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fleet solutions
by the NHS for the NHS

IT'S BUSINESS AS USUAL FOR SALARY SACRIFICE COMPANY CARS

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

Background

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

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

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

Overview of the new rules

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

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

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

What the new rules mean

- **Ultra Low Emission Vehicles ("ULEVs")**
  ULEVs with CO2 emissions of 75g/km or less will be excluded from the new rules and will be taxed based on the existing rules. However **all** drivers can continue to choose from hundreds of makes and models with varying savings depending on their own circumstances and the CO2 emissions' rating of their vehicle.

- **Grandfathering**
  Grandfathering applies where the salary sacrifice company car arrangements for an employee were in place before 6 April 2017. In these circumstances, the existing tax and NIC treatment continues until 5 April 2021. This means that there is potential for up to four years' of grandfathering. However, note that transitional protection ceases if and when there is a variation in or renewal of the arrangements, unless it is beyond the control of the parties.

- **Transitional rules**
  Where an agreement to a salary sacrifice is made before 6 April 2017 and the reduced salary/provision of the benefit applies after 6 April 2017, transitional rules will apply. For example, where a variation to terms and conditions of employment is made prior to 6 April 2017 in respect of a company car that is delivered some weeks later due to normal delivery delays transitional rules apply.

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

Mixed messages...

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

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

  Fleet Solutions data illustrates that more than three quarters of forecasted 2017 orders would not be affected by the new rules, either because drivers will opt for a ULEV or because they will already be paying more in gross company car benefit than the salary being sacrificed. For the rest, most will see an average increase of less than £10.00 per month. Due to the fact that NHS Fleet Solutions use the Crown Commercial Services (CCS) Framework to source all of their cars, competition drives down prices, resulting in fewer cars being affected by the changes.

- **What about the employer's costs/ savings?**
  Under the NHS Fleet Solutions model and unlike other scheme providers, savings made by all employers will remain the same post OpRA.

- **Are only ultra-low emission vechiles (ULEV) available under salary sacrifice?**
  Employees will still be able to choose any type of car under a salary sacrifice scheme and (with NHS Fleet Solutions) employer savings will be the same regardless of the vehicle chosen.

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

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

News

PRESS ASSOCIATION

NHS ups efficiency stakes with mandatory plan

By Seamus Ward

The NHS in England has been handed a mandatory 10-point efficiency plan, while emerging accountable care systems (ACS) have been offered the prospect of a one-stop shop regulatory regime with NHS England and NHS Improvement.

The plans were set out in the NHS forward view delivery plan, *Next steps on the NHS five-year forward view*, published at the end of March. As well as the streamlined regulatory regime, an ACS could receive a devolved transformation funding package in 2018, potentially including national funding for the GP forward view, mental health and cancer services. It listed nine potential candidates to become an ACS.

The document sets out goals for the next two years, recognising there must be trade-offs to maintain financial balance. The national service priorities for 2017/18 are on A&E performance (see page 5), better access to GP services and improving cancer and mental health services. However, the plan accepts that 'some providers' waiting times will grow'.

Sustainability and transformation plans (STPs) are being updated to reflect national priorities, but the plan said significant risks to delivery remain – on bed occupancy reductions required, workforce supply, capital requirements and residual financial gaps. An STP update that will include final agreed control totals and plans for 2017/18 will be published in the first quarter.

> **"The plan also sets out where progress has not been as quick, with rising pressure on A&E and acute wards"**
> **Simon Stevens**

The plan highlighted three NHS truths:

- It is one of the most efficient healthcare systems in the industrialised world
- Health spending is likely to rise significantly over the coming decades because of growing demographic pressures, rising demand and technology advances
- However, substantial opportunities to cut waste and increase efficiency remained.

To deliver these savings, the plan set out a 10-point list of mandatory actions (see box) that aims to save £1bn in 2017/18, with further savings in running costs and reimbursement for the care of overseas patients. NHS England and NHS Improvement will oversee their delivery.

In 2017/18 they include a £100m cut in back-office costs through consolidation; £350m in procurement savings; almost £380m through medicines efficiencies; £130m in diagnostics; and £100m in estates.

NHS England chief executive Simon Stevens acknowledged the pressure on the service, but said the plan set out practical steps to improve care.

While it outlined significant progress, including cutting waste, particularly in agency staffing bills, he added: 'It also, however, frankly sets out where progress has not been as quick, with rising pressure on A&E and acute wards partly caused by delayed transfers of care.'

The document highlighted improved financial grip, including commissioners contributing a planned £800m underspend in 2016/17 to balance overspends in other parts of the NHS.

NHS England chief financial officer Paul Baumann said CCG forecasts increasingly showed the impact of savings required. At month 11, commissioners forecast a year-end underspend of £0.5m, but CCGs predicted ending the year with a £550m overspend – at month nine the forecast was £370m.

This will be offset by underspends in direct commissioning and NHS England expenditure. While 79 CCGs were forecasting a year-end overspend, 37 were unplanned.

The 10-point efficiency plan

- Hospitals, local authorities and primary and community services must cut **delayed transfers** of care and free up 2,000-3,000 beds
- There will be a further clampdown on **agency costs**, with an emphasis on cutting locum doctor spending. While making cuts in temporary and agency staffing as a whole, £150m should come from reductions in locum bills.
- Better trust **procurement** will release £350m of savings in 2017/18 on a baseline spend of more than £8bn. All trusts must participate in the nationally contracted products programme and use the price comparison tool to get best value.
- The NHS must improve efficiency in community **medicines**, saving at least £128m on medicines and products of low clinical value and helping hospitals save £250m in 2017/18 by implementing the top 10 medicines savings options.
- The service must reduce **avoidable demand** through schemes such as RightCare.
- It must use the *Getting it right first time* methodology to drive **quality and productivity** improvements and, subject to local consultations, the centre will support well-designed and affordable STP proposals to split emergency and elective care delivery.
- In 2017/18 the NHS must save up to £130m a year in **diagnostics** through improved deployment of pathologists and imaging, and £100m in **estates**, by reducing variation in energy costs, for instance.
- It must cut provider **back-office** costs by £100m in 2017/18 via consolidation across STP areas, where appropriate, and a further £150m in NHS England and CCG running costs by 2019/20. NHS England and NHS Improvement will streamline management of their joint work in 2017/18.
- Improve cost recovery from **non-UK residents** – the target is £500m a year.
- Each trust and CCG must live within their financial means, and it is no longer acceptable that overspending in some organisations or areas has an impact on other areas or services. This could mean scaling back locally **unaffordable services**.

A&E targets will be sole trigger for STF performance payments in 2017/18

By Seamus Ward

The performance element of the sustainability and transformation fund (STF) in 2017/18 will be based on meeting A&E waiting times, better management of A&E demand and a reduction in delayed discharge.

In a joint letter to trusts, commissioners and local authorities, NHS Improvement and NHS England chief executives Jim Mackey and Simon Stevens said payment of the performance element of the 2017/18 STF – worth 30% of the total – will depend on A&E performance alone. Previously, the performance element also included meeting 62-day cancer and 18-week elective care targets.

As well as managing demand and freeing up acute beds by cutting delayed discharges, they said trusts must step up their A&E performance. They must ensure 90% of patients are seen within four hours before or in September 2017 and this must be sustained and improved upon to hit the 95% target by March next year.

The latest A&E performance figures – covering January 2017 – show 85% of patients were admitted, transferred or discharged within four hours, the worst performance since monthly reporting began in 2010.

In the March Budget, social care was allocated an extra £2bn over three years, including £1bn in 2017/18. The letter said the NHS and local authorities must ensure the additional funding in 2017/18 is used in part to free up 2,000 to 3,000 acute hospital beds.

While NHS leaders must engage with their counterparts in social care to plan how to reduce delayed discharge, some hospitals had not yet adopted best practice in patient flow. Measures such as more timely hand-off between A&E clinicians and acute physicians, discharge to assess schemes and seven-day discharge should be adopted everywhere before October, Mr Mackey and Mr Stevens insisted.

Trusts hoping to receive the performance element of the STF must work with local partners to improve A&E performance by

FDs' quality warning

Nearly two-thirds of trust finance directors and more than half of clinical commissioning group chief financial officers believe the quality of care locally has deteriorated in the past year. According to the King's Fund's latest *Quarterly monitoring report,* finance directors said the deterioration was not due to lack of planning – 70% had added to staff to cope with winter pressures, while 80% of CCGs paid for additional primary care resources.

The lead finance officers said the worsening A&E performance was the result of sicker patients with more complex illnesses – 80% of finance directors identified these patients as the main source of pressure on A&E, while 70% believed delayed discharge was a key factor. Only 27% pointed to poor access to GPs and 20% to clinical staff shortages.

Trusts and CCGs remained pessimistic about their financial position in 2017/18, with 53% of trusts and 63% of CCGs fairly or very pessimistic about achieving financial balance by year-end. Almost 30% of trusts said the financial pressures meant they were planning to reduce their permanent clinical staff numbers.

Health Foundation calls for review of emergency marginal rate

The Health Foundation has called for fairer reimbursement of emergency care, after it found trusts have been losing elective income as they prioritise non-elective services to meet rising demand.

In a report on the financial position of providers, *A year of plenty?*, the foundation urged NHS Improvement and NHS England to review the marginal rate for emergency care and whether there should be a similar system for elective activity.

The foundation said the increased NHS provider focus on emergency work has meant more and more elective care has gone to non-NHS providers.

However, while elective activity is paid at full tariff, a proportion of emergency care is paid at a marginal rate. This is currently set at 70% of the standard tariff for activity above a baseline monetary value.

Anita Charlesworth (pictured), the Health Foundation's director of research and economics, said: 'Rising demand for emergency care meant NHS providers haven't had the capacity to deliver planned care and patients had to be diverted outside the NHS. NHS hospitals were left squeezed by sharply rising drug and staff costs with little additional funding.

'The NHS urgently needs to look at how to ensure additional funds reach NHS providers,' said Ms Charlesworth. 'The health service needs to plan better for emergency demand, fund emergency care fairly and make sure it gets the best possible price for care provided outside the NHS.'

• ***See A bumpy ride, page 8***

"To avoid a repeat next winter of this past winter, we need to make concrete changes"
Letter from Jim Mackey (above) and Simon Stevens

introducing triage/streaming at every emergency department by October; improving care home access to clinical advice; and rolling out evening and weekend GP appointments to 50% of the population by March 2018 and 100% a year later.

The letter said: 'Throughout this winter, there have been three consistent themes relating to urgent and emergency care: difficulties in discharging inpatients when they are ready to go home; rising demand at A&E departments, with the fragmented nature of out-of-hospital services unable to offer patients adequate alternatives; and complex oversight arrangements between trusts, CCGs and councils.

'To avoid a repeat next winter of this past winter, we need to make concrete changes on all three fronts.'

Report outlines steps to combat staff stress

Finance directors could take steps to combat and manage workplace stress in their teams, according to a paper from the HFMA West Midlands Branch research and development committee.

The document, *Stress management in finance functions*, said finance staff face an increasingly complex and challenging working environment, which could trigger stress. The levels of stress in many finance departments is relatively high, it said, due to the financial pressures on the NHS, the need to hit financial targets and the fact that delivery of savings can occasionally still be seen as a problem for the finance function alone.

Finance teams can face significant extra workload when facilitating reconfiguration plans, supporting sustainability and transformation plans and answering requests for information from regulators. Without adequate transformation, moves to find savings in back-office functions, including finance, through consolidation could risk workforce wellbeing, the research said.

Stress can lead to low morale, inconsistent work, breakdown of working relationships and poor staff retention. But finance directors can take actions to counteract stress, the report said, by:

- Ensuring there is an up-to-date stress management strategy, tailored to finance staff needs
- Focusing on making the finance department a great place to work and engaging with NHS Future-Focused Finance
- Training managers on their roles and responsibilities in handling stress suffered by staff
- Clearly describing tasks, ensuring staff have the necessary skills and providing feedback promptly
- Providing access to peer support and counselling.

See FFF update, page 32

Corporate spend could be cut by £400m, trusts told

By Seamus Ward

The NHS could save more than £400m a year on corporate services, including finance and payroll, if all trusts performed as well as the average, according to NHS Improvement.

In March, the oversight body sent each trust a bespoke analysis of their corporate costs. It found significant unwarranted variation in an overall spend of £3.2bn a year.

The work follows on from last year's Carter report, which found considerable variation in corporate and administration costs. There was some criticism at the time Carter was published that it made comparisons based only on pay costs, ignoring where organisations had outsourced service provision. But the NHS Improvement analysis, based on a targeted collection, includes both pay and non-pay spending.

NHS Improvement said the top 10% of trusts that spent the most on corporate services had an average spend of £7.50 per £100 of funding for patient care. But, at the other end of the scale, corporate services cost the 10% of lowest spenders an average of £2.80 per £100 of patient care funding.

The analysis was based on returns from nearly all trusts (230 out of 236). Small trusts spent proportionally more – those with a turnover of less than £300m spent the equivalent of £5.40 per £100, while those with more than £300m turnover spent £3.90.

Looking at specific examples, NHS Improvement said the average cost of producing a payslip was £4.28, but for some it was more than £5 and in outliers almost £10.

Overall, if all trusts achieved the national average, the NHS would save £422m a year.

Jeremy Marlow (pictured), NHS Improvement's executive director for operational productivity, said: 'The closer you look at the NHS the more you see variation in what things cost and the knock on effect this can have on hospitals and patients is huge.

'We want to support trusts to have high-quality, efficient corporate services they can rely on and we are asking them to work together to become more efficient, so that the NHS as a whole can benefit.'

Individual reports on corporate services costs were sent to providers. But the data will be available on NHS Improvement's Model Hospital in the near future. After a year in prototype form, the Model Hospital, which brings together wide ranging metrics on provider performance, has now been formally released.

- *See Leading by example, page 20*

News review

Seamus Ward assesses the past month in healthcare finance

The set piece event of March took place early, with chancellor Philip Hammond delivering his first full Budget. As expected, he found more funding for local authorities – they will receive an additional grant of £2bn over three years for social care, with £1bn available in 2017/18. Contrary to expectations, he also allocated more money to health, with £325m of capital funding available to the most advanced sustainability and transformation plans (STPs). This will be allocated ahead of the autumn Budget, which he said would include a multi-year capital scheme for STPs. He also announced a further £100m of capital to help hospitals extend the use of GP triage in A&E.

