healthcare finance

March 2016 | Healthcare Financial Management Association

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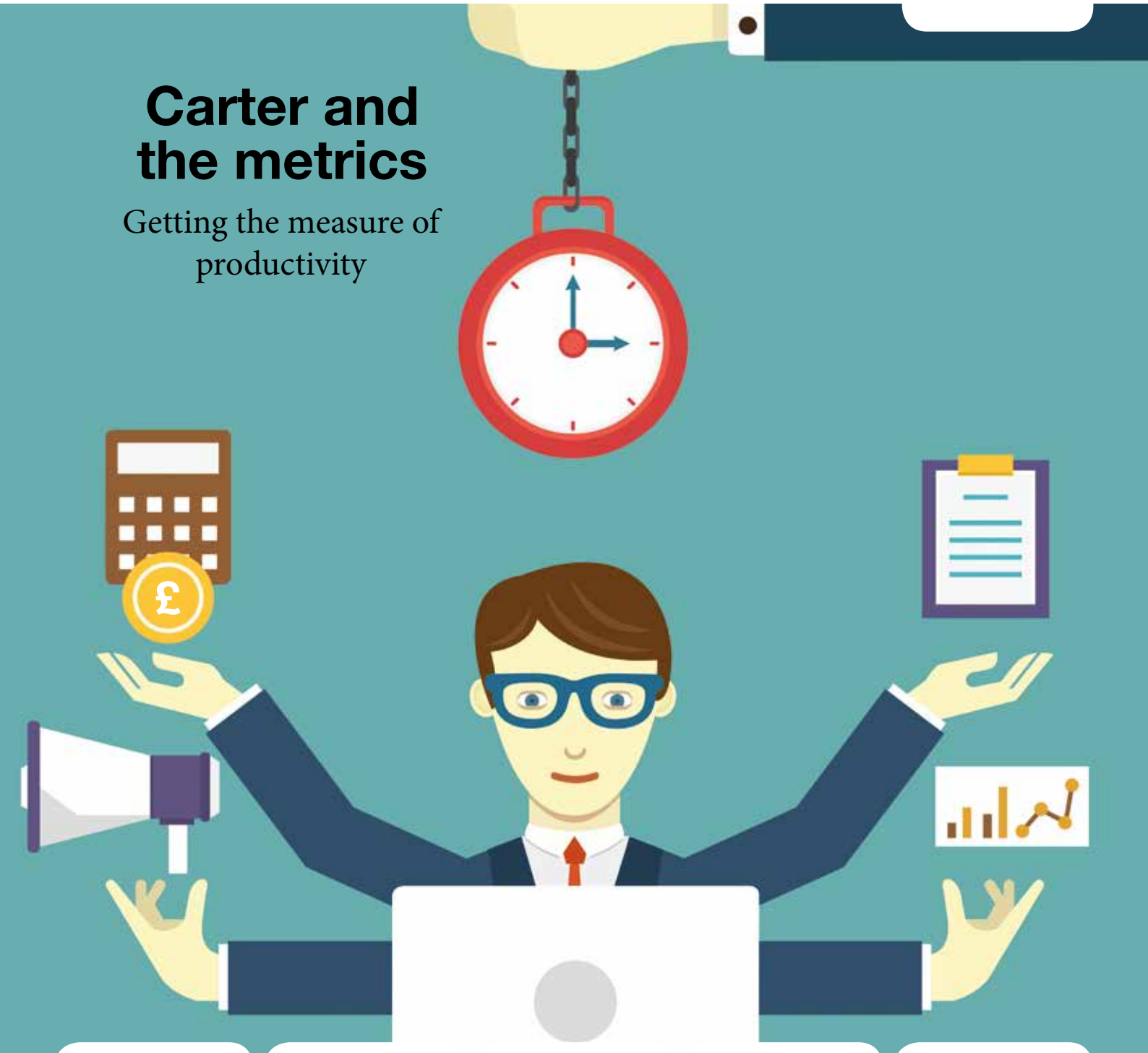

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Patricia McAuley
Programme Co-ordinator
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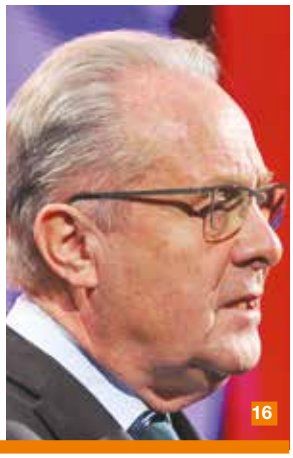

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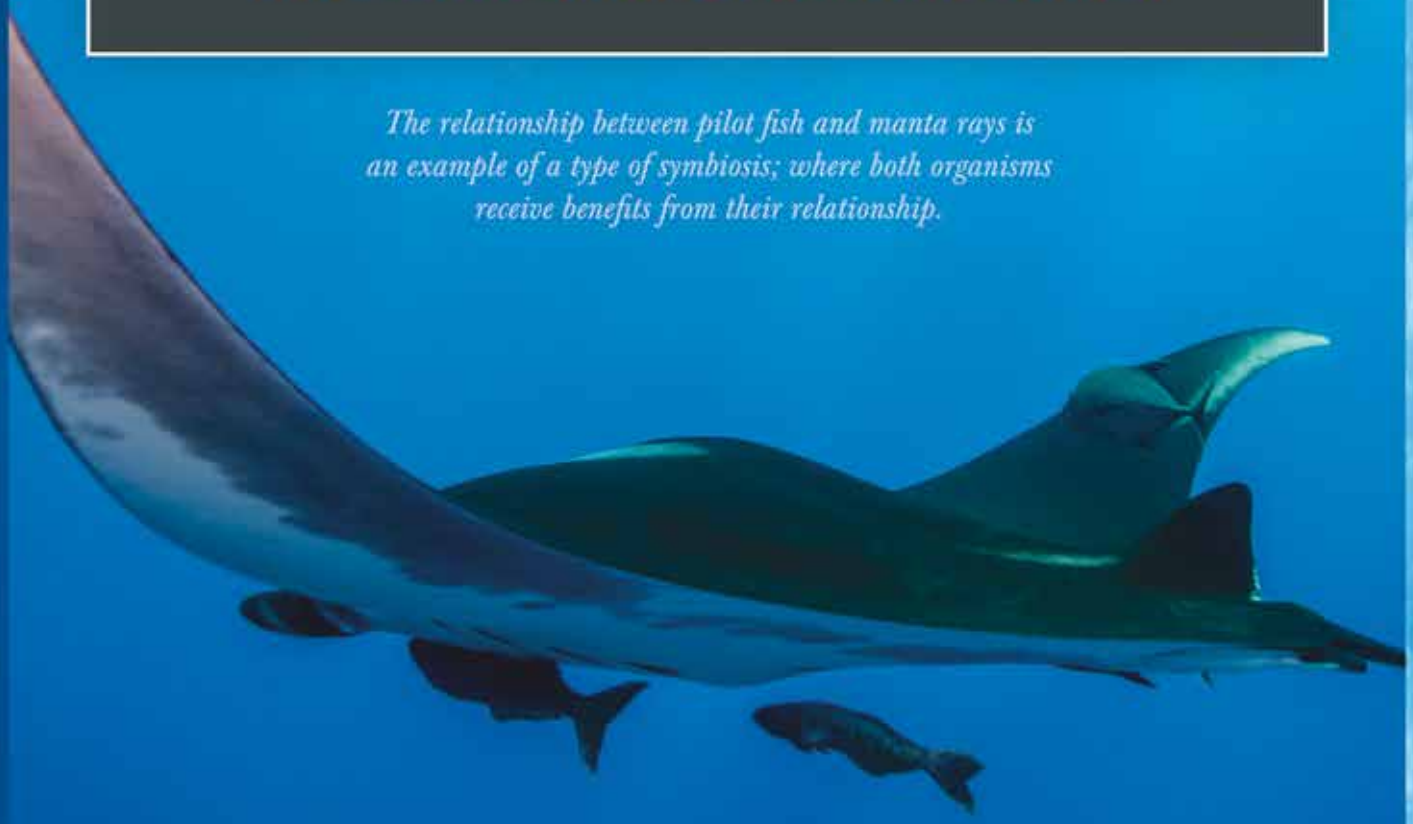
CGMA® REPORT

FINANCE BUSINESS PARTNERING: THE CONVERSATIONS THAT COUNT

The relationship between pilot fish and manta rays is an example of a type of symbiosis; where both organisms receive benefits from their relationship.



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News

Review calls for rethink on maternity tariff system

Warwick: recognised provider concerns

By Steve Brown

An NHS England-commissioned review of maternity services has called for a reformed payment system to underpin changes that would see more maternity services delivered in the community through local hubs.

A new pathway tariff payment system was introduced in 2013 for maternity services, replacing a system that paid providers for individual interactions. But the national maternity review report *Better births: improving outcomes of maternity services in England* calls for the payment system to be reformed 'so that it is fair, incentivises efficiency and pays providers appropriately for the services they provide'.

The review said the system should take into account the cost structures of different services, particularly the high fixed costs in obstetric units. Currently providers receive one of two prices for deliveries (to reflect complexity) and one of three prices for ante and postnatal care. These prices are not setting dependent.

Cathy Warwick, chief executive of the Royal College of Midwives (RCM) and a member of the review panel, said the review had heard concerns about the total spent on maternity and how it is split between providers. 'We had to separate concerns with the tariff from concerns about the money in general,' she said. 'Any changes need to be thought through quite carefully.'

The RCM has separately identified a need for 2,600 more midwives, but it believes some of this could be funded from reduced agency staffing.

As a first step in payment reform, the review team wants NHS Improvement and NHS England to undertake a 'comprehensive review' of cost structures to propose adjustments to the existing tariff. This is understood to be separate to a costing exercise Monitor has been undertaking to inform 2017/18 maternity prices. 'This could include potentially introducing different prices for home births, freestanding midwifery units, "alongside" midwifery units and obstetric units,' the report said.

The review also wants the two tariff bodies to 'test more radical changes' in the longer term.

It suggested a revised system similar to plans for urgent care tariffs. This might mean multi-part payment, recognising the higher fixed costs of some units, including an element of volume-based payment, while also incentivising quality and efficiency improvements, the report said.

It also hints at a system that takes account of provider rurality. And it suggests a strong local element to payment with localities deciding the best payment structure and choosing the most appropriate outcome measures. Proposals should be worked up in 2016/17, piloted in 2017/18 and implemented from 2018/19, the report said.

The review team has also proposed new personal maternity care budgets, although a reported figure of 'at least £3,000' appears to have been more illustrative than accurate. Choices would include where to give birth, the type of antenatal or postnatal care, preference for home visits, choice of breastfeeding support services and services offering greater continuity of care.

Although the approach has parallels with existing personal health and care budgets, it is not clear how this might work for maternity. The choices available under personal maternity budgets in most cases already exist – women can choose different providers for their antenatal and delivery phase – and much of the care delivered is a formal part of the pathway.

Other recommendations include: providers and commissioners joining up in local maternity systems covering populations of 500,000 to 1.5 million; every woman being assigned a midwife who would be part of a small community-based team with links to a named obstetrician; and community hubs giving access to care and electronic maternity records by 2020.

Financial position worsens

The provider sector in England is forecasting a year-end deficit of almost £2.4bn in the latest figures by Monitor and the NHS Trust Development Authority.

Month nine figures from the bodies, which are to be merged to form NHS Improvement in April, said trusts had a year-to-date deficit of £2.26bn (£622m worse than plan) with a forecast outturn of £2.37bn. Financial improvement measures of £452m, identified by providers following calls for urgent action from Monitor and the TDA in January, are included in the year-end forecast.

The national bodies, which regulate foundation and NHS trusts, said this level of deficit was neither sustainable nor affordable. They would work 'relentlessly' to reduce the deficit to the control total of £1.8bn.

NHS Improvement chief executive designate Jim Mackey warned that 'further improvements will be required by the whole NHS at pace and scale to tackle the current financial and operational challenges it faces'.

Capital to revenue transfers will be part of the package of measures to reduce the deficit. At Q3, capital expenditure was £1.13bn (32%) less than planned. The Q3 report said providers have identified £320m of capital expenditure that can be safely deferred to support local capital to revenue transfers.

Q3 figures also show that 179 of the 240 providers reported a deficit at month nine, including 131 acute trusts, driven by agency staff costs, delayed transfers of care and failure to deliver cost improvement plans.

See 'Balancing act', page 8

King's Fund: quality not finance should be guiding strategy for English NHS

By Steve Brown

THE NHS needs a quality improvement strategy, with every organisation developing quality improvement capacity supported by regional and national expertise, according to think tank the King's Fund.

Writing alongside a new report on quality management, King's Fund chief executive Chris Ham said: 'Quality not finance should be the guiding strategy of the English NHS.'

NHS Improvement and the Care Quality Commission have recently called on providers to consider quality and finance equally in planning decisions. And the King's Fund highlighted the risk that quality of care could be seen 'as a lower priority until finances have been stabilised'.

However, defining quality improvement as 'designing work processes and systems that deliver…better outcomes and lower cost, wherever this can be achieved', the think tank called for improved financial performance to be 'framed as a mission to deliver better value'. This was the only way to engage staff, it said.

'While the NHS needs to live within its means, bringing spending into line with available funding needs to be done in a way that promotes quality improvement rather than making it more difficult,' the report said.

Professor Ham pointed to recent encouragement from national bodies for providers to use all means at their disposal to reduce deficits, including reviewing headcount.

'There is little recognition that improved financial performance can be a consequence of improvements in quality, nor that changes in clinical care should be a key focus,' he said.

While the NHS had pursued quality improvement in fits and starts, a 'coherent and integrated' approach would draw lessons from the past and from organisations and systems in the UK and around the world.

The report stressed the importance of clarity about the role of inspection. 'Inspection, done well, has a part to play in quality assurance, but this should not be confused with quality improvement,' it said. The authors claimed the failure to understand this had led to a 'relative

Quality improvement strategy

1. Enable NHS organisations to build in-house capacity for quality improvement
2. Support NHS organisations through shared learning and regional support
3. Establish a modestly sized national centre of expertise
4. Integrate work on quality improvement with work on leadership development
5. Ensure national bodies provide unified, co-ordinated support to the NHS as full participants in a single strategy
6. Involve frontline clinical leaders and leaders of NHS bodies in developing strategy
7. Commit to involving patients and public in designing and implementing the strategy
8. Be open to learning from other organisations at home and abroad
9. Work with other organisations and experts outside the formal structures of the NHS
10. Reflect, measure and learn rapidly about what does and doesn't work.

