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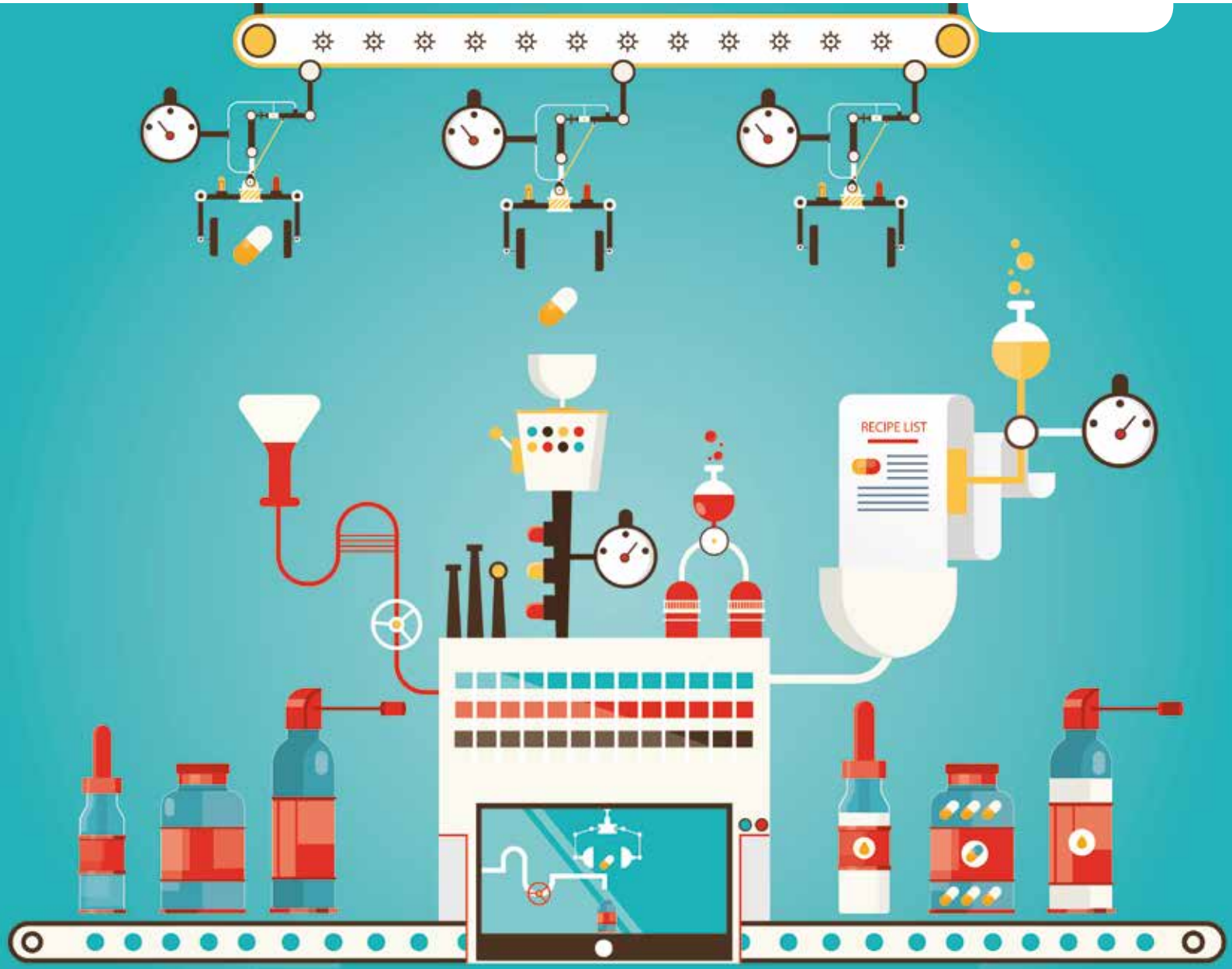

Bright ideas

Putting innovation on the production line

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winscribe

Identifying Missing Return on Investment from Technology

Paul Southwood, Marketing Manager at Winscribe, on getting the bang for your buck

Many Trusts have technologies for cost reduction and improvement that haven't met the promised ROI, highlighting efficiency gains and annually recurrent savings yet to be received. Winscribe and Bloor Research have put together their tips to find benefits from already implemented technology; to help scrutinise the existing technology on site to unlock the theoretical ROI and build a future-focused technological roadmap. Using some of these steps Sandwell, ROH & BCH Trusts have worked extensively on their clinical documentation technology, an area which can provide huge ROI in a short term.

Identify

"Identifying savings associated with technology is not as easy as vendors sometimes imply" explains Bloor's President Richard Rose. "I've seen huge ROI claims associated with buying, say, analytics software, because the contributions of the analysts and the business were ignored, and the business returns allocated entirely to the software purchase." To work out ROI he suggests;

1. Work out what the status quo is costing you. Defining scope is important. Remember that a person (full time equivalent) costs a more than just their salary (up to two times as much).
2. Repeat the calculation with or without the technology you are assessing. This will be an estimate, as the technology may change the process.
3. Tangible benefits are best. Beware of placing infeasibly high values on intangible benefits – unless you actually want to skew the results.

Decide what percentage of this saving is associated with the technology and what's the people or process – could you have performed better by retraining or hiring people without acquiring the technology? Remember, if you propose savings from staff reduction you will not get these until you sack or redeploy the staff gainfully. The costs associated with this should be included in your analysis. Whatever is laid out should be stuck to, ensuring that the ROI remains achievable. With all of this, the resultant analysis may end up as an 'informed guess' skewed by vested interests and politics. Bear this in mind.

> **Even proven benefits aren't necessarily realised when fully implemented and rolled out. Exploiting Technology is all about choosing the right system but then engaging with users to make sure it works. Only then can real efficiencies be gained. It's called change management!**
>
> *Chris Rodwell, Winscribe UK Head of Healthcare*

Change

When implemented the key to receiving the outlined ROI is user behaviour. Beverley Bryant, NHS Digital, in at NHS Confed illustrated this stating that operational productivity was 'not about technology, [but] about people'. This is the place of change management. Winscribe's knowledge of change management comes from why this failed in the past whilst working with over 90 Trusts. Our recommendations are;

1. Agree the **Nature of the Change**. Outline use cases and behaviours that provide the return on investment. List the reasons for the change, and ensure there are senior backers.
2. **Communicate to the individuals**. An accessible training plan (avoiding the 'no time to attend' excuse!), including one-on-one coaching. Highlight 'Exemplars' – those who readily adopt the new behaviours and help others to do the same.
3. **Communicate the process** and documentation project wide. Publish successful users. Resolve issues fast, communicating the resolution; a person's experience can become contagious.
4. **Publish** improvement data. Their involvement made this happen; allowing for people to be active participants or agents of change.

A structured approach to technology implementation whilst encouraging return on investment from existing technology will provide demonstrable cost decreases and efficiency gains. Our final advice is to ask help from suppliers; their vast experience in implementing the technology and providing the ROI is a valuable resource.

As the leading provider of document production software, Winscribe have been working with independent research company Bloor to develop an innovative independent analysis complementing Winscribe's own consultancy. Both believe in helping NHS Trusts to find recurrent savings within their existing document creation processes.

To hear more, sign up to the free webinar through the HFMA on 5th October 2017

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News

Baumann highlights change in risk reserve structure

By Seamus Ward

NHS England chief financial officer Paul Baumann has reminded the service that this year's risk reserve has a new structure, with providers as well as commissioners making a contribution.

Clinical commissioning groups have again been asked to set aside 1% of their allocations for non-recurrent investment. However, half of this – £360m – is uncommitted to provide a contribution to a system risk reserve to support the wider health system if required. The other 0.5% can be spent non-recurrently to support transformation and change under sustainability and transformation plans.

The £830m reserve, according to this year's planning guidance, is made up of £360m from CCGs; up to £200m from NHS England, funded from drawdown; and £270m from the provider sector. To create the latter contribution, the guidance said 0.5% of the local CCG CQUIN scheme would be held back. If a provider delivered its 2016/17 control total, the funds would be paid to the provider, but it is required to hold it as a reserve until authorised to release.

The CCG holds the reserve if a provider did not accept or failed to deliver its control total. However, in both cases, the funding will only be released for investment by the provider when it is demonstrated that the local health system is delivering its control total.

Speaking at the NHS England board meeting in July, Mr Baumann highlighted the contribution commissioners made to overall financial balance in England in 2016/17, when their 1% risk reserve (£800m) was fully used to help offset provider deficits.

> **"It is essential the professional discipline of commissioners in holding and releasing the system risk reserve is maintained"**
> **Paul Baumann (pictured)**

'This year the system reserve is constructed slightly differently, with commissioners and providers each contributing to the reserve – £560m from CCGs and NHS England, and £270m from providers in the form of a reserve within their CQUIN earnings.

'Given the deficits in provider plans and the significant in-year delivery risks in both commissioner and provider sectors, clearly it is going to be essential that the professional discipline of commissioners last year in holding and releasing the system risk reserve is maintained by both sectors this year.'

The commissioning sector as a whole reported a small underspend at month two, but it is forecasting it will end the year broadly in line with plan (£4.9m overspend, excluding the release of the 0.5% CCG risk reserve).

Mr Baumann said the figures do not include the impact of the capped expenditure programme (CEP), where 13 local health economies have made additional adjustments to their spending plans to ensure they keep within their spending envelopes.

'Successful execution of the measures under the CEP is absolutely essential if we are going to live within our means in the most challenging year for a long while.'

In the current year, commissioners planned to deliver efficiency savings of £3.4bn, almost £1bn more than 2016/17 – which was in itself a record year for efficiencies, Mr Baumann said. But he added: 'Most of the increase is due to come from transformational schemes, so the easy stuff is largely done; the difficult stuff lies ahead of us.'

HFMA Scotland shortfall warning

The HFMA in Scotland has called for the introduction of multi-year budgets for health and warned that the service could require efficiency savings of up to 5% this year.

In its response to the Scottish Parliament Health and Sport Committee, which is consulting on the government's draft Budget for 2017/18, the HFMA said budgets that covered a number of years would help develop longer term plans and support decision-making.

It recognised the extra funding allocated to health boards in the draft budget (a rise of £252m or 2.8%). However, the biggest additional sum was £107m for social care. The increase included the alcohol and drugs budget (almost £54m), which was previously in the overall health and sport budget. This leaves £91m available for health cost pressures (less than 1%).

While £72m of investment had also been ring-fenced for primary care, and extra cancer funding promised – £100m over the next five years – health boards are not clear how much should be spent each year.

The HFMA submission highlighted financial pressures, such as increased demand, new technologies, the apprenticeship levy of 0.5% of pay and historic pressures on prescribing costs.

It also referred to the HFMA research paper *Medicine costs in Scotland*, which highlights the reducing funds for the New Medicines Fund and the increasing costs of these drugs.

HFMA Scotland Branch chair Derek Lindsay said efficiency savings of around 4% to 5% (more than £400m) would be needed this year. 'The underlying budget increase available to meet health cost pressures is about 0.4%, after taking account of the reduction in the New Medicines Fund, and the remaining uplift in funding is committed to social care or other priorities defined nationally by the Scottish government.

'This means that to meet health cost pressures in the range of 4% to 5%, efficiency savings are required.'

New STP assessment sets baseline to measure partnerships' development

By Seamus Ward

NHS England insisted it now has a baseline position to judge the development of sustainability and transformation partnerships (STPs), following its publication of the first STP progress dashboard.

Each of the 44 STPs were categorised in four overall ratings – outstanding, advanced, making progress or needs most improvement. The ratings are based on performance against nine categories, including finance, demand management, leadership, emergency care and elective care.

While five STPs were rated outstanding, 18 were assessed as advanced, 16 making progress and five needing most improvement.

The finance rating is calculated as the overall financial surplus or deficit expressed as a percentage of the aggregate control total – the combined 2016/17 surplus or deficit of all the trusts and clinical commissioning groups in the area divided by the total resource available (financial control total).

Unsurprisingly, given the financial difficulties in recent years, the calculation produced a positive figure in only 19 STPs.

NHS England said the STP assessments would provide a baseline across the whole of each local system. It showed the scale of the challenge facing each STP. Its chair, Malcolm Grant, said the report should not be read like a report on failing schools. 'This is not an Ofsted report. This is a way of assessing maturity at the very early stages of what is a highly complex planning process and development of partnerships,' he told the NHS England July board meeting.

'The object of the exercise is to respect and reflect those who are truly outstanding. [It will also] identify where we can work closely with all the other partnerships.

'This is positive in its purpose and helps us to assess what are the next steps we need to be taking collectively to develop the STP process

UoR assessment

The new use of resources (UoR) assessment was launched this month with an initial focus on acute, non-specialist trusts. The rating will be used by the Care Quality Commission as part of its trust-level inspections, as well as by NHS Improvement to assess providers' needs under the single oversight framework.

The UoR assessment follows recommendations in the Carter report and is based on five key lines of enquiry (KLOEs), including clinical services, people, clinical support services, corporate services and finance. The initial metrics in the finance KLOE contain the finance and use of resources theme metrics in the single oversight framework.

Further intelligence will be gathered and assessments made before an overall rating (outstanding, good, requires improvement or inadequate) is determined.

NHS Improvement said that initially the CQC will publish separate UoR and overall quality ratings. However, from early 2018 it anticipates there will be combined ratings for UoR and quality. There will be a consultation in the autumn to seek stakeholders' views on how a combined rating could be developed and applied.

WPB handbook supports ACO development

A whole population budget (WPB) handbook has been published by NHS England and NHS Improvement.

***Whole population models of provision: establishing integrated budgets* is part of a suite of publications, some new and some updated, supporting the development of accountable care organisations (ACOs) and systems.**

Other documents look specifically at the incentive frameworks for ACOs and procurement issues.

The handbook has been in draft form for over a year and has been used by vanguard sites, and informed by their work, as they have set up new integrated models of service provision.

Existing activity-based payment systems – for example, using national tariff prices – are seen as incentivising activity, while block contracts provide little incentive to deliver services not specified in the contract.

