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September 2016 | Healthcare Financial Management Association

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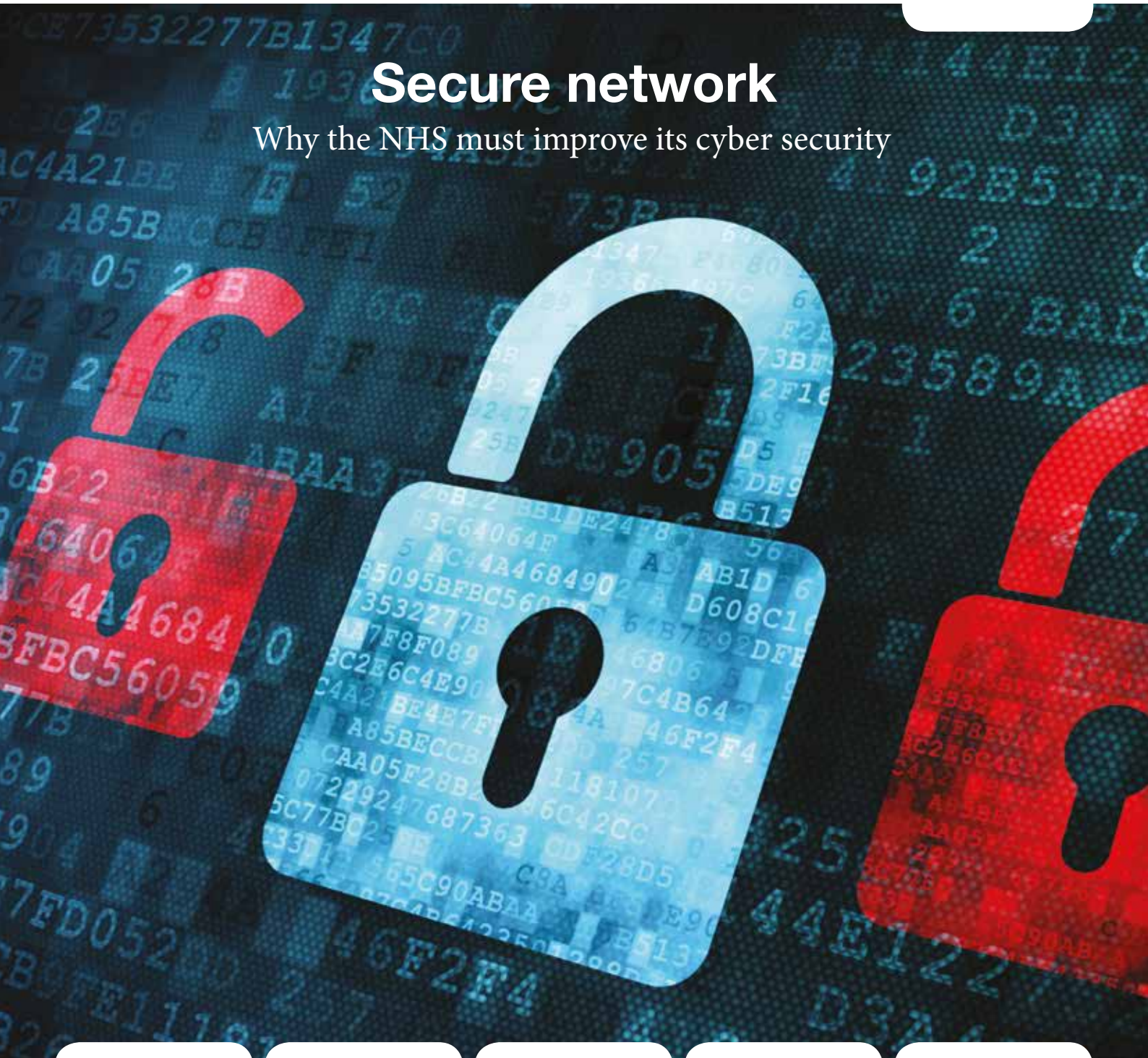

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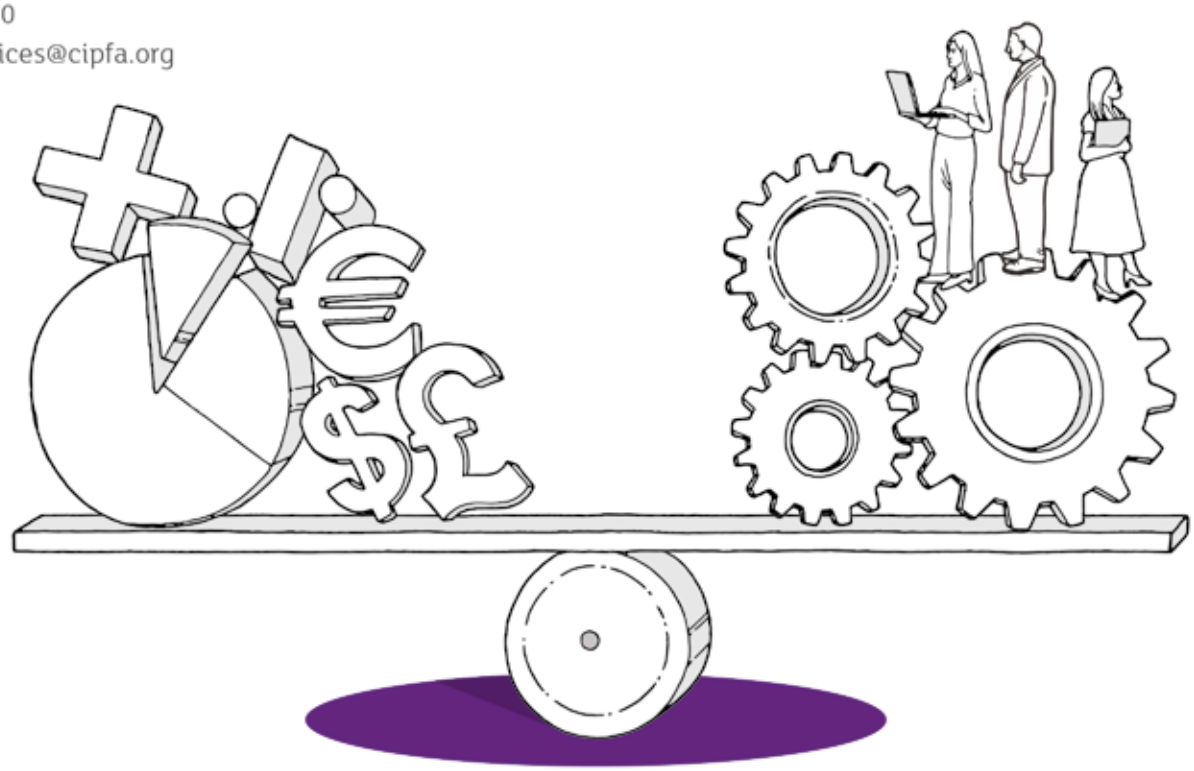

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Fancy a change?

It has never been more important for the voice of finance professionals to be heard and you could be part of making it happen.

The HFMA is looking to expand its policy and technical team, could you fit the bill?

Working for the HFMA provides fantastic opportunities to make a difference and see the finance and governance issues facing the NHS from a different perspective. You would have regular exposure to the most senior finance professionals working in the NHS as well as other NHS stakeholders. Working for HFMA also provides a unique opportunity to learn about how the NHS works across the UK, comparing and contrasting the different systems. It is an excellent stepping stone for those wishing to progress their NHS finance careers. The Association is a great place to work and these are excellent opportunities to raise your profile and develop your skills within a really friendly, effective and fast-paced team.

We are looking for individuals with a thorough and practical understanding of the workings of NHS finance. The successful candidates will have excellent written communication skills and be able to undertake independent research.

The roles are home-based and you must be organised and self-motivated, as well as being able to work 'virtually' with colleagues. Some travel to meetings and events (mostly London-based) will be required.

Research managers

Band 8c equivalent

We are looking to recruit to recruit new research managers to identify and lead research projects for the Association. These are key roles within the HFMA and involve gathering the views of NHS finance staff and ensuring that they are heard at the highest levels.

If you would like an informal discussion about these posts please contact Emma Knowles, head of policy and research at **emma.knowles@hfma.org.uk**

Assistant technical editor

Band 7 equivalent or qualified by experience

We are also looking to appoint an assistant technical editor to help update and develop the HFMA's suite of e-Learning modules, including those that will form a key part of our new qualification in healthcare finance.

If you would like an informal discussion about this post please contact Debbie Paterson, technical editor at **debbie.paterson@hfma.org.uk**

Call for associates

We are also looking to develop a pool of associates to produce aspects of HFMA's work programme on an ad hoc basis. If you are interested in joining the associate pool please contact Emma Knowles, HFMA's head of policy and research at emma.knowles@hfma.org.uk for further details.

For the right candidates we are prepared to be flexible and will consider applications for all posts that are part-time or secondments.

Job descriptions can be found at: jobs.hfma.org.uk

To apply please send your CV and covering letter setting out which post you are applying for and why you would be suitable for the role to sarah.moffitt@hfma.org.uk by 5.00pm on Tuesday 20 September 2016. Interviews will be held in London on Monday 3 and Tuesday 4 October 2016.

News


Alexander: 'demonstrable progress'

Promising Q1 position tempered by demand fears

By Seamus Ward

NHS providers reported an aggregate financial performance better than plan for the first time in three years, but despite the improved figures, there is concern about operational pressures, the finances of several trusts and the overall delivery of cost improvement plans.

In his quarter one report, Bob Alexander, NHS Improvement deputy chief executive/ executive director of resources, said the overall provider deficit for the quarter was £461m, £5m better than plan. However, this was achieved with £450m from the sustainability and transformation fund, paid to trusts that achieved their control total and agreed a specific plan for some waiting time standards.

NHS Improvement said the Q1 results showed that trusts were making progress in stabilising and improving their financial positions – demonstrated by falling monthly agency staffing costs since last April.

It said trusts were on course to cut £1bn this year from their combined annual agency staff costs, while the aggregate pay bill (which includes agency costs) was £9.8m less than the Q1 plan. The number of trusts reporting a year-to-date deficit fell from 190 in Q1 2015/16 to 153. At the end of 2015/16, 157 had a deficit.

While the headline position is improved, there will still be areas of concern for NHS Improvement, especially rising demand. In Q1 there were an additional 300,000 A&E attendances compared with the same period last year, and the number of emergency patients that needed to be admitted also rose by over 6%. Of the 214 trusts that accepted their control total, 29 did not meet their first quarter targets to gain access to STF payments.

NHS Improvement said work was needed on non-pay costs and efficiency. Non-pay costs remains the biggest area of overspend, with drugs and clinical supplies £44m over plan, accounting for 60% of the non-pay overspend.

NHS Improvement said a new purchase price index benchmarking tool, to be rolled out shortly, should ensure that trusts 'realise material non-pay savings' in the second half of the year.

There was a £45m shortfall in cost improvement plans. And some providers were indicating that their outturn could be worse than plan. Without further action, this would increase the planned deficit from £580m to £644m. The report acknowledged actions announced over the summer to reduce the overall deficit (on pay growth, back office and pathology consolidation and unsustainable services) and strengthening financial performance and accountability would not have had an impact on the Q1 figures. These aim to take the overall deficit down to £250m.

A series of measures will be used to help trusts tackle variance to plan, such as:

- Ensuring consistency of forecasting, which would improve under the new single oversight framework
- Engagement by regional finance teams to establish corrective actions
- Exploring the potential for a small number of organisations to increase their potential surplus.

Mr Alexander acknowledged the Q1 figures were an early indicator of financial performance and that 'the provider plan profile has a challenging trajectory for the remainder of this year'.

But he added: 'It should also be recognised many providers are making demonstrable financial progress and this is a promising start for the sector. Indeed, it is noticeable the sector's achievement of meeting its aggregate financial plan for the quarter bucks the trend of recent periods being significantly off plan at Q1.'

Provider figures reaction

NHS Improvement said 2016/17 was a crucial year for the NHS as it unveiled the Q1 provider figures. 'The results have demonstrated providers are up for the challenge and are starting to get a grip on their finances,' said chief executive **Jim Mackey** (above). 'It's early days – and there is still much to be done – but the figures show providers are meeting some of the ambitious plans that trusts' boards have signed up to. This is a promising start to the year.'

The **HFMA** was encouraged by the improvement against plan. But association director of policy **Paul Briddock** warned that the results should only be seen as a 'work in progress'. 'The demands on the NHS are extremely high, with waiting times struggling to hit targets,' he said. 'We must move forward with caution, but it is clear that finance directors are tackling the challenge head on and setting good foundations for the coming year.'

NHS Confederation chief executive **Stephen Dalton** (below) said it was too soon to see the impact of the extra money. 'As the NHS moves on from a terrible financial year, we must use this critical opportunity to get the NHS back on track for vital transformation plans,' he said. 'Cuts to social care and public health, as well as increases in employers' pension contributions, have all heaped unplanned pressure on the NHS.'

NHS Providers said slowing the 'runaway train' of provider deficits was 'positive news'. But chief executive **Chris Hopson** (above) said a finance director survey showed four in 10 would be unable to sustain this. 'We've only just kept our heads above water because we have transferred the investment intended to fund long-term transformation into reducing the deficit most NHS trusts face.'

Questions over outpatient block payment move

By Seamus Ward

The HFMA has questioned plans to replace the national tariff for outpatient follow-ups with block payments.

NHS England and NHS Improvement made the proposal in its early engagement documents on the two-year tariff for 2017/18 and 2018/19. They said the national mandated price would be removed and replaced with local agreements on a single payment for all follow-ups.