Though not as much as STPs believe they will need, the health service welcomed the capital funding and the possibility of more to come. However, it soon became the subject of some controversy as Budget documents showed that all of the £325m would not be available immediately, as initially thought, but over three years, with £130m available in 2017/18.

In the run-up to Mr Hammond's statement, NHS stakeholders pushed hard for additional funding. NHS Providers said that over the winter months, bed occupancy in England spiked at 96% and remained above the recommended safe level of 85%. The British Medical Association called for the UK's health spending to increase by £10bn to bring health spending in line with other leading European countries. It said spending in the 10 leading European economies averaged 10.4% of GDP, but the UK's was 9.8% – a gap of £10.3bn.

The NHS Confederation said the government should admit the NHS does not have enough funding to offer all services. While the service had coped better than many had predicted, it was time for the government to acknowledge the limitations patients can expect and that services must be able to prioritise what they can and cannot provide. A joint letter from NHS Providers, the Royal College of Physicians and the Royal College of Emergency Medicine urged the chancellor to ensure any additional cash for social care will be spent in a way that benefits NHS patients. Though extra money was forthcoming, NHS Providers later said there were no guarantees it would alleviate the pressure on the health service.

The 44 sustainability and transformation plans in England will struggle to reduce hospital activity unless they are given more money and staff to develop new services, the Nuffield Trust said. In a report – *Shifting the balance of care: great expectations* – the trust said schemes to move care out of hospital were often better for patients but largely fail to save money. The trust looked at 27 of the most common schemes to move care closer to home and found many had the potential to improve patient outcomes and experience. However, only seven had saved money, many produced no overall saving and six would likely increase the cost to the NHS. The seven money-saving schemes included: additional support to people in nursing homes; better support at end of life; and giving GPs access to specialists such as dermatologists.

After warning in February that it was considering placing 12 trusts into financial special measures, NHS Improvement announced in March that three would move onto the regime. The oversight body said the trusts – St George's University Hospital NHS Foundation Trust, North Lincolnshire and Goole NHS Foundation Trust and University

The month in quotes

'Out-of-hospital care is often better for patients and the right aspiration for the NHS given the growing and ageing population. But it is not likely to be cheaper for the NHS in the short to medium term – and certainly not within the tight timescales under which the STPs are expected to deliver change.'
Nuffield Trust policy director Candace Imison on moving care out of hospital

'Increased support to the NHS in delivering candour in practice and in sharing learning for improvement will be coupled with a fresh approach to resolution, which reduces the need for costly and stressful court proceedings.'
NHS Resolution chief executive Helen Vernon outlines its new five-year strategy

'The chancellor's initiatives will provide support in the short term. But they do not by themselves provide sustainable solutions for the NHS and care services over the medium to long term. The gap between what the NHS is being asked to deliver and the resources available will continue to grow.'
Saffron Cordery, NHS Providers' policy and strategy director, reacts to the Budget measures

'At autumn Budget, I will announce a multi-year capital programme to support the implementation of approved high-quality STPs. In the meantime, the health secretary expects a small number of the strongest STPs may be ready, so I am allocating an additional £325m of capital to allow the first selected plans to proceed.'
Chancellor Philip Hammond unveils extra capital funding – but this will be spread over three years

Hospitals of North Midlands NHS Trust – had not kept up with their agreed control totals and were forecasting a combined year-end deficit of £145m. The trusts will receive support to ensure their financial systems work effectively, improve their efficiency and productivity and ensure they are paid appropriately for the work they do.

NHS Improvement said its controls on agency spending have saved £1bn since they were introduced in October 2015. It said this was due to an outstanding effort by trusts, 77% of which had been able to cut their agency spending since last year. More than half of these trusts (95 trusts or 40% of all trusts) had reduced spending by more than 25%. But it said more could be done to curb medical locum spending, which is expected to be £1.1bn this year. NHS Improvement said £300m could be saved if all medical locum rates were within the price cap.

Prescription charges in England increased by 20p to £8.60 for each medicine or appliance dispensed

In further NHS Improvement news, chair Ed Smith said he would step down in the summer. Announcing his retirement, he said he wanted to give his successor time to recruit a new chief executive for the oversight body. Current chief executive Jim Mackey joined NHS Improvement in November 2015 on a two-year secondment.

NHS England will support bed closures that arise from proposed major service reconfigurations, but only if they satisfy one of three tests. Simon Stevens, NHS England chief executive, said that, from 1 April, it would only allow significant bed closures to go ahead if they demonstrate sufficient alternative provision; or show new treatments or therapies will reduce admissions; or, where it has been using beds less efficiently, a hospital can show it has a credible plan to improve performance without affecting patient care. Major closures would still be subject to public consultation.

Also from 1 April, NHS-funded nursing care rates have been reduced. The Department of Health said that following a review, the standard rate will be £155.05 per week and the higher rate £213.32. Currently, the standard rate is £156.25 and the new rate is the result of a reduction in the agency cost component, partially offset by a 1.7% uplift to reflect nursing wage pressures. Prescription charges in England increased by 20p to £8.60 for each medicine or appliance dispensed. Pre-payment certificate prices have been frozen at £104 for an annual certificate or £29.10 for three months. Prescriptions are free in the rest of the UK.

GP pay and expenses will increase by 2.7% in 2017/18 under the new contract agreed in Wales. Announcing the deal, Wales health secretary Vaughan Gething said the uplift included a 1% pay rise, an increase of 1.4% to cover practice costs and other elements, such as a contribution towards increasing indemnity costs. There are also a number of new enhanced services.

The NHS Litigation Authority launched a five-year strategy underlining a strategic shift to becoming involved in incidents at an earlier stage. It has also changed its name to NHS Resolution to reflect the extension of its role beyond claims management. The new organisation brings together the NHS Litigation Authority, the National Clinical Assessment Service and the Family Health Services Appeal Unit, though the statutory remit is unchanged. It said it aims to improve the experience of patients, families and staff, focusing on prevention, learning and early intervention to avoid unnecessary court action.

The British Medical Association and Royal College of Nursing called on the home secretary to exempt the health and social care system from the immigration skills charge. The bodies said the charge, due to be introduced on 6 April, will impose an upfront charge of £1,000 per year for employers who bring staff into the UK on a Tier 2 (general) work visa. In the year to August 2015 this would have cost the NHS £3.5m, they said.

SHUTTERSTOCK

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in the media

During last month, the HFMA gained further coverage of its new qualifications and its commitment to training and development.

HFMA policy and technical director Paul Briddock discussed the benefits for all staff of training and development in NHS finance in a comment for *National Health Executive*. While development was important for finance staff at all levels, he wrote, increasing the skills of general managers, clinicians, practice managers, other healthcare professionals and non-executive directors will go a long way to ease the sometimes conflicting pressures.

Writing a blog for the Future-Focused Finance website, HFMA education director Alison Myles said the new qualifications, which can lead to an MBA, help give finance professionals the skills to deliver plans focused on sustainability and transformation. The modules had been carefully designed with the current challenges in mind, she added.

The association's work on transforming the profession's role was also highlighted in an article in the *British Journal of Healthcare Management* on the progress of FFF (see also *Healthcare Finance*, December 2016, p35). The BJHM article highlighted how 2013 president Tony Whitfield had adopted '*Knowing the business*' as his theme, which focused on closer ties between clinicians and finance staff. This has been echoed in the FFF *Close partnering* workstream.

News analysis

Headline issues in the spotlight

A bumpy ride

As a new financial year begins, what is the prognosis for the English NHS, grappling with deficits, transformation and missed targets? Seamus Ward reports

With each new financial year the prognosis for the NHS in England is increasingly dire and 2017/18 is no different. It's not hard to see why. Waiting list and the four-hour A&E targets – the two great weathervanes for the service – have largely been missed. But is it time for doom and gloom or should the NHS be cautiously optimistic? Has 2016/17 been about steadying the ship, before turning it around?

Even before the refreshed *Five-year forward view* (see page 3), it is looking as though the service will hit overall financial balance in 2016/17 – helped by a £1.8bn sustainability and transformation fund and an £800m commissioners' risk reserve.

The reserve will offset a provider deficit that at quarter three was forecast to reach £873m. HFMA policy director Paul Briddock said viewing the provider position as poor because they are still in deficit is too one dimensional. Compared with 2015/16, he said the deterioration in providers' financial position has slowed and potentially stopped.

'It's quite a remarkable achievement, especially as providers pulled out efficiencies of 3.3% by the end of the third quarter and believe they will get to nearly 4% by year-end,' Mr Briddock said. 'We have to remember they are facing a 3.5% rise in A&E attendances and a 28% increase in delayed transfers of care due to issues with social care funding. They are more or less absorbing these pressures and taking a huge cut out of agency spending, though obviously waiting times have suffered. However, that doesn't mean that I think next year is going to be any easier.'

Following a frontloaded spending review settlement, funding growth over the next few years will fall before recovering to some extent in the final two years (see table). 'The NHS has done well in 2016/17, but the reality check is that the years between 2017/18 and 2020/21 are going to be tough,' said Mr Briddock.

NHS Providers said trusts had an average CIP of 4% in 2016/17. However, 30% of trusts have not agreed their control total for 2017/18 – this group of trusts were asked to deliver an average CIP of 6.4%. In some trusts, the CIP is 9% or more (see box).

According to NHS Providers, trusts will need to absorb a 5.2% demand and cost increase, together with delivering key waiting time targets and eliminate the aggregate deficit. New commitments on cancer and mental health could cost £150m to £200m. While funding will increase by 2.6%, NHS Providers said this is not enough to cover rises in demand and costs. A further £2.4bn to £3.1bn would be needed to ensure performance targets were met.

NHS Providers chief executive Chris Hopson said this added up to 'mission impossible' for trusts. 'The standards on A&E and surgery were set for a good reason – they are a good proxy for the quality and access to care the NHS should provide. But trusts can only deliver if funding keeps pace with rapidly rising demand,' he said.

'Trusts won't be able to recover the A&E and elective surgery targets across the whole year. Just stabilising the rapidly increasing performance decline would be an achievement in itself. Given that demand and cost increases will easily outstrip funding and efficiency increases, just reproducing this year's financial performance is a stretching target.'

He called for greater flexibility, with trusts given more realistic performance trajectories and more support to eliminate unwarranted variation. Money could be directed from central budgets to the front line.

Mr Briddock argues that the case can be made for additional funding, with the UK spending less on health as a proportion of GDP than the likes of France and Germany. 'If there is no more money for health, that will mean more co-payment or the NHS scaling back on the

NHS Providers survey findings

Trusts will be required to deliver a step change in cost improvements in 2017/18, according to NHS Providers.

It found that 70% of 99 surveyed providers had agreed control totals for the new financial year. On average, their cost improvement requirement was 4.2% - up slightly on the 2016/17 average.

However, the 30% that had not agreed control totals – and so not able to access sustainability and transformation funds – had an average CIP of 6.4%. Some 5% of trusts were asked to make savings in excess of 9%.

The survey highlighted trusts' reliance on one-off measures, including capital to revenue transfers, to make up the shortfall in recurrent savings. Two-thirds of respondents said they had relied on such measures, though fewer expected they would depend on one-off savings in 2017/18.

NHS Providers finance policy adviser Edward Cornick said: 'We can see the scale of the task facing providers next year equals not a gradual change but a dramatic one. The fact that NHS Improvement concluded 30% of providers need to make a 6.4% cost improvement clearly shows that the service is in for a very bumpy year financially. Under such circumstances it is hardly surprising, from a governance perspective, that these providers felt unable to agree to control totals.

'We are entering a year when providers are being asked to make savings that are simply of a different magnitude than at any other time,' said Mr Cornick.

	2016/17	2017/18	2018/19	2019/20	2020/21
NHSE funding	£105.8bn	£109.2bn	£111.7bn	£114.8bn	£118.9bn
Rise in allocation	£5.5bn	£3.6bn	£2.5bn	£3.1bn	£4.1bn
Budget growth	5.5%	3.2%	2.3%	2.8%	3.6%
Real-terms change in funding per head of population	3%	0.6%	-0.4%	0%	0.7%

levels of service provided. That's happening already with waiting times.'

Waiting times targets have not been hit for the best part of two years and health secretary Jeremy Hunt has insisted they will be met in 2017/18. Mr Briddock accepts that additional social care funding may reduce delayed discharges, but he does not think this will have a major impact on existing capacity shortages.

The King's Fund said financial pressures are not just affecting waiting times. Its report, *Understanding NHS financial pressures*, said community and public health services were often the hardest hit by the slow down in funding since 2010/11. It found evidence of cuts in sexually transmitted infection and district nursing services, adding there was emerging evidence that elective hip replacement was beginning to be affected.

British Medical Association council chair Mark Porter claimed care was increasingly being rationed. 'Waiting lists should not be rising, and yet they are,' he said. 'Decisions on patient care should be based on individual clinical need and follow royal college or other evidence-based standards. Doctors always want to deliver the best care for patients, but we can't continuously plug gaps by penny pinching and poaching from elsewhere in an overstretched NHS.'

Hopes to address these issues lie with the 44 sustainability and transformation plans (STPs). However making progress is extremely challenging 'People are fire fighting and working hard on balancing their year-end position. It's difficult to find the headroom to work on the transformation agenda – changing service delivery models or increasing self management of care, for example,' Mr Briddock said. However he added that, while there were concerns over governance, the association's last *Financial temperature check* highlighted improving relationships across health economies.

"We can't continuously plug gaps by penny pinching and poaching from elsewhere"
Mark Porter, BMA

It's not a revelation to say 2017/18 will be tougher than 2016/17. The service has done a good job in largely stabilising its finances, but in 2017/18 it will once again be asked to deliver – on finance, transformation, safety and, as ministers have made clear, slippage in waiting times will not be tolerated.

Comment

April 2017

(Just like) starting over

Commentators tell us why we can't deliver – we need ambitions that create conditions where we can

HFMA president Mark Orchard

The beginning of a new calendar year is traditionally when we reflect on our personal and family achievements during the outgoing year and set new goals for the months ahead. So as we flip from one financial year to the next, it is important we similarly take time to reflect, reset and reload.

I was reminded this month that there is difference between just working in a team and being part of an effective, high-performing team. This usually comes down to being able to answer 'yes' to three questions:

- Does your team have clear objectives?
- Do you have to work closely together to achieve these objectives?
- Do you meet regularly to review your team effectiveness?

This is pretty obvious stuff, I know. But it is also backed up by a strong evidence base.

Why, then, do we and our teams often pay lip-service to our individual and collective objective setting? Especially after having usually invested so much time and energy shaping the business planning priorities and objectives of the organisations we serve?

