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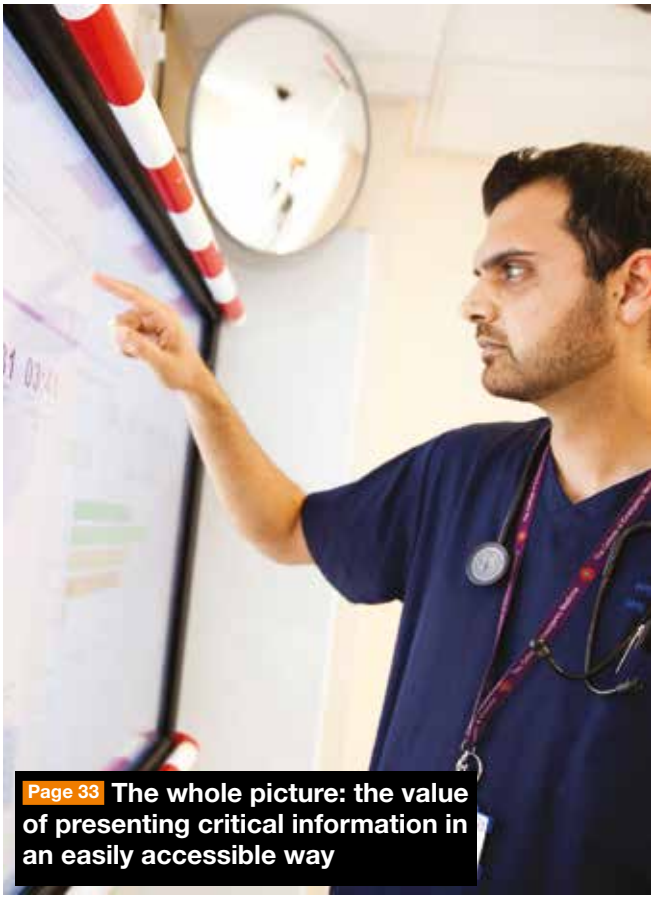

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News

Mackey: tariff should help trusts back to balance

By Seamus Ward

The 2016/17 national tariff must help NHS providers to get back into financial balance, according to Jim Mackey, chief executive designate of NHS Improvement.

He was speaking as Monitor and the NHS Trust Development Authority (TDA) issued a report showing NHS providers faced continued financial and operational strain six months into the financial year. NHS Improvement will bring together Monitor and the TDA.

Providers in England – NHS trusts and foundation trusts – predicted a combined year-end deficit of £2.2bn. They recorded a half-year aggregate deficit of £1.6bn. This was £358m worse than planned at the start of the year, with 182 out of the 241 NHS providers reporting deficits.

"The tariff for next year will need to be set at a level where trusts can plan to bring themselves back into financial balance"

The figures, released before the spending review, confirmed the NHS will receive a real-terms increase of £8bn over the next five years, with £3.8bn frontloaded for 2016/17. Monitor and NHS England are expected to publish details of the tariff, including the tariff efficiency factor, early in the new year.

Monitor and the TDA insisted measures now being implemented would improve operational and financial resilience. These included the new rules capping spending on agency staff; trusts' reviews of their plans; controls on management consultancy spending; and reduced capital expenditure, where it is safe to do so.

The report said at Q2 the total capital expenditure of £1.4bn was about 36% less than planned, suggesting considerable scope for reducing capital expenditure.

It could take time for these measures to realise their full benefits, added the report. But trusts would be expected to deliver a year-end financial performance that achieved, or was close to, initial plans with a further benefit of delayed capital spending.

Mr Mackey said: 'The new measures we are putting in place will mean providers have a better chance of improving their financial position throughout the remainder of this year. However, it is clear – especially as we see the majority of providers struggling with their financial situation – that the national tariff for next year will need to be set at a level that will create the conditions where NHS trusts and foundation trusts can begin to plan to bring themselves back into financial balance, which will enable them to focus on what matters to patients: improving care.'

While revenue was broadly on plan, the quarter two report said expenditure was 1.1% above plan. This was due to £1.9bn spent on agency staff in the first six months – the result of unplanned activity, inefficient use of permanent staff and recruitment difficulties.

Delayed discharges contributed to the adverse financial and operational performance. The Q2 report said they had cost providers £270m in the year to date and had affected performance in A&E in particular, where the four-hour waiting target was missed.

Agency spending affected planned cost savings. Pay cost savings make up almost 49% of planned cost improvement programmes and, though providers had delivered £1.1bn of efficiencies at Q2, this was £189m below plan – 62% was related to undelivered pay savings.

Commissioners are forecasting a small year-end overspend, according to an NHS England report on the financial position at month six. The report said the year-to-date position was a headline overspend of £29m (0.1%) and a forecast year-end overspend of £71m (also 0.1%). It is due to overspends at clinical commissioning groups and in specialised commissioning, including the cancer drugs fund. Nineteen CCGs forecast a year-end position worse than planned – three being unplanned deficits. Two CCGs with planned deficits said their position had deteriorated, while one improved to break even.

HFMA policy director Paul Briddock said: 'With more than three-quarters of all providers in deficit, it is obvious it is a systemic problem that needs urgent attention. The NHS is simply not living within its means.'

King's Fund policy director Richard Murray (above) said the provider figures show the NHS 'in the grip of an unprecedented financial meltdown. Deficits on this scale cannot be attributed to mismanagement or inefficiency. Quite simply, it is no longer possible for the vast majority of NHS providers to maintain standards of care and also balance their budgets.'

See Spending facts, page 10

Staying in touch at this year's conference

Members will have several ways to keep in touch with the views and debate at this year's HFMA annual conference.

A dedicated conference app will offer information on the conference schedule, speakers and exhibitors, and allow users to create a profile to join in the debate and send messages. Delegates can also tweet using #HFMA2015, and *Healthcare Finance* will be reporting from the event – go to the December issue on the website, www.hfma.org.uk.

The conference takes place in London on 9-11 December, entitled 'Stronger together' after Sue Lorimer's (pictured) presidential theme for 2015. Speakers include Lord Carter, chair of the Department of Health productivity and efficiency board; David Williams, the Department's director general of finance; and Jim Mackey, chief executive designate of NHS Improvement.

Survey reveals lack of confidence over mental health payment proposals

By Steve Brown

The HFMA has warned Monitor and NHS England that only four out of ten mental health providers are confident that they could introduce specified new payment approaches in 2016/17.

The two bodies responsible for tariff and payments systems consulted on proposals for changes to payment rules in November. The proposals would require commissioners and providers of mental healthcare to adopt a payment approach based either on year-of-care/episodes of treatment or capitation and for a proportion of payment to be linked to outcomes.

But an HFMA survey to inform a response to the consultation found that only 42% of 36 providers replying were moderately confident (27%) or highly confident (15%) of being able to meet the requirement in 2016/17. Confidence was low in 44% of providers and very low in those making up the balance.

There is greater confidence that new contracts could be in place for 2017/18, with 85% of providers believing this is a realistic ambition.

Monitor and NHS England are keen to eliminate the use of crude block contracts in mental health and to have greater transparency for local contracting arrangements. The proposed approach would build on requirements to move towards cluster-based contracts in recent years, although contracts written in cluster days have been ruled out.

However, in its response to the consultation, the HFMA has pointed out the gulf between where the service is and where it needs to be. According to the survey, 89% of respondents have block contracts in place for 2015/16 – although this falls to 47% in planned contracting arrangements for next year.

'Although this indicates a positive direction of travel, it is clear that a number of local health economies are some way from implementing new or different arrangements,' said HFMA policy and technical director Paul Briddock.

The response says that clinical commissioning groups are vital to any change over. Moving from block contracts to new payment approaches would result in 'gainers and losers' across commissioners.

Robust data to inform contracts remains a challenge across the sector and the association said that a mandatory data format would be important, particularly to operate outcome measures. The HFMA also said that greater clarity of the use of clusters as the basis for the payment mechanism was important, so that clinical engagement around the use of the recently adopted currency was not lost.

Under pressure

A report from the King's Fund, *Mental health under pressure,* said the sector was under huge strain, with about 40% of trusts experiencing a cut in income in 2013/14 and 2014/15.

The briefing said this was in marked contrast to the acute sector, where the income of more than 85% of trusts increased over the same period. The report suggested large-scale changes to mental health services, driven by the need to reduce costs, were a 'leap in the dark'.

Monitor VFM report to be published in new year

Monitor has delayed publication of its value-for-money report to support its costing transformation programme.

The report is seen as a vital foundation for the ambitious programme, which will see the whole English NHS implement patient-level costing using a revised and consistent methodology. With a general presumption that value for money will be established, the report has been developed in parallel with initial work on costing transformation.

However, it is seen as playing an important role in getting providers to buy into the programme, which may require investment in systems and costing staff to realise the full benefits.

A report to November's Monitor board meeting said the delay was 'due to a higher than expected response from the sector of high-level case studies and other potential evidence'. Further time would enable Monitor to 'properly analyse and collate the information to assess potential to be included in the publication' – now expected at the end of January 2016.

The November board paper also said the regulator had completed recruitment to its own costing team, including a permanent director of costing. This position has been filled on an interim basis by Jamie Gannaway, with the new permanent director due to start in the new year.

Monitor ended consultation on draft minimum requirements for costing software in November. Costing systems will in future need to be accredited. The minimum requirements describe what systems will need to do to support the new methodology – from importing minimum data sets, applying allocation methods and outputting robust data.

Graham James, vice-president of healthcare solutions at CACI, which supplies the Synergy costing system, said its latest system upgrade had looked to address draft requirements.

'We are seeing some early adopters, particularly in the acute sector, coming forward wanting to get the costing transformation programme requirements up and running before the deadline,' he said.

But with many providers waiting for the accreditation system to be in place, road test partners' experience with different software would be crucial in influencing future purchase decisions.

See Cost mapping, page 18

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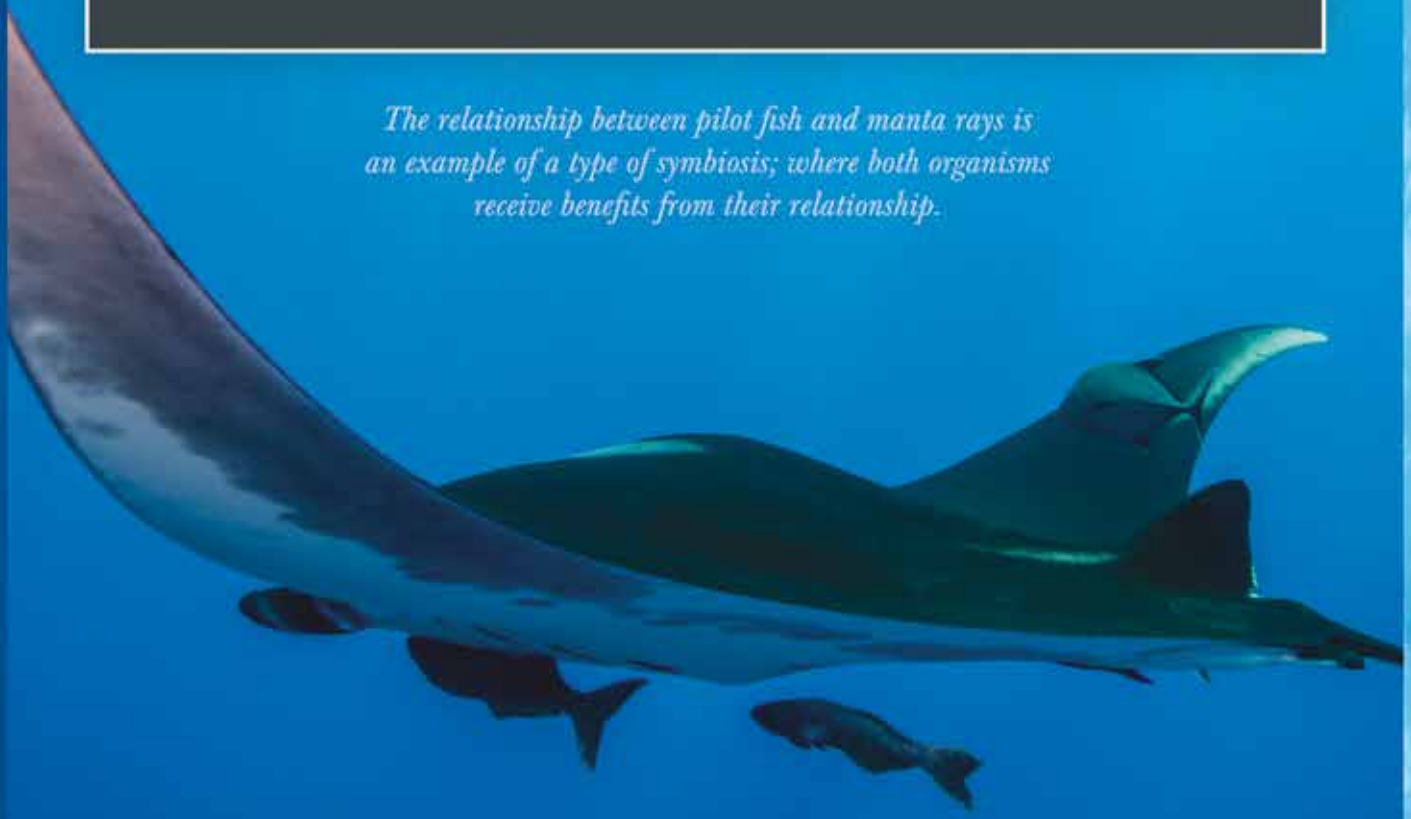

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Hamilton unveils £48m funding boost and NI health shake-up

By Seamus Ward

Northern Ireland's health and social care services have been given a £48m in-year boost, with much of the funding to be spent reducing waiting lists.

Health minister Simon Hamilton announced the additional funds following an agreement between the Assembly parties on welfare reform. This agreement has freed up funds to be allocated to health and other parts of the public sector. The bulk of the additional funding (£40m) will be spent relieving waiting lists.

The latest figures show that almost 63,000 patients were on the waiting list for inpatient admission at the end of September. More than half had been waiting more than 13 weeks for inpatient treatment. Some 230,000 patients were waiting for a first outpatient appointment, more than 12,000 for a clinical assessment and 90,000 for a diagnostic service.

The minister said the extra £40m would fund up to 40,000 additional assessments and between 10,000 and 15,000 additional operations and treatments. 'This investment will improve the lives of thousands of people and marks the start of my plan to bring waiting lists under control,' he said. 'I recognise this will not be easy and unfortunately will take time to restore but I am determined to succeed.'

Mr Hamilton has called for health and social care funding to rise by £1bn to about £6bn in the next five years. He said he wished to use 'a sizeable element' of any new funding to transform how services are delivered, encourage innovation and invest in world-class facilities.

Also this month, Mr Hamilton announced his intention to introduce sweeping reform of the local commissioning system. This would include the closure of the Health and Social Care Board (which currently commissions services), giving health and social care trusts responsibility for planning and delivering care to their local populations.

Mr Hamilton said his proposals were about 'structures, not people'. A directorate would be created within his department to focus on the financial and performance management of the trusts. 'My proposals would mean that many of the board's existing functions, and staff, would revert back to the department. Some would move to the new Public Health Agency, while others – especially those in respect of planning for need – will move to our trusts,' he said.

"This investment will improve the lives of thousands of people and marks the start of my plan to bring waiting lists under control"
Simon Hamilton, health minister

Specialised top-ups to be phased in

Monitor has proposed a phased introduction of a system for defining and calculating specialised top-ups.

The regulator opened a consultation following the proposal to switch to HRG4+ in 2016/17 and changes in the way specialised services are defined. It proposed changing the set of specialised services eligible for top-up in 2016/17. It also recommended the amount paid for top-ups should be based on a new model developed by the University of York.

Specialised services top-ups currently amount to £250m-£300m a year, which is top-sliced from total tariff payments, reducing payments for non-specialised activity. Funding is in four areas – neurosciences, orthopaedics, paediatrics and spinal surgery. But with the introduction of prescribed specialised services (PSS) and the new model for calculating top-ups, the consultation proposes 36 top-ups,

These are spread across specialties covered by existing top-ups, plus new areas – cancer, cardiac, respiratory and other (largely vascular and colorectal surgery).

Some services previously eligible for top-ups would no longer receive them under the PSS 2015/16 monitoring tool. But for services not subject to top-ups, new HRG4+-based prices should better reflect the costs of delivering more complex activity under the core tariff.

York University analysis also identified additional services eligible for top-ups. As a result, the total value of top-ups would rise to £400m in 2016/17.

However, rather than implementing the changes in full immediately, Monitor proposed a transition to minimise the impact. It has invited comments and expects to make a final proposal in the statutory consultation on the 2016/17 national tariff early in 2016.

See Paediatric rethink, page 15

NHS England consultation on cancer drugs fund

NHS England has launched a consultation on proposals for a revised cancer drugs fund (CDF).