Under current payment approaches, a provider wanting to deliver services more proactively in the community and focus more on prevention to reduce hospital admissions might be financially disadvantaged. Whole population budgets are seen as a way of incentivising providers to optimise services across whole pathways, with providers given greater freedom in how services are delivered and commissioners holding them to account for outcomes.

The handbook covers the key stages in developing WPBs, including using current spend on in-scope services to set the baseline budget. It also describes how improvement payment schemes can incentivise performance improvement across priority areas and covers gain/loss sharing mechanisms.

• See New payment model, Healthcare Finance July/August 2017, page 16

NHS ENGLAND

"This helps us to assess what are the next steps we need to be taking collectively to develop the STP process through to ACSs and ACOs"
Malcolm Grant, NHS England (above)

through to ACSs and ACOs.'

NHS England national director for operations and information Matthew Swindells added: 'In a year's time we will get a sense of how STPs are helping to move systems forward. It's a good baseline and tells us something about the way systems stand at the moment.'

The national commissioning body also published its annual assessment of CCGs, which is based around 29 policy areas, such as finance, delivery and outcomes. In 2015/16, 26 CCGs were rated inadequate, but this fell to 23 in 2016/17. CCGs assessed as requiring improvement fell from 91 to 66, while the number of good CCGs increased from 82 to 99. The number of outstanding CCGs doubled – from 10 in 2015/26 to 21 in 2016/17.

HFMA gives value an international platform

The HFMA Healthcare Costing for Value Institute is running a second international symposium examining how different countries are turning the theory of value-based healthcare into practice.

The October event follows a successful inaugural symposium on value last year. This followed earlier work by the HFMA to share learning on international approaches to improve clinical costing and to learn more about the German health service approach to costing and tariff setting.

Institute head Catherine Mitchell (below) said sharing understanding across country borders was crucial to supporting the development of value-based healthcare. 'There is a growing recognition across the world that healthcare must be managed on the basis of delivering better value – measured in outcomes and cost,' she said. 'There are examples in many countries of organisations and systems that are attempting to put the theory into practice.'

She added that many of the challenges – establishing robust outcome and cost data, engaging clinicians and finance practitioners and making information available in an understandable and timely way – are common to all health systems. 'It makes sense to know how other systems are squaring up to these challenges.'

This year's event will provide a platform for speakers from Germany, Sweden, the Netherlands, Australia and Canada, as well as involving UK-based case studies.

- The symposium, on 4 October, is open to institute member organisations. The HFMA is also offering places to HFMA Provider Finance Faculty members, as well as international delegates.

Training funds increase to follow students

By Steve Brown

Higher education institutions will be eligible for an immediate 4.6% uplift in the number of funded placements for nurse, midwife and allied health professional training. But they must work with local health organisations to secure up to 1,500 additional placements this year.

In a letter to the education bodies, Health Education England said the increase in placements this year was the first step in meeting the government commitment to as many as 10,000 additional clinical placements by 2020.

While the funding for 2017/18 will follow the students through their courses, any uplift in 2017/18 is not considered recurrent. Work on the funding mechanism for 2018/19 to 2020/21 is ongoing, though HEE said funding for a further 2,500 placements will be available in 2018/19.

The government also committed to training 1,500 more doctors a year by 2020 – a 25% increase in the number of domestic medical students. From next year, existing medical schools will collectively be able to offer an extra 500 places to future doctors, while the remaining 1,000 places will be allocated across the country based on an open bidding process. The extra places will be targeted at under-represented social groups.

Health minister Philip Dunne (right) said: 'We are committed to giving more talented students the chance to be part of our NHS workforce. Not only is this the biggest ever expansion to the number of doctor training places, but it's also one of the most inclusive; ensuring everyone has the chance to study medicine regardless of background, and ensuring the NHS is equipped for the future with doctors serving in the areas that need them most.'

In the shorter term, NHS England announced it was accelerating its recruitment of qualified GPs from overseas. This financial year it will aim to recruit 600 doctors, and a total of at least 2,000 over the next three years. Previously, the target was to recruit 500 doctors by 2020/21.

As well as asking recruitment agencies to join a framework to support the drive, NHS England said it was establishing an international GP recruitment office to manage the programme. Initially it will focus on doctors from European Economic Area countries – their qualifications are recognised in the UK under EU law.

NHS England director of primary care Arvind Madan said: "Most new GPs will continue to be trained in this country, and general practice will benefit from the 25% increase in medical school places over the coming years. But the NHS has a proud history of ethically employing international medical professionals, with one in five GPs currently coming from overseas.

'This scheme will deliver new recruits to help improve services for patients and reduce some of the pressure on hard working GPs across the country.'

News review

Seamus Ward assesses the past two months in healthcare finance

The NHS continued to create headlines this summer, often with familiar stories. Perhaps the most high profile was in late August, when Stephen Hawking and health secretary Jeremy Hunt clashed over the NHS's future.

Professor Hawking said he was concerned the NHS was slipping into a US-style insurance system and believed there was increased private provision – including the use of agency staff. 'The more profit is extracted from the system, the more private monopolies grow and the more expensive healthcare becomes. The NHS must be preserved from commercial interests and protected from those who want to privatise it,' he said. Mr Hunt said it was a 'pernicious falsehood' that the government wanted a US-style insurance system.

The cost of continuing healthcare (CHC) has been a worry for years and, according to the National Audit Office, the number of people in England assessed as eligible for CHC is rising. Between 2011/12 and 2015/16 the numbers eligible for funding increased from 125,000 to 160,000, it said, while spending on CHC between 2013/14 and 2015/16 rose by 16%. A report, *Investigation into NHS continuing healthcare funding*, said CHC accounted for 4% of CCG spending in 2015/16. It added that NHS England wants to make £855m of savings in CHC spending by 2020/21 – through administrative savings, reducing variation in spending and greater consistency in CCG interpretation of eligibility criteria. However, to date, it had not set out a costed breakdown of how it would deliver savings in the cost of care, the NAO added.

The cost of clinical negligence – another well-trodden line – was also highlighted. NHS Resolution (the new operating name for the NHS Litigation Authority) said it paid more than £1bn in damages to claimants in 2016/17– a 14% rise on the previous year, and despite a 2.5% fall in the number of new clinical negligence claims. The rise in compensation is partly due to payments for claims initiated in previous years. The amount paid to claimants' lawyers continued to rise, it said – up by 19% to almost £499m.

Local authorities are planning to cut public health budgets by around £80m this financial year, according to the King's Fund. Analysing figures from the Department of Communities and Local Government, the fund said, on a like-for-like basis, councils plan to spend £2.52bn on public health this year, compared with £2.6bn in 2016/17. The fund said cuts included a £30m reduction in sexual health service budgets, £22m less on tackling drug misuse in adults and a £16m reduction in smoking cessation services.

The UK exit from the EU is set to dominate news and will affect the NHS. In July, the Brexit Health Alliance – a group of 15 NHS organisations and pressure groups – outlined its five priorities for UK healthcare in the negotiations to leave the EU. The group includes medical royal colleges, industry bodies, NHS Providers and the NHS Confederation. The priority areas are: achieving maximum levels of collaboration on research and innovation; ensuring regulatory alignment to support better population health; preserving reciprocal healthcare arrangements; delivering robust co-ordination of health and wellbeing mechanisms; and securing a strong funding commitment to health and public health sectors.

The reverberations from this year's general election are also being felt. The deal struck by the Democratic Unionist Party and Theresa May's Conservative government brought much-needed funding for Northern Ireland, including at least an extra £250m for local health and social care this year and next. But the need is also great in Wales and Scotland and those nations'

This summer in quotes

'I urge you to lift the 1% pay cap for public sector workers in public bodies reserved to the UK government and to urge the independent pay review for NHS staff to do the same, just as I intend to do for the NHS and other employees of devolved public sector bodies in Scotland.'

In a letter to chancellor Philip Hammond, Scottish finance secretary Derek Mackay calls for a shift in pay policy

'These planned cuts in services are the result of central government funding cuts that are increasingly forcing councils to make difficult choices about which services to fund. The government must ensure councils get enough resources to fund vital public health services.'

David Buck, senior fellow in public health and inequalities at the King's Fund, warns about sexual health service cuts

'Our review highlights the extent of the financial challenge negligence presents to the NHS. By supporting NHS trusts to be candid and manage concerns fairly and openly when things go wrong, we hope to jointly deliver the learning that goes hand in hand with any claim for compensation.'

NHS Resolution chief executive Helen Vernon says clinical negligence must be tackled

'The arrangements offered to Northern Ireland read across to areas of devolved responsibility. For this reason, the benefits of the additional spending should be mirrored across all parts of the UK. By operating in this way, the UK government has failed to provide Wales with the resources to invest in infrastructure, the NHS and education system – depriving Wales of an additional £1.67bn.'

Welsh finance secretary Mark Drakeford says Wales should receive its fair share following the Conservative-DUP deal

SHUTTERSTOCK

"The NHS must be preserved from commercial interests and protected from those who want to privatise it"
Professor Stephen Hawking

governments have opened a formal dispute resolution process over their right to receive extra funds following the DUP deal. The Scottish and Welsh governments said they should receive consequential funding as a result of the deal. If the Barnett formula was applied, Wales would receive an additional £1.67bn and Scotland £2.9bn, they said.

The NHS in Wales must develop new models of care and streamline governance, finance and accountability arrangements, says the interim report of the *Parliamentary Review of Health and Social Care*. The review said the new models should enable primary, secondary, community and social care services to work together more effectively, and there should be a focus on continuous quality improvement and prevention. The final report is due by the end of the year.

A reduction in prescriptions for ineffective, over-priced and low-value treatments has been targeted by NHS England. The commissioning body launched a formal public consultation on draft national guidelines, drawn up with GPs and pharmacists. The guidelines say 18 treatments – which cost taxpayers £141m a year – should generally not be prescribed, including homeopathy and herbal treatments. It suggests limiting prescribing products for minor conditions such as cough mixture and cold treatments, eye drops and laxatives. Prescriptions for these self-limiting conditions currently cost taxpayers £50m-£100m a year.

In August, Wales health secretary Vaughan Gething said a £50m funding package will help the local NHS target improvements in waiting times for elective surgery, diagnostics and therapies. He said demand for hospital services had risen by 20% in the past five years. Though referral to treatment indicators had improved in the past two, further gains were needed. He also announced an extra £1m for end-of-life care.

The Scottish government will end the 1% public sector pay cap from the 2018/19 pay round. In a letter to chancellor Philip Hammond, Scottish finance secretary Derek Mackay said he would work with unions to develop a public pay policy that reflected inflationary pressures and affordability. Some uplifts, such as for the NHS, are set at UK level and Mr Mackay urged the chancellor to lift the cap.

Meanwhile, the Senior Salaries Review Board said executive and senior managers in the Department of Health arm's length bodies (ALBs), should receive a 1% pay rise. The report said that, with limited data, there does not appear to be a problem with recruitment to the ALBs, but failure to make an award averaging 1% could have a detrimental effect on morale during a highly challenging time for the NHS.

Former Department of Health director general, finance, Richard Douglas (pictured) is now the interim chair of NHS Improvement. The appointment will be until the end of the calendar year or until a substantive chair is appointed, whichever is sooner.

NHS Employers warned that staff incentives such as prize draws to increase flu vaccination uptake could be seen as inappropriate use of public money. Incentives are suggested in a NICE draft consultation. But NHS Employers said a more appropriate incentive would be offering vaccinations in developing nations in return for getting the flu jab.

from the hfma

The HFMA has been busy over the summer, publishing briefings and reporting on a number of surveys. There were briefings on the financial challenges facing general practice (produced with NHS Future-Focused Finance, see page 13) and medicines costs in Scotland – this explains the medicines approval process and how it differs when medicines for rare or end-of-life conditions are being considered.

In August, a survey examining the maternity pathway payment mechanism showed that all respondents experienced day-to-day problems with provider-to-provider payments or recharges. The survey was initiated by the NHS England pricing team and supported by the HFMA National Payment Systems Special Interest Group to identify issues ahead of the 2019/20 national tariff.

In his latest blog for the HFMA website, Bill Shields, who moved to Bermuda earlier this year to become chief financial officer of its hospitals board, describes his first experience of appearing before the territory's Public Accounts Committee – a much lower key affair than its Westminster counterpart. Look out for the next instalment (www.hfma.org.uk/news/blogs), which will be available early this month.

Each week during August, the HFMA policy and technical team has been looking at key aspects of its work. Topics have included:

- Partnership working
- Governance
- Costing and value
- Payment systems.

Visit www.hfma.org.uk/news/blogs for further details.

News analysis

Headline issues in the spotlight

Back in the spotlight

There will be a renewed focus on the NHS during the autumn as the government sheds more light on its funding plans, says Seamus Ward

This year's election marked the high point of discussion of health and social care finances, with all the major parties promising additional funding for the NHS.

Since then it's been quieter, perhaps due to the focus on talks about Britain's exit from the European Union and then Parliament's summer recess. But even without the profile afforded by the election campaign, health service pressure groups, unions and think tanks have still been voicing concern about the future of the NHS.

An early sign that the NHS is set to jump back into the headlines came in a warning from Stephen Hawking about the future of the service. The *Brief history of time* author, who has lived with motor neurone disease most of his adult life, was concerned about the role of the private sector in the NHS, including the use of agency staff. He claimed the government had failed to undertake 'proper due diligence' in respect of the availability of staffing for seven-day services.

He also claimed that there were signs the NHS was moving to a US-style insurance-based system. This was false, according to health secretary Jeremy Hunt, who added that the proportion of people with private medical insurance had fallen since 2009.

A brief skirmish perhaps, but warnings on the future of the NHS will likely come further to the fore as summer turns to autumn. There will be a short return to Parliament in early September, before party conference season, and then Parliament will be back in full swing from 9 October.

In November or early December, chancellor Philip Hammond will deliver his first autumn Budget. Under a new timetable introduced this year, the Budget timetable has been flipped on its head and the Budget will now be in the autumn, with a financial statement in spring.

In terms of NHS finances, there are a number of things to look out for in the Budget. Will the Conservatives make good on their election pledges to increase NHS funding by £8bn in real terms over the next five years and deliver an increase in real-terms funding per head of population for every year of the Parliament?

