CIPFA The Chartered Institute of Public Finance & Accountancy

from desire to delivery

CIPFA asked Roundtable participants to expand a little on some of their key contributions. Here's what they said...

INSIGHTS

for public financial management

CIPFA, the Chartered Institute of Public Finance and Accountancy, is the professional body for people in public finance. Our members and trainees work throughout the public services, in national audit agencies, in major accountancy firms, and in other bodies where public money needs to be effectively and efficiently managed.

As the world's only professional accountancy body to specialise in public services, CIPFA's portfolio of qualifications are the foundation for a career in public finance. They include the benchmark professional qualification for public sector accountants as well as a route to qualification and membership for people already working in senior financial management positions. These are taught by our own CIPFA Education and Training Centre, as well as at other places of learning around the world face to face, online and by distance learning.

We also champion high performance in public services, translating our experience and insight into clear advice and practical services. They include information and guidance, counter fraud tools and qualifications, courses and conferences, property and asset management solutions, advisory and recruitment services for a range of public sector clients.

Globally, CIPFA shows the way in public finance by standing up for sound public financial management and good governance. We work with international aid donors and agencies, partner governments, accountancy bodies and the wider public sector as well as private sector partners around the world to advance public finance and support better public services.

how should we move towards the right balance of spending between primary & community care, secondary care and social care?

By Christine McLaughlin (Deputy Director, Finance, ehealth and Pharmaceuticals, Scottish Govt, and Chair, CIPFA Scottish Branch)

All components of Integrated Care show signs of stress from increasing demand driven by an ageing population with ever more complex needs and the curve continues to rise - over the next two decades the number of > 65s will rise by 50%.

Historic structures have encouraged a silo mentality, but the flow of patients ignores such artificial boundaries. This winter we have seen a reduction in the number of care home places and at the same time a deterioration in performance against the 4 hour target A&E waiting time – hardly surprising given that over two thirds of A&E admissions are from the >65 age group.

If keeping people healthy, self-sufficient, and at home wherever possible is the overall aim then we need our care system to be in balance – from there the balance of spending will follow. Without whole system balance, we risk throwing money at short term fixes focussed on effect rather than cause – a low value rather than best value approach. We need to know not just the value of our spend but how to disinvest in low value spend in order to remove fixed costs.

In the short term however, so long as people continue to flow into the secondary care system, no matter how appropriate, funding must follow to protect the quality of care that the NHS has worked so hard to achieve. But there remain significant opportunities to improve efficiency in secondary care that have not yet been grasped. These need to be tackled at scale to improve value for money.

To disinvest and remove fixed or semi fixed costs in secondary care in the medium term, we need alternative models of care in the community that change the flow of activity. We need more intelligent use of data to model the impact of service redesign alongside an ageing population – without that how can we be sure what the balance should be? So before we can disinvest and get the balance right, it is very likely that we will need to invest – in new models of care, in innovation such as new uses of technology, but also in big data analysis on a scale far beyond the status quo.

A 'leap of faith' is not going to be enough to deliver a rebalancing of services or resources. Something on this scale needs a well thought through plan, robustly modelled and costed – and incredibly well executed. It will require co-production with the public and extends far beyond the traditional boundaries of healthcare.

measuring and assessing preventative spend

By **John Rae** (Director, Resources, Welsh Local Government Association)

'Prevention is better than cure' is sound advice for anyone's health, but increasingly has general applicability to the way we view our public services in the current economic climate. While it has been part of the political debate for some time and makes numerous appearances in the language of public services reform, prevention has proved difficult to define and measure. However we all know what we're trying to achieve: early action to reduce demand on acute, high cost services and improve citizen outcomes.

At national level governments have started to think about how their own budgets focus on prevention. The Sottish Government has made good progress and the Welsh Government features prevention heavily in its impact assessment. The approaches have a number of advantages including thinking about outcomes and priorities in terms of finances but there are a number of weaknesses in the approaches as well. Firstly there may be weak evidence linking interventions to the mitigation of negative social outcomes in the future, and it may be difficult to control for other factors. Where there is evidence there is little in the way of frameworks or tools that help financial decision-makers allocate scarce invest-to-save resources to competing budgets: where can you get the 'biggest bang for your buck'?