Other key proposals included a two-year tariff, covering 2017/18 and 2018/19; the introduction of a new currency – HRG4+ phase 3; smoothing to reduce the impact of changes in prescribed specialised services; and changes to maternity payments.

In its response to the engagement documents, the HFMA said it was surprised to see the outpatient proposal at a time when the service was trying to move away from unaccountable block contracts in mental health.

'We understand the need to ensure outpatient follow-ups are value for money, but it is not clear how a crude currency change will achieve this,' said HFMA policy and technical director Paul Briddock. 'As they currently stand, the measures could incentivise trusts to minimise the use of outpatient follow-ups. But where these follow-ups are clinically appropriate, they should not face financial disadvantages. We believe the objective could be better achieved by benchmarking the activity against national data.'

He warned that the proposal could discourage providers from seeking out and moving to new, more cost-effective ways of delivering follow-up appointments, while discussions over the appropriate contract value could add to discussions and disagreements when contracts are being finalised.

The HFMA's tariff response added that progress must be made on currencies and payment models in mental health. There was concern that a number of health economies were some way from introducing new or different arrangements.

The association welcomed the proposed move to a two-year tariff, though it said assumptions about cost inflation, Clinical Negligence Scheme for Trusts premiums and efficiency must be clear, transparent and evidence-based.

Developments in medical practice, technology and quality can add to costs, and simply applying an across-the-board uplift could create additional pockets of financial pressure for providers, it said.

The HFMA broadly supported the introduction of the HRG4+ phase 3 currency, recognising a number of benefits, including a period of stability following its introduction

Mental health costing call

NHS Improvement has called on mental health costing practitioners to take an active role in the development of patient-level costing in the sector.

The oversight body's Costing Transformation Programme aims to introduce patient-level costing across the whole NHS using a new prescribed costing approach. Draft standards setting out the approach for acute organisations were published in April and these will be followed in January by draft standards for ambulance and mental health bodies.

NHS Improvement is already engaging with three mental health trusts as formal roadmap partners and has a number of costing practitioners supporting the development of the draft standards for the sector. But it is keen to expand this.

NHS Improvement costing director Richard Ford (pictured) said that development of the standards was well under way. 'However, for the standards to be practical and achievable, we need to ensure we include a cross-section of approaches and methodologies that are as wide as possible,' he said.

He added that NHS Improvement wanted to build on the HFMA's work with practitioners to develop the HFMA *Mental health clinical costing standards* and maintain the momentum for improvement. 'We're looking for costing practitioners who have experience in costing mental health services who would be available to contribute to the working papers that underpin standards development,' Mr Ford said. The working papers will cover the costing process from general ledger to reconciliation to the final accounts.

Work is also continuing on the development of the acute standards. The next draft in January will provide further support in costing for cataract surgery, hip and knee replacements and outpatient attendances. Enhanced costing methodologies will be detailed for theatres, medical staffing, treatment of private finance initiative costs and incomplete patient events.

NHS Improvement is also running monthly webinars until the end of the year to help build costing capability and familiarly with the new standards.

To get involved in standards development, contact NHSI.costing@nhs.net

See Costing tour, page 23, and technical review, page 28

Education tariff freeze

Tariffs for non-medical placements and medical undergraduate and postgraduate placements in secondary care have effectively been frozen in 2016/17.

In guidance on the tariffs, published in August, Health Education England (HEE) said it faced cost pressures due to an overall 4% rise in student numbers in the past two years. There were other unavoidable cost pressures, such as the increase in medical and dental student tuition loans from £3,000 to £9,000 a year.

As a result, HEE will reduce the 2016/17 tariff for each type of placement by 2% compared with the 2015/16 prices. However, as this could destabilise some NHS providers – and to reflect the late confirmation – in 2016/17 it will include an additional payment of 2% for each tariff, bringing them up to 2015/16 levels.

Both the new tariff and the additional payment will be adjusted by the appropriate market forces factor to calculate the final payment.

The 2016/17 tariff price will be the starting point for calculating the 2017/18 tariffs.

"We believe the objective could be better achieved by benchmarking the activity against national data"
Paul Briddock, left

and the use of more up-to-date reference cost information to calculate prices – under the proposals 2014/15 reference costs would be used.

It also backed separate work on understanding and correcting orthopaedic prices and specialist top-ups. However, the move would be a fundamental change and it would be difficult to work out its impact because of other changes that are being proposed.

See The fine print, page 8

Scope of shared services could grow

NHS Improvement has suggested sharing provider back office services could go beyond traditional transactions such as payroll and accounts payable and receivable.

The move is part of a package of measures – to address pay bill growth, consolidate back office and pathology services and identify new ways of re-providing unsustainable services – to cut the provider deficit to £250m by financial year-end.

In mid July, NHS Improvement deputy chief executive/executive director of resources Bob Alexander wrote to provider chief executives asking them to complete a high-level summary of opportunities for consolidation in back office and pathology and re-provision of unsustainable services.

He said these 'two-page notes' – required by 31 July – would, in each sustainability and transformation plan (STP) area, 'ensure rapid progress during 2016/17 in starting to improve efficiency and quality'.

In August, NHS Improvement executive director of operational productivity Jeremy Marlow listed the areas considered priorities for review, including elements of finance, HR, IM&T, procurement, payroll, governance and risk, estates and facilities and legal services.

In finance, the functions listed included: financial accounts; income planning; management accounts; accounts payable; accounts receivable; commercial teams; and internal audit. In many trusts, management accounts, for example, with its close links to frontline services through business partnering, has not previously been considered for shared delivery.

Each STP must complete a template business case by the end of this month, with implementation in October and November.

Association key contributors honoured

By Seamus Ward

The HFMA has honoured 12 key contributors for their efforts in supporting the organisation. At the annual key supporters' dinner, held this year at Warwick Castle, four of the key contributors were honoured for the first time, while the other eight had previously received the award but were recognised for their ongoing and significant support for the HFMA.

HFMA chief executive Mark Knight said the key contributors were the lifeblood of the association. 'Without these volunteers, the branches, committees and the association would not be the success they are,' he said.

The newly honoured members (pictured above clockwise from top left) were:

- Sarah Brampton – for her leadership of the South West Branch, which has recorded many successes, notably its accreditation scheme.
- David McMullan – for his tireless work as Northern Ireland Branch treasurer since 2010 and for securing funding for the branch.
- Tim Saunders – for being a stalwart of the Eastern Branch committee for more than 10 years and participating and contributing to events.
- Stuart Wayment – for many years of support for the Kent, Surrey and Sussex and South West branches, including the management of the KSS 24-hour learning event.

The individuals re-nominated for the award were:

- Kim Ferguson
- Gill Jacobs
- Kevin Green
- Rod Smith
- Christopher Lewis
- Mal Turner
- Kim McNaught
- Carol Potter

For further details, see www.hfma.org.uk

News review

Seamus Ward assesses the past two months in healthcare finance

With some providers struggling with finances and demand over the summer, it is worth remembering that July saw a financial and operational 'reset' for the NHS in England. NHS Improvement and NHS England launched a seven-point plan to deliver an aggregate deficit of £250m by the end of the current financial year. Their ambition is that providers will begin 2017/18 in aggregate run rate balance.

As well as allocating the £1.8bn sustainability and transformation funds, they announced that national fines will be replaced by trust-specific incentives linked to their improvement trajectories. Every trust and clinical commissioning group has agreed control totals, for which their boards, chief executives and governing bodies will be held accountable. This will be backed up by a new intervention regime for trusts and CCGs not meeting their financial targets, with five providers and nine CCGs immediately entering special measures. There will be new controls to cap the cost of interim managers in CCGs and commissioning support units and to speed up savings in back office, pathology and temporary staffing in providers. Providers have been asked to work specifically on three areas: manage excessive pay bill growth; accelerate implementation of the Carter recommendations on back-office services; and consolidate unsustainable planned care.

The reset was broadly welcomed. HFMA director of policy and technical Paul Briddock said it was a high-profile recognition of the importance of living within resources. But in a blog on the HFMA website, he insisted that implementation must be nuanced. For example, he said, an indication of high pay bill growth should prompt investigations into the causes and context rather than an 'unquestionable indicator of excessive spending'.

The reset came a few days after the Commons Health Committee voiced fears that short-term measures were masking the true scale of the financial problems facing the NHS in England. In a report on the impact of last year's spending review on the NHS, the committee said capital to revenue transfers, reviews of balance sheets and the use of 'accounting devices' meant the true financial position was not obvious. While it welcomed the spending review decision to frontload additional funding, *Impact of the spending review on health and social care* said money provided in sustainability and transformation funding was being used largely to 'plug provider deficits, rather than to resource essential changes to the health and social care system at scale and pace'.

In August, the Nuffield Trust said that even if NHS providers make cost savings of 2% a year, there will still be a funding gap of £6bn by 2020. Its report, *Feeling the crunch: NHS finances to 2020*, said providers had an underlying deficit of £3.7bn at the end of 2015/16. Reducing this to the £2.35bn required by the reset would mean efficiency savings of 4%. Further savings of 4% and 3% would be required in the following two years to reduce the deficit altogether – a level of recurrent savings never before achieved. Providers would require support from the sustainability and transformation fund to balance their positions in the meantime.

In July, the British Medical Association announced that its junior doctor members had rejected the latest contract offer, even though it had received the support of their BMA leaders. In response, health secretary Jeremy Hunt said

The reset in quotes

'This suite of measures will help ensure providers facing the greatest financial challenges are supported to bring about rapid financial recovery, while maintaining or improving quality. This plan is intended to restore financial discipline and ensure ongoing financial sustainability.'
NHS Improvement chief executive Jim Mackey

'The service has already made unprecedented savings in hugely challenging circumstances. The uncertainty following the Brexit vote is likely to compound financial concerns. Now is an important time for the government and national bodies to assure NHS leaders that a focus on stability does not come at the expense of transformation.'
Stephen Dalton, NHS Confederation chief executive

'We need to use this year to stabilise finances and kick-start the wider changes everyone can see are needed. Most trusts and CCGs know what needs to get done to release funds for local reinvestment in better patient care and now is clearly the time to fire the starting gun.'
NHS England chief executive Simon Stevens

'We need a revised approach to financial planning in the long term and a much smaller set of priorities on which the NHS ruthlessly focuses in the short term, with everything else taking second place. Without these, we cannot even begin to tackle the likely consequences of the middle years of this parliament when available funding reduces dramatically.'
Saffron Cordery, director of policy and strategy, NHS Providers

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the deal would be introduced from October for senior obstetrics trainees only. It will then be rolled out across foundation year doctors and other juniors, with all on the new contract by October 2017. Mr Hunt also announced an independent inquiry into reducing the gender pay gap among junior doctors. The juniors are to ask the British Medical Association council to sanction fresh industrial action from this month.

Many juniors oppose the government's plans to implement seven-day services in the NHS, though they support the broad principles behind them. They insist there are not enough staff to deliver it safely. In August, a leaked Department of Health risk register reportedly showed concern over staff shortages, as well as the lack of detailed costings, risk assessment and limited data supporting the policy. The Department said it was trying to address unacceptable variation in care at the weekend.

The reset is a high-profile recognition of the importance of living within resources, but implementation must be nuanced
HFMA

NHS England clarified its position following the High Court ruling on the provision of pre-exposure prophylaxis (PREP) for HIV prevention. It said the court ruled that both NHS England and local authorities could commission PREP, but it was appealing the judgement as PREP would cost £10m-£20m a year.

The Scottish government said it will invest £1.1bn in the NHS estate over the next four years. The funding, for major projects, will be supplemented by £290m to support the integration of health and social care, it said. The investment plans are detailed in the *Annual state of NHS Scotland assets and facilities report for 2015*. This also said backlog maintenance had fallen by more than £110m since 2011 and most of the backlog is in buildings planned for disposal over the next 10 years or in non-clinical parts of the estate.

June's Brexit vote led to a new prime minister, Theresa May. Despite a cabinet reshuffle, she kept Jeremy Hunt as health secretary. Philip Dunne joins him as care and support minister, with Nicola Blackwood and David Mowatt as junior ministers. Lord Prior remains parliamentary under-secretary for NHS productivity.

Wales health secretary Vaughan Gething has ordered work to begin on implementing a new law on nurse staffing. The legislation puts health boards and NHS trusts under a duty to calculate and maintain nurse staffing levels in adult acute medical and surgical inpatient wards, while considering the number of nurses needed to provide the right care in all settings. Work will begin to develop guidance, which will be followed by a public consultation later this year.

And in Northern Ireland health minister Michelle O'Neill has received a report on the future clinical and financial sustainability of local health and care services. The report, put together by a team led by health reform expert Professor Rafael Bengoa, will be published in the autumn, alongside Ms O'Neill's vision for the configuration of health and social care.

in the media

Summer was not a 'quiet' time for the HFMA and media coverage. While the HFMA commented on several NHS financial issues, two stood out.

The *HFMA temperature check*, published in July, generated much media response, from national papers and broadcasters to trade and regional press. The ITV website reported the survey's finding that a fifth of finance directors believe patient care will deteriorate over the next year, with concern growing over access and potential cuts in the range of services on offer. Speaking before the financial reset, HFMA policy and technical director Paul Briddock told the *Mail online* that it was unlikely providers would get into aggregate financial balance by year-end, as initially planned. He added that all NHS organisations had to work together to redesign services and put an end to shifting financial issues between sectors.

Mr Briddock provided *Public Finance* with a comment article on the financial reset. While the plan was welcome, he said there was a danger it could give the impression the service's financial issues were due to financial management. He said issues such as focusing on 63 providers with significant pay bill growth must be handled sensitively – assuming the growth is excessive is simplistic, though using it to prompt a greater understanding of the causes would be helpful.