The Tories' commitment to their manifesto has at times been sketchy – as the shift in policy on social care funding showed. And, as with all parties, there's a talent for sophistry (last Parliament's controversy over whether health was getting £10bn, £8bn or less over five years is still fresh in many minds). So any announcement on NHS funding will be under the microscope.

The Institute for Fiscal Studies said the Conservatives' manifesto pledge suggested an increase in Department of Health spending to £132bn (today's prices) by 2022/23, assuming all other aspects of Department funding were frozen in real terms. This would amount to an average growth of 1.2% a year between 2016/17 and 2022/23. Current plans – set out in the 2015 spending review – would see an average 0.8% real-terms rise in Department spending between 2017/18 and 2020/21.

"There is simply not enough capacity in the system to assure patient safety in the winter. We need an immediate decision on whether trusts will be funded to cover the current capacity gap"
Phillippa Hentsch, NHS Providers

On current plans, the IFS said real terms per capita spending is set to fall slightly in 2018/19 and 2019/20, though it will be 3.5% higher than in 2009/10. When the figures are adjusted to take account of the age of the population, however, by 2019/20 age-weighted per-capita spending will be 1.3% lower than 2009/10 levels, it said.

Though any increase in funding will be welcomed, the NHS will have to deal with inflationary pressures, including the pay bill. There was pressure during the election campaign to end the 1% cap on pay rises, with Mr Hunt signalling his sympathy for the case put by the health unions.

Staffing is an issue, generally and in particular specialties and regions, and this is putting additional pressures on pay spending.

An NHS Providers survey, published in July, said that more than 70% of mental health providers expected increased demand this year, but fewer than one in three were confident they had enough staff to deliver the current demand, never mind extending services or creating new ones.

Meanwhile, NHS Digital said that in England NHS bodies advertised more than 86,000 vacancies between January and March this year. Nurse and midwife positions accounted for nearly 40% of these.

The Nursing and Midwifery Council (NMC), which registers nurses and midwives to practise in the UK, said the number of nurses leaving the profession had outstripped those joining for the first time. Although there has been a recent focus on the falling number of nurses from European Union countries registering to work in the UK, the NMC said that the overall downward trend was mainly due to UK nurses and midwives leaving the register.

Capital funding is likely to attract a lot of attention at Budget time. Sustainability and transformation partnerships (STPs) will be hoping for an announcement on capital funding.

SHUTTERSTOCK

Department of Health budget plans

	2016/17 (estimate)	2017/18	2018/19	2019/20	2020/21
Resource	£116.1bn	£117.6bn	£120.3bn	£123.2bn	
Capital	£4.6bn	£6.1bn	£6bn	£6bn	£5.9bn

SOURCE: HM TREASURY, SPRING BUDGET 2017

In the last spring Budget, in March, Mr Hammond allocated an additional £100m in capital funding to aid A&E department triage and increase provision of on-site GP facilities.

He announced £325m of capital investment over three years for STPs that had the strongest cases for investment – this was allocated in July to 15 areas, including up to £50m for Greater Manchester to concentrate urgent and emergency care across four hub sites.

He promised further STP capital. The Budget document said: 'In the autumn, a further round of local proposals will be considered, subject to the same rigorous value for money tests.

'Investment decisions will also consider whether the local NHS area is playing its part in raising proceeds from unused land, to reinvest in the health service.'

During the election campaign, Theresa May committed a re-elected Conservative government to boosting NHS capital funding by £10bn over the course of the Parliament. Backing the recommendations of the Naylor report on NHS property, which was published in March, she said the funds would come from a variety of sources.

The Naylor report said £10bn could be needed and identified the potential for the NHS to release £2.7bn from the sale of surplus property. This figure is adjusted for risk, though the report noted receipts could rise substantially if the NHS takes a more commercial approach to sales – for example, by first obtaining planning permission.

It also said the balance of the required funding could come from the Treasury and private investors. NHS Improvement has explored the potential for private finance to fund new buildings in secondary care and more details may emerge this autumn.

A&E performance

Operational performance will continue to concern clinicians and managers, as well as the public. The latest figures for A&E waiting times in England show some improvement on the winter months, but it is now two years since the 95% standard was met. In June, 90.7% of patients were admitted, transferred or discharged within four hours. This dropped marginally to 90.3% in July.

In Scotland, 95.5% of patients were seen within four hours in June, but the other devolved nations did less well, though they showed signs of improvement.

In Northern Ireland, 81.2% of patients were seen within the four-hour target in June – an improvement on June 2016, when the standard was met in just over 75% of patients.

In Wales, 84% of patients were seen within four hours in June – 0.7 percentage points higher than June 2016.

It is clear A&E performance throughout the UK is affected, at least in part, by the rising number of attendances and this tide is unlikely to subside in the winter.

Commenting on the NHS England figures, NHS Providers head of analysis Phillippa Hentsch said the service was working at full stretch even during the summer. Despite the efforts to focus on A&E performance, it remained similar to June and July 2016.

'The lesson here is that there is simply not enough capacity in the system to assure patient safety in the coming winter. We need an immediate decision on whether trusts will be funded to cover the current capacity gap.

'We estimate that somewhere between £200m and £350m is required – that must be something we can find within an overall health budget of £124bn.'

Urgent action was needed to help the service prepare for winter, she said. Efforts should focus on reducing delayed transfers of care (DTOCs), especially patients waiting for a care package in their own home – in June these patients accounted for 21% of all delayed days.

'The lack of progress in reducing DTOCs for patients who are ready to move on is particularly worrying, as this leads to longer waits right across the system, including for those who need to be admitted,' said Ms Hentsch.

'The increase in DTOCs attributable to social care – especially those waiting for suitable support in their own home – must be addressed.'

The NHS is entering its busiest period with many questions hanging over it, particularly on funding. Some of these will be answered in the autumn and, though additional funding is likely, it could lead to more questions.

Will it be enough or can the NHS safely make up any shortfall?

Comment

September 2017

Brothers in arms

Individual trusts must play their part if whole systems are to succeed together

HFMA president Mark Orchard

Those of you who know me will understand that I am very excited by the news that the Brownlee Brothers – Olympic medal-winning triathletes and former world champions – will close this year's HFMA annual conference in December.

Triathlon is a brutal sport that requires mental toughness as well as physical strength and mastered technique. To swim, cycle and run in a single long-distance competitive event is not for the faint-hearted.

In our own game, we also have a triple aim: better health, better care and value for money. And in recent years we have increasingly discovered that system collaboration is the binding force for effective patient services.

In that sense, success has become a team game, where whole systems need to work together to avoid sub-optimal outcomes for service users, who should not be concerned with organisational boundaries.

We will all have our favourite sporting memories. Witnessing Alistair Brownlee forgo his individual race to carry his exhausted younger brother Jonny over the finishing line at the Cozumel Grand Finale last year, is one that's hard to beat. The race was gone and getting to the finish line was the fastest route to medical attention – in a split second nothing else mattered.

I can think of no better metaphor to illustrate how, despite best plans, sometimes the margin between success and failure can be so narrow that the definition of success changes on the journey.

In our world, organisational recovery plans are the consequence of actual performance falling short of carefully planned

On the reading list

Annual accounts are more than a governance tool and should command a wider readership

Healthcare Finance editor Steve Brown

Many of us will have recently been through the stress of exam results. Perhaps not personally, but we may have shared the nerves with friends, children or other relatives as they waited and received results for GCSEs, A-levels, highers and other exams.

The focus is exclusively on the grades achieved. This is completely understandable as – rightly or wrongly – the grades are so important in enabling the students concerned to make their next step.

But from a learning perspective, they can be frustrating. Why did a student perform as they did – what went well, what went disastrously? There is no analysis – no performance report – that provides an insight into what the student had understood and got right and where work might still be needed if the goal was understanding the subject rather than simply meeting entry requirements for the next stage.

The Department of Health's annual report can be treated somewhat similarly. From the media's, and therefore the public's, perspective, It is all about the result: in this case, did the Department achieve financial balance – not a given in recent years?

In reality, we generally know the broad answer before the annual accounts and report hits the streets. Providers' final figures for 2016/17 (a net deficit of £791m) were published in June. And, although, there was no formal confirmation, NHS England chief executive Simon Stevens used a mid-June conference to reveal that the commissioning sector had delivered its side of a system balance bargain by finishing the year with an underspend of just over £900m.

The Department's annual report, published in July, provides final official confirmation that the service crossed the financial line, adding in all technical adjustments and covering the wider departmental group. But unlike a simple pass/fail result card, the annual report does delve into performance, including performance against core standards, and drills into the detailed spending in different areas that underpin the overall financial position.

Okay, the report might in general put a positive spin on the figures, achievements and context within which the NHS is operating. But, nevertheless, there is a wealth of detail on

"Without corrective action, maintaining a positive cash balance will be an even bigger challenge later in the year"

assumptions. Increasingly, sharing risk (and reward) across whole health and care systems is seen as the future. But old habits may be hard to break.

How could each party assure itself that others had done everything within their gift to do what they said they would do – effectively controlling their own operating cost – before seeking a system offset?

In Dorset, despite having agreed a 'one NHS' approach to delivering the aggregate of individual financial control totals, putting this to the test is something we are all desperately keen to avoid.

Having delivered within agreed planning parameters for each of the last three years since coming out of financial special measures, Poole Hospital reported adverse performance against plan for both June and July. The single biggest reason for this relates to an increase in the cost of pay, with an unforeseen hike in our reliance on premium rate agency nursing staff.

There are many factors at play, but with such a fine margin between success and failure, subtle changes can move you to the wrong side of the line. Our run-rate is enough to confirm that, without corrective action, maintaining a positive cash balance will be an even bigger challenge later in the year.

Time will tell whether the corrective action we have taken will be enough to move us back into planned run-rate by the end of the summer.

Without any doubt, Poole Hospital will do everything and anything to continue to self-finance the high-quality services that we are proud to deliver for Dorset. After all, delivery maintains our autonomy, and ultimately secures our licence to continue to operate.

We are now approaching the business end of the financial year – the time when we define success in the current period and plan for success in the next.

It seems to me that, as we move sensibly towards a greater system focus, increasingly in the future we may need to look to our metaphorical siblings for the support needed to continue to cross the line again and again.

However, individual trusts must play their part if whole systems are to succeed together.

Contact the president on president@hfma.org.uk

offer. Much of it may not be 'news-worthy', but there is a huge amount of information that could be classed as 'of interest'.

Accounts clearly have a formal role in governance and holding organisations to account. But with such wide-ranging data on performance – some high level and some detailed – they should surely have a broader audience too.

At a simple level, the accounts should provide an authoritative source for wide ranging NHS financial figures. Various figures get bandied around by commentators for NHS or healthcare spending. Often, these are correct, but you need to know the context – are we talking about revenue and/or capital, gross or net spending, or spending within the NHS or including arm's length bodies and the Department itself (see *Reading the numbers* page 25)? The report provides some context for all these various figures.

And it is not all spin. The Department acknowledges that 'the plan to deliver financial balance did not work as well as planned' with funds earmarked for transformation diverted towards improving the overall position. And the Comptroller and Auditor General's explanatory report, included within the publication, underlines that the system remains under considerable pressure and is still some way from achieving financial sustainability.

There are progress reports on the DH2020 change programme, aiming to ensure the Department has the right skills to lead the health and care system effectively, while operating with reduced running costs.

"With such wide-ranging data on performance, the Department's accounts should surely have a broader audience"

Some 573 staff left the Department through early release or voluntary redundancy. This has helped to increase median earnings as a higher proportion of leavers have been from junior grades. Together with the highest earner in the Department earning less than in 2015/16, the ratio of highest paid director to median earnings has fallen.

Annual accounts are unlikely ever to become general reading matter for the whole population. Despite attempts to improve transparency, you still need a reasonable understanding of finance – and at times accountancy – to get a full understanding of what the numbers mean. But there has to be a happy medium between the annual accounts being broadly ignored and them becoming a high-street best seller.

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primary support

With the shape of general practice and the services it offers shifting, the HFMA and FFF set out to identify how finance professionals could help meet GPs' changing needs. Seamus Ward reports

A lot of the commentary around service transformation and new models of care has focused on the impact on hospitals, but less has been said about how it will affect general practice. Like its hospital-based counterparts, primary care is battling with rising demand and workforce shortfalls. Add in practice closures and new demands such as evening and weekend access, as well as the potential transfer of care out of hospital, and there is also uncertainty about the future structure of general practice.

Against this background, the HFMA and Future-Focused Finance (FFF) launched research earlier this year to gather GP and practice manager opinion about the sustainability of general practice and to clarify the support they need to manage the financial challenges ahead. The report, *The financial challenges facing general practice*, published in July, says that on the first count the message is clear – 87% of respondents were either not at all confident or had concerns about the financial outlook for their practice in two or three years' time. Respondents said the most significant pressures were: the inability to meet existing or growing demand within current core funding (94%); growth in obligatory costs (90%); and capacity needed to deliver additional activity (90%).

Looking ahead

Despite the gloomy financial forecast, just under two-thirds thought their practice would still exist in five years – either as a distinct organisation or as part of a larger provider such as a GP federation or alliance. The remainder believed their services would be provided by acute or community service providers. While some GPs have voiced fears about being railroaded into new service structures, in the survey there was a clear preference for practices to get together in federations or other forms of merger. Respondents felt these models, rather than being part of acute or community providers, were more likely to promote general practice sustainability.

The survey said there was a gap in financial knowledge, with respondents calling for training on the financial implications of federation or alliance working, as well as broader aspects of NHS finance, including clinical commissioning group finance, NHS contracts and the *Five-year forward view.*

Liz Angier, a portfolio GP in Southampton, points to the training priorities of family doctors and practice managers. 'Finance training is always needed,' she says, 'maybe not in the traditional aspects, which they are already familiar with, but on newer forms – such as on federation/alliance, primary care and wider NHS finance.

'The survey shows they want that type of training, but also the training requirements might be specific to different layers of the workforce – salaried GPs, locums and partners might have different interests.'