The Local Government Information Unit (LGiU) has published a step-by-step guide to tracking preventative spend based on some work it did with Camden – see http://www.lgiu.org.uk/wp-content/uploads/2013/10/Tracking-your-preventative-spend.pdf. Analysing and mapping budgets can never be a scientific process but what the LGiU have produced is a framework that helps think about how local services contribute to primary, secondary and tertiary prevention. The example does this against one of the council's key outcomes from the Adult Social Care Outcomes Framework; to keep older people living independently for longer.

However this approach needs be widened to cover spend across the whole of public services in any one geographic area. It should identify where the system requires the investment and where the benefits accrue. For example recent work by the Joseph Rowntree Foundation shows there is little incentive for local authorities to invest in anti-poverty measures when 80% of the savings accrue to central government. With more evidence, this type of framework could prove an invaluable evidence-base for pooling budgets and providing the basis for health and social services integration.

grounds for optimism through personal budgets

By **David Pearson** (Corporate Director, Adult Social Care, Health and Public Protection at Nottinghamshire County Council and President of the Association of Directors of Adult Social Services)

Recent media coverage of social care has focused on the issues of quality in residential or home care settings; the terms and conditions of staff; the £3.5bn (26%) savings that have had to be made over the last few years; the reducing numbers receiving support; and what social care can and cannot do for the NHS. What we also know is that the number of people who need social care is rising from the current 1.3m. The number of over 85's will double over the next two decades, and the number of people with learning disabilities needing social care is likely to rise by 25% by 2026.

We also know that social care can transform people's lives. Despite the challenges, 80% of those receiving social care in their own homes are in receipt of a personal budget, with an increasing minority receiving a direct payment with which they can organise their own care or be helped to do so. The satisfaction rates (of admittedly reducing numbers of people receiving services) have improved from 90 to 91% and the In Control, Lancaster University, Think Local Act Personal survey shows just how much 4000 people value the extra control that personal budgets affords.

So let me describe what good can look like building on this experience.

For most of us, access to health treatment when we need it – with a greater emphasis on advice to help stay active and healthy, sharing responsibility for our own health and wellbeing – does the trick, and will continue to do so for most of our lives.

There are, though, 18 million of us living with long term conditions. We need to become experts on our own conditions, making the best of treatment, advice and support to enable us to get on with our lives.

There are 3 million of us who have multiple long term conditions or disability that require something different. Within ten years there will be at least 5 million. We often experience episodic, fragmented treatment, care and support. When thinking about health and care, governments and policy makers often leap to changing structures and pooling budgets. But surely what's needed is person centred, coordinated care to help people and their carers to achieve the best outcomes they can. This is the approach developed by organisations representing the lens of users of health and care such as National Voices.

I think there are many clues from experience of social care of the best way of supporting people with multiple long term conditions or disabilities.

The four main elements of a personalised approach which enhances independence choice and control are:

- great advice and information
- effective recovery, reablement and rehabilitation
- person centred care, based around the use of personal budgets
- supportive, caring and enabling neighbourhoods, families, communities and businesses

Success is a partnership at a local level to join up the statutory, private, voluntary and community effort. People's needs are not in a health and social care box.

The joint NHS and social care initiative of nine pilots for integrated personal commissioning (personal budgets to you and me) from April 2015 has the potential to be revolutionary in the health and care system. The culture, technical and professional barriers are forbidding but the prize of truly joining up approaches through personal budgets is the best way to cut through system so that it's driven by individual needs and desired outcomes. The selected sites will give us the confidence and information to understand how integrated personal commissioning will work in practice over a three year period. I hope that during this time we can rapidly learn from this experience and make faster progress towards personalising and enhancing the experience of millions of people in this country by the end of the decade. Perhaps, indeed, the pilot can be reviewed after a year of its planned three year course, and some acceleration put in place if the initial stages look promising.

Let's not build the future around the illusion that building new organisational health and care pyramids will provide the solution, let's truly put the people in the driving seat, towards better outcomes and good lives.

are population health management organisations the key to sustainable care?

