healthcare finance

May 2016 | Healthcare Financial Management Association

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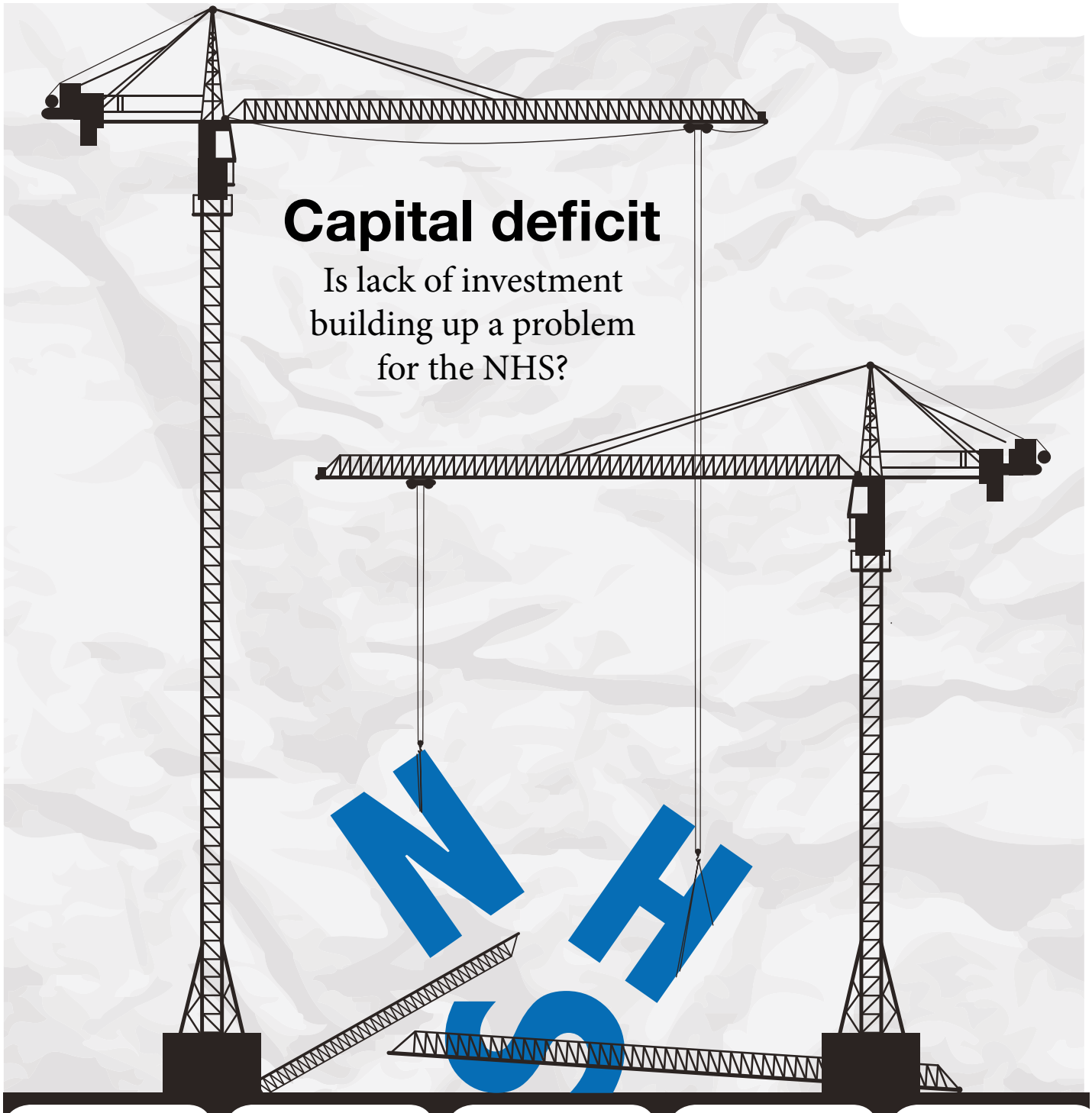

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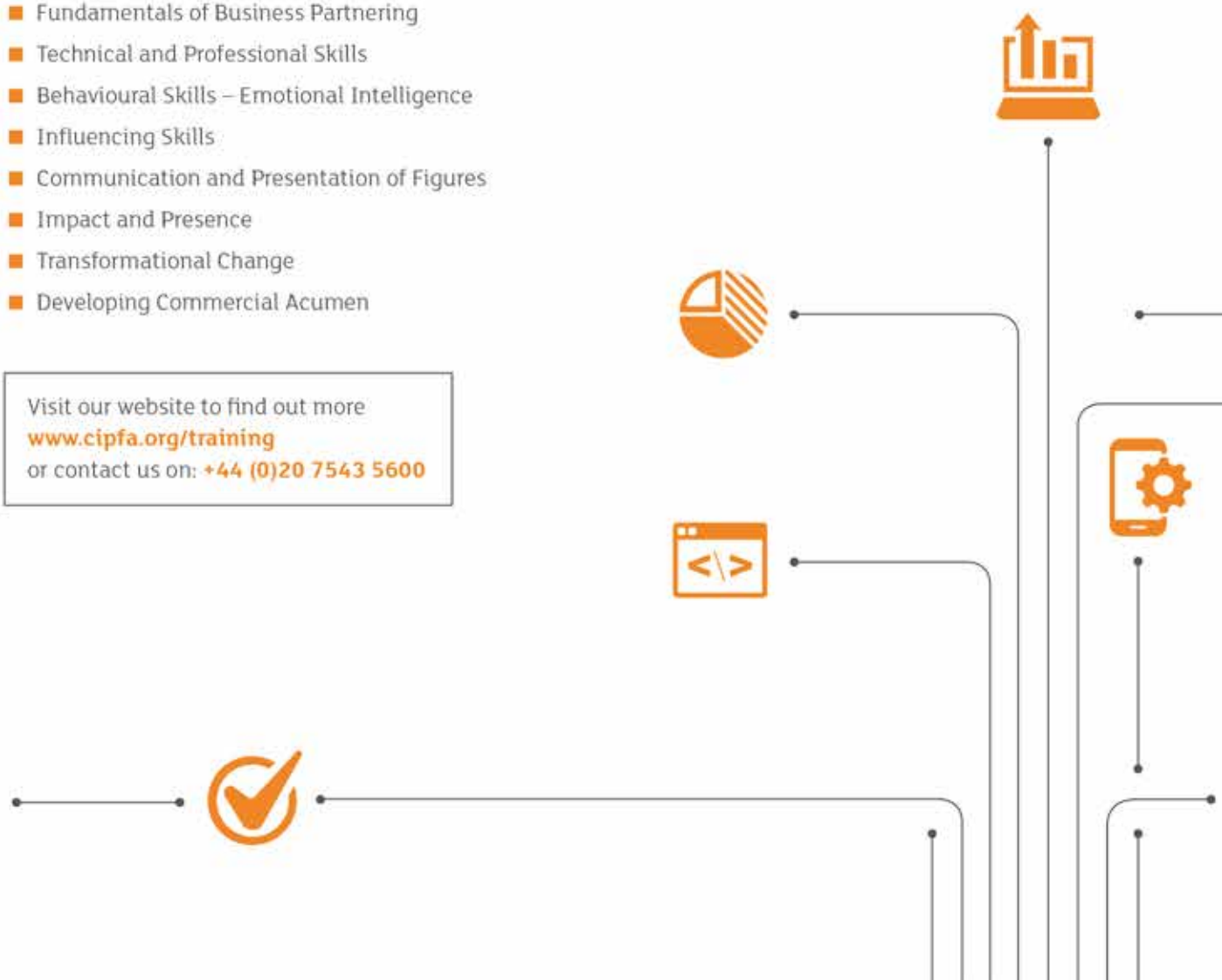


News

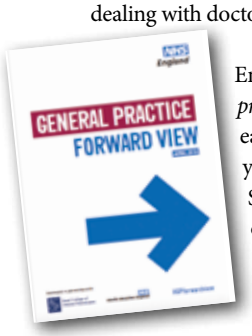
GP forward view promises new funding and formula

Stevens: 'we need to act' on GP pressures

FLICKR/NHS CONFEDERATION

By Seamus Ward

GPs have welcomed NHS England plans to inject funds into primary care, revise a practice funding formula and bring forward a new way of dealing with doctors' professional indemnity.



At the end of April, NHS England published its *General practice forward view*, which earmarked an extra £2.4bn a year for GP services by 2020/21. Spending on the services is currently £9.6bn and the extra funding will mean a 14% real terms rise over the period.

It added that it would also make a £508m sustainability and transformation plan (STP) package available to support practices, while clinical commissioning groups would also provide additional funding.

The STP package will include funding for service redesign (£246m), workforce (£206m) and practice resilience (£56m). The service redesign funding will include a requirement on CCGs to provide about £170m of practice transformational support.

Individual practices, GP federations and large groups of practices (super-partnerships) will be given support to redesign care and direct funding for improved access. There will be a new voluntary GP contract supporting integrated primary and community health services.

The workforce plan aims to double the growth rate in GPs – adding 5,000 GPs in the next five years – through new incentives for training, recruitment, retention and return to practice. There will also be funding for practice-based mental health therapists, nurses and managers.

As well as upgrades to practice premises, the forward view proposes allowing up to 100% reimbursement of premises developments, investment in technology to support appointment, consultation and workload management systems, and better record-sharing to support teamwork.

There is a commitment to reform the Carr-Hill formula, which is used to calculate the global sum paid to each practice. This is one source of income, based on the number of patients registered. It includes provision for the delivery of essential and additional services, staff costs and locum reimbursement. It does not include money for costs such as premises and information technology.

The document said NHS England was working with the British Medical Association to examine the impact of deprivation, age and other factors that influence practice workload.

NHS England chief executive Simon Stevens said: 'If anyone 10 years ago had said: "Here's what the NHS should now do – cut the share of funding for primary care and grow the number of hospital specialists three times faster than GPs", they'd have been laughed out of court. But looking back over a decade, that's exactly what's happened. Which is why it's no great surprise that a recent international survey revealed British GPs are under far greater pressure than their counterparts, with rising workload matched by growing patient concerns about convenient access. So, rather than ignore these real pressures, the NHS has at last begun openly acknowledging them. Now we need to act, and this plan sets out exactly how.'

Royal College of General Practitioners' chair Maureen Baker said the plan meant general practice funding would account for more than 10% of NHS spending – the college has campaigned for the figure to be about 11%.

'This is a huge and important step in the right direction and, if implemented correctly, our profession, the wider NHS and, most important, our patients will reap the benefits,' she said.

Dr Baker also welcomed NHS England's pledge to tackle the cost of GPs' professional indemnity, rising due to the increasing number of claims and higher level of awards. The GP forward view dismissed suggestions that GPs be given Crown indemnity – giving patients who suffer as a result of clinical negligence no route to financial compensation. In July it will publish proposals on containing these costs; reducing individual costs for part-time GPs and others with special circumstances; and to enable new care models such as multispecialty community providers to take on corporate indemnity.

Standards mark renewed costing push

The compilation of patient-level costs following newly prescribed standards will become mandatory, but NHS providers are being encouraged to jump before they are pushed.

NHS Improvement last month published its long-awaited *Case for change* document – making the case for its Costing Transformation Programme, alongside its first draft of new acute costing standards and minimum software requirements.

Speaking to the HFMA costing conference in April, NHS Improvement director of costing Richard Ford said adoption of the standards would become mandatory from December, leading to a preset timetable for each provider sector.

'I don't want it to be a regulatory issue,' he said. 'I want you to adopt as early as you can, so that when mandation happens in December it's not a big issue for anyone.'

The new standards are primarily for six roadmap partners. But they will be of interest to all providers as the first to underpin a revised approach that maps costs to resources and activities. Further draft acute standards will be published in January 2017, alongside first standards for other sectors.

The standards to be used for the first mandatory collection are due in January 2018.

Organisations taking part in this year's voluntary patient cost collection will use the existing *Approved costing guidance* supported by HFMA's costing standards. NHS Improvement has confirmed that for the voluntary collection in September 2017, acute providers will be 'encouraged' to use the new draft costing standards to be published next January.

See 'Clear direction of travel', page 12

Providers report parity of esteem funding gap

By Steve Brown

Mental health service providers have raised concerns about the level of funding being allocated to mental health services to deliver the government's ambitions for parity of esteem between physical and mental health services.

Planning guidance for 2015/16 – repeated in guidance for 2016/17 – required 'each clinical commissioning group's spending on mental health services to increase in real terms and grow by at least as much as each CCG's allocation increase'.

However, in a survey undertaken by the HFMA in conjunction with NHS Providers, only half of the 32 mental health trusts taking part (55% of all trusts) said they had received an increase in funding that met these requirements.

This was despite more than two-thirds of these lead CCGs signing up to the principle of parity of esteem. All CCGs taking part in the survey (representing 10% of all CCGs) said they had signed up to parity of esteem and had increased real-term investment in mental health services in line with the planning guidance requirement.

The report highlighted a 'disjoint' about whether the investment requirement is being met. It said that part of the problem was 'what organisations badge as mental health spend'.

Some respondents said that commissioners were investing in areas not provided by secondary care trusts, such as primary care, drugs, the mental health component of continuing healthcare and out-of-area services.

'This means that commissioners might report that they have increased their spend on mental health services, while some providers will have seen no direct investment or even, in some cases, disinvestment,' the report added.

NHS Providers and the HFMA said it was 'concerning that investment priorities and funding are not currently aligned at a local level'. They also highlighted tension created by different rules – the increased investment requirement sat alongside a starting point for contract discussions of a 1.6% reduction in contract prices, in line with the national tariff adjustment.

The survey also found that only a quarter of provider respondents (at the time of the survey) were confident their commissioners were going to increase investment in mental health services

ONLINE VIEW

Writing in a blog on www.hfma.org.uk/news/blogs, NHS Providers' policy adviser Philippa Hentsch (below) said it was worrying that 'despite the rhetoric around increasing funding … the necessary investment is still not reaching many local areas and services'.

She added that the 'lack of alignment between investment priorities and funding at the local level needs to be addressed'.

Association publishes devolved nations survey

The HFMA has published its first census and attitudes survey of finance staff in Wales, Scotland and Northern Ireland.

The census highlighted that a total of 1,389 people worked in NHS finance in Scotland, with 1,018 in Wales and 984 in Northern Ireland at the end of June 2015.