FFF *Clinical partnering* lead Sanjay Agrawal – who is also consultant in respiratory and critical care medicine at the University Hospitals of Leicester NHS Trust – says there are several points to take away from the survey. 'Many general practices are worried, or at least not confident, about the future,' he says. 'That worry is around a number of areas – whether they are going to be in the same form as today, a federation or part of a PACS [primary and acute care system] or MCP [multi-specialty community provider].

'Most felt they were going to change in some way, but the preferred model was a federated model. Even then, they are worried about how they get from where they are today to the best federated model.'

Federations are defined quite broadly, says Dr Agrawal. Some are formal, sharing back office functions, for example, while others are federations in name only and lack the focus on collaboration. 'That's why we identified that it's not just about the information, it's about the skill set or helping them to be able to federate. That's where they want more input, whether from CCGs or local medical committees.'

The report recommends CCGs undertake detailed capacity planning for work transferring from secondary to primary care and ensure training and recruitment needs are met. CCGs and local medical committees (LMCs) should discuss future models with small practices and the former should consider providing non-recurrent funding and professional advice to support the development of federations and alliances. It adds that CCGs should work with federations and alliances to find the most efficient ways of releasing back-office savings.

Dr Agrawal suggests closer working between LMCs and CCGs locally could produce the best outcomes. GPs are more likely to see LMCs as

friendly, while CCGs can drive forward the NHS England agenda.

He adds that training on the finances of the wider NHS could be useful, but resources will also be needed. 'The ills of general practice will not be cured with just a bit more training. In the survey, people are making the point that they are under-resourced for the demand that's currently there and it's likely to grow, based on the ambition of moving secondary care services out of hospital and into primary care. There's a resource gap for staffing, for back office and for other skills.'

Data collection burden

The burden of data collection on general practices seems 'enormous,' Dr Agrawal says, and he was surprised how much information was required. Survey respondents said information provided by CCGs varied and, though most received information on spending on medicines, just over a quarter were given figures for direct access diagnostics. GPs wanted to receive data on medication spending, with local and national benchmarks, while practice managers were also interested in more information on secondary care referrals.

The report suggests that CCGs should streamline their data requirements, only collect information that's absolutely necessary, and ensure that the practices understand why the data being collected is needed. Commissioners should consider how performance information could be collected centrally from existing data sources to minimise the burden on practices.

CCGs need a greater understanding of general practice and the fact that they are small businesses that depend on smooth cash flow, Dr Agrawal says. The report recommended organisations contracting with general practice recognise the commercial realities of general practice and ensure payment for additional services is simplified and aligned to the underlying cost profile of the service delivery.

'Contract payments come in a block every quarter or every year, but you have to pay staff every month. There must be a better alignment of payment for work,' he says.

Dr Angier adds that if practices don't get paid on time they cannot recruit or retain staff and run their service, which is facing many complex demands. Ongoing payment delays can interrupt workforce remodelling and planning. Workforce capacity and new ways of delivering the service need to be supported financially for the shift in care to the community to be realised, she says.

Would the recommendations lead to a change in CCG duties, giving them a more strategic role? This could happen, Dr Angier says, but there may be a question mark over the long-term future of individual CCGs. Perhaps local commissioning groups could become part of the wider sustainability and transformation partnerships, which are acting strategically.

'Hospitals and CCGs, and now STPs, are trying to look at costing healthcare pathways, but this is nuanced and difficult,' she says. 'How do you calculate return on investment? Would this include a marker for avoidance of admissions, fewer emergency admissions or inpatient bed days, fewer initial outpatients, fewer follow-ups, or better patient outcomes and experience and quality or life?

'There will also be a cost of upskilling staff and equipping integrated teams to deliver care in the community.'

However, there could be advantages, particularly given that many STPs are looking at population-based health models with population sizes of 30,000 to 50,000 – which is seen as the optimum range for good population health management. 'In an ideal world, it would mean clear and quick transactions, the ability to have funds to employ interdisciplinary teams, dashboards that monitor activity and outcomes and peer support for practices,' says Dr Angier.

"Many general practices are worried about the future in a number of areas – whether they are going to be in the same form as today, a federation or part of a PACS or MCP"
Sanjay Agrawal, FFF

The report recommends CCGs provide support and appropriate costing information to practices involved in designing new pathways to ensure decisions are financially sound. The HFMA has started masterclasses on costing pathways, Dr Angier says.

She adds that, in the future, a combined approach – with finance staff working alongside clinicians, looking at guidelines and current practice and then considering which treatment and information is best for patients as part of a pathway – could lead to shared learning in delivering care and better outcomes. Closer working between clinicians and protected and funded time for training in finance matters could help solve some of the current difficulties.

Unanswered questions

The survey covers some aspects of primary care, adds Dr Angier, but many questions are still unanswered and future surveys could be devised to look at ongoing barriers and facilitators in the changing landscape.

'The development of trust, and good working relationships with local finance directors, is important,' she adds. 'It may be time they played a wider role in sharing their expertise while also being supported to understand the different clinical contexts and the population-based health approach.'

General practice is in a state of flux, with uncertainty over future delivery models and finances running in parallel to rising demand and workforce issues. But practices would welcome the help of finance professionals – to explain the financial implications of new models, as well as broader aspects of NHS finance, to help them move to the new federations and alliances; to support greater efficiency; and to work with them to develop financially robust patient pathways.


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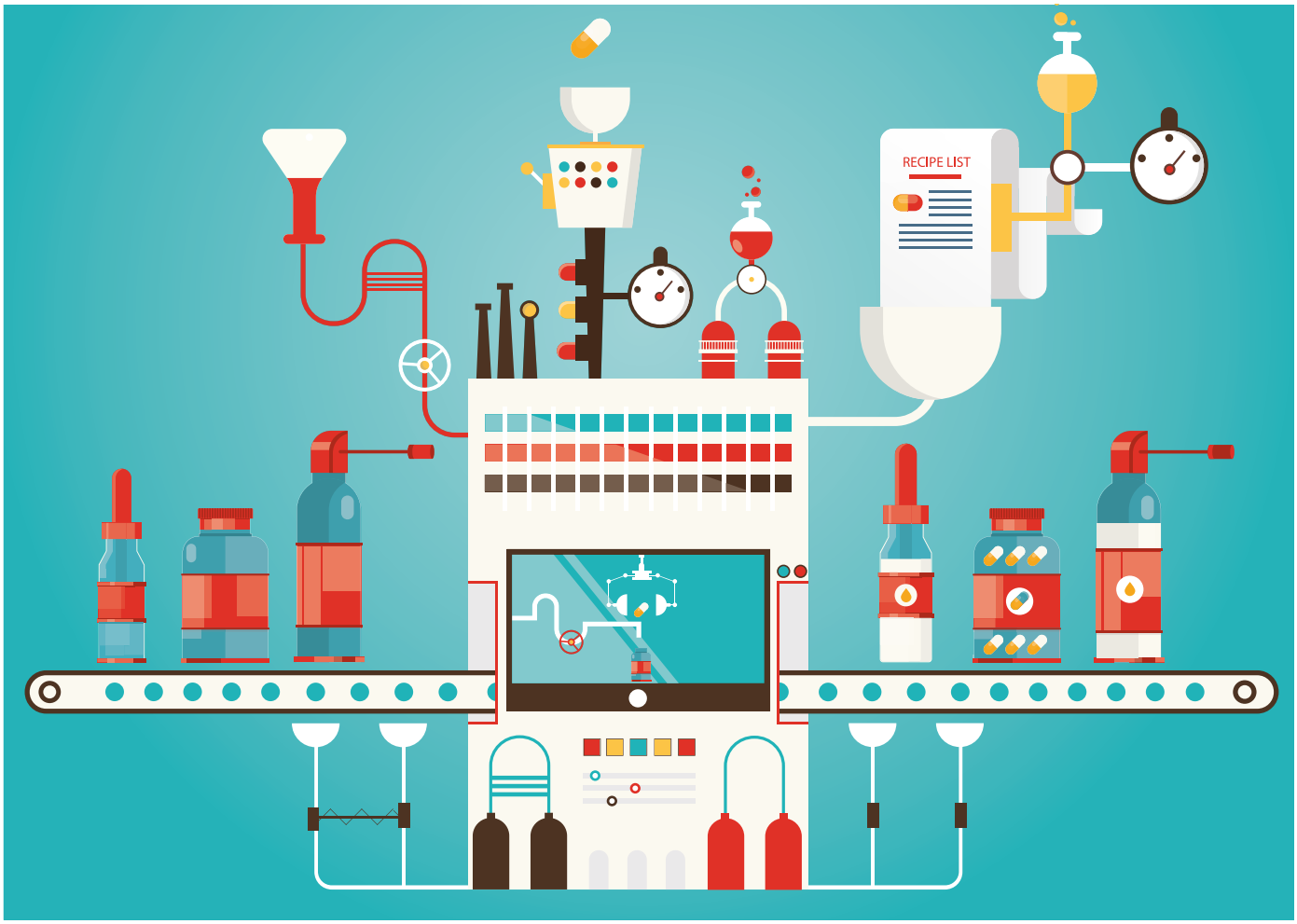
Ideas factory



Some NHS providers have increased their income by developing their own commercial services. Seamus Ward reports

It is well known that some trusts earn additional income outside the day-to-day activity of treating NHS patients. Many will be familiar with private patient services or providing payroll or sterile services to other NHS organisations, for example. But how surprising would it be to learn that a trust has developed its own range of skincare products that's on sale online and on the high street, with the profits funnelled back into the NHS?

Salisbury NHS Foundation Trust has such a range – MyTrusty – as a result of work by clinicians to help patients with dry or damaged skin. The first cream, based on sunflower oil, was made in the hospital pharmacy in 1987. But demand grew, not just from patients, but also staff and the public, and in 2012 the trust decided to commercialise the product.

Malcolm Cassells, who retired as the trust's finance director last month, has been a key figure in commercialising the product. He says the driver for putting the range on wider sale came from staff, patients and customers. 'They think it's wonderful, and the nice thing about it is that we've managed to get it out to far more people, who are now benefiting from it.'

The range is stocked in larger branches of Tesco, Superdrug and 500 Lloyds Pharmacy stores. There are six products in the range, though further products are in the pipeline.

Mr Cassells says: 'There's been a lot of learning. You need to get the expertise in to help – for example, in terms of marketing. We've had publicity over the years – the product's been on TV and in the national papers – but we've never managed to use that to enable the sales to really take off.

'We've had enormous numbers of sales on the website – thousands of customers – but because we didn't understand the market it is only since we started to put it in large retailers that we are starting to see good growth. This will be worth a lot more going forward and international sales will increase the potential.'

The MyTrusty range is still overseen by the trust, though there are plans to move it into a spin-off company. 'When we do that, it could well be worth a lot more in due course. That's very exciting and has huge potential for this trust in the future,' Mr Cassells says.

Many trusts have income generation schemes. These could involve charging for

certain services, such as private rooms, or commercial ventures, including pharmacy or estates services.

Trusts have set up commercial departments or separate companies and entered into joint ventures to sell products ranging from management consultancy and software to education. Some offer their buildings as real-life settings for films and TV shows.

But, as the NHS commercialises its innovations, there are questions. Should tight NHS funds be used to support a non-core activity that may never reap a dividend, or if it does it could be years? And what of the NHS name? Is it acceptable to use this trusted and recognised brand, perhaps putting NHS funding and reputation at risk?

Managing the risks

Mark Stocks, a partner with Grant Thornton, which recently published a report on NHS companies, says the risks are manageable. 'I don't think the financial risk is that significant because they can be limited by guarantee or through a limited liability partnership.

'There are risks, particularly where a trust invests heavily in something that fails, but why take that level of risk? If something is too big, it's better to take a commercial partner to limit it. The risks are manageable, but you need the right people in place to manage the risks.'

The Department of Health set up seven – now six – regional innovation hubs in the 2000s to capitalise on NHS innovation and support NHS bodies in what for many will be unfamiliar territory. The North West hub, known as Trustech, provides legal and commercial support to local NHS organisations and helps find development funding. Hosted by Central Manchester Hospitals, Trustech has a collaboration agreement with the University of Manchester.

Its efforts to bring forward ideas have led to *Dragons' Den*-style events – one, organised with Salford Clinical Commissioning Group, examined digital innovations from within and outside the NHS. As a result, two ideas from Salford Royal NHS Foundation Trust – a pharmacy communication platform and an electronic solution to help those at risk of falls live in their own home – are being piloted.

Trustech's business development and partnerships director Raj Purewal feels the NHS may still not be exploiting the potential of its ideas but that there are barriers to commercial development. Medical technology can take time to develop – 12 years from bench to bedside in some cases, Mr Purewal says.

He adds that NHS organisations may find it difficult to justify diverting money away from frontline care. 'The NHS tries to harness its innovations, but it has competing demands,' he says. 'Inventions can raise funds, but the remit of the NHS is to treat patients. Its job is not to raise funds, but to deliver care and provide treatment.'

The good news is that external funding is available – business grants, university research and development funding and private equity – but specialist help is needed to access these funding streams. And Mr Purewal says these interests will often seek a return for their investment, reducing the amount that can go back into the NHS.

The tariff can be a barrier – providing a disincentive to the adoption of innovations that move care out of hospital, for example.

Despite such barriers, he still believes the commercial development of NHS innovations is worthwhile. Indeed, Trustech has helped local NHS organisations develop a wide variety of products, from a device that treats difficulty with swallowing (dysphagia) to training packages for giving emotional support to cancer patients and a rehabilitation device that helps patients with lower limb injuries.

A partnership between Trustech, University Hospital of South Manchester NHS Foundation Trust and the University of Manchester developed a new device for fixing ruptured anterior cruciate ligaments (ACLs). The ACL stabilises the knee joint when changing direction. However, ACL reconstruction can fail in up to 80% of cases because fixation fails in the immediate post-operative period.

"There's been a lot of learning. You need to get the expertise in to help – for example, in terms of marketing"

Malcolm Cassells

Salisbury NHS FT's MyTrusty skincare range

An alternative was developed by an orthopaedic surgeon at the trust, together with mechanical engineers from the university. Mr Purewal says the device, known as GraftBolt, reduces the failure rate to 20%. Trustech and university funding was used to develop the device and it has been on the market since 2010, sold under a licence agreement negotiated by Trustech.