By **Mike Farrar** (Strategic adviser on health, CIPFA)

Of all the aspects of the Simon Stevens penned NHS Five Year Forward View, the most striking is the opportunity to pursue a capitated budget as part of a new model of care. The effect would be to move away from activity-driven payments to bring hospitals, community and mental health into line with the way GPs are funded. The aim would be to make it easier to integrate care across the whole pathway, and to prioritise spending according to what benefits the whole population of an area, rather than as the accumulation of individualised responses. Offering two forms of population health management organisation in Multi-Speciality Community Providers (MCPs) and Primary and Acute Care Systems (PACS), the emerging policy landscape now allows for local leaders to take up these radical options and emulate other models from across the world such as the Accountable Care Organisations from the USA and the Ribeiro-Salud model from Alzira, in Valencia province.

But are these options really capable of providing a platform for delivering £22bn of additional value by 2020? Or is this another NHS clutch for the productivity and efficiency straws?

In truth the answer may well be - it depends, and the key will be to understand what might make them successful rather than await failure. Stripped back to their bare bones, they definitely have a fighting chance of success as they have the ability in one fell swoop to reconnect the budgets disconnected by the Lansley reforms and to recognise the importance of 'place' based budgets in activating local communities and patients. But there are other lessons that need to be understood.

Experience from elsewhere suggests for population health management to work, the clinical model has to change, not just the organisational structure; populations have to be more engaged, not seen as passive recipients of services; contracts need to be longer (most ACOs have 3-5 years, in Alzira it's 15) if the organisation is to benefit from 'invest now to save later' strategies; partnerships must form across organisations if they are to be able to invest in one part of the system to save in others; local workforce flexibilities are needed to align individual contracts with organisational objectives; and finally politicians may need to embrace new public private partnerships in terms of inward investment and new relationships with technology suppliers.

Many of these look challenging in the run up to a general election but, though ignoring them might bring short term solace, it will almost inevitably bring longer term costs and downstream strife for a beleaguered health and care system.

The experience of a capitation approach in Spain

The Alzira model in Valencia has operated in its current form since 2003 and has employed different mechanisms with the objective of providing integrated and efficient health services. The model has utilised both capitation and outcome-based mechanisms in support of this objective.

Key to the model's success has been the adoption of a primary care orientation as part of the integration of primary and secondary care. A single provider is responsible for all healthcare provided to the population of the region, receiving a fixed annual capitated budget.

The contract requires that, for residents from Alzira using the service, the provider is paid at 80% of the rate for healthcare in the rest of the province. Should a resident choose to go elsewhere for treatment, Ribeiro-Salud, the provider organisation in Alzira must pay at full cost for their care.

A number of key clinical and patient experience outcomes are used to assess provider performance.

The model has delivered the following outcomes:

- Improved clinical outcomes and high patient satisfaction, facilitated by closer integration of services and pathways.
- Emergency waiting times in an acute setting of 60 minutes – versus a wider regional average of 131.
- The costs of providing health services to the commissioner have been reduced by 25 per cent, with costs far lower than regionally and nationally.

taking account of culture

By **Elaine Lawther** (Head of Finance Training & Support Unit, NHS Education for Scotland)

As finance professionals we are pretty adept at noticing things. We see patterns and gaps where colleagues see jumbles of numbers. Most times we have a sense of what to do next and with these skills we offer a unique contribution to our organisations.

There is a growing recognition that to meet our challenges, that achieving the right culture is one of the most important elements to consider. It's the way things are done, or the reason they are not done. It impacts on almost everything – every team, every initiative. Yet I realised that as a busy finance professional I tended to notice culture and its impact in hindsight. When I was aware of it I saw it as fixed. It was something that had to be tolerated or worked around.

Look at any strategic vision or strategy and I expect you will find a reference to culture. It is now to be valued, measured and influenced. As an accountant I still struggle to get my head around this but have been challenging myself and those around me to stop and think about the culture I am working within and the culture I help create.

Looking at culture naturally draws us into looking beyond our own experiences, our own teams and even our own organisations. It draws us into the concept of whole systems thinking, another phrase that is sprinkled across our strategic plans. Through a whole systems lens we are invited to see things as they are from the widest range of perspectives. This brings potentially overwhelming complexity but it also provides us with a whole new data set to look at.