The current arrangements for the CDF are due to end in March 2016 and, in light of this and the escalating cost of the fund, NHS England has called for new arrangements to be in place from April.

The CDF was established in 2010 with a budget of £200m, but this has increased to £340m for the current financial year. While NHS England recognised that the fund had unlocked access to treatment for a large number of patients, the current model did not allow sustainable access to innovative treatments.

It added that an increasing share of the cancer budget was being directed to less cost-effective treatments, towards patients' end of life, and this was having an impact on other areas of the cancer pathway. Under the proposals, the fund will be integrated into the National Institute for Health and Care Excellence appraisal process. The CDF will become a transitional fund, with clear criteria for entry and exit.

The consultation closes on 11 February.

News review

Seamus Ward assesses the past month in healthcare finance

November health news was dominated by two stories – the spending review (see p10) and junior doctors. Juniors – any doctor in training – in England were balloted on industrial action over government plans for a new employment contract that it hopes will support the introduction of the seven-day NHS. In an increasingly rancorous dispute, both sides have issued claim and counter-claim over safe working hours and how much pay juniors may gain or lose.

The junior doctors, represented by union the British Medical Association, walked out of talks earlier this year, alleging the government had threatened to impose a contract if agreement was not reached. The subsequent ballot on industrial action showed overwhelming support for action, planned to include emergency cover only for 24 hours on 1 December and two full walkouts later in the month. The BMA said 76% of trainees voted in the ballot, with 99.4% of juniors in favour of action short of a strike and 98% supporting industrial action including strikes.

Announcing the ballot result on 19 November, the BMA offered to take the dispute to the conciliation service, ACAS. Health secretary Jeremy Hunt initially said no, preferring direct talks, but on 25 November he agreed to ACAS talks. On the eve of the first planned action, a breakthrough was made and the government withdrew its intention to impose a contract. The BMA suspended industrial action until January, but hospitals across England had already cancelled thousands of elective operations, leaving many patients unhappy. As *Healthcare Finance* went to press ACAS negotiations were continuing.

Pay will remain a hot topic with the 2016 pay round fast approaching. In November, the Department of Health wrote to the NHS pay review bodies setting out their remit for the 2016/17 pay round. Both letters confirm the government pledge to fund average pay rises of 1% over the next four years and ask the independent bodies to consider recommending targeted rises to urge recruitment and retention.

NHS Clinical Commissioners set out potential changes to the ambulance service and the barriers it must overcome to meet the challenges of the emergency and urgent care review. A discussion paper said changes could include a new payment system that supports the shift of fixed and semi-fixed costs, as well as variable costs, from the secondary sector to community and primary care. This would require a period of transition. The group said a new payment mechanism would support changes in services, including non-conveyance of patients and treatment closer to home.

The centre continued to keep an eye on costs. Final guidance on the caps trusts can pay per hour for agency staff was published by Monitor and the NHS Trust Development Authority in November. The caps came into effect at noon on 23 November and apply to all staff groups, except substantive/permanent or bank staff, as well as those employed by ambulance trusts. The final guidance includes changes to earlier proposals, including the exclusion of bank rates from the cap, NHS Employers said. Monitor also gave greater detail on the £515m spent on agency staff by foundation trusts in the first quarter of this financial year. Medical and dental agency staff cost almost £205m, while temporary nursing and health visitor cover cost £168m. Other agency staff cost just over £142m.

Deterioration of finances at the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Liverpool Women's NHS Foundation Trust led Monitor to open investigations. The regulator said that although

The month in quotes

'While I believe the right thing to do is to return to the negotiating table directly, it is clear that any talks are better than strikes.'

Jeremy Hunt agrees to take the junior doctors' contract dispute to ACAS

'For the UK, the message seems to be that where healthcare is concerned, you get what you pay for. Our lower than average level of public investment in healthcare is mirrored by somewhat mediocre performance across the board.'

Nuffield Trust chief executive Nigel Edwards on the OECD *Health at a glance 2015* report

'When things go wrong, it must be clear who will be held to account. Taxpayers must understand who is spending their money, how that money is allocated, and where responsibility lies if the system fails to deliver good value.'

Commons Public Accounts Committee chair Meg Hillier on city devolution deals

'We regret the inevitable disruption that this will cause but it is the government's adamant insistence on imposing a contract that is unsafe for patients in the future, and unfair for doctors now and in the future, that has brought us to this point.'

BMA chair Mark Porter explains its position on industrial action

The Scottish government announced that work is under way to establish six elective treatment centres involving £200m investment

it has concerns over waiting times at the Royal Bournemouth, the investigation would focus on the trust finances – it has forecast a year-end deficit of more than £10m. While Liverpool Women's had taken steps to address its financial challenges, the regulator had stepped in to see what additional support it could offer. The trust has forecast a deficit of £7m this financial year.

The King's Fund called on the NHS to move away from a fortress mentality to place-based systems of care. NHS bodies would collaborate with other health service organisations to improve the local population health. However, this would require the support of national bodies and policy makers, as well as fundamental changes in NHS commissioning.

Clear and well-resourced local scrutiny and accountability measures will be critical in the devolution of health spending, the Commons Public Accounts Committee said. In a report on the government programme of devolution to cities, the committee recommended the Department for Communities and Local Government should share learning and best practice with public bodies potentially involved in devolution, such as NHS England and the Department of Health.

Devolution is one of the models that could be used to integrate local health and social care from 2020, but the King's Fund said it raised questions on financial sustainability, provider deficits and accountability. A fund briefing on how city devolution deals will affect the NHS also questions how the differences between local authority and NHS financial regimes can be resolved. It concludes that devolution holds potential benefits, but it was not a silver bullet. Savings are likely to take time to deliver and will probably require upfront investment.

The government has decided to amend legislation to provide a route for NHS England, clinical commissioning groups and local authorities to use a pooled fund to jointly commission additional primary medical services. The decision follows a consultation earlier this year and will bring primary medical services into pooled arrangements. It will not impose a requirement to use the new flexibility and commissioners will only be allowed to use it where it would improve services.

The Scottish government announced that work is under way to establish six elective treatment centres. It has announced a £200m investment to create the centres to help the local NHS cope with a forecast growth of almost 40% in the most common procedures by 2025.

Waiting times are under continued pressure and unlikely to improve in the near future, analysis by the Nuffield Trust and Health Foundation said. In *Closer to critical?* they said conditions did not appear to be in place for maintaining care quality and improving services while meeting the financial challenge. The Nuffield Trust also said the OECD *Health at a glance 2015* report highlighted the UK's 'somewhat mediocre' performance across the board, from relatively low staffing levels to high rates of avoidable admissions for asthma and lung disease.

in the media

The publication of the latest HFMA *NHS financial temperature check*, the spending review and the latest financial position ensured November was a busy time for the HFMA in the media. The temperature check was covered on BBC Radio 4's *Today* programme. Other national and regional news outlets covered the survey, including the *Guardian*, *Financial Times* and *Independent*. Published before the spending review, the newspapers covered the temperature check call for the £8bn funding to be frontloaded, together with finance directors' concerns over how the £22bn in efficiency savings can be achieved.

Speaking to *Pharma Times* in response to the spending review announcement, Mr Briddock welcomed the decision to frontload the funding – the money would support NHS organisations when most faced a difficult 2016/17.

After half-year figures from Monitor and the NHS Trust Development Authority showing a £1.6bn deficit, Mr Briddock told *Public Finance* it was alarming that the provider Q2 position was worse than the 2014/15 year-end. With three-quarters of providers in deficit, the NHS had a systemic problem.

Mr Briddock also spoke to the *HSJ* about plans for capital to revenue transfers. He said this was usually done nationally. This was perhaps the first time it had been done 'systematically at a local level'.

News analysis

Headline issues in the spotlight

Spending facts

The detail of the spending review tells us a lot about the NHS in the next five years. Seamus Ward reports

So now we know. After months of lobbying, the NHS in England has an overall view of its budget for the next five years. On the face of it there were few surprises in the combined spending review and autumn statement on 25 November. The NHS will be required to make £22bn in efficiency savings and the government will meet its manifesto pledge to provide an extra £8bn in real terms for health. This is a £10bn increase compared with the 2014/15 settlement, counting the £2bn extra in the current financial year.

This was already widely known. But that does not mean the spending review held little of interest for the health service. As is often the case in Whitehall funding announcements, the detail revealed many of the potential pinch points and policy developments over the next few years.

Health and social care integration was given a huge push in the spending review. Chancellor George Osborne said every area must have an integration plan by 2017, implemented by 2020. While the exact form integration takes will be decided locally, it could include accountable care organisations, devolution deals and lead commissioning structures.

The better care fund (BCF) will be expanded – NHS mandated contribution will be maintained in real terms, while from 2017 the government will give councils extra funding to be included in the BCF. This will be worth £1.5bn by 2019/20.

Local authorities will be allowed to put a precept on council tax of up to 2% for social care funding, which the chancellor said could raise £2bn by 2019/20 if every eligible council used this new power. However, the Local Government Association (LGA) said the precept would raise £1.7bn by 2020 and this was not guaranteed as not every council will be able to or want to raise council tax in this way.

LGA deputy chair Sharon Taylor said: 'The additional provision of a £1.5bn increase in the better care fund is good news but it is vital this is new money and must be spent on adult social care. We are concerned that councils will not see the benefit until towards the end of decade, when services supporting our elderly and vulnerable are at breaking point now.'

In England, total Department of Health spending will rise from £116bn in 2015/16 to £133bn in 2020/21. The extra funding will be passed through to the devolved nations' overall budgets, but it will be up to their administrations to decide how much to allocate to health.

The government listened to lobbying from the service and has frontloaded the extra funding. In 2016/17, NHS England will get an additional £5.5bn, a £3.8bn increase in real terms. In the latest HFMA *NHS financial temperature check* (see box) – published before the spending review announcement – 56% of all finance directors said the £8bn would only be enough to maintain quality if received early in the five-year period.

NHS Confederation chief executive Rob Webster said: 'The commitment to frontload funding across the next two years gives the NHS a fighting chance to transform the way that care is delivered to patients.'

NHS leaders and politicians will hope service transformation implemented as a result of the frontloading will work quickly, with 2018/19 and 2019/20 looking comparatively tough.

King's Fund chief economist John Appleby said the NHS had received a relatively good settlement. But he added: 'Seen in the context of unprecedented financial pressures and rising demand for services, it falls a long way short of the new settlement needed to place the NHS and social care on a sustainable footing for the future.'

Finance directors pessimistic

Published before the spending review, the latest HFMA *NHS financial temperature check* showed finance directors were pessimistic about the future.

The twice-yearly HFMA survey of lead finance officers asked whether they thought the NHS could continue to deliver current levels of quality within the promised £8bn funding increase. It defined quality as services that are patient-centred, safe, effective, efficient, equitable and timely.

A third of clinical commissioning group chief finance officers and half of trust finance directors said the funding would be insufficient. But two-thirds of CCG and 47% of trust directors said it would only be possible if the money was frontloaded. And there was scepticism that the new care models and Lord Carter's productivity work would be enough to meet the £22bn funding shortfall.

Finance directors said it would be a challenge to keep the overall provider deficit to less than the forecast £2bn this financial year. Two-thirds of trusts predicted a year-end deficit, including all acutes, driven mostly by underachievement of savings plans and a rise in agency staff costs.

A quarter of finance directors believed their year-end position would be worse than planned and most said the risks associated with achieving their 2015/16 plan were medium or high. Risks included rising demand, slippage in savings plans and the impact of social care funding cuts.

HFMA policy director Paul Briddock said: 'Our report confirms the financial problems in the NHS are systemic and across the board, with particular and immense pressure being felt on the acute provider side. The scale of deficit reported is unprecedented. The NHS is not living within its means, which has consequences.'



PRESS ASSOCIATION

He welcomed the decision to frontload the funding, but added: 'A significant chunk of this will be absorbed by additional pension costs and dealing with provider deficits, leaving little breathing space for investment in new services and unlocking productivity improvements. The new funding will stabilise services in the short term, but smaller increases later in the parliament and the requirement to implement seven-day services will leave budgets stretched to the limit.'

Look a little closer at the £8bn in real terms for health in England and it becomes apparent that the increase has not been applied to the Department as a whole, but only to the NHS. The Treasury defines the NHS as the funding spent by NHS England, which admittedly looks after the lion's share (£101bn this year of a total £116bn). This can be seen in the tables, which show departmental expenditure limits (DEL) and total departmental expenditure limits (TDEL) for the Department and the NHS. TDEL includes both resource and capital spending.

This new definition has consequences as the government now only has to make good its £8bn pledge on part of total health spending.

Anita Charlesworth, chief economist at the Health Foundation, said: 'The spending review's interpretation of what the NHS encompasses has cost the health system dearly – £3bn less than if the increase had applied to the full health budget in 2020/21. The chancellor has given with one hand and taken away with the other.'

Some of the additional funding will be found from Department central budgets, which will be reduced by 25%. This will not just mean a cut in spending on administration. With the ring-fence applying only to NHS England, other budgets to be squeezed include capital and public health, as well as administration costs and arm's length bodies. The training budget for nurses, midwives and allied health professionals is another casualty. The NHS will no longer offer bursaries to students in these professions; instead they will have to take student loans.

The chancellor spun this as the lifting of caps on training places, which could translate to an additional 10,000 nursing and health professional training places by the end of this parliament. To an extent this is true – under the old system a limited budget bought a defined number of training places.

"Smaller increases later in the parliament and the requirement to implement seven-day services will leave budgets stretched to the limit"
John Appleby, King's Fund

Royal College of Nursing general secretary Janet Davies said the new policy broke the link between the NHS and trainee nurses, potentially making it harder to plan its workforce.

'There are still a lot of question marks about how the system will actually work, but the RCN is certain that anything that makes people worse off or deters them from becoming nurses, would be a big loss to our society,' she said.

Public health spending will also be hit. The LGA said this funding will be cut by almost 4% over the next five years and it was 'short-sighted' to reduce public health spending when prevention was at the heart of the forward view. However, the government intends to consult on options for boosting public health funding, including allowing councils to divert retained business rates to public health.

Some of the new money has already been assigned. The seven-day NHS could be one of the biggest draws on the new funding, with £750m invested in a new national seven-day GP contract. There were further announcements, including £1bn for new technology and £600m for mental healthcare.

Changes in national insurance following state pension reform and the new apprenticeship levy will increase costs. From April 2017, NHS organisations with annual pay bills in excess of £3m will have to pay an apprenticeship levy, set at 0.5% of the pay bill.

The funding settlement is relatively good but tight. Inevitably, the focus over the next few years will be on finding efficiencies of £22bn and in the process changing how services are delivered.

Department of Health

	Baseline (£bn)					
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Resource DEL*	111.6	115.6	118.7	121.3	124.1	128.2
Capital DEL	4.8	4.8	4.8	4.8	4.8	4.8
Total DEL	116.4	120.4	123.5	126.1	128.9	133.1

NHS

	Outturn (£bn)						
	2014/15	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
NHS TDEL*	98.1	101.3	106.8	110.2	112.7	115.8	119. 9
Real terms growth rate		1.9%	3.6%	1.3%	0.4%	0.7%	1.4%
Cumulative delivery of £10bn commitment		2	6	7	8	9	10

* excludes depreciation Source: Department of Health

Comment

December 2015

Over to us

With frontloaded growth, next will be the key year for tackling the NHS deficit

Suddenly I find myself writing my last comment article as president of HFMA. It feels like the year has passed very quickly but that's not surprising – 2015 will certainly be a year that we will remember.

My theme of 'Stronger together' is about building personal resilience and strong relationships, both with clinicians inside our organisations and with colleagues across local health and social care systems. But in 2015 the battle to cope with rising staff costs, difficult savings targets, the requirements of the standard contract and battles over tariff have put individuals and relationships between commissioners and providers under constant pressure.

It feels to me that HFMA has done a valuable job this year in supporting members to cope with those pressures. While visiting our fantastic network of branches right across the UK, local chairs have told me they are seeing unprecedented numbers of delegates at events. They tell me staff have relished the chance to hear the latest views from system leaders and, more importantly, to be able to get together and talk about how it feels for them.

Large numbers of staff have also been able to benefit from the programme of 'Stronger together' development events that

HFMA president Sue Lorimer

Finance's big ask

The spending review firms up the overarching numbers, but leaves huge amounts of uncertainty

How should we feel after November's spending review settlement for the NHS? A sense of relief? Certainly the government made good on its promise of an additional £8bn in real terms for the NHS by 2020/21 – even if this involved a few boundary changes to what people generally understood to be the ringfence.

And a good chunk of the additional real-terms funding – £3.8bn – will come in 2016/17. Again this meets the 'frontloading' demands of finance directors (see HFMA *NHS financial temperature check*, p10), representative bodies and wider commentators.

But few finance directors in providers or commissioners will see this as a return to sunny days. The received wisdom is that the deal is the bare minimum needed and the best the NHS could have expected.