News analysis

Headline issues in the spotlight

The fine print

While the tariff proposals for 2017/18 and 2018/19 appear to give the service what it's asked for, the impact could be significant, as Seamus Ward reports

At first glance, the proposed two-year tariff for 2017/18 and 2018/19 gives the service two of the things it has asked for most over the past few years. A multi-year tariff to promote stability – check. A move to HRG4+ to ensure prices better reflect the cost of delivering services, particularly more complex cases – check.

But, while NHS organisations have broadly welcomed the proposals in the initial engagement, there is some disquiet about the impact they will have as currently configured.

Initial engagement on the proposals, produced by NHS Improvement and NHS England at the beginning of August, ended just after *Healthcare Finance* went to press. The proposals were accompanied by a plethora of supporting documents from a workbook containing draft prices to the release of the tariff grouper software. But it was the move to the two-year tariff and HRG4+ that caught the eye. There will be further testing and engagement through the autumn, with the statutory consultation taking place before the end of the year.

NHS Improvement and NHS England are trying to walk the line between making desirable improvements in the tariff and destabilising the service. And, in making a move to introduce HRG4+ a year after it was postponed over fears that it would create too much volatility for providers, they will offer some mitigation.

Overall, the national bodies' impact analysis shows that the proposals would change the operating revenue of 52 NHS providers (27%), by more than +/-1%. For the other 144 trusts, the change would be +/- 1% or less. NHS Improvement and NHS England are considering whether and how to mitigate revenue volatility, particularly for the most-affected providers. The engagement document added that they were not considering introducing a marginal rate for specialised services between 2017 and 2019.

The changes to proposed prices would result in increases in maternity (£221m or 8.3%) and emergency medicine (£132m, 6.5%). The biggest decreases would be in non-admitted consultations (£233m, 4.4%) and interventional cardiology for acquired conditions (£115m, 12%).

The statutory consultation will include a two-year tariff with a price list for each year, as well as currencies, national variations and rules that would apply to both years. The price differences would reflect changes in inflation, efficiency, Clinical Negligence Scheme for Trusts premiums and service developments.

A spokesperson for NHS Improvement and NHS England, said: 'The introduction of a multi-year tariff will provide NHS organisations with greater certainty and stability on the amount they will be paid for the care they provide over a longer period.'

There would be no need for a separate consultation on a tariff for 2018/19.

'This stability will help the NHS provide patients with high-quality, sustainable care, whilst also encouraging innovation and transformation in how health services are provided,' the spokesperson added.

'Moving to a multi-year tariff will give providers and commissioners critical financial information earlier than ever before. This greater certainty will help providers and commissioners make robust investment decisions, and support their joint plans on how best they can deliver services to patients.

'We see this change as a continuation of work on strengthening the payment system, so that it does more for patients, and promotes better financial management among NHS organisations.'

However, NHS Improvement and NHS

Maternity moves

There are concerns that proposals on changing maternity payments could be contrary to national policy on choice.

The maternity pathway currently includes three stages: antenatal, delivery and postnatal. Antenatal and postnatal have different payments, reflecting greater levels of complexity (and thus cost). These are known as standard, intermediate and intensive.

NHS Improvement and NHS England said they collected casemix information in 2015 that suggested more cases were allocated to the intermediate and intensive antenatal pathway than had been assumed.

In response, while keeping the same funding level, they have proposed to change the relative weightings between standard, intermediate and intensive antenatal prices.

This will be achieved by updating the casemix assumptions, increasing activity at intermediate level from 27% to almost 39% and intensive level from 7% to 11%, while reducing standard level from 65.5% to 50%.

The national bodies said engagement on the change last year showed significant support, though a planned three-level payment structure for the delivery phase is not ready to be introduced.

The NHS Confederation's Paul Healy (left) said there was good evidence for making the change, but it could have the unintended impact of reducing choice. 'You have to ask where the money is going,' he said.

'The broad intention in maternity is to give choice, but if a technical change puts more money into high-risk services, and incentivises trusts to provide them, does that run contrary to the national policy objective?'

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England said they would not be able to alter the tariff once it has been set, even if issues arise during the period. The next statutory consultation would be on the 2019/20 tariff and any change before then could only be made with the introduction of a new tariff following a consultation.

One finance manager told *Healthcare Finance* that while, overall, the move to a two-year tariff was a good thing, he had concerns about the fixed nature of the tariff. Some things that could affect costs could not be foreseen – a new national policy, for example, or a new fast-tracked drug.

'As the tariff is so complex, I'm worried that there's something there that hasn't been tested or there's an unintended consequence that has a major impact that they will not have the ability to fix,' he added.

The national bodies propose to use phase 3 of the HRG4+ currency design, which was first used in the 2014/15 reference cost collection. (It proposes to use this data as the basis for the two-year tariff prices.)

Last year they proposed to introduce an earlier version of HRG4+ in the current financial year, but it soon became clear that it would produce big swings in prices for some services, including orthopaedics.

While it appears that there is less variation in phase 3 than in phase 2, there are still some significant swings. For example, two specialist orthopaedic trusts would have the largest falls in nationally priced revenue (around 4% in both cases). In response, the tariff-setting bodies said they were considering options to limit financial volatility as a result of introducing HRG4+ or because of inadequate costing data.

"Moving to a multi-year tariff will give providers and commissioners critical financial information earlier than ever before" **NHS Improvement**

NHS Confederation senior economic adviser Paul Healy said: 'Our members are asking how committed the centre is to the two-year tariff. If HRG4+ increases the level of volatility, they would expect policies to be changed mid year.'

He believes that HRG4+ will increase the prominence of coding, but said the function will have to 'step up' to ensure trusts are paid accurately for the care they provide.

'In the latest audit of reference cost data, 50% of providers had material inaccuracies in their submissions. If that trend continues, we've got to be careful about how sophisticated we make the system. We might need to improve costing data first.'

To complement HRG4+, NHS Improvement and NHS England proposed a number of changes, including updating top-up payments for specialised services and removing the interventional radiology best practice tariff.

There would be four new national prices – for cochlear implant procedures, complex computerised tomography scans, complex therapeutic endoscopic gastrointestinal tract procedures and photodynamic therapy. The first three were due to be introduced in 2016/17, but held back following the decision to postpone the adoption of HRG4+.

There would also be changes to the maternity pathway (see box).

Top-ups for specialised services would change following the introduction of the more granular HRG4+ phase 3, together with new definitions for specialised services (prescribed specialised services – PSS – flags outlined in May) and the adoption of University of York recommendations on refining payments for specialised services.

Moving straight to PSS flags would increase the total value of specialised top-ups from about £320m to £415m. This increase is due to the introduction of top-ups in several new areas (including cancer, respiratory and cardiac) totalling £100m, as well as a £21m increase in neurosciences, partly offset by a fall in spending in other top-ups areas. Paediatrics and orthopaedics would see significant reductions.

Clearly, provider finances would be destabilised so that the national bodies have proposed to 'transition' to these services over a four-year period, with 25% of the proposed shift in income implemented in 2017/18.

Proposals to change outpatient follow-up payments have proved particularly controversial, with one finance manager describing them as 'barmy'. The nationally mandated price would be removed and replaced with local agreements on a single payment for all outpatient follow-ups.

The consultation's rationale for the change is that providers currently have no incentive to reduce inappropriate attendances or to move to new ways of delivering follow-ups, such as by phone. The block payment could incentivise the reduction of unnecessary attendances. 'It may be unsafe as it could encourage trusts to discharge patients too quickly,' said one finance director.

While the initial engagement has now ended, providers and commissioners alike will welcome the transparency it has afforded them. But, as ever, the devil is in the detail.

Comment

September 2016

Summer blues

The summer offered little chance to recharge financial batteries, but teams will need all their energy going forward

HFMA president Shahana Khan

Long gone are the days when the summer brought a well-earned respite in the intensity of workload. With the accounts filed and costing returns out of the way, summer was often an opportunity to regroup.

But the finance agenda and the endless deadlines have meant there's been no time to catch our breath.

If anything, the workload has increased, with finance teams being pushed to the maximum. The 'reset', unveiled at the end of July, looks suspiciously like a further step back towards command and control. The centre is taking an unprecedented interest in the detail of our operations.

The scrutiny on providers' waiting list payments is the latest example in a list of areas where the regulator is casting an inquisitive eye. This is both regrettable and understandable. The desire to get a grip on the finances is clear and the Department of Health cannot afford to steer as close to the expenditure limit as it did in 2015/16.

But the problem cannot be micromanaged, with unrelenting requests for data and permission having to be sought for the smallest decisions. The service needs the space and time to deliver.

The challenge facing many providers is stark. If they don't stay on their set financial trajectories and meet their access targets, they will not receive the sustainability funding

In defence of the tariff

The tariff may not be perfect but it is not to blame for current financial problems

Healthcare Finance editor Steve Brown

Why do we have the national tariff? Many finance managers may well have asked themselves this question while working their way through the more than 100 pages of tariff proposals and impact assessment published by NHS Improvement and NHS England during August.

It is hugely complex, with different payments for elective and non-elective activity, best practice tariffs, marginal rates, top-ups for specialised services, special arrangements for high-cost drugs, and devices and rules governing variations and for services without actual national prices.

In England, it is crucial to the way money flows around the health service – yet other UK nations appear to cope without it.

There is also widespread acceptance that the current tariff in England is not fit for purpose. It was born at a time when the service wanted to incentivise acute activity to reduce waiting times and lists. Now the focus is on new models of more integrated care, which in many cases will involve moving services into community settings or delivery in different ways, making greater use of modern technology, for example.

Current incentives not only fail to encourage these changes, but trusts could find themselves at a financial disadvantage

"Perhaps the silver lining of the reset is that it brings all the requirements on the NHS into one place "

fundamental to achieving their ambitious control totals. They are not only caught between a rock and a hard place, but the gap is being narrowed and they are in danger of being crushed.

Perhaps the silver lining of the reset is that it brings all the requirements on the NHS into one place – and makes it clear commissioners and providers share the responsibility for delivery.

For some footprint areas, it has taken this strong push to finally get parties in the same room – although there are still issues in some places.

The 'quieter' summer period also saw system leaders present tariff proposals for 2017/18 and, crucially, 2018/19. Understanding the implications of these proposals is key. With earlier deadlines for financial planning, contract negotiating and identifying savings and the need to work through STP plans, it is clear we are going to be truly tested from September.

I hope that, where members have managed a short summer break, they have come back completely refreshed as they will need all their energy and ability.

And we should not forget another 'ask' in relation to sharing back-office services including finance. There can be no special treatment for any services. If activities can be delivered as well or better for less, that is what should happen. However, corporate functions such as finance and human resources are already hard pressed – and Carter and transformation will only increase the workload on these key professions.

This isn't to say we won't or shouldn't look into this. But we just need to ensure we get the priorities right and keep our eyes on the bigger prize.We need to be clear shared back-office services can deliver quality services and financial savings, and that those savings are worth distracting our teams away from a vital broader agenda.

Contact the president on president@hfma.org.uk

when they pursue them. Recent years have seen many areas sidestepping tariff arrangements in favour of simpler payment approaches and developing risk-sharing arrangements to mitigate the impact of tariff.

Add into the mix the fact that tariff prices are based on cost data that enjoys a poor press and relies on coding that has been shown to be inconsistent across different providers, and you might make a case for abandoning the whole project.

But that would be to ignore the huge benefits that the tariff has brought to the NHS. As a side benefit, it has reinforced the need for robust cost data (although informing local decision-making remains the main driver for improved costing). And it has improved the simple act of counting and coding activity, which has benefits and potential benefits way beyond tariff systems.

But the core benefit is that it has to be right to have a transparent link between services delivered by a provider (and, increasingly, the outcomes) and the money paid.

Without this link, how can healthcare providers or commissioners plan for sustainable services, cope with changes in activity levels and cost, or move from one model of provision to another?

The danger is that the tariff gets the blame for the current financial problems facing the service. In reality the core problem is the mismatch between available funding and the demand for services.

Impose an unrealistic efficiency requirement on tariff prices (as has been the case in years before the current year) and you shouldn't be surprised when an equivalent sized hole opens up in provider finances.

Although 2016/17 has seen a more realistic efficiency ask of providers, the plans for 2017/18 show that the tariff is still being used as a balancing tool – the block proposals for outpatient follow-ups being an obvious example. Again it is not the tariff approach per se that is at fault.

"It has to be right to have a transparent link between services delivered by a provider (and, increasingly, the outcomes) and the money paid"

The tariff is nowhere near the finished product. It is clear its initial 'activity times price' structure doesn't work for all services. Non-elective and critical care activity payments have to take account of capacity, and year-of-care and capitation models will make more sense for patients with chronic conditions. And we need more sophisticated mechanisms to link payment to outcomes and to share risk.

But we should resist the temptation to blame the tariff for not addressing a financial problem outside of its control.

We will come out of the current financial challenge – or at least the extreme intensity of it – and when we do, the service will benefit from having a more sophisticated payment system that links money to the services and outcomes delivered.

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a king-size challenge

King's College Hospital in London has a significant efficiency task ahead of it and it has identified a fundamental transformation of the trust and its finance function as a key foundation for success. Steve Brown reports

King's College Hospital NHS Foundation Trust in south-east London has a significant underlying deficit and a seemingly heroic control total. Like other providers, keeping spending within this control total is key to the release of vital sustainability and transformation funding. Perhaps where King's differs from other providers is in the sheer scale of the challenge – it will require unprecedented levels of savings of £72.5m this year. The trust recognises it needs a step change in financial performance, and a major transformation of its finance department will be at the heart of its improvement programme.