What could we achieve if we looked at culture as data? What patterns would we identify? What solutions and ways forward could we find, beyond what may be apparent from our current viewpoint? What contribution could we make to our organisations and our country if we notice things a bit more?

data protection issues

By **Sandra Lomax** (Director, Baker, Lomax and Shackley ltd)

Personal data has acquired huge economic significance with some estimates showing the value of European citizens' personal data to grow to nearly €1 trillion annually by 2020. This has led to concerns from both citizens and regulators on the adequacy of compliance with Data Protection legislation and the ability of the regulator, the Information Commissioner's Office (ICO) to issue adequate sanctions including monetary penalties of £500k.

It is widely accepted that significant financial savings can be made across the Public Sector through sharing and integrating systems. In order to achieve this, the perceived barriers of data protection and information governance must be addressed.

At a strategic level data sharing agreements are often in place between organisations which regularly share information, this provides a framework on how and why information will be shared. However, at an operational level, staff is genuinely concerned about the consequences to them and their organisation if they share data inappropriately these include: ICO monetary penalties, disciplinary action, media interest, reputational damage and harm to the individual whose data was incorrectly disclosed.

In order to harness the benefits of data sharing the concerns of staff need to be addressed and put into perspective. Organisations need to understand data protection legislation and support their staff by providing the necessary physical, technical and governance arrangements backed by adequate training. The table below provides an overview of the current Data Protection principles.

Principle	Statement	Which means
1.	Personal data must be processed fairly and lawfully.	You must have legitimate grounds for collecting and using personal data provide adequate Privacy Notices, handle people's personal data lawfully and only in ways they would "reasonably" expect.
2.	Personal data must only be processed for one or more specified purposes.	Understand initially why you are collecting personal data, notify the ICO formally of the information you collect and for what purpose. Undertake Privacy Impact Assessments (PIA) to show privacy considerations have been addressed for each new initiative where personal data is collected. Regularly review the personal data held and the purpose for holding it.
3.	Personal data must be adequate, relevant and not excessive in relation to the purpose for which it is processed.	Consider the different access rights on IT systems and ensure they are aligned to roles and responsibilities. Ensure regular reviews of data held and identify any "excessive" information that should be removed.
4.	Personal data must be kept accurate and up to date.	Linked to Principle 5, consider the level of information you hold where there is no legal requirement to do so and the potential time and cost of storing, retrieving, maintaining and providing information in relation to this e.g. Freedom of Information requests.

5.	Personal data must not be kept for longer than necessary for the purpose for which it is being processed.	Ensure you have a records management and storage policy which is aligned to both IT systems and paper records e.g. staff notebooks, appropriate archive modules on IT systems. Audit compliance against the policy. Careful consideration must be given to the secure disposal of information which is no longer required.
6.	Personal data must be processed in accordance with the rights of individuals under the DPA.	Organisations must know what personal data they hold, where it is held and how to access it. Under a Subject Access Request, organisations have 40 calendar days to provide a copy (redacted where appropriate) of information comprised in their personal data. Other rights include: a right to claim compensation for damages caused by a breach of the Act, a right, in certain circumstances to have inaccurate personal data rectified, blocked, erased or destroyed
7.	Organisations must take appropriate technical and organisational measures to keep personal data secure.	Know who is responsible for information security, ensure technical, physical and organisational arrangement are robust by training staff, socialising policies and procedures and protecting the environment in which data is captured, used, stored and disposed of.
8.	Personal data must not be transferred to countries outside of the European economic area unless the country has adequate levels of protection in relation to the processing of personal data.	There are no restrictions on the transfer of data within the European Economic Area.

Ensure you are aware of the country hosting any “cloud” technology belonging to your organisation.