Health was not the only budget 'protected' as police, education, international aid and defence also avoided cuts. But elsewhere – for transport, energy, business and the environment – the chill winds of austerity continue to blow.

The challenge remains stark. At the halfway point in 2015/16, providers were forecasting a combined £2.2bn deficit – and eliminating

Healthcare Finance editor Steve Brown

"If we don't make real inroads into the financial deficit next year we will store up big problems for the following years"

branches have provided free of charge to members to help them develop their personal resilience and confidence. I have been hugely impressed by the commitment of our staff to the NHS and to the patients we serve.

Despite 2015 being dominated by financial problems in the NHS, there have been some really positive developments. The vanguard programme is well established, with new models of care being developed right across the country; Lord Carter's work with providers continues to progress; and the Greater Manchester devolution is preparing to go live in April 2016.

And I write this following a spending review that has allocated an additional £3.8bn above inflation for NHS England. It is a huge achievement to have been able to get so much of the additional £8bn commitment frontloaded into 2016/17.

Of course there are some significant cuts in other Department of Health budgets and the impact of these will only begin to emerge in the coming weeks. Providers will be keen to see how much of the new funds go into tariff and how much has strings attached.

The headline figure of £2bn growth in the current year didn't appear to have any visible impact on the financial performance of the service, so I'm sure that finance directors will, as ever, be cautious about next year.

But the onus is on us to use next year to drive some real transformational change. Growth figures from 2017/18 reduce significantly, so if we don't make real inroads into the financial deficit next year we will store up big problems for the following years.

NHS system leaders have secured as good a deal as we could get. It's up to us to rise to the challenge and make a real difference. I hand over the HFMA presidency to my colleague Shahana Khan this month and she will be urging us on to do just that. I wish her and all of you the very best of luck for 2016.

Contact the president on president@hfma.org.uk

any recurrent elements of this overspend will be a first call on any new funds.

There are other pressures also coming downstream, perhaps the biggest being the cost to employers of pension changes from next April. Implementing seven-day services will be another.

Perhaps the most natural state of mind following the spending review settlement is one of uncertainty. The whole settlement and indeed the *Five-year forward view* are built on the premise that the NHS needs to close a £30bn funding gap by 2020/21 and that it can deliver £22bn of improvement in that timescale.

Whether £30bn captures the overall size of the challenge posed by an ageing population, rising demand and changing disease patterns is up for debate – especially given apparent new demands such as seven-day services and the continuing pressures of ensuring safe staffing levels.

And can the service really outperform previous levels of productivity growth and deliver the implied 2%-3% efficiencies needed each year?

NHS England's five-year strategy was clear that achieving the 2%-3% would need a combination of 'catch up' (bringing less efficient providers up to the level of the best), 'frontier shift' (new models of care) and 'moderating demand increases'. However, NHS England's case was built on a 'more activist prevention and public health agenda' and the availability of social care services.

How will the cuts to non-ringfenced budgets, including public health, play into this? And are the announcements around additional money for the better care fund and a new social care precept enough to ensure the financial challenges in local government don't simply shift across the dividing line?

Staff are clearly the service's biggest cost driver and recent deficits have been exacerbated by growing agency staff expenditure. Over the long term, changes around funding (bursaries to loans) for student nurses will have an impact on providers' ability to recruit to permanent positions – but will this improve the current situation or exacerbate it?

Rising agency costs are a very immediate problem. But central initiatives including greater mandation of approved framework contracts, ceilings on numbers and (most recently) maximum hourly rate caps, have not yet had time to have an impact. Providers welcome any tools they can use to curb these growing costs, but it is not yet clear how well these measures will work in practice.

"New models of care are desperately needed – not just for sustainability reasons but to properly support changing patient need"

New models of care are desperately needed – not just for sustainability reasons but to properly support changing patient need. But the short-, medium- and long-term financial impacts are far from clear.

Part of finance directors' job is to identify risks and uncertainty and mitigate against them. But the current levels of uncertainty are unprecedented. The challenge for the finance community is to find a way to support both the delivery of financial targets in the short term, while supporting the improvement and transformation work that will help shape a sustainable future.

This will involve supporting reduction in unnecessary clinical variation, improving core efficiency (supported by the Carter review) and developing clinically and cost-effective new patient pathways. It is a big ask.

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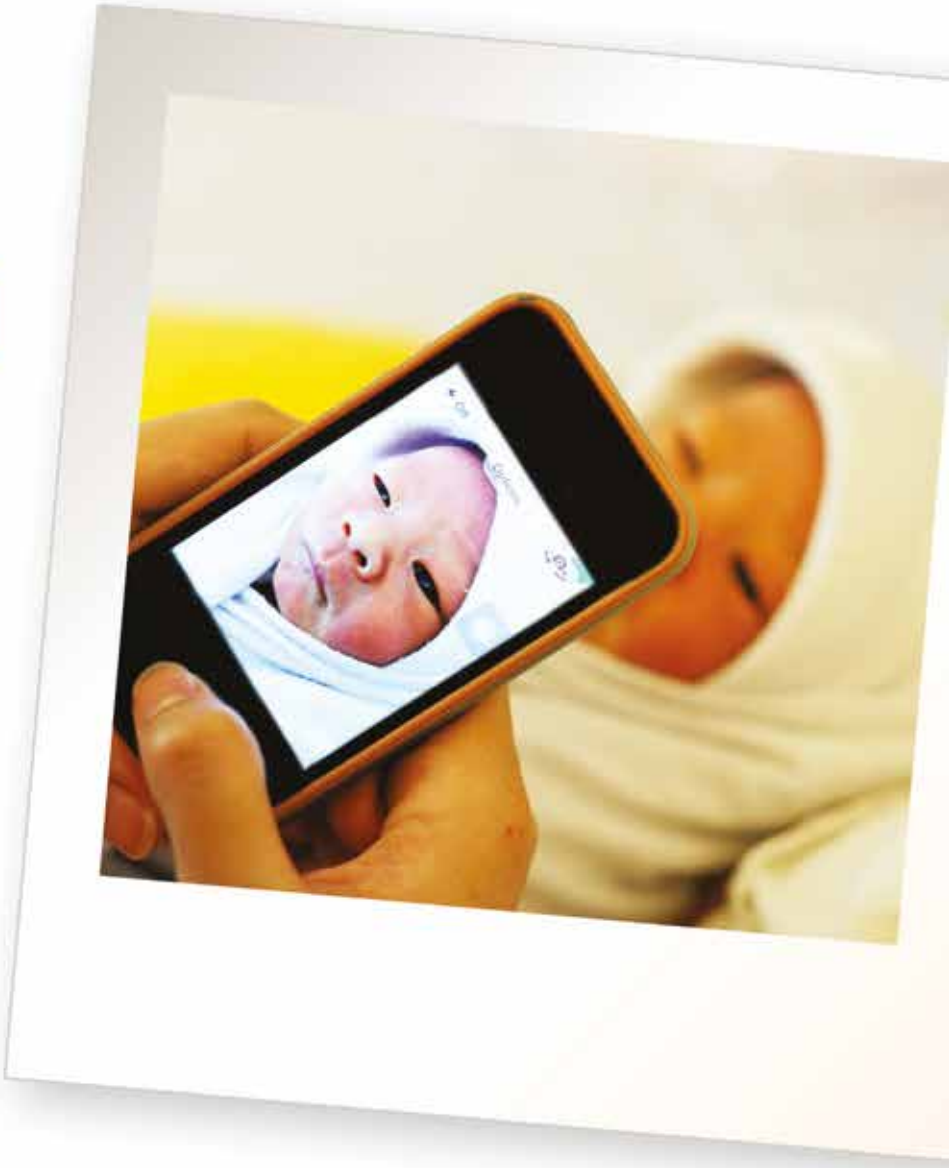

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*Source: The Independent

paediatric rethink

Next year sees the use of revised healthcare resource group currency HRG4+ in the national tariff. In the first of a short series, starting with paediatric medicine, Steve Brown examines what this will mean for payment of different services

In terms of how care is paid for, paediatric medicine faces significant changes under national tariff plans for 2016/17. The changes are the result of the adoption of a new healthcare resource group design (HRG4+) covering inpatient activity and outpatient procedures. HRG4+ builds on its HRG4 predecessor, providing a more granular currency for the tariff that enables better recognition of the additional costs of complex interventions.

Trusts have in fact been costing activity using the revised HRG4+ currency for a while. Changes were phased in over three years, starting with the reference costs in 2012/13. The changes to the paediatric chapter were made as part of the second phase, used for reference costs in 2013/14. But 2016/17 will mark the first use of HRG4+ for payment purposes (using this second phase version). While HRG4+ builds on its HRG4 predecessor, it takes a different approach in a number of areas, including the introduction of complication and comorbidity (CC) scores rather than simple with/without splits (see quick guide on page 17). But the Health and Social Care Information Centre's National Casemix Office has taken the opportunity to do some further restructuring within the paediatrics chapter.

Chapter P covers paediatric medicine (for children aged up to and including 18 years old) and neonatal medicine. Surgical procedures remain in the various other relevant HRG specialty chapters, with an age split used to differentiate HRGs for adults and children (FZ69B, for example, *Complex small intestine procedures, 18 years and under*).

Table 1: Example of how activity mapping changes under new HRG4+ design

Non-elective inpatients: long-stay FCEs

Data source			FCEs	Unit cost (£)	Total cost (£)	Inlier bed days	Avg LoS
RC 2011/12	PA23A	Cardiac conditions with CC	2,680	4,523	12,122,615	13,644	5.09
RC 2011/12	PA23B	Cardiac conditions without CC	864	2,112	1,824,458	2,673	3.09
		Total cost (£)			**13,947,073**		
		Total FCEs; total bed days	**3,544**			**16,317**	
		Avg cost per FCE; avg overall length of stay			**3,935**		**4.60**
RC 2013/14	PE23A*	Paediatric cardiac conditions with CC score 13+	224	11,048	2,474,698	2,534	11.31
RC 2013/14	PE23B	Paediatric cardiac conditions with CC score 10-12	280	6,828	1,911,902	2,580	9.21
RC 2013/14	PE23C	Paediatric cardiac conditions with CC score 6-9	729	5,391	3,930,060	5,180	7.11
RC 2013/14	PE23D	Paediatric cardiac conditions with CC score 3-5	931	3,656	3,403,282	4,818	5.18
RC 2013/14	PE23E	Paediatric cardiac conditions with CC score 1-2	691	2,740	1,893,521	2,748	3.98
RC 2013/14	PE23F	Paediatric cardiac conditions with CC score 0	455	1,741	792,169	1,387	3.05
		Total cost (£)			**14,405,632**		
		Total FCEs; total bed days	**3,310**			**19,247**	
		Avg cost per FCE; avg overall length of stay			**4,352**		**5.81**

** The PE23 HRGs make up six of 12 HRGs in the new paediatric cardiology disorder sub-chapter*

HRG4+ means an expansion in the number of HRGs used to describe paediatric medicine. The 114 HRGs in HRG4 become 194 separate groups. In addition, the previous single sub-chapter PA (paediatric medicine) has been deleted and replaced with 17 new sub-chapters relating to the relevant body systems. These sub-chapters better align with the broader HRG4+ structure, adopting the letter used to define the adult medicine/all age surgery HRG4 chapters where this is possible.

So sub-chapter PC covers paediatric ear nose and throat disorders, mirroring HRG4+ chapter C, which covers ear nose and throat disorders for adults and surgery for all patients. And sub-chapter PF covers paediatric gastroenterology disorders because chapter F covers the digestive system more generally.

The new structure has also retained the numbering convention used within the former HRG4 PA sub-chapter. The lower respiratory tract disorders without bronchiolitis covered by the former PA14 HRGs, for example, translate into PD14 (with further splits to recognise complexity).

Provider impact

To get an understanding of the impact this might have on what providers get paid, we can look at paediatric cardiac conditions in 2011/12 reference costs (the basis for enhanced tariff option prices in 2015/16 using HRG4) and the 2013/14 reference costs (the proposed basis for the 2016/17 tariff using HRG4+). While reference costs do not turn automatically into tariff prices – and simple tariff prices paid to paediatric providers will often be subject to additional tariff top-ups – they are the starting point for setting prices.

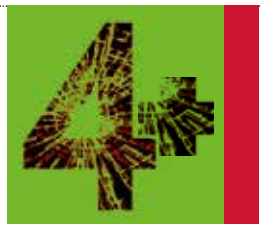
The total number of non-elective long-stay finished consultant episodes was similar across the two years – a reduction from 3,544 to 3,310, although inlier bed days went up (see table 1, page 15).

The 864 'without CC' FCEs in 2011/12 have turned into 455 FCEs with a CC score of 0 in 2013/14. You might expect the two 'no complications' categories to show similar levels of activity. However, the CC lists that accompany each sub-chapter identifying comorbidities and complications by ICD10 diagnosis codes have changed between the two

Table 2: Paediatric tariff rates 2015/16 and 2016/17 (draft)

Non-elective			
ETO 2015/16	PA23A	Cardiac conditions with CC	£3,177
ETO 2015/16	PA23B	Cardiac conditions without CC	£1,187
2016/17	PE23A	Paediatric cardiac conditions with CC score 13+	£8,912
2016/17	PE23B	Paediatric cardiac conditions with CC score 10-12	£5,454
2016/17	PE23C	Paediatric cardiac conditions with CC score 6-9	£3,938
2016/17	PE23D	Paediatric cardiac conditions with CC score 3-5	£2,280
2016/17	PE23E	Paediatric cardiac conditions with CC score 1-2	£1,329
2016/17	PE23F	Paediatric cardiac conditions with CC score 0	£831

The 2016/17 prices are draft price relativities before any adjustments for efficiency and cost inflation



years. Instead of a single CC list for the PA HRG4 sub-chapter, there are now specific CC lists for each paediatric sub-chapter.

Also, remembering that there are two years between the two sets of reference costs, it is also possible that coding has become more thorough, capturing some of the additional secondary diagnosis codes that indicate the presence of complications and comorbidities.

However the real benefits will be for the more complex activity. In 2011/12 all non-routine patients were grouped into the single HRG PA23A and had an average unit cost of £4,523. But in 2013/14, this same non-routine activity is broken into five HRGs (PE23A-PE23E) depending on the CC score (see quick guide).

This clearly highlights the different costs incurred in treating patients that were previously all collected in a single HRG. The most complex cases (CC score 13+) actually cost £11,048 and the simplest non-routine cases cost £2,740. This is a difference in costs between a patient with a score CC of 1-2 and the most complex cases (CC score = 13+) of £8,308, in large part reflecting significantly different average lengths of stay.

With the HRG4+-based 2016/17 tariff due to be finalised soon, teams will need to increase their familiarity with the changes and understand the financial impacts

Complex model

An analysis of hospital episode statistics run through the 2013/14 reference cost grouper by the National Casemix Office suggests a typical patient in this most complex group might be a two-year old with a primary diagnosis of primary pulmonary hypertension. But they might have serious secondary diagnoses that could include congestive heart failure, atrial and atrioventricular septal defects, acute bronchiolitis, wheezing and a rash. During their stay – typically more than 10 days – they might undergo one or more relatively minor surgical procedures such as a fibre optic endoscopic percutaneous insertion of a gastrostomy tube to enable stomach feeding or the insertion of central or tunnelled venous catheters.

Translating these relative costs into more granular tariff prices should mean more accurate tariffs. It is possible the old two-group approach under HRG4 would have worked for a provider with the right mix of with and without CC activity. But for a provider with a casemix heavily weighted towards the more complex activity, it is clear the simple 'with CC' tariff would have left them running at a loss.

Monitor's draft prices (published during the summer without adjustments for efficiency and cost inflation) show how tariffs might look for the new HRG4+ structure – see table 2. There is no direct read across from reference costs to tariff prices – finance practitioners have long called for greater transparency – but there are two major high level reasons for the differences.

First of all average unit costs in reference costs are simply the average of all reported costs and are not adjusted for unavoidable cost differences (represented by providers' individual market forces factor). The tariff prices represent the minimum that any provider would be paid, with providers with an MFF of more than 1 receiving more (MFF x tariff).

You also need to allow for specialist top-ups so providers eligible for either of the paediatric specialist top-ups could receive an inflated tariff price. To date this has involved a top-up of either 64% (high) or 44% (low) for eligible providers in eligible cases, but a revised approach to top-ups is proposed for 2016/17.

HRG4+ is relatively new to many finance practitioners. However, with the HRG4+-based 2016/17 tariff due to be finalised soon, teams will need to increase their familiarity with the changes and understand the financial impacts.

A quick guide to HRG4+

HRG4+ was developed by the National Casemix Office, part of the Health and Social Care Information Centre, and builds on the pre-existing currency HRG4. Next year – 2016/17 – will see the new currency used for the first time for payment as part of the national tariff. But costing practitioners should be familiar with it, as it made its first appearance in the reference costs submission for the 2012/13 financial year.