King's College Hospital is a big trust, with a turnover of £1.1bn. It has an international reputation for good clinical services, although an inspection by the Care Quality Commission last year returned a 'requires improvement' rating overall. It also has significant challenges in restoring required access standards, both on the four-hour wait in accident and emergency and on referral to treatment (RTT) targets.

Its size is matched by the scale of its financial challenge and its position has deteriorated significantly in recent years. A reported surplus in 2013/14 of £66m perhaps overstated its financial health. The acquisition of the Princess Royal University Hospital had improved the reported position, but its deficit before exceptional items was a relatively modest (by current standards) £3.1m – £5m off a target surplus of £2m.

In 2014/15, the problems became clearer, with an operating deficit of £16m and an overall deficit, after financing costs, of £52m. This increased again last year to a bottom line of just over a £65m deficit. Even this position (broadly on plan) relied on one-off mitigating actions, including clinical commissioning group sustainability funding and capital to revenue transfers (as called for by NHS Improvement).

'The underlying deficit is £118m – a run rate deficit of about £10m a month,' says Colin Gentile, the trust's chief finance officer. The timing of the transfer of the Princess Royal in October 2013 would appear to coincide with the downturn in financial performance. But Mr Gentile doesn't believe this fully explains the current financial position. He and the current executive team are determined to establish a firmer grip on the finances and governance as the trust moves forward – but it will be a challenge to keep out of the newly defined special measures regime.

Changes have been introduced, with revised business case and business planning processes, and a whiteboard in the finance director's office spotlights the big issues facing the trust. Mr Gentile says it is a large board. The finance function will be key to establishing a firmer grip, and people have risen to the challenge. But it needs to change – a view reinforced by an independent review undertaken by consultancy RSM. Its overall conclusion was that the function is 'sub-optimal',

although structure, multiple systems and an over-reliance on manual processes (often required because a lack of purchase orders or poor-quality feeder information) are at least partly responsible.

'The report found a lot of strengths – its day-to-day operational financial control is good and the numbers it produces are highly accurate, but its focus is in the wrong place,' says Mr Gentile. 'This view is backed up by external and internal audit opinions.'

A modern finance team should typically be spending 65% of its time on strategic, value-adding roles (such as providing analysis and support to frontline teams) and just 35% on transactional activities, according to the RSM report. But it found the King's team has these proportions turned on their head, with 75% of work being transactional.

'In short, we need to develop more of a business partnering model,' Mr Gentile says. 'The basic numbers are credible and reliable but it takes too long to generate them and we are not adding enough value back to the business.'

This chimes with a customer survey held as part of the review. While finance service users typically saw the team as 'ambitious and hard-working', they also noted a number of 'frustrations, pain points and blockers'. Some of the key identified problems were around:

- **Reporting** A lack of analysis that would enable forward-looking decisions
- **Timeliness** Information requests received late so that decisions were based on outdated information
- **Training non-finance staff** This rarely happens, inhibiting relationships
- **Processes** A reliance on manual processes leads to inefficiency and lack of transparency.

While the report clearly included some criticism of current practice, it also pointed out that the cost of the function was well below the average (0.63% of turnover compared with 1.06%) and it also had fewer staff and a lower average grade than median benchmarks.

Mr Gentile says this makes a good argument for further investment in the function downstream, but that the existing 110-strong team is already rising to the challenge.

Transformation plan

The report was shared with staff and a financial transformation plan was launched in July. This year-long work programme aims to be highly participative, with staff getting involved to redesign inefficient processes identified in the review. 'The energy in the room each time we meet is amazing,' he says, 'and we are developing a governance process to ensure that changes happen and processes work as intended.

'There will be a lot of simple changes we can make – we have a quick-wins workstream. These changes will help the accuracy and, more importantly, the timeliness and format of the information to support end users. There is a lot that can be done.'

The trust has both patient-level costing and service line reporting systems in place, but the focus has been on producing rather than using data. 'One of the issues is that we are not using these tools in the trust as we should to help us develop the organisation,' says Mr Gentile. 'So one of my objectives is to kick life into these initiatives – get clinicians engaged, refine the data and start using it to inform change.'

He says recent workshops with consultants have convinced him that they are enthusiastic to get more financial analysis to support service development.

Away from the finance department, NHS Improvement has also helped in supporting the trust to undertake a whole trust transformation programme, giving the green light for getting in some consultancy

support. This will see three clean-sheet redesigns for bariatric services, emergency care and theatres. 'The core idea is to ask: "If we weren't starting from here, what would services look like?"', Mr Gentile says.

An improvement academy is being set up to train staff in lean skills, with a first crop of yellow belts (lean qualifications) qualifying over the summer. 'The idea is to help change the whole culture and move towards an attitude of continuous improvement.'

Revised pathways emerging from these redesigns will be underpinned by the trust's electronic patient record, with the trust looking to introduce more routine clinical decision-making support tools. 'This will help us analyse variations in treatment patterns and decision-making and move towards and maintain world-class services,' he says.

Mr Gentile says the changes being made across the organisation and within finance are not being driven by the wider financial challenges – they would be the right things to do whatever the economic situation. They will also contribute to reducing the current financial gap and help deliver sustainable services over the medium to longer term. But there is no doubt that they add to the trust's burden in the short term. 'This is difficult and undeniably a big challenge,' says Mr Gentile.

The control total set for King's as part of July's financial reset requires the trust to make a deficit of no more than £1.6m. The basic maths is that the £118m underlying deficit is being covered by the £72.5m savings programme, £30m in sustainability and transformation funding and then some benefit from the tariff and some margin on extra work when clearing RTT and other activity. After three months, the trust had planned to be showing a year-to-date deficit of £19.6m, with the savings programme profiled to have an increasing impact as the year goes on. But figures for the end of June showed the trust off trajectory by £5.3m.

The position looks even worse according to central returns to NHS Improvement. The spreadsheet will not allow the trust to accrue for the receipt of its first quarter's STF funding (£7.5m) while the trust is off its required performance trajectory.

'The danger is that this creates an unvirtuous circle,' says Mr Gentile – trust staff feel that, despite their

"One of my objectives is to kick life into [costing and service line] initiatives – get clinicians engaged, refine the data and start using it to inform change"
Colin Gentile

• King's College Hospital's Denmark Hill site (facing page) and the Princess Royal in Orpington (above)

best efforts, they are nowhere near the required financial position. CIP slippage is an issue (£1.8m) but the biggest problem has been failing to hit activity targets due to operational problems – a combination of the junior doctors' strike, a norovirus outbreak at the Princess Royal and a backlog of repairs in theatres. 'We are completely focused on the delivery of the CIP, but we also need to deliver the activity in our plan at a cost that allows us to make a margin,' he says.

Teams have had to submit business cases to access funds for any commercial opportunity, including growth activity. But with agency costs still rising in some specialties – especially for medical staff – many business cases for delivering additional activity have been identifying a margin below the amount built into the plan. While these may still make a contribution to overheads and help the overall financial position, they create an additional cost pressure in meeting the planned outturn.

Transparency is key

It has been important to operate with complete transparency. 'The position isn't easy but what the board like is that they are sighted on all of this,' says Mr Gentile. Newly designed and clear finance reports are available on the trust's website, and the trust has been frank with NHS Improvement about its position and the risks in meeting the control total. 'The risks are very explicit and on the record,' he says.

Mr Gentile says month four figures will be crucial in 'gaining a clearer view of the cost improvement programme'. He then plans to undertake a risk-based projection of the outturn position and this will be underpinned by a review of the trust's capacity plan.

A broader restructuring programme is looking to get more wholesale clinical involvement in financial and service improvement and to strengthen the operational function. There has also been a move to be clear about objectives and accountabilities – all executives, for example, now have a performance contract with the chief executive.

Mr Gentile is convinced the trust is on the right track. 'Everybody is doing the right thing and there are a lot of good people doing a lot of hard work in this trust. It is very focused,' he says. But the financial context is very challenging and it will take time for the changes to have the required impact. In the meantime, Mr Gentile says, the executive team 'will carry on working hard, trying to take the right approach'.

Screen test

Screening to diagnose some common cancers earlier is just one aspect of a wide-ranging new model of care being trialled as part of the national vanguard programme. Steve Brown reports

Cancer services provide a good example of the challenge facing the whole NHS – in fact, they may well face even more of an uphill struggle to deliver sustainable services than other specialties. Incidence of cancer is growing by 2% a year and costs are expected to rise by 9% a year if nothing changes. And while standards of treatment are often good, albeit variable, outcomes in terms of mortality rates compare poorly with other countries – largely due to later diagnosis and poor public health and prevention.

The national cancer strategy, published by an independent taskforce in 2015, set out a five-year plan of reform. Its proposals were widely welcomed and included: better prevention; earlier diagnosis; more focus on patient experience; more support for people living with and beyond cancer; more investment in equipment and workforce; and overhauling commissioning and provision with pilots to test new models of care.

So it should be no surprise that when NHS England asked for applications to be vanguards, it received three looking to test out new models for cancer provision. In fact, NHS England asked the three providers – The Royal Marsden NHS Foundation Trust, University College London Hospitals NHS Foundation Trust and The Christie NHS Foundation Trust – to combine their work in a joint vanguard.

So the trusts have been working together on some activities and following different paths elsewhere to enable the approaches to be compared and contrasted and then, potentially, rolled out across other providers.

Marcus Thorman, chief financial officer at the Royal Marsden, says there are three focus areas for the trust. It needs to change

Royal Marsden: revising payment

The change in payment arrangements will inevitably add financial risk for local providers and commissioners. And the task of designing a payment system is being led by the Royal Marsden's associate director for financial strategy implementation, Matt Backler. He says RM Partners are looking at various models – including alliances, lead provider, joint venture and integrated systems. 'Lead provider does look most likely, but it is not finally decided yet,' he says.

Scope is the key issue – what is in and what is out. And primary care is a major consideration. 'Primary care is hugely important,' says Mr Backler. 'I'm not sure we can include it directly in the payment system, but we absolutely have to understand the primary care resource and have them involved and at the table.' NHS England has a place in the development team and there are also a number of GPs involved.

Spend on acute services, whether with the Royal Marsden or one of the other cancer providers such as Imperial, St George's, Chelsea and Westminster or Hillingdon, is relatively straightforward. However, even here there are likely to be complications – for example, cancer patients coming to accident and emergency and being coded as a cancer patient but treated for something else.

Mr Backler says palliative care is another issue. 'We are committed to providing access to seven-day palliative care,' he says. 'But can we have a different model – and payment system – for cancer and non-cancer services? We are very much in the foothills with this process at the moment. We are aware of all the questions but we are only just starting the work.'

In fact, the trust was tendering for support over the summer. The payment system needs to enable providers to cover

costs, but it also needs to support changes in the service model where this is the right thing to do. So if there was a plan to centralise or decentralise a service, the payment system would need to be flexible enough to support it.

A gain and loss sharing mechanism will be needed to underpin the whole set-up. Mr Backler believes this would need to work at two levels – a global level, so that overspends or underspends are shared across commissioners and all the providers involved; and a more granular level, so that risk and reward is proportionate to the ability to affect the outcomes. For example, if services were transferred from one provider to another in a patch, the gain/loss might need to be shared across specific providers and the relevant commissioners.

An element of payment will also be linked to outcomes and this will needed to be cascaded down to all the contributing providers. 'For example, if a proportion of payment was linked

the system architecture, transform the clinical model and implement enabling infrastructure.

By system architecture, he means structures, contractual arrangements and governance around the delivery of cancer. And enabling infrastructure will cover the underpinning IT (including an exchange system for imaging), making better use of outcomes and performance data as part of business as usual, and ensuring services have access to the right number of appropriately skilled staff.

'In terms of system architecture, we have had a commissioner-provider model for several years, with providers often doing their own thing – doing the best they can for patients in their part of the pathway,' says Mr Thorman. 'But that often leads to duplication and a sub-optimal overall pathway.'

Instead, the aim is to bring all the cancer services together into an accountable care network. West London has 24 providers of cancer care, including acute hospitals, cancer centres, cancer units, hospices and community providers. And it is likely the Royal Marsden will take on a lead provider role in what is being called RM Partners. The Christie is also exploring a lead provider model, while UCLH is considering some form of alliance approach.

'We're looking to take the resources for the whole of west London for cancer care and use that resource in a better, more efficient way,' says Mr Thorman. The point is not about creating more work for the Marsden, he adds. In fact, its constrained footprint in Sutton in south west London means it has already been looking at ways to keep people out of hospital or reduce the number of visits they must make.

'However the current payment system and tariff doesn't incentivise us to make these changes,' he says. 'It hasn't stopped us from making the changes, but they have caused financial issues.' For example, 3,000 women treated for breast cancer, but rated as low risk for a recurrence, have been transferred onto an open access community model. This replaces follow-ups in hospital, which are costly and can cause unnecessary anxiety for women. While this is better for the patients, the trust loses outpatient income.

This has added to more general financial pressures. The trust typically has a more complex casemix than non-specialist hospitals and says that in many areas treatment costs are higher than the tariff paid. The trust's ability to stay in surplus has relied to an extent on its large private practice – which represents about 25% of total revenues – and a strong charity that has helped with key assets. But surpluses in recent years have been declining and this year's breakeven plan will be tough to deliver.

Transforming services

Going forward, Mr Thorman is clear that sustainable services completely depend on transforming service delivery. The trust will initially rely largely on traditional savings to meet the 2% efficiency expectation on all trusts set out in the *Five-year forward view* – providers' contribution to the £22bn savings challenge by 2020/21. But it will need early wins from the improved system architecture – eliminating waste from duplicated scans, for example – to make a contribution in 2017/18.