Trust and confidence are required by all organisations who share data with each other. This only comes with a culture change brought about by strong leadership, adequate and regular staff training and awareness of policies and processes. However the best prepared organisations will be tackling all the relevant issues across their whole infrastructure.

http://europa.eu/rapid/press-release_SPEECH-14-607_en.htm Sept 14 speech re DP

http://europa.eu/rapid/press-release_MEMO-14-186_en.htm March 14 press release EU

http://europa.eu/rapid/press-release_SPEECH-14-568_en.htm Aug 14 – right to be forgotten Martine Reicherts, EU Justice Commissioner

sharing international experience to benefit health and care systems

By **Mike Farrar** (Strategic adviser on health, CIPFA)

The drive to do more for less is clearly not confined to the NHS in the UK. For many CEOs and FDs there is real merit in looking across international boundaries to identify different models of care or financial incentives that appear to offer better value. Indeed it could be argued that the Five Year Forward View is largely inspired by the USA's Accountable Care Movement appears. But it's not just in the new models of care espoused that lessons might be learnt.

The 2014 Commonwealth Fund Report gave the NHS a leading position but that was amongst only the 11 mature democracies that were in the comparator group, where, by the way, despite our balanced scorecard performance, there were many areas in which the UK could learn from others. There is also comparative data from elsewhere in the world which might help us to learn about and value things in our own system. Nowhere exemplifies this more in my view than primary care and our approach to general practice,

Let's consider the positive side – it's undoubtedly true that the NHS achieves very high scores for efficiency, fairness and equity because of our list based system of General Practice. I would also argue that the gatekeeper function inherent in our system also constrains costs and reduces duplication of tests and uncoordinated care (even if we think it's not, it looks good by comparison!)

However, its inherent risk is the over-medicalisation of our care responses and the problems this can cause for the responsibility which we have as patients for the management of our own care, and more importantly our own health. This might be controversial but look at emergent nations, Mexico has done a lot of work on telehealth, whilst African nations do a lot to use mobiles for health advice. They, with scarcer resource and even fewer general practitioners, are beginning to use technology and direct-to-consumer health applications to create greater self management capability in their communities and a more empowered group of patients. There's real potential here for the NHS to leapfrog.

So this presents us with a challenge. How best to develop our successful model of primary care to embrace more patient, family and community engagement, a broader technological base to improve access, and enable a potentially a wider group of professionals and informal carers to feature in care planning and delivery. And to do this by building on strengths rather than frightening the very horses on which our current success rides.

CIPFA clearly has a role to play here in the learning that trainees gain in those early years, and the understanding they might develop of a variety of models of care from across the world rather than a sheep dip of our own usual colour. This will help them to challenge and to value what we do in a way that allows them to develop it for themselves later.

The world genuinely is a smaller place nowadays but we shouldn't forget it's also a great classroom!

making best use of the estate

By Carol Culley (Deputy City Treasurer, Manchester City Council)

It is the policy of all political parties to drive the further integration of health and social care. However it is fair to say that if you were starting with a blank sheet of paper you would not start from here.

The NHS Five Year Forward View articulates why change is urgently needed. It describes various models of care which could be provided, for example 'the future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions' with a commitment to taking decisive steps to break down the barriers of how care is provided.

As well as being able to make optimal decisions for care models and how they are funded, decisions need to be made on the best way to maximise the use of NHS and social care estates. Whilst there are examples of good practice, for many of us this remains in the too difficult box.

I would argue that resourcing decisions relating to the estate should be made and decided at a local level with the proceeds from the sale of any of the estate retained locally. This would support the rationalisation and transformation of the estate portfolio, and with some careful planning, support some of the transition costs of implementing new models of care.

Currently all ex- Primary Care Trust estate not transferred to providers is owned by NHS Property Services Ltd – a limited company set up by the Department of Health with the legal title to 4,000 assets valued at c£3bn. Much of the primary care estate is owned by GPs. Local government asset sales are forecast to total £13.3 billion between 2015/16 and 2017/18. Integrated local management of estates issues is therefore very challenging.

The One Public Estate Programme, funded by the Cabinet Office Government Property Unit (GPU) and delivered by the Local Government Association (LGA) is designed to facilitate and enable local authorities to work successfully with central government and local agencies on public property and land issues through sharing and collaboration.

There is a need now to give the work some real momentum. Localities are planning for how the objectives in the Five Year Forward View can be delivered in a way that is clinically and financially sustainable. Surely this must be supported by a clear plan for estates. Consideration could be given to the development of local property vehicles which can own and optimise estate across health and social care. Whilst this will be challenging, with the resource pressures we are facing, can we really continue with the status quo?

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