent years, trusts have been given extra financial support to help them through the winter, but he questions whether it will be available this year. If not, further lengthening of already-long waiting times seems inevitable.

Mr Compton is not confident the savings will be achieved. 'There will be five months until the end of the financial year and the question is whether or not they will be able to get £70m out in the teeth of winter when some pressures will be enormous. Cash control on agency and locum spending is going to be enormously difficult unless you're prepared to have queues of people waiting for service. I think they will make a sizeable amount, but it's a tall order.'

But what of the savings? It is worth saying that the trusts have been delivering year-on-year savings of 2% for some time, though the late confirmation of allocations means trusts will find it difficult to spend all of their funding specifically aimed at service development. This slippage is reflected in the savings plans (see box below and overleaf).

Emergency focus

The trusts and the Department are keen to minimise the impact on patient and client care. 'The HSCB will work with trusts during the consultation to develop actions to mitigate as far as possible the proposed temporary service changes to maintain quality of provision. Maintaining patient safety remains the prime priority,' the Department says.

As far as possible, trusts have taken account of the principles of deliverability, safety,

Savings plans

BELFAST HSC TRUST

- **Savings required:** £26.3m (budget: £1.3bn)
- **Proposals:** Major or controversial proposals account for half of the trust's proposed savings – better management of agency workforce (£1.75m); reduction in elective surgery in high-volume specialties and deferral to 2018/19 (£2.95m); temporarily reducing access to domiciliary care for new patients (£0.75m) and nursing and residential home placements (£2.3m); deferring access for new patients to the regional fertility centre (£0.75m); reductions in drugs spending (£4.5m). The other £13m would be saved in areas that have little or no impact on patients – £7.7m from anticipated natural slippage in implementing new services; procurement savings (£2m); £2m from estates; £1m in productivity savings from new service models such as rehabilitation and reablement; £0.5m on reduced management and administration costs.
- **Impact**: if the trust cannot source sufficient staff from bank or contracted agencies, 65 beds will close; waiting times will rise; 35 fewer beds due to less elective surgery; 365 patients affected by limits on domiciliary care, 230 by proposals on nursing and residential care; higher A&E attendances.

NORTHERN HSC TRUST

- **Savings required: £13m** (budget: £655m)
- **Proposals**: Major or controversial proposals have a temporary service impact of almost £6.7m – savings in temporary staffing £2.4m, with £2m saved by deferring 2,400 elective procedures. It also plans to cut independent sector-commissioned community rehab beds by 25, saving £0.45m. Containing the growth of community care home placements and domiciliary care packages would save almost £1.48m. Proposals to end domiciliary meals provision, increase car park charges and reduce the use of private non-emergency ambulance transport would save £335,000. Low patient impact savings plans, totalling £6.3m, include: deferral of service developments (£2m); one-off technical adjustments, such as reviewing liabilities for ongoing staff settlements under Agenda for Change (£2m); retained savings, used to address the trust's deficit (£0.8m); natural slippage on resettlement of long-stay hospital residents to community (£0.56m); proactively managing absence (£0.4m); and non-pay efficiencies, including procurement (£0.5m).
- **Impact**: The trust proposes temporarily closing rehab services, which relies on agency staff, at one of its hospitals and redirecting trust-employed staff to working temporarily on other services. Staff would also be redirected from elective surgery to other parts of the trust. This would reduce use of flexible staffing, but affect hospital discharge and waiting times.

SOUTH EASTERN HSC TRUST

- **Savings required**: £10.8m (budget: £600m)
- **Proposals**: Proposed reduction in agency and locum staff spending would contribute £2m to savings requirement. It plans to temporarily reduce locum costs by £1m – it spent £8.6m in 2016/17 and forecasts at least £9m this year. The trust says a big cut in emergency department locums, which accounts for 40% of medical locum spending, is likely to lead to the temporary closure of an emergency department or reduced opening times. So, it

continued overleaf ➤

limiting service impact and maintaining its strategic direction. However, they accept some services will be affected.

Launching the Northern Trust consultation, its chief executive, Tony Stevens, said: 'We are part of a system that's under significant financial pressure, but the HSC system is working collaboratively to find solutions. We will prioritise services to protect the sickest and most vulnerable. The proposals we have put forward seek to minimise any adverse impact on our plans for reform and modernisation.

'The proposals, if implemented, will however have an immediate impact on current service provision. There will be no direct impact on current staff, but the trust will maintain its vacancy management processes. We will continue to seek to find ways to mitigate this.'

In a statement, Western Trust chief executive Anne Kilgallen added: 'The safety of patients and clients under our care is our utmost priority and we have borne this in mind in developing our proposals. The trust has sought to protect emergency and unscheduled care, red flag and cancer patients, looked-after children, frail people and people with a disability. It is important to note that the draft savings plan is a public consultation – no decisions have been made regarding the implementation of the proposals contained within the plan.'