And by 2019/20, it will be heavily dependent on efficiencies from the new clinical model to make the 2% target. Getting up to the 3% envisaged in the forward view for the later years of the period will need savings from areas outside the current vanguard scope.

Early work has seen the three vanguard trusts collaborate to analyse rich data that

to one-year survival rates, this would need to be mirrored down into sub-contracts.' However, he anticipates it being more sophisticated than a single set of outcomes, the achievement of which triggers payment across all providers.

There are other issues to be addressed. Identifying current spend on in-scope cancer services provides a baseline. But if that budget is based on tariff prices that underestimate the real costs of care, the new system will start life in deficit. And the cancer strategy, based on assumptions for forecasts in the *Five-year forward view,* suggests cancer spend will grow by around 9% a year over the next five years.

Clearly some of the actions proposed by the cancer strategy and being taken forward by the vanguard are intended to suppress some of this cost growth – but what is the right amount of inflation to build into contracts – to cover providers' appropriate costs and encourage greater efficiency? Again, Mr Backler suggests the gain share mechanism between commissioners and providers could be crucial, with a proportion of underspends being shared back with commissioners.

The vanguard only received details of its £7m vanguard funding in May and is still targeting next April for some form of change to its payment system. Mr Backler says it is unlikely this will be a big bang implementation next April for what could be a budget of £350m to £500m, but it could involve shadow running or focusing on a single pathway.

X-ray ahead of radiotherapy (left) and PET/CT scanner at the Royal Marsden

is already collected for cancer services. This includes data from the cancer outcomes and services and the systemic anti-cancer therapy datasets – comprehensive datasets that are generally under-used for informing service change. 'Our analytics team have been able to benchmark for each bit of this data,' says the Marsden's chief nurse and vanguard executive director, Shelley Dolan. 'So for men with prostate cancer we can look at where delays are in the pathway across all of London and all of Greater Manchester by clinical commissioning groups and provider.'

This flags up potential good practice to be copied and can help clinicians to understand the performance of their teams. It can also highlight patient experience issues too, such as the impacts of access to clinical nurse specialists or to the holistic needs assessment.

The vanguard trusts have also worked together to look at the demand and capacity for imaging and endoscopy – at the heart of plans to improve early diagnosis rates.

'Anecdotally we would hear there were delays in the system because all the scanners were being used for A&E or cardiac patients,' says Dr Dolan. 'We did an important piece of work across all three patches to identify the actual issues and to take a five-year forward view too.

'This helps us to set the baseline on capacity and to understand how we can work differently to use that capacity to meet demand and what new capacity we might need.'

Early diagnosis is a key focus for the vanguard. The cancer strategy highlighted that, for example, more than nine out of 10 people with bowel cancer survive at least 10 years if diagnosed at the earliest stage. But if diagnosed at a late stage, survival is below 5%. Yet fewer than one in 10 people are currently diagnosed at the earliest stage.

There is similar trend for lung cancer and many other types of cancer. Cancer Research UK estimates there would be a 0.5% increase in 10-year cancer survival for every 1% increase in the proportion of patients diagnosed at the earliest stages (1 or 2) across all cancers.

But as well as clear and significant improvements in outcomes, there is often a financial benefit too. Dr Dolan says expensive radiotherapy and chemotherapy treatments for stage 3 and 4 cancers can be replaced by surgery or single-application radiotherapy to remove small nodes in early stage cases. 'It is much less costly and the outcome so improved as to be not comparable.'

The treatment costs for some cancers can be so different – typically £20,000 per case for a stage 4 colorectal treatment compared with closer to £12,000 at stage 1 – that the financial case even stacks up when you take into account the increased cost of early screening.

Early diagnosis

The vanguard plans to use targeted screening to improve early diagnosis of lung cancer – focusing on high-risk smokers and offering a low-dose CT scan screening programme. 'There are added advantages, as you can also pick up concomitant non-cancer conditions such as early chronic obstructive pulmonary disease, and there is an opportunity to convince the participants to stop smoking, to provide a wider health benefit,' Dr Dolan says.

This programme will be taken forward locally through CCGs. The aim is to use some vanguard funding but to keep costs down by using scanners in protected times at the end of a day or the weekend, avoiding extra capital costs for new scanners. Referrals to this screening would be direct from GPs.

National Orthopaedic Alliance: joint work

The core aim of the National Orthopaedic Alliance – another acute care collaboration vanguard – is to set out what good practice in specific orthopaedic pathways looks like and then award quality standards to providers that meet those requirements.

The vanguard was launched by the Robert Jones and Agnes Hunt and Royal Orthopaedic Hospital NHS foundation trusts and the Royal National Orthopaedic Hospital NHS Trust. But two other major orthopaedic providers quickly joined – Nuffield Orthopaedic Centre (part of Oxford University Hospitals NHS Trust) and Wrightington, Wigan and Leigh NHS Foundation Trust. And there are a further nine associate members. Together they are focused completely on the practical aspects of establishing and then implementing best practice across the expanding membership.

There is wide recognition of significant potential to improve orthopaedic services for patients and increase value. It is the health service's biggest surgical specialty with the biggest spend and the longest waits. Recent years have also seen an explosion in data about musculoskeletal services.

While RightCare data has provided this from a commissioner perspective, the *Getting it right first time* (GIRFT) initiative has shone a spotlight on variation in practice across England's orthopaedic providers. This data has been wide-ranging. For example, it has revealed high proportions of surgeons doing only small amounts of activity for some procedures. It has shown wide-ranging prices paid for the same prostheses and underuse of more cost-effective cemented joints for appropriate hip replacements. And it has put a spotlight on application of known good practice such as ringfenced beds for elective activity.

The vanguard now aims to build on the GIRFT work. 'They will mutually reinforce each other,' says Rob Hurd, chief executive of the Royal National Orthopaedic Hospital NHS Trust. GIRFT provides the initial data to highlight variation and

'We are also looking at mobile CT, as has been done with breast screening. This tends to be used with big national screening programmes, but we will look at it, though still on the basis of referrals. We want to get on with it as soon as we can,' she says.

The new model also aims to provide access to 24/7 palliative care, but one of its main strands will look to reduce variation in treatment. The cancer networks in each of the three vanguard trust areas publish guidelines on how particular cancers should be treated along various timelines. These guidelines spell out in more detail than national access targets how to treat patients, using timed exemplar pathways. The aim is to agree and establish the same guidelines across the whole vanguard.

'We are looking with teams right across the pathway – by tumour type – to see where the delays and gaps are. Is it clinician behaviour or a backlog issue? Is it because A&E performance is being prioritised? We are looking at all those things and asking how we can unblock things,' syas Dr Dolan.

The trust is targeting an early win by reducing duplication of investigations. 'There is a lot of repeat scanning, which causes delays, isn't great for the patient and costs lots of money,' she says. 'This is not about blame. Sometimes unnecessary scans can't be helped – you don't always know what you're looking for and a scan only becomes unnecessary with the benefit of hindsight.' Consistent adherence to guidelines should eliminate much of this waste.

"The fact of the matter is that we need to bend the cost curve to treat more people with the same amount of money"
Marcus Thorman, Royal Marsden

Another project is looking at dose banding for chemotherapy. Currently chemotherapy drug doses are matched to specific patients based on height and weight, but dose banding would band patients. All patients (apart from certain cases) in that band would then receive the same dose. Dr Dolan says this has the potential to save time and money with no impact on patients.

She believes that the current financial environment adds to the challenge. 'We can identify the right thing to do in terms of better outcomes and saving costs over time, but in the short term we may be talking about invest to save and in today's environment that is really hard, because everybody is just trying to survive,' she says.

Having the national teams supporting the vanguard is important, she adds, in terms of understanding both the short-term costs and longer term benefits of making changes.

The current financial environment also means getting a revised payment model in place will be crucial. Get it right and it will underpin and incentivise new model working. Get it wrong and there is the danger of destabilising existing providers or the whole system (see box page 16).

'We are not trying to save money compared with what we are currently spending,' says Mr Thorman. Given the 2% rising incidence and estimated 9% rising costs, this would be unrealistic. 'But we are trying to reduce the cost per individual with cancer. The fact of the matter is that we need to bend the cost curve to treat more people with the same amount of money.'

He is hopeful of some early wins particularly around earlier diagnosis and reductions in unnecessary imaging. But he believes it will be a year or 18 months before they will know if the new approach is starting to deliver as planned on the broader improvements.

opportunity. The vanguard will show what best practice looks like and support its achievement. Then the GIRFT data, through quarterly dashboards, will demonstrate the achievement and maintenance of improved outcomes and efficiency.

Mr Hurd says the GIRFT initiative and pilot programme was all about normalising the publication and sharing of data and 'winning the hearts and minds of clinicians about where there was unwarranted variation. The vanguard is now about bringing the organisations in'.

'We are talking about the management of the orthopaedic department and multidisciplinary teams running those services,' he says. 'We want them self-assessing against the standards, joining up to this membership model and sharing best practice at a very detailed level. There is a lot of benchmarking that goes on, but making it real and turning it into best practice is what this vanguard is all about.'

The vanguard will define best practice pathways in its key service areas – spines; hips and knees; sports injuries; foot and ankle; shoulders; orthopaedic cancers; bone infections; pain services; rehabilitation; and rheumatology. There may be anything from two to 10 high-volume procedures or treatments in each area. And the vanguard will set best practice across the whole pathway, from referral and preoperative assessment to discharge, measuring outcomes and involving patients in shared decision-making.

The quality standard approach has yet to be finalised but could see organisations awarded a bronze, silver or gold rating, depending on how they measure up against the standards in a particular pathway. At bronze, an organisation might have identified its development opportunities and have an improvement plan in place. A gold mark would indicate that it is meeting all the standards in a specific pathway and is evidencing the outcomes being achieved.

The identification of best practice is being led by clinicians, who have been collating and comparing existing approaches alongside existing standards set by the British Orthopaedic Association. First agreed standards should be published this autumn. The agreement of expected outcomes will be a key part of the process and could pave the way for aspects of the future payment system to be linked to outcomes.

LOCKING UP

Cyber security is a growing issue for the NHS as it moves to electronic systems. But how big is the threat and how can NHS organisations protect their data? Seamus Ward reports

SHUTTERSTOCK

The words 'cyber crime' conjure up the Hollywood image of a hacker, a hooded figure in a darkened room up to no good, whether the motivation is mischief, malice or money. Governments and corporations, even individuals such as US presidential candidate Hillary Clinton, have been targeted. But what of the NHS? After all, in the private sector, an entity with a £100bn plus turnover and a mass of sensitive, business-critical information would be a prime target.

It's an issue that would be easy to sensationalise, though IT and security professionals believe it's a case of when, not if, an NHS organisation is hit by a serious cyber attack. While the NHS does not appear to have been directly targeted, and there are no official figures, a number of Scottish health boards and at least one English trust have been hit. Given the sensitivity of the subject it is not surprising that trusts do not wish to speak openly about cyber security, though many recognise it is an area where they could improve.

There is growing concern from national bodies. The report on data security, consent and opt-outs from Dame Fiona Caldicott in July recommended all NHS organisations provide evidence that they are taking action to improve cyber security. While the greatest danger was from staff – through carelessness or lack of proper systems – the report acknowledged the threat from outside the NHS, particularly from basic cyber attacks such as malware in emails, was growing. The Care Quality Commission says it will amend its assessment to ensure the Caldicott recommendations are being met.

A spokesperson for NHS Digital (formerly the Health and Social Care Information Centre, HSCIC) says all organisations, including in the NHS, face an ongoing and increasing risk from cyber-security attacks. And while each NHS body is responsible for its security, the HSCIC this year set up the CareCERT programme to help protect NHS bodies.

'CareCERT has not been set up in response to a particular threat, but in recognition of the fact that risks from cyber attacks are ongoing and ever changing and health and social care information should be protected with the highest possible standards of security,' says the spokesperson. 'Our role is to support individual health and care organisations, who are responsible for the data they hold, to best protect that information and to ensure their own cyber-preparedness. We want to empower organisations to be accountable for cyber security locally, but to support and enable them to improve and enhance what they do.'

The programme includes CareCERT Broadcast, which sends alerts to more than 10,000 health and care professionals responsible for IT, security, networking and information governance. These alerts provide real-time advice on cyber security threats, along with guidance for recommended proactive or remedial actions.

NHS Digital is also testing a national e-learning system that will train all staff on fundamental data security alongside more complex modules for specialists. It will be available to all health and care organisations.

Gary Colman, head of IT audit and assurance services at the West Midlands Ambulance Service NHS Foundation Trust, says the risk of cyber attack is real, though UK NHS trusts have yet to be targeted by serious criminals. 'You're more likely to be caught out as collateral damage – if someone is after a person or organisation and your website is hosted on the same server, for example.'

Common terms

Malware A general name for malicious software, often contained in emails with bogus links to websites or documents. The software is often sold on the internet by developers for others to use. Malware can allow users to take over a computer, encrypt its data or glean information, such as passwords.

Ransomware An app that can lock down or encrypt a computer system, with the criminal demanding a ransom for its release.

Patches Updates from software developers that prevent hackers using vulnerabilities in a programme or app to gain access to a system or network.

A dedicated unit at the ambulance trust provides information security and assurance services to NHS organisations, local and national government and the private sector (manufacturing and healthcare).

'I haven't heard of any significant successful cyber attacks against the NHS, but I think it's just a matter of time,' he says. 'If you consider the amount of money that's going through the NHS – a criminal who hacks into an NHS network could target the payment systems. That's a fair incentive for a cyber criminal.

'If you hack a trust's website, you can change the website and attack anyone that uses it. It can be a staging point to a further breach in the organisation or to patients.'