First NHS company

Salisbury NHS Foundation Trust has a wide range of commercial activity. As well as MyTrusty, the trust set up Odstock Medical – the first NHS company – in 2005, which now trades nationally and internationally. It supplies electrical stimulation devices, which can help in the rehabilitation of people with loss of limb movement through stroke, multiple sclerosis or cerebral palsy, for example.

It also set up the South West Innovation Hub in 2007 and, although this ceased trading from April this year, it will continue to collect royalties. It has helped to promote innovation in the South West and also protect and exploit NHS intellectual property.

Its laundry company, Salisbury Trading, was spun off from its internal laundry service in 2013 and trading is expanding. 'The laundry is a case study in what you can achieve,' Mr Cassells says. 'If you look back five years, the laundry was losing a lot of money and we tried many things to improve that. We eventually decided to put it into a company, bring in commercial management, do more marketing and develop the quality – and we've never looked back. We've turned a loss into a healthy profit. The company has huge potential for further development and other NHS laundries are now being acquired or established.

'The really nice thing is that it's saved the NHS large amounts of money recurrently

because we work with other trusts to reduce the amount they spend on linen. The reject rate is low and we work with trusts to reduce the amount of linen they use. This is the opposite of what private sector competitors do.'

The trust has one joint venture, SSL, which provides sterile supplies. Another, Healthcare Storage Solutions, is being launched to market an electric bed stacking system for storing beds close to where they might be needed.

In all of these enterprises, the focus is always the customer and services, insists Mr Cassells. 'We recently took over a very large payroll and we are looking to save our clients money. We have a lot of expertise to help them change their systems and avoid overpayment and ensure staff are paid properly and promptly. I get great satisfaction from customers thanking me and my staff for the services we provide.'

The trust's 2016/17 annual report and accounts set out a range of income-generating services – MyTrusty, accommodation, catering, car parking, private patients and sterile supplies. The total income from commercial activities was £14.6m. Some areas, such as its day nursery and staff club, aim to break even but the others contributed surpluses.

'This is about an innovation culture. It's about doing things differently and new ways of working; taking ideas and bringing them to market or at least putting them into operation locally,' Mr Cassells says. 'It's hugely exciting and when I leave here, it's where my legacy will be. The potential for the future is massive.'

Business benefits

But why create new companies? Grant Thornton's Mr Stocks says there are many reasons. Those that set up pharmacy services may be attracted to the VAT benefits, putting them on an even playing field with commercial pharmacies; some will be trying to fix services in difficulty; others will be looking to exploit commercial expertise or access to capital.

But while the overall plan is to increase income, he adds: 'This isn't the solution to the NHS's problems – it's nowhere near big enough. But it can add some value. The NHS does a lot of research and I'm never quite sure whether it exploits its intellectual capital well.'

Mr Cassells says there are good reasons for creating NHS companies, but they are not necessarily right in every case. There's a lot of administration, including dealing with Companies House, but the benefits include bringing in commercial expertise, and sometimes funding, while also being able to fund marketing campaigns. 'In the NHS, that's quite difficult, as people say, "Why are you spending public money on marketing your products?". It's different if the company is doing it using internally generated resources.' It also facilitates investment in new products through research and development.

Mr Cassells believes the VAT advantages are incidental rather than the driving force behind decisions to establish NHS companies.

Other benefits include more flexible employment terms. In its laundry business, staff are no longer on Agenda for Change terms and conditions. They have contracts for 40 hours a week, are paid statutory sick pay when ill, and are paid less for overtime and working out of hours. They also receive bonuses based on performance, and those who wish to can join the NHS Pension scheme.

'The whole package means people are paid slightly more [compared with AFC], but absenteeism is very low and productivity has doubled,' Mr Cassells says. 'The aim is to benefit the NHS through revenue streams which would not otherwise be available. There's also the potential for big financial benefits if a profitable company were to be sold.'

Mr Stocks says NHS organisations should not believe their new ventures will offer a quick fix. But, with patience and the right support, they can work well.

Mr Cassells adds: 'It is difficult to commercialise an idea, though it can depend on the type of invention. It takes years for some to come to market. Through the innovation hub, I've seen a number of products developed, but with some taking years to commercialise. You need innovation champions to drive forward initiatives, backed by sound commercial expertise.'

It can be hard to find the right commercial partner to develop and market the product or even the right manufacturer to make it. The IP must be managed and protected; there must be checks to ensure a similar product is not available; and regulatory bodies must be satisfied. Mr Cassells says the establishment of Odstock Medical had to be approved by the Department of Health and the Treasury, as Salisbury was not a foundation trust at the time. Through these processes, board support is vital. 'Everything we've done has been approved by the board or its finance committee. Some trusts are nervous about some of these things, but my board is very supportive. It's great to have good news stories from the NHS when it is under such immense financial pressure.'

That financial pressure is forcing trusts to re-evaluate where savings can be made or income generated. While it will not solve all financial problems, this may well prompt more to look into the potential benefits of creating their own commercial organisations.

New ventures

Other examples of NHS commercial ventures are:

- **SWFT Clinical Services** – wholly owned subsidiary of South Warwickshire NHS Foundation Trust offering outpatient pharmacy, private patent services and online information to support patients
- **Viapath** – joint venture between Guy's and St Thomas' NHS FT, King's College Hospital NHS FT and Serco to provide pathology services
- **Stride** – Strategic Transformation, Real Innovation and Delivery Excellence is Burton Hospitals NHS FT's joint venture partnership that aims to maximise estates efficiency
- **Leeds Solution** – developed at Leeds Teaching Hospitals NHS Trust to preserve abdominal and thoracic organs for transplantation for longer. The products were incubated by innovation hub Medipex and in 2015 Organ Preservation Solutions was created to take the solutions through the clinical trial stage.

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keeping up the pressure

Trusts may have made major progress in reducing spending on agency staffing in 2016/17. But there is still room for improvement, particularly on medical staff spend and expansion of NHS staff banks. NHS Improvement's Dominic Raymont talks to Steve Brown

NHS providers have turned a corner on agency spending in 2016/17, reversing the trend in recent years for year-on-year growth. But agency spending still remains at unsustainable levels and providers will need to intensify their efforts to reduce costs even further.

A letter from NHS Improvement chief executive Jim Mackey to provider chief executives in July set out the extent of the improvement. 'Total agency spend reduced in 2016/17 by £700m compared with 2015/16 and represented 5.8% of total NHS pay bill as opposed to 7.4% the previous year,' the letter said.

This reduction follows sustained growth over the previous four years, before which spending had been a more manageable 4% of total pay. In July 2015, monthly spending reached more than double this historical level when it hit 8.2% of total pay.

In terms of absolute numbers, agency spending fell from £3.6bn in 2015/16 to just over £2.9bn in 2016/17. Dominic Raymont, NHS Improvement's deputy director of agency intelligence, says trusts have done a 'cracking job'. While a series of centrally introduced controls has provided the framework for these reductions, he says the credit is with the local providers that have implemented key changes in process.

But he is also clear that the job is only half done. 'If we don't continue the effort, spend could easily go up again. We need to keep paying attention to this issue, recognising that 5.8% is still really high and unsustainable,' he says.

A further reduction of £500m is being targeted this year, which if successful would bring agency spend under 5% of total pay. 'That's not the end result we would like, but it is getting there,' adds Mr Raymont.

Agency controls were introduced in October 2015, starting with ceilings for the amount of agency nursing expenditure as a proportion of total pay. These were quickly followed by a requirement to use only approved framework contracts for sourcing temporary nurse staff.

Then, in November the same year, price caps were brought in for all staff groups. These rates were tightened in two further steps known as the ratcheting process. This meant that in April 2016 all rates were capped at 55% above basic substantive staff pay rates for the relevant roles. The 55% premium is calculated to cover holiday pay, employers national insurance and pension, as well as framework, agency and other fees. The idea is that the capped rates are effectively equivalent in cost

terms for NHS employers as employing substantive staff and should provide little incentive for staff to opt for a temporary position over a full-time role.

Mandatory use of approved frameworks was extended to all staff groups in 2016/17, with ceilings set for total agency spend. This final measure was given real teeth by including performance against it as a metric in the single oversight framework's use of resources assessment. Now poor performance on agency spending has a direct impact on assessment of overall financial performance and holds implications for greater scrutiny.

NHS Improvement believes the controls have been important in moving the balance of power away from agencies and back towards the NHS. Temporary staff remain an important resource for trusts to cope with varying levels of demand, meet short-term needs and cover vacancies. But there are concerns that in recent years it has become far too much of a sellers' market.

In the long term, however, controls over spending levels and rates are not the answer. 'The best solution is more substantive staff, but there are supply challenges that the whole sector is facing,' says Mr Raymont.

He adds that the oversight body is working with royal colleges and others about how they get the right numbers in future. It also recently launched a new programme to help trusts improve retention levels particularly among nursing staff.

The UK's exit from the European Union adds a further uncertainty over future supply of staff and the need for temporary cover. Recent reports have highlighted stark reductions in the number of registrations of EU nurses coming to work in the UK since last year's Brexit vote.

Mr Raymont says it is not clear that this has had an impact on temporary staff spending already. But NHS Improvement is aware of the potential added pressure.

'We are in a two-year period of negotiation before leaving the EU in April 2019,' he says. 'As we lead up to that date, it will be a potential time of risk. We are working with providers as much as we can.' All of which means that keeping the pressure on to reduce agency spending is vital, given the current financial pressures

Spending on agency staff needs to be seen in the context of overall spending on pay. In 2016/17, providers' total pay bill reached £51bn, £811m higher than plan and £1.8bn (3.8%) higher than in 2015/16.

Pay inflation pressures played a big part in this increase, with the combined impact of pay awards, pay drift and changes to pensions adding an estimated 3.3% to costs. So in fact the pay bill grew by just 0.5% in real terms in the context of a 2.4% growth in cost weighted activity. While that suggests a good result overall, NHS Improvement is adamant more can be done.

Permanent and bank staff spending was £252m above plan (0.5%) while agency and contract staff spending was £559m over plan (23.5%). And while 85% of providers reduced expenditure compared with the previous year, only 66 providers met their agency ceiling.

Medical locum costs are seen as a specific challenge, with staff shortages in emergency departments in particular driving the high spending. There are still some extraordinary rates being paid to some locums – up to £357 an hour in one case reported during the last financial year.

NHS Improvement wants to see £150m savings on medical locums in 2017/18 compared with the just over £1bn spent in 2016/17 (36% of total agency spending of £2.9bn).

Small changes can make big differences. Reducing the rate paid for medical and dental shifts over the price cap by just £1 per hour would save £8.7m a year. Do this across all staff roles, including nursing and administration, and the service potentially saves nearly £20m a year.

The push to reduce locum costs in 2017/18 faced challenge in the shape of new IR35 tax rules aimed at staff delivering services through personal service companies. Initial guidance from NHS Improvement had suggested that trusts would need to treat all locums as 'inside IR35' for tax purposes, but it later clarified that assessments should be on a case-by-case basis.

Provider staff costs 2016/17

	Plan £m	Actual £m	Variance £m	Variance %
Permanent and bank	47,432	47,684	252	0.5
Agency and contract	2,376	2,935	559	23.5
Total	**49,808**	**50,619**	**811**	**1.6**
Agency as % of total pay	4.8%	5.8%		
Performance against 2016/17 agency ceilings	2,445	2,935	489	
Number of trusts that met 2016/17 agency ceilings		66		

IR35 distraction

In some ways the IR35 issue has been a distraction from the main job of reducing costs. In fact the change initially led to some locums seeking higher rates to compensate for less favourable tax treatment and made some posts harder to fill.

NHS Improvement believes the sector at least now has a 'good understanding' of the rules, and it has urged trusts not to accept increases in locum costs beyond current levels as a result of any changes.

Mr Raymont says there is also an opportunity stemming from the IR35 changes. 'Virtually all staff should be subject to the same rates of taxation, regardless of their method of engagement, which is expected to act as a major push factor for staff signing up to a revitalised NHS bank offer,' he says.

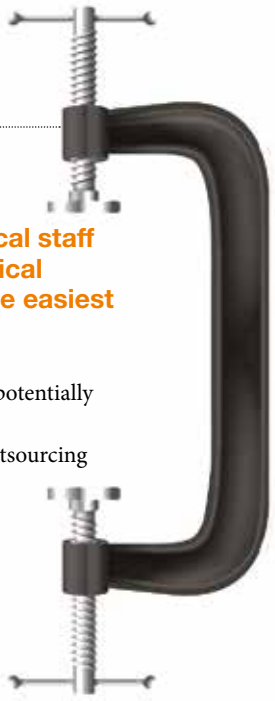
While urging NHS providers to 'go further' in applying existing measures – including improving use of e-rostering, job planning and the turnaround of vacancies – new measures in 2017/18 aim to help organisations put more effort into reducing agency spend. These take the form of providing more scrutiny of current agency spend and encouraging greater use of in-house staff banks.

From April this year, trusts now have to report weekly on

- Total agency shifts
- Breakdown of shifts by core and unsocial (medical) and by day, night/ Saturday and Sunday/public holiday (Agenda for Change)
- 10 longest serving agency staff
- 10 highest cost agency staff
- Shifts worked above £120 an hour, with evidence of sign-off
- Shifts off-framework and above cap, with evidence of sign-off

The data being requested is the type of data used by trusts that have

"We are in a two-year period of negotiation before leaving the EU in April 2019. As we lead up to that date, it will be a potential time of risk. We are working with providers as much as we can"
Dominic Raymont



significantly reduced agency spend,' says Mr Raymont. He highlights good practice in one trust that has helped to reduce monthly spend on locums by more than £800,000 per month.

This has involved the medical director scrutinising all locum requests daily and removing the highest cost locums where appropriate, formalising the staffing request process, launching a new staffing framework and introducing rigorous governance around paying above price caps. This calls for executive sign-off and is only permitted for exceptional patient safety grounds.

Mr Raymont says that the key aim of the additional data collection is to improve visibility. 'It allows us to get closer to what is going on in trusts – finding out more for example about [use of agency staff to fill] core and unsocial hours,' he says, with agency staff typically making up a higher proportion of non-core shifts than core shifts.