Accounting standards paramount, says HFMA

Closely adhering to accounting standards and engaging auditors will be important in closing this year's accounts, according to the HFMA.

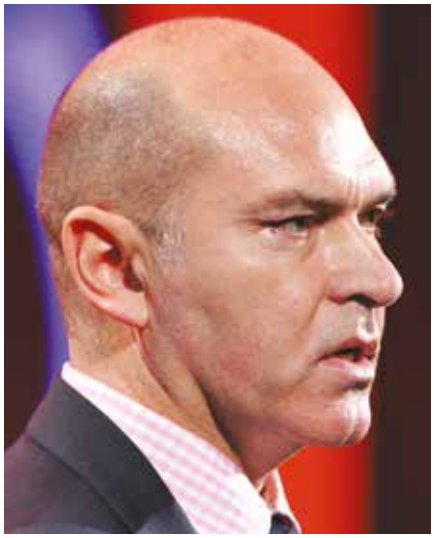
Last month the Commons Public Accounts Committee published a letter from a foundation trust finance director, who expressed concerns that finance staff are under pressure to play down financial problems in 2015/16 forecasts and 2016/17 plans. NHS Improvement has urged providers to implement a number of measures, such as local capital to revenue transfers, to improve the sector's overall financial position.

HFMA policy and technical director Paul Briddock said: 'Things are undoubtedly difficult financially in the NHS and we are in unprecedented times, particularly for providers. It is important therefore that all parts of the NHS work effectively together in these tough times to minimise deficits and to try to balance NHS finances.

'However, directors of finance and chief financial officers need to work within their professional boundaries and guidelines, and use accounting standards appropriately when making financial judgements and estimates. In reporting the financial position, finance directors and their boards need to be completely transparent about any non-recurrent measures and work closely with auditors in the preparation of accounts.'

The letter was sent to the PAC to inform its current inquiry into the sustainability and financial performance of acute trusts. It said the finance director had concerns that trusts' short-term actions to reduce headcount could compromise patient safety.

It added that potential 2016/17 cost savings could be exaggerated and finance directors could be tempted to make 'questionable adjustments' to their 2015/16 accounts.



At an inquiry hearing in January, NHS Improvement chief executive designate Jim Mackey (above) insisted the accounting adjustments being asked of trusts and changes in accounting treatment were 'entirely legitimate'.

Chris Ham (right) urges 'quality not finance', while John Graham says 'we need to get better at sharing examples of win-wins'

neglect of quality improvement and unrealistic expectations of what inspection can achieve.'

John Graham, director of finance at the Royal Liverpool and Broadgreen University Hospitals NHS Trust and chair of the HFMA Costing for Value Institute, said there were increasing examples of where improved quality and better outcomes led to a reduction in costs. 'We don't always have the capacity to deliver this improvement in-house and we need to get better at sharing examples of these win-wins,' he said.

The report was clear that progress would not be achieved overnight. 'As difficult as a quality improvement strategy is, and as long as it may take to harvest the changes at full scale, we simply do not see a more promising alternative,' it said.

Early decision planned for HRG4+

Monitor and NHS England have been taking informal soundings on the currency design to be used in the 2017/18 tariff.

Plans to implement HRG4+ – a revised version of healthcare resource groups that takes a more granular approach to complexity – in 2015/16 and 2016/17 have previously been postponed in favour of providing greater stability during the current financial challenges. But the national bodies responsible for the tariff want to take an early decision on the approach in 2017/18 to help the service prepare for changes and to support publication of tariff documents in 2016/17.

A meeting of the HFMA Payment System Group was briefed on three options: remaining with the current HRG4 design or using phase 2 or phase 3 of HRG4+. It is believed that retaining the status quo – HRG4 – has been all but ruled out – in part because it is based on old cost data covering 2011/12.

HRG4+ has already been introduced for reference cost collection purposes with changes made in three phases. Each phase broadly introduced changes to 25% of HRG sub-chapters, with the final 25% not requiring a redesign.

The choice facing Monitor and NHS England is between phase 2 (used in 2013/14 reference costs) and the 'technically superior' but more ambitious phase 3 (2014/15 costs). The HFMA group was told the relative impact between the two designs was small, with high-income providers benefiting more from phase 3. Both phases would imply income reductions for orthopaedic specialist providers – although this is still subject to a separate piece of work to fully understand it and would be subject to smoothing.

Following discussion, the HFMA group backed a single move to phase 3.

NHS Improvement targets return to earned autonomy

By Seamus Ward

NHS Improvement will have a more hands-on approach in the short term, but it intends to return to earned autonomy, according to the new body's plans for implementing the NHS *Five-year forward view.*

Monitor and the NHS Trust Development Authority will merge formally on 1 April to form the new regulator. Setting out its plans, NHS Improvement said the scale of the financial and operational problems faced by providers means it will have greater involvement with them in the short term.

However, it said such an approach had limitations and in the longer term it wished to develop an oversight model that would seek first to support organisations to improve, intervening only when it had to.

While the plan is largely about the implementation of the five-year view, it also recognises the importance of more recent developments, such as the Carter review, in trust operation over the next five years.

Much like the Carter model hospital single version of the truth, NHS Improvement said it would work with the Care Quality Commission and NHS England to create a single simple definition of success for providers. This would cover finance and use of resources, quality, operational performance, leadership and strategic change.

The finance/use of resources element would include the new use of resources assessment being developed with the CQC and reflect Carter's recommendations on metrics.

Beyond the plans for a short-term grip on providers' finances and operational performance, there would be a return to earned autonomy. Successful providers would be allowed greater freedoms, including a relaxation of restraints on decision-making, fewer data and monitoring requirements and simpler processes for transactions

However, those with the biggest challenges – foundation trusts in breach of their licence, for example – will be given 'more directive support'.

NHS Improvement chief executive designate Jim Mackey said: 'NHS Improvement will stand shoulder-to-shoulder with the service, whether that is in getting a grip on the financial situation or providing stability and offering support as our NHS seeks to change and improve to meet the needs of its patients.

'Clinical expertise will be at the heart of our work. That's why we're setting up an Improvement Faculty to advise and lead the creation of an "improvement movement" across the NHS.'

News review

Seamus Ward assesses the past month in healthcare finance

There's only one place to start. In February the junior doctors' contract dominated the health news in the first half of the month. After a 24-hour walkout that left emergency cover only on 10 February, employers' lead negotiator Sir David Dalton called on the health secretary to end the uncertainty over the contract. The NHS needed clarity to plan and offer training grade posts for the August switchover, employers argued.

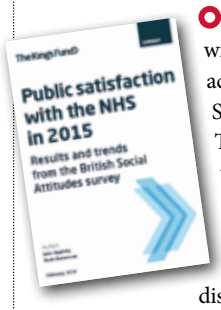
The health secretary duly obliged, telling the Commons he had decided to implement the proposed junior doctor contract despite opposition from doctors. He also announced a review of non-contract measures to improve juniors' morale. The BMA said juniors 'cannot and will not' accept a contract they view as unfair and bad for patient care. It would consider 'all options' in response.

The BMA has called three further days of industrial action and is planning a legal challenge. But will the dispute peter out as juniors move into new jobs and the contract becomes an everyday reality? What effect will the imposition of the contract have on juniors' morale – will they go abroad or to Scotland, Wales or Northern Ireland, where health minister Simon Hamilton has said he wants a negotiated deal? Managers on the ground will have to heal the wounds caused by this dispute.

In the wake of the announcement, the NHS in England was warned it must hold the line and implement the contract consistently. NHS bodies have received letters from NHS Improvement chief executive Jim Mackey and Health Education England chief executive Ian Cumming on the new contract. Mr Mackey wrote about the importance of consistent implementation of the contract throughout the service. Professor Cumming expanded on this. He said he was 'not prepared' to see competition for junior doctors based on trusts offering more favourable terms and conditions. Recruitment should be based on patient and service need and the quality of training, he added.

In a further twist, reports of a leaked Department of Health report said it was unable to prove that greater consultant presence and availability of diagnostic tests would lower mortality rates of patient admitted at the weekend. The need for increased weekend staffing is one of the cornerstones of the government's case for its proposed changes to both consultant and junior doctor contracts.

The other big story of the month – the Carter review – focused attention on efficiency and productivity, and the University of York Centre for Health Economics (CHE) said NHS productivity grew between 2012/13 and 2013/14. In the latest report in its series, the researchers said productivity grew by 2.07% – a substantial rise on the estimated 0.36% growth in the previous year. They found that output growth was 2.64% for the health service as a whole, with quality improvements accounting for 0.27 percentage points of this growth. This was an increase on the previous year's 2.34% growth.



However, satisfaction with the NHS is falling, according to the latest British Social Attitudes survey. The data, published by the King's Fund, saw a fall of five percentage points to 60% satisfied in 2015. At the same time, dissatisfaction rose by eight percentage points to 23%. While general practice remains the area with greatest approval, its satisfaction rate of 69% is 10 percentage points behind 2009 and the lowest GP rating since the survey began in 1983.

The month in quotes

'Prudent healthcare describes the distinctive way of shaping the Welsh NHS to ensure it makes the most effective use of all its resources and staff skills, to secure health and wellbeing for our future generations.'
Wales health minister
Mark Drakeford

'Our message to the government is clear: junior doctors cannot and will not accept a contract that is bad for the future of patient care, the profession and the NHS as a whole, and we will consider all options open to us."
BMA junior doctors' leader
Johann Malawana

'The summer months have started to show performance similar to past winters. This has a knock-on effect in the months that follow, particularly on planned operations, thus making it harder for the health service to cope each winter. It's then more difficult for hospitals to recover the following summer, which could lead to a continued downward spiral.'
The Nuffield Trust's Elizabeth Fisher

'While I understand that this process has generated considerable dismay among junior doctors, I believe that the new contract we are introducing - shaped by Sir David Dalton, and with over 90% of the measures agreed by the BMA through negotiation - is one that in time can command the confidence of both the workforce and their employers.'
Health secretary Jeremy Hunt

FLICKR/NHS CONFEDERATION

The health services in Wales and Scotland both launched initiatives built on value-based care. The Welsh government launched a prudent healthcare action plan. The document, *Securing health and wellbeing for future generations*, sets out where prudent healthcare can have a big impact – in ensuring tests, treatments and medications are appropriate; changing the outpatient model; and getting all public services to work together.

A national clinical strategy for Scotland outlined how health and social care will respond to an ageing population, a shift to more multidisciplinary working and rapid advances in technology over the next 10-15 years. The strategy said value is more important than a focus on finance alone. But it conceded that in the period to 2030 the increase in life expectancy is likely to add costs of £120m a year (1% of total spending), while increased cost of medicines would add 5%-10% a year.

The Department of Health confirmed an extra £1bn investment in mental healthcare by 2020 as it accepted the recommendations of the Mental health taskforce report. The taskforce made a number of recommendations, including: funding to ensure all acute hospital emergency departments have mental health liaison services; ending out-of-area acute inpatient care; and supporting 30,000 new and expectant mothers.

NHS Confederation chief executive Rob Webster (above) is to become the new chief executive of South West Yorkshire Partnership NHS Foundation Trust. Mr Webster, who has been at the confederation for two years, said it had been a privilege to lead the body, but he was keen to return to the front line.

Demand pressures normally seen only in winter are being seen at other times in the year, according to research from the Nuffield Trust and Health Foundation. *Winter pressures: what's going on behind the scenes?*' said the 2014/15 winter was the most difficult for the NHS since it started collecting weekly figures on key metrics such as waiting times. In February, the Welsh government allocated an additional £45m to the NHS to help it deal with winter pressures. The funding, allocated to this year's budgets, will come from government reserves.

Current arrangements for managing the supply of clinical staff to the NHS are fragmented and do not represent value for money, the National Audit Office said. While conceding the size of the NHS workforce (824,000 full-time equivalent clinical staff) made planning difficult, it insisted Health Education England do more to strengthen the process. *Managing the supply of NHS clinical staff in England* said vacancies were 5.9% in 2014 (50,000 whole-time equivalent clinicians) and 61% of temporary staffing requests in 2014/15 were to cover vacancies.

Monitor has launched an investigation into Southend University Hospital NHS FT after an independent audit found problems with the way it analyses patient services costs. The regulator is to work with the trust to ensure national costing guidance is followed. While Monitor had agreed after a 2015 audit that the trust use national averages rather than its own data, it said little progress had been made.

in the media

The publication of the final Carter report on productivity and efficiency in NHS acute trusts led to requests for HFMA comments. In the *Health Service Journal*, HFMA policy and technical director Paul Briddock said the report recommendations should not be used as a stick to beat finance directors and their teams. 'Ensuring the process of implementing Lord Carter's recommendations is collaborative and open, rather than top-down, with the entire healthcare system working together will be vital,' he said.

In *Pharma Times* he said the report brought the NHS a step closer to understanding exactly where to find the savings outlined in Carter's interim report.

Several reports on the financial position of the NHS in England (see p8) included the King's Fund quarterly performance report. This estimated the NHS deficit would reach around £2.3bn by the end of 2015/16. Mr Briddock told *Hospital Doctor* that despite finance directors' earlier confidence that quality could be maintained, the financial position had deteriorated further and was having an effect on services.

Following the publication of the Monitor/NHS Trust Development Authority quarter three figures, he told *The Guardian* that it was disappointing so many key performance targets had been missed.

News analysis

Headline issues in the spotlight

Balancing act

As the finances of the NHS in England deteriorate further, access to patient services is starting to be affected. Seamus Ward reports

It has been clear that the financial position of NHS providers in England has been deteriorating for some months now. Despite the tough outlook earlier in the financial year, finance directors were confident that quality of patient services could be maintained. In the HFMA *NHS financial temperature check* in November, more than 80% of clinical commissioning group and trust finance leads said quality would improve or stay the same.