Maybe John Lennon had the answer to that conundrum in 1980, when he wrote: 'It's been so long since we took the time. No-one's to blame. I know time flies so quickly.' In this context, I think we can all relate to John.

So, back to the evidence. What it tells us is that when

Turning data into information

Data initiatives offer chance to build an information rich NHS

Healthcare Finance editor Steve Brown

When asked about the most valuable resource in delivering health and care services, most people would rightly say 'the staff'. From frontline to support functions, NHS workers are typically united by their focus on helping others and their pride in being involved with the country's most prized institution. But second on the list must be data – or at least it should be. The NHS produces data in huge quantities on everything from waiting times and clinical performance to procurement, human resources and finance data.

The problem is that, too often, the quality of data in the NHS has been too poor to use in any serious decision making. Or even where the data quality is fine, a reputation for poor quality data means that information is too easily dismissed. Decisions remain untaken and changes unimplemented.

There is a good argument for the service being data rich, but information poor.

Costing data has had a particularly bad press. While validations built into costing workbooks have addressed some of the more spurious cost data in recent years, you don't have to go back too far to hear stories of knee replacements apparently undertaken for less

than the cost of a knee prosthesis. Often in costing, it has been core data at fault, not the number crunching process itself. Activity not counted, miscounted or wrongly classified

"By working effectively as teams, this clarity will provide a framework for individuals to feel more personally powered"

teams do get it right, there is a demonstrable increase in staff (and user) satisfaction, wellbeing and engagement.

This happens alongside a significant decrease in waste, turnover and sickness absence. Furthermore, this stuff leads to reduced cost and a virtuous cycle of innovation and improvement. The opposite is also true of course. So it would surely follow that this is one of life's 'no brainers'?

Providers across England have recently received benchmarking reports highlighting relative financial investment in business support services.

Across Dorset, as I'm sure is the case across all the 44 sustainability and transformation plan footprints, this further challenges the pace at which we move towards our 'one NHS' vision. And similar questions will be being asked in Northern Ireland, Scotland and Wales.

Inevitably, this creates uncertainty for our highly valued and much needed staff across finance, information, procurement, estates and human resources – at a time when we need to draw on the skills of these staff more than ever.

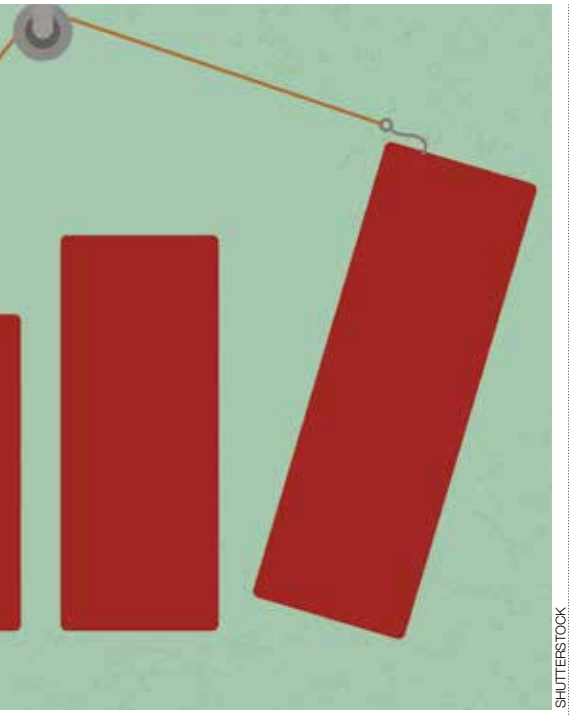
Not only do we expect them to continue to meet daily demands, but our colleagues are central to moves towards greater use of data and evidence-based decision-making.

So it is crucial we take the time to ensure we can answer those three earlier questions in the affirmative. Let's get our goals clear and ambitious and work closely to achieve them. And, I'll bet that, by ensuring we are working effectively as teams, this clarity will provide a framework for individuals to feel more personally empowered to make the best decisions at the right level.

So as we put 2016/17 to bed and set forward with a plan to deliver on 2017/18 challenges, let's make sure we are individually and collectively ready to be our effective best.

After all, as I keep saying, everyone counts.

Contact the president on president@hfma.org.uk



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will lead to meaningless cost data. Recent reference cost audits have highlighted there is still considerable room for improvement in the coding and classifying of data – an issue explored by an HFMA roundtable last month (see page 23).

But the data problems go beyond costing data. There are wide-ranging examples of organisations recording or submitting data in returns in slightly different formats or to differing degrees of completeness. And while electronic staff records may provide an accurate picture of staffing levels at the organisation level, they won't always reflect the exact services or departments those staff work in.

The current transformation agenda needs to be built on evidence and the NHS – on the face of it – has data in abundance to lay the foundations. There is a lot of data that is fine and could and should be used more. But there are also examples of implausible data that undermines everybody's confidence in the apparent messages or disengages the very staff an organisation is trying to engage.

Despite lots of rhetoric and promises about data and moving towards a greater evidence-based model, data quality has tended to improve in small increments. Current initiatives in the service – RightCare (page 16) and the Carter-inspired Model Hospital (page 20), for example – are a major attempt to ramp up the pace. Both initiatives feed back existing data – to commissioners in the case of RightCare and to providers for the Model Hospital – so they can compare performance and spending levels across wide-ranging activities.

"With greater confidence in data, energies can be redirected into making decisions on the back of it"

There are already examples of the data being put to good use to inform change, often providing hard data evidence of existing suspicions over improvement opportunities. But the initiatives also put the service on track to make a reality of its promises around evidence-based decision-making.

By putting the data out there – and showing relative performance – and starting to use it, the hope is that the data quality will improve rapidly and 'I don't believe the data' excuses will become a thing of the past. With greater confidence in data, energies can be redirected into making decisions on the back of it. This won't be achieved overnight but the prize of an information-rich NHS is surely well worth pursuing.

Uncertain times

Northern Ireland has integrated health and social care, but it also has the longest waiting lists and significant financial pressures. Seamus Ward looks at how the service is addressing these issues

Looking from the outside at Northern Ireland's health and social care (HSC) services, healthcare managers from elsewhere in the UK must be confused. Across the six counties health and social care has been integrated since 1973 and health is a devolved matter, allowing decisions to be based on local priorities. Spending per head is higher than the rest of the UK and accounts for nearly 50% of the local executive's budget. So why does Northern Ireland have the longest waiting lists and significant financial problems?

The answer is, in part, uncertainty. Since 2011, there have been four major reviews of the structure and delivery of services, met with widespread agreement, but virtually all their recommendations have yet to be implemented. Regular ministerial changes have meant proposals have been set aside, not formally abandoned but left in the pending queue, as each new politician stamps their own imprint on the health and social care brief.

The recent collapse of the power-sharing executive and subsequent election has created further uncertainty. As *Healthcare Finance* went to press, no agreement on a new executive had been reached, with health and other parts of the public sector entering the new financial year without a budget.

To address this, civil servants at the finance department could access up to 75% of the 2016/17 budget and decide how it is allocated. If no agreement is made by the end of July, this sum could rise to 95%.

However, there is a suggestion that legislation could be needed in Westminster for funds to flow to Northern Ireland public services. Either way, there is concern that, at least initially, services face cuts.

Besides the budget, a new minister's in-tray will be topped by a report from a team led by Spanish health systems expert Rafael Bengoa, and the response from former health minister Michelle O'Neill, which broadly accepted the Bengoa vision. These set out a case for a transformed and reconfigured service, with more care provided in the community and the creation of elective care centres and assessment and treatment centres.

Bengoa said if costs rise as predicted, a 6% budget increase would be required each year to stand still. By 2026/27, this would mean more than £9bn

Bengoa set out many of the issues facing Northern Ireland – an ageing population, with rising demand and more chronic illness. It said if costs rise as predicted, a 6% budget increase would be required each year simply to stand still. By 2026/27, this would mean a budget of more than £9bn (currently £5bn) would be needed to maintain the current system.

This system, with its reliance on hospital-based care, had created problems. The report said: 'Current service provision and commissioning is overly transactional, based on historical patterns and not on assessed population need. Services are not always planned around patients' needs but rather on filling rotas and maintaining unsustainable models.'

The report recommended the HSC take the triple-aim approach – improving population

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health, patient experience and value. It said new cost control measures should be implemented, which are 'measurable, comparable and outcomes based', while the process of paying for value, not just activity, should be started. It said that by 2020, 50% of the budget should be linked to value.

Implementing Bengoa would mean moving more care out of hospitals, with services being provided across organisational and professional boundaries, complemented by strengthened primary care. An earlier review had pointed out that, elsewhere in the UK, a population of 1.8 million would be served by four acute hospitals – Northern Ireland has 10. A consultation on the criteria for reconfiguration closed in February.

Managers welcomed the Bengoa approach and many feel the integration of health and social care provides a solid foundation for reconfiguration and transformation of services.

Political pressure

The knock-on effects of the political process are frustrating – without a budget and a minister, health and social care bodies cannot press ahead at pace to implement the Bengoa reforms, according to Heather Moorhead, director of the Northern Ireland Confederation for Health and Social Care (NICON).

'A new minister might change the branding, but we are hoping that there will be no change in the direction of travel, as the current policy has been widely politically agreed,' she says.

'But we will also need the underpinning finances to deliver the transformation. We need to make changes at pace and scale, but the context is not helpful.'

Health and social care have been integrated since 1973, though managers accept that silo working remained entrenched for years. However, the advent of trusts in the mid-1990s saw some of the barriers between health and social care break down.

'I think the biggest benefit of integration for us is that we have been able to move money between health and social care, and therefore, unlike England, we have not seen the big additional pressure on the NHS from reducing council budgets,' says Ms Moorhead.

'However, we have not done as much as we could to integrate services. There has been a good deal of work recently to develop this agenda, shaping services better to support people at home and in their communities.'

The Bengoa reforms will add impetus to this work within a new structure, Ms Moorhead adds. 'Integration must be part of the transformation agenda to improve the efficiency and quality of services.'

HFMA Northern Ireland Branch chair Owen Harkin, who is finance director at the Northern Health and Social Care Trust, says making the most of integration has been a gradual process – particularly with the challenges faced by the HSC in terms of workload, capacity and the ageing population. 'We are all working towards breaking down the barriers even further. In my own trust, for example, we focus on community staff involvement at the front door and in the flow team within the hospital thus enabling our community colleagues to put in place responsive and appropriate packages for patients as they leave hospital.'

For the Northern trust this means greater day-to-day involvement of community care professionals in decisions on discharge. The trust has also restructured, with its six divisions reporting to a single deputy chief executive/director of operations. It also has four localities, aligned with primary care, serving its 450,000 population, each with further local teams to deliver more responsive services.

'We think this is beginning to pay dividends for us. Our community staff, have day-to-day involvement in making sure flow of patients and discharge run smoothly,' he says.

Given the direction of travel on care delivery, Mr Harkin agrees it is vital to strengthen community services. He adds that the trust's reform and modernisation plan (RAMP) is compliant with the Bengoa principles.

He highlights the funding of domiciliary care as a key difference with the English system. Over the past few years an additional £15m to £20m a year has been put into community care across Northern Ireland, despite the pressures in the system with financial shortfalls and long elective waits.

'As an integrated provider of services, and given the Northern trust has the highest proportion of older people in the region, it was important to continue to invest in community services as well as maintain acute flow.'

Generally, more than 50% of domiciliary care providers are in the private sector, where costs are rising. Some trusts are retendering domiciliary care, looking at whether the current payment model is appropriate.

The question, Mr Harkin says, is whether they should be paid for the amount of time carers spend going into clients' homes or on the basis of outcomes.

'Should we be paying them by outcomes – maintaining somebody at home or stopping them going to the ED regularly? We are considering innovative pilot projects to inform

Fact file

- **Population** 1.8 million, projected to rise to 1.9 million by 2024 – while the number of over-65s are expected to increase by 26%, the working age population will rise by less than 1%
- **Waiting times** At December 2016 there were just over 246,000 patients waiting for a first outpatient appointment, including 47,000 for more than a year
- **HSC budget** £5bn, about 46% of the NI executive budget. Health spend is £2,500 per head (£2,000 in England, £2,400 in Scotland and £2,000 Wales)
- **Structure** Five health and social care trusts, providing a wide range of acute, mental health, community and social care services. There is one ambulance trust and one centralised commissioning body, which is slated for abolition with its functions transferred to trusts and the Department of Health

this with a view to developing a more robust model going forward.'

Some areas have too few nursing home places. The Causeway coast area, part of Mr Harkin's patch, has the oldest population in Northern Ireland and a shortage of places, so the trust is considering how it can engage and stimulate the market to respond to need.

The ageing population is just one of the factors putting financial pressure on the HSC. For the past few years it has relied on additional in-year allocations from the executive and non-recurrent measures to balance its books.

Vision for the future

The health minister in the last Assembly government, Michelle O'Neill, highlighted the impact of not addressing the issues when launching her vision for the future. She said: 'The reality is the current model is unsustainable. If we continue to provide services in the same way, using current models of care, demand projections show that ten years from now the HSC will need 90% of the entire executive budget.'

One finance manager says: 'Regionally, we have achieved breakeven over recent years using a range of non-recurrent measures such as slippage on development, technical adjustments and non-recurrent funding in the face of a reducing ability to secure recurrent efficiency savings. The financial challenge is therefore going to continue to grow. In this difficult financial environment it would, however, be important to maintain allegiance to the Bengoa principles to ensure that the health and social care model for the region is as viable and sustainable as possible.'

Attracting and retaining the support of primary care clinicians will be vital to implementing Bengoa, but this sector has its own problems. Many GPs are due to retire in the next five years. And recently, GPs have issued undated resignation letters due to concerns over funding and pressures on the workforce. Some of this is the result of the lack of an agreed budget, and finance managers believe it is important that a strategy, including primary care, is agreed at the earliest opportunity.

Another finance manager, who asked not to be named, adds: 'We need about 6% savings year-on-year but are getting nowhere near that. We are muddling through with non-recurrent measures, but we can't do that much longer.'

Ms Moorhead says the requirement to break even each year has meant that waiting lists have slipped.

NICON members are critical of the year-end balance requirement, which they say leads to a conservative approach to spending in the first three quarters of the year, followed by a rush to spend the remaining funds in the final quarter.

Bengoa recommended moving to a rolling three-year budget cycle to allow more strategic commissioning and planning of services.