That was the first of three phases over which the new currency has been introduced. Approximately 25% of HRG subchapters were redesigned for reference costs 2012/13, a further 25% for reference costs 2013/14 and 25% again for 2014/15.

The remaining 25% of sub-chapters did not require a redesign. Next year's tariff will in fact use the phase 2 design of HRG4+ (2013/14 reference costs) with an expectation that the final changes will be brought in as part of phase 3 in the 2017/18 tariff (using the 2014/15 reference cost design).

HRG4+ is more granular than its predecessor. Monitor and NHS England say there are around 2,000 currencies in HRG4+ compared with the 1,300 in HRG4. In fact these numbers just refer to the HRGs with national prices. The HSCIC points out that its engagement grouper for the 2016/17 tariff includes 2,361 HRGs.

The key change responsible for the increase in HRG volume is a more sensitive approach to the impact of complications and comorbidities on the costs of care. The current HRG4 currency, versions of which are used in both the default tariff rollover and enhanced tariff option tariffs, basically splits many HRGs by with or without CC (complications and comorbidities). But under HRG4+, CC scores are introduced. What might have been a two-way with or without split in HRG4 might become a four-way split (see example below for root HRG FZ67).

The CC score is built up using a scoring system related to secondary diagnoses – each recorded CC is assigned a score and these are summed to derive a total CC score. HRG4+ can also take account of multiple procedures, formalising the use of procedure grouping logic in some areas and using single or multiple intervention splits as a proxy for disease severity in others. Again, the overall aim is to ensure that higher cost spells are separated from more standard cost spells.

FZ67 – major small intestine procedures 19 years and over

HRG4			HRG4+	
			FZ67C	CC score 7+
FZ67A	with CC	→	FZ67D	CC score 4-6
FZ67B	without CC		FZ67E	CC score 2-3
			FZ67F	CC score 0-1

cost mapping

Understanding where you stand cost-wise should be valuable intelligence, but the reference cost publications seem to happen without anyone paying much attention. With a continuing and even growing role, is it time people took more notice of the annual cost publication, asks Steve Brown

It can be all too easy to dismiss the annual publication of NHS reference costs. An audit of the 2013/14 costs found that nearly half of a sample of 75 acute providers had materially inaccurate reference cost submissions. And with sector regulator Monitor promoting major changes to NHS costing through its costing transformation programme, switching the service from what is traditionally seen as top-down reference costs to more accurate bottom-up patient-level costing, it is hard to know what to make of the ongoing reference costs collection and publication.

But despite concerns about some inaccuracies, reference costs continue to play a significant role in the NHS right now – and arguably that role is increasing. The national average costs produced by reference costs – using a currency based on healthcare resource groups and outpatient attendances – underpin the national tariff and are likely to do so for several years yet.

They also form the basis for many local prices outside of national tariff areas. And the cost data will be needed to inform development of new payment approaches such as year-of-care and capitation contracts.

It is also too simplistic to view reference costs as a completely separate approach to patient-level costing – reference costs bad, patient-level costing good. In fact many organisations have been pursuing patient-level costing for a number of years. In the latest reference costs, some 128 providers used patient-level costing to inform some or all of their reference costs return.

Reference costs reality

Monitor's proposals for 'transformed' costing will see a revised methodology adopted in a consistent manner across all providers, but the reality is that patient-level costing is already driving some of the numbers in reference costs, particularly in the acute sector. In some ways, reference costs should act as a marker for how costing teams are stepping up to the challenge of improving costing in general, including the adoption of patient-level costing.

Patient-level costing is already driving some of the numbers in reference costs

In its reference cost reports, the Department of Health lists a number of local and national uses of the cost data. But this year a new one has been added as Lord Carter is proposing to use the reference costs as the starting point for a new efficiency metric – the adjusted treatment index. This effectively builds on the reference costs index to support NHS providers in making up to £5bn of productivity improvements.

The Department, which collects reference costs on behalf of Monitor, published the 2014/15 data in the middle of November. The latest publication shows how £61bn of NHS funding was spent by 239 NHS providers delivering care in the last financial year. While the value of reference costs may divide opinion, the high-level statistics certainly qualify as interesting reading.

The £61bn – up from £58bn in the 2013/14 collection – represents just over 55% of total NHS revenue expenditure. Admitted patient care (day case, elective and non-elective) – covering 2,782 treatments and procedures and more than 16 million finished consultant episodes – accounts for 41% of reported costs. Outpatient attendances account for 14%, mental health 11% and community services a further 9%, with accident and emergency, outpatient procedures and other non-acute services making up the balance.

More than a third of the £25bn spent on admitted patient care is in just three areas: the musculoskeletal system (16%, £3.9bn); the digestive system (12%, £3.1bn); and cardiac care (10%, £2.4bn). Add in respiratory (£2.1bn) and obstetrics (£2bn), and together the five HRG chapters, out of a total of 21, account

FCE-based average costs			
Point of delivery	**2012/13 (£)**	**2013/14 (£)**	**2014/15 (£)**
Day case	693	698	721
Elective inpatient*	3,366	3,375	3,573
Non-elective inpatient*	1,489	1,542	1,565
Excess bed days	273	281	303
Outpatient attendance	108	111	114
A&E attendance	114	124	132

**excluding excess bed days*

for more than half of the total admitted patient care spend.

The average costs for care in different settings – an elective inpatient episode at £3,573, for instance – may not provide any meaningful benchmarks. But they should provide some useful 'rule of thumb' ball park figures to inform general discussions about how pathway costs fit together (see table above).

The reference costs split effectively into two parts – the reference costs index (RCI) and the schedule. The RCI provides an indication of relative cost difference between different NHS providers. In essence, it does this by taking a provider's actual costs (unit costs x activity summed across all HRGs) and dividing this by the expected costs (national average mean unit cost x activity) – multiplying the result by 100. A trust with a score of 100 has costs equal to the national average. A score of 110 suggests costs are 10% above the average, while 90 indicates 10% below average costs.

Hospitals face some unavoidable cost differences (reflected in provider specific market forces factors or MFFs). RCIs are most frequently reported having taken account of these unavoidable cost differences – adjusted using the MFF.

HRG-based tariffs

In contrast, the schedule provides costs at individual HRG level – and hence provides the starting point for HRG-based tariffs. (Typically HRG costs for one year will inform the tariff three years later – 2014/15 costs providing a tariff in 2017/18, for example). As well as providing national average costs for each HRG, the schedule shows lower and upper quartile costs across all submissions and average length of stay. The costs reported are the actual costs reported – not adjusted for MFF.

The RCI is possibly the most contentious part of reference costs. In many ways, RCIs do not compare like with like. While HRGs are a way of comparing costs for similar activities, each HRG will in fact cover a range of cases of differing complexity. Within a single HRG, a teaching hospital or specialist provider might expect to see a more complex caseload than a district general hospital, perhaps as a direct result of tertiary referrals from that general hospital. This will inevitably mean the specialist provider reports higher costs for that HRG than more routine service providers – pushing it higher up the RCI range.

As an index that shows costs relative to other providers, the index is also sensitive to the accuracy of costs in other providers. One provider could look expensive or cost-effective compared with another based on the accuracy of the costs of that other provider – not because of its own costs.

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Keeping this in mind, the figures for 2014/15 show a range across all providers of 75 to 141 – or from 25% lower than national average costs to 41% higher. This full range of 66 percentage points is slightly narrower than the 78 percentage point range in 2013/14. However, this full range includes all organisation types – including mental health, community providers and ambulance trusts.

Looking at just providers delivering primarily acute services, where cost and activity data is arguably more robust and where the currency is more established, reveals a tighter range of just 28 percentage points – three percentage points tighter than last year.

This range stretches from 116 (King's College Hospital NHS FT) and 114 (Hinchingbrooke Health Care NHS Trust and University Hospitals Birmingham NHS FT) down to 88 (Surrey and Sussex Healthcare NHS Trust and Kingston Hospital NHS FT).

This range only tightens up slightly more if you look at the data by different provider types:

- Large acute, 23 percentage points
- Medium, 24 percentage points
- Small, 25 percentage points
- Teaching, 27 percentage points.

This reflects the fact that there are examples of all provider types towards the top and bottom of the index range.

Only 52 providers across all types (out of a total of 239) have costs that are more than 5% higher than national average costs. And when you look just at acute and teaching hospitals (not including the specialist providers), this falls to 22 or just 16%.

Only 52 providers have costs more than 5% higher than national average costs

Acute providers are traditionally regarded as having more robust costs than other sectors, driven by the existence of a national tariff and better activity data. But mental health trusts have also put more of a focus on costing in recent years – and the introduction of a cluster-based currency to underpin local pricing has made services more comparable. The full range of RCIs for mental health trusts stretched from 75 to 141. However, five trusts' RCIs are considered to be outliers. Stripping these providers out leaves a range of 81 to 124.

Many organisations regard the RCI as providing only a rough indication at best of relative costs. However, there are still organisations that report the annual index to their board and track performance over the years as a measure of improvement both of the costing team performance and of service efficiency.

Using the schedule

The schedule is arguably the more used part of reference costs – providing the starting point for national tariff setting and often feeding into local contracting, either using national average costs or local costs to set local prices. Given the relationship with tariff prices, perhaps the first thing to look at is relative stability of costs between years.

Back in 2012, Monitor published an evaluation of the payment by results reimbursement system that raised concerns about the impact that fluctuations in costs were having on the volatility of prices from year to year. In particular it said that 40% of individual prices had changed by 10% or more from one year to the next since 2005/06.

Average costs are likely to be more volatile for low-volume activities, where small numbers of high- or low-cost events could have a major impact. To compensate for this, we looked at HRGs in the 2014/15

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schedule that also existed in 2013/14 (HRG4+ is being introduced in phases) and that included at least 100 episodes of activity.

Looking first at HRGs across all settings combined, just over 1,300 HRGs exceeded the activity threshold and 21% of these had changed (up or down) by 10% or more compared with the previous year's costs. Treating HRGs in each setting separately (day case, elective, non-elective) revealed 3,350 setting-specific HRGs meeting the activity criteria, with 32% showing a cost change of 10% or more.

The schedule enables pathways to be examined for specific procedures and treatments. For example, 14,220 tonsillectomies were undertaken on adults in 2014/15 (HRG CA60A) at an average cost across all settings of £1,430. The vast majority of these were undertaken as elective inpatients (5,617) or day cases (8,387).

According to the schedule, day case activity now accounts for 59% of adult tonsillectomies, up from 53% in 2013/14. This increase may indicate that a best practice tariff – incentivising day case activity – is having the desired effect, providing benefits to patients.

The benefit for providers not only comes in the improved price paid for day cases but by incurring lower costs. According to reference costs, an average day case tonsillectomy costs £1,257 compared with £1,651 for an elective inpatient stay.

The 2013/14 reference costs audit does not make good reading for NHS costing. Monitor said it was 'concerned that almost half of trusts audited submitted materially inaccurate reference costs'. In particular it said that 'the lack of compliance suggests that most acute trusts … do not see the benefit of devoting resources to producing accurate costing information'. Monitor has suggested before that NHS providers will need to increase costing teams to meet the requirements of its costing transformation programme.

"As ever, more can be done, and we continue to work with others to help improve costing"
Sarah Butler, DH

A survey, run alongside each year's reference costs collection, shows how thin some costing teams are. In acute trusts, on average, fewer than two whole-time equivalent finance staff are running costing systems and producing cost information with minimal support from IT staff. This is closer to one member of staff for ambulance and community providers.

Costing teams are often also responsible for service line reporting, patient-costing work and education and training reference costs – as the service looks to move towards an integrated collection for reference costs and education and training costs.

This may well need to increase to improve reference cost quality, meet the needs of ongoing costing work, such as for education and training, and enable the switch to Monitor's proposed new patient costing regime.

The value for money report – to support the costing transformation programme – is due in the new year and will be crucial in helping the service to understand the importance of this investment. However, the recent audit is based on the 2013/14 costs and there is an expectation among national bodies that providers – not just those subject to the audit – will have responded to many of the issues raised, leading to improvements in the quality of the 2014/15 data.

Focus on accuracy

According to the Department of Health's deputy director of performance, Sarah Butler, good-quality cost data is more important than ever, given the role it has in supporting local decision-making, underpinning tariff and the development of payment systems – and, more recently, the development of efficiency metrics. But further improvements are needed.

'Both costing and cost collection have seen significant improvements over the past decade, which is s huge credit to everyone who works in the area both at local and national level,' she said. 'But as ever there is always more that can be done and we continue to work with organisations to help improve costing.'

At the national level, this includes the Department working with Monitor and other arm's-length bodies on the costing transformation programme, providing an ongoing collaborative process to support providers to improve their costing and improve the cost collection processes. But Ms Butler said the improvements would not be delivered by central initiatives alone.

'Ultimately, NHS providers have the most to gain from understanding their costs better. And so they have the responsibility to improve their internal costing processes and their systems to help better understand the cost of delivering services and to improve the quality of data submitted,' she said.

She suggested these improvements needed to start with organisation-wide recognition of the importance of costing – beginning with the board. 'Experience tells us that it is only through organisations actively using data and through good clinical engagement that we will see real improvements,' she said.

Greater use of the cost data nationally would also mean greater scrutiny. 'As the reference cost data set is being used more and more at a national level, it is even more important to focus on the quality of reference costs,' Ms Butler added..

The publication of annual reference costs has become a low-key affair. There is no big fanfare, no press release and not a huge amount of attention paid to them by the costing community, whose big focus is on completing the annual return rather than the compiled results. Unarguably, they can be better – as the 2013/14 audit has made perfectly clear – and will eventually be superseded by richer patient-level data. But given their importance as the starting point for tariff prices and their new role in underpinning the adjusted treatment index, they should perhaps be paid a little more attention.

Women leaders in health

Nearly two-thirds of all NHS finance staff are women, but at the most senior level they account for just over a quarter of finance directors. An FFF/HFMA roundtable set out to discuss why and what might be done to improve the gender balance. Steve Brown reports

Women dominate the NHS workforce, representing more than 77% of staff. And it is a position that is mirrored in the NHS finance function, where latest figures suggest that women account for 62% of all finance staff.

However, the gender split is very different at the most senior levels within the service. According to NHS Employers' estimates, just 41% of chief executives are women. And in finance, the position is even worse, with just 26% of finance directors being women (see figures page 28).

The HFMA, working with Future-Focused Finance, convened a roundtable event in November, bringing together women and men with a specific interest in the subject to discuss what might be done to deliver a better representation of women at the top of the finance function.

Sue Jacques, former finance director and now chief executive of County Durham and Darlington NHS Foundation Trust, said the finance function was not alone in facing a gender imbalance at the most senior levels – and nor was this a UK-only problem. However, there was a real opportunity to effect change.

'We have a unique network in the HFMA that enables us to act collectively if we can identify the right actions,' she said. 'And FFF, as part of its 'Great place to work' work stream, has already built up great momentum on plans to transform the function. In particular, this is looking to ensure finance departments provide excellent working environments and that finance staff are supported in developing their careers. Supporting women so that they make the most of their careers and the NHS benefits from their talents is a key part of this.'

There was recognition that the issue was not specific to NHS finance. Other statistics show women only hold 40% of NHS board positions and this is higher than in the private sector. It was recently announced that FTSE100 companies had achieved a voluntary target by exceeding 25% of board positions filled by women, although much of this was achieved through non-executive appointments. Nonetheless, Ms Jacques said the NHS figures were compelling.

Delegates agreed that the current imbalance meant the NHS was missing out. Research suggests that greater gender balance in senior roles improves financial and operational performance. Some commentators believe better balanced leadership could support changes in culture needed to underpin reform.

In summary, there was a consensus that the NHS would benefit from a better gender balance at the most senior level and that something was happening to deter or prevent some women from seeking these roles.

Jennifer Howells, NHS England regional finance director for the south, said there was no value judgement on current managers, but the statistics were simple and clear. 'Given that more than 50% of NHS staff are women, more than 50% of the finance function are women and around 50% of the qualified accountants in the NHS are women, the fact that we don't have at least 50% of our senior leaders as women means we are losing, or possibly not attracting, some of the best people for the job,' she said.

There was agreement that improvements in gender balance at the most senior levels needed to be taken forward alongside improvements in diversity more generally. Senior finance post holders should better reflect the populations they serve in terms of black and ethnic minority representation as well as gender. However, it was agreed that there was value in understanding any specific issues that might be hindering the appointment of women to senior finance roles.