A third of finance staff in Scotland are qualified or studying for a finance qualification, including 21% who currently hold or are studying for a CCAB or equivalent body qualification.

In Wales, 49% have or are working towards a finance qualification, with just over a third holding or studying for CCAB or equivalent qualification.

Meanwhile, in Northern Ireland, there is a smaller proportion of qualified staff, with 28% qualified or studying and 21% who either have or are studying with CCAB or an equivalent body.

Different use of shared services across the UK nations could explain some of these differences.

The gender imbalance in top NHS finance jobs across the UK is largely reflected across the devolved nations.

In Wales, only 25% of finance directors are women, even though women make up 65% of finance staff. Women make up 69% of the Northern Ireland finance workforce, but hold only 38% of finance director posts. In Scotland, however, 71% of finance staff are female and 63% of finance directors are women.

Average job satisfaction in Scotland is 6.4 out if 10 and 64% would like to spend the rest of their career in the NHS. The figures are similar in Wales.

However, while Northern Irish finance staff have the same level of job satisfaction, a lower proportion (45%) would like to spend the rest of their career in the NHS. Staff in Northern Ireland were also more likely to have spent time working outside the NHS.

See www.hfma.org.uk/publications for further details

Access standards challenge

The Department of Health and NHS England are making progress in supporting mental health access and waiting time standards, but much remains to be done, according to the National Audit Office.

Access standards were set in October 2014 as part of plans to achieve parity of esteem between physical and mental health. However, an NAO report said that the full cost of implementing the standards and meeting longer term ambitions was 'not well understood'. It said there was not yet enough information to measure how far the NHS is from meeting the standards.

NAO leader Amyas Morse described the recognition that mental health had been treated as a 'poor relation', the goal of parity of esteem and setting access standards as 'bold and impressive steps forward'. 'It is important these steps are supported by implementation in a reasonable timescale if they are not to be a cause for disillusionment,' he said. 'And this looks challenging in current conditions.'

"It is important that commissioners are open and transparent about where the extra funding is being distributed"
Paul Briddock, HFMA

in line with allocation growth in 2016/17.

Paul Briddock, HFMA director of policy, said commissioners and providers needed to work collaboratively. 'The report shows that we are not quite where we would like to be. It is important that commissioners are open and transparent about where the extra funding is being distributed, what it is being spent on and the impact it is intended to have,' he said.

'This will give concerned providers the reassurance they need that the right financial investment will reach the front line, and the patients it needs to at a local level.'

HFMA seeks member views on work plans

The HFMA has announced its draft policy, research and technical work programme for 2016/17 and has invited members to comment.

It has asked members to complete a five-minute survey (details below) that contains a list of proposed work. The planned work is in addition to the regular policy and technical output, such as the introductory guides, e-learning modules, costing and value work and responses to consultations.

HFMA policy and technical director Paul Briddock (pictured) said he wanted to ensure that the chosen topics were relevant to members' work and to discover if there were any key issues not being covered.

The policy and technical programme is designed to contribute to the association's overall vision of 'better quality healthcare through effective use of resources'.

It will also facilitate the delivery of its strategy to represent and support healthcare finance professionals; influence health policy; and promote best practice, education and continuing professional development.

Planned activities focus on a number of areas, including briefings on transformation and integration, efficiency, payment systems and financial management and reporting.

The draft programme added that the policy and technical team will work with branches to help them establish a research function if they wish to do so.

To take part in the survey, please go to http://tinyurl.com/h7z3jys

The system will cover devices used in some operations

High-cost device procurement system set to improve value

By Seamus Ward

A deal to centralise the purchase of high-cost medical devices and implants will lead to savings of £60m in its first two years, NHS England has said.

The devices, which are typically specialist and used in a small number of providers, are currently paid for separately from the tariff under pass-through arrangements. However, the planning guidance for 2016/17, published in December, announced that a national system would be established.

NHS England said it currently spends £500m a year reimbursing specialist units for the devices. These are paid at cost, but there are wide variations in the prices paid by trusts and the rates of use across the country.

The deal, agreed with the NHS Business Services Authority and operated by NHS Supply Chain, would generate savings through economies of scale and reducing price variation.

The new system includes bespoke orthopaedic prostheses; carotid, iliac and renal stents; and peripheral vascular stents. However, it does not appear to include all the devices in the 2016/17 national tariff high-cost devices list.

NHS Supply Chain will provide support to each trust currently purchasing high-cost devices to ensure a smooth migration to the new arrangements by the end of 2016, NHS England said. The system is due to operate until September 2018, when it is expected that new NHS-wide procurement arrangements will be in place.

NHS England director of specialised commissioning Jonathan Fielden said: 'By bearing down on price and quality variation and making the most of our national purchasing power, NHS England will now be able to deliver these same high-cost devices for less, freeing up funding to help meet the increasing demands on specialised services from new and effective treatments.'

NHS Supply Chain has announced that it has reached its target of delivering £150m in cash-releasing savings for the health service by 31 March this year. According to Supply Chain, it had reached the target through collaborative working, product standardisation and rationalisation. The organisation added that it would continue to work in this way to deliver the next £150m of savings to achieve the overall target of £300m by September 2018.

Building block, page 16

News review

Seamus Ward assesses the past month in healthcare finance

As the junior doctors' contract dispute rumbled on, a new regulator was created in April. NHS Improvement – which brings together the NHS Trust Development Authority and Monitor, as well as other safety and support teams – has announced its new board. Chair Ed Smith will be joined by eight non-executives, including Professor Lord Darzi, Lord Carter of Coles and Richard Douglas, former director-general of finance at the Department of Health. Five executives will also sit on the board, including chief executive Jim Mackey, director of resources Bob Alexander, director of regulation Stephen Hay, director of nursing Ruth May and medical director Kathy McLean.

The new body's in-tray is stacked with issues such as further tariff reform, costing changes and the new Carter metrics, but it immediately faced operational and financial issues. April saw the publication of the worst A&E performance figures in England since monthly reports were introduced in 2010. According to the figures for February, 87.8% of patients were seen within the four-hour target, down on the 88.7% in January. NHS England said a delayed flu spike and social care-related delayed transfers of care contributed to a decline in A&E performance in February.

NHS Improvement moved to investigate and act at trusts facing financial and operational issues. It opened an investigation into the financial position at Birmingham Women's NHS Foundation Trust. The regulator said it would examine whether the trust needs extra support as it plans its recovery. The trust was forecasting a worse than expected year-end position for 2015/16, predicting it would have a £3.4m deficit.

NHS England does not have consistent information on the cost, access to, outcomes and efficiency of specialised services, according to the National Audit Office. Despite taking over their commissioning three years ago, it does not have an agreed strategy for the services, it added. An NAO report, *The commissioning of specialised services in the NHS*, said NHS England has found it challenging to control the rising costs of these services, with the budget increasing on average by 6.3% a year between 2013/14 and 2015/16.

The King's Fund set out three challenges for the NHS in England: sustaining existing services and standards of care; developing new and better models of care; and tackling the challenges by reforming the NHS from within. The think-tank reiterated its proposal to implement an integrated system for health and social care with a single local commissioner as a way to tackle the challenge on sustaining services. On transformation, it called for a national workforce strategy to ensure the workforce was fit for purpose and aligned to the new care models set out in the *Five-year forward view.*

There was change at another arm's length body – the Health and Social Care Information Centre is to be renamed NHS Digital from July and will have a new chair, Noel Gordon. The Department of Health said the new name for the data, analysis and IT systems provider will build public confidence, recognition and trust. Mr Gordon is currently non-executive director and chair of the specialised services commissioning committee at NHS England.

A Nuffield Trust briefing focused on emerging changes in primary care and how digital technology can help managers and clinicians to deliver them. The paper looks at e-digital requirements for new primary care models and examines how technology can underpin a series of changes enabling primary care to meet its challenges. Drawing on six case study sites using new technologies, the briefing looks at innovations such as shared health

The month in quotes

'Unfortunately we are not going to see any significant improvement in meeting the A&E four-hour target until both the number of patients admitted as emergencies, and the number who cannot be sent home, are reduced as well.'
Candace Imison, Nuffield Trust director of policy

'Our central estimate deems a 4% reduction [in food waste] could be achievable through iterative adjustments to menus in response to the results of plate waste audits. This could result in significant cost savings by reducing purchases of ingredients – given the £541m annual expenditure on providing catering services for patients, only small changes are required to achieve these savings.'
Hospital food standards panel report

'Those from disadvantaged backgrounds are now more likely to access an undergraduate degree. Our proposed reforms will extend these benefits to nurses, midwives and allied health professionals, who have been excluded.'
Health minister Ben Gummer

'In a tax-funded system, the public rightly demand high standards of probity from NHS staff and healthcare suppliers. Recent cases have underscored the need for action. "Sunshine" rules to bring greater transparency, tougher restrictions on conflicts of interest, and clearer guidelines on industry partnerships and influence will benefit patients and protect taxpayers.'
NHS England chief executive Simon Stevens

FLICKR/POLICY EXCHANGE; NHS CONFEDERATION

records, patient portals for booking, remote consultation and telehealth.

The Welsh government will spend £60m over the next year to join up health and social care services. This includes £50m of revenue funding from the intermediate care fund to improve co-ordination between social services, health, housing, education and the third and independent sectors. The remaining £10m is capital funding to support reablement or step-down services, for example.

The new NHS Improvement board includes Richard Douglas (above), former finance director-general at the Department of Health

The Senior Salaries Review Body said it was unable to recommend a pay rise this year for NHS very senior managers (VSMs). The Department of Health had not provided it with an opportunity to review a new pay framework, it said. As a result, it could not advise on the suitability of the framework or on transitional arrangements. However, the review body was at pains to say this did not mean it was recommending a pay freeze. It pointed out that funding for an average 1% rise was available, Agenda for Change staff received a 1% rise from April and in five of the last six years VSMs have not received an award. It recommended that, if the government decides to give VSMs an award averaging less than 1% this year, it should hold back the funding to allow a potentially bigger rise next year.

The implementation of new guidelines to improve hospital food could save the NHS around £2.5m a year. The Department of Health published its hospital food standards panel's recommendations on hospital food and drink. A cost-benefit analysis, made available alongside the main report, said the guidelines were expected to cost around £7m a year. However, better nutrition in patients would reduce lengths of stay and, coupled with catering efficiencies such as reduced waste, would generate savings of £9.6m. In addition, a further £1.5m is expected in terms of health benefits to staff and patients, the analysis said.

A consultation on proposed changes to student funding for nurse, midwife and allied health professional degree places is now open. The proposals, announced in the 2015 spending review, will mean that from 2017, all new students will receive funding and financial support through the standard student support system rather than through the current NHS bursary scheme. Loan repayment terms will be the same as for other graduates. The government said two-thirds of people applying to become a nurse in the current system are not accepted. However, it said the changes would create up to 10,000 more training places by 2020. The consultation closes at the end of June.

Measures to combat conflicts of interest have been unveiled by NHS England. It said the plans would bring a stronger, more consistent approach to managing potential and existing conflicts of interest across the NHS. The measures include revised guidance for clinical commissioning groups; a new task and finish group to set rules that can be adopted across the NHS; a 2016/17 standard contract requirement for providers to keep a register of gifts, hospitality and conflicts of interest; and a strengthening of NHS England's internal policy.

in the media

The HFMA/FSD NHS finance census and staff attitude survey garnered plenty of attention from the press in April. HFMA policy and technical director Paul Briddock told *National Health Executive* only 46% of staff surveyed felt valued by clinicians in their organisation. There was a need to ensure finance staff were trained on how clinical services are delivered and for clinicians to understand better the workings of NHS finance.

Hospital Management magazine and *The MJ* (*Municipal Journal*) both took similar lines. They highlighted the fact that almost two-thirds of NHS finance staff hoped to spend the rest of their career in the health service, but only 47% expected to remain employed by the NHS until they retire. Mr Briddock said the need for the service to retain finance staff had never been higher to facilitate high-quality services with restricted financial resources.

***PQ* focused on the finding that only 5% of NHS finance professionals feel valued by the public, but public sector values keep them going to work. It also highlighted the gender imbalance in senior finance roles.**

In *Pharma Times* Mr Briddock also commented on last month's Commons Public Accounts Committee report on financial sustainability and performance of acute trusts. He said the sector 'had a mountain to climb' and recent performance figures showed that quality of care was beginning to suffer.

News analysis

Headline issues in the spotlight

Finding an end to the gridlock

The positions of both sides in the junior doctors' dispute have become entrenched, but what are the key points of difference? Seamus Ward reports

Impasse. Deadlock. Stalemate. As *Healthcare Finance* went to press, junior doctors in England had carried out the first all-out strikes in the history of the NHS, and the only thing that seems to have changed is that positions have hardened. It is now a question of which side will blink first.

The dispute is about a new contract that the government insists is needed to implement its manifesto promise of a seven-day NHS.

Looking back, it's difficult to see how we got to this point. Both sides want a seven-day NHS, both believe the juniors need a new contract and, according to reports, 90% of the contract has been agreed. So how have we reached a point where thousands of scheduled operations and outpatient appointments have been cancelled as juniors stand on verges outside hospitals?

Two days before the all-out strike, doctors' union the British Medical Association (BMA) wrote to health secretary Jeremy Hunt offering to call off the action and return to talks if he agreed to lift the imposition of the new contract in August. Mr Hunt refused, saying a union should not be able to hold to ransom a government that was merely attempting to implement its manifesto.

It's become a highly politicised situation, with claims both that the BMA has been trying to bring down the government and that the government has been attempting to privatise the NHS. But headline-grabbing statements like these do little to solve the dispute or explain what it's all about.

When not slinging mud, the high-level discussion carried out in the media often boils the dispute down to two issues – the BMA says the new contract threatens patient safety; the government refutes this, implying the unions' opposition is purely down to pay.

Both safety and pay are important factors, but teasing these apart reveals a number of other issues, including working hours and cost. Taking a step back, the government insists the contract is needed to implement seven-day services. But what does a seven-day NHS mean?

It is often explained as giving patients the same level of care at the weekend as they get on a weekday. Mr Hunt has clarified that this does not mean elective treatments at the weekend as well as the emergency and inpatient care already provided. On the eve of the latest industrial action, he said: 'Our plans are not about elective care but about improving the consistency of urgent and emergency care at evenings and weekends. To do this, the Academy of Medical Royal Colleges (AMRC) has prioritised four key clinical standards that need to be met.'