A reliance on agency staff adds to financial pressures. Some smaller, more geographically isolated, hospitals have problems attracting enough medical staff, particularly in emergency medicine, paediatrics and acute care of the elderly. With fewer staff, on call rotas can be more onerous than in larger hospitals. As in other parts of the UK, difficulty attracting and retaining staff has led to a reliance on locums, ramping up staff costs and leading to quality and sustainability doubts.

There is also an issue with junior doctors, with most wanting to train in Belfast, as they believe they will get better training. But as a consequence, hospitals outside the capital can be left short staffed. As in other parts of the UK, the difficulty attracting and retaining staff has led to a reliance on locums, ramping up staff costs and putting question marks over safety and quality.

Yet finance managers contacted by *Healthcare Finance* believe that with the North's relatively small size and good road network, hospitals should be able to collaborate to provide cover. 'We are small enough, so I would like to think that we can address this in an innovative way by working together,' one says.

The UK's exit from the European Union is also a significant issue, with Northern Ireland having the only land border between the UK and an EU country. It throws up all kinds of questions about staffing – many members of staff live on one side of the border and work on the other side. Will their ability to move freely across the border continue? NICON's Ms Moorhead says that due to the uncertainty its members are already finding it difficult to recruit from EU member states.

Recent moves to create all-island or even regional cross-border services could also be threatened. For example, there is a cancer centre in the North West – based in Derry and covering the western counties of Northern Ireland as well as Donegal, the most northern county in the Republic – and specialist cardiac services in Dublin for patients from across the island. 'Members believe these have been very positive achievements, which colleagues would seek to build on,' she adds.

Northern Ireland has similar issues to the rest of the UK that it is seeking to address in similar ways. But with the outlook clouded by question marks over its political future and the undetermined impact of EU exit, uncertainty seems to be the only certainty.

"We focus on community staff involvement at the front door and in the flow team within the hospital"

Owen Harkin, Northern HSC Trust

unlocking variation

Reducing unwarranted variation is the answer to improving people's health and outcomes and to creating a sustainable health system. And the RightCare programme could hold the key. Steve Brown reports

RightCare is far from a new programme. It can trace its roots back to the launch of the programme budgeting initiative in the early 2000s. This required commissioners to identify their spend across 23 different programmes of care and, over the years since, the RightCare programme has set this spend information alongside growing information around disease prevalence, activity and outcomes. But over the last year, the pace has picked up in a major way.

There have been RightCare pioneers for several years. But at the end of 2015, NHS England announced an 'expansion and industrialisation' of the programme in support of the *Five-year forward view*.

An expanded team of 20 delivery partners in the NHS England-hosted RightCare team is supporting clinical commissioning groups to start using the improvement approach, which highlights key areas of variation for CCGs (see RightCare basics box, page 17). Wave one, involving 65 CCGs, got under way in February 2016 with the remaining 144 local commissioners forming the second wave in December.

Tackling variation is seen as one of the major ways the NHS will close its £22bn efficiency gap by 2020/21. With Lord Carter's work on productivity and the *Getting it right first time* initiative supporting providers to address variation, RightCare is aimed specifically at commissioners. 'RightCare is about delivering the best care to patients, making the NHS's money go as far as possible by identifying and dealing with unexplained variation in healthcare,' says Matthew Cripps, national director of NHS RightCare.

NHS England's expansion of the programme comes with big expectations. Of the service's £22bn efficiency requirement by 2020/21, the spending review's assumptions were that £4.3bn would come from activity-related efficiencies in commissioners. New models of care, specific work around urgent and emergency care and self-care all make contributions.

The National Audit Office's *Financial sustainability of the NHS* report put RightCare's share at £1.5bn, although other sources put the figure at £1.7bn. This savings expectation really kicks in this year – *Healthcare Finance* understands that the original spending review assumptions anticipated that about a third of the RightCare total contribution would be delivered in 2017/18.

Professor Cripps says the targets are achievable. 'We're encouraged by progress in wave one,' he says. 'The focus on better patient outcomes and increased value we tested when piloting the RightCare approach previously is holding true when implemented at scale.'

> **"The focus on better patient outcomes and increased value we tested when piloting the RightCare approach is holding true when implemented at scale"**
> **Matthew Cripps, NHS RightCare**

There have been some concerns that CCGs are using RightCare data to justify higher thresholds to access certain services and so reduce spend – with hips and knee replacements in particular in the news. While making no direct comment about specific cases, it is understood that NHS England has recently written to CCGs to underline how RightCare data should be used in these service areas.

The letter restates earlier comments in commissioning for value musculoskeletal (MSK) focus packs that high activity should be a trigger for further analysis, not immediate changes to access. 'There is strong evidence that hip and knee replacements are extremely cost-effective interventions when warranted by clinical need and patient preference,' the packs say. 'High rates should only be interpreted as an opportunity to reduce activity after further investigation.'

Given the rapid increase in expectations for RightCare-related savings, it is lucky that CCGs are not all starting from scratch. For some, it is about accelerating and embedding the use of data. Or, as Mr Cripps puts it, 'helping commissioners to optimise their use of the tools and establish a common view of the problem'.

Part of the roll-out is about sharing what has already been shown to work. Last year for example, RightCare published a cardiovascular disease prevention pathway to signpost easy wins for improvement. Within this it flags up Bradford's *Healthy hearts* programme, which was launched in 2014 following analysis of RightCare data.

That programme has seen some 6,000 cholesterol lowering statin users switched to a different generic statin and a further 7,000 at risk patients started on the drug, in line with NICE guidelines, without putting an unmanageable burden on general practice. Other work has looked at atrial fibrillation and high blood pressure.

Youssef Beaini, GP and CVD specialty lead across Bradford Districts, Bradford City and Airedale, Wharfedale and Craven CCGs, says CVD was already on the radar from earlier public health data – with Bradford Districts having the seventh worst death rate for strokes and heart attacks among under 75s across all CCGs.

'But RightCare packs definitely focused our minds,' he says. 'It is very clear data that helped us to focus on areas of low hanging fruit. Without this focus, programmes can just languish. But it gave us a framework to think through our CVD aspirations. It was a great catalyst.'

The ongoing *Healthy hearts* campaign has already delivered some

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RightCare – the basics

RightCare looks to address unwarranted variation in access, quality, outcomes and value – in particular helping to address both overuse and underuse of services. The overarching aim is to optimise population healthcare in a way that drives financial sustainability.

The programme talks about 'triple value'. Allocative value describes how well assets are distributed between programmes of care (such as cancer or respiratory), between systems in each programme (asthma and COPD, for example) and within each system (prevention, drug therapy or rehabilitation).

Technical value describes how well resources are used to deliver valid outcomes. Personalised value describes how well an actual outcome relates to the values and hopes of each individual.

There are three stages:

- Using spend and outcome data to decide where to look for improvement opportunities
- Planning what to change
- Developing practical solutions and deciding how to change.

It is an iterative process, with priorities changing as areas are addressed or as data is refreshed, ending up with continuous improvement being business as usual.

Commissioning for value data packs are produced for each CCG. 'Where to look' packs (refreshed in January this year) highlight the five top service areas where CCGs should look for improvement.

These are supplemented by focus packs that drill deeper into areas such as cancer, musculoskeletal and long-term conditions. The data packs have also been recut to show opportunities across sustainability and transformation plan footprints.

good outcomes and is being expanded, but Dr Beaini says RightCare data is now used routinely to help identify priorities for the CCGs. Respiratory and diabetes are new services currently under the spotlight. He encourages other CCGs not yet using the data in detail to do so and welcomes the new mandatory approach across England.

A number of CCGs in wave one of the roll-out say RightCare has already proved useful in confirming local priorities for improvement.

Ian Baines, director of organisational development for three CCGs covering Cannock Chase, Stafford and Surrounds, and South East Staffordshire and Seisdon Peninsula, underlines this. 'Our organisations have been in various aspects of special measures and turnaround for two to three years and as a consequence we have developed a strong relationship with business intelligence around our QIPP programmes and improvement work,' he says. 'We were already data driven, so when the RightCare programme came along, the principles aligned nicely with what we were already doing.'

But it has been useful in reinforcing existing approaches and extending some of the data sources. The 2016/17 QIPP programme contained projects that broadly addressed the priority areas highlighted in the CCGs' 'where to look' data packs. For the new year, the CCGs are taking a slightly different approach, using the data to feed into broader analysis around variation in primary care as well as including reference to the RightCare approach and data as part of every QIPP project.

Cumbria CCG, another wave one body, also credits RightCare with providing useful and focussed supplementary intelligence on where to target improvement. It had already identified pain management within its MSK services as needing to be overhauled. It knew it had an overly acute model of care that didn't meet NICE guidance. And staffing difficulties had led to some services in the north of the county being outsourced to the private sector.

MSK savings

On joining the programme, RightCare data provided confirmation of this diagnosis on MSK services, with January 2016 data showing the CCG was spending nearly £8m more on elective and day case admissions than the best five CCGs from a peer group of 10.

On top of this, it was exceeding the average on non-elective admissions and prescribing. More detailed data showed high relative spend on back pain injections. 'We were benchmarking very high on the amount of surgical intervention and it was clear that we didn't have alternatives to that acute service in place,' says Ray Beale-Pratt, Cumbria CCG's business, finance and performance manager.

All the pointers were towards a revised NICE compliant pathway based on a biopsychosocial model of care – and taking this approach for all pain, chronic fatigue and medically unexplained symptoms, not just back pain. 'RightCare data helped confirm what we already knew,' explains Mr Beale-Pratt. 'It was a case of triangulation, making it a stronger argument for change, and giving us confidence around the business risk and affordability [of the changes].'

High intensity focus

Early users of RightCare data, the two clinical commissioning groups Blackpool and Fylde and Wyre, used commissioning for value data packs and other data sources to identify unscheduled care services as an improvement priority.

A small group of service users were seen to be consuming a disproportionate amount of the £86m unscheduled care spend. Further data showed the top 100 frequent 999 callers called 1100 times in three months, resulting in about 1,000 A&E attendances and 300 admissions.

With high levels of self-harm incidents associated with these cases, it was clear that patient outcomes were poor despite the high spending levels.

A new support mechanism was needed for these high-intensity users. So advanced paramedic Rhian Monteith set out to provide a 'de-medicalised' service based on emotional intelligence, empathy and coaching. She contacted each high-intensity user, focusing on their issues and needs and not the nature of their emergency calls.

'My role was to listen to what the issues were and work through what was real and not real; not looking at solutions initially, but active listening and personalised coaching,' she says. 'Then my role was to unpick things one at a time to a position when they can flourish – it might be an eviction that's triggered a crisis, unresolved grief or no sense of purpose.'

Ms Monteith would then help address specific issues, bringing in other services where needed. 'The concept is to first provide emotional support and then practical support,' she says. Clients were encouraged to contact Ms Monteith when they needed to talk, instead of 999, or if they recognised any crisis triggers. And, with relapse common after about three months, access channels remained open to help the client course-correct and move forward again.

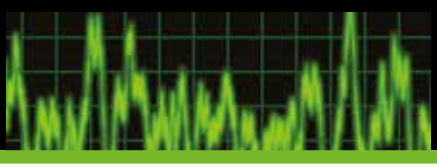
The results have been impressive. Over 15 months, 999 calls and accident and emergency attendances fell by around 90%, admissions by 82% and recorded self-harm incidences by 98%. And the big reductions were all in the first three months. In total the study suggests the 15-month pilot delivered more than £2m savings.

Ms Monteith says that while there is no formal 'discharge', users typically become less reliant on the service after about three months. And while clients can re-access the service at any point, simply by making a call, it is at this point that she can think about taking on new clients.

At Blackpool and Fylde and Wyre CCGs, the focus expanded to high-intensity service users, not just 999 callers. The programme has also started to look at high users of primary care services and those patients frequently self-presenting on wards.

Ms Monteith is now supporting a national rollout of the work for RightCare. A resource pack was published in January suggesting local areas can see results in as little as five months from starting the initiative. Some 30 CCGs are taking work forward and replicating Blackpool's individual lead approach, with Ms Monteith believing each lead could support 50-70 clients per year to help these vulnerable people flourish.

Blackpool's 'where to look' opportunities, January 2016



Helping Slough on its data journey

The use of data to inform service improvement is now embedded in the way Slough operates. Sangeeta Saran, associate director of planned care, says the CCG was already on this 'data journey' before RightCare emerged, with clinicians analysing prescribing data. 'But it had been a relatively blunt tool, with comparison limited to our own population and neighbouring commissioners,' she says. 'RightCare gave us a much greater breadth of data.'

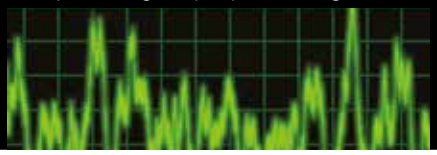
RightCare data, supplemented by local data and analysis, highlighted diabetes as a priority for improvement. Ms Saran says the local diabetes service in 2012/13 was low cost with poor outcomes.

The data suggested two prongs of attack. The town's 16 GP practices exhibited wide-ranging prevalence of diagnosed diabetes and different outcomes in terms of meeting key process targets. It also highlighted poor engagement with South Asian people (40% of its total population), where prevalence of diabetes can be six times higher.

A general practice training programme aimed to improve the identification of people with or at risk of diabetes. This has reduced variation between practices in terms of diabetes identification and an increase in the numbers of patients receiving the eight national recommended diabetes care processes.

The South Asian community has also been targeted with a lifestyle intervention programme. '[The existing service] wasn't tailored to their needs, it wasn't ethnically sensitive,' says Ms Saran. Instead of simply talking about five fruit and vegetables a day, this community needs help to understand how they can replace or reduce certain foods used in cooking – ghee, palm oil white rice and salt all being known problem ingredients.

Both programmes have contributed to an increase in detection rates. Those at risk of developing diabetes are also more engaged and being formally reviewed. More generally, control of diabetes is improving – the percentage of people meeting blood glucose, blood pressure and cholesterol targets has more than doubled.



With support from clinical pharmacists, practices have also reduced prescribing costs. 'Following the RightCare process, we've moved from low outcomes and low cost to high outcomes and low cost,' says Ms Saran.

The approach is now planned to be rolled out across two neighbouring CCGs (Bracknell and Ascot; Windsor, Ascot and Maidenhead) and Ms Saran says collectively the commissioners believe they can save in annual costs, while improving the consistency and outcomes of services.