US healthcare organisations are a major target of cyber criminals and a number have been the subject of ransomware attacks. Mr Colman says this is mostly because they deal with financial information. However, UK patient and staff records contain information such as NHS and national insurance numbers – data that security experts say is potentially way more valuable to those bent on identity theft, for example.

Mr Colman adds that healthcare organisations should take the same care with staff records that contain identifiable information as they do with patient records. 'Both should be treated as highly confidential. If you can get a foothold, a breach in the NHS network, as a cyber criminal you would look to widen that access and take advantage of its payment system.'

Peter Sheppard, senior ICT audit manager and cyber security lead at business assurance services provider TIAA, has been helping NHS clients with cyber security for 14 years. He believes the health service could step up its game. 'It's a real and credible threat, but that doesn't mean we should all panic,' he says.

Boards must acknowledge the threat, he says. 'Some NHS organisations do not have cyber security in the corporate-level risk register. This is deeply concerning as an attack could damage critical systems or make patient records unavailable. We have to be mindful that the potential impact of this type of risk is quite high and could have a detrimental effect on patient care.'

Mr Sheppard highlights much of the risk lies in legacy systems, which can be exploited more readily than modern ones, as the manufacturer may no longer be producing patches updating their security.

Replacing systems

The bad news for finance directors facing a funding squeeze is that the only way to reduce the risk is to replace outdated systems. Indeed, Caldicott and the CQC recommend outdated and unsupported systems are replaced 'as a matter of urgency'. Where new deployments are made, Mr Sheppard adds, security must be designed into the fabric of any new system, not delivered as a bolt-on. 'It is imperative that systems are secure by design when deployed, not as an afterthought.'

NHS bodies should be aware of the risks, particularly for breaches of patient-sensitive information, when decommissioning hard drives and other storage devices. Mr Sheppard is aware of one incident with which TIAA was asked to help, when disks containing NHS data were stolen from a company subcontracted to destroy them.

Mr Colman says there is no single solution to prevent cyber attacks, but basic steps can be taken, such as having an up-to-date IT governance framework that is implemented and regularly reviewed.

'People introduce new systems or devices without realising they can open up a new vulnerability,' he says. 'Patching and updates to systems must also be done – the amount of unsupported systems we see is scary. The situation has improved over the past couple of years, but there are unpatched systems out there.

'User awareness is a massive deal. Staff take information governance toolkit training, which has some element of cyber security, but there is room for improvement. When people are back at work they do not always scrutinise email addresses or websites.'

In at least one of the US cases of ransomware attacks, the healthcare body refused to pay and was able to restore its data from a back-up. Mr Colman says this is the ideal solution, but not always foolproof.

'You may have a back-up, but if the back-up is online and attached to the network, it too could be encrypted. For this reason, you need an offline back-up. I am aware of three trusts that have been hit by ransomware, but basic controls in place limited the impact to a few wards or departments. In each case, the infection was in an email attachment.'

Sophisticated scams

It's often not simply the case of a member of staff clicking on a link or attachment in an email written in poor English. Some scams are more sophisticated. A cyber criminal could send the email from an account that looks like the chief executive's – the address could say @nhs.co.uk rather than @nhs.net, for example. While such emails could be used to deliver malware, they are often vectors for one of the oldest criminal scams – impersonation. The 'chief executive' could attach an expenses claim form, for example.

'I am aware of some instances of pretty large payments that have almost been made but picked up at the last moment,' Mr Colman says.

Educating users and limiting high-level access to NHS networks are vital, Mr Sheppard says. 'Staff may not be tech-savvy, so they will not be aware they are doing something risky or wrong.'

He is aware of one non-NHS organisation that, like many employers, including some in the health service, allowed staff during breaks to access the internet using their network. A staff member viewing personal email clicked on a bogus link, and, within minutes, their employer's server was encrypted by malware.

Moves to give patients and the public wifi access in hospitals poses a threat if strong barriers between hospital and public networks are not put in place, Mr Sheppard says. 'One of the biggest threats to our cyber security is ourselves. We are the weakest element, but we need to think about cyber security holistically, not just in terms of firewalls. It's not about stopping people getting on with their digital lives, but the NHS needs to think about it sensibly, particularly when most people now have smartphones for their email.'

"A criminal who hacks into an NHS network could target the payment systems. That's a fair incentive for a cyber criminal"
Gary Colman, West Midlands Ambulance

While the traditional method of gaining assurance about network security, by undertaking 'penetration' testing (paying an outside body to try to hack your system) – is helpful, Mr Sheppard insists it shows the vulnerability or strength of a system only on the day the test is done. New exploits or weaknesses will be found subsequently, so it cannot be done and forgotten.

Other practical IT solutions are useful. Simple logging and monitoring of who is accessing the network can aid security, but is not always performed in NHS organisations, he says. Implementing data loss prevention software can also help detect actual and attempted breaches before they cause serious damage.

There is no single solution to NHS cyber security, but it must start with staff being more aware of the dangers.

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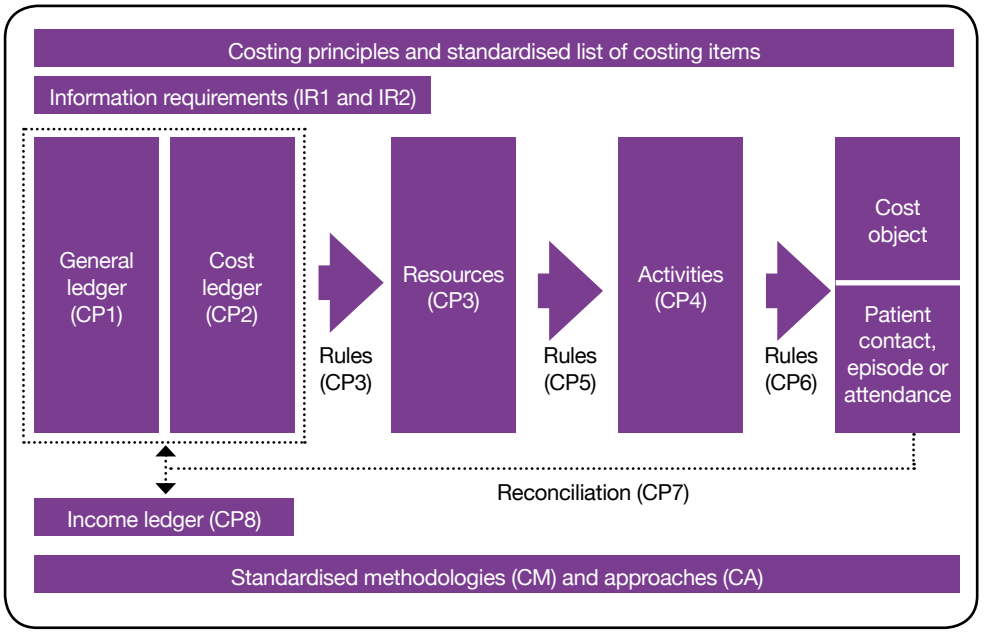
Costing tour

As part of its costing transformation programme, NHS Improvement has published new draft costing standards that introduce new concepts and approaches for NHS costing practitioners. Julia Gray points out the highlights

In April, NHS Improvement published its first healthcare costing standards to set out a consistent methodology for compiling patient-level costs in acute provider bodies. These standards are not mandatory and are still in draft format. However, the clear aim is that in future all providers – initially in the acute sector but then moving on to cover ambulance, mental health and community providers – will be required to adhere to the standards.

NHS Improvement's costing transformation programme (CTP) is following a staggered timetable. The first mandatory collection for all acute providers will be in July 2019, with all providers joining in by July 2021.

This may seem a long time away, but the timetable is ambitious, with providers across different sectors and within each sector facing a different scale of challenge. This will depend on their starting position in terms of existing systems, source data and staff engagement (including clinical staff).



Patient-level activity feeds prescribed by standard IR1

Number	Title
1	Admitted patient care (APC)
2	Ward stay – discharged
3	Admitted patient care – not discharged (APCND)
4	A&E attendances (A&E)
5	Non-admitted patient care (NAPC)
6	Non-admitted patient care – did not attend (DNA)
7a	Critical care – paediatric
7b	Critical care – adult
8	Inpatient contacts
9	Pathology
10	Blood products
11	Inpatient pharmacy drugs dispensed
12	Clinical photography
13	Radiology
14	Theatres
15	Cancer multi-disciplinary team meetings

No-one can afford to postpone getting to grips with the new costing approach as set out in the new standards. Getting some familiarity with the key components – and how the approach differs from existing costing methodology – is a fundamental starting point. Alongside eight costing principles, there are 24 standards in the following categories:

- Information requirements (2)
- Processes (8)
- Methodologies (9)
- Approaches (5).

Below are a few highlights from these standards, along with explanations of some of the 'new' concepts and language being used.

Information requirements

Costing begins with good-quality source activity data. The information requirements standards describe the activity information required to implement the other costing standards. And they set out how costing teams can work with informatics and service departments to obtain good-quality data for costing. These standards should be shared with the informatics department and departments providing activity data for costing.

Standard IR1: collecting information for costing purposes

The CTP aims to standardise the collection and use of information in costing. This standard prescribes the minimum 15 patient-level feeds (see table left) for implementing the standards. As providers may not currently collect all this information, a lead-in time may be required before all of it is available for costing. NHS Improvement also recognises that these 15 patient-level feeds do not cover all the activity a provider delivers.

Costing processes

The costing processes standards explain the steps of the costing process, from recording information in the general ledger through to producing the final patient unit cost and reconciling reported costs to audited accounts. The process standards should be applied to all the services provided by an organisation.

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Source: Patient Level Costing: Case for Change April 2016 (NHS Improvement)

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Standard CP2: producing a cost ledger

'Cost ledger' is new terminology for the costing process. As the general ledger is not generally set up for the costing process, most costing practitioners will need to move costs to their correct starting positions for costing. 'Cost ledger' just puts a name to this preparation work.

The purpose of the cost ledger is to ensure the costs are aggregated or disaggregated to the appropriate level to start the costing process and to ensure all costs are in the correct 'starting position' for the costing process. For example, where the general ledger separately identifies pay, pension, national insurance and overtime, these are combined into a single staff cost for the cost ledger.

On the other hand some costs need to be disaggregated. A subjective code in the general ledger containing nursing costs for different categories of nurse needs to separated into: specialist nurse; qualified nurse; and midwife.

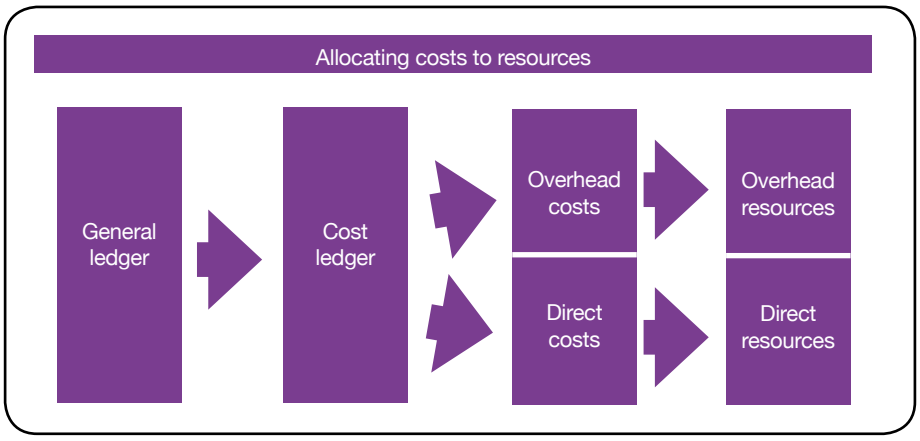
A chart of accounts for the cost ledger will be published in the first version of acute costing standards to be published in January.

Standard CP3: allocating costs to identified resources

Costs from the cost ledger are first allocated to resources – the components used to deliver healthcare activities. Costs are mapped either to a direct resource (such as staffing, supplies or systems) or to an overhead resource (such as finance, human resources, estates or portering). The standard provides the prescribed list of resources. Costs do not need to be allocated against every resource listed, just against those that are most appropriate. Organisations will need to have the ability to report patient-level costs at both a resource group level (for example, 'devices, implants and prostheses') and at an individual resource level (for example, 'heart valves' or 'hearing aids').

Standard CP4: identifying activities

Resources must be mapped to a list of prescribed activities, but the first step is for costing practitioners to identify their own organisation's activities and map these to the prescribed list. The 15 patient-level feeds prescribed in the information requirements standards do not cover all the activities performed by acute providers. However, all activities should be mapped to the prescribed list of activities and costed regardless of whether they are supported by a patient-level feed or not. An example of an activity group might be 'chemotherapy', containing separately identified activities of 'drug issue', 'nursing clinical supervision' and 'pharmacy dispensation.'



Standard CP5: allocating resources to activities

This standard provides the costing allocation methodology for each resource and activity combination. There is only one prescribed allocation method for each combination. This is important to ensure that the costing process is standardised as far as possible to allow meaningful benchmarking.

NHS Improvement understands that providers may not be able to meet the prescribed costing allocation methodology immediately. In this case, providers may use a locally relevant methodology and document this in their costing manual.

Providers will also need to demonstrate they are working towards achieving the prescribed allocation methodology.

It is also the case that providers may be using superior allocation methodologies to those prescribed in the standards. A list of 'superior' costing methodologies is currently being compiled. Again, providers should document in their costing manual where they have used a 'superior' method. A list of costing methodologies that will not be accepted as superior or as local workarounds is also being produced and this will include using income or national averages to weight costs.