Services provided by the Western Health and Social Care Trust's Altnagelvin Hospital could be affected under the plans

None of the trusts plan redundancies, but a crackdown on agency and other temporary staff spending is one of the main themes coming through all of their proposals. The Belfast Health and Social Care Trust is taking a leaf from Lord Carter's efficiency review in England, proposing to maximise the use of internal banks for temporary staff and locum doctors, and use only contracted agencies to reduce the fees paid. Others plan to cap fees for locums, maximising their staff bank or taking temporary staff only from contracted agencies.

The focus on temporary staff is considered a major change that could have an impact on patients and the trusts acknowledge the risks.

The plans also recognise that the reduction in temporary staff, plus other major changes such as reductions in elective surgery, will lead to the temporary closure of beds and a likely increase in waiting times.

Waiting times will be a big concern for the public. Northern Ireland already has the longest times in the UK, and it remains to be seen how the service will recover on this key measure of performance.

Uncertainties remain. Will the trusts get their proposals through the consultation process? Will they be able to deliver on their plans in the five months of the financial year that will remain? And if a new Assembly government is formed, would an incoming health minister halt the savings plans?

Savings plans (continued)

proposes a more modest 5% cut plus reductions in elective locum numbers to meet the £1m saving. Agency measures would reduce costs by a third (£1m) compared with 2016/17. Qualified nurse posts are not included as the trust says it would risk patient safety. It proposes to save £8.7m through low patient impact measures – natural delays in implementing new services (£3.5m); procurement savings (£752,000); delays to the transfer of patients to a new ward block (£1.5m).

- **Impact**: The cuts in elective locum numbers could lead to 600-700 fewer planned procedures for the remainder of the year, while there could also be increased waiting times for emergency care. Reductions in agency staff could mean delays in areas such as physiotherapy or patients travelling to different sites for treatment.

SOUTHERN HSC TRUST

- **Savings required**: £6.4m (budget: £568m)
- **Proposals**: Mostly low impact on patients (£5.6m) – £2.8m through slippage of planned spending on services due to rise because of demand pressures; deferring recruitment when staff leave (£1.1m); more than £1m in procurement (discretionary spending and bulk purchase of water filters). The trust says £75,000 will have to be found from major or controversial measures such as changes in community equipment procurement. The provision of single-use small aids and appliances through local pharmacies will be replaced by a home delivery service from the local Business Service Organisation. This will include recycled, decontaminated goods of the same specification.
- **Impact**: The trust considers its plans will have minimal impact on patients. The changes in community equipment provision would have little impact on patients or staff, though 54 local pharmacies would lose income.

WESTERN HSC TRUST

Savings required: £12.5m (budget: £600m)

- **Proposals**: savings of £3m from low patient impact measures, including £950,000 by bringing forward efficiency and cost improvement plans due to complete in 2018/19. However, most of the savings (£9.4m) will come from major and/or controversial measures – releasing £1.6m through reduced use of agency staff and £700,000 by capping locum pay rates; move to temporarily reduce elective activity and consolidate day case elective surgery (£1.8m); temporary reduction or delay of some services or service developments (£2.5m); temporary reduction in domiciliary and nursing home packages (£1.16m); residential and day care services consolidated onto fewer sites; vacancy controls and revising annual leave policies (£1m); temporarily remodelling some services (£0.5m).
- **Impact**: Agency and locum staff reductions will lead to the closure of 30 beds/care spaces across medical and care of the elderly services, which will affect throughput in acute hospitals. Access to routine elective care will be reduced and the trust's two acute hospitals will lose about 40 beds. Some 275 domiciliary care places will not be established. New annual leave policy will mean staff cannot carry over unused leave at the end of this financial year, except in exceptional circumstances.

If the cap fits...

The capped expenditure process appeared out of the blue, creating dramatic headlines. But what is it and how does it differ from other financial controls? Seamus Ward reports

Secret cuts to services. Bed closures. Rationing. These are accusations the NHS has to address, seemingly, on a more regular basis. Around a year ago, these fears were raised about sustainability and transformation plans (STPs). And, while these concerns remain, this year a new bête noir has emerged – the capped expenditure process (CEP).

Mentioning the CEP to finance managers generally brings a blank stare, as many have never heard of it. This is undoubtedly due to the fact that the process applies to just 13 areas of England, some of which cover whole STPs; some smaller local health economies. But it is also because so little is known about it.

News of the CEP emerged only in early summer, even though NHS England and NHS Improvement launched it (with no fanfare) in April. Even now, information is limited to a few board papers and briefings put together by health unions and think tanks. *Healthcare Finance* contacted NHS Improvement and NHS England and both declined to comment. Many NHS organisations involved in the CEP did the same.

So what do we know? It applies to 13 areas of England (see box overleaf) and is aimed at areas that have historically overspent their fair share of NHS funding and those deemed to be most at risk of breaching their budgets in 2017/18. The latter may be due to a failure to agree a cross-system plan or failing to agree a plan that fits within the available financial envelope. The available envelope is made up of clinical commissioning group allocations, adjusted for the CCG and provider control totals and any sustainability and transformation fund money.