NHSI is also keen to feed back this data to trusts to allow anonymous benchmarking via the Model Hospital platform.

However, Mr Raymont says the big push this year is around staff banks. Jim Mackey's recent letter highlighted that, for the first time since the agency controls began, monthly agency spend was now less than bank spend. While he recognised this as a 'great achievement', the oversight body believes banks have an even greater contribution to make in reducing overall staff costs and improving quality.

'We are looking for all trusts to have banks across all staff groups,' says Mr Raymont. A recent stock-take has highlighted major variation across the country. 'While almost every trust has a bank of one sort or another, some trusts don't cater for particular staff groups,' he says. So, for example, many trusts don't have a bank for medical staff and not all have administration and clerical banks – despite this potentially being the easiest bank to set up and operate.

Many trusts don't have a bank for medical staff and not all have administration and clerical banks – despite this potentially being the easiest bank to set up and operate

Mr Raymont acknowledges there is a market for outsourcing bank arrangements and accepts this may suit some organisations. But in general he is keen to see trusts investing more in their bank operations – the premiums being paid for locum staff provide a good cost-benefit argument for setting up an in-house medical bank.

As a start, he suggests banks remove any obstacles for staff to work through the bank rather than an agency. This might require mirroring agencies in meeting temporary staff preferences – the ability to book shifts using smart phones and weekly payment are good examples.

He also wants to see more collaboration across providers and areas, potentially linking individual organisations to a wider group of bank staff before having to consider agency supplied staff.

Overall it is case of more of the same and then push harder. 'We need to make sure the existing controls continue to be applied,' Mr Raymont says. 'Keep going with them because there is a lot more we can do. And we can't assume the savings are sorted. We need trusts to work with us on developing banks and make more inroads into the locum market.'

Walk, don't run

We are told that the future is about new models of care underpinned by capitation budgets. But there are also plans for individual and potentially mandatory tariffs, such as for ambulatory care, to incentivise specific interventions. Are these plans at odds with each other, asks Steve Brown

Ambulatory emergency care is defined as a service that allows a patient to be seen, diagnosed, treated and discharged in the same day. The route into such a service is either via the emergency department or direct referral from GPs and the aim is to avoid hospital admissions and overnight stays where it is clinically appropriate.

An emergency admission for an ambulatory care sensitive condition is seen as a sign of poor overall quality of care, even if the episode itself is managed well. In these cases, an ambulatory response is better for patients, can ease pressure on emergency departments and reduce demand for inpatient beds, either cutting costs or helping achieve access targets.

In 2015, NHS England's publication – *Safer, faster, better: good practice in delivering urgent and emergency care* – identified ambulatory emergency care (AEC) as a key component of a well-resourced system. It called on acute sites to 'consider establishing an AEC facility that is resourced to offer emergency care to patients in a non-bedded setting'.

The British Association of Ambulatory Emergency Care now lists more than 50 clinical scenarios where an ambulatory care approach could work. A best practice tariff was introduced in 2012/13 to encourage take-up of this approach for a range of clinical scenarios, including asthma and deep vein thrombosis.

The best practice tariff (BPT) sets a higher rate for emergency admissions that have a zero day length of stay – typically £240 higher than the non-best practice tariff rate. This reverses the old approach where the non-elective tariff was reduced for short stays – which provided a perverse incentive not to increase rates of ambulatory care.

There are now 26 clinical scenarios covered by the BPT. Although tariff guidance allows for flexibility in operation, a briefing published by the HFMA earlier this year highlights that there are problems with its operation.

Issues raised in the briefing include:

- An organisation doesn't need an ambulatory care unit to get the best practice payment
- The tariff doesn't capture patients treated in an ambulatory manner, but diagnosed with something outside of the clinical scenarios covered
- An emergency admission is needed to obtain the BPT, even though the overall aim is to avoid admissions
- Subsequent attendances – relatively standard in ambulatory care units – are not reflected in the price paid.

A survey to inform the briefing, run by the association's National Payment Systems Group, found that respondents were equally split between using the national BPT price and agreeing a local price.

But there were clear differences in how first attendances were recorded including:

- Non-elective emergency admissions
- Mixture of A&E attendance and emergency admission
- Outpatient first appointment
- Outpatient follow-up appointment.

One organisation said that from April this year, these attendances were now being recorded as a ward attender, rather than a non-elective emergency admission. In addition, just over two thirds of the respondents' trusts recorded a second visit as an outpatient follow-up.

Respondents said changes were needed to make the BPT work properly. They were keen for greater clarity over recording and collecting data, with a change to the Secondary Uses Service to introduce a third category separate from outpatient or admitted patient care.

The lack of robust data has led to some local approaches on payment. In one case, the commissioner had offered to pay the top A&E tariff to cover both any A&E attendance and ambulatory care. However the trust had felt that A&E triage and care given by the ambulatory unit should be treated separately – leading to the agreement of a block contract.

The introduction of a new emergency care data set from October this year should help by better describing what happens to patients attending accident and emergency departments, minor injury units, urgent care and walk-in centres.

Ambulatory emergency care is not within the scope of the new data set, but the greater granularity of the data – covering condition/injury, triage time, time seen, diagnosis and procedures undertaken – should help improve understanding of patient pathways.

Tariff guidance for this year and next states that nationally mandated prices could be developed to encourage further shifts from the admitted care setting 'once data sets become rich enough to capture the activity of ambulatory emergency care'.

Models of care

This begs the question: how does the developing approach to ambulatory care – through the best practice tariff and potential future national tariffs – fit with ongoing work on new models of care supported by capitation-based budgets?

New models of care are already being implemented in some areas to provide different pathways for some groups of patients such as the frail elderly and those with chronic conditions. The basic purpose of a capitation budget is to make providers accountable for the outcomes they deliver, but give them flexibility in how they design pathways to deliver those outcomes. The idea is that this

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would incentivise many of the same responses targeted by the ambulatory care BPT.

Both would look to minimise unnecessary emergency admissions to better serve patients and reduce overall system costs. The capitation budget approach arguably gives providers greater flexibility and encourages a more system-wide approach, with the aim of avoiding emergency presentations altogether.

However the ambulatory care BPT may provide more direct incentives to pursue a specific and evidenced best practice response.

Lee Outhwaite, finance director at Chesterfield Royal Hospital NHS FT and chair of the HFMA National Payment Systems Group, says the issues raised by possible moves towards a more mandated tariff for ambulatory care raise questions about the most appropriate way to incentivise system transformation.

'Providers and commissioners want to provide services that best meet the needs of patients in the most cost-effective way. But service change is complex. There are examples where existing national tariff approaches act as a barrier to change – this is widely recognised. Local flexibility in price setting is one response, but this leaves local bodies needing to have detailed negotiations about how to manage risk and deliver more sustainable services.

'There are clear tensions in a local versus national price setting approach and with broader capitation approaches,' he argues. A national price may take no account of the impact of outreach services that aim to reduce emergency episodes. A provider that's invested in community outreach for chronic illness patients may have less activity coming through A&E and ambulatory care. In this case, the provider wouldn't benefit from an enhanced BPT to the same extent as a provider that was less proactive in terms of outreach.

Any investment in such outreach services would need to be separately recognised by commissioners if providers weren't to be disadvantaged by taking a more holistic view.

"Tariffs priced locally or nationally may help systems take steps towards revised pathways "

Lee Outhwaite

Long term, capitation budgets may be the way forward – leaving the provider to make changes to different parts of the pathway, with the commissioner focusing solely on outcomes.

Mr Outhwaite says there may still be a role for episodic tariffs – ambulatory care and other components within a pathway – as part of a transition path. 'Transformation is far from straightforward. Moving to revised pathways with significant changes in services may not be possible in all areas, and the potential risk in making these moves without payment systems that track activity levels may be significant.

'Individual tariffs, priced locally or nationally, may help systems take manageable steps towards revised pathways – and learn more about the impact of those changes – as part of a move towards capitated payment approaches, where appropriate.'

This calls for robust tariffs underpinned by robust data collected consistently, particularly if the aim is to instigate this nationally. 'The future is likely to involve using a mix of payment models. We need to continue to feed back on the operation (good or otherwise) of payment approaches. And we need to develop a better understanding of the role that payment systems can play in system transformation.'

reading the numbers

NHS performance is hot news all year, but the ultimate performance report – the Department of Health's annual report and accounts – appears to slip out without anyone really noticing. Steve Brown looks at the headline figures

After much mid-year gnashing of teeth and nail biting, the Department of Health finally underspent on its key revenue budgets 2016/17 by some £563m, according to its annual report and accounts.

Compared with overall expenditure, this underspend is small – just 0.48% of its total budget of £117.6bn. It is an improvement on last year's £207m revenue overspend and needs to be seen in the light of extreme pressures facing NHS bodies.

This is acknowledged by the Comptroller and Auditor General (C&AG), who added an explanatory report to the audit opinion for the second year running. Unlike 2015/16, the C&AG reports that the Department has not been forced to use one-off accounting adjustments to remain within budget. But he notes that some local NHS organisations have relied on such adjustments to meet the requirements for the sustainability and transformation funding. He concludes that while the Department has seen some overall improvement in the financial position in 2016/17, it is still some way from achieving financial sustainability.

What the annual report and accounts show is that there are many ways of assessing the financial position and performance of the NHS and it takes some work to tease out exactly what the headline figures mean.

Local clinical commissioning groups (CCGs) and NHS providers reported major overspends. CCGs finished the year with an underlying aggregate overspend of £556m, before the release of a risk reserve largely aimed at covering provider deficits, while providers reported a £791m aggregate deficit before provisions and other adjustments.

The Department's key revenue 'must-do' is to keep spending within its revenue departmental spending limit (RDEL). Spending that counts against this limit splits into three broad categories – spending by commissioners (NHS England RDEL), by providers and by the Department itself with its arm's length bodies.

A £935m over spend by providers (after adjustments) was broadly balanced by a £971m underspend in commissioning. This net underspend of £36m was further supplemented by an underspend of £527m by the Department and its ALBs – giving the full underspend of £563m.

The accounts explain the make-up of these different figures, highlighting the more familiar and widely reported figures for provider and commissioner deficits and underspends within the overall reported figures. For example, the overall commissioning underspend of £971m includes an underspend of £70m on depreciation (funding for depreciation is ringfenced under Treasury rules and cannot be used for non-ringfenced spending).

The Department's accounts highlight the £0.8bn risk reserve created by commissioners (1% of allocations) to offset system pressures and expected provider deficits. It then portrays the overall commissioning underspend as NHS England finding savings of a further £100m.

Within this, it says there was a CCG overspend of £0.6bn, which was offset elsewhere 'notably in specialised and other direct commissioning and NHS England central costs'. In strict accounting and reporting terms, each CCG reports its final position including its share of the risk reserve. Several CCGs needed to use some or all of their part of the risk reserve to cover their own overspent positions compared with plan.

Looked at this way, using NHS England's accounts, CCGs reported an overall underspend of £154m (with £707m of the risk reserve included in CCG positions).

Risk reserve

The NHS England report describes 2016/17 as a 'year of unprecedented challenges for NHS commissioners'. The creation of the risk reserve increased the level of savings that commissioners needed to make from 2.2% of allocations in 2015/16 to 3%. The NHS England group also had to absorb a £190m increase in Department-set rates for funded nursing care.

In the end, CCGs delivered £2bn of efficiencies in the year compared with £1.5bn in 2015/16. Most CCGs delivered their planned position in addition to the release of the risk reserve. However 85 CCGs reported operating overspends totalling £607m, leading to the aggregate CCG overspend of £556m, taking account of £17m of underspends by 24 CCGs and £34m of underspend on the quality premium budget.

Of note elsewhere in the commissioning budget was an underspend of £58m on specialised services (within the direct commissioning budget). And the cancer drugs fund, operating under new rules, stayed within budget compared with the £126m overspend in the previous year.

The provider sector's total deficit of £935m on RDEL spending includes the widely reported £791m provider deficit, plus £144m of technical adjustments relating to categorisation of provisions, the private finance initiative, donated assets and prior period adjustments.

Commissioning financial performance 2016/17

	Plan	Actual	Under/(over)spend	
	£m	£m	£m	%
CCGs	76,630	76,476	154	0.2
Direct commissioning	25,610	25,314	296	1.2
NHS England admin/central progs/other	3,312	2,874	439	13.2
Historic continuing healthcare claims	150	137	13	8.6
Total	**105,702**	**104,800**	**902**	**0.9**

SOURCE: NHS ENGLAND ANNUAL REPORT AND ACCOUNTS 2016/17

The £791m deficit compares with a £2.45bn deficit in 2015/16. However, while the accounts say the trend of increasing provider deficits has been 'addressed and reversed' in 2016/17, supported by the agreement of provider control totals, the provider deficit was still £211m above planned levels. This position also includes the benefit of the £1.8bn sustainability and transformation fund.

Compared with 108 providers that had planned to be in deficit, 105 ended the year in deficit – but the gross deficit rose from a planned £1.43bn to £1.82bn. Offsetting this, there was a small increase in the number of trusts delivering surpluses, compared with plan. Their combined gross surplus increased from £648m to £914m – in some part due to the distribution of elements of the STF that were uncommitted in the plan.

The big contributions to the Department and ALB underspend came from lower spend than anticipated on the depreciation ringfence, Department central budgets and the NHS Litigation Authority.

During the year, providers were under pressure to keep capital expenditure within plans in order to ensure that the departmental capital expenditure limit was met. It worked. Total gross capital spending amounted to £5.2bn, with £650m of income – mostly from disposals – supplementing £4.56bn of capital DEL spending. This was £60m under the limit of £4.62bn.

Providers accounted for the majority of the CDEL spending with capital expenditure of £2.9bn – an overspend of £126m. This was offset by underspends in non-NHS bodies in the group.

The Department is also required to stay within its annually managed expenditure (AME) budget. This budget is set outside of the spending review and covers impairments and provisions, which 'have no real impact on the fiscal framework or need for taxes to be raised to cover the spending'. (This is not typical to most government departments, where AME spending does have an impact on the fiscal framework in the same way as DEL spending.)