He went on to say that these include:

- Ensuring patients are seen by a senior decision-maker within 14 hours of arrival
- Twice-daily high-dependency reviews
- Seven-day availability of diagnostic tests with a one-hour turnaround for the most critically ill patients
- 24-hour access to consultant-directed interventions such as interventional radiology or endoscopy.

He added that around a quarter of the country will be covered by trusts meeting these standards from next April, with the whole country by 2020.

The BMA said the AMRC clinical standards had implications for the way doctors work, as well as funding. It agreed that urgent and emergency care should be prioritised but said that only when this was improved should the debate about extending elective services into the weekend begin.

So, there is broad agreement about the scope of seven-day services in the immediate future. The dispute lies in questions of staffing, safety and funding.

Both sides insist safety is the key reason behind their stance. The government says the juniors' industrial actions are threatening patient safety, while the doctors believe that the new contract will do the same by spreading the existing workforce across the week.

Mr Hunt said numerous academic studies had shown a 'weekend effect' – essentially there are more deaths following weekend admissions.

He believes part of the issue is lack of medical staff, though there are other contributing factors such as reduced diagnostic support. Some academics and the BMA cast doubt on this conclusion, arguing that the studies have not presented evidence for this.

The BMA highlighted the fact that junior doctors provide most medical cover at weekends already. Some people would argue that, if there is an issue with medical cover, it is a lack of senior doctors in work on Saturdays and Sundays.

There are gaps in current rotas. According to research by the Royal College of Physicians last

Contracts across the nations

The junior doctors' dispute applies to England only, with the devolved nations having responsibility for contracts. None of the nations wish to follow in England's footsteps. In Scotland and Northern Ireland ministers have indicated that a new contract is needed, but they wish to come to a negotiated agreement.

Northern Ireland health minister Simon Hamilton has said he has 'no desire' to impose a new contract and that this would be the 'worst possible outcome'. Scottish health minister Shona Robison has also said a new contract would not be imposed.

In Wales, the Assembly government has said it wishes to retain the current contract. Indeed, ministers appear to see England's difficulty as Wales' opportunity – launching a recruitment campaign aimed at attracting disaffected doctors in England.

SHUTTERSTOCK

"Our plans are not about elective care but about improving the consistency of urgent and emergency care at evenings and weekends"
Jeremy Hunt (right)

year, one in five of their consultants reported gaps in junior doctor rotas.

Doctors are worried that such gaps will be exacerbated by the new contract and a shift to seven-day services. They fear they will have to work longer – and thus an unsafe number of hours – to meet patient need.

However, the government said it has included safety features in the new contract:

- A maximum 48-hour working week (down from 56 hours) for those not opted out of the working time directive
- A maximum 72 hours in any seven-day period (reduced from 91)
- Various controls on the number of shifts that can be worked on consecutive days.

Although the BMA has complained about plans to end formal penalties for unsafe working hours, an independent guardian in each organisation will have the power to levy fines and oversee enforcement of the new rules.

Funding and cost are obviously closely linked to staff numbers and pay. The HFMA undertook a small study of the cost of seven-day services for acute and emergency care, together with supporting diagnostics in 2014. It found that costs would be typically 1.5% to 2% of total income or, put another way, a 5% to 6% increase in the cost of emergency admissions.

However, the health secretary wants the new juniors' contract to be cost-neutral – and there lies one of the contract's sticking points. To facilitate this, the new contract redefines the hours that attract premium pay and the amounts paid.

Under the current contract, normal time is defined as 7am to 7pm, Monday to Friday, with payments in six bands (between 20% and 100% of salary) to reflect hours worked outside this. However, the new contract redefines normal time as 7am to 9pm, Monday to Friday, and 7am to 5pm, Saturday.

Under the new deal, hours worked after 9pm and before 7am on any day will receive a 50% supplement on basic pay. Saturday hours between 5pm and 9pm and Sunday between 7am to 9pm will attract a 30% supplement.

Doctors rostered to work a shift starting at any time on Saturday at a frequency of one week in four or more will get a 30% enhancement for plain time hours worked on Saturday (7am to 5pm). Automatic pay progression has been removed and there will be new on-call pay arrangements. In return for this, juniors would receive an average basic pay rise of around 13%.

NHS Employers, which led the negotiations on behalf of the Department of Health, said around 25% of junior doctors would be eligible for pay protection. But once these doctors have moved through the system and been replaced by new juniors, will the overall pay bill reduce by the amount of pay protection being paid initially? This could allow the NHS to employ more doctors to cover seven-day services.

However, an NHS Employers' spokesman insisted the contract was not designed to deliver savings. 'There may be a slight cost pressure at the start but otherwise the money used to cover pay protection is intended to be recycled back into the pay envelope each year, as it is freed up by doctors' protection coming to an end and the need for the protection diminishes. There are not intended to be any savings and no reduction in the pay bill is planned,' the spokesman told *Healthcare Finance*.

Only doctors in foundation year one (mostly those straight out of medical school), plus perhaps a handful of others – around 10%-15% of all doctors – will begin on the new terms in August, he added. Implementation will be phased and all juniors are expected to be on the new contract by December 2017.

Juniors, never mind the general public, have found it tricky to work out what it all means. Last September, juniors said the (now changed) contract could lead to a 40% pay cut, although Mr Hunt insisted that only a handful would receive less. But much will depend on how the new rotas are structured.

The BMA firmly rejects any suggestion that the dispute is now just about the premium paid for working on a Saturday, as the health secretary has suggested.

'There are a number of outstanding issues other than this, including how safe working hours would be regulated, ensuring that doctors have access to adequate breaks and changes to definitions of what is regarded as unsocial hours,' a spokesperson for the union said. It does not believe the seven-day NHS can work without further investment.

It's a confusing picture, with little real-world information to go on. For now, patients are collateral damage and trusts, charged with implementing the contract, will hope to remain on relatively good terms with their junior workforce. But for the BMA and the government the question is, what now? And can either party afford to back down?

Comment

May 2016

Engaging for a new year

Close partnering has never been more important

As the 2015/16 financial year has drawn to a close, we await with bated breath to see the final figure the NHS lands on for the year. We enter the unknown if we bust the Department of Health's expenditure limit and find out what impact that has on NHS finances in 2016/17. Throughout the year, we have seen control measures introduced to avoid this worst-case scenario, both innovative and technical, and with varying degrees of success.

HFMA president Shahana Khan

Auditors have been watching attentively and I am sure there have been some interesting discussions, with more organisations in danger of not meeting their break-even duty.

Discussions can get even more colourful when non-executives start talking about an organisation's status as a 'going concern'. This is where the skills of the finance director come into play as they lead the NEDs through the technicalities of the situation faced.

On a more upbeat note, April saw NHS Improvement launch its draft acute costing standards. And the HFMA costing conference was the best attended yet, with more than 250 finance practitioners and even a couple of clinicians.

Initially, the new standards will only be used in anger by the handful of roadmap partners helping the improvement body and regulator to fine tune its patient-level costing process. But they will be of much wider interest. As NHS Improvement's director of costing told the HFMA conference, patient-level

Beyond the picket line

Further negotiation is the only answer to a confusing and polarised dispute

Healthcare Finance editor Steve Brown

The European Union referendum campaign officially got under way in April, with fear the defining characteristic of both the remain and leave sides of the argument – fear over expanding EU membership and the impact on immigration and the burden on public services, to fear of the financial cost that would result from making a break.

Many claims have been challenged or exposed as telling only part of a story – leaving the poor member of the public struggling to find hard facts that they can rely on to inform such a key decision.

There are parallels with the current dispute over junior doctors' contract. Public opinion on the ongoing contract dispute is unlikely to be as close as we are told is the case for the in/out referendum – junior doctors seem to continue to enjoy substantial public backing.

But there is more fear and sloganeering in the two sides' 'campaigns' than hard fact. In such circumstances, the public could hardly be blamed for basing its judgement on gut reaction and who it trusts more.

Neither side – the Department of Health or the British Medical Association – has covered itself in glory in making its case. The

"All of us – from finance directors to junior members of the team – have a duty to turn warm words about closer working into real collaboration"

costing 'is the future, this is going to happen'.

There are significant challenges ahead – new systems to implement, new data feeds to bring on stream, source data to be improved and staff to be trained. These challenges will differ depending on whether you sit within an acute, mental health, community or ambulance trust.

Where you start from will also have an impact on your own local implementation.

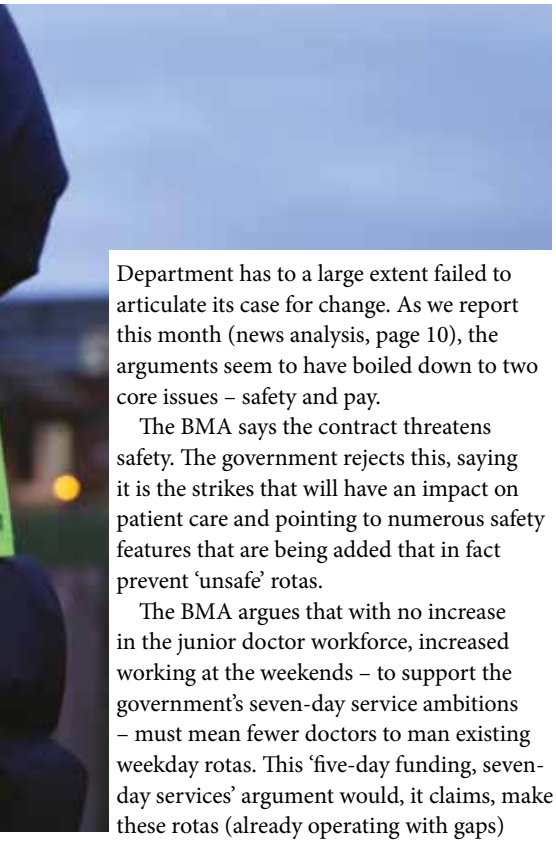
One challenge common to all organisations is the need to get clinicians involved. At times it might seem hard to get even finance managers interested in the detail of costing. But if we don't engage the broader clinical community, we won't even get robust cost data, let alone achieve the real goals of understanding clinical practice, revising pathways and eliminating unwarranted variation.

Clinicians should be involved in the costing process from the outset. But the need for engagement goes so much wider than costing – it is the fundamental foundation for transformation across the service. Clinicians commit resources – not finance managers – so it is clinical practice that holds the key to changing how those resources are used and improving value.

The number of times I have queried our financial assumptions with clinicians where they have managed to shed a completely different light on it. Or where they haven't realised how their actions had such a direct influence on finances.

Future-Focused Finance's 'Close partnering' work stream has put clinical engagement at the heart of its development programme (see page 20). It has done great work – with its finance educators' network, for example – but engagement is a local activity. We need good engagement between individuals. All of us – from finance directors to more junior members of the finance team – have a duty to turn the warm words about closer working into real collaboration on a day-to-day basis.

Contact the president on president@hfma.org.uk



Department has to a large extent failed to articulate its case for change. As we report this month (news analysis, page 10), the arguments seem to have boiled down to two core issues – safety and pay.

The BMA says the contract threatens safety. The government rejects this, saying it is the strikes that will have an impact on patient care and pointing to numerous safety features that are being added that in fact prevent 'unsafe' rotas.

The BMA argues that with no increase in the junior doctor workforce, increased working at the weekends – to support the government's seven-day service ambitions – must mean fewer doctors to man existing weekday rotas. This 'five-day funding, seven-day services' argument would, it claims, make these rotas (already operating with gaps) even more stretched, which would have an unavoidable impact on patient care.

The government says the BMA agreed to 90% of contract changes and the union's objection is all about pay – in particular for weekend working. It argues that this objection is despite an increase in basic pay and a commitment that average earnings will stay the same and there will be no change to the junior doctors' pay bill.

For the public, and many in the service, it is all very confusing. If the doctors say this will lead to unsafe care, why wouldn't they be believed? If the government says the pay bill won't fall, why is it so committed to reform? How can a contract that apparently has so much agreement cause this much unrest?

The collateral damage is huge. Cancelled elective lists will clearly impact on access targets and could lead to higher costs as hospitals look to catch up, potentially further increasing the use of agency staff at a time when the service is pulling out all the stops to reduce this expenditure.

It also has the potential to inflict untold damage on management-clinician relationships at a local level. This would be

"The disruption is inflicting untold damage on management-clinician relationships at a local level – destructive at any time"

destructive at any time, but even more so at the moment. The ability to roster more staff at weekends may be important for transforming some aspects of NHS services, but the transformation needed in the NHS goes much further than this. And the revised pathways and changes to point of delivery will need a clinical workforce that works right alongside management to make the changes.

Clinical engagement (see HFMA president Shahana Khan's comment above) is also crucial to the broader development of sustainable services that deliver better value measured in both outcomes and costs. The Department must avoid winning the battle, only to lose the war.

Given the public stances taken, it is hard to see how the two sides can be brought back to the negotiating table. But it needs to happen. And quickly.

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Clear direction of travel

Delegates at the HFMA costing conference were told in no uncertain terms that patient-level costing was where the service was heading – and they should get involved sooner rather than later. Steve Brown reports

The NHS will adopt patient-level costing and the sooner organisations make the move, the better. This was the clear message from Richard Ford, director of costing for NHS Improvement when he addressed the HFMA costing conference in April.

Earlier in April, the newly constituted improvement body and regulator published a collection of costing guidance and publications to support its Costing Transformation Programme (CTP) – including *Case for change*, new draft acute costing standards and minimum requirements for software.

In essence the *Case for change* document, rather than putting forward the argument for patient costing, argued that the case had already been accepted. Numerous organisations and reports – including Lord Carter's work on productivity – had identified the need for robust costing data to support cost improvement and the elimination of unwarranted clinical variation.

Mr Ford trailed this view in an interview with *Healthcare Finance* (April 2016, page 16) and he reinforced the message at the conference. Trusts needed to 'realise this is the future, this is going to happen', he said. The primary reason for introducing patient costing is as a source of business intelligence, although the centre also has a vested interest in national collections to support tariff development.

The collection of costs at the patient level, using NHS Improvement's prescribed process, will become mandatory – due to be confirmed at the end of this year – but Mr Ford insisted that trusts should not wait to be pushed.

Lots of organisations have patient-level information and costing systems (PLICS). This ranges from fully engaged trusts already using patient data to inform change, to organisations that have 'bought a PLICS system to tick a box on a reference cost return'.

Signalling the move to mandatory status is about providing a clear message on direction of travel. 'I don't want it to be a regulatory issue,' said Mr Ford. 'I want you to adopt as early as you can, so that when mandation happens in December, it's not a big issue for anyone.'