'Research has shown that if a job is advertised and a man thinks he can do 60% of what is required, he will apply. But a woman who thinks she can do 90% of what is needed won't apply, because she doesn't think she has all the right skills,' said Ms Jacques, who recently attended

Roundtable participants (l-r)

- Jo Spear, national officer, Managers in Partnership
- Jane Tomkinson, chief executive, Liverpool Heart and Chest Hospital NHS FT
- Roger Kline, research fellow, Middlesex University Business School and director, NHS Workforce Race Equality Standard
- Cathy Kennedy, deputy chief executive, North East Lincolnshire CCG
- Rebecca Edwards, former management accountant, Chesterfield Royal Hospital NHS FT
- Caroline Barnwell, finance lead for financial strategy and allocations, NHS England
- Sheree Axon, director of organisational change and programme delivery, NHS England
- Sue Jacques, chief executive, County Durham and Darlington NHS FT
- Sam Sherrington, nurse leader at Trafford CCG and FFF stakeholder lead
- Audrey Fearing, partner, EY
- Stephen Eames, chief executive of the Mid Yorkshire Hospitals NHST
- Jennifer Howells, regional finance director for the South, NHS England
- Claire Yarwood, director of finance, Tameside Hospital NHS FT
- Sue Lorimer (HFMA president), North of England business director, NHS TDA

an HFMA US conference on women finance leaders. 'There is also a lot of research that says that success is as much correlated with confidence as it is with competence.'

Confidence is critical

Claire Yarwood, director of finance of Tameside Hospital NHS Foundation Trust, underlined the point. Having worked with prospective finance directors ahead of creating clinical commissioning groups in Greater Manchester, confidence was a key issue with many potential women candidates. 'Some needed persuading that they could achieve this level,' she said.

HFMA president Sue Lorimer, North of England business director for the NHS Trust Development Authority, said there was a need to understand at what point in their careers some women lost the ambition to push for the top jobs or felt these roles were unattainable. 'We need to work out what we can do so they are as ambitious as they possibly can be and are helped to realise those ambitions,' she said.

The perception of the finance director role was seen as one potential stumbling block. There is a view that the role is 'always on', often demanding 60- to 70-hour weeks and diaries full weeks in advance. Burnout in colleagues and the level of personal responsibility often taken by or imposed on finance directors – heightened in the current difficult financial environment – also contribute to putting people off.

While the perceived demands of the jobs could deter men and women, Jo Spear, national officer for union Managers in Partnership, thought it might hit women harder. 'Women with children often still feel it is their personal responsibility to see their children safely into school,' she said. As a result, flexible working and childcare arrangements remain big issues for women – especially given that school start and finish times are typically incompatible with long, inflexible office hours. With a lack of work flexibility, she said, some women felt they had to choose between family and career.

Mrs Yarwood said that having spent an extended period off work sick herself, a good work-life balance was now a non-negotiable part of her role – and should be for all men and women in the finance function. 'When I came back to work, I tried to influence my organisation on work-life balance, but mostly I have taken ownership of it for myself and taken positive steps to create a balance for me,' she said. 'I now work flexibly and I'm keen to apply it to my whole team.'

She wondered whether the problems with the perception of the most senior jobs might start below director level. 'The deputy role might contribute to the ceiling,' she said, referring to their often heavy workload. 'If you don't ensure the deputy has a good work-life balance, their perception (and that of those below them) is that it will be the same or worse as finance director. It is possible that seeing the deputy role puts people off aspiring to be finance director.'

Cathy Kennedy, deputy chief executive at North East Lincolnshire Clinical Commissioning Group, said the whole deputy director structure may need examination. She leads the 'Great place to work' work stream as part of the Future-Focused Finance initiative, which aims to define the characteristics needed to be finance leaders and to understand how career paths might look in the modern NHS finance structure. 'It is a wider issue, but is our traditional structure of one deputy below a director really the best?' she asked. 'Are we looking for skills and attributes in deputies that aren't what you would necessarily look for in a finance director?'

This can have knock-on implications. 'For example, the classic deputy who runs the internal organisation and makes everything happen on time is then expected to slip into an externally-focused system management role,' she added, even though they may not be suited for this role change. 'Perhaps there is someone below them with the right strategic attributes who can't be appointed finance director because they haven't been deputy.'

Flexible working

Attendees suggested part of the response to these issues needed to be around providing greater flexibility in working arrangements and developing more of a team approach to

Claire Yarwood (left) and Caroline Barnwell

Top: Audrey Fearing and Stephen Eames Above: Cathy Kennedy and Jane Tomkinson

delivering the finance department's outputs. And Ms Jacques suggested that organisations that were not offering flexible working to help retain staff were missing out.

Jane Tomkinson, chief executive of Liverpool Heart and Chest Hospital NHS Foundation Trust and the inaugural winner of the HFMA Finance Director of the Year Award in 2007, said flexibility was increasingly being offered by switched-on organisations – and not just to accommodate women. 'In my organisation, we have conversations around the needs of staff for childcare or care of elderly dependents. Some staff work at home some days, start late or get extra support during school holidays.'

She said the service should move away from a narrow focus on inputs – time in the office, for example – and look at the outputs. Organisations needed a culture of supporting flexible working as it was in their interests. And this culture and support needed to be more visible. However, others pointed out that the ability to work flexibly often reduced as people rose up the management structure.

"If you don't ensure the deputy has a good work-life balance, their perception is that it will be the same or worse as finance director"
Claire Yarwood

Rebecca Edwards was a senior management accountant at Chesterfield Royal Hospital NHS Foundation Trust, but after finding it difficult to combine her professional role with looking after young children at home, she gave up her job. She continues to feel well connected to the NHS finance family and is a value maker with FFF, but work-life balance is a key consideration.

'I don't lack confidence and I still aspire to be a finance director, but I can't see it happening,' she said. This was despite her employer being very flexible in how she could work and dropping her role to three days a week.

She was also sponsored by senior colleagues – a formal or informal arrangement where senior leaders 'look out for' specific individuals, promoting their interests, giving protection and supporting their career progress. 'I had great sponsorship and I was mentored and coached, but none of it made a difference in terms of the work-life balance I wanted,' she said.

Ms Edwards said the idea of stepping up a further level given the challenges she had with her existing work-life balance was unthinkable. 'I just see around me finance directors and chief executives working ridiculously long hours and with diaries full for two months in advance. If there are senior leaders who do work flexibly, I don't know about them.'

The attendees agreed the NHS needed a culture where appropriate flexible working was promoted as the norm – at all levels including the most senior. Sam Sherrington, nurse leader at Trafford Clinical Commissioning Group and head of stakeholder and cultural transformation for Future-Focused Finance, said the service still had hang-ups about 'presenteeism'. 'There is sometimes an attitude of "if you aren't there, then what are you doing?"', she said. 'I've gone part time this year for the first time in my career and it has been suggested to me that I am just a bit less committed. Some people view part-time working or flexible working as a lack of commitment. But if we don't get work-life balance and wellbeing right, it can have a big impact on people personally and professionally – and that is not gender specific.'

Ms Lorimer acknowledged that there was still an 'old-fashioned element' in the finance director community. 'They don't like flexible working because they didn't have it, and see starting at seven and finishing at seven as the definition of good work,' she said. 'We need to find ways of challenging that, because if people in structures beneath them are aware of this, then they have nowhere to go.'

Where there is good practice on flexible working, it needs to spread. There was agreement that culture needed to change so that flexible working practices were normalised and people using flexible approaches were not regarded as receiving special treatment.

'It is about how the NHS values people's commitments in their personal lives,' said Ms Howells. 'People have their diaries planned for months in advance, but if the secretary of state called they would drop everything to accommodate him.

'But important personal commitments are not always recognised as having the same value. People juggle all sorts of jobs and priorities, and should feel okay to say: "I've got a really important personal commitment". We need everybody to value work-life balance.'

Stephen Eames, chief executive of the Mid Yorkshire Hospitals NHS Trust, said flexibility

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was increasingly important to retain and attract both men and women to senior jobs, particularly in the current climate. 'Some jobs are so demanding, requiring people to work out of hours and at weekends,' he said. 'But many of these roles can, at least in part, be done flexibly – for example, people staying in touch with work from home.'

This was vital to counteracting growing burnout in senior managers, he said. 'The demand isn't going to change, so we need to manage in a different way and we need teams to be understanding and supportive of different approaches.'

Sue Jacques added that managing demands as a team rather than as individuals – sharing responsibilities – would support greater flexibility and help to provide important development opportunities for managers.

Role models needed

The need for role models more generally was stressed by several delegates. Ms Tomkinson said other disciplines faced similar challenges and had identified the same need. Just a small proportion of cardiac surgeons are women, for example, she said. 'The fundamental issues for women doctors were the lack of strong role models, the lack of access to them and the lack of sponsorship for would-be women surgeons by senior male colleagues.' Career progression was often more about 'who you knew' than about how competent you were, she added.

"Things have changed in NHS finance over recent years. Sue Lorimer is the fourth woman to lead the profession as HFMA chair or president"
Jane Tomkinson

She said there were already role models for women finance leaders, women who had reached the top levels of the profession and found a balance between work and home life. But she accepted more could and should be done to increase their visibility and to share their experiences and any flexible working practices that helped them.

As more women take on the most senior roles, colleagues would be encouraged to aspire to these roles, creating a virtuous circle, said Ms Tomkinson. 'Things have changed in NHS finance over recent years,' she said. 'Sue Lorimer is the fourth woman to lead the profession as HFMA chair or president and will be succeeded by Shahana Khan in December. However, it will take time before these changes permeate through the system.'

Consultancy EY has put a big focus on developing a culture that sees flexible working as normal. Partner Audrey Fearing explained that all partners are required to promote flexible working and demonstrate this through their own practice. This involves running open diaries, including where time is taken off for personal commitments. 'I need to demonstrate to my team that this is okay for me and it is okay for them,' she said. 'If you haven't got role models at the top, it will be a really slow burn.'

The organisation also looks to support diversity in senior leadership by creating story boards of partners' career paths – demonstrating a range of diverse backgrounds. 'We've made videos or blogs, too, explaining how we got to where we are, outside interests and what is important for us,' she added. 'This has helped our senior managers to see the art of the possible and that we are from the same backgrounds as them.'

There was agreement that the current under-representation of women at senior levels could not be left to fix itself and the service should look to force the pace of change. A report, *Women in the workplace 2015* by McKinsey and LeanIn.Org, suggests that, based on the slow progress in the US over the past three years, it would take 100 years to reach gender parity in the C-suite (chief officer ranks). It identifies steps to promoting gender equality:

- Track the key metrics so you understand the problem
- Show that gender diversity is a top priority
- Identify and interrupt gender bias
- Rethink work
- Create a level playing field.

Delegates endorsed these high-level actions but saw two as priorities – demonstrating senior genuine commitment to gender diversity and creating a level playing field.

Sponsorship opportunity

Again leaning on US experience, Ms Jacques suggested that sponsorship should be one of the actions explored by the NHS and the finance function. This is where senior leaders 'look out for' specific individuals – promoting their interests, providing protection and supporting their career progress.

'It is not a familiar concept in the UK, though it probably exists informally across the NHS,' said Ms Jacques. Experience in the US suggested people with sponsors progressed further than those without, and that women with sponsors were more likely to succeed, she added.

Ms Jacques said she had personally benefited from informal sponsorship, but getting the




Top l-r: Sue Jacques and Sue Lorimer Bottom l-r: Jo Spear and Rebecca Edwards

practice more widely used and formalised would reap rewards. Mr Eames said sponsorship relied on spotting talent in need of support, and this called for a systematic approach to talent management, which could present difficulties.

Ms Spear believed talent-spotting was open to covert bias. 'We all have a tendency to look for a mirror image,' she said. 'But we need to ensure that management programmes are accessible to different types of people – extroverts and introverts, for example.'

Mr Eames agreed, insisting that 'bias gets in the way' of good decision-making and that leaders needed to be 'gender blind' as the point was to get the best talent and performance for the organisation.

Sheree Axon, director of organisational change and programme delivery at NHS England, agreed that targeting talented individuals with development and support made sense, but support should be provided for women across the whole function and particularly in non-management grades.

'There are a whole group of women who have never received any development – sometimes working their whole careers with no training or direct support,' she said. 'There is huge talent and commitment at band 7 and below – and they typically don't get the opportunity for sponsorship or talent management programmes.'

Ms Axon suggested that the well-established Springboard women's development programme could usefully be targeted at women across the NHS finance function. With a tried and tested format delivered widely across the public and private sectors and internationally, the programme helps women to improve networks, identify priorities and improve communication skills. 'Supporting people to be the best they can be shouldn't just be about the top jobs,' she said. She suggested FFF or the HFMA might look to support the development of Springboard trainers or run programmes regionally.

"We need to challenge the stereotypes and perceived hierarchies – for example, that you can't be an acute FD if you haven't worked in the acute sector"
Cathy Kennedy

EY has been using a structured approach to talent management for a couple of years, where senior executives are asked to sponsor talented individuals. 'I was sceptical at first,' said Ms Fearing. 'I was asked to sponsor three women all identified as having talent and good ratings at their year-end reviews. I didn't know them or work directly with them. My job was to coach and sponsor them and ensure they got the right roles going forward.

'I was uncomfortable at first – "If they underperform, what does that make me look like?" I thought. We had to spend time developing trust on both sides. But I'm a convert. Their positive reaction to the process and the difference I was able to make in terms of development opportunities and also challenging their approach has been incredibly rewarding for me personally.

'As an organisation, in just two years, we've seen a significant increase in promotion and retention within our sponsors.'

There was agreement among delegates that a more co-ordinated and overt approach to sponsorship would make sense. 'For finance, the sponsor wouldn't necessarily need to be someone in the function – but they would need to be someone influential,' said Ms Jacques.

Board buy-in

Getting high-level commitment to improved gender equality was a big talking point. 'Unless the leadership is focused on diversity, you will get sub-optimal results,' said Mr Eames. And everyone agreed this had to go beyond a box-ticking exercise and couldn't just be something managed by the human resources team. 'The board has got to do more than support diversity,' said Ms Fearing. 'It has to live it.'

Caroline Barnwell, finance lead for financial strategy and allocations at NHS England, is jointly leading a diverse leadership work stream for the Future-Focused Finance initiative. She undertook a review of literature and research on women in leadership to underpin the FFF work and said the research was clear on the value of diversity. It was also clear that organisation leaders had to really buy-in to better equality. 'Diversity should be part of an organisation's core values and be more than just a policy. It has to be embedded from the top down,' she said.

Roger Kline, research fellow at Middlesex University Business School and director of the NHS Workforce Race Equality Standard, said improving race and gender equality shared challenges. 'The research suggests you need a very clear vision at the top, measurable outcomes (with the emphasis very definitely on outcomes not process), accountability and transparency,' he said. 'If you have these things in place, you can make a difference.'

He said he was 'hostile to the idea' that an approach to ensuring diversity could be based around the ability of an individual to challenge a decision of a recruitment panel. Ms Kennedy agreed, saying an FFF survey showed diversity policies were widespread, but not necessarily indicative of having the right support mechanisms or behaviours in place. 'If you feel you've faced discrimination or bias and you are pointed straight at the grievance procedure route by default, it has immediately become adversarial. This should be the last resort, not where we start,' she said.

But how can boards live out their good intentions on diversity? Mr Kline said policing diversity should not be an individual's responsibility. 'We need to turn it around,' he said. 'The employer has the responsibility to recognise there are levels of disadvantage and there is not a level playing field.'

There are things that organisations can do, he said. Employers could make it clear to employment panels that there was an expectation that senior management would better reflect the staff and population. This

The case in numbers

The roundtable reviewed the latest data by Finance Skills Development and the HFMA as part of their biennial finance function census. The 2015 collection was undertaken over the summer and full analysis will be published in the new year, but delegates were given early data on the male-female split by Agenda for Change (AFC) band.

Women make up 62% of all finance staff. However, there is a clear trend of reducing numbers of women as you move up through the bands. At bands 1-4 (including junior non-AFC positions), women represent 74% of staff. This falls to 63% for bands 5-7 and 49% for bands 8a-9, culminating in just 26% of finance directors (out of a total of more than 470) being women.

Looking specifically at the individual bands, it is between bands 8b and 8c that the balance shifts in favour of men. At band 8b, women still represent more than half of staff (53%), but this falls to 46% of all band 8c staff. The decline continues – 40% at band 8d and 35% at band 9 (38% including very senior managers off the AFC scales).

Ms Jacques said the data was compelling and while improvements had been made, the pace of change was slow. A review of finance staff development and training in 2000 reported that women represented 18% of finance directors in 1998. More recent HFMA/FSD census figures showed this had risen to 21% in 2009, 23% in 2011 and 27% in 2013. The census figures for 2015 show a small percentage drop on this figure to 26%.

would stop short of involvement with individual appointments but it would be clear that over time a better balance should be achieved.

Organisations then had to get involved actively and monitor the position – how else could they ensure their intentions were being realised? NHS providers have to start this year demonstrating progress against a number of indicators of workforce race equality, including levels of BME people on the board. Mr Kline said this was an important step in ensuring employers took notice of and responsibility for the make-up of their senior management teams.

He said there were other examples of different approaches to organisations taking this responsibility and not simply taking a passive role to career progression. For example, as part of an 'on-boarding' programme, a group of trusts monitors staff against their own career goals and ambitions based on regular interviews. 'The point is that if staff don't achieve these milestones, someone wants to know why. The employer is taking responsibility and research suggests this kind of approach works,' he added.