However, new figures published in February show the financial position continues to worsen and appears to be having an impact on the quality of services to patients.

Both the King's Fund quarterly review and the combined Monitor/NHS Trust Development Authority (TDA) quarter three figures were published in February. They show broadly the same picture in terms of provider finances. The King's Fund estimated that NHS trusts would end 2015/16 with an aggregate deficit of £2.3bn – £500m more than the control total of £1.8bn agreed with the Department of Health.

The year-to-date figures from Monitor/TDA make no better reading. They show provider trusts reported an overall deficit of £2.26bn nine months into the financial year. This was £622m worse than planned and 75% of providers reported a deficit (179 out of 240).

Based on the current run rate, Monitor/TDA said the financial performance trajectory indicated that the full-year deficit could be more than £2.8bn. There was an 'urgent need for sustained collective action' to deliver the year-end control total of £1.8bn.

Providers have subsequently identified £452m of additional financial improvement opportunities – including capital to revenue transfers, operational improvement and technical adjustments – reducing the forecast outturn to £2.37bn.

However, some commentators believe the cost control measures being put in place to reduce the deficit are now adversely affecting patient care. Certainly, less than 91% of A&E attendees were treated or admitted within four hours in Q3. Demand was greater than a year earlier, with just over 5.1 million attendances – about 95,000 more than the same quarter in 2014/15.

More than a million patients attending major A&E departments required admission in Q3, but delayed transfers of care meant more than 98,500 had to wait more than four hours for a bed (2% more than in 2014/15).

The elective waiting list reached 3.1 million patients and for the first time the service failed to meet the 92% referral to treatment target – 91.6% in December.

"Performance is deteriorating and key targets being missed with increasing regularity … This is shaping up to be a make or break year for the NHS"
John Appleby, King's Fund

Jim Mackey, chief executive designate of NHS Improvement, which will bring together the two national bodies from 1 April, said: 'This performance will be very disappointing for providers, and shows the range of difficulties they're facing. Despite this, providers are making progress on improving their finances whilst also providing more treatment, to more patients with more complex care needs than ever before.

'However, further improvements will be required by the whole NHS at pace and scale to tackle the current financial and operational challenges it faces.'

Staff costs

There are many reasons for the deficit, but spending on agency staff remains one of the key cost pressures. According to Monitor/TDA, by quarter three providers had spent £2.72bn

Commissioner contribution

The commissioning sector is continuing to identify further savings to try to keep the health sector as a whole in financial balance.

In the latest NHS England board report, which covers quarter three figures, chief finance officer Paul Baumann (pictured) said the full-year forecast was a commissioning underspend of £295m after adjustments. This is an increase on the forecast at month eight (£145m). Mitigations identified by local, regional and national commissioners could increase the underspend to £413m.

The month nine figure included an expected clinical commissioning group overspend of £22m, as well as underspends of £44m in overall direct commissioning and £268m in central costs. The report said a large proportion of this central cost underspend was the release of centrally held depreciation offset reserves of £78m.

The central costs underspend also includes £156m of slippage in NHS England programmes, which have been realised to contribute to the overall financial balance across the Department of Health group. Spending on legacy continuing healthcare claims was lower than expected, at £164m.

Commissioners predict £2bn of QIPP quality and productivity gains will be delivered against £2.2bn planned.

SHUTTERSTOCK

on agency and contract staff – £1bn more than planned, though this was partly offset by savings on salaries for substantive staff. Overall, agency staff spending made up 7.5% of total pay costs – an improvement on the 7.8% reported in the previous quarter.

While providers planned to reduce their reliance on agency staff in 2015/16, recruitment difficulties and the maintenance of safe staffing levels in the face of rising demand led to a year-on-year increase in agency costs.

Monitor and the TDA have introduced measures to limit agency spending since November last year, including a ceiling on agency nurse spend, a mandatory procurement framework and hourly rate caps. However, more than half of trusts in the King's Fund survey were concerned they will breach new caps on agency spending.

The national bodies said that, though it was early days, the monthly spend on agency staff appeared to have stabilised over the past four months. However, they acknowledged that costs were too high and would take some time to come down.

In a separate report, Monitor said that in the six weeks following the introduction of the new rules, between 180 and 201 of the 228 trusts subject to the rules reported paying staff in excess of the price caps. But the number of individual shifts in excess of the caps fell steadily in December across all staff groups, including key groups such as nursing, midwifery and health visiting. Trusts expect to spend around £3.5bn on agency staff this year.

Non-pay costs were also a concern, chiefly delayed transfers of care, highlighted as a major issue in the Carter efficiency and productivity review. The quarter three report said there had been a 10% year-on-year rise in delayed transfers during the quarter.

The direct cost of this was in the region of £104m, but Monitor and the TDA said other estimates put the cost at much more. Delayed transfers can lead to constraints on bed availability and the cancellation of elective procedures, affecting quality, trust income and spending, the report added.

Trusts failed to deliver their cost improvement plans. They had made £1.94bn of savings (£257m less than plan) by the end of Q3.

Improvement challenge

NHS Improvement said providers must improve their finances and services to ensure patients receive good-quality care. A turnaround in the underlying financial position and significant technical measures would be needed in Q4 if the sector was to achieve the £1.8bn control total.

It added that boards must explore all legitimate and possible savings, particularly in areas such as accruals and bad debt provision. There was also slippage in capital spending. At Q3 it was £2.4bn – 32% less than planned – offering scope for a one-off capital to revenue transfer of £320m, part of the £452m savings identified. Further slippage is expected in the fourth quarter.

While attention is paid to the provider sector deficit, the Department will want to ensure health as a whole does not end the year in deficit. While the commissioning sector is pulling out all the stops (see box) to contribute to the overall position, in February the Department received a helping hand from other parts of Whitehall.

"There must be serious doubts about whether it can realise the £22bn of savings required by 2020/21 while also maintaining the quality and range of services"
Anita Charlesworth, Health Foundation

The Treasury announced that the 2015/16 Department of Health resource budget would be increased by £205m. It said the additional funding would cover central pressures, mainly a result of the pharmaceutical price regulation scheme rebate from manufacturers being £156m less than expected. The estimates also show the Department will make a £945m capital to revenue transfer.

Health Foundation director of research and economics Anita Charlesworth said 'ballooning' deficits were now too big to be managed within the spending envelope previously agreed. 'This is an indication of the dire state of NHS finances halfway through its decade of austerity. The capital transfer will help the NHS avoid an immediate crisis but will not solve its financial woes. The NHS urgently needs practical support to help it deliver productivity gains.

'But there must now be serious doubts about whether it can realise the £22bn of savings required by 2020/21 while also maintaining the quality and range of services on offer.'

King's Fund chief economist John Appleby, said the service faced a huge financial challenge. 'Even with the additional funding recently provided by the Treasury and a big switch from capital to revenue spending, it is touch and go whether the Department of Health will be able to balance its budget at the end of the year. At the same time, performance is deteriorating and key targets being missed with increasing regularity, and increasing concerns are being raised about the quality of patient care. This is shaping up to be a make or break year for the NHS.'

With further savings to be found in 2016/17 and beyond, the NHS will be keen to ensure quality does not slip while it brings it books back into balance.

Comment

March 2016

Get Carter!

The Carter report gives finance teams much needed support – now it's up to us to use it

HFMA president Shahana Khan

This time of year always gives me the jitters! For finance professionals, the agenda is always huge with so many balls up in the air and the threat of dropping one. One of them looks as if it is about to fall with the Q3 figures published in February. Rising demand, staffing problems and an impossible provider efficiency requirement have continued to broaden the funding and spending gap across the provider sector.

Some providers will be responding better to the pressures than others, but this is undeniably a systemic problem. And the shortfall is growing. Provider forecasts at Q3 indicate a £2.8bn deficit at the year end, albeit reducing to £2.4bn on the back of subsequently identified financial improvement opportunities.

This is £0.6bn out of kilter with what was proposed by system leaders back in January. This, and the fact that reports suggest a third of providers have not agreed to the proposed 2016/17 control totals, may have an impact on the availability of next year's sustainability and transformation funding.

Minimising this year's provider overspend is not just a problem for the national bodies. How we land this year will have immediate consequences at the local level next year. We are duty bound to do what we can to deliver the best possible financial position for our own organisations, our health systems and the national service.

But nor can we afford to focus solely on the immediate financial position – we need to keep an eye on planning for next year and those five year system plans.

Corporate cap could be false economy

Corporate cost caps are at odds with value approach to productivity

Healthcare Finance editor Steve Brown

There is a major tension at the heart of the Carter report on productivity in NHS acute hospitals. It rightly evangelises about the need for data across all activities. But it also seeks to impose an arbitrary cap on the costs of managers that will surely be needed to deliver this step change in performance measurement and benchmarking.

Of course finance and other back-office functions need to be focused on delivering services that support the frontline. And they can't and shouldn't be overlooked in the search for efficiency. But the approach on corporate and administration costs seems at odds with the rest of the report – which is about understanding variation rather than simply applying central controls – and against the principles of value-based delivery.

Carter found corporate and administration costs ranged from 6% to 11% (with a mean of 8%) of trust income and said £300m could be saved by getting all trusts to 7%. His recommendation is for all to trusts 'to ensure their costs do not exceed 7% of income by April 2018' with a further drop to 6% by 2020.

Shared back-office services are seen as playing a big part in this cost reduction, with trusts facing a requirement to at least test their services against shared service solutions. Back office is about much more than financial

METRICS
See analysis of the full Carter report (page 16) and a guide to the new metrics (page 20)

"No provider can flip a 'Carter switch' to raise productivity levels across the board"

This demands that systems rethink how they can improve time spent. What doesn't add value? How much time is being spent in commissioning rounds fighting over the same pound or about where the financial risk will fall?

Wouldn't time be better spent working together on coherent joined-up plans? Next year's additional funding in reality buys the service some time. But if we do not use the slight breathing space to transform the way we deliver services, all we will have done is delayed the worsening financial position.

The Carter report, published in February, provides us with some support. Its target of £5bn savings would certainly be welcome. Achieving even a proportion of this savings target will require discipline and action on multiple fronts. However we need to get as much benefit from the work as possible.

The report provides some high level signposts to where savings can be realised. Now we need to do our own local analysis on the areas that will deliver savings most readily locally. In reality, no provider can flip a 'Carter switch' that will raise productivity levels across the board.

Instead improved productivity is likely to be delivered service-by-service, department-by-department and ward-by-ward. The data flows envisaged by Carter are fundamental to this – providing an opportunity for increased evidence-based decision making.

Finance staff need to be really active – networking with colleagues across the profession to bring ideas back to their own organisations and engaging with clinical colleagues across their own organisation to help them understand the cause of unnecessary variation where it exists.

A leading commentator recently called for finance departments to be closed in favour of having finance experts 'embedded in every team and department'.

This misunderstands how finance teams work. Finance already works closely with clinical teams and simply does not work in isolation. But he is right that clinical engagement – and ever increasing engagement – will be the key to success. Let's step up and make it happen.

Contact the president on president@hfma.org.uk

SHUTTERSTOCK

services, but it is clear that many providers have to date preferred an in-house option for their own finance team.

Being asked to test this in-house provision against alternatives, including shared approaches, is not the problem. But setting a simple input-based cap on the costs of some of these activities could be.

The report is full of metrics and data collection requirements, some involving existing measures and some new to the NHS. All of these will support the new model hospital approach promoted by Carter.

The creation of this huge and potentially useful database will clearly place a burden on providers. Carter adds his voice in support of Monitor's costing transformation programme, which itself is likely to require trusts to invest in their costing teams.

But even with the data in place, analysis or supporting others, including clinicians, to analyse the data will place even greater burden on support staff. This should be fine if overall it delivers better value. In some cases, more back-office support could deliver far greater value in terms of addressing clinical variation or improving productivity. Yet a crude cap on corporate costs could keep this added value off limits.

Instead, as with other metrics and service areas, providing boards with comparative data about costs, average costs and perhaps even specifying typical ranges would enable them to challenge their own corporate and administrative set-ups.

"The bottom line should be that corporate costs are set at the optimum level to deliver maximum value"

It is also hard to see how the control can be effectively policed. The NHS has long done away with management cost controls, but they were backed up by complex definitions. It is not clear that the electronic staff record can reliably pick out completely comparable costs. And how would the cap take account of trusts that provide back-office support to other NHS bodies – where support costs will undoubtedly be higher?

The bottom line should be that corporate costs are set at the optimum level to deliver maximum value. And if higher than average corporate costs lead to overall better productivity and effectiveness, that should be seen as a good result.

Heads up

The HFMA and Finance Skills Development have published their latest finance staff census tracking changes in the size and make-up of the function over the last two years. Steve Brown presents the highlights

The NHS finance function in England has remained relatively stable over the past two years. With the service facing significant financial challenges in this period, the latest headcount of NHS finance staff shows only minimal increases in staff numbers.

This has been accompanied by small changes in the balance of services delivered by finance teams – with rising numbers of staff identified as 'financial management' at the expense of reductions in the numbers of financial accountants and staff working in services such as payroll and audit. The function is also increasingly qualified.

But, with nearly two-thirds of the function made up of women, there remains an imbalance in the number of women reaching the most senior roles – just over one in four finance directors are women.

The HFMA and Finance Skills Development have been collaborating since 2009 to develop a biennial census of the English finance function (the HFMA is undertaking similar exercises for the first time in Northern Ireland, Scotland and Wales this year with results due to be published later in 2016). A new briefing from the two organisations sets out the results of their fourth formal census based on the finance staff in post at the end of June 2015. The HFMA has published the findings of its latest staff attitudes survey alongside the census (see page14).

The census covers 529 organisations, including 488 'core' NHS bodies. These core bodies cover providers, clinical commissioning groups, the various tiers of NHS England – counting the specialised commissioning hubs as separate organisations – and commissioning support units. The wider definition of organisations includes 'non-core' bodies such as the NHS Trust Development Authority, Health Education England and, for the first time, the Department of Health as well as a small number of shared service and audit providers and some social enterprises.

The census figures show a total finance function headcount of 16,211, suggesting a 3% increase or an extra 481 staff compared with the 2013 figure of 15,730. Adjusting these figures for a more like-for-like comparison – stripping out the 173 Department finance staff not included in the 2013 census – and the total falls to 16,038, an increase of just 2%.