> **"I don't want it to be a regulatory issue. I want you to adopt as early as you can, so that when mandation happens in December, it's not a big issue for anyone"**
> **Richard Ford, NHS Improvement**

This will be backed up by audit, with discussions ongoing about getting costing onto the existing use of resources assessment

Buy a system or ensure your existing system is capable of meeting the required costing standards and then start optimising that system and apply the standards, Mr Ford said.

Helping hand

NHS Improvement is trying to make this easier in two ways. First, it has abandoned earlier plans for a costing system accreditation programme in favour of setting up a framework contract so that trusts can 'call off' systems rather than all go through an individual procurement process (see box).

'We want to create some transparency as well in what services are, so you can make informed decisions – do you want a Rolls Royce [system] or something else?' he told the conference. Second, the improvement agency and regulator wants to ensure the essential nature of buying a new system is recognised.

'If a trust is in financial distress, you will have to ask the Department of Health when you spend money. But if this is a PLICS system, we are working on the idea that you get a free pass – you don't have to go through the same process because this is the right thing to do. We are trying to set it up so that when you try to adopt [new systems and costing standards], there are no barriers,' he said, adding that NHS Improvement also had a team of people to support trusts looking to procure and implement.

NHS Improvement's approach will involve publishing costing standards in January each year covering the financial year from the following April, which require national submission in the following financial year.

So mandatory acute standards published in January 2018 will cover the 2018/19 financial year, leading to a first mandatory acute cost collection using the new process in September 2019. While that may seem a long way off, NHS Improvement is looking for substantial progress and engagement in the interim.

While the current draft standards are targeted very definitely at the six roadmap trusts helping NHS Improvement to fine tune the new system, they are also there to inform development across the NHS.

A further version of the standards will be published next January alongside a first draft for mental health and ambulance providers.

Alongside this standard development process, the annual voluntary collection of patient cost data will continue and NHS

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Two conference speakers: Sarah Butler and Richard Ford

Improvement wants as many organisations taking part as possible. 'The quicker we can get a data set to drive tariff, the quicker we can turn off reference costs,' Mr Ford said.

Sarah Butler, deputy director of the performance insight team at the Department of Health, which oversees the collection of reference costs on behalf of NHS Improvement, told the conference that misunderstanding about costing was rife. 'It's not about PLICS versus reference costs,' she said. 'One describes how you cost, the other is just the name of the national cost collection.'

The reality now was that many organisations were using patient-level cost data as the basis for their more aggregated level reference cost returns. The CTP was looking to broaden this – getting the whole service to focus on patient-level costs – while also ensuring it follows a tightly defined and consistent process.

Reference costs may become a thing of the past, but a national collection would very much be part of the future. There is also parallel work to ensure the right amount of costs are included in the process to start with. In particular, work in recent years has looked to end the practice of netting education and training income off the cost quantum. This process effectively assumed that E&T income equals E&T costs. Instead, the ambition is to have accurate costing of both service activities and education activities.

This year will see a significant step forward with this agenda, following two years of running a separate E&T costing exercise alongside the 'business as usual' reference costs. A first integrated collection will take place this summer, albeit continuing to run initially alongside the 'business as usual' process.

The implications of this integrated collection are two-fold. First, it will start to get to the bottom of any cross-subsidisation of costs between patient services and E&T activities. The separate E&T collections for the past two years have suggested that E&T costs are in fact higher than the income received. This could mean that service costs have been slightly inflated, which could have implications for tariff levels – although the position won't be fully understood until the integrated collection is properly embedded.

The second implication of the integrated collection is a potential reduction in the burden on costing departments once the separate collections can be shut down. This could free up teams to focus on the broader requirements of the transformation programme. With the integrated collection adding between eight and 16 working days to the national return process, according to a recent pilot, reducing this burden is a good incentive.

"The 2015/16 integrated cost collection won't be perfect, but it is important we learn as much as possible to make the 2016/17 collection as good as it can be"
Sarah Butler, Department of Health

A timetable highlighted by Miss Butler suggests that 2016/17 (collected in summer 2017) could be the last year of trusts being required to make two national cost submissions. She said that the move to a single integrated cost collection would depend on the quality of the data.

She also said any delay in the move would have an impact on the broader CTP and the move to a national patient-level cost collection. 'The 2015/16 integrated cost collection

The right tools

The HFMA Healthcare Costing for Value Institute has published a patient-level information and costing systems (PLICS) toolkit for acute services. It aims to support providers and costing practitioners to turn the data generated by PLICS systems into powerful intelligence. Examples are provided of how data can be presented in different ways to different audiences including the executive team, clinicians and the wider finance team. It also provides 'top tips' from organisations that have made the most progress with patient costing to date.

PLICS toolkit for acute services – the basics is free for institute members. More details about the kit or Healthcare Costing for Value membership can be found at **www.hfma.org.uk/our-networks/healthcare-costing-for-value-institute**

System thinking

For system suppliers, the Costing Transformation Programme (CTP) presents both an opportunity and a threat. For a start, it pushes those trusts that have so far been reluctant to implement patient-level costing to make the move – so there will be completely new business. But it also creates a pressure for trusts to review existing systems. Some will decide to keep an existing system or upgrade to a latest version of that system; others may use the national requirements as an opportunity to opt for a different system.

Mark Smith, financial services product owner for costing system supplier CACI, says a framework instead of an accreditation approach will make little difference. It may delay a few trusts procuring systems, but given the clear messages that 'patient costing is happening', the procurements will take place.

The company claims the latest version of its costing system, Synergy 4, is CTP-compliant and flexible and is being used by a 'couple of the road map partners'.

Other enthusiasts among its 90-plus system users are keen to upgrade. But Mr Smith says: 'We anticipate a lot of traction after reference costs when trusts are gearing up for patient-level costing. Our feedback is that this will be staggered over a six-month period. Not everyone wants or is brave enough to make the jump initially. There is a natural caution to let a few go first and learn from their experience of the new model.'

Bellis-Jones Hill supplies the Prodacapo costing system to nearly 40 NHS trusts. Director Robin Bellis-Jones says the piloting process will be more important in getting the market moving than the change from accreditation to a framework procurement solution.

'The work with the roadmap partners over the next few months will be hugely significant because it will give evidence of the extent to which all software suppliers can conform with the software requirements and cope with the new costing standards,' he says. 'This will be quite revealing once this information becomes available and that may allow trusts to start making decisions.'

Gavin Mowling is the managing director of system supplier Healthcost, currently used by 25 trusts. He says most existing suppliers are already represented on existing framework contracts, either directly or through partners. He can't foresee any supplier not making the minimum level to be part of the new framework. But he says trusts should look beyond the minimum requirements.

'There is growing recognition that the use of costing data is changing,' he says. 'It is not about populating reference costs but about producing clinical engagement data and changing practice.' So, data needs to be detailed enough to drive change. For example, he says trusts need to be able to analyse when pathology or diagnostics are being undertaken to help reduce length of stay. Yet a system's ability to provide this time stamp to data goes beyond current minimum system requirements.

"The biggest challenge is training and retaining more people in costing. Trusts need to put the right commitment and resources behind the whole costing approach"
Steve Haines, Civica

Steve Haines is managing director of Civica's public sector costing division, which provides the Costmaster system to more than 60 NHS trusts. He says the costing system market has been extremely active. 'It's certainly as busy as I've seen it in the past four years,' he says.

This is despite some trusts 'holding back' to see how central policy develops. The activity comes when suppliers have been tasked with ensuring systems meet costing software minimum requirements, which were only in draft form until recently, and can deliver costing standards that have also just been published in draft.

But while getting the right system to fit local and national requirements is important, he says a system alone won't deliver better costing. 'The biggest challenge is training and retaining more people in costing. Trusts need to put the right commitment and resources behind the whole costing approach. While trusts need to get on with working towards compliance with standards, they shouldn't overlook the primary reason I believe they need to be developing their use of PLICS – to use the outputs to help with informed decision-making,' he says. 'The effort needed by trusts to fully embrace a costing system is significant and requires buy-in throughout an organisation.'

won't be perfect, but we know that it is possible, and it is important we learn as much as possible to make the 2016/17 collection as good as it can be,' she said.

While the focus was often on acute care in the plenary sessions – reflecting the earlier deadlines facing acute hospitals – workshops picked up issues relating specifically to community and mental health services.

With mental health often playing catch-up on costing compared with acute providers, Chris Cressey, head of financial delivery at Northumberland Tyne and Wear NHS Foundation Trust, said the materiality and quality score tool and template (MAQS), developed by the HFMA as part of its costing standards work, was a useful way of assessing 'where you are on your costing journey'.

'The real appeal of the MAQS is what's behind it – a list of allocation methods we can all strive for,' he said. He also urged mental health costing practitioners to engage with NHS Improvement as it develops mental health costing standards to avoid the adoption of an 'acute model tweaked for mental health'.

Limiting factors

There was also concern that aiming from the outset for 'gold standard' allocation methods – currently unachievable because of limited patient-level data – could put off trusts.

Back in the main hall, Chris Chapman, professor of management accounting at University of Bristol, broadened the conversation with a more semantic question. 'Is costing giving us the right language to facilitate improvement?' he asked.

While there were lots of good techniques emerging under the general banner of costing, was it actually helping to call these 'costing'?

'Cost' was too closely associated with 'reduction' and 'containment', he said. 'Costs tend to be things we want to get rid of.'

His point was serious, as cost data and

Chris Cressey: MAQS champion

analysis is about informing better value care and the success of this will depend on clinical engagement. His alternative – 'mobilising resources to deliver effective healthcare' – might capture the point of costing and appeal more to clinicians, but it is hard to see it being built into costing practitioner job titles any time soon.

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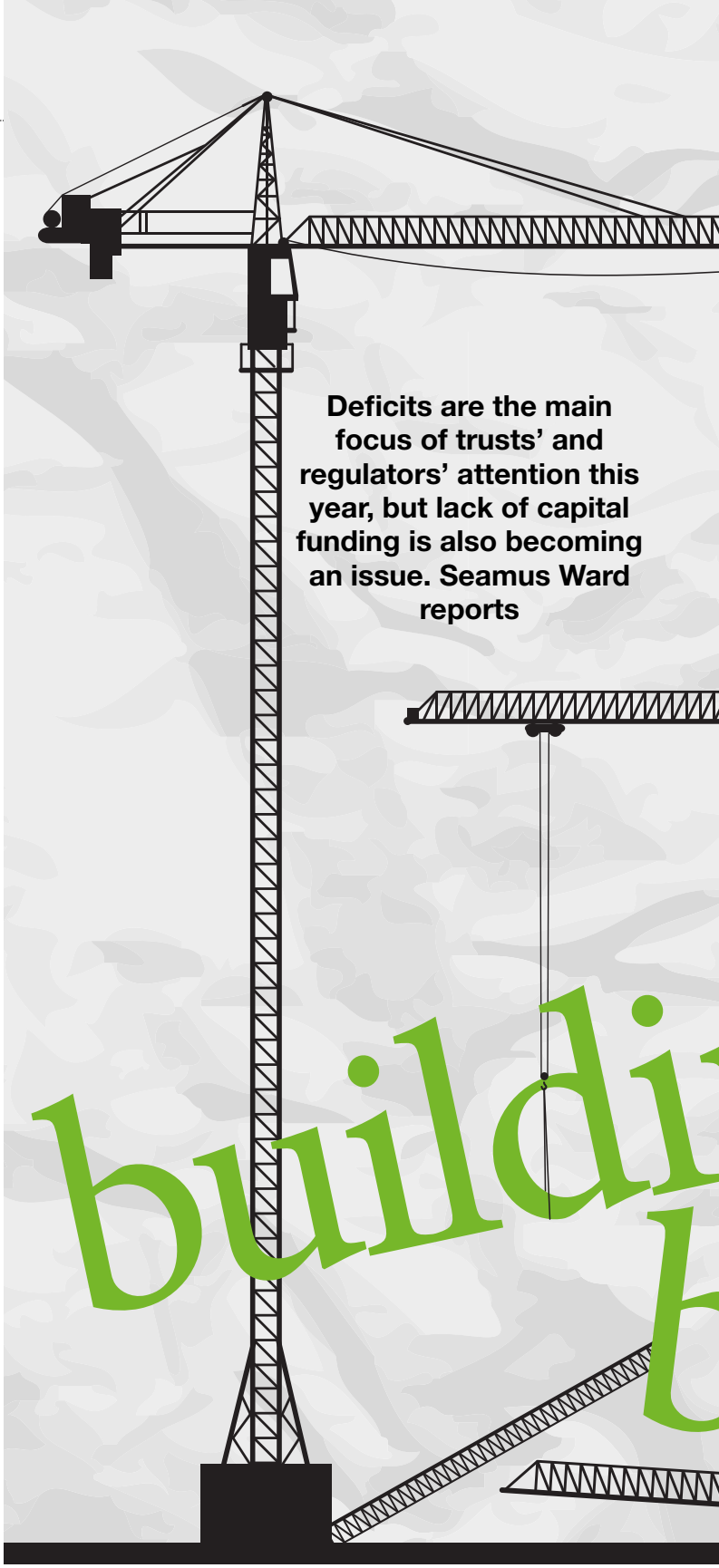

Deficits are the main focus of trusts' and regulators' attention this year, but lack of capital funding is also becoming an issue. Seamus Ward reports

In recent months, the focus for NHS finance in England has been on reducing the forecast revenue deficit in providers, particularly in acute trusts. A number of measures have been taken, including local and national capital to revenue transfers. And in 2016/17 capital allocations have been reduced to transfer funds to support revenue budgets. The message is clear from the centre (NHS Improvement and its predecessors): capital is being restricted as efforts to get the NHS provider revenue budget back into balance takes precedence.

But can the service afford to reduce the availability of capital funding? The spending review allocated £4.8bn to NHS capital budgets in each year of the five-year period, although for 2016/17 this appears to have been reduced by about £1bn in the March Budget.

The Department of Health promised £500m of the original sum would be spent on building new hospitals. The Department also hopes the NHS will generate £2bn from the sale of surplus estate over the course of the parliament. Internally generated funding such as from asset sales and depreciation will be vital – NHS Improvement is clear that loans will only be made in a rapidly reducing number of exceptional cases.