Ms Jacques said boards had to be clear about their intentions. 'Organisations have to intend for this to happen, to see greater diversity as a good thing, and to actively make it happen rather than for it to happen in a haphazard way.'

There had to be different approaches at different levels, said Mr Eames – at the system level, as an organisational framework, and in supporting individuals. Mr Kline agreed but was uncertain about the value of targets being set across the whole NHS. 'It works if organisations set targets themselves,' he said, or they make it clear where they expect to see progress.

Career paths

Ms Jacques added that there was also a potential role for the finance function in underpinning improvements in equality at senior levels, supporting individuals and organisations. Mrs Yarwood believed this was important, especially given the different development opportunities and approaches to equality in different settings. 'Getting the right finance people trained and moved around organisations to get skills and experience across a patch needs a more co-ordinated approach at the geographic level, tackling diversity and development at the same time,' she said.

Ms Axon believed the fragmentation of the system meant people often didn't know what their career path looked like anymore. In addition this meant they didn't know what skills and experience they needed to be successful.

'Our approach to talent management looks at performance but doesn't talk to individuals about their aspirations and ambitions and about what their career path might look like,' she said.

The approach to staff retention during reorganisations, while understandable and well-intentioned, acted as a barrier to change and to increased diversity, she added. 'Every time we go through an organisational change, we make appointments from the pool of people at risk – so in a way we are just reappointing the same people. While this is right in terms of protecting jobs and mitigating the costs of reorganisation, we miss the opportunity to bring in fresh talent.'

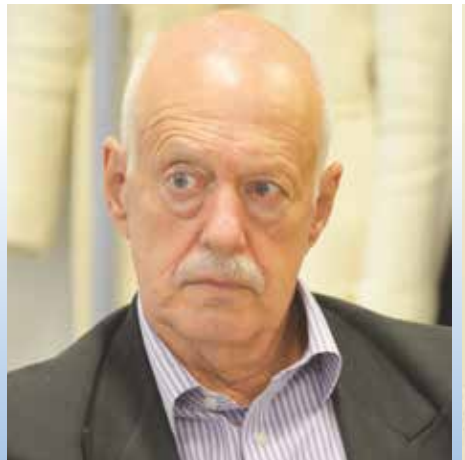
Ms Kennedy said the career path issue was part of what FFF was trying to tackle – work was in hand to describe what good finance leaders look like and the different experience and backgrounds that contribute to these qualities. This could help address organisations' tendency to appoint similar candidates.

'We need to challenge the stereotypes and perceived hierarchies – for example, that you can't be an acute finance director if you haven't worked in the acute sector,' she said, adding that in the current financial environment, organisations tended to be more risk averse.

Ms Kennedy suggested that organisations may need support in understanding the real skill sets needed to be a financial leader and there could be a role for the profession here. 'We may need to describe financial leaders in a different way, not just to finance staff but to chief executives and non-executive directors who are making key appointment decisions,' she said.

Ms Sherrington wondered if the profession could support the development of a formal women's network. She acknowledged that the HFMA already provided a good finance network, but was keen to explore if there was additional value in something specific for women, in finance or across different professions.

Summing up, Ms Jacques said that the finance function needed to demonstrate its absolute commitment to improving gender equality in its senior roles. This would involve a partnership of individuals, organisations, national bodies and the finance profession. 'But we should establish our ambition, stating clearly what our markers for success should be. Then we should look to deliver these over a clearly agreed timescale.'



Top: Sam Sherrington Above l-r: Sheree Axon, Roger Kline and Jennifer Howells

The whole picture

Presenting complex information in an instantly understandable way is key to clinical engagement and improving performance. Seamus Ward reports

It is often said that the NHS is awash with information. It certainly generates a lot of data and, while useful as standalone facts and figures that can shed light on overall financial position or inform a staff roster or to record a patient has been given a course of antibiotics, there is a belief that more could be done with this information. Many call this 'operationalising' the data – turning raw data into information that can be used to ensure the organisation runs efficiently, delivering high-quality care.

It is a way of engaging frontline staff in suggesting ways to make services better for patients and more efficient and realising the financial impact of decisions. Presenting this information in a clear and accessible way is critical to achieving this engagement and NHS organisations are increasingly using dashboards to get across the message.

Often the dashboards are bought in as off-the-shelf solutions and adapted to trusts' needs, but several trusts and commissioning support units have developed their own business intelligence tools, which they are now selling to their peers.

Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) has developed a number of leading edge business intelligence applications or apps to turn raw data into real-time visual insight. Healthintell, a partnership between the trust and NHS Shared Business Services (SBS), is offering these to the wider NHS. Rob Forster, WWL's deputy chief executive and director of finance and informatics, says the trust began developing the platform in summer 2014, partly through necessity.

'We realised that we needed the engagement of our staff in all aspects of the business,' he says. 'As with many other trusts, we weren't using technology to its maximum, and improving the two things worked together really well. Healthintell allows individuals to manage their work in real time using reliable, accurate information. It has transformed the way we do things and gives a line of sight from boardroom to ward.'

Mark Singleton, head of business information, says pressure on A&E – even in summer – also prompted the initiative. Over two months, clinicians and managers pared down the information doctors and nurses needed to improve the efficiency and performance of A&E. This was then developed into an app. A large touch screen in A&E (pictured above), the chief executive's office and elsewhere in the trust shows the latest position.

Since its introduction and over 12 months of refinement, seasonally comparable patient waits have reduced by an average of 30 minutes in A&E, and the trust wants to make further reductions.

'We feel some of our success is attributable to the use of the technology. For example, we cover the greatest population in Greater

"We are the one of the few trusts achieving the 95% A&E target. There will be a range of reasons for that, but some will be due to the way we use technology"
Rob Forster, WWL

Manchester – around 320,000 people – and we have the lowest number of beds per 10,000 population,' Mr Forster says.

Despite this, to date this year we are the one of the few trusts achieving the 95% A&E target and in the top 10% both regionally and nationally. There will be a range of reasons for that, but some will be due to the way we use technology.'

The app has some rules built in and helps facilitate work across the health economy, which is the basis of the local approach. For example, if a patient who was recently discharged presents at A&E, the trust community access team is alerted. This alert goes out once they register at A&E, rather than when they are triaged or seen by a doctor. It means the access team can see the patient sooner and put together an appropriate package of care and support.

There are financial benefits – fewer breaches of the A&E target mean performance fines are reduced. The benefit from the penalties alone pays for the investment in the tools, Mr Forster says.

'There is a real thirst for data and transparency in the NHS at the moment,' says David Morris managing director of WWL's partner NHS Shared Business Services. 'This is a good example of a board being able to see, in a clear way, a dashboard of what's happening in A&E. It allows them to understand the pressures in their organisation, monitor the pinch points and manage workflow more effectively.'

Using Qlik

WWL's Healthintell uses Qlikview to gather and present information. David Bolton, Qlik healthcare industry director, says more than 150 NHS bodies are using Qlik, deploying the firm's products mainly in finance. 'This is largely due to the pressure on health organisations to make better use of technology to improve efficiency and reduce costs,' he says. 'There is an acceptance that better use of data can improve efficiency. Qlik is about enabling health organisations to explore their data – clinical, financial or operational – and it's usually a combination of all three. We are engaging staff to interrogate data, which can lead to improvements in care, reduction in costs or a higher volume of patients.'

Qlik allows NHS organisations to combine data from several sources, which in an acute trust could be 30 or 40 different systems. 'The challenge is moving from a silo reporting approach to something that provides them with the whole picture. It allows them to see the impact of an action across the organisation.'

On the Qlik platform, Qlikview is the main app in the NHS and is often used for patient-level costing. Qlikview, and its sister app Qlik Sense (which has a greater emphasis on self-service), use an associative model that links data from multiple systems.

For example, a look into variations in the cost of knee replacements could compare the 'profit and loss' by surgeon. A number of surgeons could cost more than others, but the system would help to identify the variation, across all the available data sources. The surgeons may use the same prostheses as their colleagues, ruling out one possible cause of cost variation, but their patients spend more time in theatre, have a longer length of stay or a greater chance of readmission. They may need a refresher course to bring them up to best practice and reduce theatre time, length of stay or many other factors. Qlik enables clinicians and managers to see the whole story across their data, rather than relying on individual system reports, says Mr Bolton.

One of the largest trusts in the country, East Kent Hospitals University NHS Foundation Trust, has also developed its own platform to provide real-time data. To spread its use, it has formed a company, Beautiful Information, which is 50% owned by the trust and the Kent, Surrey, Sussex Academic Health Science Network. It is currently being used in several other NHS trusts.

Mobile phones

Director of information Marc Farr, says the initiative sprung from the trust IT department. Information is provided on users' mobile phones, showing, for example, performance in the emergency department in real time or the trust financial position. The East Kent trust also uses Qlik tools – for trend analysis, for example – using data from its platform.

Dr Farr (PhD) says a lot of business information tools are available to the NHS, but they can be expensive so the trust decided to build its own mobile platform.

Apps sit on the platform, which acts like an operating system such as Windows. One app, Operational Control Centre (pictured left), is refreshed every two minutes and gives users an overview of the emergency departments across the trust's three sites. The information includes: how many patients are in the department; average waiting time: how the department is performing against the four-hour A&E target; delayed transfers of care; and availability of clinical decision unit beds and how many will be needed in the next hour.

'There's no duplication or double entry as all the information is pulled from existing databases. If you go to A&E and are admitted, the apps will pull the information about you from the database behind the patient administration system,' says Mr Farr.

'We push the same information to our wider clinical colleagues, so they can see on their phones how we are doing in terms of referrals and A&E performance. If we are doing really well on one site and struggling on another, there may be things local GPs can do to help.

'A couple of years ago, trusts were quite closed about their data, but in the current financial climate it is not about taking as much money from clinical commissioning groups as you can; it's about the whole health economy.'

A second app, Activity and Finance Tracker (AFT), compares current activity and income against plan. It is updated every two hours. 'If you said you would do 100 knee replacement operations by a certain point in the year, but had only done 95, it will prompt the team to catch it up – by

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doing a Saturday list or a three-session day, for example,' Dr Farr says.

'The app takes the average price for each operation, outpatient appointment or A&E admission and multiplies by activity. If you are, say, 2% behind on day cases, the finance director may look at that and pick up the phone to the head of surgery to say we need to get cracking.'

Average price is sufficiently accurate on which to base near real-time management decisions, he says. Traditionally, this information would be generated about once a month and Dr Farr adds that although it is high-level, the AFT allows managers and clinicians to act quickly and ensure the trust operates smoothly.

Healthintell app

Healthintell also has its own finance app, Devolved Financial Management (DFM). DFM has customer (budget holder) and finance department facing views. 'Both have the same information, but the difference is in how it's portrayed,' Mr Singleton explains.

'While the finance information is in real time, the budget holders see more historic information on a monthly basis. This allows the accountants to make the accruals and adjustments needed and means the budget holder is not presented with something that does not take everything into consideration.'

The budget holder interface offers easy to understand financial performance information – spend against budget for the last month and year-to-date, for example. Those achieving their budget have a green smiley face and red if overspent (these were suggested by users). 'It highlights problem areas and the biggest variance against plan; what's causing problems in their budgets,' says Mr Singleton.

Going deeper, they can view a more traditional expenditure statement view, with pay broken down to Agenda for Change levels. In the non-pay section, there is flexibility to drill down to invoice or transaction level.

'The app was introduced half way through the 2012/13 financial year and in the six months that followed, the number of green budgets increased by 12% – the equivalent of £2m improvement in that short period,' he says.

The finance view shows which budget holders are using the app and which are not. It also takes some of the legwork out of financial reporting by automatically generating a set of standard spreadsheets. Accountants played a key role in deciding on these. 'This frees up their time so they can engage with their clinical divisions, offering their support on service redesign, writing business cases or on costing exercises,' Mr Singleton says.

Gone are the days of divisional accountants meeting with budget holders each quarter to pore over their budget position on A3 sheets. These have been replaced by regular ongoing team business catch-ups. This reflects the speed of change and team solution approach required in the NHS today, as opposed to accountants being seen as simple bean-counters providing reams of numbers once per month, he adds.

Some of the information offered in the Healthintell dashboard is reflective – what happened yesterday or last week. But Mr Singleton believes it has been a success at WWL because of its ability to offer real-time data and its capacity to predict future A&E demand. 'When we started looking forward, we realised we had a challenge – how do you take the unpredictability out of emergency care?' The system can predict,

"NHS trusts are swimming in volumes of data, but they aren't the best at putting it to use. This is about using information trusts already have"

Mark Singleton, WWL

Wigan's A&E touchscreen

to a degree of around +/- 5%, the demand on A&E in the next few hours, next week or next month.

Again, the trust involved clinicians from the start and all the way through (using agile development) to iron out potential problems. Even now, the app is enhanced regularly. The predictive element of the app uses data from several sources, including historic and recent data. Although as yet it doesn't link to an e-roster, it is used when planning staffing of wards and departments

Both Healthintell and Beautiful Information use data already collected by the trust – for example, what is used for commissioning data sets. Mr Singleton says: 'In the NHS we are focused on collecting data – trusts are swimming in volumes of data, but aren't the best at putting it to use. This is about using information trusts already have.'

WWL is looking to extend Healthintell and its intelligence to wards – for example, gathering and presenting information on lengths of stay and delayed discharge.

Spreading usage

Dr Farr believes the principles behind the Beautiful Information platform and its apps can be applied to other parts of the hospital. The East Kent team is working on an HR app, which could present near real-time information on agency spend and mandatory training compliance, for example. Other developments could focus on referral to treatment times and an app to support integrated discharge.

There is nothing to stop other trusts developing their own tools based on existing software. Healthintell and Beautiful Information believe they simply provide a quicker route to the benefits. Mr Morris of SBS says his firm can smooth the introduction of Healthintell – its predictive element makes it distinctive. This can be tailored to trusts, with 80%-90% of sources of information common to all NHS providers. SBS and WWL hope to add parameters to make its forecasts more accurate.

Dr Farr says the advantage of Beautiful Information is that it has been developed by the NHS, for the NHS. It used agile development – asking clinicians and other users what they wanted; building it and then testing it with them to ensure it worked and met their expectations. 'If another trust was to develop a system like this, it would have to have a decent database and development skills. It could take ages. But I think most trusts are sensible and see our development is a great idea.'

The NHS is embracing the power of business intelligence tools to present complex information, clearly, to all members of staff. Whether it is an off-the-shelf or bespoke solution, their use looks set to grow.

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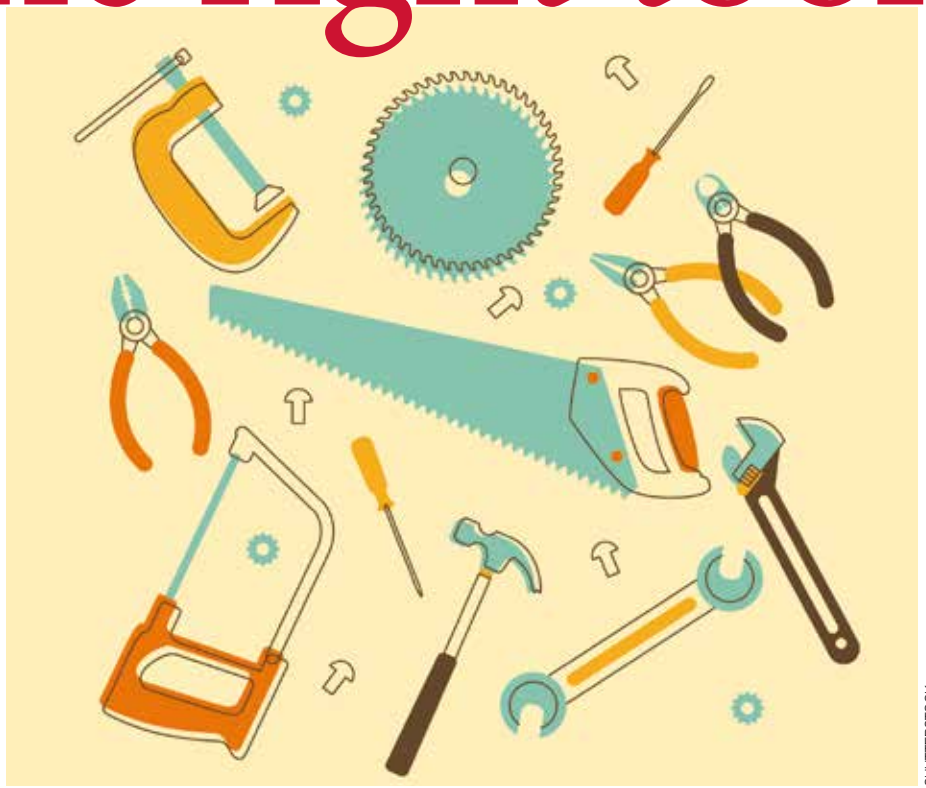
The right tool



SHUTTERSTOCK

NHS Future-Focused Finance has developed a decision-making toolkit to help the service make better value-based decisions, reports Seamus Ward

Does your organisation make good, value-based decisions? Are they made as quickly as stakeholders expect? How often are they implemented as intended? Are sufficient resources allocated to making and executing decisions?