This same increase – 2% – can be seen within the core NHS, where the NHS finance family has grown by 362 staff to 15,403.

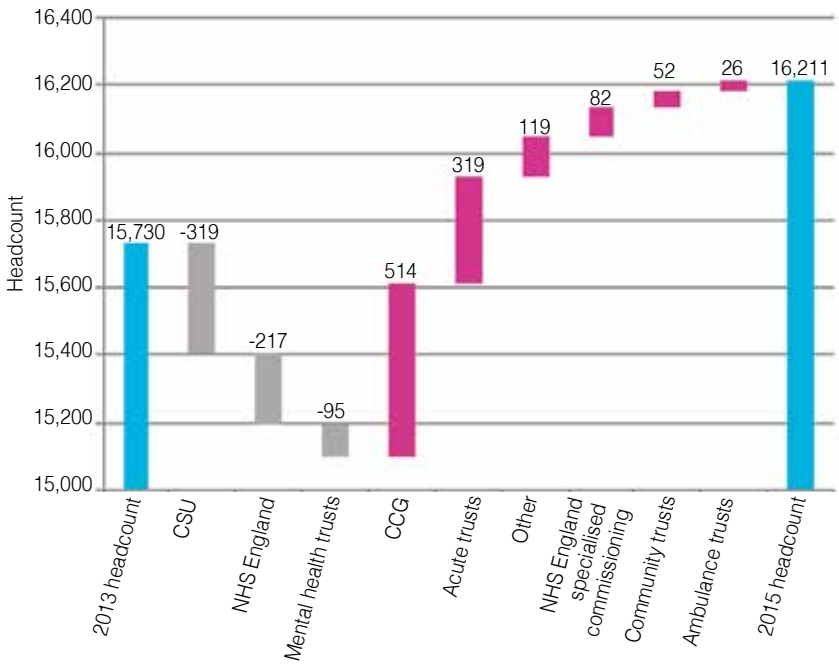
There have been bigger increases in finance staff numbers in London (9%). However, some of this can be attributed to changes in how NHS England has reported staff numbers by region – the figure across non-NHS England core bodies is still high at 6%. Staff numbers have stayed static in the south.

Analysing the headcount figures by organisational type shows significant reductions in finance staff at CSUs (30%) and at NHS England (21% including specialised commissioning). These reductions reflect the consolidation of CSUs and the 2015 restructuring of NHS England into four regional tiers and the effective reduction of area teams. These are balanced and then outweighed by increases in commissioning organisations and providers.

However, there are differences between provider types. For example, a net increase of 302 finance staff across all provider types masks a reduction in staff at mental health providers. It is not clear why. Closer examination of the figures reveals there have been big percentage swings in both directions within mental health trusts.

The overall reductions in mental health equate to an average reduction of two staff per provider from 2013's average of 41 staff. In

Change in finance staff numbers between 2013 and 2015



mental health NHS trusts specifically, average staffing levels dropped by five. These contrast with increases of four and five respectively in the average staffing levels for foundation trust and NHS trust acute organisations.

Finance team size will depend on a number of factors, including whether any services are outsourced or if services are provided in-house for other NHS bodies. Some trusts provide payroll, for example, to more than 10 other local bodies. But there is a clear link in finance team size and the overall size of the organisation, measured in turnover.

Team size rises from an average of 21 staff for acute trusts with under £100m turnover up to more than 100 staff on average in the biggest providers turning over more than £500m. There are no mental health trusts with a turnover of more than £500m, so average team sizes do not stretch so high, but the core trend is similar.

There is little difference in staffing levels in acute and mental health when comparing organisations of similar size. For example the average team size in the 28 acute trusts between £100m and £200m is 32, while the comparable figure is 34 in the same number of similarly sized mental health organisations.

In commissioning, the trend has been for staff increases at the local level offset by reductions at the centre. Across NHS England's various levels, there has been a 21% reduction in finance staff with just under 500 staff now serving national, regional, sub-regional and specialised commissioning teams. A 30% reduction in headcount at commissioning support units reflects 11 fewer units compared with 2013.

In headcount terms, CCGs added more than 514 staff (475 whole-time equivalents) to their finance teams, adding more than two staff to the average CCG staffing level. However, a quarter of the increases can be attributed to four CCGs, with the increases likely to reflect changes in local commissioning support.

Big increases in London CCG average staffing levels – in part due to changes in commissioning support arrangements – have to be seen alongside lower average staffing levels per billion of turnover, compared with CCGs in the other three regions.

Levels of seniority

The collaboration between HFMA and FSD provides a view of the NHS finance function broken down by seniority (by Agenda for Change pay band) and function. There are 476 director level finance staff across the 529 bodies in the census – the difference reflecting shared director arrangements and vacancies.

Nearly 6,100 staff working at band 7 or above represent 38% of the whole function, with a further quarter operating at band 5 or 6. Staff at band 4 or below make up 34% of the complete finance team. This represents a slight fall in absolute numbers and percentage terms at bands 1-4 and a corresponding increase at band 7 and above. This may reflect further moves to outsource transactional services to organisations not included in the census and also suggests the increase in staff has come at the senior end of the finance function.

There continues to be a higher proportion of more senior staff in London organisations – not including directors, 47% of staff on average are at band 7 or above, compared with, for example, 34% in the north.

Analysing bandings by organisational type shows CCG finance teams have a higher proportion of senior staff (52% band 7 and above compared with 34% in providers). CCGs' mandatory use of the integrated single financial environment provided by NHS Shared Business Services for core finance and accountancy services will be a key contributor to this difference.

There have also been some changes in the activities undertaken by finance teams. The census identifies three broad roles for finance staff. Financial management covers financial planning, management accounts, performance, commissioning, costing and contracting. Financial accounting covers accounts payable and receivable and treasury. And financial services includes audit, payroll, financial systems and projects.

The majority of the function are in financial management roles (53%) – a slight increase on the 50% in the 2013 census. This increase is delivered by small decreases in the proportion of staff working in financial accounting (27% down from 29%) and financial services (18% down from 19%). The remainder operate in administrative or secretarial roles.

The function remains highly qualified, with a majority having a specific finance qualification (or working towards one). Nearly one in three (31%) has a CCAB or equivalent qualification with a further 13% studying to join them. A further 12% have or are working towards accounting technician qualifications. There is a good argument for suggesting the function is continuing a trend towards greater qualification. This possibly reflects moves towards a more strategic and less transactional role and also the increasing use of shared services, which may see transactional staff move outside of the NHS.

The 7,111 CCAB or equivalent qualifieds or students represent a large absolute increase of 379 staff since 2013 and 551 since 2011, although stripping out the Department of Health staff (newly added to the census), these increases fall to 310 and 482 on a like-for-like basis. Looking just at the core NHS, the increase in qualified and student accountants (276) accounts for three quarters of the total finance staff increase (362). But as a percentage of the whole function, the function continues to move towards being more qualified (up to 44% from 43% in 2013 and 40% in 2011).

Of the 7,111 CCAB or equivalent body qualified or student staff, almost half (48%) are CIMA qualified or studying, while 33% are ACCA qualified or studying and 13% CIPFA.

The census also confirms that the NHS has made no progress in improving the number of women occupying the most senior finance roles. While women make up 62% of the NHS finance staff headcount, they only hold 26% of

NHS finance staff pay bands by region

finance director roles – in fact a two percentage point fall on the 2013 figures.

In some more junior bands, women make up more than 75% of all staff and across all bands up to and including band 6, they represent 71% of staff. For bands 7 to very senior manager grades (not including directors), the split evens out. However within these more senior roles, they represent just 40% of band 8d and 35% of band 9s.

The HFMA has recently looked to gain a better understanding of any obstacles to achieving a better gender balance in finance director positions (see 'Women leaders in health', December 2015).

For the first time, the census undertook a voluntary collection of information about the ethnicity of the finance function. This shows that the function is predominantly white British, with 72% of the function identifying in this category (76% in the slightly broader 'white' category). However there are large regional variations. London, for example reported just 34% of staff as white British, although ethnicity details were not disclosed for a quarter of all finance staff in the capital. By comparison, the North reported 83% of finance staff as white British.

Some 9% of finance staff are Asian or Asian British and 4% are Black or Black British. For London the Asian and Black communities are larger at 19% and 12%.

The function largely mirrors the ethnic composition of the broader NHS workforce. NHS Employers figures for the whole NHS suggest that 78% of staff are White, 5% Black or Black British and 8% Asian or Asian British.

In reality the 2015 census might provide a baseline against which to compare the impact of changes to corporate and administrative services flowing from February's Carter productivity report. Lord Carter has suggested trusts that have 'not examined' these functions 'closely' could save 8%-10% on current costs. He has also spotlighted the potential for greater use of shared services as providers look to meet a new corporate/administration workforce cost cap of 7% of income.

These changes could have a significant impact on how financial services are delivered across the whole service.

Behind the numbers

The HFMA/FSD census provides the numerical analysis of the finance function, but the HFMA's attitudes survey asks finance staff how they feel about their jobs. Steve Brown reports

Finance staff typically spend long periods with the same organisation, often more than two years in a specific role. Overall they enjoy their careers. And while there are concerns that current pressures may have a negative impact on job satisfaction and a feeling that finance isn't always valued as it should be, almost two-thirds would like to spend the rest of their careers in the NHS.

These are some of the findings of the HFMA's second staff attitudes survey, published alongside the HFMA/FSD census.

The survey, open to qualified finance staff and those studying, drew a response from 526 staff in England – representing 7% of the 7,111 qualified and student body.

Half of the sample had worked for their current organisation for more than three years – with nearly one in four racking up more than 10 years with the same organisation. But turnover of roles was higher – half the sample had been in their current role for less than two years and fewer than 15% for more than five years.

Job satisfaction is skewed towards the positive end with a mean score of 6.7 out of 10 – the 2013 score was 6.8. Job satisfaction rises with seniority and is greater in the north (7.1) than in London (6.3). Where there is low satisfaction, respondents cited job pressures and increasing workloads as the key culprits. There were also concerns about a lack of development and promotion opportunities and organisation-specific issues such as poorly designed processes.

Nearly one in five think job satisfaction will worsen over the next year, though more (29%) think it will improve and half anticipate no change. Two-thirds of the sample would like to spend the rest of their careers in the NHS, but only 47% think this is likely. With one in six not expecting to complete their career in the NHS and nearly 40% not knowing, the HFMA acknowledges there is a degree of uncertainty and concern among finance staff about job security. In fact 45% of the sample were concerned about losing their job in the next few years and an additional 13% in the next year.

The NHS's current financial pressures are reflected in the hours put in by finance staff. More than one in four said they 'always' worked in excess of contracted hours, and working excess hours 'at least three times a week' was the norm for a further 22%.

Three-quarters of the sample are happy with the career opportunities offered by NHS finance and 78% believe they have been given adequate development in their current role. Some said career progression would mean moving to a different organisation – not always easy for those with family commitments. Others suggested there was a mismatch between the good support provided to graduate and director-level staff and that offered to middle managers.

Nine out of 10 finance staff say their department provides value to their organisation. Comments suggested there were still opportunities to improve finance staff knowledge of the business and to improve finance systems. There were also concerns about the impact of staff turnover, vacancies and the use of interims.

Nearly 80% of staff said they felt valued by their line managers, but very few felt valued by the Department of Health, the public or patients – one in five said they were 'not at all' valued by these three groups. More than 70% – as in the 2013 survey – said they were driven by 'public sector values' to work in the NHS. Remuneration was only seen by one in five as a motivation, but there was more recognition of the pension benefits.

'We're going to rely heavily on finance directors and their teams to see the NHS through the current financial challenges so the key now is to keep the most skilled people in the service and keep them motivated,' says Paul Briddock, HFMA policy and technical director. 'We must be mindful of the immense pressure these people are under and make sure that the new initiatives, caps and rules being introduced in a bid to make savings and improve productivity aren't being used as a stick to further beat them with. Rather, we need the entire health and social care system to work together collaboratively.'

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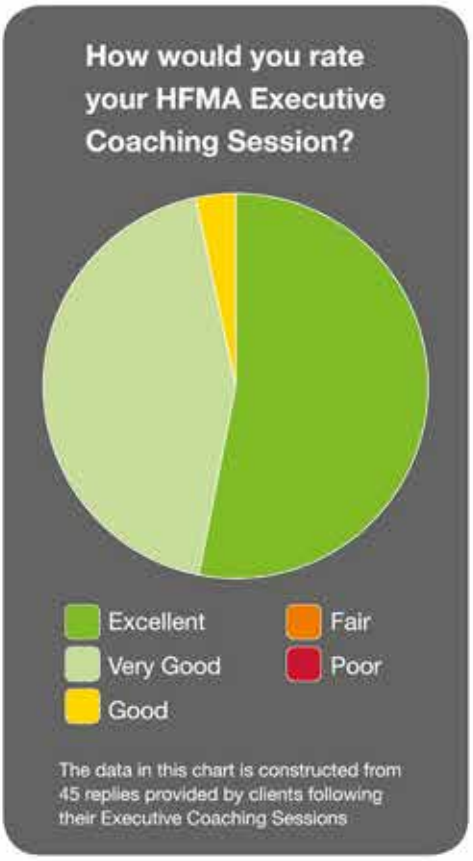

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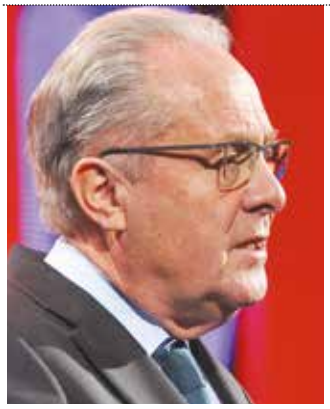


Action plan

The Carter review of efficiency and productivity sets out a huge agenda for acute trusts. Seamus Ward takes a more detailed look

It is said that the best way to lose weight is by making small changes to your lifestyle. Lord Carter has a similar prescription for acute trusts in England to make them leaner, more efficient and more productive. But while a dieter may make a handful of changes, the final Carter report on acute trust efficiency and productivity recommends a huge number, covering clinical and non-clinical services. It's a big improvement agenda and one that the NHS will have to get to grips with quickly.