Cost of transformation

But there is growing concern. Service transformation could be particularly capital-hungry as care is moved out of hospitals, perhaps to new or refurbished units in the community. One finance director says each of the 44 sustainability and transformation plan footprint areas will have its own capital needs. And, while surplus land and building sales will help, he doubts they will raise enough to meet their requirements.

There will also be significant need for new IT and diagnostic and imaging equipment must be refreshed regularly. Meanwhile, the Department says backlog maintenance exceeds £4bn, including £1.5bn needed to address maintenance classed as high or significant risk.

So how are trusts coping? In general, there is a feeling that capital for transformation may be needed further down the line – next year possibly. But capital is still needed this year as trusts begin to address Carter efficiency measures (implementing step-down facilities to reduce delayed transfers of care, for example) and beef up electronic patient records, as well as procuring new equipment and carrying out vital maintenance. It's not difficult to find building or refurbishment projects that have been postponed, and trusts are sweating assets beyond their planned life cycles.

Finance directors say trust capital funding and cash positions cannot be seen in isolation. Surrey and Sussex Healthcare NHS Trust chief finance officer Paul Simpson says restrictive cash controls are being applied to encourage trusts to manage their financial positions and deliver NHS Improvement's priorities, such as control totals and agency spending reductions. It is tougher to access working capital.

His trust had a £6.6m deficit in 2015/16, with a £12.5m working capital facility. Going into 2016/17 with the restrictions outlined above, its senior leaders have thought carefully about how it will manage cash.

One of the steps the trust has taken is to discuss how it will spend its capital funds with its chiefs of service – consultants who lead service directorates such as cancer, surgery and women and children's services.

Surrey and Sussex Healthcare NHST has spent £14m on theatres

Mr Simpson says: 'With the agreement of chiefs of services, executive committee (of which chiefs are part) and board, we've set our capital programme £3m lower than our capital resource limit is expected to be. We have done this at the start of the year so that later in the year we can take the decision to spend it or keep it if we need it for cash flexibility.'

Nick Gerrard, East Kent Hospitals University NHS Foundation Trust director of finance, says the position is getting tougher. 'When I got to the trust last May, cash was a serious issue so we took a decision to

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cut £5m from the capital programme and put in train another £5m of asset sales. To take the £5m off the capital programme meant we had to delay some refurbishment, procurement of equipment and backlog maintenance to safeguard our cash position.'

The move worked, but compromises had to be made – the purchase of a CT scanner was postponed until the new financial year, though the building work to house the scanner was completed. The refurbishment of surgical assessment and fracture units was also delayed.

Mr Gerrard says his trust has a balance sheet of £320m and an ageing estate. Last year, after the reduction in the capital budget, it spent about £12.5m on capital and plans to spend around £14m this year. 'Compared with our needs, it's a drop in the ocean,' he says. 'It's an emerging risk for all trusts. There's insufficient money to replace equipment so assets are running well beyond their standard lives in pathology and radiology, for example – all the big-ticket items. The cath labs that were bought nationally 10 or 12 years ago are all coming to the end of their lives too.'

"We recognised that restricting the capital programme would be problematic; hence the discussions with the service chiefs. We are now taking a breath so we can consider how we move forward"
Paul Simpson, Surrey and Sussex Healthcare NHST

There are other signs of a slowdown in capital spending. Mr Gerrard sits on the NHS Supply Chain customer board for the south of England, leading work on the co-ordination of capital projects to maximise the health service bulk buying power. Near the year end there is usually a marked increase in deals as trusts look to spend their available capital.

But he says: 'There was hardly anything at the end of 2015/16, as people were safeguarding their cash and some had given up capital in exchange for revenue.'

Mr Simpson acknowledges that the restriction on capital will be tough for his trust. A capital investment programme over the past five years has been a vital part of rebuilding its reputation for clinical quality. The Care Quality Commission rated the trust as 'good' in 2014. 'We have spent £14m on new theatres, got a new A&E department and main entrance – we have been doing a range of things linked to changing how we work. We recognised that restricting the capital programme will be problematic; hence the discussions with the service chiefs.

'We are now taking a breath so we can consider how we move forward with the key things we need.'

Making a difference

The current capital programme may sound mundane, but will make a difference, Mr Simpson says. The completion of an on-site medical records unit will include areas for consultants and others to work, freeing up space for patients elsewhere in the hospital; the emergency department will get its own CT scanner, ending the need to move its patients around the hospital; and the trust will be spending significantly on basic ward refurbishment.

He adds that the trust is aware that clinicians identify needs for capital expenditure during the year, after plans have been made. 'Our flexibility is considerably reduced, but if there is an absolutely essential need we will do something about it. However, we have found that this process has resulted in chiefs of service managing this and that will help us be clear about anything we urgently need to do while being fair. Their input, rather than just our capital group doing it, is a notable shift in terms of the management of the hospital.'

The Surrey and Sussex trust will need extra capital and intends to lodge a business case with NHS Improvement for a loan to further develop its electronic patient record. 'This would bring revenue benefits [in 2017/18], reducing lengths of stay by providing better information to clinicians, quicker and in the right format,' Mr Simpson says.

There are potential alternative sources of capital funds. Some trusts

Capital focus

While the NHS in England has cut capital spending in 2016/17 and transferred capital funding into revenue budgets, Scotland appears to be bucking the trend.

It has a recent history of publicly funded hospital projects, including the £842m Queen Elizabeth University Hospital in Glasgow (pictured), which opened just over a year ago.

This year, capital investment will increase by £292m to £495m. Most of this (£352m) will be held centrally to support a number of building projects, such as the new Edinburgh Royal Hospital for Sick Children and the Dumfries and Galloway Royal Infirmary.

While the Edinburgh and Dumfries developments are being funded through the non-profit distributing model – the Scottish government's replacement for traditional private finance initiative projects – public funds have been set aside for items such as enabling works and equipment.

A recent agreement on the balance sheet treatment of NPD has opened the door for the model to be used more widely, according to law firm Blake Morgan. Partner Simon McCann said: 'I'd expect this development will now kick-start the adoption of NPD projects across the UK. As long as the projects are properly structured, there is no reason why they cannot become the "new PFI".'

The territorial health boards will receive a total capital allocation of £133m while special health boards will receive around £9m.

The funding includes £23.5m to begin work on a network of diagnostic and elective treatment centres.

Though organisations in England are transferring capital to revenue budgets to minimise deficits, in Scotland territorial health boards have been sending funds the other way – from resource budgets to capital. The Scottish government has recognised this and in 2016/17 has included £53m of additional capital in boards' allocations to remove the need for resource to capital transfers.

are exploring the possibility of using partnerships with local authorities and other public sector bodies to gain access to non-NHS capital.

Mr Gerrard says some central funding for specific uses is available, highlighting the Department's technology fund for IT infrastructure. However, the £1bn fund announced in the spending review is spread over five years and will primarily support the move of care out of hospital and the integration of health and social care records.

Technology demands

Demand for new IT is rising – from the likes of new pharmacy, procurement and costing systems, while joining up systems to share data will be crucial to the Carter process. Lack of capital could have as much impact on IT schemes as on traditional capital projects, such as buildings and equipment. A Department review of NHS IT, including electronic health records and the paperless NHS, is due to report in June.

'We have been talking about a business case to replace a lot of our paper medical records,' Mr Gerrard says. We are looking at £5m in capital over the next five years and £3.5m in revenue in transition and implementation costs. At the minute, it's hard to see where that could come from. Trusts will have to take harder and harder decisions – do you replace an ultrasound or choose an IT project instead?'

While the watchwords will be 'make do and mend' in some cases, in others it will be about other ways of procuring equipment, such as leasing and managed equipment services (MES).

Some finance directors see them as too complex and expensive, but trusts are looking to sign deals with the private sector. Just last month, Asteral signed a five-year managed maintenance contract with Royal Berkshire NHS Foundation Trust, covering its diagnostic imaging equipment, including MRIs and CT scanners.

Nancy West, Siemens Healthcare head of business development, healthcare enterprise solutions, says that while NHS trusts' appetite for purchasing new equipment has not declined, financial pressures sometimes lead to projects slipping. She adds there is a 'healthy interest' in MES with more routes to procure these deals.

With MES paid from revenue, she accepts that they could add to the pressure on a trust's revenue budget, but believes that the benefits outweigh these costs. MES contracts add value by offering the opportunity to forge a partnership that can lead to further efficiencies and access to new technologies.

'MES contracts typically offer price certainty and assured equipment

refresh during the concession term. These long-term contracts typically include finance and performance risk transfer. MES contracts have usually also enjoyed favourable VAT treatment as they are delivered as a service, with assets typically owned by the MES provider.'

Her colleague Chris Wilkinson, head of sales for healthcare and public sector for Siemens Financial Services in the UK, adds that leasing and other asset finance techniques remain important for the NHS. As well as allowing the cost to be spread over an agreed period, trusts can expect to benefit from improved operational efficiency and patient care, he says.

'The equipment can be paid for from the trust's revenue budget over its working life, thereby removing the need for a large initial outlay,' says Mr Wilkinson. 'Recent research from Siemens Financial Services shows that a majority of healthcare organisations regard access to such flexible financing techniques as an important prerequisite to meet the common challenges the sector faces.'

Surrey and Sussex is also looking at newer and innovative sources of funding. When granting planning permission, local authorities can levy funding from developers. This community infrastructure levy (CIL) can be earmarked for a number of public sector projects, including in health. Sums raised vary, though perhaps the most significant CIL is helping fund London's £14.8bn Crossrail project – in just under four years to date, the mayor's CIL had raised about £200m.

Outside the capital, the amounts raised by CIL will be less, but the Surrey and Sussex trust is keen to tap into this potential source of funding. Mr Simpson says the trust has written to around 20 local authorities in its area and received responses from all.

'CIL used to be restricted to things like GP surgeries, but as emergency activity grows – we had 6% growth across the trust last year – it is acknowledged there is an issue with infrastructure in hospitals,' he says. 'One of the district councils has already invited us to submit a bid. Working with councils on this has also helped joint working and planning in a more co-ordinated way.'

"A majority of healthcare organisations regard access to flexible financing techniques as an important prerequisite to meet the common challenges the sector faces"
Chris Wilkinson, Siemens Financial Services

The trust and councils are working more closely with local clinical commissioning groups, he adds, with growing recognition that increases in population have an impact on hospitals, as well as primary care.

The trust is working with East Surrey Clinical Commissioning Group and Surrey County Council to reduce the number of delayed transfers of care in patients who are medically ready to be discharged from hospital. In January, they opened an integrated reablement unit run by social care staff, with the building funded by £900,000 from each of the three organisations. Mr Simpson says trusts will increasingly be looking at this model. Indeed, the trust is working on a similar project for frail patients.

Other partnerships are important. It opened a cancer information centre with Macmillan Cancer Support, funded with £400,000 from the trust and the balance of £1.2m from the charity. It is also working with Brighton and Sussex University Hospitals NHS Trust on a pathology joint venture that will require a new microbiology laboratory to centralise services and a substantial joint managed lab service contract.

With traditional funding constrained, it is clear trusts will have to be innovative as they look to provide new facilities, maintain existing ones and procure the latest diagnostic equipment.

Close call

The NHS needs finance staff and clinicians to be more engaged and the Future-Focused Finance initiative is providing the practical support to make it happen. Steve Brown reports

In many ways, engagement is what the Future-Focused Finance initiative is all about. Finance staff have engaged with the initiative in their droves and their enthusiasm is infectious. It has even launched the NHS finance community into the virtual world of social media – the busy FFF twitter feed has more than 2,000 followers.

Perhaps we shouldn't be surprised by this. After all engagement, albeit between clinical and finance staff, is at the heart of the initiative.

Set up in 2014, FFF aims to ensure the finance function remains fit for purpose. The NHS needs to transform to meet its current challenges – a result of an ageing population, changes in disease patterns and restricted finances. And the finance function will need to transform along with it – providing the evidence for this broader transformation, identifying the opportunities to increase value and making its own contribution to improved efficiency.

The initiative has six specific work streams, arranged under three strategic themes of 'Securing excellence', 'Knowing the business' and 'Fulfilling our potential'. Clinical engagement – or 'Closer partnering' to give it its formal title – is one of the work streams under the 'Knowing the business' theme. It is, appropriately, headed by Dr Sanjay Agrawal, consultant respiratory intensivist at University Hospitals of Leicester NHS Trust – the only clinician among the initiative's six key senior responsible officers.

Better engagement between the key groups of finance and clinical staff is widely recognised as a fundamental building block for a transformed health service. This is hardly a new message, There have been many earlier attempts to put the issue in the spotlight, including reports and initiatives from the Audit Commission, the HFMA, the Department of Health and the Association of Medical Royal Colleges. But this time FFF wants to stay focused on providing practical help to improve engagement.

Dr Agrawal recognises there has been improved engagement in recent years – tracked in part by a crude self-assessment included in the Department's annual reference costs survey. But he suggests this is often in pockets – for example, where trusts have pushed ahead with patient-level costing. And there is definitely room for improvement.

A survey conducted by Ipsos Mori for FFF last summer found that 50% of clinicians think they have a good understanding of finance issues. However this differs, depending on what aspect of finance you are talking about. Clinicians in general confess to having a poor understanding of procurement and equipment replacement, but feel more confident where their income comes from and managing costs to a budget. Similarly, nearly three in five finance staff think they have a good grasp of a patient's journey. But this reduces if you look at specific patient outcomes.

Clinicians' view of finance staff understanding of clinical issues is not as complimentary. 'The bottom line is that finance people could know more about the clinical side of healthcare, and clinicians could do with consolidating and improving their financial knowhow,' says Dr Agrawal.

'Senior clinicians are often overseeing budgets of millions of pounds – and it is clinical decisions that commit these resources. Yet our survey shows that 50% of clinicians don't really understand how finance works. It is a simple fact that better understanding of finance by clinicians will help the service improve value.'