The CEP is in line with the *Next steps on the NHS five-year forward view* statement that some health economies were 'living off bail-outs arbitrarily taken from other parts of the country or from services such as mental health'. Some of the areas include trusts or clinical commissioning groups already subject to regulatory interventions and the CEP aims to align with these.

Siva Anandaciva, King's Fund chief analyst, says that, initially, the areas were asked to think the unthinkable, some with the support of external consultants, broadly across three types of actions:

- Review and stress test existing plans
- Meet *Next steps* recommendations
- Examine more difficult decisions.

As a result, proposed measures mixed controversial actions with the more mundane. They included the downgrading of hospitals, wards and services; further caps on agency spending; private finance initiative buyouts; selling surplus land; limiting or blocking outsourcing and patient choice; extending waiting times; and tighter controls on IVF treatments.

In Cambridgeshire and Peterborough, for example, local trusts and the CCG could not agree plans that remained within the available funding. The gap between the aggregate control total and the plans was £9.7m and, as a result the STP area entered the CEP. A Cambridgeshire

and Peterborough CCG spokesperson says: 'The Cambridgeshire and Peterborough health system has been recognised as one of the 11 most financially challenged areas in England, and is also part of the capped expenditure process.'

The CCG is considering several measures to meet its financial duties:

- A minimum 12-week elective wait, but retaining the 18-week referral to treatment standard
- Helping practices avoid prescribing over-the-counter medicines and reducing prescribing of drugs of low clinical value
- More consistently applying exceptional and clinical threshold policies
- Reducing referrals to outpatients where this is of low clinical value.

'We hope that these initiatives, along with our quality, innovation, productivity and prevention (QIPP) savings, will help to address the CCG's financial pressures and risks,' says the spokesperson.

Another STP – Devon – says it is working with NHS England and NHS Improvement on a balanced plan for 2017/18 as part of the CEP. This includes finding savings of £18m.

A spokesperson from the STP says: 'Like other local systems around the country, we're currently working to bring down spending levels to what they need to be. The annual savings the Devon system needs to make in 2017/18 have increased from £151m to £169m as a result of the CEP.'

Like many systems, Devon faces many challenges, says the spokesperson – huge growth in demand for health and social care, an ageing population, rising costs due to new treatments and medicines, and difficulty recruiting to core NHS and social care roles. 'Big changes are needed to meet these challenges. We will clearly need to change some NHS services, some of which will require consultation, adopt more national best practice, for instance developing specialist centres to improve outcomes (for example, stroke), provide more care at home, review how we utilise our estates and facilities and better integrate health and care services.'

Progress report

Deloitte was commissioned by NHS England and NHS Improvement to undertake a rapid financial review of the Eastern Cheshire local health economy to help stay within its means. A line-by-line review of existing spending and an assessment of the risk associated with local cost improvement programmes and QIPP productivity schemes also took place, together with benchmarking against NHS RightCare and Carter recommendations.

While some individual measures will, no doubt, be distressing to the patients affected, do the steps that we know are now being considered really add up to the radical savings programme the CEP was initially made out to be?

The King's Fund's Siva Anandaciva detects a change in the mood music. In June, NHS Improvement chief executive Jim Mackey wrote a letter telling the CEP areas that savings measures under the process must not compromise patient safety or affect their NHS Constitution rights, such as on choice and maximum waiting times. As part of this 'softening' of the approach to CEP, Mr Anandaciva claims the reported aggregate savings targeted by the scheme fell from £470m to £250m.

Some of the proposals have been on the table for some time – such as property sales – and many of these, together with some of the more radical proposals, will not realise benefits in 2017/18. Service reconfigurations may require public consultation, while PFI buyouts and repatriating patients back from private providers will require negotiation and expense. Deferred demand will have to be met at some point.

'There was a lot of activity between April and June – replanning, reprofiling – but in the post-June period the pressure on CEPs seems to have been turned down a bit,' he says.

"The message seems to be: 'try harder on the things you are already doing', but there seems to be less emphasis on more significant changes"
Siva Anandaciva, King's Fund

'The message seems to be: "try harder on the things you are already doing", but there seems to be less emphasis on more significant changes, such as closing a hospital site or selling off a parcel of land. That seems realistic – if you are putting together a land sale and want to get a good market price or if you are closing a hospital, you are not going to do it before the end of 2017/18.'

He says the perceived secrecy – which in turn raises patient and staff fear of behind-the-scenes deals and cuts – is a problem.

'The service should have learnt from the STPs,' he says. 'Everyone tells you that if you are doing significant system change, engage early and build on the public discussions and opinion, rather than them thinking you are developing plans behind closed doors.

'I understand where NHS England and NHS Improvement are coming from – they can't have some parts of the country doing their best to reach their financial targets, while there is a perception that others are not trying as hard but are being rewarded. The debate with the Treasury is that the NHS must demonstrate it is doing everything it can, but if that's what you want to achieve, I think there are different ways of running that process.'