While Carter's report, *Operational productivity and performance in English NHS acute hospitals: unwarranted variations*, makes only 15 headline recommendations, there are more than 80 sub-recommendations, detailing how they will be delivered. As in his interim report published last summer, Lord Carter believes acutes have the opportunity to save £5bn in areas such as better use of staff and procurement. The report, based on work with 32 acute trusts, acknowledges the Commonwealth Fund's assessment of the NHS as the best value healthcare system in the world. But Carter has identified inexplicable or unwarranted variations in acute trust use of resources. Reducing these variations will deliver savings of £5bn from the £55.6bn spent by non-specialist acute hospitals.

NHS Improvement, with support from NHS England, the Department of Health and the Care Quality Commission, will play a central role in delivering the Carter recommendations – indeed, Lord Carter has accepted a non-executive post on its board to help drive through the changes. Chief among NHS Improvement's responsibilities will be the development of the model hospital. Through a series of metrics and benchmarks proposed throughout the report (see page 20), Carter says a single picture of 'what good looks like' can be used to help trusts become more efficient. The metrics include the adjusted treatment cost, a new metric based on reference cost data; the weighted activity unit (WAU) and cost per WAU; and specific measures such as revenue per whole-time equivalent and, for procurement, the purchasing price index.

The interim report broke down the £5bn savings as £2bn from optimising the use of the clinical workforce, with £1bn each from procurement, pharmacy and estates and facilities. However, with six months' data from the metrics outlined above, Carter has been able to give more details and added further categories. While he still believes £2bn can be saved through optimising the workforce and £1bn in estates, he now says £800m can be saved in hospital pharmacy and medicines optimisation; £200m in pathology and radiology; at least £700m in procurement; and £300m in back-office costs. The report claims that much of the potential savings are close at hand. The Carter review team spoke to all 136 non-specialist acute trusts last autumn and confirmed that £3bn of the £5bn has already been recognised by trusts.

While there is much of interest to finance managers throughout the report, most of their focus will fall on the model hospital and the section on optimising resources. In this section, Carter looks at clinical and non-clinical resources. The former concentrates on better workforce management and with acute trusts spending almost £34bn on staff each year this represents the biggest area for potential savings.

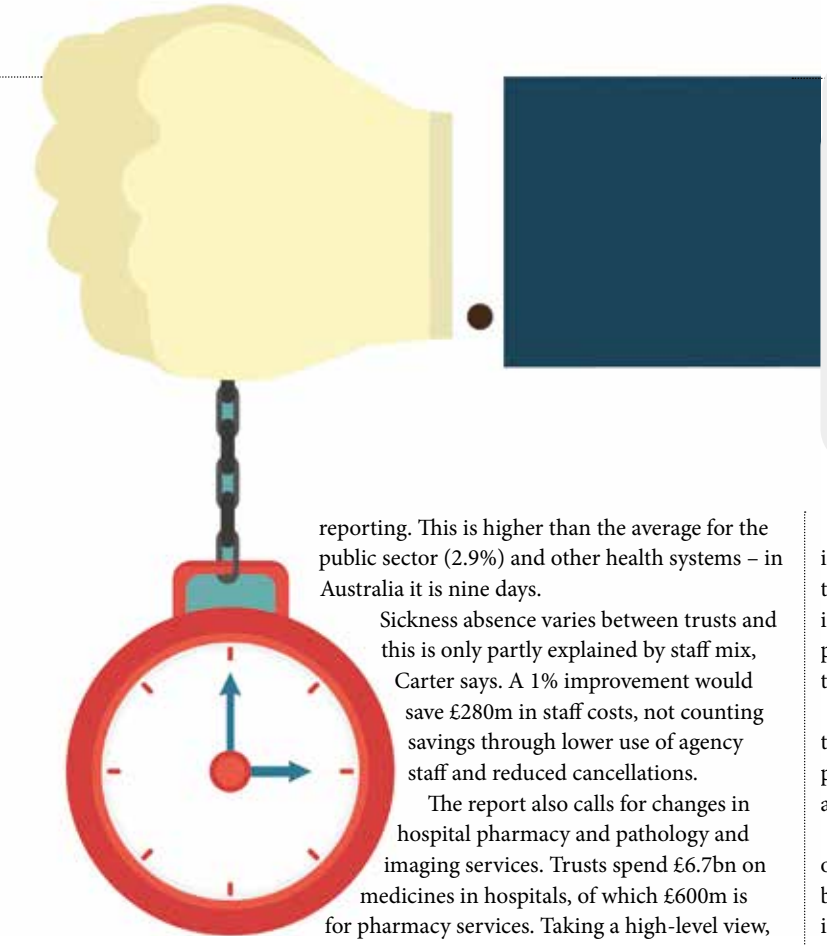
A £2bn saving would represent an efficiency increase of 7% and, based on its engagement with trusts, the Carter review believes this is achievable within three years. Greater efficiencies would then be within reach by April 2021. Nursing and care staff take up more than half of acute trust workforce spending and Carter believes addressing variations could reduce current cost pressures. Guidance will be issued on getting a tighter grip on unproductive working time, headroom, managing bank and agency demand and a review of new nursing roles. All will show best practice as part of the model hospital and will focus on the recording and reporting of nursing and care staff deployment (including metrics such as care hours per patient day), making fuller use of e-rostering systems and specialling (enhanced) care. It says e-rosters should be published six weeks in advance and be reviewed against key performance indicators such as proportion of staff on leave, training and appropriate use of contracted hours. There should be a formal process to improve rosters and cultural change to tackle underlying issues.

The report says there are wide variations in staff absenteeism, turnover and alleged bullying, and in general the NHS does not score well when compared with other sectors. Good staff wellbeing is linked to improved productivity in other sectors and the NHS needs to improve in this area, it says. For example, sickness absence rates are around 6% (13 days per working year of 225 days), taking into account under-

At a glance

Quality

- By April, NHS Improvement and NHS England should establish a joint clinical governance system to set best practice for all specialties.
- Key digital information systems should be in use by October 2018, enforced by NHS Improvement using 'meaningful use' standards and incentives.
- National NHS bodies should work with local government to ensure smooth transfers of care.
- NHS England, NHS Improvement and trust boards should identify quality and efficiency opportunities from greater collaboration across health economies.



At a glance

Model hospital

- NHS Improvement should develop the model hospital and underpinning metrics. This will show 'what good looks like', with one source of data, benchmarks and best practice.
- To ensure there is one set of metrics and a single approach to reporting, NHS Improvement, together with NHS England and the Care Quality Commission, should develop an integrated performance framework.

reporting. This is higher than the average for the public sector (2.9%) and other health systems – in Australia it is nine days.

Sickness absence varies between trusts and this is only partly explained by staff mix, Carter says. A 1% improvement would save £280m in staff costs, not counting savings through lower use of agency staff and reduced cancellations.

The report also calls for changes in hospital pharmacy and pathology and imaging services. Trusts spend £6.7bn on medicines in hospitals, of which £600m is for pharmacy services. Taking a high-level view, the NHS could save at least £800m if all trusts achieved the average pharmacy and medicines cost, it says.

Generally, the buying, making and supply of medicines is most efficiently delivered through collaborative or shared services models, and do not always need to be delivered by NHS-employed staff. This would free up hospital pharmacists' time to spend on patient-facing services – currently only 45% of their time is spent on these. The report says a hospital pharmacy transformation programme – with plans developed locally, regionally and nationally – is needed to give pharmacists more time on medicines optimisation and to ensure the NHS gets the best prices when buying medicines.

The report estimates the total cost of pathology (across all sectors) is between £2.5bn and £3bn a year, while trust costs ranged from less than 1.5% of income to more than 3%. It says trusts could save £200m in pathology provision and recommends they should achieve the pathology model hospital benchmarks by April next year or have plans to consolidate or outsource pathology services by January.

Similarly, diagnostic costs varied from less than 3% of income to almost 5%. The Carter indicators are not as well developed as in pathology but these benchmarks will be developed and trusts should achieve them by April 2018.

The report's section on optimising non-clinical resources focuses on procurement, estates and facilities management and corporate and back office costs. The latter is new to the final report. It says there are inexplicable variations in corporate and administration costs, which total £4.3bn in acute trusts. Variations range from 6% to 11% of trust income (mean 8%), irrespective of the type and size of organisations. It estimates savings of £300m if all trusts operated at 7% of income. Evidence from other sectors showed shared services could produce savings of 20% to 25% – the equivalent of £375m a year in the NHS. System integration could save even more and the Carter team found some evidence of local NHS bodies collaborating to capture the benefits of scale.

It believes savings of 8%-10% for trusts that have not closely examined their corporate and administration costs – even those that had done so could benefit from more rigorous use of shared services. Trusts should routinely check their existing services against proposed national solutions – it is unclear what these are as yet – and where they could save 5% or more, they should commit to that solution. In the shorter term, trusts should use the model hospital corporate and administration costs benchmarks for human resources, finance, procurement and information management and technology. These are to be issued by NHS Improvement in July. Trusts spending more than 7% should submit a cost-cutting plan to NHS Improvement by October and these should include plans to join national shared services models. Costs should fall to 6% by 2020.

The acute sector spends around £6bn a year on procurement of goods and services and, as in the interim report, the review team believes

At a glance

Implementation

- All acute trusts should take steps to implement the recommendations to expedite productivity and efficiency improvement plans for each year until 2020/21.
- The national bodies should work with trusts to produce a timetable of efficiency and productivity improvements up to 2020/21. They should also track the delivery of savings.

At a glance

Resources

- NHS Improvement should develop a people management strategy by October.
- NHS Improvement should develop and implement metrics to analyse worker deployment, such as care hours per patient day, to optimise clinical teams.
- Trusts should develop plans to transform their hospital pharmacies by April 2017. These plans should ensure the pharmacies achieve benchmarks on, say, accurate cost coding.
- Trusts should achieve pathology and imaging benchmarks on cost and quality, agreed with NHS Improvement, by April 2017. If pathology benchmarks are unlikely to be achieved, trusts should agree plans to outsource to or consolidate with other providers by January 2017.
- From April, trusts should report procurement information to create an NHS purchasing price index. Greater collaboration on procurement and the Department's Procurement Transformation Programme should result in greater transparency and a 10% reduction in non-pay costs by April 2018.
- By April 2017, where appropriate, trusts should have plans to have no more than 35% of floor space for non-clinical use and 2.5% of unoccupied or under-used space, delivered by April 2020.
- The cost of corporate and administration functions should not exceed 7% of income by April 2018, reducing to 6% by 2020. Alternatively, plans must be in place for sharing services or outsourcing to other providers by January 2017.

£1bn of this could be saved. However, it is now seen as a stretch target, with around £700m being achievable by exercising controls such as purchase order compliance, bulk buying, collaborating with at least five other trusts and sharing price information through a new national purchasing price index. The Department told *Healthcare Finance* that the £700m-£1bn saving opportunity identified by Carter is the same as the savings being pursued by its procurement transformation programme – which is looking to save £750m.

The report proposes procurement benchmarks to aid reform, including % transaction volume with a contract and % transaction volume with a purchase order. These benchmarks would be incorporated into the model hospital, with targets – 90% of transactions covered by an electronic purchase order by September 2017, say.

The cost of running NHS facilities is more than £8bn a year and, again, the Carter team found significant variation between acute trusts. Comparison of estates costs is tricky because hospital locations and age varies widely. However, working with the 32 trusts, it has developed a dashboard showing estates and facilities management costs and where savings could be made. The report says up to £1bn could be saved if all trusts moved to the median benchmark of their peers. Unoccupied non-clinical space, for example, ranges from 12% to 69% and it says at most this should be 35%. As a whole, a trust's unoccupied or underused space should be no more than 2.5%. Better use of energy could save £36m of the £500m trusts spend each year on fuel bills, while green measures such as LED lighting and combined heat and power could increase the annual savings to £125m.

Eradicating variation in soft facilities management costs could save £93m a year (from a total cost of £725m), while there was an opportunity to save £52m a year in the £407m spent on patient food.

Carter recommends all trusts put a strategic estates and facilities plan in place to secure cost reductions in 2016/17 based on the model hospital and benchmarks. By April 2017 they should have an investment and reconfiguration plan covering their whole estate, where appropriate.

Carter also looked at quality and efficiency, picking out delayed transfers of care as a particular problem for trusts. Delayed transfers could cost providers up to £900m a year and blocked beds can lead to elective operation cancellations. This work often went to the private sector.

The incentives and processes around transfers are often unclear, adding to costs. Some trusts had set up their own step-down facilities, sometimes in partnership with local authorities or the independent sector and Carter says trusts should be encouraged to do more of this.

Mixed reaction

Finance professionals' reaction to the report is mixed. While they welcome the focus on efficiency and the potential power of the model hospital to drive improvements, there is also a worry about the scale of the agenda. One senior director believes trust boards will have to prioritise, choosing the Carter actions that will have most impact, particularly as outsourcing – whether pathology or back-office functions – could take 18 months and would take up a lot of board time. Another says: 'Boards will certainly need to prioritise how the recommendations are tackled. Every trust will have additional schemes and this agenda needs to be manageable. The key is clinical and service engagement and where possible leveraging progress through system-wide working.'

One of the common responses from the finance managers contacted by *Healthcare Finance* is that Carter has not highlighted new areas – failings in procurement and the inability to learn from success elsewhere in the NHS are well known. But Carter gave some impetus to addressing these areas and should become part of providers' everyday business.

There is scepticism over the new ceilings for corporate and administration costs. Finance directors say clear definitions are needed. A ward clerk in one trust could have a clinical title in another, and one finance director doubts NHS Improvement will have the capacity to police it. Others say it seems counterintuitive to be setting out a huge managerial agenda (that will require greater clinical engagement), while at the same time demanding cuts in corporate and administrative spending.

Finance directors say it will be easier to act in some areas than others, with less opposition to outsourcing procurement, say, than to doing the same with pathology. One believes the new WAU metric is useful, but worries that driving down costs could also drive down quality. He says: 'The focus is getting to average cost, but I'm sure we don't also want to get to average performance. A provider can take costs out, but that could impact on performance and quality. The question is, how far do we go? It brings us back to the concept of what good looks like.'