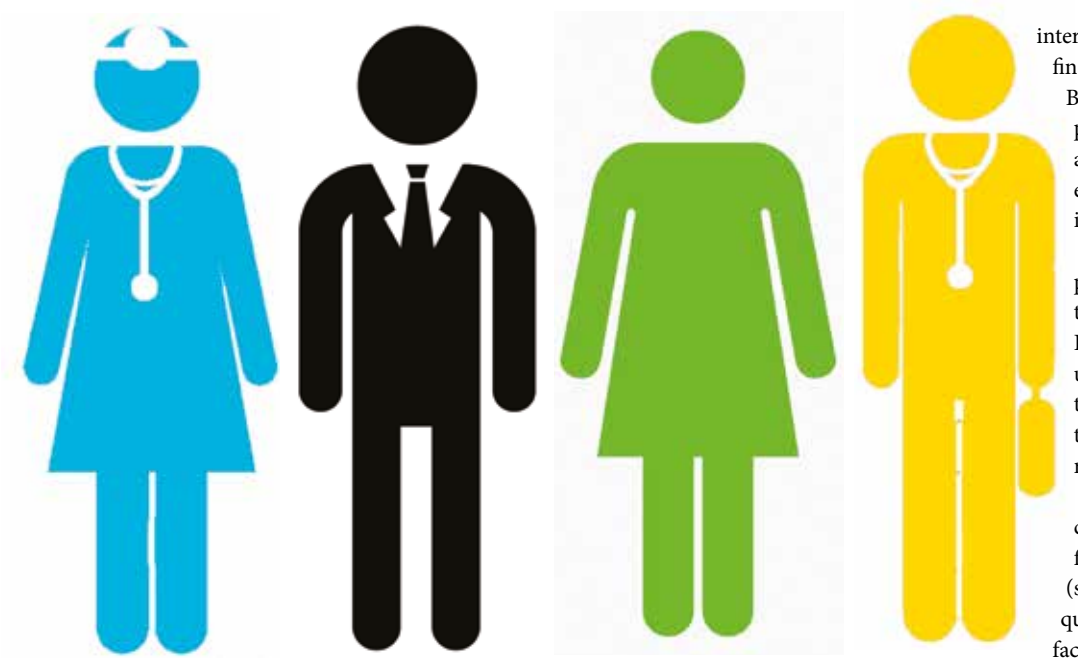
Educator network

The FFF team has taken practical steps to support this goal, with the creation of a 130-strong network of finance educators. The eventual intention is to have one in every NHS body including all commissioners and providers. This cohort of finance staff was provided with some training in presentation and the aim is that they will deliver financial training to clinicians and budget holders in their own organisations.

'It is not an additional role – being a finance educator,' says Pam Kaur, commercial finance manager at University Hospitals Coventry and Warwickshire NHS Trust and the FFF lead on the educator network. 'This is already part of the day job. Finance managers should, and do, interact with clinical colleagues and managers on a daily basis. The aim is to demystify finance to create clinical value, make our interactions more effective and give the educators access to

Factors for teamworking

1. Make sure you are on the same path and share the same goal
2. Be clear what your role is in the team
3. Spend time with each other as a team
4. Put down roots – expect to work together
5. Deal with conflict quickly and reasonably
6. Take time to reflect on how you're doing as a team
7. Use the support from your organisation



support, some national recognition and profile.'

Just over a year since the network launched, Ms Kaur is convinced it is having an impact. 'We get good feedback and overall I think we are being more effective,' she says.

One of the key benefits is access to resources developed elsewhere across the network, free at the point of use – with training notes and slide sets all being shared so that people can avoid duplicating effort and pick up on tried and tested good practice.

'We have to recognise that some people are more active than others in terms of providing financial training to budget holders and clinicians,' says Ms Kaur. She is as keen to help people taking their first steps into formalised training as to help more experienced educators try new ideas. 'The key this year is to keep the momentum going, spread the message and increase active participation in the educator network,' she says.

These approaches can be underpinned with e-learning, which can fit in well with clinicians' busy professional lives. The HFMA, for example, provides numerous general and specific e-learning modules on topics such as budgeting, costing and payment systems.

Dr Agrawal is clear that there needs to be a parallel process with clinicians helping to demystify clinical terminology and practice for finance staff, but he recognises that this may not be delivered through a national network of clinical educators. And he adds that there is no substitute for local engagement. FFF's real campaign, he says, is to 'promote localism'.

Finance staff will benefit from a basic grounding in clinical subject matter – what are the key conditions treated within a particular specialty? What do the different patient pathways look like? What are the standards and protocols in place?

He also wants teams engaging about problematic issues such as how you might change staffing arrangements to cover low-volume services at night or how different roles – such as advanced nurse practitioners – might help improve services and value

'We recognise that education on its own is not enough,' says Dr Agrawal. 'Education is pointless without a relationship. That's how finance learns about clinical issues – by meeting regularly with clinicians.'

Face to face

The Ipsos Mori survey threw more light on this subject. Both clinicians and finance staff report that most interaction currently is by email or telephone, and both sides agree that they would prefer the majority of interaction to be face to face.

But both clinicians and finance identify a number of obstacles to better working relationships. Both cite lack of time – although interestingly this is seen as a problem by more finance staff (75%) than clinicians (57%).

Both also see the lack of robust data, particularly around costs and income, as an obstacle – even though better engagement is one of the ways this can be improved.

Here, too, the FFF team has provided support to underpin better teamworking across professional divides. It commissioned the King's Fund to undertake work that would both reinforce the case for collaboration and identify the key components in successful relationships.

This work – styled as a toolkit for collaborative team work – identified seven factors known to improve team working (see box, page 20) and provides a questionnaire based on these factors for teams to self-assess their effectiveness.

The toolkit went through a pilot process involving 22 trusts and an evaluation of this process by CIPFA concluded it had been 'a highly beneficial exercise', with the toolkit adaptable to specific organisational needs.

Supporting improved mutual awareness of each other's business and improving relationships are key work areas for the 'Close partnering' team. But Dr Agrawal also wants the better partnering to stretch to the general public. A series of patient focus groups confirmed suspicions that there is generally limited understanding about the health service in general and its funding in particular among the general public.

This may not be surprising, but Dr Agrawal says that improved understanding will be crucial to some of the changes likely to come in as part of the transformation agenda. This could see services relocated or provided in completely different ways. However, there is not a great track record on public understanding of NHS changes – with a common suspicion that changes are driven by financial rather than clinical factors.

There is clearly a financial imperative to looking for better delivery models, but the overarching driving force is the ability to deliver quality services that meet changing patient need in a sustainable way. So while better clinical-financial engagement may identify the opportunities for reform, this may

CALL FOR EDUCATORS

Future-Focused Finance is looking to expand its network of finance educators, which is due to meet on 1 July in Birmingham. Anyone interested in getting involved, or if you just want to know more about the programme, contact futurefocusedfinance@nhs.net

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count for nothing if the public are not brought along on the journey.

'We can't think this is somebody else's responsibility,' says Dr Agrawal. 'The public are key stakeholders in this change process and we need to contribute to finding better ways to communicate any planned changes and the reasons for making them.'

There are big plans within the 'Close partnering' team for the year ahead. 'We need to keep highlighting what is being done in some trusts and show it can be done in all trusts,' says Dr Agrawal. 'Clinicians are up for learning more about finance – our survey showed they are more interested than finance thinks they are.

'We've made a good start with our research work and establishing our educators' network – now we need to mature and grow it. At the moment they are more likely to be focused on basics, but we would hope this would develop into engaging with more detailed issues and introducing things like the best possible value toolkit [developed by the 'Best possible value' work stream and including the decision effectiveness framework] and NHS Improvement's costing transformation programme. Why can't the finance educators become agents for change and be skilled up for quality improvement techniques?'

"50% of clinicians don't really understand how finance works. It is a simple fact that better understanding of finance by clinicians will help the service improve value"

Sanjay Agrawal (left)

These are ambitious plans, but Dr Agrawal insists the immediate focus is on ensuring the work stream can 'walk before it runs'.

However, with the Finance Leadership Council – made up of the national system finance leaders – challenging the initiative to be 'really purposeful' in the year ahead, he is determined that 'Close partnering' will start to have a tangible impact.

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The Dudley Group NHS Foundation Trust (DGH) serves the population of Dudley and surrounding communities. The Trust annual inpatient activity is approx 150,000 Fully Coded Episodes (FCE's).

In line with the NHS as a whole, DGH faced financial pressures against the backdrop of a budget freeze and the requirement to make more savings year-on-year. The Trust continued its drive to make efficiency savings and developed schemes to deliver £10m of savings and revenue generation in 2014/15.

Project outline

Sue Levitt, Clinical Coding Manager, and her coding team at The Dudley Group NHS Foundation Trust started working with 3M Health Information Systems, (HIS), in July 2014 as a development partner for the Data Quality Analytics (DQA) Solution. During this time, continuous improvements have been made to the DQA Solution to ensure it delivers tangible benefits to the Trust.

Financial results were produced by processing a month's data and amending codes, i.e. using a more specific code and also adding codes where DQA highlighted a potential error and on further investigation where extra codes could be added.

Data was processed by 3M DQA and reviewed by the Clinical Coding Manager, using their audit skills and with reference to the full case notes.

The 3M HIS team worked with the clinical coding manager to identify areas where changes would improve the user's experience and allow them to focus more quickly on key areas.

3M DQA showed a direct correlation between improved documentation and increased accuracy of the coded clinical data.**

"The 3M DQA Solution has helped identify where improvements can be made in our departmental processes."[1]

Financial balance

3M DQA highlighted HRG errors, prompting the introduction of a new coding process to code common combinations of procedures and to ensure accurate payment.

"3M DQA allows you to check for errors you never knew you had, therefore improving your income"[2]

The Trust reviewed all activity coded with these procedures and made changes to some episodes prior to submission. To date, following deployment, the Trust increased income using the tool by £60k in three months.

Quality versus quantity

The Clinical Coding Manager used the standard report in the 3M™ Medicode™ Clinical Encoder to assess the daily throughput.

"3M DQA gives me confidence during busy periods – because I can check the quality of the data in real-time."[3]

Reviewing the case notes against the coding with the coder allowed the clinical coding manager to overcome and reduce errors.**

Financial benefit*

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> "3M DQA works alongside the Medicode clinical encoder, highlighting possible issues with source documentation, coders and clinicians."[4]

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1, 2, 3, 4 – Quotes provided by Sue Levitt, Clinical Coding Manager at The Dudley Group NHS Foundation Trust. *Financial results were produced by processing a month's data and amending codes, i.e. using a more specific code and also adding codes where DQA highlighted a potential error and on further investigation where extra codes could be added. **Data on file with the Clinical Coding Department at The Dudley Group NHS Foundation Trust.

a permanent solution

Agency staff spend controls have made an early impact, but NHS Improvement believes finance directors may be key to delivering further improvements. Steve Brown reports

Controls on agency spending have saved nearly £300m between October 2015 and the end of February, and the trend of rising agency costs has been reversed, NHS Improvement has claimed. But more benefits could be realised and finance directors need to take a more central role.

These are the key messages from an assessment by the provider improvement body and regulator of the impact of the controls and caps introduced to reduce agency spend, which is making a significant contribution to wider provider deficits.

The backdrop to the new controls was a rapid increase in temporary agency staff spending, which reached £3.3bn in 2014/15 and was on trend to grow by 30% in 2015/16.

A series of controls has been introduced starting last October with an overall ceiling placed on each provider's agency nursing expenditure and a requirement to use only approved frameworks to source agency nurses.

However, the main control – a cap on the prices paid by providers to agencies – was brought in towards the end of November. These caps were initially set at a relatively high level around the median of what was being paid at the time. This equated to a 100% uplift on basic pay rates for nurses and 150% for junior doctors. Following a planned timetable, these were subsequently tightened to 75% and 100% in February and then 55% for both groups from April. Non-clinical staff caps were set at 55% from the outset.

The new capped rates are intended to be equivalent to national NHS pay rates for substantive staff, with the top-up covering holiday pay, employer national insurance and pension contributions, as well as the agency charge.

Levelling the field

The aim is that staff should see little or no benefit in pay rates for undertaking extra work through an agency rather than taking a full-time role or taking overtime or working through a trust's own staff bank.

Additional controls setting out the maximum wage rates to be paid to agency workers – due to be introduced in July – will strengthen this further.

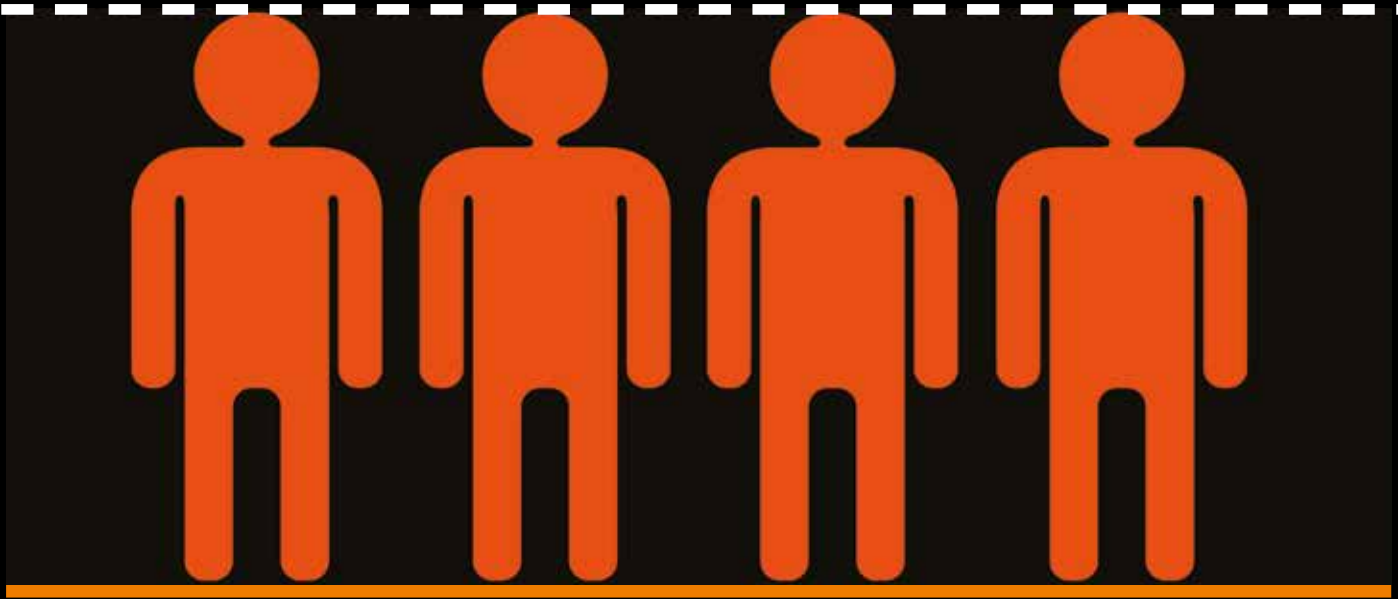
Chris Mullin, NHS Improvement economics director, says the organisation is happy with how the controls are working out. 'It is in line with our best expectations and we are very pleased with the way the sector has got behind the initiative,' he says.