Slough's diabetes prevalence, from long-term conditions pack 2016

The standard referral pathway now for the county's new persistent symptom management service is for triage in a community-based service, instead of direct GP to acute services in all but urgent or complex cases. After a multi-disciplinary assessment, patients might receive a range of therapies either one-to-one or in group settings.

A year in and the service now receives more than 100 referrals a month. Patients like it and Mr Beale-Pratt says outcome measures have been 'consistently excellent'.

GP attendances are also expected to show a reduction, especially for those patients with medically unexplained symptoms who are regular attenders. Importantly, there has been a major shift in referrals away from secondary care intervention. Early indications are that the new community service addresses patients' needs in a sustainable manner, rather than simply delaying the need for acute care.

Cumbria is quick to emphasise that cutting costs was not the prime motivation. The changes sought to improve outcomes and address the fact that current services were not sustainable. But the new service has also been a 'financial success' with significant savings to the health economy being delivered.

Capturing these improvements across all commissioners will be important in terms of demonstrating the value of the RightCare approach centrally. CCGs have to prepare quarterly reports. This helps the centre to identify good practice that they can help to share more widely (see box, page 18). But it is also how CCGs will report on the financial improvements being delivered.

Wave one CCGs were asked to identify savings equal to 1% of turnover or 30% of the opportunities identified in their RightCare packs. This has risen to 40% for wave two CCGs.

Some managers detect a change in emphasis, with an increasing focus on delivering savings. However, RightCare prefers to talk about the 'co-ordinated reallocation of capacity' or CROC rather than savings. Resource needs to be taken out of unwarranted interventions or sub-optimal care and reallocated to meet or avoid growing demand or to tackle unseen demand.

NHS England's February board paper references one STP that has around 500 beds being used for potentially unwarranted activity. At the same time, the footprint area has an estimated 43,000 undetected members of the population with at least one of five conditions that drive overuse of secondary care. 'There is likely to be at least some cause and effect within this variation,' it says.

Optimising the system

Mr Cripps insists that it is not as simple as closing acute beds in favour of community services. 'What our analysis shows is that some patients are in hospital who could more appropriately be cared for in a sub-acute setting or for whom better co-ordinated care could have avoided a hospital admission,' he says.

Meanwhile, for other patients their condition deteriorates while they wait for a hospital bed.

'The key thing to focus on is optimising the whole system,' says Mr Cripps, 'which may result in investment in community services reducing the need for hospital beds, but in most places is also likely to see beds used for frail elderly patients being made available for emergency admissions or elective surgery while the elderly are supported in their own homes. This lowers the cost of all parts of the system by deploying resources for better outcomes.'

It has taken several years for RightCare to become part of mainstream NHS commissioning. It has good central support with commissioners and clinicians appearing to like the data-driven approach. But in many ways, the real work starts now, as all eyes will be on what it can actually deliver in terms of improved outcomes and better value services.

leading by example

NHS Improvement's Carter-commissioned Model Hospital is aiming to support productivity improvement now while also driving an increasing focus on data quality. Steve Brown reports

The NHS has long been condemned as being data rich, but information poor. And managers have frequently complained about the time-consuming returns they submit without the contained data being put to any apparent useful purpose. The new Model Hospital published by NHS Improvement is trying address both these complaints.

Actually 'new' isn't quite right. Born out of a recommendation from the Carter report on productivity in acute providers, the Model Hospital has in fact been up and running in prototype format since March 2016. However, April sees it 'launched', albeit without fanfare, in its first iteration – making good on a specific Carter-set deadline.

Lord Carter's idea was to help NHS providers – acute providers in the first instance – improve productivity across all their frontline and back-office services by identifying 'what good looks like'.

More specifically, the Model Hospital project would show how different hospitals performed across a series of service and function specific metrics – helping organisations to compare their productivity, quality and responsiveness with their peers, identify best practice and find opportunities to improve value.

There are already examples of such portals around the globe – a cost and activity information system in the Australian state of New South Wales is well regarded (see *Healthcare Finance* July/August 2016, page 23). And the English system would in some ways be even more ambitious, eventually covering all service lines and based on comprehensive patient-level costings.

There are longer term plans – again to comply with Carter recommendations – for the Model Hospital to be used as the basis for an integrated performance framework. But Emmi Poteliakhoff, NHS Improvement's director of Model Hospital and analytics, says the focus of the Model Hospital is to support hospitals, not judge them.

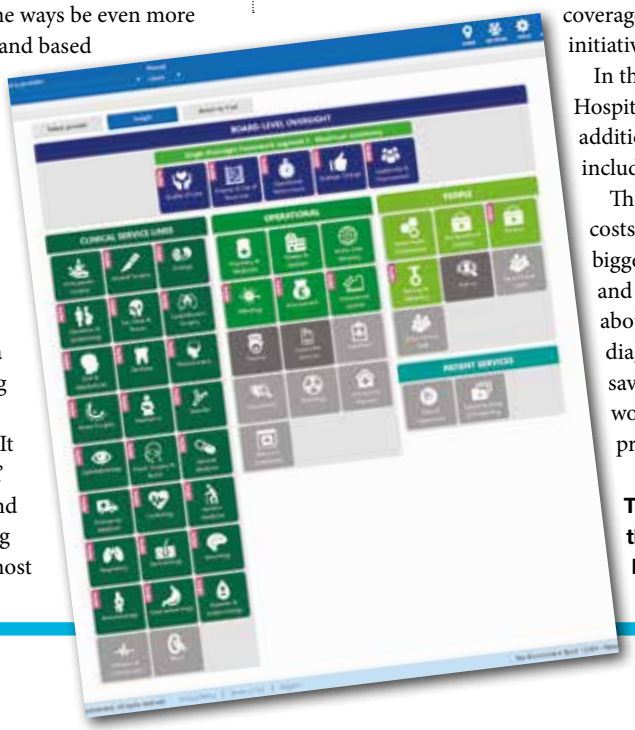
'The Model Hospital is about presenting data and information to people to aid understanding and enable them to compare against other organisations for their own learning,' she says. 'It is about improvement rather than stick waving.'

She insists the model is not about 'naming and shaming', but there are no apologies for building the new Model Hospital on a foundation of almost complete transparency. Although the public won't be able to see the Model Hospital data in this development phase, anyone working in NHS providers can be given access – with non-executive directors a particular target group. Trusts will be readily identifiable and their relative performance clearly visible in graphical displays. The system also uses red and green colours so that trusts can quickly see which quartile their performance puts them in.

On accessing the portal, there are five main ways into the Model Hospital. A board-level oversight 'lens' is structured to align with the single oversight framework, with 'compartments' for:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement

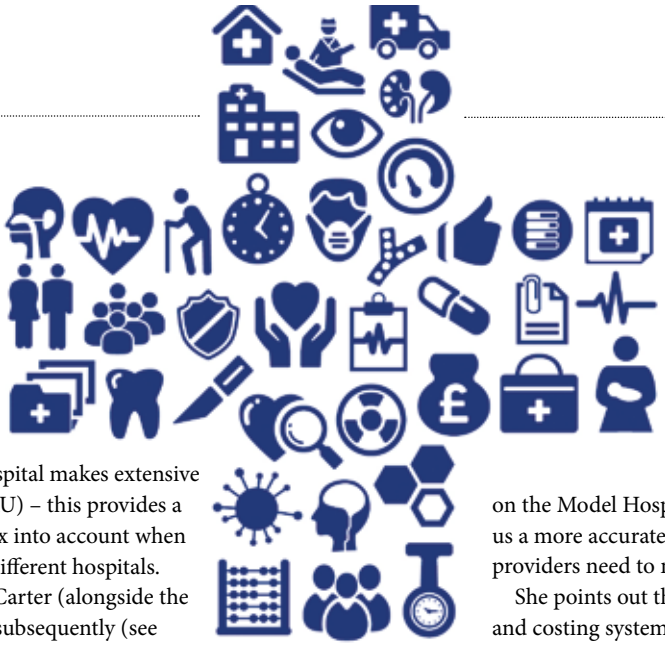
Compartments of more detailed metrics are then viewed through four further lenses covering: clinical service lines; operational activities; people; and patient services. It is a rapidly expanding database. The compartments initially released as part of the prototype have already been supplemented and there are plans for major expansion of the clinical service lines covered, in particular to support the expanding coverage of the *Getting it right first time* initiative.



In the April release, the Model Hospital has 34 compartments live (in addition to the board level dashboard) including almost 2,000 metrics.

The Carter report identified staff costs (£34bn for acute trusts) as 'the biggest opportunity' for productivity and efficiency savings – contributing about £3bn (with medicines and diagnostics) to Carter's overall £5bn savings target. To support this, a workforce analysis compartment provides detailed analysis of

To register for access to the Model Hospital visit https://model.nhs.uk



clinical activity per staff member broken down by various disciplines within different specialties. More detail again can be found within dedicated 'people' compartments looking at doctors, nurses and allied health professionals.

To ensure everyone is using a common currency when talking about hospital output, the Model Hospital makes extensive use of the weighted activity unit (WAU) – this provides a way of taking complexity and casemix into account when talking about the clinical activity of different hospitals. The WAU has been well trailed – by Carter (alongside the related adjusted treatment cost) and subsequently (see *Healthcare Finance,* March 2016). But there are hopes that it can become the established way of comparing productivity (for example, the cost per WAU, staff numbers per WAU, or spend on high cost medicines per WAU).

Soon after the Carter report was published, there was criticism that the new high-level 'cost per WAU' productivity metric, which ranges from £3,000 to £4,100 across all acute trusts, was undermined by its reliance on flawed reference cost data. Reference costs submissions for 2014/15 were found to be materially inaccurate for half of a sample of audited trusts.

Ms Poteliakhoff says there is 'a good awareness of the weaknesses of reference cost data'. Not all trusts currently prioritise the cost data and while data has improved in recent years, it has not improved fast enough. This recognition of the problems with reference costs – coupled with an appreciation of the potential value of granular, robust patient-level costs – is inspiration for NHS Improvement's ongoing Costing Transformation Programme.

That programme is ambitious in supporting the whole English service to start costing at the patient level using a new, consistent and mandatory methodology.

'Once that is in place, it will revolutionise the work we are doing on the Model Hospital,' says Ms Poteliakhoff. 'It will give us a more accurate picture of operational intelligence that providers need to make decisions.'

She points out that new patient-level information and costing systems are as much about the patient-level information – what tests, drugs or therapies a patient has received – as they are about the costs.

The Model Hospital's value may be enhanced with a more detailed costing foundation, but Ms Poteliakhoff says there is huge value already in the system and that data is good enough to help trusts ask questions and highlight where trusts are outliers in terms of productivity.

Data quality has long been a problem for the NHS in moving towards more evidence-based decision-making. It has often been too easy to ignore or dismiss variation on the basis of not believing the data. But there is also a recognition at NHS Improvement that the way to improve data is to use it and make it visible. So NHS Improvement is playing a short and long game with the Model Hospital. There is immediate value from the outset (see box below) and some compartments that are already proving their worth among users – the pharmacy and medicines, nursing and midwifery and orthopaedic surgery

Preparation is paramount for Plymouth

Data verification and engagement with staff is key to making the most of the data contained in the Model Hospital, according to Laura Langsford (pictured), Model Hospital programme manager at Plymouth Hospitals NHS Trust.

Building on its role as a Carter pilot site, the trust has been working with the Model Hospital data since the prototype version went live last year. She encourages providers to prepare the ground properly. 'Before trusts rush ahead with what the data is telling them, data verification is really important,' she says.

Making sure the data is robust and that the methodology to derive the metric is understood will pay off. 'If you don't do this, it can be difficult to talk to stakeholders,' Ms Langsford says – and it is the engagement with staff that will lead to actual improvements.

She says it is important to realise the data is not absolute. Whether a trust is in a red or green quartile doesn't automatically mean good or bad, but the trust should understand initially why it is showing that position, and most importantly assess the ability to improve on it.

One early avenue being explored is the trust's medical staff productivity, with the trust showing a more challenged productivity position compared to its peer group, in relation to medical staff costs. While doctors are becoming more comfortable with the data, Ms Langsford says they must get familiar with their staff cost per WAU metric at a speciality level, and start to get a feel for what it is telling them.

The trust has been engaging with consultants and non-consultants in two formal committees – and it's paying off. 'We are starting the financial year in a good place in terms of engagement in improving the metric,' she says.

One reason for the lower productivity is likely to be about £15m of elective activity undertaken in the local independent sector, squeezed out because hospital capacity has been occupied with increased emergency admissions. But Ms Langsford says elective cancellations, skill mix and outpatient clinic efficiency are also being examined. 'It is not one single thing, but there is a clearer focus on what a cost improvement programme might deliver and what might contribute to better performance,' she says.

Finance director Neil Kemsley says Model Hospital data has also 'reinforced Department of Health data' in highlighting the opportunity to increase cost recovery from overseas visitors. 'That metric and the audit work shows we might see a 10:1 return on investment in admin support in this area,' he says. The trust is also pursuing opportunities to improve its portering productivity metric.

Ms Langsford is clear that data quality is paramount to getting value into the system. But the new data warehouse has 'brought visibility and allowed us to talk a new language'. It is no panacea, but it provides another tool as trusts look to address the financial challenges facing the NHS.

"By allowing trusts to see the data and make use of it for benchmarking and learning, it will provide an impetus to standardise the way they code"
Emmi Poteliakhoff, NHS Improvement

compartments, for example, have all been accessed more than 1,200 times since the start of the year. But the value of the resource will grow as data improves.

A lot of the finance data is taken from audited accounts and so is understandably viewed as robust. These figures need to be adjusted to reflect the fact that the total expenditure reported in the accounts is different from the quantum included in reference costs.

The electronic staff record is also widely used by the Model Hospital as a data source. This is primarily a payroll system, not a data collection system. And while it is extremely reliable at the aggregate level, coding at a more detailed level can be less consistent. So, while a trust might accurately have its nurse numbers and bandings accurately recorded for the organisation as a whole, it may not have these nurses accurately assigned to different service lines. 'By allowing trusts to see the data and make use of it for benchmarking and learning, it will provide an impetus to standardise the way they code,' says Ms Poteliakhoff.

Similarly NHS Improvement hopes the greater visibility of data will encourage providers to review the quality and completeness or other returns – to joint registries for example.

Most of the data in the system is already produced or submitted by trusts as part of regular returns. However, the Model Hospital plays this back to trusts alongside how other trusts – or a self-selected peer group – are performing.

So a trust may have suspected that its skill mix among speech and language therapists was too high or too low, but it would not have had comparative data to back this up or challenge existing performance.