Standard CP6: matching activities to cost objects

Matching costed activities to inpatient episodes, outpatient attendances and contacts is crucial for accurate patient unit costs. An aim of the CTP is to standardise the costing process at every stage. This ensures that the results can be benchmarked as any cost variation will be due to service delivery decisions rather than variation in the costing methodologies used to calculate the costs.

Prescribed matching rules will reduce 'false-positive' matches – when the costed activity is not matched to the event it took place in. These rules will continue to be refined as the process is complex, with each activity potentially taking place in many different care scenarios.

The matching principles depart from current practice. Unmatched costed activities should not be absorbed by patients who did not incur these costs. The true cost of any procedure will never be established if patient unit costs are inflated by costs that were not incurred during the delivery of that procedure.

There will inevitably be some costed activities that do not match. Either the activity took place too long before the episode/contact/attendance, or the information in the activity feed is so poor that an appropriate match cannot be found.

Unmatched activity should not be assigned to other patient contacts, episodes or attendances.

To achieve consistent and comparable costing outputs, unmatched activity must be treated consistently across providers. This means the following rules must apply for any unmatched activity:

- If the specialty that ordered the item is identified but the item cannot be matched to a patient episode, contact or attendance, the cost sits in the specialty under reconciliation items. It should not be matched to the other patients in that specialty.
- If the specialty that ordered the item cannot be identified, the cost sits in the providing department under reconciliation items. For example, if a pathology test cannot be matched to a patient contact, episode or attendance and the requesting specialty (for example cardiology) cannot be identified, the unmatched activity would be reported under pathology as a reconciling item. This rule helps identify data quality issues.

The volume of unmatched costed activity is a good measure of the accuracy of the data used for costing purposes. It is an aim of the CTP to improve the quality of this data.

Reports of unmatched costed activity and the reasons why they could not be matched can be helpful in illustrating to informatics and other departments the importance of

good-quality data to costing. As data quality improves, unmatched costed activities can be expected to reduce.

It is appropriate that some costed activities are not matched to any inpatient episodes, attendances or contacts because they were not part of this care. This could include activities relating to patients not in the provider's care, including direct access activity and activity conducted on behalf of other providers. The cost group 'reconciliation items' has been adopted to record these costed activities so patient unit costs are not inflated.

Costing methodologies

The costing methodology standards provide guidance on how to cost high volume and high value areas within an organisation. These supplement the costing process standards.

Standard CM1: allocating overheads

This standard adopts approaches that depart from current practice. The first difference is that costs are classified as either patient facing or supporting, the indirect classification is not used.

Costs are driven in two ways only: by the cost objects (direct) or by other resources/activities (overhead/supporting). The indirect classification relates to organisation structure, not how costing is undertaken. Its inclusion is a management classification, which is separate and should be achievable by attributing the different resources/activities in the model.

For example, the cost of a radiology scan can be directly attributed to those patients who were scanned. Within costing, it is directly driven by the cost objects. For management purposes, it is an indirect cost as the scan is a clinical support service provided at the request of a main specialty such as trauma and orthopaedics.

We have adopted three different ways to allocate overheads to cost components. This is because detailed analysis of the overheads indicated that a one-size-fits-all approach does not accurately reflect how overhead costs are incurred. The use of three methodologies attempts to allocate overheads at the appropriate point in the costing process.

Standard CM7: theatres

Although it is not the approach used by many providers, this standard requires sessional costing as it addresses challenges in costing theatres such as overruns and cancellations. It is seen as a starting point for investigating the methodologies to include in future versions of the standards that more accurately cost overruns and underruns, as well as out-of-hours and emergency theatre work.

No-one can afford to postpone getting to grips with the new costing approach and standards

Standard CM8: critical care

Critical care nursing costs should be allocated using length of stay weighted by acuity, not the number of organs supported. The results using this methodology are being reviewed as the costing standards are implemented by roadmap partners. While the standards set out a hypothetical example of how weightings might look for different levels of acuity in critical care, the standards call for the development of local relative weight tables in each provider. A relative weight table should also be used to allocate non-pay costs. Medical costs should be allocated across all patients based on length of stay without an acuity weighting.

Julia Gray is costing standards lead at NHS Improvement

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Events, people and support for finance practitioners

Cautious support for single oversight framework but fears over WAU factor

Technical update

Finance practitioners have given a qualified thumbs up to NHS Improvement's planned new single oversight framework.

The framework will provide the triggers for helping the oversight body decide how to target support on provider organisations. It will replace existing risk assessment and accountability frameworks for foundation trusts and NHS trusts and will 'align' with the Care Quality Commission's rating approach.

The finance community has a particular interest in how the new framework assesses provider finances and use of resources. And at first glance, there is little change from what providers are already familiar with.

Ratings on capital service capacity and liquidity are carbon copies of those in the existing financial sustainability risk rating with the same thresholds for rating levels. Variance from plan becomes variance from control total. And income and expenditure margin becomes EBITDA margin (earnings before interest, tax, depreciation and amortisation) – EBITDA being seen as a better measure of operational efficiency.

So basically the only change for providers is to get used to a reversed scoring system in which 1 (good) is the new 4, and 4 (bad) is the new 1. Finance practitioners were a little bemused by the change and think work will be needed to counter any confusion among stakeholders.

The qualified aspect of finance practitioners' response to the financial assessment relates to new work-in-progress metrics. Three new metrics will operate in shadow form for the rest of 2016/17, presuming the framework gets the go-ahead:

1. Change in cost per weighted activity unit (WAU)
2. Distance above capital control total
3. Distance from agency spend cap.

The 'distance above capital control total' has raised some eyebrows, given the lack of any such control total – presumably an indication that such totals are coming, perhaps set initially at a default level of a provider's depreciation.

But it is the cost metric that is causing most concern. 'There is very little detail on how it will be calculated and whether it will provide the expected insight into efficiency,' the HFMA said in its response to the consultation.

Lord Carter introduced the cost per WAU in his final report on NHS productivity in acute providers. It is inextricably linked to the adjusted treatment cost (unveiled in Carter's earlier report), with both metrics repackaging reference cost data into more usable formats.

The cost per WAU represents the cost of providing £3,500 of healthcare– basically the national average cost of an inpatient episode based on 2014/15 reference costs. Take a trust's activity for a specific healthcare resource group and multiply it by the national average cost for that HRG in the relevant point of delivery, then divide by £3,500 and you have the number of WAUs that activity represents. Do this for all types of activity and then divide actual costs by the total WAUs and you have the cost per WAU. NHS Improvement proposes to monitor the change in cost.

Typically, NHS Improvement would calculate forward risk ratings based on annual plan submissions and then calculate in-year ratings using actual information in-year.

However, reference costs for 2016/17, say, would only be available to NHS Improvement by summer 2017 long after annual plans are produced. Recognising timing issues, NHS Improvement says it will use different, more frequently reported activity and cost datasets to calculate in-year costs per WAU.

Presumably this would involve actual activity data from the SUS system and cost data from regular finance returns – but the figures would be less reliable than the annual calculated numbers. And what would be the comparator year for these in-year costs, given there wouldn't be firm reference costs for the previous year until halfway through the following year?

One possibility under consideration is to calculate a planned change in cost per WAU from future planning templates. Alternatively the initial score could be based on the latest available change in cost per WAU data available at point of plan submission. This would then be amended in year.

NHS Improvement is completely clear that the metric is a work in progress. It wants to understand what the metric can tell it and whether the thresholds are the right ones. Everyone is agreed that operating the metric in shadow form is essential.

Given a potential formal introduction in 2017/18, finance practitioners need to get to grips with the new metric fast.

For more on the cost per WAU and other metrics introduced by Lord Carter following his review of productivity, see 'Measure by measure', *Healthcare Finance* March 2016. NHS Improvement's consultation on the single oversight framework closed at the start of August – the HFMA's response can be found on www.hfma.org.uk.

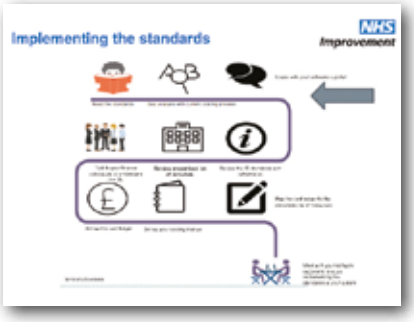
Technical review

This summer's key technical developments

Technical round-up

The NHS Improvement and NHS England guide to new payment approaches for mental health services was updated in August. The update adds revised outcome measures to the previously published case study on the outcomes-based commissioning model at Oxford Health NHS Foundation Trust. A fifth of the capitated contract value is based on outcomes – the bulk of these payments are based on seven locally agreed outcome measures, including timely access to assessment and support and fewer physical health problems related to mental health.

NHS Improvement has produced an infographic (pictured) setting out the key steps for NHS providers in implementing new costing standards as part of the Costing Transformation Programme. With first draft standards published in April, NHS Improvement is working on the next development version for publication in January. For acute organisations, developments will include guidance on cataract surgery, multidisciplinary and other outpatient attendances and hip or knee replacements. Six roadmap partners implemented the existing draft standards with a test output undertaken in August for a data collection this month. Standards for the ambulance and mental health sectors and to cover the costing of education and training are also under development – again aiming for draft release in January. This year's voluntary patient-level cost collection began in August and will run until October – a month longer than usual. A prototype costing assessment tool is also planned for a January release. This will help organisations assess their compliance with national standards and other quality metrics such as clinical engagement, costing staff numbers and frequency of reporting.



• *For infographic, see costing webinar (IR1 and IR2 slides) at www.improvement.nhs.uk*

The HFMA has published a new briefing on financial forecasting in the NHS. As well as providing definitions and examining the basic principles of good forecasting, the briefing looks at the key steps involved in preparing a forecast. The briefing, prepared with input from the HFMA commissioning and provider technical issues groups, includes a number of case studies to illustrate how the theory is applied in practice.

The HFMA has also published its response to the consultation on the Department of Health *Group accounting manual 2016/17*. As well as responding to questions in the consultation, the association makes a number of general points – for example, suggesting the annual process of updating the manual should begin with an examination of historical issues and new developments that could cause problems for NHS organisations. It suggested the guidance could then be written to address these issues.

NHS Improvement has published a 'metrics engine' on its website, which explains how tariff prices change as the modelling process progresses. It said the tool gives users a view of the journey from raw underlying costs to final published prices and allows national and local organisations to see the impact of policies – to ensure their impact is as intended and to understand better their effect at a more granular level. A user guide, narrative on price modelling and its processes, as well as a glossary, have been published alongside the engine.

Sepsis guideline could cut costs

NICE update

The recent NICE guideline NG51 offers best practice advice on the recognition, diagnosis and early management of sepsis. Sepsis is a common condition that can be triggered by an infection (bacteria, viruses or fungi). There are about 123,000 cases in England every year, resulting in around 36,900 deaths. Over 70% of cases arise in the community. The incidence of sepsis is increasing as people live longer and more medical and surgical interventions are performed.

The UK Sepsis Trust estimates that improved sepsis management could save the NHS £170m each year – £1.25m a year in a typical medium-sized general hospital – and that 10,000 deaths per year could be avoided. Care of two-thirds of sepsis patients could be improved, it adds.

It can be hard to identify cases that need urgent treatment to prevent progression to severe sepsis. Current standard practice varies because of the facilities available and the clinical experience of the healthcare professional making the initial assessment. Treatment involves immediate recognition, early treatment with antibiotics and continual monitoring and reassessment.

Implementing the guideline focuses on using current NHS resources effectively and ensuring sepsis is identified at the first opportunity using a 'think sepsis' approach. It may require extra upfront resource to rule out sepsis and may result in more costs due to:

- Additional primary and secondary urgent care referrals
- Medical staffing levels, including out-of-hours services
- Monitoring and testing services, particularly at night and weekends
- Critical care outreach services.

The improved recognition, diagnosis and

Diary

September

9 (B) Yorkshire and Humber Branch: student event, Leeds
13 (B) Eastern Branch: student conference, Cambridge
14 (I) HC4V: costing regional networking and training, London
15 (F) Provider Finance: technical forum, London
15 (F) Commissioning Finance: forum, London
19 (B) South Central Branch: NHS operating game, Southampton
20 (B) London Branch/HPMA joint event, Rochester Row
22 (F) Chair, Non-executive and Lay member forum, London
22-23 (B) South West Branch: annual conference, Bristol
29-30 (B) Wales Branch: annual conference, Hensol
29 (N) CEO Forum, London
30 (B) Kent Surrey and Sussex Branch: introduction to NHS finance, Dover
30 (B) South Central Branch: football, Southampton

October

7-8 (B) Kent, Surrey and Sussex Branch: annual conference
12 (I) HC4V: international symposium, London
12 (B) South Central Branch: technical update, Southampton
13 (B) East Midlands Branch: annual conference, Leicester
14 (B) Eastern Branch: annual conference, Newmarket
15 (B) Northern Branch: treasure hunt, Newcastle
19 (N) Charitable funds, London
20 (F) Provider Finance: directors' forum, London
21 (B) Northern Ireland Branch: annual conference, Belfast
25 (F) NHS operating game
27-28 (B) Scotland Branch: annual conference, Glasgow

November

10 (I) HC4V: technical costing update, London
11 (B) Northern Branch: annual conference, Durham
14 (B) Eastern Branch: national tariff, Newmarket
16 (F) Commissioning Finance: forum, venue tbc
17 (B) West Midlands Branch: AGM, Birmingham
23 (F) MH Finance: directors' forum, Grant Thornton UK
24 (F) Audit conference, London

December

7-9 (N) HFMA annual conference *Step up*, London Hilton

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

key (B) Branch (N) National (F) Faculty (I) Healthcare Costing for Value Institute

early management of sepsis will likely lead to big savings from reduced mortality and morbidity, potentially offsetting the extra costs. Early management of sepsis could reduce critical care bed days.