Mr Anandaciva says the CEP came as a surprise to many. 'The process

CEP areas

The areas selected for the CEP include:

London
- North West London
- North Central London
- South East London

Midlands and East
- Staffordshire
- Cambridge and Peterborough

North
- Humber, Coast and Vale
- Cheshire and Merseyside
- Lancashire and South Cumbria

South
- Sussex and East Surrey
- Cornwall and the Isles of Scilly
- Devon
- Somerset
- Bristol, North Somerset, South Gloucestershire

Other financial improvement schemes

Provider control totals All providers are offered a control total for each financial year, which they can choose to accept or reject. However, access to the sustainability and transformation fund depends on providers agreeing and delivering the control total. Control totals can be set to allow a year-end deficit. With the introduction of STPs, there is talk of indicative or shadow control totals for each STP area, which is a simple aggregate of the control totals of the organisations. However, there is no basis for enforcing control totals at the STP level, just at the level of the individual organisation.

Single oversight framework An NHS Improvement regulatory framework that assesses a provider's performance against five domains: quality of care; finance and use of resources; operational performance; strategic change and leadership; and improvement capability.

Success regimes This aims to support and challenge health economies with long-term financial and operational difficulties. There are currently three success regimes – in parts of Devon, Essex and Cumbria – and the focus is on short-term financial and performance improvement, medium and long-term transformation, including introducing new models of care, and developing leadership.

Financial special measures Intervention to support rapid financial turnaround in troubled providers and CCGs. It was launched as part of the financial reset in July 2016.

Financial improvement programme This is a voluntary scheme created by NHS Improvement to allow providers to buy in external support and advice to improve their financial position. Sixteen trusts in the first wave aimed to save £50m in the first year.

seemed to come out of nowhere. The two-year contracting round was supposed to create planning stability – once agreed they could get on with delivery, but a lot of people were blindsided by this new process.'

He adds that some CEP areas are uncertain why they were selected. 'A few areas involved in CEP have told us they are unsure why they were chosen but not their neighbours who seem to be in a worse position.'

Nevertheless, he believes the CEP has been helpful in some ways. NHS Improvement and NHS England have acted almost like an old-style strategic health authority, he says. They have brought together commissioners and providers, pointed out where efficiency measures could be implemented quicker or planned spending deferred, for example.

'There is a benefit even by bringing commissioners and providers together to examine their QIPPs and CIPs. There's a lot of benefit in bringing out the dead and understanding the scale of the problem,' says Mr Anandaciva.

It has been a difficult process, drawing local and national media attention to potential service cuts. But perhaps exposing the scale of local issues – some of which may have been stuck at an impasse for years – and marking them for action by STPs, could be its legacy.

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Updated guidance confirms A&E link for STF performance fund

Technical update

The performance element of the £1.8bn sustainability and transformation fund (STF) in 2017/18 and 2018/19 will only be linked to A&E performance, NHS Improvement has confirmed, *writes Steve Brown.*

Providers' oversight body announced its plans earlier in the year to drop the link between STF payments and cancer and elective access targets. But guidance, updated in September, has now formally confirmed how the fund will operate for the coming two years.

The sustainability and transformation fund and financial control totals for 2017/18 and 2018/19: guidance also confirms that providers will only be able to access the performance element of their fund allocations – 30% of the total – if they first meet their agreed control totals.

Performance against the year-to-date control totals in each quarter of both the years will act as a 'binary on/off switch' to access STF funds.

A provider that misses its Q1 control total will not receive any STF funds for the quarter. If it subsequently achieves its Q2 control total, it will become entitled to previously missed quarters of STF, including performance funds if all the relevant criteria have been met.

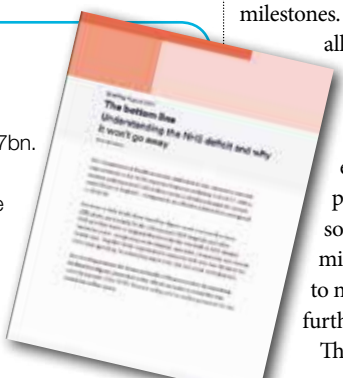
To access the performance element, providers will need to achieve nationally set A&E trajectories through 2017/18, while making progress on A&E primary care streaming milestones. This will include achieving 95% of all patients seen within four hours by March 2018 and then sustaining this in 2018/19.

Control totals will be measured excluding receipt of the STF. This prevents a trust being penalised twice, so that a performance failure leading to missed STF funding cannot contribute to missing a control total – causing further funds to be withheld.

The guidance clarifies the technical accounting basis for control totals and this will be consistent across NHS trusts and foundation trusts. When calculating the performance against control total this year, the reported surplus/ deficit for the year will be

continued overleaf ▶

Underlying deficits



A report from the Nuffield Trust in August, claimed that while providers ended 2016/17 with a reported deficit of £791m, their real underlying deficit was £3.7bn.

In coming to this underlying figure, it added back non-recurrent efficiency savings and the sustainability and transformation fund on the grounds that the fund is also non-recurrent as far as providers are concerned.

The thinktank said even trusts earning STF funds and achieving a surplus last year can't spend the funds this year as this would mean overspending compared to income received in 2017/18. This would mean missed control totals this year and prevent access to a further share of STF.