Those expectations, set out in October, were to reduce spend by £1bn over three years. This figure was effectively made up of three years of estimated annual savings of £370m, across all three staff sets (medical, nursing, non-clinical) based on a compliance rate of 70%.

NHS Improvement says the service has already achieved savings of £290m from October to February. While this appears to put the service well on the way to meeting the overall annual saving, the sums are not completely comparable.

The £290m is based on the fact that the NHS spent £1.5bn on agency staff in the period. Based on previous trends (spending rose by 30% in the first six months of 2015/16 compared with the same period the year before), NHS Improvement says spending was expected to be in the region of £1.8bn.

So the nearly £300m of savings takes into account expected increases in agency costs, whereas the £1bn savings was compared with actual prior year expenditure. Neither of the savings figures takes account of any increased



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expenditure on substantive or bank staff as a result of any reduced agency usage.

The point is that agency spend is still growing if you look at quarterly spend compared with the same quarter the previous year – although the controls have put the brakes on the rate of increase – and month-on-month spend is falling (see charts).

Further, the February expenditure was a reduction of 13% compared with the peak monthly spend of £331m in July last year.

Mr Mullin adds that, in a March survey, two-thirds of providers said they had delivered net financial savings, with just 2% reporting increased net costs.

Reversal of growth

Formal reports also show a 5% reduction in agency spend for the quarter following the new rules' introduction – from £951m in Q2 to £902m in Q3.

'Prior to the new rules, spending was out of control,' says Mr Mullin. 'But we've seen a reversal of the growth trend, even though this has been in operation during the winter months, when pressure on staffing usually increases.'

He adds that providers also continue to back the new rules – both in general and the tightening of the ratchet with the lowering of the cap. 'In our March survey, 71% said they supported the April ratchet, with just 16% saying no,' he says.

'We've also done some analysis on the prices, based on a sample of providers, and we've seen a 10% reduction in nursing prices between October and February,' he adds. The overall thrust is that the policy is working.

Mr Mullin also wants to ensure that trusts look beyond the high-profile clinical roles involving doctors and nurses. Spend on agency staff actually splits fairly evenly between medical, other clinical and non-clinical staff – and savings are expected from all three areas.

Many of the high-volume breaches for trusts are in frontline roles with the cap breached by a small amount. But there are smaller numbers of breaches in administration and estates roles, with rates significantly above the capped levels.

'Six months in from the introduction of the November rates and there are some very high prices being paid in these areas, with big potential savings,' says Mr Mullin.

Not everyone is convinced the policy is fully working as intended yet. Financial and workforce solutions company Liaison has analysed data from a sample of 55 trusts that use one of its medical workforce systems. Just looking at four grades of doctors (consultants, staff grade, ST3 and FY2) in the first 10 weeks of the caps, it claims that 74% of shifts worked were not compliant with the rate caps. This was before the caps were made even lower and amounted to an overspend against the cap of £10.8m in 10 weeks across all trusts.

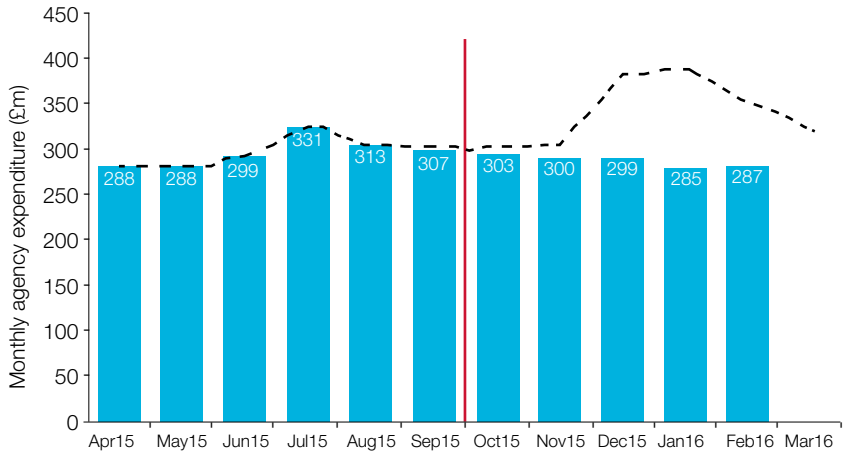
Also during April, Lancashire Teaching Hospitals NHS Foundation Trust downgraded the emergency department at one of its hospitals to an urgent care centre. The trust blamed difficulties in recruiting middle grade doctors. While national shortages of emergency medicine doctors and too few doctors in training were issues, the trust said the national agency cap had also 'impacted our ability to secure enough locums to fill gaps in the rota'. A February board paper had noted that 'some organisations were offering advantageous pay rates to clinical staff outside the capped rates, which had attracted clinical staff away from the trust'.

NHS Improvement rejects any connection between the cap and the staffing problems at Lancashire, although it acknowledges there have been local pressures with significant jumps in demand. And it stresses that from the outset trusts have been able to override the caps if staff are needed to ensure patient safety.

However Mr Mullin says that the regulator would 'come down hard' on any trusts that were gaming the rules to attract staff. 'We want trusts to work together and share data on compliance,' he says.

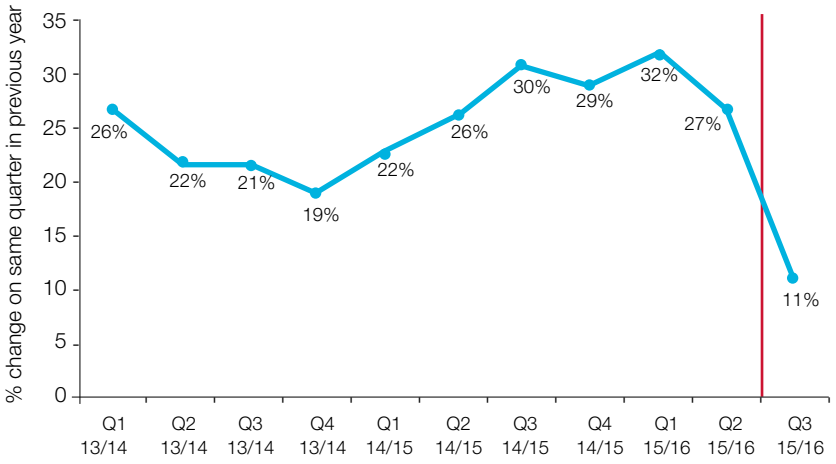
It is not a straightforward issue. For a start,

Chart 1: Monthly agency



Actual spend compared with trend prior to agency controls (red line = controls start to be introduced)

Chart 2: Change in quarterly expenditure across FTs, relative to previous year



overrides do not necessarily represent non-compliance. And not all providers are required to adhere to the caps – foundation trusts not in breach of licence or in receipt of Department of Health financial support are 'exempt'.

However, they are encouraged to do so and a value-for-money condition within the regulatory framework attempts to make it effectively a requirement.

Mr Mullin points out that 'there is no foundation trust that isn't attempting to comply with the caps'.

This is further strengthened by providers' access to sustainability and transformation funding being linked to compliance with the agency controls guidance. The exact nature of this compliance has yet to be confirmed, although it may well involve a trust not breaching its overall agency spending ceiling.

Despite a good start, Mr Mullin thinks the service can consolidate this improvement and do even better. 'It's a good news story from a finance perspective,' he says. 'However we don't feel that finance directors are in the lead enough and if they were, I think we would be better placed to capitalise,' he says.

Finance directors are the nominated lead for reducing agency spending in just 'four or five' out of around 240 trusts, according to NHS Improvement. Mr Mullin accepts some trusts may have done this deliberately to keep the emphasis on safe staffing rather than financial savings. But he thinks that trusts may be missing out on finance directors' core skills.

"A large chunk of providers' costs is their workforce, and agency is close to being the marginal variation"
Chris Mullin (above)

'This is bread and butter to finance,' he says. 'It is an opportunity to introduce good financial discipline across whole organisations – ensuring a more common approach across different areas. We have seen some organisations that have more of a grip on their agency nurse expenditure than with medical or with good finance systems in parts of an organisation. Finance directors may be better placed to ensure a more consistent approach and implement trust-wide systems.'

He also thinks that finance directors should be actively looking to take on this role. 'Agency spend is a good leading indicator of the overall finances of a trust,' says Mr Mullin. 'A large chunk of providers' costs is their workforce, and agency is close to being the marginal variation.'

The point is that if agency shift data provides the earliest indication of a potential overspend, finance directors should want to be both getting the data as early as possible and proactive in implementing any mitigating measures.

NHS Improvement's message is clear. It believes that finance director involvement equates to a stronger grip on agency spend and it wants to see more of them in the front line of this initiative.

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Corporate cost cap aims for back office savings

Technical update

The inclusion of a corporate and administration function cost cap in Lord Carter's report on NHS productivity has caused concern in finance quarters, *Steve Brown reports.*

It certainly took many by surprise, although an early management costs metric was shared with Carter's engagement trusts about a year ago. However, while many other recommendations promote the compilation of data to inform decision-making, the report goes a step further for corporate and administration costs by setting a firm target as a proportion of provider income.

According to the Carter report, acute trusts spend about £4.3bn on staff in their corporate back office (£2bn) and administration (£2.3bn) functions. This equates to an average of 8% of trust income but with a range from 6% to 11% – a range that is clearly bothering Lord Carter.

The report estimated that savings across providers could be at least £300m if all trusts operated at 7% of their income. In fact, it is understood this is a conservative figure. Rather than setting this as a simple benchmark, the report recommends all trusts get their costs below this level by April 2018 – with a further tightening of the screw to 6% by 2020.

The alternative, in Lord Carter's eyes, is to have plans in place for 'shared service consolidation with, or outsourcing to, other providers by January 2017'.

Finance leaders have raised concerns with the proposals, believing overall value should be the goal rather than simply reduced costs. If higher corporate costs lead to better overall value (in outcomes and costs) at the front line, that should be okay, HFMA policy and technical director Paul Briddock has argued (see 'When the cap doesn't fit' www.hfma.org.uk/news/blogs).

Finance understandably feels in the firing line of these proposals. The Carter report identified 137,100 staff working in corporate (53,500) and administration functions (83,600). The HFMA's biennial census reveals that there are 16,000 NHS finance staff in England. If these were all counted within corporate totals (as per old management cost definitions), any cuts to corporate staff numbers may have major implications for finance staff. (*Healthcare Finance* now understands that finance staff are more likely to be split between both corporate and administrative staff in the Carter definitions.)

Lord Carter: concern over back-office costs

But pressure to reduce finance staff numbers needs to be seen alongside other proposals in the Carter report that could imply increased finance and support staff – greater use of patient cost data and collecting and analysing new cost metrics such as the adjusted treatment cost.

It is fair to say that the corporate cost proposals are a work in progress – despite the definite-sounding ceilings and deadlines announced. *Healthcare Finance* understands the data used for the analysis exposed an inconsistency in how staff are recorded in the electronic staff record – both using occupation codes and 'staff group' and 'area of work' fields – even if the overarching totals are likely to be right. The hope is also that greater scrutiny will lead to better data.

But a lot of grey areas remain. For a start, it appears clear the measures of cost used (being just workforce) do not include the costs of services bought in. So a trust that had outsourced its financial services could appear cheaper than a provider with in-house delivery. This could make the difference of a trust being

Heart failure drug – costs and benefits

NICE update

NICE guidance (TA388) states that sacubitril valsartan is a recommended option for treating symptomatic chronic heart failure in certain people, *writes Nicola Bodey.*

Heart failure – the inability of the heart to supply sufficient blood flow to meet the body's needs – may be associated with reduced left ventricular ejection fraction, where the left pumping chamber's ability to pump is impaired.

About 410,800 people were recorded as having heart failure in England in 2014/15. Of these, 72% (295,800) had heart failure with reduced ejection. It is estimated that about 108,000 people are eligible for sacubitril valsartan each year and that around 64,500 people will have sacubitril valsartan each year from 2020/21, once uptake has reached 60% of the eligible population.

The annual cost of treatment is about £1,200 per person, with an estimated overall resource impact (England) of £12.6m in 2016/17, rising to £69m from 2020/21 (plus VAT, where applicable). This is equivalent to £23,000 rising to £127,000 per 100,000 population.

The introduction of sacubitril valsartan may reduce the costs of hospital admissions because of heart failure. Potential savings in England are estimated at around £0.9m in 2016/17, rising to £5.4m from year five.

Sacubitril valsartan also improves both

In brief

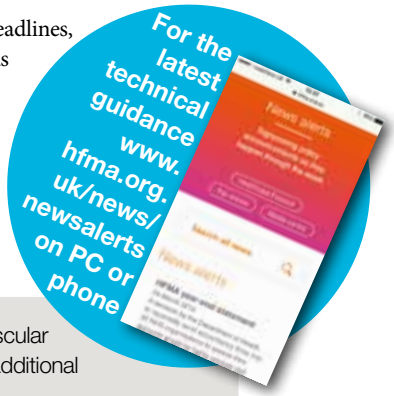
- **NHS Improvement has updated its foundation trust financial accounting guidance, including an FT consolidation fixer and 2016/17 changes for agreement of balances.**
- **The HFMA Healthcare Costing for Value Institute has published a toolkit (*PLICS toolkit for acute services – the basics)* to help acute trust members make the most of patient-level information and costing systems data.**
- **A technical guide to commissioning revenue allocations over the next five years has been published by NHS England. They cover the target allocations and the pace of change policy. Background to clinical commissioning groups' running cost allowances and Better Care Fund contributions is also included.**
- **The Department of Health has released its first standard sub-contract for providing clinical services. Although not mandatory, it aims to save provider effort and ensure consistency with the NHS contract.**

under or over the cap and would appear to make an assumption that outsourced services are inevitably better value than in-house – regardless of the actual costs or value of services delivered.

Similarly, the metrics as currently compiled would not take into account staff employed to deliver services to other trusts – payroll services, say – which again would tend to make a trust look expensive. This might in theory lead to the counterintuitive unpicking of current shared service arrangements to comply with the cap.

The Carter report suggests NHS Improvement is developing a national set of benchmarks for human resources, finance, IT and procurement. It says these will be ready by July. It also says trusts with costs above the 7% ceiling should submit a plan for reducing them – again to NHS Improvement – by October.

With rapidly approaching deadlines, *Healthcare Finance* understands a note will be published over the coming weeks to provide further clarification about how this metric will be used in practice.



overall mortality and cardiovascular mortality, which may lead to additional cost savings.