AME volatility

AME spending is demand-led and volatile as it is subject to many variables outside the Department's direct control such as changes to the discount rates to measure the value of long-term provision liabilities. The budget was set anticipating changes to the way provisions are calculated for clinical negligence settlements. But in the end this increase wasn't needed, contributing to a £6.6bn underspend on the revenue AME budget. This technical accounting change masks to some extent the impact on clinical negligence settlements made by the Lord Chancellor's change to the discount rate used to value personal injury settlements. This resulted in a £4.7bn increase in the clinical negligence provisions provided for in year.

The accounts reveal a wealth of detail on the running of the NHS. But in overall terms they help to convey the size of the organisation (or organisations).

Figures for overall spending for health are frequently cited in numerous sources. The accounts make it clear that figures of £130bn, £127bn, £117bn or even £106bn could all be correct, depending on the context and what is included.

So more than £130bn was spent across the NHS system in its widest context in 2016/17 – made up of £127.1bn of revenue spending and £5.2bn of capital spending. These are gross figures, with some £10bn of gross revenue income supplementing the department's net revenue funding of £117bn and gross capital income of £650m supplementing the £4.56bn of net capital spending.

The gross revenue income includes funds from local authorities, private patient income and prescribing income, while the capital income is from disposals.

A figure of £106bn would also be an accurate figure for NHS funding, stripping out the £11.7bn of central department and ALB running costs from the overall RDEL funding figure.

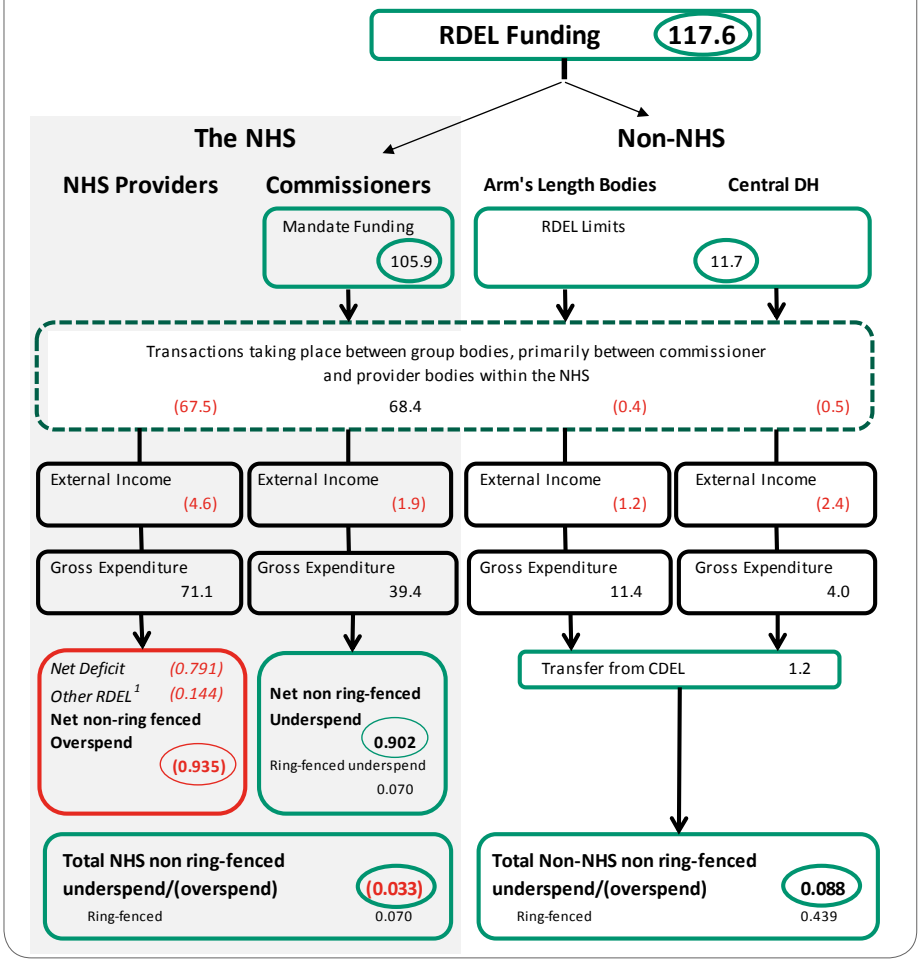
A helpful flowchart in the accounts providers a handy summary of how the RDEL breaks down (see above). The majority of net funding (90%) flows through commissioners – representing NHS England's mandate funding. Nearly two-thirds of this is tied up in transactions between different parts of the NHS group (chiefly commissioners and providers). The biggest additional chunks of expenditure involve spend with non-NHS providers (£13.7bn, gross), primary care (£11.3bn) and prescribing (£8.5bn).

The finance data is accompanied by reports on performance against core standards and progress with important facilitators such as developing the workforce and improving use of digital technology. There is an inevitable positive gloss put on everything, but it still contains significant detail on the health service's overall performance.

The lack of media interest in the report and accounts is interesting, given the high level of interest in the NHS financial position all through the year. The press pack has clearly moved on to the more current story of how the service is performing against plan this year. But there is a wealth of information in the accounts for those prepared to put the reading in.

The accounts make it clear that figures of £130bn, £127bn, £117bn or even £106bn could all be correct, depending on the context and what is included

Revenue departmental expenditure limit (RDEL) - sector breakdown



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Valuations and asset sales – getting to grips with the accounting treatment

Technical update

The Royal Free London NHS Foundation Trust made the news earlier this year when it struck a deal to sell surplus land, *writes Steve Brown*. The profit generated by that sale initially boosted the trust's revenue position for the year, entitling it to a greater share of the incentive element of sustainability and transformation funding.

Auditors later judged that the benefits of the transaction should be accounted for in 2017/18.The sale had been planned for a long time to support funding of a new hospital at the trust's Chase Farm site (pictured). Regardless of this, reports of the transaction drew some (anonymous) comments about 'hastily arranged deals' and 'accounting wheezes'.

Concerns ranged from the timing of the deal to the fact that the valuation for sale was so far ahead of the value carried in the trust's accounts (£50m compared with a zero book value, giving a £47m net benefit after £3m provisions were made for site clean-up).

Without dealing with all the specifics of the case, it is worth examining the process that should be followed in terms of valuations for sale and accounting for any proceeds.

First, it should be said that NHS bodies are encouraged to dispose of surplus assets – the process for doing so is set out in *Health building note 00-08 part B*. In general, assets should be sold for the highest price. This generates cash for the selling organisation. These capital receipts can generally be kept by the organisations to finance new capital expenditure. And where there is a profit on disposal, it can increase any operating surplus or reduce a deficit.

A profit equates to the selling price minus the value of the asset as recorded in the body's statement of financial position (SFP) minus any

costs associated with the sale.

However, value – and valuing – is not a straightforward business. The value of property, land and equipment is not simply recorded as the amount paid for it. Instead the valuation of an asset is reassessed over its useful life.

This 'revaluation model' (see paragraphs 29 and 31 to 42 of property, plant and equipment standard IAS 16) requires that assets are held at their 'fair value'. This is the price that 'would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date'.

The accounting standard is written with the assumption that assets are held to generate income either through their use or by selling them. Public sector bodies' assets are held to provide services so, when valuing operational assets, they apply an adaptation to IAS 16 that means they are valued at current value for existing use (see page 32 of the Treasury's *Financial reporting manual*). For specialised assets, this is an assessment of the present value of the asset's remaining service potential. NHS bodies have to use a modern equivalent asset approach to establish this value. This is the cost of an asset built with modern materials to produce the same throughput, perhaps even on a different site.

An asset can have a completely different value once it is surplus to requirements, and has no restrictions on its disposal, when it could be valued at an open market rate established by professional valuers.

However, there are special rules for assets that are held for sale. These are defined as assets meeting the criteria of the accounting standard for non-current assets held for sale and discontinued operations (IFRS 5). This basically means the asset is available to sell, there is a commitment to sell and it is being actively marketed.

At this point, the asset is removed from the property, plant and equipment note in the accounts and moved into current assets. Accounting rules dictate that these assets are valued at the lower of their carrying value immediately prior to the change of classification and their fair value (less costs to sell). No depreciation is charged from this point.

If the actual sale price is then above this 'frozen' value, the profit is recorded as income in the SOCI, improving the reported financial position, but not changing any underlying position. It might boost an existing underlying surplus – showing a one-off benefit for the year. Or it could improve an underlying deficit position, by enabling the trust to show a surplus despite spending more for that year than it had received in recurrent income.

The cash received from the sale (minus the book value) would be recorded as a current asset in the SFP, matched by an increase in the income and expenditure reserve courtesy of

continued overleaf ▶

the improved financial position. This would be recorded in the accounting period in which the transaction took place, as long as it was deemed that the transfer of risks and rewards of ownership also took place at the same time.

The further twist in the Royal Free case is that, rather than having to calculate a theoretical modern equivalent value for the old Chase Farm site and facilities, the trust is actually building a modern equivalent on a small corner of the existing site. The residual value of this subsection of the land and the assets built upon it remain in the books, leaving the surplus land for sale at a value of zero.

Now consider the case where the asset had not met criteria for assets held for sale but had no further restrictions on it and was no longer in use. If a valuation had indicated a higher value than that held in the accounts, different treatment would apply. In this case, the asset value would be increased and the asset would continue to be reported as a non-current asset.

This increased value would be balanced by a corresponding increase in the revaluation reserve. If this asset was then subsequently sold for a sum equal to its revised valuation, the organisation would reduce its non-current assets by the asset value and increase its current assets by the sale value. A sum equal to the difference between the revised asset value and the previously recorded asset value would be transferred from the revaluation reserve to the income and expenditure reserve.

The statement of financial position would look exactly the same as in the 'assets held for sale' scenario. The only difference is the impact on the SOCI. The treatment is dictated by the standards and whether the asset meets the relevant criteria for assets held for sale – it is not a choice for the organisation.

• *Support provided by HFMA technical editor Debbie Paterson*

Technical review

Recent key technical developments

Technical roundup

The Department of Health has issued guidance on re-employing staff who have retired and taken their NHS pension benefits. The guidance – aimed at employers and staff – says 'retire and return' schemes can benefit both parties by helping the NHS retain skills while facilitating a better work/life balance for the employee. But it notes the scheme has attracted negative media coverage, insisting applications should not be approved automatically.

Cash donations made to front line staff need to be managed carefully and it is important that controls are in place to receipt, bank and account for them. These charity donations can result in large numbers of separate funds on different wards/clinics that are unwieldy and inefficient to manage. A new briefing from the HFMA – *NHS charities (England and Wales) – good practice in handling cash donations* – examines how such donations should be managed, informed by work done by members of the HFMA Charitable Funds Special Interest Group.

An HFMA briefing paints a largely positive picture of the 2016/17 year-end accounts process, though several small issues have been highlighted. Finance managers described it as a 'business as usual' year in terms of the accounting process, with key areas of difficulty anticipated ahead of the year-end. These issues included co-commissioning for clinical commissioning groups; accounting for the sustainability and transformation fund for providers; and non-current asset valuations and the impact of the financial position on the NHS.

The Department has published the healthcare education and training tariff for 2017/18. As well as the national tariffs for education and training placements, this sets out implemention and circumstances in which they can be varied. The tariffs cover non-medical and medical undergraduate placements, as well as postgraduate medical placements, in secondary care.

Immunochemical tests could reduce colonoscopies

NICE update

New NICE diagnostic guidance (DG30) recommends a number of immunochemical tests that should be used in primary care to guide referral for suspected colorectal cancer in certain circumstances, *writes Nicola Bodey.*

The tests – the OC Sensor, HM-JACKarc and FOB Gold quantitative faecal immunochemical tests – are recommended for people without rectal bleeding who have unexplained symptoms but do not meet the criteria for a suspected cancer pathway referral (outlined in NICE's NG12 guideline).

Other recommendations include requiring commissioning groups to audit outcomes and monitor the associated resource use.

Faecal immunochemical tests, a type of faecal occult blood test, are designed to detect small amounts of blood in stool samples using antibodies specific to human haemoglobin. Sometimes, blood in stools is not visible (faecal occult blood) so tests are used to detect its presence.

Quantitative faecal immunochemical tests can be used in primary care to triage low-risk symptomatic populations for suspected colorectal cancer referrals and may lead to savings from a reduction in the number of colonoscopies performed. The average cost of a faecal immunochemical test is £4.81 and the cost of a colonoscopy is £403 (2017/18 national tariff).

The number of people eligible for faecal immunochemical testing each year should be assessed locally. A resource impact template has been published to help organisations assess the potential savings of implementing the guidance. It illustrates potential savings by using a starting population of current suspected lower gastrointestinal cancer referrals requiring a first outpatient appointment within two weeks (about 300,000 people in England per year).

The potential annual savings for England (if 5% of the current two-week suspected

Diary

September

11 Ⓑ Eastern: student conference, Cambridge
14-15 Ⓑ South Central: annual finance event, Reading
14 Ⓑ North West: health sector insight briefings, Liverpool
19 Ⓕ Provider Finance: STP finance forum, London
20 Ⓝ CEO forum, London
21 Ⓝ/Ⓕ CIPFA/HFMA health and social care conference, London
21-22 Ⓑ Wales: annual conference, Hensol
22 Ⓑ London: football tournament, Camden
26 Ⓕ MH Finance: forum and roundtable, Manchester
26 Ⓑ London: introduction to NHS finance, Rochester Row
28 Ⓘ NHS costing – regional networking and training event, Birmingham
28-29 Ⓑ South West: annual conference, Bristol

October

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

November

1 Ⓑ West Midlands: new care models, Birmingham
3 Ⓑ East Midlands: annual conference, Loughborough
8 Ⓝ Annual mental health conference, London
9 Ⓑ London: VAT, Rochester Row
9 Ⓑ West Midlands: AGM, Birmingham
10 Ⓑ Northern: annual conference, Durham
10 Ⓑ South Central: technical update, Southampton
14 Ⓝ Audit conference, London
15 Ⓕ Commissioning Finance: future of primary care and general practice forum, London

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

key Ⓑ Branch Ⓝ National Ⓕ Faculty Ⓘ Institute

lower GI cancer referrals have a faecal immunochemical test initially) is £4.5m, increasing to £9m if 10% of current referrals have a faecal immunochemical test.