The analysis doesn't however acknowledge that these surpluses could in theory be used on much needed building programmes – with sustainability and transformation plans needing significant levels of capital. However, overall capital spending is already constrained by the Department of Health's restricted capital expenditure limit. NHS Improvement's STF paper (see story above) also stresses that trusts 'need to be prepared for continuing restrictions on both external finance access and deployment of existing cash reserves'.

adjusted to remove the effect of impairments charged to expenditure except those that arise from loss or damage, abandonment of projects or over-specification. Like last year, the I&E impact of capital donations and gains/losses on transfers by absorption will be removed from the calculated position.

The baseline used for a trust's 2017/18 and 2018/19 control totals was its control total for 2016/17. This means that providers that did better than their control total in 2016/17 on the basis of recurring savings face a less demanding efficiency requirement this year. The guidance sets out the adjustments made to these baselines to calculate the new control totals.

The STF will amount to £1.8bn in both 2017/18 and 2018/19. There is a general element, including £1.5bn for providers of emergency care, allocated in proportion to the cost of the emergency services they provide, and a further £100m for non-acute services. The non-acute general element – for ambulance, mental health and community trusts – is allocated based on operating revenue. The remaining £200m makes up a targeted element of the fund.

The STF has been put together from resources that were allocated to the NHS as part of a recurrent real-terms uplift.

However, the guidance stresses that STF funding is non-recurrent for trusts and they should not count on it beyond 2018/19 (see box, previous page).

For the time being the fund remains focused on sustainability rather than transformation. As such it is intended to deliver a 'pound-for-pound improvement' in each trust's bottom line. Commissioners cannot ask for the fund to be spent on delivering increased volumes of activity.

Technical review

Recent key technical developments

Technical roundup

- The Department of Health has launched a consultation on regulation changes to support the introduction of accountable care organisations (ACOs). The need for change has been highlighted by the development of a version of the **NHS standard contract to cover ACOs**. In some cases, these changes would create additional flexibilities – for example, enabling GPs to enter into ACO arrangements without terminating their existing contracts. However, most of the changes are minor. The consultation closes on 2 November.

- The HFMA has updated a briefing on the **reform of intermediaries legislation** to reflect recent guidance and experience. The briefing explains the background to the revised off-payroll rules covering the public sector and identifies and summarises all the available guidance.

- The Department has issued the timetable for the Q2 **agreement of balances exercise**, setting out four deadlines. It has asked parties to note that agreement between counterparties and submission to the Department are not mandated for month six, though they are encouraged, following exchange of statements, to raise and respond to queries.

- The Department has issued guidance for NHS bodies on the acceptance, management and transfer of **charitable funds**. *NHS funds held on trust* outlines the general principles that determine the responsibilities of NHS charity trustees. It includes advice on their duties in accepting and managing funds, as well as accounting and reporting.

- An updated **financial reporting briefing** from the HFMA updates on developments that will have an impact in 2017/18 and beyond. It covers amendments to cashflow statements requiring additional disclosures relating to changes in liabilities arising from financing activities and implementation of IFRS15 – *Revenue from contracts with customers*.

Intermediate care can improve independence and cut costs

NICE update

NICE has published a guideline (NG74) on intermediate care including reablement, making recommendations covering the four categories of intermediate care defined in the National Audit of Intermediate Care: crisis response; home-based intermediate care; bed-based intermediate care; and reablement.

Hospital admission and delays in hospital discharge can create significant anxiety, physical and psychological deterioration and increased dependence. Multidisciplinary services, which help people recover, regain independence and return home, are vital.

In facilitating timely transfer of care from hospital, intermediate care and reablement services aim to maximise independence and reduce hospital admission. Intermediate care uses a range of service models to help people be as independent as possible.

NICE recommends offering reablement as a first option to those being considered for home care, where this could improve independence. This should lead to long-term savings due to lower use of home care and reduced admissions to hospital in the first two years after reablement. Short-term costs are higher, but the net cost of providing reablement for an extra 1,000 people being considered for home care is anticipated to be £293,000. For bed-based intermediate care, the guideline recommends the service is started within two days of receiving an appropriate referral. While the average wait for bed-based intermediate care from referral to assessment is 1.3 days, the average wait from referral to care is three. About 76% of care is provided within two days of referral. So to provide the 24% of care not currently being received within two days of referral will require extra capacity in bed-based intermediate care. This would involve an estimated net cost of £31.3m in England from year five onwards. Increasing capacity in bed-based intermediate

Diary

October

6 B West Midlands: future workforce, Birmingham
11 F Chair, Non-Executive Director and Lay Member: forum, Central Manchester
12 I NHS costing – networking
13/14 B Kent, Surrey and Sussex: annual conference, Ashford
13 B South Central: football tournament, Southampton
17 F Chair, Non-executive Director and Lay Member: NHS Operating Game for new non-executives, London
20 B Eastern: annual conference, Newmarket
26/27 B Scotland: annual conference, Clydebank