There is a fear that, under pressure to deliver, NHS Improvement will use benchmarks and metrics as blunt instruments that take no notice of local needs. Attention will now turn to NHS Improvement, which will be the driving force behind implementation – from developing key metrics for the model hospital to assessing trusts' strategic plans. But ultimately the pressure is on trusts to turn Carter's recommendations into real efficiency and productivity savings.

"The focus is getting to average cost, but I'm sure we don't also want to get to average performance"

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Measure by measure

The Carter report on productivity calls for 'constant analysis' of performance to identify opportunities to improve. Steve Brown reviews a few of the metrics that are about to take centre stage

There is significant unwarranted variation across all of the main resource areas in the English NHS. This was the conclusion of Lord Carter of Coles in his summary of his review of NHS productivity, which reported in February. There are lots of examples of good practice but 'no one hospital is good at everything'.

There is a possible prize of £5bn attached to eliminating this variation (see page 16). But Lord Carter was clear that before they can access this, trusts need to know what they are looking for and where to look. Currently, the report claims, 'leadership teams report they often do not know whether individual parts of their hospital are operating at high quality and efficiency'. The result is 'planning based on scattered and often anecdotal information'.

'Highlighting variation requires the right metrics with detailed guidance on what good looks like,' the report concludes.

The need for good-quality data to inform decision-making is a common theme of the report. In some cases it is about getting managers to start using existing metrics to inform decision-making. In others it is about making comparable data more widely available so that organisations can see where they stand compared with their peers. But there are also completely new metrics, such as the weighted activity unit and adjusted treatment cost.

In fact, Lord Carter wants to pull all this data into a model hospital creating a 'single version of the truth on what good looks like from board to ward'. The model hospital, which NHS Improvement has been tasked with continuing to develop along with its underlying metrics, would appear to be envisaged as a form of interrogate-able dashboard – or in reality a series of linked dashboards.

Different layers of management would be able to access different levels of the model, with boards gaining high-level assurance of performance, while senior or operational managers could drill down into greater levels of detail. Organisations would be able to compare performance against internal plans, peer benchmarks and the views of NHS experts – the report says.

Although the Carter review has got the ball rolling, setting out the basic anatomy of the model (see above) and identifying or developing some of the metrics to be used, there is a considerable body of work here for NHS Improvement, particularly as the first 'full phase of development' is due to complete in April 2017.

Building on this model, the Carter report also calls for an integrated performance framework to be developed incorporating a 'set reporting cycle from ward to board to drive efficiency, productivity and care improvements.

The report is clear that analysing metrics 'will not in itself deliver improvements'. But it is the starting point. And without the data, much of the potential improvement and savings will stay off-limits.

Metric 1: care hours per patient day

The Carter report calls for care hours per patient day (CHPPD) to be adopted to provide a 'single consistent way of recording and reporting deployment of staff'. There is nothing very new about this – many may have referred to it as nursing hours per patient day. But the Carter proposals are for the metric to be given a much higher profile and for providers to start using the metric in a more hands-on way to manage staffing levels – both from a planning perspective and in matching actual day-to-day staffing levels to fluctuating demand.

It is derived by adding the hours of registered nurses to the hours of healthcare support workers and dividing by the total number of inpatient admissions in a 24-hour period (see box below). As with other metrics, it borrows from metrics used in Australia, New Zealand and the US to keep a 'firmer grip on staff productivity'.

It effectively builds on NICE's safe staffing guidance for acute wards, which had called for the acuity of patients to be taken into account when setting ward establishments. But it also called for trusts to monitor actual staffing levels on a day-to-day basis against not just these establishment totals but against real-time assessments of the nursing needs of patients.

In fact, calculating the average nursing needs of patients in hours per patient day is the first step in the NICE process for setting ward requirements. But rather than being a hidden – or implied – figure within a calculation for setting staff levels, Carter wants it to become the key metric, with 'efficiency reviewed within a CHPPD range,' and providers checking 'variation at ward level on a daily basis'.

In addition, NHS Improvement, working with the Royal College of Nursing among others, has been tasked with defining 'staffing ranges for different types of wards as a guide for trusts to help them meet their quality and efficiency requirements'. The lack of reference to 'safe' staffing levels appears to underline that it is impossible to be definitive about the actual level of staffing that will be needed. However, providers that are outside of a range – or outlying compared with their peers – should want to understand why.

There are different methodologies that will help providers factor in acuity and dependency so that they can then calculate their actual and required CHPPD based on patient need.

The Safer Nursing Care Tool (SNCT) is perhaps the most widely used within general adult ward settings – particularly for setting establishment levels. While this provides an approach for taking account of the acuity of patients in setting their care hours' needs, some believe it fails to recognise patient dependency adequately – with specialling (one-to-one care) being an extreme example.

Allocate Software supplies e-rostering systems with an integrated safe care staffing module. Its director of healthcare, Paul Scandrett, says the recommendation for the metric is sound. 'If we can get CHPPD used routinely, factoring in models such as SNCT and, of course, alongside other metrics like skill mix, it will be a great help,' he says.

Experience in the US – where a similar approach is used including a working hours per unit of service metric – suggested having a single number that deals with care and cost can really help engagement between finance and clinical teams, he adds. 'You know that if you are running too rich, you may be incurring unnecessary cost and too lean might mean you have safety issues,' he says.

It can make some decisions easier. For example, if a trust had enough staff to meet demand and then needed to open another bed, it knows at a glance from a budget perspective, how many extra care hours it needs to support that bed on average.

Mr Scandrett says local knowledge and experience will always be important, but more consistent, informed decision-making has to make sense. Providers also needed to understand their establishment and actual figures in much more detail.

'For example, you need to know how many specials your establishment can deal with and what occupancy levels were in the calculation,' he says. 'Changes to these or to the acuity/dependency on a particular day would have an impact on the required CHPPD, which would have an impact on the staffing levels you need.'

The CHPPD metric would be used to monitor trends in planned (establishment), required (daily demand for care) and actual (the staff actually on the ward on a given day) care hours. The report calls for NHS Improvement to start collecting CHPPD data on a monthly basis from this April and aim for a daily basis by April 2017.

Care hours per patient day = $\frac{\text{hours of registered nurses + hours of healthcare support workers}}{\text{Total number of inpatients}}$

Procurement metrics

A new purchasing price index will enable trusts to compare their performance in terms of price and volume on a basket of about 100 products.

With collection starting more or less immediately, the Carter team wants the index to develop this year, with more products added and monthly reporting.

Three separate sub-indices would focus on common goods, clinical consumables and high-cost medical devices.

The report also envisages NHS Improvement holding trusts to account on their performance against the index from this April. Within one to two years, a national analytics and reporting system would have emerged giving trusts full visibility of what and how much they buy and what they pay, and how this compares with their peers.

Other metrics specifically highlighted by Carter in the procurement arena include

- Percentage transaction volume on a catalogue with a purchase order
- Percentage transaction volume with a purchase order
- Percentage transaction volume with a contract
- Inventory volume.

Carter recommends that all trusts should be operating with 80% of transaction volume through an e-catalogue by September 2017, by which time 90% of volume should also be covered by electronic purchase orders.

Metrics 2 and 3: weighted activity unit and adjusted treatment cost

To assess efficiency, you need a common currency to measure hospital output. So says the Carter report. Enter the weighted activity unit (WAU) – a unit of activity equivalent to an average elective inpatient stay.

The WAU – or more precisely the cost per WAU (pronounced 'wow') – will complement other productivity measures including the adjusted treatment cost (ATC) (introduced in Carter's interim report) and area-specific metrics such as the new proposed purchasing price index. Providers will be encouraged to triangulate the results to draw conclusions.

Again the WAU borrows from abroad. Australia's national weighted activity unit, used with a national efficient price to fund hospitals, and the cruder US adjusted admissions are the key influences.

Although the WAU is presented as a separate metric from the ATC, the two are inextricably linked and both effectively repackage reference cost data into formats that may be more engaging for clinicians, non-executives and managers. The aim is to get the data out and raise its profile so that organisations start comparing, asking questions, understanding variations and identifying opportunities for cost improvement.

'They are two equivalent measures of productivity and calculated in much the same way,' the report points out in a footnote. 'The cost per WAU represents the cost of providing £3,500 worth of healthcare at a given trust, whereas the ATC represents the cost of providing £1 worth of healthcare in that trust. Trusts with a high total cost per WAU (>£3,500) will have an ATC index over £1 and trusts with a low cost per WAU (<£3,500) will have an ATC less than £1.'

The £3,500 figure is basically the national average cost for an inpatient episode (based on 2014/15 reference costs and rounded up). The number of WAUs within each provider is calculated by adding together all the different types of activity weighted according to the national average cost of providing that activity.

All types of activity counted in reference costs are included, such as non-elective work, outpatients and diagnostic tests, and elective admissions. For example, where one outpatient appointment costs on average £120, about 30 outpatient appointments count as one WAU.

Each trust's own cost per WAU can be calculated by dividing its total costs (its reference costs quantum) by this weighted activity. So if a trust carries out 100 units of a certain HRG that has a national average cost of £4,000, the cost weighted output assigned to the trust for that work would be 100 x £4,000 = £400,000 (about 114 WAUs). If that trust spent £500,000 delivering those units of activity, their cost per WAU would be £500,000/114 = £4,375 per WAU. The same trust's ATC for that output would be £500,000/£400,000 = 1.25.

The ATC was billed in the interim report as combining reference costs and total expenditure from the annual accounts. This spending is then adjusted to be equivalent to the quantum in reference costs – making the ATC a mirror image of the reference costs index (with a provider having an RCI or ATC of 100 exhibiting national average costs). The tweak to the final Carter report is to move from being an index to being based round £1 – how much does it cost this trust to provide £1 of healthcare at national average cost.

The cost per WAU can also be broken down into the amounts within this total spent on, for example, labour, non-labour, nursing, consultants and medicine. This is not a precise breakdown as it basically takes the proportion of costs spent on these elements from the accounts and adjusts this in line with the overall 'accounts to reference costs quantum' adjustment. But, again, the point is to get organisations asking questions and drilling further. Further breakdown of the cost per WAU will be possible over time and increased use of these datasets is expected to drive improved data quality and consistent coding.

The ATC is also being used to calculate potential savings for non-specialist acute trusts – this is completely new. This basically looks at the savings that could be made by a trust if it brought the HRGs where it is higher than average cost down to the average (with some capping rules where differences are very large). So while the headline ATC, WAU and reference costs give a net view, this focuses just on savings potential. It makes big assumptions (that cost allocations are correct and costs in other areas wouldn't rise if over-cost areas reduced costs), but it may help focus attention.

> **"There can be no mistake that Carter thinks corporate services can and must make their contribution to the efficiency ask"**

Metric 4: corporate costs

Back-office costs may be more of an absolute control than a management metric, but a proposed cap on corporate and administration costs was perhaps the big surprise of the final Carter report. In most areas, the broad approach of the review has been to make more comparable data available and get organisations to start asking questions about their relative performance. But for the back office, the review has gone beyond this and recommended all trusts' corporate and administration function costs be constrained to 7% of income by April 2018 and 6% by 2020.

This is accompanied by a major push on the use of shared services, with organisations expected to test existing services against shared solutions and where savings of 5% or more are available 'these savings should be delivered'.

The report found that acute trusts attribute £4.3bn of workforce spend to corporate back-office and operational administration costs. Corporate accounts for some £2bn, with administration the other £2.3bn. This incorporates 137,100 budgeted whole-time equivalents – 53,500 corporate and 83,600 administration.

Variation in combined costs ran from 6% to 11% with a mean of 8% of trust income. Getting all trusts to 7% would save an estimated £300m, the report said. The range for corporate costs was 1% to 6% and 3% to 8% for administration.

Currently, trusts do not officially report corporate or administration costs. The figures used in the Carter report appear to be extracts from the electronic staff record, which classifies staff by occupational code and by the services they work in.

However, it is hard to see how a rigid rule on corporate or administration costs could be sensitive to different local situations. For example, a provider running services such as payroll for multiple organisations might legitimately exhibit higher support costs.

It is not clear how this control will be taken forward and how local context may be taken into account. However, it seems at odds with other sections of the Carter report, where the approach is to be transparent with data and encourage providers to challenge, justify or reduce costs as appropriate.

There can be no mistake that Carter thinks corporate services can and must make their contribution to the efficiency ask – regardless of the fact that much of the rest of the report seems to imply a bigger role for management in providing clinical support and supporting transformation.

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Despite a range of reforms planned for July, the Cancer Drugs Fund remains controversial, as Seamus Ward discovers

a bitter pill

There are few topics in healthcare that are more emotive than the availability of cancer drugs. Many members of the public believe treatments or drugs that ease pain or prolong lives – even by a few months – are a worthwhile use of NHS resources. But a publicly funded healthcare system has to be sure it is getting value from its drugs spending. This is the sharp end of NHS finance, where cost-effectiveness must be balanced with the understandable desire of patients to get the drug that they and their clinicians believe will help.

It's also a political issue. The prime minister set up the Cancer Drugs Fund (CDF) in 2010 to ensure patients could access new cancer drugs as well as medicines for less common cancers. It is thought to have supported around 72,000 patients. It was initially conceived as a short-term fix while reforms to the National Institute for Health and Care Excellence (NICE) processes and a new value-based pricing system for all branded medicines were developed. But delays and lack of agreement meant that the CDF was extended to March 2016. As *Healthcare Finance* went to press, a new CDF was announced, beginning in July.

Cost is a key factor in any discussion of the CDF and its reform. The NHS spends about £1.3bn on cancer drugs through routine commissioning, including high-cost drugs, which are paid for in addition to the tariff. The CDF supplements this routine funding.

The CDF has a single national list of drugs and indications (particular conditions or cancer stages) where the drug will be funded. In February 2016, there were 32 drugs on the list, covering about 40 indications, although NHS England will consider requests from individual patients for rarer cancers, including those affecting children.