Some metrics have required new data collections. This has been the case for both pathology (collecting data about the costs of different types of test) and corporate services (using a more sophisticated cost analysis than the pay-only estimates used in the Carter report). This approach will be used where necessary so that useful metrics are included, but also recognising that the service cannot support a major increase in data collections.

A number of clinical service compartments and corporate services should come on line from mid-April. Compartments aligning with the new GIRFT specialties will include subsets of the metrics identified for detailed use by the programme.

Growing interest

Even while still in its prototype stage the Model Hospital has developed a reasonable audience with some 3,350 registered users and more than 10,000 page 'hits' a week. Within this NHS Improvement has identified more than 120 'power users' who have returned to the tool at least 25 times – with the top 10 users logging in on average 160 times each. More than a quarter of active users have logged in at least 10 times.

So there is justification for saying users are doing more than satisfying their curiosity. Activity to date suggests that senior finance professionals are prominent in this user group.

The Model Hospital is an ambitious project. Few people argue against the theory of sharing robust data on wide-ranging activities to support decision-making and service improvement. But it is often in practice where the enthusiasm wanes.

This is a work in progress. It will help organisations to identify opportunities to improve – or at least ask questions. But it also provides a statement of intent and puts the NHS on a course for finally turning its copious amounts of data into real information and intelligence.

Participants

- Paul Briddock, HFMA (chair)
- Richard Allen, head of income and contracts, Moorfields Eye Hospital NHS FT
- Mike Barnes, director, EPS Research
- Helen Cookson, associate FD, Imperial College Healthcare NHST
- Carolyn Cooper, clinical coding head, Guy's and St Thomas' NHS FT
- David Jellicoe, contract income planning head, Barking, Havering and Redbridge University Hospital NHST
- Paula Monteith, head of the National Casemix Office, NHS Digital
- David Moon, chief finance and strategy officer, University Hospital Coventry and Warwickshire NHST
- Pippa Ross-Smith, chief finance officer, Brighton and Hove CCG
- Ben Roberts, head of finance transformation, Bolton NHS FT
- Dawn Scrafield, FD, Colchester Hospital University NHS FT
- NHS Improvement: Amit Patel (pricing), Milton Salas Martinez (economist) and Dr Jarvis Punsalan (clinical lead)

An HFMA roundtable in March called for a greater focus on clinical coding and an increased awareness among clinicians of the value of this core data. Steve Brown reports

Coded message

HFMA ROUND TABLE

There is broad agreement the NHS needs to take an evidence-based approach to the management and transformation of services. But if this is going to become a reality, then the service will need to focus more on ensuring its core data is robust enough to enable the right decisions to be taken with confidence. This was the conclusion of an HFMA roundtable in March.

The roundtable – supported by healthcare software and analysis specialist EPS Research – brought together finance and coding managers alongside representatives from NHS Digital and NHS Improvement to talk about 'data quality – coding and the move to HRG4+'.

Delegates were quick to dismiss tariff as being the main driver for improving data quality. The original move to payment by results resulted in an increased focus on both coding (to ensure accurate payment) and cost data (to inform tariff setting and for service line reporting). But they were clear that the need for robust data was about much more than payment.

Many delegates reported that activity-based contracts were now accompanied by caps and collars, income guarantees or other risk-sharing mechanisms – even block contracts in some places – so the link between coding and payment was in some ways less direct. But this did not reduce the importance of getting data right.

'Good-quality data is fundamental to how you run health services,' said HFMA policy director Paul Briddock, chairing the session. 'If we are going to transform services in the way we have to, it is key that we understand what we are currently doing for patients and how we can implement changes to meet patient needs in a better, more cost-effective way.'

Coding of patient episodes is at the heart of robust data, but Mike Barnes, director of EPS Research said better coding began with clinicians. 'We need to get clinicians involved from the start. If they are clear in the notes, information will flow through the system properly,' he said. This would deliver sound information to inform provider and commissioner decision making and underpin whatever payment system is in place.

He also warned that coding departments were already 'overstretched' and that any attempts to improve data should place a minimal extra burden on clinical coders.

Clinicians were too often providing insufficient detail in patient notes. 'They need to understand the importance of writing down the primary diagnosis, for example, not simply what the patient presented with,' he said. On occasion, patient notes might just record that the patient had a headache or chest pain, but not include the eventual diagnosis made. Analysis of multiple presentations by the same patient shows differences from spell to spell – for example, a diabetes comorbidity being recorded on one occasion but not the next, then back again.

Patient care

'The key driver for this is patient care, if the right co-morbidities are not captured, it could be harmful for patients or lead to sub-optimal care,' said Helen Cookson, associate director of finance at Imperial College Healthcare NHS Trust.

The delegates were unanimous in dismissing upcoding – over-coding or coding cases at a higher complexity level – as a myth. Coding departments didn't have the time and clinicians

and coders did not have the inclination.

Accurate coding should mean accurate payment, but clinicians and coders do not need to think about the income side of things when they were completing notes of adding codes. Richard Allen, head of income and contracts at Moorfields Eye Hospital NHS FT, said clinicians did ask about how they ensure they get the right payment. 'But the message is to just get the coding right, the funding is not an issue.'

Carolyn Cooper, head of clinical coding at Guy's and St Thomas' NHS Foundation Trust, agreed. 'Healthcare resource groups and coding can't be about money – it is about the importance of patient care.'

It could have a direct impact on a specific care episode, as well as undermining more general analysis of trends and activity.

Properly coded data could provide a wealth of information to inform service change, Mr Barnes said. He showed delegates an analysis of patient activity for a single trust, with patients organised by primary reason for inpatient care (such as respiratory conditions) or as complex, where multiple diagnoses or interventions mean they don't fall easily into any one category.

Just 1,200 patients accounted for a staggering 80,000 bed days across a two-year period – losing the trust about £10m in the process. These patients were typically medical patients. Often diagnoses were unspecific – with codes for both chest pain or abdominal pain, for example. More than half of these patients were also being admitted on several occasions for the same things – multiple infections or falls, perhaps.

'You can also see clear evidence of patients getting sicker while they are in hospital,' said Mr Barnes. Patients might come in with heart failure, get a urinary tract infection while they are in hospital and then develop sepsis. They may well need physiotherapy to help get them more mobile again so they are fit for discharge.'

Earlier intervention

He said that the data was typical for most acute hospitals. Although there is room for improvement, there were opportunities to use this analysis to consider how services were currently provided for this cohort of patients, many of which will be frail elderly. 'If we can get to these patients earlier, there are significant benefits for patients and significant savings [from avoided admissions] downstream,' he said.

Even if admissions aren't avoided, Mr Barnes said, systems should be able to flag these patients on arrival into the hospital so that the appropriate response can be initiated quickly to avoid deterioration in condition and attempt to stop the repetitive cycle. The data could also be analysed to provide early warning signs of patients likely to become the next cohort of complex patients before they start having multiple admissions.

> **"Identifying the high-intensity users and the complex patients and understanding when they are medically fit for discharge is potentially really powerful"**
> **Pippa Ross-Smith**

But he added that the analysis, understanding and response could be even greater if documentation for coding improved. 'In an episode where a patient has been given antibiotics to tackle a presumed chest/urinary infection, it may not be clear from the notes what the actual infection was and therefore we can't fully understand the problems or develop a better response for the patient,' he said.

Inconsistent coding was evident, with the same patients having ischaemic heart disease for one spell, but not the next. And there were potentially useful codes often underused – living alone and delayed transfer codes for example. Mr Barnes stressed that the real potential lay with examining the detailed codes, not the healthcare resource groups in this instance.

'These complex patients often have few procedures undertaken – other than diagnostic imaging – and the HRG often doesn't provide the full picture about the patients' conditions or treatments,' he said. 'The relevant HRGs also typically have long trim points – up to 70 days in some cases – and so there is little financial incentive for commissioners to drive changes in the pathway.'

Delegates agreed there was huge potential to inform change based on robust coded activity.


Amit Patel

Pippa Ross-Smith, chief finance officer at Brighton and Hove Clinical Commissioning Group, said well-coded activity had huge potential in the current transformation climate in which there is pressure to move services out of acute settings. 'Identifying the high-intensity users and the complex patients and understanding when they are medically fit for discharge is potentially really powerful,' she said.

The NHS had to develop better ways of meeting the care needs of the elderly and this would involve trend analysis and joint planning, on the back of robust data, between commissioners and providers.

David Jellicoe, head of contract income planning at Barking, Havering and Redbridge University Hospital NHS Trust, agreed. Getting patients through the hospital and meeting referral to treatment targets was a challenge. So developing better responses for patients who were staying in longer than was good for them, and longer than necessary, made sense.

Ben Roberts, head of finance transformation at Bolton NHS FT, warned that, from a financial perspective, the trick would be to extract cost while changing pathways. 'You are talking about a small cohort of patients and the issue for providers is what cost you can take out,' he said. Patients staying longer than necessary in hospital was not good for patients, but lowering costs would need to involve reducing bed numbers and associated staff.

Dawn Scrafield, finance director at Colchester Hospital University NHS FT, said improving recording was a challenge. 'Coding is typically retrospective and the data quality is not quite good enough to pinpoint exactly how an intervention could have been different,' she said.

The group identified two focus areas for improving coding – the coding team and clinicians. Delegates stressed again that coding teams were under pressure – and continuing


Ben Roberts

calls to reduce corporate and administrative costs in the face of extreme financial restrictions made it difficult to invest further in the coding function. However, failure to do so could be short-sighted given the potential to help identify and inform transformation.

Lack of investment

There was concern that this lack of investment even stretched to a reluctance to support coders' development – some organisations have refused to allow coding team members to attend a first national coding conference.

Paula Monteith, acting head of the National Casemix Office within NHS Digital, said it was important to be seen and heard to value the coding function. 'You often hear things like "SNOMED CT [clinical terminology used in electronic patient records] could replace clinical coding". No it won't. But what you do in the process is upset the coding team and they leave. We need to find ways of showing they are valued as a profession.'

She said the story around coding – why it is important – needed to change. 'It is not just about income. Instead coders need to understand that they are responsible for telling a patient's story – and investments, service transformation and key decisions will all be based on this information. It is really important to make sure that coders are hearing this. Too often they are treated as an overhead when really they are about compiling clinical information to help people make the right decisions to help people get better.'

Delegates suggested there was more scope for improving coding by concentrating on clinicians. 'There is a lack of education for clinicians about how important data quality is,' said Mrs Cookson. 'For junior doctors, when they come to a trust you have about one week of induction programme and then they have so much clinical work and learning to do that it is almost too late. We need to educate them earlier, while they are still at university.'

Mrs Cooper underlined the point. 'What training they do get is around information governance – not writing something down that could get them into trouble at a later date,' she says. 'I don't think they always understand where the data goes and what it is used for.' She added that coders were often faced with multiple different diagnoses in notes and that it was often the coder making a judgement at the time of coding on the correct primary diagnosis.

Mrs Ross-Smith said getting junior doctors to examine previously coded notes would be a good start. 'If they could identify what was missing – what they would like to know about that patient to understand what happened – perhaps that would help them to include the key information when recording notes going forward,' she said.

> **"We also now have a nurse as a permanent clinical relationships facilitator. She is there to be the bridge between clinical services and the coding department"**
> **Carolyn Cooper**

Amit Patel, pricing regulation manager at NHS Improvement, said that 'engagement with clinicians' was the 'holy grail' in terms of securing better data. Clinicians were vital to better costing data, underpinning NHS Improvement's Costing Transformation Programme. And they were clearly key to better clinical coding, which provided the foundation for tariff setting and decision-making.

Mr Patel said he had previously worked on the reference cost audit programme. For 2014/15 data, this programme found that 34% of providers needed to improve diagnosis and procedure coding. 'From observation, it appeared that data quality was taken more seriously in organisations where coding sat under the medical director,' he said. 'In organisations where coding sits within finance and informatics, it was found to be difficult for the coding team to get the traction required to achieve positive clinical engagement to improve data quality.' He suggested that medical leadership of this function might encourage more clinicians to engage.

Mrs Cooper also said trusts needed to broaden their focus beyond the medical workforce to include all clinicians including nurses and allied health professions. 'We have included coding and data quality as part of our nurse training programme,' she said. Introductory courses – to coding in general, tariff payment and the SNOMED clinical terminology – were open to all interested staff, although Guy's and St Thomas' were yet to run a dedicated course for medical school undergraduates.

Coding work

Mr Allen said that at Moorfields clinicians had worked directly with coders to improve coding quality. However, he acknowledged that this was more achievable in a single specialty trust. David Moon, chief finance and strategy officer at University Hospitals Coventry and Warwickshire NHS Trust, said he had 'blitzed every specialty' with the head of coding at a previous trust to talk about the value of good coding. But this had not


Dawn Scrafield


Helen Cookson


David Moon

yet been replicated at UHCW. It was an effective approach, but time consuming.

Guy's and St Thomas' has transformed its coding performance in recent years, largely due to a programme of clinical engagement. Each specialty now has a coding triangle – made up of named coding, clinical and management leads. These meet regularly to discuss issues that arise, validate data and to encourage engagement between the different teams delivering and using coding data.

Mrs Cooper said it was a good system, although the coding workload was such that it was difficult for coders to juggle this additional responsibility and meet coding activity deadlines.

She also stressed that coders were trained for the coding process and to extract information. 'But they are not trained for clinical engagement or for improving education in that way,' she said. Others agreed that it could be intimidating for coders to seek out, confront or talk to clinicians, especially where they were challenging the accuracy or completeness of patient notes.

'As part of these triangles, coding leads now attend local inductions and have a section on the nurses and junior doctors' induction,' said Mrs Cooper. 'We also now have a nurse as a permanent clinical relationships facilitator. She is there to be the bridge between clinical services and the coding department. She has been brilliant, quadrupling the amount of clinical information recorded by clinicians that can be used for coding.'

Coding reviews

Specialty-specific audits and reviews of coding were used by many trusts to identify opportunities for improvement. Other trusts said that coding reviews were built into deep dives into service line performance.

Recording of comorbidities was a specific angle that some trusts have looked at. Ms Scrafield said a comorbidity self-service report was one tool the trust had developed to enable clinicians to see variation in current coding and to challenge it and feedback where appropriate.

Mrs Cooper also suggested that trusts should be comparing the level of comorbidities being reported with local prevalence data for the relevant conditions to gauge whether they are capturing comorbidities to a sufficient depth. 'By looking at prevalence data, you can roughly determine the level of comorbidities you should be seeing in your activity data,' she said.