November

1 B West Midlands: new care models, Birmingham
3 B East Midlands: annual conference, Loughborough
8 N Annual mental health conference, London
9 B London: VAT, Rochester Row
9 B West Midlands: AGM, Birmingham
10 B Northern: annual conference, Durham
10 B South Central: technical update, Southampton
10 B North West: student event, Liverpool
14 N Audit conference, London
15 F Commissioning Finance: future of primary care and general practice forum, London
21 B North West: AGM, Liverpool
21 B Wales/South West: road to resilience, Chepstow
22 B Eastern: health sector insight briefing, Cambridge
24 B Northern Ireland: annual conference, Belfast
27 B West Midlands: autumn budget briefing, Birmingham

December

4 B South Central: technical update, Reading
6 N HFMA annual conference, London

January 2018

17 F Chair, Non-executive Director and Lay Member: annual chairs' conference, London
25 B Yorkshire and Humber: annual conference, Broughton
29 B Eastern: introduction to NHS finance, Fulbourn
31 N Pre-accounts planning, Manchester

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

key B Branch N National F Faculty I Institute

care is likely to create capacity in other areas such as consultant-led beds. This may lead to improved productivity for providers and additional income from increased activity.

NICE has produced a resource impact report and template to help organisations assess and plan for the resource impact of implementing the guideline. Intermediate care including reablement services is commissioned by local authorities and clinical commissioning groups (CCGs). There are a number of providers including NHS hospital trusts, local authorities, community providers and not-for-profit social enterprises.

Nicola Bodey, senior business analyst, NICE

Events in focus

HFMA annual mental health conference
8 November, London

Long seen as a Cinderella service, there has been a renewed focus on mental health, with successive governments moving to invoke policies on parity of esteem with physical services. And under the mental health minimum investment standard, commissioners are expected to increase funding in line with the overall rise in their budget. But there is continuing concern that the national rhetoric is not being matched with funding at the front line. A number of surveys, including by the HFMA and NHS Providers, have highlighted the challenges involved in increasing investment in mental health to meet the standard. At the same time, the mental health payment system is being developed. The conference, now in its 14th year, is aimed at finance staff in commissioners and mental healthcare providers. Speakers include Luke Edwards, NHS Improvement director of sector development – operational productivity, and Tim Kendall (pictured), national clinical director of mental health at NHS England and NHS Improvement.

• Email emily.bowers@hfma.org.uk for more details or to book a place – there are discounted rates for Mental Health Finance Faculty members

HFMA audit conference
14 November, London

The need for robust governance and audit arrangements is stronger than ever. The NHS is in a difficult financial position and must ensure it is getting best value for taxpayers' money and gain assurance that all efficiencies are reported accurately. At the same time, the service is entering an era of new models of care, more joint working and new structures such as sustainability and transformation partnerships and accountable care systems. This one-day conference will provide a practical forum for NHS organisation chairs and audit committee members to discuss the latest developments. Confirmed speakers include Paul Dillon-Robinson, an experienced NHS internal auditor, who is former director of internal audit and risk at the House of Commons. He will be joined by National Audit Office director Robert White (pictured), who is also a former NHS finance director.

• Visit the HFMA website www.hfma.org.uk for details

Your safe space

Association view from Mark Knight, HFMA chief executive

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

My HFMA

I often wonder, jokingly, whether we should rename the association something like 'the Oasis'. This might better capture the association's role in allowing professionals to come together, network and learn. There's such positivity among colleagues when they get together, however difficult things look back at the office.

The HFMA provides the glue in the system, the place where we can leave the challenges of work aside and learn how we can make ourselves and our organisations even better. To that extent, the HFMA is an oasis of calm.

We are just starting on our nationwide tour of a long list of branch conferences and I hope you've been able to get along to one. The local branch events remain our connecting point with members. Our brave president Mark Orchard will be the first one since 2009 to attend all 13 if he can navigate the country's transport system. If he achieves it (and I'd be surprised if he didn't), it will be the fulfilment of his vision 'everyone counts' – a clear conviction on Mark's part to connect with all the members.

The end of the grand tour is the annual conference in December, the largest event of its kind in healthcare finance. We're proud of our conference – the format and venue have served us well over the years. However, we can't stand still. I'd like in future to be able to get the price down to make it more accessible and I'd like to continue to develop the programme.

We're trying a different format on the Thursday this year, with shorter, punchier presentations designed to showcase 'healthcare today' and 'healthcare tomorrow'. Look out for details on this. And at the end of that day, we'll get a political briefing from BBC political editor Laura Kuennsberg, keeping up the tradition of similar presentations in past years from Andrew Neil, Michael Portillo and Andrew Marr.

On the Friday, to send everyone home energised, we've got Olympic medal winning triathletes, the Brownlee brothers. People ask why we have sports stars at the conference. To get to the top in professional athletics, you not only need talent and ability, but spectacular levels of motivation, dedication and energy. You can't say we don't need that in healthcare finance! We can all look forward to leaving conference motivated to put in winning performances at the office.

HFMA chief executive Mark Knight

I'll finish by paying tribute to a remarkable person who's leaving the UK for pastures new – last year's president Shahana Khan (pictured), finance director at George Eliot NHS Trust. Shahana and husband Najam are relocating to the Middle East.