Its budget was a relatively modest £200m in 2011/12, but it has grown and for the past two years it has overspent. NHS England controls the budget as part of its direct commissioning duties and an overspend in the CDF has become almost a standard element of its monthly financial updates. The cost of the fund grew from £175m in 2012/13 to £416m in 2014/15 – the latter a £136m overspend. And, despite increasing funding to £340m this year and two culls of drugs on the CDF list (with a third possible soon), NHS England still expects to overspend by between £70m and £90m. The new fund budget will be fixed at £340m.

Provider finance managers have told *Healthcare Finance* that the CDF is not a big issue for them, though it can sometimes lead to disputes with commissioners. Sometimes cancer drugs can be used for a number of different indications, some of which may not be on the CDF list. NHS England may argue, for example, that a drug was not used for the indication on the CDF list and should be funded through tariff or (if a high-cost drug) via pass-through arrangements.

There are three ways a licensed cancer drug can get onto the CDF list – it hasn't been appraised by NICE; it is being appraised by NICE;

SHUTTERSTOCK

or it has not been recommended for routine use by NICE because it has failed to meet its clinical or cost-effectiveness thresholds. Many of the drugs prescribed under the CDF are for common cancers – for example, between April 2013 and March 2015, 59% of patients supported were being treated for three of the four most common cancers: colorectal, prostate and breast cancers. Half the patients were receiving drugs that had been rejected by NICE on clinical or cost-effectiveness grounds.

When assessing cost effectiveness, NICE uses a measure called the quality adjusted life year (QALY). In broad terms, drugs that cost less than £30,000 per QALY gained are deemed to be cost-effective. However, for drugs used towards the end of life this is adjusted, allowing NICE to consider life-extending drugs that cost more. The end of life criteria include treatments that are indicated for patients with a short life expectancy (normally less than 24 months); there is sufficient evidence to show the treatment offers patients at least an additional three months; or it is indicated for a population of not more than 7,000.

Payment controversy

The fact that the NHS is paying for drugs rejected by NICE has been criticised in some quarters. A York University study last year claimed the threshold should be reduced to £13,000 and that for every year of life gained under the CDF, five QALYs will be lost in other NHS patients. But others have argued that the fund is the only way patients can get access to innovative – and therefore usually expensive – treatments.

Last month, the Commons Public Accounts Committee weighed in with a critical report on the CDF. The committee said the Department of Health and NHS England were not using their buying power effectively and pointed out that when NHS England proposed removing some drugs from the CDF to control costs, pharmaceutical companies reduced their prices to help keep the drugs on the list.

The committee added that the Department and NHS England had no way of determining the impact of the fund on patient outcomes. Routine collection of outcomes was not mandated until April 2014 and even then there were significant gaps in the data – 93% of records did not have an outcomes summary, for example.

Commenting on the report, PAC chair Meg Hillier said: 'A vital step in addressing the financial challenges must be to properly evaluate the health benefits of drugs provided through the fund. If cancer patients seeking its support are to get the best possible treatment, there must be confidence that public money is being spent on the right medication, and at a fair price.'

While the access given to thousands of patients was welcome, it was clear that the CDF requires 'significant and urgent' reform if it is to be sustainable, she added.

That reform is imminent. It is proposed that the new Cancer Drugs Fund will be a managed access fund, providing time-limited funding while a promising drug proves its worth. Under the proposals, the process for funding a new cancer drug or indication will start around the time it receives a licence.

Before a cancer drug receives a licence, NICE will issue draft guidance. This will have one of three outcomes – the drug is rejected on clinical and cost-effectiveness grounds; it is approved for routine use; or it is recommended that it is funded by the CDF for a period of up to two years while evidence is gathered about its effectiveness.

A drug approved for routine use will be funded under the CDF until it receives a final verdict from NICE. This would normally be within 90 days of a cancer drug receiving a licence.

A joint NICE/NHS England committee will decide whether a drug recommended for the CDF will be funded. This decision will be based on the commercial access agreement – the financial arrangements that determine the cost to the NHS, which are agreed between the manufacturer and NHS England – and arrangements for data collection. The manufacturer will be responsible for funding the data collection and analysis. An NHS England spokesperson says that after a maximum of two years, NICE will undertake a short appraisal of the drug using the new evidence – at this point, it will only be able to recommend the drug be approved for routine use (and funded from baseline commissioning allocations) or that it not be recommended for routine use.

The end of life criteria would be amended under the proposals – removing the restriction on patient population (currently 7,000), while appraisal committees will be reminded of the discretion available to them when assessing a drug that extends life. A number of charities, including Sarcoma UK, have asked for clarification on how this will work. The fact that the NICE appraisal remains largely untouched is the elephant in the room as far as cancer patient groups and drugs companies are concerned.

Paul Catchpole, Association of the British Pharmaceutical Industry (ABPI) value and access director, says significant changes are needed in the appraisal process, particularly in the £30,000 per QALY value threshold. 'The proposal is to use a threshold that hasn't changed in the 16 years since NICE was set up. In that time investment in healthcare has changed dramatically and the cost of production has changed. It seems unreasonable to expect drugs to be assessed against the threshold when everything else has changed. If the QALY was adjusted in terms of inflation it would look very different.'

"The proposals require drugs to meet or have the potential to meet the cost effectiveness threshold and that's just not achievable sometimes"
Sally Greenbrook, Breast Cancer Now

He acknowledges the introduction of the end of life criteria in 2009 allowed patients access to life-extending drugs and says it effectively raised the threshold to £50,000 per QALY.

Sally Greenbrook policy manager at charity Breast Cancer Now, does not believe the proposals will lead to patients getting more effective breast cancer drugs. 'The QALY threshold is certainly part of the problem as we haven't seen it change for many years,' she says.

The charity would like greater flexibility around pricing. 'The proposals require drugs to meet or have the potential to meet the cost effectiveness threshold and that's just not achievable sometimes.'

The money allocated to the CDF will be fixed and cost control mechanisms have been proposed to ensure it remains within budget. Each drug in the new CDF will be allocated funds based on the number of patients needed to collect sufficient data and the cost-effective price implied by the initial NICE appraisal – these will be factored into the commercial access agreement. A contingency provision and cost cap will

Other funding mechanisms

As well as the Cancer Drugs Fund, patients and their oncologists have other funding routes to access expensive, new or innovative medicines.

Patients who believe they could benefit from a drug rejected by NICE or not on the CDF list can make individual funding requests. Clinicians make the request on their patient's behalf, making the case for 'clinical exceptionality' – where the patient is different to others with the same condition or might benefit in a different way.

Clinical urgency is a further reason for a request. This is where NICE has not completed an appraisal and the patient's condition would get worse without any prospect of recovery. As well as clinical evidence, in this case the clinician must demonstrate that the treatment offers value for money. If a review panel agrees to the request, the clinical commissioning group will provide the funding.

The Early Access to Medicines scheme started a year ago to give access to drugs that are not yet given a licence by NICE. There may be some uncertainty about their safety, effectiveness or side effects and the scheme can only be used where patients have a life-threatening or seriously disabling condition. The CDF can also fund drugs without a licence.

Manufacturers cannot charge for drugs under the early access scheme, but in return they can gather 'real world' information about its use, cost-effectiveness and value that could be used as evidence in a NICE technology appraisal, for example.

Drugs used in chemotherapy are defined as high-cost drugs in the NHS in England. The cost of these and other high-cost drugs is reimbursed according to locally set prices, additional to the national tariff.

Drugs can be added to the high-cost list if they are new and not captured in national prices; if currency design has not been developed or adjusted for their use; or if the treatment or intervention is carried out by a small number of providers and represents a disproportionate cost.

be introduced for each drug. Under the provision, a percentage of the amount due under the commercial access agreement will be retained until the end of the year. If the CDF has remained within budget, the contingency will be released and paid to manufacturers in proportion to the payments already made during the year. If the fund has overspent, the contingency will be used to balance the budget and if any funds remain, they will be released. However, if the overspend exceeds the amount held as a contingency, the shortfall will be recouped by an across-the-board reduction in prices for each drug on the list.

Pharma risk

The proposals represent a shift of risk to the pharmaceutical companies. Not only would they have to fund data collection and analysis, but they would also have to pay for any spending over and above the fixed sum. These proposals concern both the companies and patients' representatives.

Dr Catchpole argues against a fixed pot, believing better horizon scanning should be introduced to inform operational and financial planning. This would mean the amount allocated to the fixed sum would change each year – up or down – depending on the cancer drugs coming forward for licence as well as those exiting the CDF.

'We know very well what medicines are going to be coming out three to four years at least before they get a licence. We have good information on what to expect and we share it with budget holders in the NHS. We have got to try to integrate that information better into NHS financial and service planning,' he says.

'Our feedback from companies is that these [cost control] mechanisms are not going to be viable in some cases,' he adds. Companies are already taking a considerable financial hit as they are rebating significant sums on branded medicines through the Pharmaceutical Pricing Regulation Scheme (PPRS), he insists, and they have also negotiated lower prices on some drugs in the CDF.

'Under the proposals, 100% of an overspend would be paid for by the industry and the UK companies will have to seek permission from their parent companies to offer commercial arrangements that may be more harsh than in other comparable countries. That could be a step too far.'

Drugs currently on the list will be appraised during 2016/17 and NHS England has confirmed that patients receiving a treatment on 31 March 2016 will continue to receive it until the patient and their consultant agree it is no longer appropriate.

However, there is concern that some currently on the list will not pass the cost-effectiveness test, making them unavailable to new patients from July. Ms Greenbrook says Breast Cancer Now is worried about the future of two CDF medicines used for breast cancer patients – trastuzumab emtansine (Kadcyla) and pertuzumab (Perjeta). Both extend life, but she believes that despite the changes in the end of life adjustments, they would struggle to meet the criteria.

'They are hugely effective,' she says. 'One extends life by 16 months, which is unheard of in secondary cancers. But unless there is substantial negotiation on price, there is no way they will go into the new system. That would be a backward step for the treatment of breast cancer.'

An announcement on the new CDF is expected soon, but although it attempts to maintain access and protect the public purse, questions will remain about whether the new scheme has struck the right balance.

"Our feedback from companies is that these [cost control] mechanisms are not going to be viable in some cases"
Paul Catchpole, ABPI

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Closing date for applications 12 February.

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For more healthcare finance jobs visit jobs.hfma.org.uk

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Financial challenges raise profile of going concern assessment

Technical update

In the commercial world and the public sector, entities are usually expected to prepare their accounts on a 'going concern' basis. However, this expectation needs to be tested each year, *writes Debbie Paterson.*

Accounting standard IAS 1 requires that, each year as part of the accounts preparation process, management makes an assessment of the entity's ability to continue as a going concern. This responsibility usually falls to the audit committee. Last month, it was reported the NHS provider sector posted a deficit of £2.26bn at the end of December 2015, with 75% of provider bodies reporting a deficit. In this context, the going concern assessment is something that is likely to attract more management time and attention than in previous years.

The Treasury's *Financial reporting manual* (FREM) provides the following interpretation of the going concern requirements set out in IAS 1. 'The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.'

Both the Department of Health's *Manual for accounts* and the foundation trust *Annual reporting manual* provide further guidance on what this means for different types of NHS bodies. But, generally, unless there is evidence a particular service will no longer be provided by any public sector body, the entity is assumed to be a going concern. Given this interpretation, it is unlikely that any NHS accounts will be prepared on a non-going concern basis this year.

So, why bother with the assessment? IAS 1 also requires that where management is aware of material uncertainties that cast significant doubt on the entity's ability to continue as a going concern, those uncertainties should be disclosed.

This year, many NHS bodies will face material uncertainties around their financial future for the first time. Some are in receipt of cashflow support or expect to request it in the near future. Others have had, or expect to need, one-off or recurrent funding. Some of this will have been agreed and documented with the regulatory bodies. But it is unlikely any longer term financial support will be formally agreed at this stage, as some is tied to the as-yet-incomplete sustainability and transformation plans.

Given the inevitable level of focus on NHS bodies' financial positions at the year end, it is worth considering now what information the audit committee (and possibly governing body) will want to see when undertaking a going concern assessment. Now is also the time to start drafting the disclosures in both the annual accounts and the annual report. This could

Costs and savings reviewed for trauma guidelines

NICE update

NICE has five guidelines (*NG37-NG41*) describing and encouraging good practice in areas of trauma – complex fractures; non-complex fractures; spinal injury assessment; major trauma; and major trauma services. Major trauma is the leading cause of death in people under 45. It is estimated there are at least 20,000 cases of major trauma each year in England, resulting in 5,400 deaths and many others result in permanent disability requiring long-term care (*National Audit Office 2010*).

In 2013/14, there were about 844,200 A&E attendances with dislocation, fracture, joint injury or amputation as the primary diagnosis, and 758,400 referrals from emergency departments to fracture clinics (*Health and Social Care Information Centre, 2015*).

People who have major trauma (injury severity score greater than 15) should be treated in a major trauma centre. These provide specialised care for people with multiple, complex and serious major trauma injuries and work closely with local trauma units. Major trauma centres operate 24 hours a day, seven days a week. They are staffed by consultant-led specialist teams, including orthopaedics, neurosurgery and radiology teams with access to diagnostic and treatment facilities.

A resource impact report looks at the impact of implementing these guidelines in England. Areas of potential costs include:

- Providing airway management in pre-hospital settings
- Additional use of computed tomography or magnetic resonance imaging for first-line imaging for spinal injury assessment and non-complex fracture
- Providing a definitive written report of emergency department X-rays of suspected fractures before the person is discharged from the emergency department.

Areas of potential savings include:

- Reduced emergency department costs, saving £56-£239 per attendance
- Reduced repeat hospital attendances.

In brief

- The Department of Health has set out requirements for the collection of reference costs for 2015/16. The cost collection will take place between 20 June and 29 July. The Department said the changes supported the development of price setting and improvements in data quality, validation and assurance.
- The HFMA has produced a summary and early impact assessment on the requirements of IFRS16 on accounting for leases. It looks at the detail of the standard, including definition, disclosures and transition to the new standard. The European Union and the Treasury must endorse the standard before it can be applied in the NHS.
- The HFMA has also published a briefing of the NHS England/Monitor consultation on the proposed national tariff for 2016/17. The consultation period will close on 11 March.
- The Department of Health has updated its guidance on charging overseas visitors for hospital care to bring the guidance in line with *The National Health Service (charges to overseas visitors) (amendment) regulations 2015*.

have an impact throughout the document, in the overview and performance analysis, the governance statement, the accountable/accounting officer's statement as well as the accounts themselves. It will be important that the whole document is consistent and 'tells a story'.