Savings arise because it is assumed that all people who present in primary care and have suspected colorectal cancer have a colonoscopy – it is estimated some 25% of people who have a faecal immunochemical test initially are referred for a colonoscopy. This technology is commissioned by clinical commissioning groups. Providers are NHS hospital trusts through pathology networks and primary care.

Nicola Bodey, senior business analyst, NICE

Events in focus

Chair, NED and Lay Member Faculty forum
11 October, Manchester

The next HFMA Chair, Non-executive Director and Lay Member Faculty forum will focus on devolved healthcare to city regions, leadership and costing and value. Sessions on Manchester will book-end the event, which will be held in the city. Salford Royal NHS Foundation Trust chair Jim Potter and Steve Wilson (pictured), executive lead – finance and investment at Greater Manchester Health and Social Care Partnership, will outline the progress made in the devolution of health and care to the city. And in the final session of the conference, Grant Thornton head of public sector Sarah Howard and public sector director Paul Hughes will review the outcomes of the firm's Manchester Health Inquiry.

Aneurin Bevan University Health Board deputy chief executive and medical director Paul Buss will examine the importance of good costing data in assisting senior decision-making. And Devon Partnership NHS Trust director of finance Sarah Brampton will describe the development of local leadership and governance in the North, East and West Devon Success Regime. The HFMA has asked finance professionals to draw non-executives' attention to the event.

• **Email grace.lovelady@hfma.org.uk for further details**

Future workforce: two sides of the same coin
6 October, Birmingham

This joint event, organised by the HFMA West Midlands Branch and the Healthcare People Management Association, is aimed at senior finance and HR professionals.
The event recognises the challenges shared by finance and HR staff, as they seek to get the right staff in place to meet quality and safety standards while maximising efficiency. The event is free to HFMA members.

There will be a number of national and local speakers, including Health Education England director of finance Steve Clarke (pictured), who will examine some of the challenges set out in the forthcoming national workforce plan.

He will be joined by NHS Improvement director of people Caroline Corrigan and Danny Mortimer, chief executive of NHS Employers.

Other speakers include former trust and clinical commissioning group finance director Ian Baines, currently director of organisational development across three CCGs, who will look at the role of organisational development in supporting staff and organisation through change.

• **For further details, email rosie.gregory@hfma.org.uk**

Improving communication

Association view from Mark Knight, HFMA chief executive

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

SHUTTERSTOCK

My HFMA

As a very wet summer comes to its end, I hope you could catch some sun somewhere. Rest and relaxation particularly in the frenetic world of healthcare finance is important. The HFMA starts the important run-up to the December annual conference with a host of events through Finance Skills Development, branches, faculties and the Healthcare Costing for Value Institute.

Our president has committed to attend every branch conference this year in the spirit of *Everyone counts,* and is well on track to achieve his aim. As ever, our branch conferences offer professional development opportunities in a more localised setting – always very good value. Several of our autumn events are sold out, but it might be worth checking what your branch is putting on. The autumn period will be busy, I'm sure, but it's important that we continue to meet together to learn from each other.

At the annual conference in December, our final motivational session for the Friday will be led by Olympic triathletes the Brownlee brothers – something to put a spring in your step!

Our intention is to change the format on Thursday to include shorter sessions inspired by the famous TED talks. We will still have the main plenary sessions, and key figures in NHS finance will deliver 'state of the nation' speeches, but I'm keen to embrace new learning styles. The conference needs to change as we move forward.

Another notable change this year will be to our Wednesday night 'presidents dinner'. We are keen over the next few years to turn this into a celebration of all our students' achievements. Details will be announced nearer to conference, but I hope delegates can join us.

We've been doing a lot of work on our culture at the HFMA over the past few months. Founded in Bristol in late 2000, we remained relatively small – about 20 people – for over a decade. Today, we are an 80-strong team (about 50 whole timers). And when you run an organisation as complicated as the HFMA, which has over a dozen staff based 'in the field', the challenges are significant.

HFMA chief executive Mark Knight

The key issue for us is to ensure you get the very best service from the association. We're very keen on feedback and we collect a lot of it. The 'scores on the doors' are usually impressive and I'm always proud of our efforts.

However, the area we are working on is how best we communicate with organisations. We have so many products and services that it can be quite complicated. So we're hoping shortly to have more of a single point of contact for each organisation.

This will give you smoother access to our services – and it will mean we don't bother you unnecessarily. We hope organisations will notice a change. You are, I'm sure, already aware of our website (www.hfma.org.uk) and our extensive presence on social media. And we are still open to more traditional means of communication – pick up the phone and give us a call.

December sees the launch of a new HFMA app and the test versions I've seen are extremely impressive. I anticipate this being a popular and useful addition to our offering.

The HFMA is always changing and moving forward – if you have any ideas as to how we can improve our services, please drop me an email at chiefexec@hfma.org.uk

Member news

Now in its fourth year, the HFMA North West awards programme, sponsored by CIPFA, had a record number of entries. Winners were announced at the branch annual conference gala dinner in Blackpool in June. The judging panel, composed of former HFMA presidents Sue Lorimer (pictured) and Tony Whitfield and Lancashire Care NHS FT chief finance officer Bill Gregory, presented awards in three categories:

- Finance team - Tameside NHS Foundation Trust
- Innovation award - North West Skills Development Network
- Unsung hero - Craig Sharples, Salford Royal Foundation Trust

The HFMA's London Branch recently held a workshop, *Positive psychology to improve wellbeing and resilience,* at which 20 delegates practised how to understand their own and others' behaviour, build resilience and be happier and healthier. A key message was that happy teams work better together and are more productive and effective.

HFMA office administrator Lizzy Coghill is taking part in the Alzheimer's Society's Memory Walk 2017 in memory of her nan who passed away recently. To donate to Lizzy's cause, go to https://goo.gl/LVZTjr

NHS Improvement is creating a resource for mental health trusts, focusing on quality improvement. Sixteen volunteers, including 11 directors of finance, from the HFMA Mental Health Finance Faculty have come forward to give examples of good practice. To attend the first meeting, which is being held at the end of September, email emily.bowers@hfma.org.uk

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Member benefits

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

Network focus

My HFMA

Eastern Branch

Networking opportunities for all bands and breaking down traditional cross-organisational barriers seem to be at the heart of the approach taken by the HFMA Eastern Branch.

After realising that networking opportunities for senior colleagues in the region were limited, at the end of February 2016 the branch held its first meeting for directors of finance and deputy directors of finance.

'These meetings are a good forum for the organisations and an opportunity to share some of the issues and challenges we face. Quite often, the session will be focused on some particular challenges – cash flow, planning or cost improvement programme delivery, or closedown from one year to the next,' says Simon Rudkins, deputy director of finance at The Ipswich Hospital NHS Trust (pictured).

'It's a good forum for airing some of those conversations and either benefiting from others or just sharing and offloading, realising that we are all in the same boat.'

He became a member of the HFMA at the start of his career over 20 years ago and is hoping soon to join the committee and give back to the local NHS finance community.

The forum also has a focus on those beginning their finance career. The branch will hold its student conference on 11 September in Cambridge. The event is open to all NHS finance staff in the East of England who are studying or about to embark on a course of study. The day will feature plenary sessions and workshops.

On 20 October the branch is hosting its annual conference. Among the speakers for this one-day event are Bob Alexander, NHS Improvement deputy chief executive and executive director of resources, together with Falkland war veteran Simon Weston.

'The branch events help you to feel part of a wider peer network that allows you to tackle challenges as a whole system. We are moving towards working as a system and this is a change from more recent times when there was an organisational focus.

'If you have already built some wider networks through HFMA events such as the Eastern Branch annual conference, then you've already broken down quite a lot of the barriers in our financial profession. This might help influence other professions where perhaps that hasn't been achieved. We are already working in partnership,' Mr Rudkins says.

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Appointments

After nearly three years as the national finance director for specialised commissioning with NHS England, past HFMA chairman **Andy Leary** has moved to a new role with NHS England as national director of financial resilience. He will work with the regional NHS teams, and directors of commissioning operations and commissioning finance to help clinical commissioning groups be better prepared to manage future financial difficulties. Mr Leary will also work with NHS Improvement on system-wide approaches and solutions that align with sustainability and transformation plans and accountable care system footprints. He will continue to cover for his previous role in the short term.

Sam Dukes (pictured) is now head of finance business planning and development at NHS North East Hampshire and Farnham Clinical Commissioning Group. He was on the regional Graduate Finance Management Training Scheme, run by the HFMA on behalf of local NHS organisations. Mr Dukes is due to become chair of the HFMA South Central Branch this month, which will make him the youngest HFMA branch chair on record.

Paul Vater has been named chief operating officer at Swindon Clinical Commissioning Group. He was previously chief finance officer at Dorset Clinical Commissioning Group, where **Stuart Hunter** has succeeded him.

Lee Outhwaite has been appointed director of finance and contracting at Chesterfield Royal Hospital NHS Foundation Trust. The role has been filled on an acting basis by assistant finance director **John Williams** since the departure of former finance director **Steve Hackett**. Mr Hackett moved to Rotherham, Doncaster and South Humber NHS Foundation Trust in May. Mr Outhwaite, who spent seven years as finance director of Derby Hospitals NHS Foundation Trust, was most recently a business director at NHS Improvement.

Contrary to the report in the appointments section of our July issue, we can confirm that **Pete Papworth** is substantive director of finance at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. We apologise for the error and any inconvenience caused.

Jane Payling (pictured) is the new chief finance officer at West and East Suffolk and Ipswich Clinical Commissioning Groups, succeeding **Chris Armitt**, who has been acting CFO. Ms Payling was head of health and integration at CIPFA. Her NHS career started with East Anglia's NHS finance training scheme, and she spent 10 years as Papworth Hospital NHS FT's finance director before joining CIPFA.

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

"We can easily articulate the issues facing us. It is my role to ensure that collectively we use the resources we have to best effect"
Maureen Edwards, Belfast HSC Trust

Edwards in Belfast role

On the move

It may be one of the biggest jobs in NHS finance, but Maureen Edwards says her new role at the Belfast Health and Social Care Trust is to support medical staff and other clinicians as they deliver effective and safe services.

The trust's new director of finance, estates and capital development succeeds Martin Dillon, who has become chief executive of the trust, which is one of the biggest in the UK and has a turnover of £1.3bn.

She has experience at this level – she was interim finance director when Mr Dillon was acting chief executive for eight months in 2014, and interim director of finance at the Royal Hospitals Trust in the six months leading to its merger with the other five Belfast trusts in 2007.

'When the opportunity came up, I thought I could make a difference – even more so with Martin at the helm,' she says. 'As an executive team, we respect his direction of travel and his focus on safety and quality improvement. As the finance director, I want to be there supporting the agenda.'

Mrs Edwards is a member of the national HFMA Policy and Research Committee and through this she has learnt that good engagement with clinicians is the mark of a successful finance professional.

'Over the last few years I have been involved in some interesting and highly effective work as part of a medical finance engagement team. I'd established this with a number of consultants who had a shared commitment to improving outcomes and experience for our patients and clients. We have implemented several initiatives, including a trust-wide reduction in unnecessary lab tests, which has significant benefits for patients and staff – the doctors took the lead on this with finance support. I think as a finance person you contribute more in a supportive role.'

She was previously co-director of financial management at the trust and began her career in 1993 as an NHS finance trainee in West Wales. Once her training was complete, she joined North Glamorgan Trust as a directorate accountant, before returning to Belfast.

With a background largely in financial management, Mrs Edwards says she is relatively new to the estates and capital development elements of her portfolio. But she is learning quickly. The trust has one of the flagship capital developments in Northern Ireland – a new regional children's and maternity hospital. 'With a significant rise in costs in Northern Ireland's construction industry, it's a big challenge in terms of capital affordability.' she says.

Financial issues are always present. 'Locally, we're no different to many other parts of the UK, in that our underlying recurrent deficit has been masked by year-on-year non-recurrent funding. A regional transformation programme, led by the Department of Health, has begun and will help us manage our resources more effectively.

'In the shorter term, we are all striving to break even each year. But without a significant injection of additional recurrent funding and with year-on-year reductions in the amount of in-year monies available to health and social care, it is difficult to see how trusts can continue to achieve in-year financial balance without having to consider interventions that might impact on the level of service provided.'

Costs are rising by about 6% year-on-year. 'It is no surprise that with growing pressure on the Northern Ireland public sector budget, our allocation has not kept up with our costs.

'We can easily articulate the issues facing us. It is my role to ensure that collectively we use the resources we have to best effect. But despite the trust making some good productivity gains in terms of patient flow, we have just about handled the increases. With greater financial pressure to come, we know we need to do more.'

Integrated health and social care allows services to operate in a joined-up fashion, she says. 'It means we also have the same social care problems as local authorities in England – social care needs are growing and the market is affected by the living wage and is under great pressure.'

Best value call

Future focused finance

NHS Future-Focused Finance has updated its *Best possible value* (BPV) decision framework and is calling on finance professionals and others responsible for use-of-resources decisions to get involved.

The update includes new example templates, instructions for upfront planning and advice on making the case for change and modelling the value of available options.

There are a number of ways to engage with BPV – at one level, staff can join the online group to discuss and debate BPV. FFF says this is an ideal resource for value makers and finance and clinical educators to learn more about the action area, though access is not limited to these groups. FFF has started offering online BPV-related activities to help new users.

Decision-makers can also become BPV specialists – a unique volunteer role where those familiar with the framework apply the process in their own organisation.

FFF is also seeking clinical champions to work alongside its finance champions to lead and promote the BPV workstream.

Organisations can also get involved. Some organisations and local health economies are part of the national demonstration exercise, but FFF is inviting applications from organisations and economies interested in applying the framework.

BPV senior responsible officer Caroline Clarke urged clinical, financial and other managerial professionals to sign up.

'At a time when the NHS is struggling with massive financial pressures, we need to ensure the finance community is focused on quality and cost and therefore value. That's what the decision effectiveness framework is about,' she says.

• **Visit** www.futurefocusedfinance.nhs.uk


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