Ms Monteith added that series analysis of HRG data provided a good way of looking at trends in complication and comorbidity rates and keeping a check on coding depth.

Bolton's Mr Roberts said that as well as clinical engagement, finance needed to work closely with informatics professionals to enhance data quality. And he flagged up the HFMA North West Branch annual conference – run as a joint finance and informatics conference – as a good step in the right direction .


Mike Barnes


Carolyn Cooper


Richard Allen

Technology was also seen as having a major potential to support coding with electronic patient records (EPRs) at the heart of revised approaches. Mrs Cooper said the NHS was in a 'strange place' compared with other services such as banking, where transactions are fully electronic. 'We'll record something electronically and then go and write it down on a piece of paper,' she said.

HFMA ROUND TABLE

'If a clinician makes a decision to start antibiotics as treatment for sepsis on the back of identifying the relevant symptoms, why shouldn't we take that information from an EPR as the diagnosis and push it through to the coding system. If we can suck information out and push it through to the coders – who can still be the validation point and operate to national standards – that will free up coders' time to get out there and do more clinical engagement and promote use of the data.'

Mrs Cookson said that Imperial was doing work with its EPR to make it easier for clinicians to make notes and add diagnoses in a consistent way. 'Rather than presenting a clinician with every possible diagnosis and procedure, a programme is being developed to break down information into relevant folders to make it easier for clinicians to record the right information,' she said.

Mr Roberts suggested that EPRs should provide the opportunity to flag complex patients as they reappeared in the system, helping providers to trigger multi-disciplinary responses to these patients.

'EPRs should also provide a way for coders to see previous coding of patients in earlier episodes,' he said. This could help tackle issues such as inconsistent recording of comorbidities between different episodes.

Delegates also felt that coding needed to expand to cover more activity, in a more detailed way, in the community. 'Our community services aren't data rich but the activity outside of hospital is huge and we don't know much about what is going on in detail,' said Mr Roberts, whose trust is starting to look at data quality for non-inpatient spells.

Ms Monteith pointed out that there was some detail in community services reference costs returns. Mr Barnes agreed enhanced community data would be a bonus, but that there was already a rich resource in acute data to start informing different pathways.

Overall, the delegates agreed that there needed to be better recognition of the importance of coding, breaking the misconception that it was a payment-related activity. Improvements should focus on education and awareness, with the clinical workforce – and junior doctors in particular – being the main focus. With investment difficult, organisations needed to share good practice on approaches to achieving these goals.

hfma
professional lives
Events, people and support for finance practitioners

NHS explores new ways to manage estate as capital gets tighter

Technical update

Capital finance is in the news currently with good reason as it is crucial to many of the transformation plans in place across England, *writes Debbie Paterson*.

British Medical Association analysis in February suggested the service would need an eye-watering £10bn of capital funding to deliver projects in sustainability and transformation plan footprint areas. March's Budget provided at least some response, announcing £325m of capital to allow first plans to go ahead.

Capital is certainly in short supply, compounded by capital to revenue transfers to help support the challenging revenue position. So the HFMA's capital forum in March was timely and unsurprisingly well attended.

From a national perspective, the key focus is to contain capital expenditure within the capital departmental expenditure limit (CDEL).

In 2015/16, the underspend against the CDEL was £58m, which is, in itself, a large number but is only 1.57% of the budgeted CDEL. In 2016/17, it is expected that the outturn position will be as close, if not closer. This is a relatively new phenomenon, prior to 2013/14, the underspend against CDEL was comfortably above 10% of budget.

Providers account for some three quarters of capital expenditure recorded against CDEL. The Department traditionally managed the position against CDEL by setting capital resource limits (CRLs) for NHS trusts. But foundation trusts do not have CRLs so are not controlled this way.

However, the Department is the main source of funding for capital expenditure (where NHS bodies cannot fund their own capital projects from internally generated resources) and can manage access to funding to achieve the national position.

The Department is also reliant on provider bodies' forecasts when managing the national position against the CDEL. Inaccurate forecasts make this job harder and have also been blamed for the traditional underspend on capital.

There are good reasons that capital programmes slip, and forecasts are inaccurate – business cases take time to prepare, procurement is time consuming and funding needs to be put in place. Even once capital projects are underway, they can hit delays. However, the quarter 3 performance report by NHS Improvement indicated that initial forecasts for the sector were that 45% of the forecast capital expenditure for the year would be incurred in the last three months of the year. Although this was reduced following a review – it still seems high and suggests the finance community has room for improvement in this area.

The outturn against CDEL this year will be close and capital expenditure planned for the next few years outstrips CDEL considerably

Even allowing for slippage, the outturn against CDEL this year will be close and the amount of capital expenditure planned for the next few years outstrips CDEL considerably. NHS bodies therefore need to look outside of the traditional routes to manage their estate.

The book value of any surplus property, plant and equipment that is sold counts as negative expenditure against CDEL, which means that a greater amount of capital expenditure can be incurred without breaching the CDEL.

A theme of the capital forum was working together to achieve a common objective. The HFMA and CIPFA are aiming to identify local authorities that have used their borrowing power to support NHS bodies. Local authorities' prudential code effectively allows them to set their own borrowing limit. They might invest in schemes where they can make a commercial return, managing car parks for example. Or they could support a scheme that fulfils their duties around affordable housing or economic regeneration.

NHS bodies are also exploring managed service contracts with private sector suppliers. These need to be real service contracts (ie they don't meet the IFRIC 4 definition of a lease) or be operating leases (as defined by accounting standard IAS 17) to ensure that they can be treated as a revenue cost.

Another consideration is whether these contracts, or straightforward finance leases, could be entered into by a group of NHS organisations, giving them all access to the equipment they need but reducing the overall cost to the NHS.

Technical review

The past month's key technical developments

Technical roundup

The Department of Health issued three FAQs at the end of March to make minor changes to the ***Group accounting manual***. These changes relate to:

- Calculation of the real increase in cash equivalent transfer values (CETV) and the treatment of severance payments, golden hellos and payments for loss of office when calculating salary
- Disclosure of the expected timing of cash payments relating to provisions
- Accounting for reversals of impairments.

It also issued guidance on the 2016/17 summarisation forms and agreement of balances for the final quarter of the year. The outcome of the Q3 exercise was positive, but deferred income was an issue. NHS bodies are reminded to follow existing guidance on deferred income. As *Healthcare Finance* went to press, guidance on accounting for the sustainability and transformation fund at the year end was still outstanding.

For the latest technical guidance www.hfma.org.uk/news/newsalerts on PC or phone

NHS organisations are entering into a range of joint working arrangements, from the relatively straightforward wholly owned subsidiary to the more complex vanguard schemes. But new working arrangements mean accounting practices must be reviewed to ensure organisations remain compliant. A draft briefing from the HFMA on **accounting for joint working** arrangements looks at the relevant accounting standards, VAT, legality and governance. It outlines the key considerations to examine during the planning process. ***Send comments to debbie.paterson@hfma.org.uk***

The HFMA has also published a briefing on the changes to **off-payroll rules** for public sector employers, due to take effect on 6 April. Also known as IR35 rules, they apply where payment is made via an intermediary, such as a personal service company. Meanwhile, HMRC launched its online Employment Status Service to determine whether a worker should be classified as employed or self-employed for tax purposes.

NHS bodies must open up **public procurement**, be transparent about expenditure and share expenditure data, under updated Department of Health guidance. Key changes include: a requirement to supply monthly PO data to support the national purchase price benchmarking and index tool; an extension of routine submissions of data beyond orthopaedics where registers exist; and a requirement to publish award notices for contracts over £25,000 while removing the default to higher threshold determined by standing orders.

The Department of Health has confirmed £1.2bn was transferred from its capital budget to its resource budget in 2016/17. In a memorandum on its supplementary estimate to the Commons Health Committee, it said the £1.2bn would be used to mitigate running cost pressures in the provider sector. The committee said this was the third year running there has been a **capital to revenue transfer** – £640m in 2014/15, £950m in 2015/16.

Two new HFMA briefings highlight how resources are allocated to the Department of Health and down to clinical commissioning groups. Part of a new *How it works* series, one guide starts with the overall budget-setting process as part of the spending review, and examines how this is passed on to NHS England and how spending limits work. The other follows the **allocation process** down to local commissioners, covering the needs-weighted allocation formula and issues such as the use of surpluses through the drawdown process.

HFMA work in progress

The HFMA's policy and technical team is researching the finance and governance arrangements in England, Wales, Scotland and Northern Ireland to look at what works well and can be shared between nations. A focus on integration and closer alignment with social care form part of the study and findings will be published in the autumn. Other research projects are under way for the devolved nations, examining drug costs in Scotland, funding in Northern Ireland and integrated reporting in Wales in the context of the *Wellbeing of Future Generations Act 2015*. ***More details from emma.knowles@hfma.org.uk***

Colorectal cancer treatment gets backing

NICE update

In an updated technical appraisal (*TA439*), NICE is recommending cetuximab and panitumumab, within their marketing authorisations, *writes Nicola Bodey*.

The guidance applies to some adults with metastatic colorectal cancer in combination with 5 fluorouracil, folinic acid and oxaliplatin (FOLFOX) or 5 fluorouracil, folinic acid and irinotecan (FOLFIRI). The drugs are recommended only when the companies provide them with the discounts agreed in their patient access schemes.

The two main purposes of treatment are to shrink tumour tissue for surgical resection and to palliate.

About 34,000 people were diagnosed with colorectal cancer in 2014 (Office for National Statistics 2016).

Of these, it is estimated that around 2,700 people would be eligible for treatment with either cetuximab or panitumumab in combination with either FOLFOX or FOLFIRI each year.

Following earlier appraisals, cetuximab (*TA176*) and panitumumab (*TA240*) were previously available through the cancer drugs fund (CDF) for first-line treatment of metastatic colorectal cancer, based on criteria defined in the national CDF list. Now positively recommended by NICE, cetuximab and panitumumab will be funded through routine commissioning in the first line treatment position and will no longer be available through the CDF.

Treatment for around 2,200 people was funded through the CDF and the number of people having treatment is not estimated to change.

Diary

April
6 I HC4V: annual costing conference, London

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

June
12 B London: annual conference, London
13 B Kent Surrey and Sussex: prestige event, Lingfield
19 B East Midlands: team building event, Loughborough
22 B West Midlands: annual conference, Wolverhampton
29-30 B North West: annual conference, Blackpool

July
5-6 N Annual Commissioning Finance conference, London
6 N Convergence conference, London
6-7 N Annual Provider Finance conference, London
20 B Yorkshire and Humber: annual quiz, Yorkshire Sculpture Park

September
11 B Eastern: student conference, Cambridge
14-15 B South Central: annual finance event, Reading
19 F Provider Finance: technical forum
20 F Commissioning Finance: forum
20 N CEO Forum
21 N Mental Health Finance: annual conference
21-22 B Wales: annual conference, Hensol
28-29 B South West: annual conference, Bristol

October
11 F Chair, Non-Executive Director and Lay Member: forum, Central Manchester
13-14 B Kent, Surrey and Sussex: annual conference, Ashford
19 F Provider Finance: directors' forum

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

key B Branch N National F Faculty I Institute

The list prices of cetuximab and panitumumab have a discount that is commercial in confidence.

The discounted prices of cetuximab and panitumumab can be put into the resource impact template on the NICE website to calculate the resource impact of the guidance.

These technologies are commissioned by NHS England. Providers are NHS hospital trusts.

Nicola Bodey is a senior business analyst at NICE

Events in focus

Chair, NED and Lay Member forum
17 May, London

Non-executive directors and lay members are responsible for providing oversight, governance and leadership to NHS organisations, in the pursuit of strategies to provide effective and high-quality healthcare services. The role has taken on new importance in today's economic and political climate. This forum is the latest in a series run by the HFMA specially for chairs, non-executive directors and lay members, as part of its Chair, Non-Executive Director and Lay Member Faculty. This faculty acts as an ideas exchange, an educational platform, an information source and a support mechanism for non-executives and governors, ensuring strong leadership, robust challenge and wise counsel through a sound understanding of NHS governance and finance.

Adam Sewell-Jones (pictured), executive director of improvement at NHS Improvement, will lead discussion on the importance of the role of non-executives and lay members in supporting leadership development, talent management, progression planning and improvement capability building.

Duncan Orme, deputy director of finance at Nottingham University Hospitals NHS Trust, will focus on value, the role of patient-level costing in clinical decision-making and behaviours, while considering the role of the board in supporting and driving forward collaborative ventures between clinicians, finance and management.

Karamjit Singh, chair of University Hospitals of Leicester NHS Trust, and Ludlow Johnson, lay member at Coventry and Rugby CCG, will explore equality and diversity roles and responsibilities.

For further information or to book your place on this forum, please email aimee.baker@hfma.org.uk

Branch event: Networking conference
13 June, Lingfield Park Racecourse, Surrey

This half-day seminar is aimed at all finance staff in Kent, Surrey and Sussex. Starting in the afternoon, the event will provide a range of CPD appropriate workshop sessions with topics including an NHS Pensions update, sustainability and transformation plans and service integration.

There will be plenty of opportunity to network with finance colleagues from across the region, as well as the chance to enjoy a summer evening race programme from a private area close to the finish line (free to HFMA members). Management consultancy Carnall Farrar and recruitment consultant Allen Lane are jointly sponsoring the event.

To book your place email elizabeth.taylor@wsht.nhs.uk

Brexit complexity

Association view from Mark Knight, HFMA chief executive

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

My HFMA

The end of last month marked a significant date in our history – the triggering of article 50 and the start of the Brexit process. The Parliamentary procedure that oversees the construction of about 15 to 20 major pieces of legislation on top of the so-called 'great repeal bill' will dominate Parliamentary time for years.

For the NHS that probably means no time to pass a replacement for the much criticised *Health and Social Care Act 2012,* which most agree is not fit for purpose in our new cash-constrained landscape. Whatever the merits of competition to fulfil the act's intentions, additional capacity would be needed. That isn't going to happen. And the accountable care model we seem to be moving towards is about working together not competing with one another.

The NHS is full of pragmatic people committed to getting on with the job and it seems the system leaders are doing just that. If the NHS wants to create new accountable care organisations or systems, it will just have to do it without a more appropriate legal framework.