Because sacubitril valsartan was made available through the early access to medicines scheme, NHS England has indicated this guidance will be implemented 30 days after final publication. It is the first drug commissioned by clinical commissioning groups to be approved under the early access scheme.

Nicola Bodey, NICE senior business analyst

Diary

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
19 (F) Provider Finance: Derby procurement/GS1 site visit
25 (N) Payment systems, Rochester Row, London
26 (B) East Midlands Branch: FFF/FSD/HFMA roadshow, Nottingham

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 Coast branches: developing talent conference, Bristol
17 (I) HC4V: value masterclass
17 (B) Wales Branch: coaching, mentoring and problem-solving, Cardiff
20 (B) Eastern Branch: improvement event, Newmarket
22 (F) Commissioning Finance dinner, Stratford-upon-Avon
23 (N) Commissioning conference, Stratford-upon-Avon
24 (B) Wales Branch: coaching, mentoring and problem solving, North Wales
27 (B) Eastern Branch: personal development day, Newmarket
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
12-19 (B) Wales Branch: personal impact skills, across Wales
19 (B) Kent, Surrey and Sussex Branch: introduction to NHS finance, Crawley

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

Spending wisely, HFMA annual commissioning conference

23 June, Stratford-upon-Avon

Speakers at this year's commissioning conference include NHS England chief finance officer Paul Baumann; National Audit Office director Robert White on lessons from other government departments; and NHS Right Care director Matthew Cripps, who will share details of progress to date. Stephen Liversedge, HFMA Working with Finance – Clinician of the Year winner 2015 (pictured), will focus on value in primary care, drawing from his experience at Bolton Clinical Commissioning Group. Workshop sessions will include a look at new models of primary care provision, local health economy modelling and improving population healthcare.

Visit www.hfma.org.uk for details or email grace.lovelady@hfma.org.uk

Pilots needed

Association view from Mark Knight, HFMA chief executive

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

My HFMA

I've mentioned in earlier columns the association's plans for a new set of qualifications leading towards an MBA in healthcare business and finance. We are well on the journey to making this happen. The main task is an application to the qualifications regulator for England, Ofqual, to receive recognised awarding organisation status. This will be a big deal and, not surprisingly, it isn't an easy process.

We've now appointed our module leaders and tutors, who have set about developing the curriculum and content. Alongside this we are working to develop the qualification features and assessment methodology, and building support structures such as a virtual learning environment and student management processes.

The qualifications will be officially launched at the annual conference in December for a go-live date in January. However, quality is our buzz word – we want our students to have the very best experience. We are therefore looking for volunteers to help us test out the qualifications between September and December.

The way it works is like this. We are looking for 30 individuals to study for one of the six modules between September and December. You will need to undertake a 5,000-word case study based assignment as well as participating in the online study programme. There will be five students undertaking each pilot module. Each student will have access to the full range of learning resources and support free of charge.

If you successfully complete and pass the module, you will be awarded a 20-credit certificate (see table). You need 60 credits to achieve a diploma and a further 60 credits to achieve the higher diploma, at which point you would have access to the MBA top-up programme (a further 60 credits).

The overall qualification is open to a wide range of learners, including finance staff, general managers clinicians and other healthcare professionals. However qualified accountants with at least two years' post qualification experience in healthcare may be entitled to start immediately on the higher diploma.

Module	Credit	Diploma
How finance works in the NHS	20	Diploma
Managing the healthcare business	20	
Personal effectiveness and leadership	20	
Tools to support decision-making	20	Higher diploma*
Creating and delivering value in healthcare	20	
Comparative healthcare systems	20	

** qualified accountants with two years' experience can start with higher diploma*

HFMA chief executive Mark Knight

You will need to be a member of the HFMA to take part in the pilot. The module will be free to those taking part. However, we need to be sure you are going to complete the module, so we will be charging your organisation or you £1,000 if it has not been finished by December, and will require your written agreement. In return for taking part in the free pilot, we will be asking for your regular feedback on different aspects of the programme..

If you are interested please send us your name, email address, organisation, job title and CCAB/CIMA qualification (where relevant) to the email address below by 10 June. Please state the module you are interested in taking. This is a great opportunity, but with limited places available, I'd encourage you to get in touch as quickly as possible.

Email: qualificationpilots@hfma.org.uk

Member news

Suzanne Tracey, deputy chief executive and chief finance officer at Royal Devon and Exeter NHS Foundation Trust and a HFMA past president, is preparing to cycle 300 miles from London to Paris for Crohn's and Colitis UK. Trust colleagues Hannah Jacks and Hannah Wilkins will accompany her. 'My drive to do the cycle was that the charity is close to my heart – my dad suffered from Crohn's disease for most of his life before he passed away aged 62 from stomach cancer,' she said. The three ladies, all novice cyclists, will attempt their challenge over four days in June. See virgingivingmoney.com (Suzanne Tracey) for more.

Olly Williams, who was on the HFMA South West financial training scheme, has come second in the world in his CIMA exams. Mr Williams has recently been appointed senior modelling and planning accountant at Weston Area Health NHS Trust.

Leanne Lovelock, South West skills development co-ordinator, is joining this year's Cancer Research UK's Race for Life – women-only events to raise money for research into all cancers. You can support her at justgiving.com/leannelovelock2

Clare MacLeod has joined the HFMA as West Midlands skills development co-ordinator. Georgina Callaghan is South West skills development manager.

Claire Finn, Pam Rodgers, Paul Davies, Jonny Gamble and Su Rollason – members from University Hospitals Coventry and Warwickshire NHS Trust – are doing the Three Peaks challenge in May, driving 460 miles, walking 26 miles and climbing vertically 10,000 feet. The aim is to raise money to complete the trust's children's emergency department project to make it less scary for patients. Support them at: http://uk.virginmoneygiving.com/team/UHCWthreepeaks HFMA membership executive.

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

Eastern Branch
Annual review

The first full year as chair of the HFMA Eastern Branch was a busy one for Andy Ray. Mr Ray is deputy director of finance at Basildon and Thurrock University Hospitals NHS Foundation Trust and stepped into his branch role in November 2014. Over the past 12 months, the committee has expanded and new branch administrator Kate Tolworthy has taken over from Alison Cracknell, who is now HFMA branches manager.

The branch hosted eight events that were all well attended, despite financial pressures across the sector – proof of the presence and reputation of the branch in the region. The biggest event of the year was the branch's annual conference in October, attended by more than 100 delegates.

Recently, the branch hosted its first meeting for directors and deputy directors. 'Directors of finance and deputy directors of finance forums are an important way to share ideas, understand some of the issues that colleagues are facing and provide a means to support each other,' said Dawn Scrafield, director of finance at Colchester Hospital University NHS Foundation Trust, who chaired the event.

'We plan to hold similar meetings regularly, to support senior finance professionals across the region and extend their network,' added Mr Ray. The branch also hosts an annual student conference and supports staff at all levels within the healthcare finance community.

As recognition of the tireless work of the branch committee, two of its long-standing members have received awards over the past year. At the HFMA's annual awards ceremony vice-chair Keith Wood was rewarded for his contribution to the HFMA with an honorary fellowship (pictured with past president Sue Lorimer), while treasurer Jenny Davis was given a key contributor award in July 2015.

'As this year's president's theme suggests, I encourage you to step up. Get involved, and deliver what you said you were going to do, and you too might get a tap on the shoulder for an award. Join the committee,' said Mr Wood, who first joined the HFMA 20 years ago.

Regular updates on the branch activities and information from the NHS finance world can be found on the branch twitter account @hfma_eastern.

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Appointments

Colin Martin (pictured) has beecome chief executive at Tees, Esk and Wear Valleys NHS Foundation Trust. He was director of finance and deputy CEO at the organisation. Mr Martin was named Finance Director of the Year at the 2013 HFMA Awards. **Drew Kendall**, associate director of finance at the organisation, is acting up as director of finance. Mr Kendall is a member of the HFMA MH Finance Faculty Steering Group.

South West Yorkshire Partnership NHS Foundation Trust has appointed **Mark Brooks** as finance director, starting in June. Previously chief finance officer at Southern Health NHS Foundation Trust, Mr Brooks succeeds interim finance director **Jon Cooke**. Mr Cooke was appointed to enable former director of finance and deputy chief executive **Alex Farrell** to focus on her deputy chief executive role. She is currently interim chief executive at the trust, awaiting the arrival of new chief executive **Rob Webster**, who joins from the NHS Confederation this month.

Ben Jay has been appointed chief financial officer at Bedfordshire Clinical Commissioning Group. He has a local authority perspective on health and care integration, having been chief financial officer at Tameside Council in Greater Manchester and finance head at High Peak District Council.

Gayle Wells (pictured) is now strategic business accountant for the secure division at Mersey Care NHS Trust. Ms Wells is a Future-Focused Finance value maker and 2015 winner of the first HFMA Future-Focused Finance award. She was previously assistant chief finance officer at Wigan Borough Clinical Commissioning Group.

Norfolk Community Health and Care NHS Trust has appointed **Andrew Hopkins** director of finance. He moves from Norfolk and Suffolk NHS Foundation Trust, where he was director of finance and deputy chief executive officer. He succeeds **Roy Clarke** who is now director of finance at Papworth Hospital NHS Foundation Trust.

John Ingham (pictured) is now chief financial officer at Norwich Clinical Commissioning Group. The move follows **Jo Smithson**'s appointment as chief officer. Mr Ingham was chief financial officer at West Norfolk Clinical Commissioning Group, where he is succeeded by **Chris Randall**. Mr Randall was interim chief financial officer at Uniting Care Partnership, a partnership between Cambridgeshire and Peterborough NHS FT and Cambridge University Hospitals NHS Foundation Trust.

Get in touch
Have you moved job or been promoted? Do you have other news to share with fellow members? Send the details to seamus.ward@hfma.org.uk

"Our financial sustainability is the platform we need to proceed with the necessary plans for our estate"
Steven Davies, Moorfields Eye Hospital

Davies steps up to CFO role at Moorfields

On the move

Steven Davies says becoming chief financial officer at Moorfields Eye Hospital NHS Foundation Trust was the obvious career move from his previous roles as the trust's deputy finance director and NHS finance director.

Mr Davies, who succeeds Charles Nall, has worked at the trust for more than five years. Two years after joining, he became its NHS finance director, a non-voting post on the board with a portfolio of responsibilities.

'I have been able to grow into the new role by having two years on the board prior to stepping up to CFO,' he said. 'It gave me a lot of exposure to the board and how it works. I took on strategic initiatives and saw them through the board process to fruition.'

But he added: 'It's difficult becoming a CFO and, with more accountability, it's a step up.'

Does Mr Davies think having a stepping stone to CFO could help other deputies make the move to the top finance job? 'It works in this organisation because we have distinct activities – commercial and NHS – so we are able to create portfolios of activities for a finance professional that are sufficiently large to give them board-level responsibility. It is a good way of bringing finance professionals through the system.

'But every organisation is different and there are other good ways for organisations to give their deputy finance directors and other senior finance professionals experience of the board.'

The hospital is a 'fantastic' place to work, he said. 'It's diverse and has lots of different sites and is very sub-specialised. It's also interesting as we have our NHS activities; we have research and development – we are a biomedical research centre and are co-located with the Institute of Ophthalmology; and we are an education institution.'

The trust has commercial activities, including private patients and a pharmaceutical commercial arm, and it has hospitals in Dubai and Abu Dhabi. 'It's such a diverse organisation – there's never a dull moment,' he said.

Mr Davies joined the NHS in 2000 as part of the NHS finance graduate training scheme. He has worked in acute and community trusts, as well as the former North West London Strategic Health Authority. Prior to joining Moorfields, he spent a large part of his career working in South East London.

In his new role, he manages the finance and estates functions and he is focused on ensuring he finds the right balance between his different responsibilities. The trust recorded a £2m surplus in 2015/16 and plans to have a £600,000 surplus at the end of the current financial year.

Like other NHS providers, his challenges include maintaining the organisation's financial sustainability. This will mean a focus on its cost base, he said.

Commercial activities are vital to the trust. 'It's the thing that keeps the organisation financially sustainable,' he said. 'The tariff doesn't reimburse us for all our specialist activity – we are fortunate that we can subsidise the NHS activity with the profits we make from commercial activities. The trick is getting the balance right.'

The trust also has plans to relocate its central London site. 'It's the biggest capital scheme this hospital will do in a generation. We want to progress that, and our financial sustainability is the platform we need to proceed with the necessary plans for our estate.'

Though small, the trust is a complex organisation and its size is reflected in the relative size of its finance function. 'It can be quite challenging to manage all the different priorities with a relatively small team,' he said. 'But that is part of what makes the organisation so much fun to work in. People get experience in lots of different areas that they wouldn't normally get in a larger organisation.'

Twitter's professional benefits

Future focused finance

I confess, I am a serial tweeter, *writes Gayle Wells*, and I regularly use Twitter as part of my finance professional toolkit.

My confession is usually followed by colleagues' disbelief. Isn't Twitter the place where people post pictures of their cats, they ask, or tweet companies when they want to complain?

There's much more to Twitter than that, including making my continuing professional development (CPD) easy. By following appropriate accounts (called handles – mine is @gcwFFF) I get the most up-to-date information from organisations, individuals and companies.

Twitter creates its own global record of conversations using hashtags (those annoying words prefixed by #).

All the learning is gathered together to refer to at a later date, or provided as part of a CPD record. So that means I only need to know what hashtags have interested me and I can search for them – #wefinance #valuemaker and #NHScollabor8 are some of my recent favourites.

Twitter chats are fun as well as challenging. This is a little more advanced, but if you are feeling brave, you could try joining in. These are usually scheduled and advertised.

It's great to join a chat you feel you know a little bit about, especially if you are new to Twitter, but the learning potential is significantly increased if you join a chat with another group. It builds fantastic connections across professional boundaries and really helps improve the quality of my discussions with clinicians in work.

Gayle Wells is an FFF value maker and will blog more about the benefits of social media at www.futurefocusedfinance.nhs.uk

HFMA 'Step Up!'

Programme 2016

Free training for HFMA members

The HFMA 'Step Up!' programme aims to support you in your journey to step up in 2016 and will include:

- **Branch based workshops**
- **One day national events**
- **Coaching and mentoring skills**
- **Webinars**
- **Roundtables**

For further information please contact
sarah.moffitt@hfma.org.uk

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