Auditors will also be looking for evidence to support management's conclusions and disclosures. This will vary among auditors and entities, but it is worth a joint discussion at an early stage. If your auditor wants to see supporting letters from regulatory bodies or other third parties, these can be sought as soon as possible.

Debbie Paterson is an HFMA technical editor

This may save between £76 and £130 for each avoided adult trauma and orthopaedics attendance, and £93–£144 for each paediatric trauma and orthopaedics attendance

- Reduced emergency department consultant time
- A decrease in the use of tourniquets
- Not using a rigid cast for torus fractures of the distal radius
- Offering K-wire fixation when surgical fixation is needed for dorsally displaced distal radius fractures.

Stephen Brookfield, senior business analyst, NICE

Diary

March
8 (F) Mental Health forum, Birmingham
9 (B) North West Branch: data analytics, Manchester
17 (F) Provider Finance forum: devo Manc, Manchester
17 (B) London Branch: student conference, Rochester Row

April
21 (N) Annual costing conference
27 (F) Commissioning Finance forum, commercial contracts

May
11 (F) Chair, Non-executive and Lay Member forum, London
12 (F) Provider Finance: procurement forum, London
19 (N) Innovate, integrate, motivate, annual mental health finance conference, London
24 (N) CEO forum
25 (N) Payment systems, Rochester Row, London

June
7 (N) Workforce conference, Rochester Row, London
9 (B) West Midlands Branch: annual conference, Wolverhampton
13 (B) East Midlands Branch: team building event, Beaumanor Hall
15 (B) South West and South Central Branches: developing talent conference, Bristol
17 (I) HC4V: value masterclass
22 (F) Commissioning Finance: faculty dinner, Stratford-upon-Avon
23 (N) Spending wisely, annual commissioning conference, Stratford-upon-Avon
27 (B) East Midlands Branch: team-building event, Beaumanor Hall
28 (B) London Branch: annual conference, Rochester Row

July
7-8 (N) Creating synergy, annual provider conference, Warwick

December
7-9 (N) HFMA annual conference 2016: 'step up!' London Hilton Metropole

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

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

Event in focus

Workforce – improving efficiency and value
7 June, Rochester Row, London

Workforce productivity and efficiency is a major strand of the Carter review and will be the central theme of this one-day event. Speakers from the Department of Health will include Professor Tim Briggs, national director for clinical quality and efficiency, and Professor Tim Evans, national director for clinical productivity. They will look at the Carter recommendations and in particular at good practice in achieving an efficient workforce and minimising the use of agency staff. As well as keynote speakers, the event will be practical, featuring interactive workshops, case studies and networking opportunities. It is aimed at all finance staff, especially those working in financial management.

Contact camilla.godfrey@hfma.org.uk for further details. An early booker rate is available until 15 April

Qualified response

Association view from Mark Knight, HFMA chief executive

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

My HFMA

The financial pressures facing the NHS continue to dominate our members' professional lives and the association's work. The publication of the anonymous finance director letter to the Public Accounts Committee and the *Guardian*'s interview with Trevor Shipman – both in February – perfectly highlight the pressures finance directors and their boards are facing.

These very personal views on the current challenges have added to a growing chorus of concerns over the past two years as the financial pressure has mounted. The HFMA – alongside other representative bodies – has tried to ensure that the finance profession's view is understood. Our ongoing NHS financial temperature check is about providing a platform for the finance voice.

I want our members to know that the HFMA uses every opportunity it gets to put forward your perspective – not just in public but in the meetings that I, your president, and policy director Paul Briddock have with key players.

We know it is tough at the moment and we remain concerned about the impact of these pressures on directors and the whole finance community. However, it is encouraging to see in our latest staff attitudes survey, published alongside our biennial finance function census, that while the job is tiring and demanding, job satisfaction remains high (see page 12).

We must continue to be resilient to ensure we ride through this difficult period. But no one is under the impression that it will be easy.

Event attendances remain at an all-time high and I think the networking opportunities provided by these, and the chance to pick up on best practice, have never been more important.

The census – and tracking changes in the NHS finance function – remains an important project for the association. It also sets out our potential membership – and expanding this membership is a key part of our new membership strategy. Last month the HFMA board strongly endorsed this strategy. We will now start to develop new resources and approaches to membership and will appoint a new membership manager soon.

HFMA chief executive Mark Knight

In my last column, I mentioned the groundbreaking work of HFMA education director Alison Myles on our healthcare business and finance qualification. It is a work in progress, but we are submitting our application to Ofqual to become an awarding body – a major step forward for the association that will provide us with exciting new opportunities.

The programme will offer a range of qualifications at masters level. A diploma stage will be awarded by the HFMA and comprise three certificates, each giving the student 20 credits towards a final MBA. The diploma will be accessible by a range of healthcare staff, including finance staff not yet professionally qualified, and will typically take one year to complete on a part-time basis.

A higher diploma (60 credits) will be open to anyone who has completed the diploma, as well as CCAB- and CIMA-qualified accountants with at least two years' NHS experience.

The final part of the MBA (60 credits) will be provided by BPP University, although this is subject to the university's approval.

Although we're not yet formally launching the qualification, anyone interested should email emily.osgood@hfma.org.uk

Member news

The HFMA has launched an Environmental Sustainability Special Interest Group. The group will help spread good practice in relation to linking the consideration of environmental issues with commercial and financial best practice. For further information or to become a member of this group, contact aimee.church@hfma.org.uk

HFMA immediate past president Sue Lorimer recently visited the charity KIND (pictured), after an invitation from its chief executive, Stephen Yip. The HFMA raised £7,000 for the charity at its 2015 annual conference gala dinner, to help

fund more than 1,500 Christmas food hampers for disadvantaged children and their families.

Paul Briddock, HFMA director of policy and technical, is getting ready for his second charity bike ride to Amsterdam as part of TourDeBlades – the team representing Sheffield United FC at Prostate Cancer UK's annual Men United initiative. Last year the team raised £8,462 as part of the £360,000 raised by the bike ride. TourDeBlades hopes to raise £20,000 through various events. To support Paul go to www.justgiving.com/paul-briddock

HFMA Eastern Branch has three new committee members:

- Dawn Scrafield, director of finance, Colchester Hospital University NHS FT
- Ann Hogarth, interim senior finance professional
- Leigh Fraser, head of financial operations and planning, Great Yarmouth and Waveney Clinical Commissioning Group.

Member benefits

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

Branch focus

My HFMA

Accreditation Support scheme

The HFMA South West Branch has launched its accreditation scheme for 2016/17. Accreditation boosts organisations' reputation by recognising their commitment to providing learning and development opportunities for all finance staff.

The scheme currently has 27 accredited organisations in the South West, a number that it hopes to increase this year.

The scheme supports finance staff training and development across the South West region. Finance teams in accredited organisations have access to free mentoring training and materials, helping them to create peer mentoring networks.

Every accredited organisation is given materials needed to run a finance team away day, from pre-event surveys to icebreakers and how to follow up action points from the day.

Groups of accredited organisations will continue to be supported to hold regional events (known as #Connect events), bringing together up to 10 delegates from health, social care and third sector organisations. The events are a chance to thank colleagues for their work and share best practice from each organisation's head of finance about the issues they face as a community.

Organisations must satisfy a number of conditions to join the scheme, including the finance director signing a Future-Focused Finance declaration and holding an annual finance development day.

'The accreditation scheme really gives us the opportunity to take training and development right back into the organisation. It's got motivated staff looking at options around what we can do differently,' said one director of finance. Another said: 'Why wouldn't you join the HFMA accreditation scheme? Excellent resources, support and commitment to your staff.'

Sarah Brampton (above), South West Branch chair and director of finance at Devon Partnership NHS Trust, said: 'The accreditation scheme gives organisations formal recognition of how well they develop and support their staff through training. It also gives them enhanced status, access to team development days and facilitators. Above that, it offers the peer support network, so all our staff in the South West have access to mentors in the future.'

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Appointments

Mark Axcell (pictured), director of finance at Dudley and Walsall Mental Health Partnership NHS Trust, has been named acting chief executive officer at the trust. He has worked in NHS finance for more than 20 years across acute, community and primary care trusts. He is a member of HFMA MH Finance Steering Group. **Rupert Davies** will take over as an interim director of finance at the trust.

NHS finance director and deputy chief officer **Steven Davies** has been named chief finance officer at Moorfields Eye Hospital NHS Foundation Trust. Mr Davies succeeds **Charles Nall**, who has served as chief finance officer at the trust since 2013.

Colin Gentile (pictured) is now chief financial officer at King's College Hospital NHS Foundation Trust. He joins King's from Worcester Acute Hospitals NHS Trust. The trust says he has a track record supporting NHS trusts to generate savings, while also helping to protect standards of patient care and frontline services. He succeeds interim CFO **Alan Goldsman**.

Gareth Davies has been appointed director of finance at Bridgewater Community Healthcare NHS Foundation Trust. He was previously acting director of finance at University Hospital of South Manchester NHS Foundation Trust, where his substantive role was deputy director of finance. He brings a broad range of experience to the role in both public and private sector finance.

Lesley Evans has been appointed operations director at Our Health Partnership, a new GP partnership in Birmingham and surrounding areas. It brings together 32 practices and 149 GPs, serving 276,000 patients. She was director of primary care at Birmingham Cross City Clinical Commissioning Group, and has experience at acute foundation trusts, community trusts and CCGs.

NHS Improvement has unveiled its executive team. Joining chief executive Jim Mackey, a former NHS finance director, are **Bob Alexander** (pictured) who will take up the role of executive director of resources, and executive director of regulation **Stephen Hay**. Both will also act as deputy chief executives. Among those named in the executive team are former NHS finance directors **Adam Sewell-Jones**, who is appointed executive director of improvement, and **Helen Buckingham**, who takes the post of executive director of corporate affairs. The new body is responsible for overseeing foundation trusts, NHS trusts and independent providers.

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

"Sometimes, whether or not the finance function is world class – or even if it is fit for purpose – is forgotten. I want my experience to help organisations"
Bill Shields, right

Shields' advisory move

On the move

NHS finance director and HFMA past chair Bill Shields has joined consultancy EY's Health Advisory team as executive director.

He was interim chief executive at Royal Cornwall Hospitals NHS Trust until last October, when he joined the NHS Trust Development Authority as an improvement director.

'It's an exciting time to move to an organisation like EY,' he says. 'I have worked in the NHS for more than 28 years and during that time I have been a chief financial officer for 18 years and spent a couple of years as acting chief executive. I am keen to use that experience and skill set to provide advice into organisations and to give it from a different perspective.'

In recent years, Mr Shields' name has been closely associated with 'Building world class finance', an initiative that aims to improve processes in NHS finance and move finance staff away from transactional work to a role supporting clinicians to achieve better value.

'Building world class finance' was Mr Shields' theme when he was HFMA chair in 2008 and an initiative he implemented at Imperial College Healthcare NHS Trust. He subsequently helped develop the theme further as senior responsible officer of the Future-Focused Finance Efficient Processes and Systems action area.

EY provided a significant amount of support, development and insight into the programme at Imperial, he says. 'I worked with them for a couple of years, so if I was looking to move from the public sector into an organisation providing advice to those bodies, I would look to the one I had worked with most successfully.'

In his new role, he hopes to help organisations develop their finance function. 'The focus in the service is particularly on turnaround, financial improvement and performance optimisation. But my view is that sometimes, whether or not the finance function is world class – or even if it is fit for purpose – is forgotten. I want to bring my experience to help organisations, so they become more successful. If the focus is just on optimising the back office and making savings by coming together with other organisations, I think we will miss a trick.'

While these issues are important, he says, the learning from Imperial was that finance staff spend a lot of time and effort on non-value-adding processes.

'In management accounting, for example, people spend a lot of time moving expenditure from one cost centre to another. They should be getting alongside those who are responsible for committing the expenditure – the clinicians – and working with them to ensure they understand the impact of their decisions on the organisation.'

Finance staff must take up a business partner role and move away from being predominantly focused on transactional processing, he adds. This fits well with the FFF Efficient Processes and Systems and Close Partnering workstreams.

With his experience of financial turnaround, he expects to work with challenged organisations across the UK. The NHS in England recently imposed restrictions on consultancy spending, but Mr Shields is upbeat.

'We are always working hard to ensure the work we do delivers much-needed savings as well as improvements in patient care for the NHS,' he says. 'These moves are helping us to focus on how we can be more cost-effective and can maximise the benefits for hospitals, providers and every project we work on.

'You have got to make sure you add value and are in the business of value creation. I am keen to contribute to making EY the partner of choice in the health sector and will be looking to build on my network in the NHS to ensure long-term relationships with organisations and support them to deliver their financial objectives in a difficult period.'

Collaboration toolkit

Future focused finance

Crossing professional boundaries: a toolkit for collaborative teamwork was officially launched at the King's Fund on 19 February. Chaired by Richard Murray, director of policy at the fund, it was introduced by Bob Alexander, the new executive director of resources/deputy chief executive at NHS Improvement.

The aim of the toolkit is to improve team-working between different groups, notably clinicians and finance staff. It recognises teams have a common purpose of making the NHS sustainable against the challenges of growing demand and the associated finances, which Mr Alexander summed up as 'tricky'. He called for the wholesale implementation of the toolkit in England.

The toolkit was the brainchild of the fund's Professor Michael West (pictured at the launch) who spoke of the human need for social interaction and how it played out in professional teams. He described the toolkit's steps:

- Get the right support
- Invite the right people
- Find out what people think
- Prepare for the session
- Get people talking
- Keep going, make changes, reflect again
- Support your peers.

Speakers from pilot sites, including Gloucestershire Hospitals NHS Trust, shared their experience of using the toolkit. Matron Judith Muir explained why teams need each other. 'We use a simple £10 plastic speculum on patients; it costs the trust £4.4m a year, which is 1% of turnover. That's why we need help from finance.'

- *The toolkit is free to the NHS – visit www.futurefocusedfinance.nhs.uk*

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