Many who survive sepsis have long-term physical and mental health issues. Better care for these people is likely to mean fewer have these issues, further reducing costs across health and social care. A resource impact template is available on the NICE website to calculate the impact of the guideline.

Nicola Bodey is a senior business analyst at NICE

Events in focus

Step up programme

The HFMA has a full programme of branch-based *Step up* events this autumn, which are free for HFMA members. The events are designed to help finance professionals and their teams face up to the challenges in the NHS.

Branch events are largely based on 'mixed doubles' half-day workshops, with branches choosing two workshops to be delivered on the same day. 'Coaching people out of their comfort zones' is one workshop proving popular. This focuses on helping managers to nudge team members into taking on more responsibility and expanding their sphere of influence.

The events will be of particular interest to managers who feel some members of their team are not working to their full potential. The team member may lack confidence or simply be unwilling to step up and take on more responsibility.

The session covers a range of topics such as understanding why people do not want to take on more responsibilities; removing the barriers; and using a coaching approach to help people develop.

For more information on the Step up *programme, see www.hfma.org.uk*

Charitable funds 2016
19 October, London

This event provides an opportunity for practitioners to get up to date with the latest developments in charitable funds accounting and governance.

This year's conference, which will be chaired by HFMA Charitable Funds Special Interest Group chair Ken Godber (pictured), will include a discussion on the issues related to the new statement of recommended practice (SORP), together with a chance to consider how it could be improved as part of the SORP research exercise. There will be plenary, Q&A and workshop sessions, with the latter including a focus on risk management, investment and reserve policies.

Speakers include Jeff Prescott of the Charity Commission, who will look at key changes to guidance and regulatory oversight, and Alison Paines, a partner at law firm Withers, who will explain what counts as charitable expenditure and what does not.

Support in tough times

Association view from Mark Knight, HFMA chief executive

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

FLICKR:ONEDITION

HFMA head of skills development James Blackwell is representing GB at the Rio Paralympics in the seven-a-side football. The tournament begins on 8 September with GB facing Brazil, with two other group matches against Ukraine and Ireland on 10 and 12 September

My HFMA

I trust you've had a good break, if you've had the chance to get a holiday this summer. As a keen watcher of sport I spent much of it devouring the Olympic coverage. It's great to watch people at the top of their game and it is easy to forget the years of training that have gone into it. It reminds me that we must all devote time to developing ourselves so we can *Step up* to the challenges around. It is important we network, read and reflect on our work so we can become better at what we do.

The HFMA was formed back in 1950 so that finance professionals could improve themselves. Our mission is even more relevant today, for even in post-war Britain it is unlikely they will have had to deal with the demands ahead of us now. With unprecedented pressure on the system and limited funds, 'squaring the circle' has become a tricky art for the finance professional.

We are of course committed to helping you get better at what you do. Our *Step up* programme is packed full of resources to help. Local branch seminars are supplemented by a couple of big national programmes in the autumn. We are hosting a series of new webinars on these issues and, as part of the support network, we are looking to train a new cadre of mentors. There's plenty of resources on our website and we have a great search facility, with all our items tagged to ensure you can find what you're looking for.

In England, the sustainability and transformation planning process is dominating our agendas as health economies look to demonstrate their readiness. In some areas, the process will no doubt lead to major restructuring and even some full-blown mergers.

I first wrote about accountable care organisations following a trip to see colleagues in the US some years ago and, like pay for performance before it, there is talk of the concept coming here. Of course, colleagues in the other three nations will merely feel England is catching up, though I wouldn't write off commissioning just yet. It has an important part to play in specifying and agreeing services bought locally.

HFMA chief executive Mark Knight

As usual, my colleagues are lining up more opportunities at national, branch and faculty level this autumn, so if you can spare the time, please check them out. We have a busy season of branch conferences ahead, as well as our national conference in December, at which former Sainsbury's chief executive Justin King will be a keynote speaker. And we are busy signing up one or two more. Delegate numbers are looking good, so sign up to avoid disappointment.

Finally, I wanted to announce that from 1 October you will be able to pay your subscription by monthly direct debit. It's £6 per month if you are a full paying member and £4 if you're an abated member. It's still cheaper to pay in one go (£60 by direct debit per year) but many have said forking out one lump is difficult. If you're thinking of switching, let us know, though you won't be able to switch until your renewal date.

Member news

HFMA webinars are now available only to individual members. For upcoming topics and on-demand webinars go to www.hfma.org.uk/education-events/events-webinars

Tickets for the annual gala dinner and awards ceremony on 8 December will initially only be available for personal members of the HFMA. There will be a seating plan, giving members the chance to reserve tables to sit with colleagues.

Ten teams took part in the Yorkshire and Humber Branch annual quiz at Yorkshire Sculpture Park. About 50 people from the branch were at the event, and 360 Assurance were the winners followed Lost Profits, a team from Mid Yorkshire Hospitals NHS Trust.

HFMA has launched the NHS operating game for mental health trusts. The game has been developed with 2gether NHS Foundation Trust and is ready to be rolled out by mental health trusts across the country.

Andy Ray, deputy director of finance at Basildon and Thurrock University Hospitals NHS Foundation Trust and chair of the HFMA Eastern Branch is raising money for the Polly Parrot Appeal, which fundraises for the hospital's two children's wards. Mr Ray and daughter Amy (pictured) are running together – they've so far run the Vitality London 10k and the Dirty Dozen Dash – a 6k, 15-obstacle mud race. The Polly Parrot Appeal is driven by a small group in the trust finance team, who have raised just under £200,000. The target is £250,000. 'This is a good example of how the back-office goes the extra mile to support frontline service,' Mr Ray said.

Member benefits

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

Branch focus

My HFMA

South Central Leadership

The South Central branch is on course to have what may be the youngest chair in the history of HFMA branches. Sam Dukes, 24 (right), is on a placement at East Berkshire clinical commissioning groups as part of the NHS Graduate Management Training Scheme (finance management). He will take over from current chair Alex Gild in September 2017 shortly before Mr Gild becomes the national HFMA president.

Mr Dukes will focus on expanding the networking opportunities for branch members. 'It is really important for finance professionals to understand and relate to each other, even if they come from different organisations,' he says. 'Having worked for a commissioner and a provider, I understand how different it can be and how important it is to relate to each other.

'I'll be looking at running events where people can spend a bit of time talking to colleagues from different organisations and learning about what they do. Also, I'll try to explain to financial professionals in the local region the benefits of being a member of the branch.'

At the moment Mr Dukes is vice chair of the branch. He is the main point of contact for members and works closely with the chair and the branch administrator, Alison Jerome.

The branch has had an exciting year so far. There was a 40% increase in the delegates attending the student conference, organised in collaboration with the South West Branch. Over 100 delegates came together for a mix of plenary and workshop sessions. A *Step up* event to support Shahana Khan's presidential theme also took place in June, with a further workshop due to be held this month.

In September the branch members will also have the chance to play the NHS operating game. The upcoming annual football tournament also promises to provide informal networking opportunities with a dozen teams signed up for the event already.

Following feedback from branch members, the branch annual conference will move to June from next year – historically it is held in January. This year the event looked at local new models of care vanguards and the Carter report model hospital approach.

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Appointments

Rebecca Edwards (pictured) is the new deputy programme director at NHS Future-Focused Finance. She is one of the initiative's value makers, committed to making a difference in the NHS. Mrs Edwards was previously senior management accountant at Chesterfield Royal Hospital NHS Foundation Trust.

Carol Potter has been named interim director of finance at NHS Fife, taking over from Christine Bowring. She was assistant director of finance, having joined NHS Fife in March 2014. Her NHS career started in 1993 as a national finance graduate trainee. In 2004 Ms Potter spent a short period with the Scottish government leading a review of training and development in the finance function of NHS Scotland. Ms Potter was given an HFMA key supporter award in July.

Avon and Wiltshire Mental Health Partnership NHS Trust has appointed **Simon Truelove** director of finance. He joins from Wiltshire Clinical Commissioning Group, where he has held the post of chief finance officer over the past four years.

The Royal Surrey County Hospital NHS Foundation Trust has named **Ross Dunworth** (pictured) interim finance director. He succeeds **Peter Ridley**, who is now director of planning at the Royal Free London NHS Foundation Trust.

Bill Boa is now interim chief finance officer at Cambridge University Hospitals NHS Foundation Trust. He has been director of finance for a number of organisations in most settings, including strategic health authorities, primary care trusts, NHS foundation trusts and NHS trusts. He has worked in interim and consultancy and advisory roles since 2012. His last position was interim chief finance officer at Great Ormond Street Hospital for Children NHS Foundation Trust. He is succeeded at the children's hospital by **Loretta Seamer**.

Mike Jennings has been named director of finance and estates at Sussex Community NHS Foundation Trust. He is currently commercial director at Western Sussex Hospitals NHS Foundation Trust and starts at Sussex Community on 10 October. Mr Jennings succeeds **Jonathan Reid** , who has moved to East Sussex Healthcare NHS Trust as director of finance (see page 32).

Jonathan Wood (pictured) has been appointed director of finance on an interim basis at Leeds Teaching Hospitals NHS Trust. He was previously director of finance at East Lancashire Hospitals NHS Trust. **Michelle Brown** succeeds Mr Wood as acting director of finance at the East Lancashire trust.

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

"Staff are genuinely excited about having the CQC back in a couple of months – they want to show what they have achieved"
Jonathan Reid, East Sussex Healthcare NHS Trust

Reid leads East Sussex

On the move

Although East Sussex Healthcare NHS Trust ended 2015/16 with a £48m deficit and is in special measures after being rated inadequate by the Care Quality Commission, new director of finance Jonathan Reid could not see an argument against taking the job.

'When I was looking at East Sussex, I thought to myself: "Who wouldn't go there?". The CQC report was clear – the staff are great, but were let down by history, infrastructure and leadership challenges, and the organisation wasn't getting the right opportunities to thrive. That's why I went for the job – it's a chance to contribute to helping the organisation fulfil its potential.'

Speaking eight weeks into his tenure, he adds that his confidence has been vindicated. 'Though the financial position is even more challenging than before I joined, it was the right thing to do. It's a fantastic place to be – the clinicians have great ambitions for the trust, but are also realistic about what can be achieved.

'Staff are genuinely excited about having the CQC back in a couple of months – they want to show what they have achieved, though they know there is still work to do.'

Originally from Northern Ireland, Mr Reid has worked at the National Audit Office and the Audit Commission, as well as for a commissioner and providers including Brighton and Sussex University Hospitals NHS Trust. He moved to East Sussex from Sussex Community NHS Foundation Trust, which he joined in 2011 as finance director. Since 2014 he was also deputy chief executive of the community trust.

At East Sussex, he says that as well as transforming services, areas that are 'broken' must be fixed. This includes reducing lengths of stay, improving flow of patients through the hospital, getting the right balance between emergency and elective work and ensuring that healthcare acquired infections are minimal.

'If you do these things, you would be surprised how quickly the financial challenge starts to come down. Colleagues across the trust are really focused on getting quality and operational delivery right, which makes the job of finance director really straightforward.'

Mr Reid wants to ensure he is a visible board member, spending more than half his time talking to staff and other stakeholders inside and outside the trust. He also wants to rebuild the confidence of his finance team.

'If you've been in turnaround for a couple of years, the team will be less confident about what it can contribute to the organisation. I have a fantastic team and part of my job is to support them to see that they can help the organisation address the financial problem.

'I also want to build a long-term financial road map for the trust and for the system.'

He intends to use the HFMA e-learning programme, the *Introductory award in healthcare finance* (previously *Introductory certificate in healthcare finance*), to support budget holders and correct a 'disconnect' between them and finance colleagues.

'It is a development opportunity for the budget holders and a good way to get people to think about how they can manage money,' he says.

Mr Reid is well aware that the size of the deficit could weigh heavily on staff – perhaps making them feel that any attempt to reduce it will be futile. The solution, he says, is to set sights firmly on the future.

'We must articulate the financial future for the organisation because at the moment it is hard for colleagues to see past the deficit. We must take that immediate financial crisis away and articulate what the future of health and social care in East Sussex will look like,' he says.

Mr Reid praises the support given to the trust by the local CCG, the CQC and NHS Improvement. He also adds: 'The Sussex and East Surrey sustainability and transformation plan has been a surprisingly enabling process for us. It has moved our challenges to the front of people's minds and helped to identify how the system can support us and most importantly what we can do to help ourselves.'

Toolkits bring efficiency focus

Future focused finance

The NHS Future-Focused Finance (FFF) efficient processes and systems action area has unveiled its first two process toolkits. The toolkits, developed with EY, cover 'procure to pay' (P2P) and 'hire to retire' processes, offering practical guidance on a number of areas. These include:

- Future-state process maps
- Key data attributes
- Risks and controls
- Technology and vendor options
- Example team structures and role outlines
- Key target metrics

The P2P toolkit, for example, gives a high-level view of an optimised function. It charts a process map for the P2P function from data management, through ordering goods and services, receipt, invoice processing and invoicing and reporting. It identifies risks and controls, including the provision of false supplier details, which can be controlled by accounts payable verification checks.

It also describes technology that could reduce costs and increase efficiency in three areas: enterprise resource planning/ledger and integrated reporting systems; invoice management; and workflow automation.

Several key performance indicators are described for the process, based on APQC data and drawing on the Carter report.

Efficient processes and systems action area lead Suzanne Tracey said: 'The tookits have been developed to help practitioners redesign processes and systems to reduce time on repetitive processing tasks and shift to financial insight and business partnering.'

- **For more on the toolkits, visit www.futurefocusedfinance.nhs.uk**

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