I work closely with each president, and I found Shahana to be both supportive and encouraging, as well as having a clear focus for her 'Step up' themed year. It was an important year for the association as we developed our masters-level qualifications while conducting all our usual education, policy and communications work. And Shahana really connected with members as she went around the country and in the US.

So, I'm sure you will join with me in wishing her and her husband all the best as they take on their new challenge. I'm sure we will catch up again in the future, and we look forward to that.

Member news

Sam Dukes (pictured), head of finance business planning and development at North East Hampshire and Farnham Clinical Commissioning Group, has taken over from Alex Gild as South Central branch chair. Mr Gild will be announced as the HFMA's national president for 2018 at the association's annual conference in December.

Mr Dukes, aged 25, is the youngest HFMA branch chair on record and was previously vice chair of the branch.

Stuart Wayment completed the 420km Poole to Paris cycle in four days, raising £300 for Southampton's hospital charity Planets, which is fundraising for pancreatic, liver and neuroendocrine tumour research. Mr Wayment also recently organised an event for the Alzheimer's memory walk, raising £500.

The HFMA now has a Facebook page. Please follow us at **www.facebook.com/HFMAUK** and share the page with your colleagues.

The HFMA's e-learning module, *Introduction to NHS finance*, has been updated, and will benefit all healthcare professionals. More details are available at **http://hfma.to/4a**

Have you been up to something extraordinary recently? Perhaps you have taken part in or organised a charity fundraiser or are taking a sabbatical to travel the world? Please email any news, suitable for our members' section, to yuliya.kosharevska@hfma.org.uk

hfma

Member benefits

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

Network focus

My HFMA

Chair, NED and Lay Member Faculty

Emerging models and structures are throwing up new governance challenges for chairs, non-executives and lay members. While accountable care organisations are developing, each of their constituent organisations – be they clinical commissioning groups or trusts – must fulfil their individual statutory duties. At the same time, sustainability and transformation partnership boards can't assume delegated responsibility for local organisations' statutory duties.

Phil Taylor (pictured), chair of the HFMA Chair, Non-executive Director and Lay Member Faculty (CNL), says supporting the new models is tricky, but necessary. 'It's the way we need to work in the future to provide the best possible health outcomes for our patients across the whole system,' he says.

The faculty is hosting its next forum in Manchester on 11 October. Delegates will be able to learn from local devolution champions and hear from the Devon Success Regime, introduced to help solve local problems through short-term improvements in quality and finance, medium and long-term transformation of services and the development of the local leadership.

'Devon and Manchester have taken steps within the pathway to accountable care in advance of the rest of us. They're on the cutting edge. Their experience will help us shape the way our own accountable systems work,' says Mr Taylor.

'The most urgent issue the NHS faces, however, is not the move towards accountable care, but the financial position, which creates additional governance challenges. To be able to maintain your financial position, while maintaining the quality, standard and safety of the care we offer to the public – that's the big challenge we face.'

Coping with the financial situation and the governance obstacles it brings will be on the agenda of the upcoming HFMA CNL audit conference, aimed at chairs and members of audit committees, and open to non-faculty members. Paul Dillon-Robinson, former director of internal audit and risk at the House of Commons, and National Audit Office director Robert White are among the confirmed speakers.

To get involved with the faculty or book a place on upcoming events, visit **http:/hfma.to/CNL** or contact **grace.lovelady@hfma.org.uk**

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Appointments

Sheila Stenson (pictured) has become director of finance at Kent and Medway NHS and Social Care Partnership Trust. She takes up her new position in mid-November. Ms Stenson, who was deputy director of finance at Maidstone and Tunbridge Wells NHS Trust, won the HFMA Deputy Director of Finance Award in 2016. Recently, she took part in the first NHS Finance Leaders National Talent Pool development centre, run by Future-Focused Finance and the HFMA. Ms Stenson takes over from **Philip Cave**, who becomes director of finance at East Kent Hospitals University NHS Foundation Trust, succeeding longstanding HFMA Policy and Research Committee member **Nick Gerrard**. Mr Gerrard has over 35-years' NHS experience, including interim chief executive roles in a number of organisations. He is stepping down from his full time role to focus on other opportunities in the health sector.

Shahana Khan (pictured), immediate past president of HFMA, is leaving her role as deputy chief executive/director of finance at George Eliot Hospital NHS Trust. She is moving to the role of executive finance director at Sidra Hospital in Qatar after a long career in NHS finance. Ms Khan's strategy role at the trust will be taken by **Jo Chambers**, who becomes director of strategy and partnerships. Ms Chambers, a former chair of the HFMA West Midlands branch, has held various chief executive and director of finance roles. Most recently, she was chief executive of The Royal Orthopaedic Hospital, where director of finance **Paul Athey** is now acting chief executive.

Jackie Murray is now acting chief finance officer at Bolton Clinical Commissioning Group. She takes over from **Annette Walker**, who was recently named director of finance at Bolton NHS Foundation Trust, following Simon Worthington's move to Leeds. Ms Murray joined the CCG in 2013 as deputy chief finance officer after working at healthcare trusts in Greater Manchester and Merseyside.