Finance people will be at the heart of this, the unsung heroes keeping the show on the road. And the HFMA is here to support you as you take this agenda forward. The issues surrounding Brexit are complex and no-one knows how it will pan out. However, the concerns of the many EU nationals working in the UK are all too real. These concerns stretch from the fundamental 'can we stay' to understanding what conditions may be imposed. For example, will a visa or a green card disadvantage them financially? How intrusive will any border force be?

For the NHS, it is absolutely vital we keep hold of all that talent from overseas to ensure our service can provide the level of care we need. According to official statistics, more than 90,000 EU nationals were working in the social care sector towards the end of 2016. And on top of this, we also benefit from more than 50,000 EU nationals working in the NHS.

Getting a trade deal is crucial, alongside the right for EU citizens to stay. But you don't need to look far to find an intimidating list of other 'must dos'. There are wide-ranging scientific projects and joint working in areas such as medicines management and devices regulation. The UK is a strong player in these markets and so I would hope we could continue to make a contribution to them, which will in turn help the NHS move its agenda forward.

HFMA chief executive Mark Knight

There are dark noises coming out of Brussels that cherry-picking deals in certain areas will not be allowed, so we hope that our government works closely with the EU.

Working closely together is also a theme for the HFMA this summer when our provider and commissioning faculties host separate conferences, so that we can run a common joint day in the middle of the events. 'Convergence' will explore the unique challenges of both, but also the opportunities to reshape the NHS. Have you booked your place yet? You don't have to be a member of a faculty to do so, but lower rates are available for member organisations.

The NHS is in a difficult financial position at the moment. We are clear at the HFMA that our role is to ensure support is focused on the key issues you are facing in this context and to help you to deliver maximum value.

Member news

New South Central Branch committee members include:

- Samantha Russell, finance manager, University Hospital Southampton NHS FT
- Alex Packard, commercial finance manager, Berkshire Healthcare NHS FT
- Jacob Woodford, trainee finance manager, Oxford University Hospitals NHS FT

Yorkshire and Humber has two new committee members:

- Andy Bertram, director of finance, York Teaching Hospitals NHS FT
- Jon Sargeant, director of finance, Doncaster and Bassetlaw Hospitals NHS FT

After cycling from London to Brighton in 2016, KSS Branch's Stuart Wayment (pictured) plans to tackle the Poole to Paris Pedal in July. The four-day ride will raise funds for cancer charity PLANETS (pancreatic, liver and neuroendocrine tumours). Donate at www.justgiving.com/fundraising/Stuart-Wayment

David Chandler, chief financial officer at Sunderland Clinical Commissioning Group, has taken over from Peter Dawson as chair of the Northern Branch. In addition, Caroline Trevena, director of finance at North Tees and Hartlepool NHS Foundation Trust, has taken on the role of vice-chair.

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

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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

Branch focus

My HFMA **London Branch**

Kate Anderson, associate director of finance at Lewisham and Greenwich NHS Trust, will be the new chair of the London branch. She succeeds Andrew Holden, group healthcare director at Liaison, who has chaired the branch since 2008.

In the nine years of Mr Holden's chairmanship, the branch has significantly increased its member base. 'We have around six events every year. We have tried to have some collaboration and make the branch relevant to all our members,' he says, reflecting on the events they have held in partnership with other organisations such as the Healthcare People Management Association (HPMA).

'Make new friends and enjoy yourself' is Mr Holden's message for his successor. 'I've met some amazing people through the HFMA who I wouldn't have met if I hadn't done the role.'

Ms Anderson first got involved with the branch shortly after she joined the NHS in July 2015 from KPMG, where she was a senior manager. She became a committee member soon after that. 'The London committee is a very strong committee. It has a wide range of influential members from regulator, provider and commissioner backgrounds,' she says. 'I am excited by the opportunity to take on this role, and look forward to helping to lead the committee forward from the very strong position in which Andrew leaves it.'

One of her main objectives as a chair will be to further broaden the membership within the branch, and ensure that the branch appeals to financial professionals working within the NHS at all levels and from provider and commissioner backgrounds.

She will officially take up the position during the annual branch conference in June. The event will take place on 12 June at 110 Rochester Row and delegates will have the opportunity to network and hear from prominent speakers, including: NHS Improvement executive director of resources/ deputy chief executive Bob Alexander; University Hospitals Coventry and Warwickshire NHS Trust chief executive Andy Hardy; and Sanjay Agrawal, who is Future-Focused Finance's *Close partnering* lead and a consultant respiratory intensivist at University Hospitals of Leicester NHS Trust.

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

Appointments

Phil Foster is now director of operational finance at Birmingham Women's and Children's NHS Foundation Trust – a new organisation formed from the merger of Birmingham Children's Hospital NHS Foundation Trust and Birmingham Women's NHS Foundation Trust. Mr Foster was previously director of finance at the two organisations. He is a member of the HFMA Provider Finance Faculty committee and technical issues group.

Caroline Walker has been appointed deputy chief executive and director of finance at North West Anglia NHS Foundation Trust. She was deputy chief executive and director of finance at Peterborough and Stamford Hospitals NHS Foundation Trust over the last four years. The Peterborough trust merged with Hinchingbrooke Health Care NHS Trust on 1 April to form the new foundation trust.

Royal Wolverhampton Hospital NHS Trust has named **Helen Troalen** as deputy chief finance officer. She was deputy chief finance officer at Central London, West London, Hammersmith, Hounslow and Ealing Collaborative, a partnership of five clinical commissioning groups.

After a competitive interview process, **Jill Robinson** has become the permanent director of finance at Worcestershire Acute Hospitals NHS Trust. She was previously at the organisation on a six-month secondment from NHS Improvement. Ms Robinson has held a number of senior finance roles in both the NHS and in the commercial sector.

Future-Focused Finance value maker **Nicki Emmett**

(pictured) is now director of finance and administration at Fairfield High School in Herefordshire. Before this career move, Ms Emmett was head of management accounts at Wye Valley NHS Trust. She has over 10 years' experience working in the NHS.

The HFMA's 2015 Finance Director of the Year **Simon Worthington** has been named director of finance at The Leeds Teaching Hospitals NHS Trust, moving from director of finance at Bolton NHS FT. Mr Worthington takes over from past HFMA president **Tony Whitfield**, who retired recently.

John Yarnold (pictured) has become a lay member for fiscal management at Kernow Clinical Commissioning Group. He will chair the finance committee of the organisation, which covers Cornwall and the Isles of Scilly, and be a member of its audit committee. A former chief NHS finance officer, Mr Yarnold has worked as a consultant since 2011, including most recently in an interim director role at Homerton University Hospital NHS Trust. He is also a member and past chair of the HFMA Governance and Audit Committee.

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

"My job is to take a step or two back. It's about being able to get the right reports and taking a grip of the organisation; working on the basics with regard to quality of care and the patient experience"
Martin Dillon, Belfast Health and Social Care Trust

Dillon targets quality

On the move

Safe, compassionate, effective – those are the three words that come through strongly in a conversation with Martin Dillon, the new chief executive of Belfast Health and Social Care Trust.

It is a vast trust, employing more than 20,000 people and with an annual budget of £1.3bn. It provides a range of health and social care and is the umbrella organisation for the main teaching and training hospitals in Northern Ireland.

'The breadth of the trust can take people by surprise,' Mr Dillon says. 'We have highly specialised tertiary services right across to home helps, children's homes, health visiting, mental health and learning disability services, as well as the DGH.'

But how do you manage a trust of this size? 'My job is to take a step or two back,' he says. 'It's about being able to get the right reports and taking a grip of the organisation; working on the basics with particular regard to quality of care and the patient experience; and to be out and about as often as possible.'

Walking in staff's shoes is top of his agenda. Mr Dillon plans to spend a half day with hospital porters and shadowing foster care social workers, and a day in a learning disability hospital.

He is quick to acknowledge the challenge. 'How do I, as chief executive of this organisation, remain wholly focused on the management of our quality agenda, making our care as safe, compassionate and efficient as possible?'

Mr Dillon joined the trust as director of finance in 2010, a portfolio that also included estates and capital planning. In 2014, when chief executive Colm Donaghy moved to Sussex Partnership NHS Foundation Trust, Mr Dillon stepped in as interim chief executive for eight months. During this time he had to deal with the aftermath of a major incident called at the trust's Royal Victoria Hospital emergency department and a critical regulator report.

'The organisation found itself in a difficult spot and I felt we had low levels of medical and clinical engagement. So I set about putting measures in place to substantially improve that, including tweaking structures so we could better embed doctors and other clinicians in the day-to-day running of the organisation and in shaping its direction.

'This was all with the view of becoming as safe, caring and compassionate as we could be. We have gained a lot of traction in the past two years under our interim chief executive, Michael McBride – who was also chief medical officer for Northern Ireland.'

With Mr Dillon changing roles, Maureen Edwards, co-director of financial management, has been appointed interim director of finance, estates and capital planning. Dr McBride has now returned to the CMO position full time.

Mr Dillon was deputy chief executive during Dr McBride's tenure at the trust, driving forward the engagement agenda and creating structures to devolve power closer to the front line.

Like most health systems in the developed world, health and social care in Northern Ireland faces big changes in the next few years (see p13). These include the reconfiguration of service delivery proposed in the Bengoa report, which would see a move to more out-of-hospital care and the centralisation of some hospital services.

In the meantime, Northern Ireland has long elective waiting times relative to England.

Mr Dillon says his trust has been looking into the potential of elective care centres. 'The Belfast trust had already been doing a lot of work on this direction of travel. For example, we had been looking at one big emergency care centre, one big inpatient centre, one or more day surgery units and ambulatory care centres.'

Great place to work tool

Future focused finance

Making finance a great place to work is one of the key Future-Focused Finance workstreams, but what does that look like? To answer this question, FFF commissioned coaching, mentoring and training firm Goals and Achievements to produce a literature review and survey NHS finance teams.

The literature review identified more than 100 factors and found continuous improvement was key to creating a great workplace. However, the top 10 factors in the survey differed from those found in the literature review.

The report author, Duncan Brodie, said: 'Honesty, integrity and good work-life balance were the most important factors of a great workplace according to NHS finance colleagues.'

Using these findings, FFF has developed a *Great place to work* framework – 18 tools and resources that can be used to continually improve workplaces within NHS finance. They include employee and manager questionnaires, teamwork and team performance assessments, and help on trust and communication.

The team performance assessment, for example, asks a series of questions on areas such as clarity of goals, strength of leadership and levels of collaboration.

Rob Pickup (pictured), deputy director of finance at Birmingham and Solihull Mental Health NHS Foundation Trust and project lead, said the tool linked well with the FFF finance team accreditation process. 'Implementing the framework provides the team with an opportunity to feedback whether they feel valued and supported, and helps them understand where they may need to develop and improve,' he said.

- To find out more about the literature review and the framework please visit www.futurefocusedfinance.nhs.uk (Tools)
- FFF is also hosting a tweetchat with @WeFinance about making finance a great place to work on 25 May, 8-9pm

3M Science. Applied to Life.™

Improving data quality to deliver more accurate reimbursement

An NHS Foundation Trust in the East of England that provides acute hospital and community care services to around 280,000 people has taken steps to deal with significant financial pressures and a requirement to maximise value for money with the available resources. 3M's Health Information Systems (HIS) business enjoys a strong working relationship with the Trust's clinical coding team, which uses 3M™ Medicode™ Clinical Encoder as its primary clinical coding tool.

Project requirement

Complete, accurate clinical coding is essential in NHS Trusts. The Payment by Results framework means that a Trust's revenue is dependent on its coding quality. The Trust had previously engaged an external firm to review the quality of its coded clinical data, however this had resulted in a significantly increased workload for the senior coding team, as the suggested changes were often inappropriate and had to be reviewed carefully. The Trust's Clinical Coding Manager contacted 3M's HIS team to see how it could help the Trust to better use its resources to improve data quality.

Identified needs

3M's HIS team quickly recognised three key insights.

Firstly, it was important to build on the coding team's existing knowledge of Medicode clinical encoder. Secondly members of the existing senior coding team were best placed to identify and assess anomalies in their own data. Thirdly it was necessary to reduce data to a manageable quantity by screening out activity that did not require review.

The addition of three new 3M Medicode modules was proposed to improve the coding process, optimise data quality and maximise the capacity of both the clinical coding auditor and clinical coding trainer:

One of the modules was the 3M™ Data Quality Analytics Solution (DQA) which reviews all coded episodes and reports against the national clinical coding standards, alerting the user to potential errors. Target review areas are identified effectively and efficiently at episode level. DQA fits into the daily coding process where alerts can be reviewed by people trained to recognise the impact of errors.

The results

Financial benefit

A more accurate data submission has led to an income improvement of £148,000 in the first six months, meaning an average of £24,000 per month increase in appropriate reimbursement.

Increased data accuracy

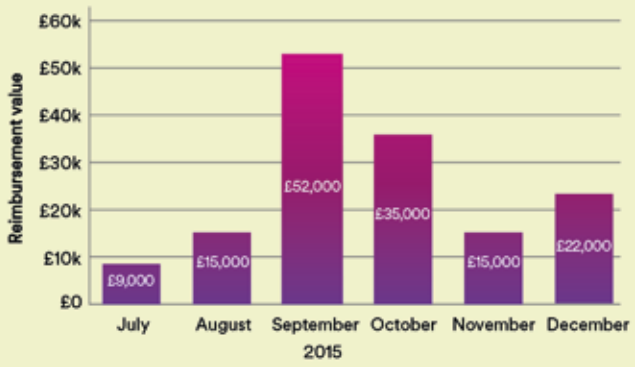
The new modules have led to improved accuracy and quality of data for both internal and external use.

Increased capacity for audit

The introduction of the new modules has meant that all coded data can now be audited internally using existing resources.

Development of people skills

DQA has allowed the existing team to optimise its efficiency and initiate a cycle of continuous learning and development.



First six months all saw improved reimbursement results, with £52,000 generated in September 2015 alone. Data on file with the Trust's Clinical Coding Department 2015.

"Twice-weekly running of DQA means that the coding team has immediate feedback, in more detail. Our month-end checks are fewer and completed nearer to the time of coding, meaning that we are able to quickly correct errors and feed back to the coders."

Clinical Coding Manager

For more information on the 3M DQA Solution:
Freephone **0800 626578** or email **help.his.uk@3M.com** or visit **www.3M.co.uk/his**

Financial results were produced by processing six month's data and amending codes, i.e. using a more specific code and also adding codes where DQA highlighted a potential error and on further investigation where extra codes could be added. Data on file 3M and Medicode are trademarks of the 3M company.

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