Future-Focused Finance (FFF) believes NHS bodies cannot answer these questions positively and has developed a toolkit that can help introduce value and structure to their decisions. And with NHS decision-making so hit and miss, there have been suggestions that the toolkit, or something like it, could be mandated.

The FFF toolkit has four stages (see box):

- What
- Who
- How
- When.

Value, which is defined as clinical outcomes plus patient experience and safety divided by costs, is a key element.

'Best possible value' action area lead Caroline Clarke says the value component of the toolkit sharpens the focus on the factors a trust wants to influence and improve.

'We surveyed several hundred staff in the NHS and found that people weren't clear about roles and responsibilities,' she says. 'They focused on very small aspects of making decisions, and there was an issue around when we say we are going to do something and then don't do it.'

Consultancy Bain & Co advised FFF on the decision tool. 'Bain talked to us about how we compared to the best companies that make good decisions. It's no surprise that there is a clear correlation between return on investment and good decision-making and staff satisfaction and good decision-making.'

The complexity of NHS organisations means that decision-making frameworks are vital. Ms Clarke's own trust, the Royal Free London NHS Foundation Trust, acquired Barnet and Chase Farm Hospitals last year, in a process that took two years, 53 board-level meetings and 19 levels of approval.

'We couldn't work out who was in charge or where the money was,' she recalls. 'It can be really hard to make decisions in the NHS and that spurred me into getting involved in this programme.'

Liverpool Clinical Commissioning Group (LCCG) and Mid Cheshire NHS Foundation Trust have piloted the toolkit. LCCG became involved in the decision-making framework pilots as part of its backing for the wider FFF programme and to support the city-wide transformation programme, Healthy Liverpool.

CCG approach

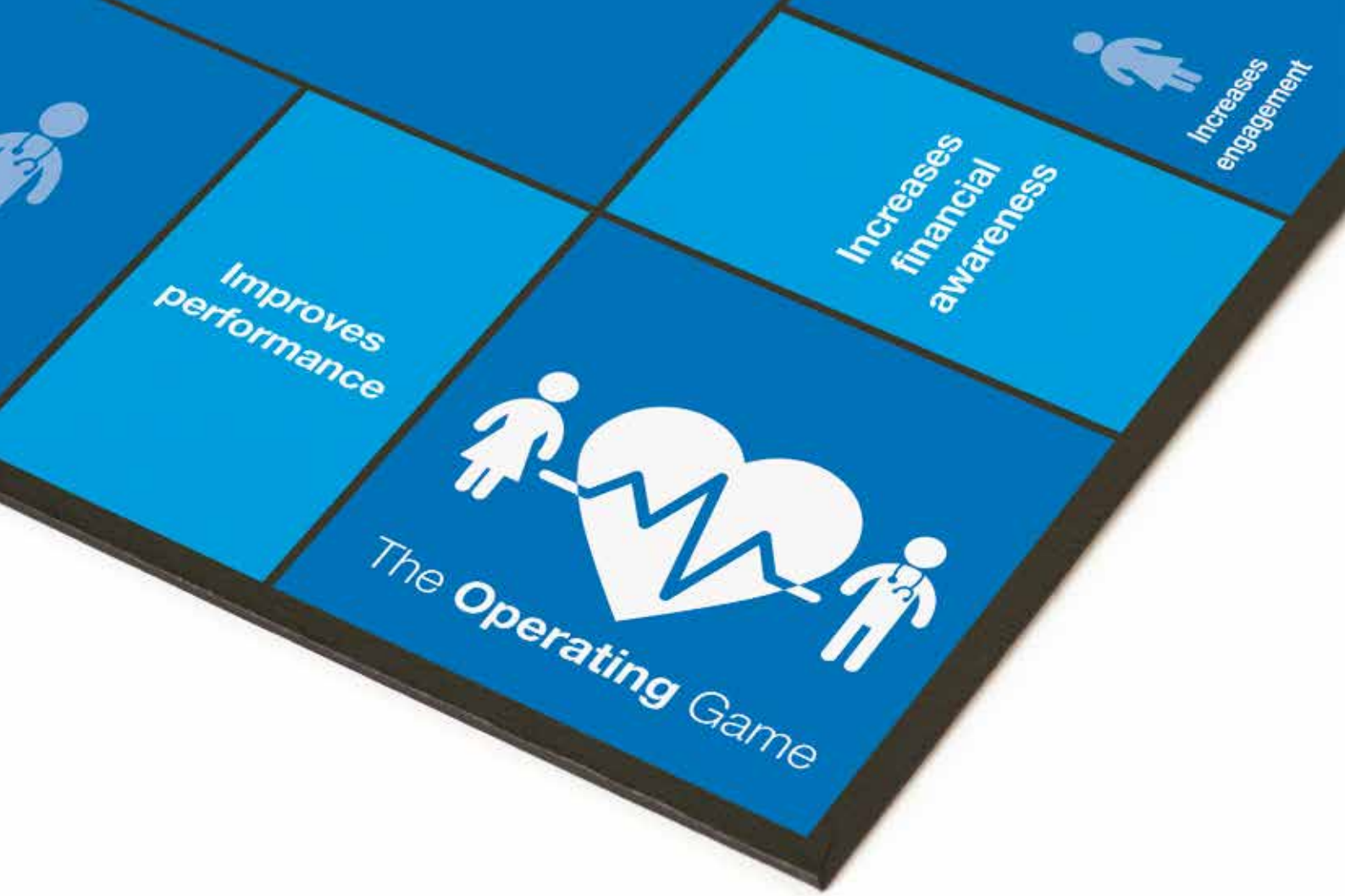
CCG programme project accountant Matt Greene says the commissioner has an opportunity to invest in new ways of providing services, but it has to be sure it is getting the best value for its money.

Mr Greene says decision-making in a CCG

Toolkit stages

The toolkit has four stages in its decision roadmap.

- **What:** define the decision; frame the decision; define the value criteria and metrics; and split into sub-decisions.
- **Who:** for each sub-decision identify the stakeholders and clarify decision roles using the RAPID method
- **How:** install a structured decision approach, including meetings and committees but ensure there is closure on and commitment to the decision, as well as feedback loops.
- **When:** ensure there are clear timelines and milestones for each stage of the project.



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Patricia McAuley
Programme Co-ordinator
Health Education West Midlands

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is complex, involving lots of stakeholders and committees, and there's also the potential for conflicts of interest. Using the toolkit and being transparent about the process can help deliver robust governance, he says.

He insists that the toolkit is not a replacement for the business case process, but it can be used before writing a business case to focus thinking, ensuring the CCG makes decisions that provide assurance and stability to future planning.

One recent Healthy Liverpool decision taken using the toolkit focused on a decision on lung cancer services, under its Healthy Lung project. The city has one of the worst lung cancer survival rates in Europe. The primary phase of the project would raise awareness of the disease and promote prevention in the wider community. In the second phase, low dose CT scans would be offered to those most at risk, to detect the cancer at an early stage.

The toolkit helped bring clarity to a complicated decision that in the past, had been delayed as a result of using traditional, consensus-driven methods. Such methods often lack clear accountability of roles, responsibilities and powers from stakeholders and committee members. The toolkit has enabled directive and participative decision-making, which, combined with an excellent project manager, has helped to move the decision forward, Mr Greene says.

With the help of Bain & Co, support organised as a result of LCCG successfully applying to be one of two FFF national best possible value pilot sites, the CCG organised a series of workshops with stakeholders. They included public health doctors, GPs and consultants, who had the opportunity to run through the toolkit with CCG staff.

'If you can get everyone to work through the decisions, they leave with a complete picture of what's got to happen and what their actions are, rather than with mixed messages,' Mr Greene says.

What phase

In the 'what' phase, the overall decision on whether to make additional investment in lung health in the city was split into eight sub-decisions, such as choosing metrics. Each workshop focused on a particular area of the toolkit and 'minutes' outlining the topics discussed, and agreements made, were written up and circulated before the next workshop. Taken together, these form a decision handbook.

In this phase, the project also examined the value components, outcomes (including clinical outcomes, patient experience and safety objectives) and resources (revenue and capital costs), including the metrics to measure these. This is captured in the value equation.

Mr Greene says this helps narrow down the objectives behind a proposed change – the desired outcomes and how to ensure services are improving, including what to measure.

'During the decision-making process a list of options to move forward should be generated,' he says. The option that offers the best trade off between the value equation components should be selected. It should be acknowledged that the toolkit does not conduct an option appraisal but capturing stakeholders' opinions of what constitutes value will make this easier.'

Mid Cheshire Hospitals NHS Foundation Trust is using the toolkit in a longer-term decision. The trust has a partnership with University Hospital of North Midlands and is exploring how this could benefit both parties.

Mark Oldham, Mid Cheshire's director of finance and strategic planning, explains: 'They have a significant challenge around elective capacity and we have some spare capacity. We are exploring how we can help them deliver the 18 weeks referral to treatment standard and support our financial position through increasing the volume of patients going through our theatres.'

Traditionally, faced with this situation, a trust with spare capacity might jump straight to making a business case for patients coming from the other trust. However, the toolkit directs the trust to consider all the issues – for example, how many patients will be able or willing to travel, or what workforce issues must

Decision architecture: Liverpool

Main decision:

Should HLP make an additional investment to improve lung health in Liverpool, and if so how can it do so in a way that delivers best value?

	Key sub-decisions
1	Decide whether to improve lung cancer in Liverpool
2	Decide on lead org / governance
3	Decide value criteria and metrics
4	Decide on set of available options
5	Decide on preferred option to work up into full business case
6	Decide on whether to invest in the preferred option
7	Decide on service spec
8	Decide how to procure

Decision architecture: the sub-decisions for Liverpool's Healthy Lung project

"We surveyed several hundred staff in the NHS and found that people weren't clear about roles and responsibilities"

Caroline Clarke, FFF

be taken into account – before working up a business case.

'The process made us sit back and consider the options and identify what value means to us, so we come up with a more rounded decision. It prevents people diving into solution mode, only to realise halfway through the project that the workforce model or the estates planning doesn't work with their solution,' Mr Oldham says.

'We have introduced the idea of value and how you quantify that. We spent a lot of time talking about value in terms of a financial contribution, but we also looked at clinical quality in terms of outcomes for patients and waiting times.

'We used these to define value – why we were doing something and how we assess it against each of these value criteria. We were keen to ensure that what we were doing would not have any unintended consequences on the quality of services to patients.'

It's a complex issue, with the Mid Cheshire trust believing that, initially, a partnership on elective work could mean 5,000 additional operations, worth £5m to £10m, each year. To address the issue, the trust created a multidisciplinary team that has boosted clinical engagement. Finance is playing a key role.

The project team produced a matrix of more than 100 options for providing the elective activity, paring this down to six possible solutions with a desktop review.

'We are working through what the operational model would look like and then we will attach the finances to that so we can assess the value of each option,' says Mr Oldham. A proposal is expected to go to the trust board at the end of next summer.

RAPID reaction

In the 'who' stage, the FFF toolkit directs the users to think about the roles different stakeholders will play. The RAPID model – recommend, agree, perform, input and decide – is used to clarify stakeholder roles in each sub-decision. Individuals or groups are assigned to each of the RAPID roles:

- **R** Largely one person or group collects the information and develops a recommendation. In the Liverpool Healthy Lung project, often this was the local cancer programme group – but again this role can shift between an individual or group depending on the decision context.
- **A** This group has influence, but does not make the final decision. They may be regulators or, in the case of the Healthy Lung project, Liverpool CCG finance team, which had A status in a sub-decision on whether to invest in the preferred option.

The toolkit offers the NHS a new way to make structured, value-based decisions … The onus is now on the wider health service to adopt it and show they are using the right tool for the job

- **P** This group are the performers – those who implement the action.
- **I** There can be multiple inputters, such as providers, cancer network and patient organisations. They voice their opinion, though their views do not have to be reflected in the final decision
- **D** Only one individual or group should make the final decision, though the identity of the decider can change depending on the sub-decision. In the Healthy Lung project, the finance, procurement and contracting committee had this role in the sub-decision on how to procure, but the CCG governing body and the Healthy Lung programme board were deciders on other sub-decisions.

Finance has a crucial role to play throughout the decision-making process. Its role often calls for input earlier in the decision-making process, but this can shift to agreement when a final decision involves committing funds must be made.

Mid Cheshire found the RAPID model useful. 'It showed us who held what decision-making powers – that was enlightening,' Mr Oldham says. 'The clinical leader on the project often said they had been unclear in the past on what they could and couldn't decide on, but in this the decision-makers are set out up front together with the opinions they need to consider.

'There are often a lot of decisions taken by committee or by people passing decision-making around because they don't want to make a difficult decision.'

Mr Oldham says that while the toolkit is useful, some organisations may wish to use their own project management structures to timetable and implement their decisions. 'It's useful for major strategic decisions, but if you are using it on a day-to-day basis, it is probably a bit unwieldy,' he says.

As a pilot site, the Mid Cheshire trust received support from Bain & Co for the first seven weeks of the project. The company provided training on the use of the toolkit, facilitated workshops and did some activity modelling.

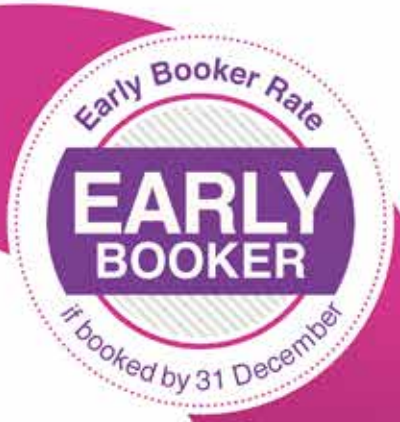
Mr Oldham believes that without this support, some organisations may find it difficult. FFF, however, is looking at a 'lighter touch' model, primarily for use on internal decisions and decisions where the value is lower.

He adds that the toolkit has prompted the Mid Cheshire trust to revisit its scheme of delegation and governance. 'We realised a decision could have to go through a number of hoops – too many in some cases. Someone could pull together a business case, an executive may sign it off, but then it would go to the executive management board, which may take a different view, so it loops back again. One business case went through this process 15 times.'

Now, the trust has executive leads who can sign off business cases, which will then go directly to the trust board rather than the executive management board.

The toolkit offers the NHS a new way to make structured, value-based decisions. Indeed, the NHS England new care models team is using a version of the toolkit to evaluate the vanguard programmes.

The onus is now on the wider health service to adopt the toolkit and show they are using the right tool for the job.



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CIPFA-HFMA survey sheds light on BCF early experience

Technical update

The better care fund (BCF) remains a key part of government plans to drive closer working between health and social care services, *writes Debbie Paterson*.

November's spending review underlined this, as it promised to expand the pooled funds that provide the foundation for the programme. While the NHS mandated contribution will be maintained, councils will be given an additional £1.5bn by 2019/20 to channel into the fund.

They will also have the ability to raise up to an estimated additional £2bn through a new social care precept (adding 2% to council tax income).

So there are clearly big plans for the fund's future. All of which should increase interest in how local areas are getting to grips with the new policy and approach. New work by the HFMA and accountancy body CIPFA aims to shed light on this – at least in terms of financial aspects. Their survey of clinical commissioning groups and local authorities looks at experience to date.

As expected, getting the better care fund off the ground has not been straightforward, but some positive messages are emerging as well as lessons that could usefully be learned across the country.

Of some concern is the level of engagement in the accounting guidance for the BCF. This was included in the Department of Health's *Manual for accounts* published back in August 2015. While just over 60% of respondents were aware that the guidance had been published, less than half had actually read it and fewer still had passed it on to their partners in the fund.

Accounting for the better care fund is high on auditors' and the Department's lists of risks for this year. It is something that cannot be done in isolation, requiring the agreement of all parties to each BCF arrangement.

Accounting for the better care fund is not necessarily straightforward and there is no 'one size fits all' solution. The accounting will depend on the arrangements in place and, in particular, which parties or party to the fund has control over it. Work to date indicates that each BCF arrangement is likely to be unique in some way.

To establish where the control lies, it is important to understand which entities can make which decisions. This will involve a review of the underpinning section 75 along with any related contracts.

It will also include an assessment of the commissioning arrangements in place, particularly whether commissioning is being done on a lead or joint basis.

The Department's guidance makes it clear that the BCF (or any pooled budget) is not an entity in its own right, so there cannot be any balances at the year-end between the fund and the partners to it. Alongside this, it is important to understand that the accounting should follow payments made for services and not funding transfers. This is especially important to understand in the context of agreement of balances as payments for services between NHS bodies will fall into that exercise.