Paul Brown has joined management consultancy Carnall Farrar as a partner. He worked within the NHS for 17 years, 10 of them as finance director for acute organisations in Sussex and Kent, followed by 15 years in the private sector. He joins Carnall Farrar from accountancy business RSM.

Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust has appointed **Chris Hickson** (pictured) deputy director of finance, succeeding Pete Papworth. Mr Hickson was head of finance for South of England at Virgin Care. In 2015 he won the HFMA Innovation Award with his colleagues from Dorset Clinical Commissioning Group where he was assistant director of finance.

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

"If we act together we have a better chance of creating these savings. We need to ensure we are driving best possible value in everything we do"
Marcus Pratt

Notts makes accountable care push

On the move

Nottingham and Nottinghamshire Sustainability and Transformation Partnership has appointed Marcus Pratt senior finance lead. The STP is one of the early implementers for accountable care systems (ACSs), and his focus will be on supporting the implementation of the ACS.

Mr Pratt will also continue in his current role as associate chief finance officer at Mansfield and Ashfield and Newark and Sherwood clinical commissioning groups.

The STP area has two delivery units, which Mr Pratt says are effectively ACSs. 'We have a well-established alliance in Mid Nottinghamshire, while the ACS in Greater Nottingham is starting to push forward in its own right.

'One of the challenges we face is how these areas interact. We have one overarching STP with two delivery units that are trying at the strategic level to bring care closer to home, looking for better outcomes for patients and reducing costs.

'The road to achieving these might be different in each area, just because of the nature of patient flow in each of the two systems.'

Mr Pratt adds that the emerging ACSs face short- and long-term issues.

'As an STP we have long-term objectives, such as how we can focus on prevention to ensure that we are improving the health and wellbeing of our population. This is also part of our short-term goals, but we have the short-term imperative of living within available resources.'

To this end, the STP has a shadow control total in place – an aggregate of the individual organisations' control totals.

'The challenge for 2017/18 across the whole system – the CCGs, the providers, social care and public health – is £186m. Meeting that challenge is very much the focus of the STP. All the individual organisations have their own targets and are striving to meet them.'

He adds that the STP is working to understand the impact of measures made by individual organisations – to generate savings, for example – on the rest of the local system. 'The next part of that is how we start to work collaboratively to deliver what's best for the system.

'As individual organisations, we can make efficiencies, so it's about how the £186m is divided up – £86m is the amount of individual efficiencies solely in control of single organisations. The rest depends on us working together.

'In finance, we have a role in monitoring the financial performance of the system and ensuring we all understand the inter-organisational impact of system initiatives. We also need to focus on changing some of our financing and contracting and payment mechanisms to facilitate the changes.'

He would like the STP to have a true control total – where all the organisations share the financial risk – in place for 2018/19, but is realistic about the challenge of bringing together six CCGs, three main providers and two local authorities. Initially, a shared control total may encompass just the local health bodies.

Leaving behind the traditional commissioner versus provider discussions as part of the annual contracting round is another step on the STP's agenda. Although it is at the beginning of this process, he believes it could greatly benefit the local health economy, while leaving some room for legitimate challenge between commissioners and providers.

'If we act together we have a better chance of creating these savings. We need to ensure we are driving best possible value in everything we do. There's a place for challenges, but not if they are only about moving money between NHS organisations for no overall benefit.'

Collaboration is key, he adds. 'There has to be something about how we do things differently. Can we use staff in a more productive way for the benefit of the system, rather than driving against each other, for example?'

FFF announces leadership changes

Future focused finance

NHS Future-Focused Finance has made a number of changes in its action area leadership. Sanjay Agrawal and Suzanne Tracey have stepped down as senior responsible officers of the *Close partnering* and *Efficient systems and processes* workstreams, respectively.

Dr Agrawal, a consultant in respiratory and intensive care medicine at the University Hospitals of Leicester NHS Trust, has been involved in FFF since its first consultation meeting in 2013 and has been SRO for the *Close partnering* action area since its inception. He will continue to be a clinical representative on the HFMA Board of Trustees. He has been succeeded as *Close partnering* SRO by Akeeban Maheswaran (known as AK, pictured), a consultant anaesthetist at the Leicester trust.

Paying tribute to Dr Agrawal, he said: 'I would like to thank Sanjay for his excellent leadership of the workstream and for getting me involved with FFF. He will be a hard act to follow. I am looking forward to working with the FFF team to build on our previous work, but with a renewed focus on three main areas: the financial challenges facing primary care; developing our finance and clinical educator network; and creating a range of tools and resources to educate and engage more clinicians in healthcare finance.'

Suzanne Tracey stood down from the *Efficient systems and processes* action area following her appointment as chief executive of the Royal Devon and Exeter NHS Foundation Trust. FFF said: 'We are grateful to Suzanne for everything she has done since she took over from Bill Shields in 2015.' A replacement is still being sought.

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