This is not simply a CCG issue, although

Menopause guideline aims to improve support

NICE update

It is estimated a new guideline on menopause diagnosis and management (NG23) will bring an annual saving of £8.7m in England. The guideline aims to improve the consistency of support and information provided to women in menopause.

The average age of women who have a natural menopause is 51 years, but this can vary depending on factors including lifestyle and ethnicity. The estimated number of women aged 50 years or older with menopause is about 1.5 million for the population of England.

The information and support offered to women during and after menopause is variable, though many women seek support for managing the symptoms from their GP or practice nurse. Current treatments used by women for menopausal symptoms include hormone replacement therapy (HRT), clonidine, lubricants, complementary therapies, herbal remedies and some types of antidepressants. The recommendations said to have the biggest resource impact are:

- Decrease the number of follicle-stimulating hormone (FSH) tests in women
- Increase use of transdermal HRT.

The FSH test measures the level of the hormone in the blood, which differs depending on age. In women under 45, measuring the levels may be helpful if premature menopause is suspected. Implementing the recommendation is anticipated to significantly reduce how many over-45s receive FSH testing. It is estimated

In brief

Monitor and NHS England have called on each provider and commissioner of nationally priced services to nominate an authorised responder to the statutory consultation on the 2016/17 national tariff. The statutory consultation documents will be published in the new year.

The Care Quality Commission has proposed fee changes – necessary to meet the government requirement that it recover its chargeable costs in full from audited provider fees. The consultation closes on 15 January.

NHS Right Care has issued a locator tool as a companion to the *Atlas of variation 2015*. The tool allows commissioners to view maps of a clinical commissioning group or local authority area. It identifies the best performers among demographic peers; quantifies potential benefits; and offers links to best practice guidance.

The Department of Health has issued an unsecured creditors' guide to NHS trust and foundation trust special administration. The guide outlines the creditors' rights, though it does not represent an exhaustive statement of the relevant law.

contributions to the BCF are likely to be material for most CCGs. While NHS provider bodies may not be formal fund members, they will be entering into transactions with it.

They need to understand how these transactions are accounted for. For example, it may be that services are being paid for by the host of the fund while the transaction is actually with another fund member.

The *FT Annual reporting manual*, published at the end of November, refers foundation trusts to the Department's guidance and stresses the importance of understanding whether bodies are acting as principal or agent in any particular scenario.

Debbie Paterson is a technical editor for the HFMA

this will save £9.6m a year in England. No other treatment has been shown to be as effective as HRT in controlling menopausal symptoms – it is used by 17% of 40- to 65-year-old women. Oral HRT is used by 85% of these. Implementing the recommendations is anticipated to result in 5% switching from oral to transdermal, costing an extra £0.9m a year in England.

Nicola Bodey is senior business analyst at NICE

Diary

December
16 (B) London Branch: Student Finance Professionals group Christmas quiz night, London
17 (B) South Central Branch: technical update, Southampton

January
14 (F) FT and MH Finance: directors' forum and new year dinner
19 (N) Pre-accounts planning, Solihull
19 (B) West Midlands Branch: choosing wisely – the organisational and cultural changes of clinical resource stewardship, Birmingham
20 (N) Chairs' conference, London
20 (F) Commissioning Finance: commissioning new models of care forum
21-22 (B) South Central Branch: annual conference, Reading
25 (B) Eastern Branch: introduction to NHS finance, Fulbourn
26 and 27 (N) Pre-accounts planning, London
28-29 (B) Yorkshire and Humber Branch: annual conference

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

February
5-6 (B) North West Branch: annual conference, Blackpool
9 (F) Chair, NED and Lay Member forum, Manchester

March
17 (F) FT Finance forum: Devo Manc, Manchester

April
20 (I) HC4V: value masterclass
21 (N) Annual costing conference

May
12 (F) FT Finance: directors' forum, London
19 (N) Annual mental health finance conference, London

June
9 (B) West Midlands Branch: annual conference
23 (N) Commissioning Finance: annual conference, Stratford-upon-Avon

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

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

Event in focus

Pre-accounts planning
19 January, Solihull
26 and 27 January, London

The HFMA has organised these three one-day events to support professionals involved in the planning and delivery of the 2015/16 annual accounts, including those working in trusts, commissioning support units and shared services.

The day will include plenary and workshop sessions, providing an opportunity to hear about and discuss changes to accounting and reporting requirements, as well as the steps needed to achieve early submission.

There will also be a chance to raise questions with representatives from NHS England, the NHS Trust Development Authority and Monitor. Auditors will give their perspective on the risks they have identified for 2015/16 and the lessons from the 2014/15 accounts process.

For details, visit www.hfma.org.uk/events-and-conferences

New year resolve

Association view from Mark Knight, HFMA chief executive

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

HFMA chief executive Mark Knight

My HFMA

What a 2015 it's been. The provider deficit shows no sign of getting any better, although we now know what we're dealing with in 2016/17 and beyond thanks to the spending review. The jury is out on whether the investment will be sufficient to meet the growing demands facing the service. But it is probably about the best results we could have hoped for. One thing is clear: there can be no let-up in the pursuit of greater productivity and new models of care as the NHS seeks to deliver the £22bn efficiencies cited in the *Five-year forward view.*

It is a difficult position and the HFMA was very restrained in the week of the spending review announcement. The settlement is undeniably good relative to other spending departments and must be seen in that context. But significant challenges remain both in terms of the delivery of sustainable health services and the interaction between health and social care.

With our *NHS financial temperature check* well established, we will continue to track your views as the new funding starts to flow from April onwards.

In 2015, we have focused on how we are 'Stronger together' – HFMA president Sue Lorimer's theme for 2015/16. Sue has been a fantastic leader this year, ably representing us in all the things she has done. That's because Sue is a time-served, paid-up member of the NHS finance family – someone who has worked in a variety of organisations and at a high level. Her ability to win people over and her considered manner have inspired me and other staff and, on behalf of the membership, I'd like to thank her.

I'm writing this ahead of our annual conference and at our annual general meeting, held during the conference, we will install the 66th president of the HFMA, Shahana Khan. I've known Shahana for years and in various roles in the West Midlands, culminating in her current post of director of finance and performance at George Eliot Hospital NHS Trust.

"Sue is a time-served member of the NHS finance family … Her ability to win people over has inspired me"

Shahana is well respected and comes to us with an energy and drive to encourage members to make the best of themselves. Her message is simple and many of us will relate to it. Her theme will attempt to bring the balance back into the system and focus on the financial sustainability of organisations. To do this we must play our part in how we move forward.

Over the course of the next year the HFMA faces some key challenges. We want to develop a new membership strategy to make it easier to attract members. We want to launch our certificate and diploma programme with our partners at BPP. And our policy and research programme continues with the development of an active media and research campaign.

Our most important objective is to listen to our members so we can represent you in the very best way. But you need to keep speaking to us and supporting the association in all we do. Together we can take forward this organisation and achieve what it says on our coat of arms: 'the greatest wealth is health'. Have a happy new year.

Member news

The HFMA Policy and Research Committee has a new member, Charlotte Moar, programme director at NHS Wales Finance Academy.

Matthew Cripps, director for NHS Right Care (below), has joined the HFMA Healthcare Costing for Value Institute council to strengthen the commissioner focus.

The 'Stronger together' webinars ended after more than 2,400 people viewed the six webinars. The topic of the series was aligned with this year's HFMA president's theme and it aimed to help healthcare finance professionals across the country develop soft skills such as time management, team building and self-confidence. All webinars at www.hfma.org.uk.

Some 98% of healthcare finance leaders using HFMA's executive coaching service rated their one-to-one sessions as excellent or very good. Launched in 2014, this is the only independent coaching service for healthcare finance leaders. Email claire.merrick@hfma.org.uk.

A new module *Introduction to understanding NHS Accounts (England)* is available from the HFMA online academy, replacing three modules for NHS trusts, clinical commissioning groups and foundation trust accounts.

The HFMA North West Branch has launched its 2016 awards programme. There are three categories – innovation/research; team of the year; and unsung hero of the year. They are open to all healthcare organisations and employees across the North West. The closing date is 6 January. For details email hazel.mclellan@hfma.org.uk.

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

Branch champions
Local heroes

HFMA branches recognise the importance of keeping alive two-way communication channels with members at the front line. In Wales, the branch has introduced local champions, one for each NHS organisation, who act as a conduit for information between members and the branch.

Mal Turner, who was the Wales Branch's chair until September, established the initiative, which has been supported by his successor, Huw Thomas (pictured).

Mr Thomas is the branch champion at his own health board, Betsi Cadwaladr. 'The champions were established to improve the responsiveness of the branch committee to the needs of members,' he says. 'They can get messages directly out to our members, and they can collate messages back in.'

He says the champions give the branch greater resilience. Some people want to get involved, but they can't travel across Wales to get to meetings.'

The initiative offers them an opportunity to support the activities of the branch closer to home, which is critical for the long-term success of the branch.

The branch recently held an event for the champions. 'It was good to get a spread of views from across Wales. The needs are different and diverse across our membership,' Mr Thomas says.

Sue Holroyd is the champion at Cwm Taf University Health Board, and is getting involved to increase the profile of the HFMA locally.

'I have benefited, both in my career and personally, from the support and networking opportunities provided and I would like to make sure that others in my organisation who may similarly benefit are aware of the opportunities,' she says.

As an HFMA champion, she hopes to outline the benefits of being a member at an upcoming finance training afternoon at Cwm Taf.

'I think it is vital that the champion initiative is a two-way relationship to ensure that the HFMA receives feedback to continue to deliver what members want and need,' Ms Holroyd says.

'The recent champions meeting was an ideal example of how a dialogue can identify ideas for future developments and opportunities.'

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Appointments

Ros Francké (right) has been appointed director of finance at Shropshire Community Health NHS Trust. The move follows Trish Donovan's departure and a short period with deputy director of finance Sarah Lloyd covering the gap. Ms Francké is on the HFMA Board of Trustees. She has more than 20 years' experience in the NHS in the West Midlands and North West regions.

Alan Davies has become chief finance officer at Luton Clinical Commissioning Group, moving from deputy director of finance at Barking, Havering and Redbridge University Hospitals NHS Trust. He succeeds Ray Davey, who was chief finance officer on an interim basis at Luton CCG.

Central Manchester University Hospitals NHS Foundation Trust has named **Kim McNaught** divisional finance director (medicine and community services). She was deputy chief finance officer at NHS Liverpool Clinical Commissioning Group – its chief accountant, **Alison Ormrod** (left), succeeds her on interim basis.

Bedford Hospital NHS Trust has appointed **Damian Reid** (right) director of finance. He was finance director at Southport and Ormskirk Hospital NHS Trust. He is succeeded by **Steve Shanahan** on an interim basis. Mr Reid has worked with Monitor and NHS London, supporting acute and mental health trusts applying to become foundation trusts.

Gareth Lawrence has become acting director of finance at Wirral University Teaching Hospital NHS Foundation Trust, following the departure of Alistair Mulvey. Mr Lawrence was deputy director of finance at the organisation.

Richard Thomas is the new chief finance officer at Richmond Clinical Commissioning Group, succeeding interim Keith Edmunds. Mr Thomas was chief operating officer at BBC World Service Group. His key achievements included the delivery of a major savings programme in response to a 20% government funding reduction.

Director of finance at South East Coast Ambulance Services NHS Foundation Trust **James Kennedy** (right) has been promoted to chief operating officer. He is a member of the Institute of Chartered Accountants of Scotland and qualified with EY's London office. He is succeeded by **David Hammond** on an interim basis. Mr Hammond has led finance teams in ambulance and acute NHS trusts for seven years.

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

'I firmly believe in working together to find solutions to problems. People are much more likely to respond with enthusiasm and imagination if they feel supported'
Hazel Robertson, right

The road to NHS Orkney

On the move

New NHS Orkney finance director Hazel Robertson discusses her new job and her career, which has included more than 20 years in senior posts in the NHS in Scotland and a recent spell as head of finance for the University of Edinburgh Development Trust.

What attracted you to the post at Orkney?
NHS Orkney is a remote and rural health board, the smallest in Scotland. Its ambitions are huge and it is an exciting time in its history – a once in a lifetime opportunity to influence how services are delivered. This is possible because of an approved outline business case for a new hospital and healthcare facility and a historic increase in funding to bring NHS Orkney up to parity under the national allocation formula.

The attraction was not just the job. This is an area of outstanding beauty and a lifestyle to match. The people are welcoming and friendly. Having left the NHS in 2012, I had not anticipated a move back. But such an opportunity to change services, be close to the people that benefit from them and improve my lifestyle made the post compellingly attractive.

Was it difficult to leave your job at the University of Edinburgh?
I was at the development and alumni department for under two years, transforming many of its financial activities. It was an exciting and energising place to work and the projects were so worthwhile. I do not regret leaving, though it was hard to leave behind the staff, many of whom I keep in touch with.

What are the challenges facing the board?
The board has implemented a consultant-led model of care in Balfour Hospital, a rural general hospital. This is an excellent development from a clinical quality point of view. But with few medical staff and a remote location, we incur high costs for locum and agency staff. A robust approvals process and strong internal controls are bringing these costs down. This is a high-risk area for the financial position. Investing in more medical staff is not necessarily the solution, rather creativity in how services can be managed.

Single-handed, sometimes part-time posts, can deliver many services. We need to extend our work on regional solutions, to ensure services are resilient but also to contain costs.

As with all other health boards, it is challenging to secure 3% efficiency savings year-on-year. Most of our target is due to be delivered through service redesign, but there is a limit to how much can be achieved. We are trying to repatriate patients from the mainland, to improve their experience and reduce the significant added costs from off-island treatment.

We rely on technology for service delivery and for the redesign of patient pathways. But connectivity, including mobile networks outside Kirkwall and broadband, is a big problem.

Our small population can make it difficult to comply with national performance targets – two patients taking longer to go through treatment could throw off our percentage performance.

Which skills help address these challenges?
I firmly believe in working together to find solutions to problems. People are much more likely to respond with enthusiasm and imagination if they feel supported, not challenged all the time.

I am risk-aware, spending time on things that will have the greatest impact. I am curious and will search out best practice elsewhere.

One of the key criteria for redesign and change is to be clear about the scope of the project. You have to envisage the future, explore all possibilities, but then come back to a realistic plan. Good project management techniques and governance are critical so you can identify concerns early and take action.

Communication is also vital, making sure staff are appreciated, involved and empowered.

Have you set yourself any objectives?
I have the usual hard-nosed objectives like achieving financial results and delivering a five-year financial strategy.

But more important, I can say I will work in partnership to achieve my objectives and, in doing so, make a difference.

Diversity matters

Future focused finance

NHS organisations' policies on equality and diversity can become nothing more than tick-box exercises, according to a survey by Future-Focused Finance, *writes Cathy Kennedy.*

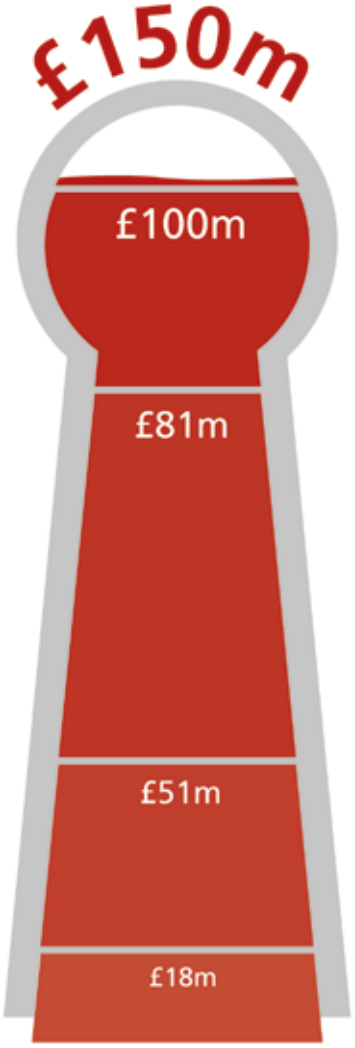
FFF aims to promote diversity at the heart of its work. It has taken diversity seriously since its inception and will soon publish the findings of the survey, which received more than 1,100 responses. And as part of its commitment to understanding staff experience, it has also commissioned HFMA/FSD to collect ethnicity data as part of their biennial census, the first time such data has been collected in the finance function.

While 90% of survey respondents were aware of their organisation equality and diversity policy, several said they were part of a tick-box exercise or simply not followed. In addition, 13% of respondents felt they had been discriminated against or harassed in the past 12 months.

Most would agree that greater workplace and boardroom diversity is a good idea, but there are no simple, quick-win solutions to achieving this. But by entwining diversity throughout our work, we hope to ensure that FFF is a listening and involving programme that values the views of members, patients, stakeholders, partners and the wider community. The survey and the census work are the first steps in achieving this.

Cathy Kennedy is senior responsible officer for the FFF 'Great place to work' action area

NHS Supply Chain



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