healthcare finance

February 2017 | Healthcare Financial Management Association

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Orchard's 2017 vision

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Further concerns on mental health parity funding

Comment
Let's focus on getting the best financial position

Features
How to make small hospitals more sustainable

Features
Knowledge boost: HFMA offers new qualifications

Professional lives
Technical, events, association news and job moves

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Source: Patient Level Costing: Case for Change April 2016 (NHS Improvement)

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Managing editor
Mark Knight
0117 929 4789
mark.knight@hfma.org.uk

Editor
Steve Brown
015394 88630
steve.brown@hfma.org.uk

Associate editor
Seamus Ward
0113 2675855
seamus.ward@hfma.org.uk

Professional lives
Yuliya Kosharevska
0117 938 8440
yuliya.kosharevska@hfma.org.uk

Advertising
Paul Momber
0117 938 8972
paul.momber@hfma.org.uk

Subscriptions and membership
Flo Greenland
0117 938 8992
flo.greenland@hfma.org.uk

Production
Wheal Associates
020 8694 9412
kate@whealassociates.com

Printer
Pureprint

HFMA
1 Temple Way,
Bristol BS2 0BU

Executive team
Mark Knight
Chief executive
mark.knight@hfma.org.uk

Paul Briddock
Policy and technical director
paul.briddock@hfma.org.uk

Alison Myles
Education director
alison.myles@hfma.org.uk

Ian Turner
Finance director
ian.turner@hfma.org.uk

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President handover

HFMA 2016 president Shahana Khan handed over the chains of office to new president Mark Orchard at the annual conference in December.

Mr Orchard, who is director of finance at Poole Hospital NHS Foundation Trust, unveiled his theme for his year in office – *Everyone counts* – at the three-day conference in London.

- ***Conference in pictures, page 8***
- ***Mark Orchard interview, page 18***

News

Providers' continued concern about MH funding shortfall

By Seamus Ward

Prime minister Theresa May has launched a new funding package for mental health, but providers have insisted they are not receiving funding at required levels.

An HFMA survey showed that while funding will increase in 2017/18 for some trusts, only a minority will receive increases big enough to achieve the investment standard. Increasing investment in mental health has been included in NHS England's mandate since 2014/15 – so-called parity of esteem for mental health. Under this investment standard, commissioners are required to increase mental health funding each year at a level that at least matches the rise in their overall allocation.

The HFMA survey received responses from 36 of the nearly 60 mental health trusts in England and, while funding increased in 30 (83% of respondents) in 2016/17, this falls to 21 (58%) in 2017/18.

For providers in the sample seeing an increase in funding, the investment standard was met in nine trusts in 2016/17; eight in 2017/18. The HFMA said the survey showed a 'lack of alignment' between commissioners and mental health providers on implementing the investment standard, with confusion over which services are covered and how much investment should be made.

In a separate survey, NHS Providers said the investment standard would be missed in nearly two-thirds of 38 mental health trust respondents over the next two years. They said the shortfall was a result of clinical commissioning groups giving funding priority to acute hospitals.

Its director of policy and strategy, Saffron Cordery, said: 'The survey findings suggest that in trying to conclude new contracts both commissioners and providers face significant pressures. Many commissioners want to increase funding for mental health but – amid other pressures – they lack the funding to see it through.'

"This is an historic opportunity to right a wrong and give people the treatment they deserve" Theresa May (pictured)

In January, Mrs May unveiled a comprehensive package of reform to ensure better mental health support for people of all ages, particularly children and young people. Under the plan, more than £80m will be invested in mental health services in England.

She said that almost £68m would be spent on speeding up the delivery of a digital mental health package. This will allow people to check symptoms and, if needed, access digital therapy immediately, rather than waiting for a face-to-face appointment. A further £15m will be invested in creating new places of safety – a similar investment has already created 88 places. Training will be provided to secondary schools and there will be a review of children and adolescent mental health services.

FLICKR/FOREIGN & COMMONWEALTH OFFICE

Mrs May said true parity for mental and physical health can only be achieved if every institution recognises the vital role it can play in delivering this objective.

'This is an historic opportunity to right a wrong, and give people deserving of compassion and support the attention and treatment they deserve. And for all of us to change the way we view mental illness so that striving to improve mental wellbeing is seen as just as natural, positive and good as striving to improve our physical wellbeing.'

NHS Confederation mental health network chief executive Sean Duggan welcomed the plan. But he added: 'Mental health services still need the government's support to speed-up promised funding, much of which is delayed, but we are very pleased that mental health is being accepted as a major priority going forward.'

Social care funding squeeze will continue to increase pressure on NHS services

By Seamus Ward

Pressure on the NHS will continue to increase and some of the most vulnerable people will not get the care they need because councils are struggling to meet the rising cost of social care, according to social services leaders.

The warning came despite the government allowing local authorities to increase the social care precept by an extra 1% (3% instead of 2%) over the next two financial years.

And, highlighting the pressure social care demands are placing on councils, Conservative-run Surrey County Council announced it would hold a local referendum on increasing council tax by 15% to pay for additional social services.

The council said its annual grant from central government had been cut by £170m a year since 2010 and, despite finding £450m of savings, it had no choice but to recommend the increase as the services had been 'brought to breaking point'.

The Association of Directors of Adult Social Services (ADASS) said social care needed significant and long-term funding. A report by market intelligence firm LaingBuisson found that the average fee paid by councils per care home resident in England was more than £100 a week less than the real cost of services.

Setting a return on capital of 11%, and basing its calculation on average pay rates, LaingBuisson said residential care homes needed to charge between £590 and £648 a week. The higher fee represents newer homes, while the lower rate reflects homes passing basic standards.

Willcox: call for 'significant, sustainable and long-term funding'

Stripping out council overheads, the firm estimated that English councils are paying an average of £486 a week in 2016/17 – £104 below the lower end of its fee range.

ADASS president elect Margaret Willcox said: 'These findings reflect universal concerns about the escalating social care crisis, resulting not least in councils struggling to meet rising costs.'

Councils were doing all they could to protect adult social care, but funding had been squeezed and pay costs were rising. Although 82% of councils had increased fees paid to care homes last year, in separate work ADASS found two-thirds of local authorities had closed residential and nursing homes, while care home providers had handed back contracts to more than half of councils.

Ms Willcox added: 'It is a cause for celebration that more people are living longer but they are doing so with increasingly complex needs. Without significant, sustainable and long-term funding, the funding crisis means thousands of older and disabled people, their families and carers will face an increasing struggle to get the care and support they need. NHS delays will continue to increase, more care homes will close and there will be more gaps and failures in the provider market.'

LaingBuisson founder William Laing said that the adoption of the national living wage and requirements to employ more carers to support residents with increasingly complex dependencies has fuelled an 'inexorable rise' in care home costs.

'Most councils responsible for supporting publicly funded residents do not have the budgets to pay a reasonable cost for care and despite councils' freedom to raise further funds from the social care precept, the situation is unlikely to change in 2017/18.'

• *See Bleak midwinter, page 10*

Positive signs on locum fee curb

There are further signs that the price caps introduced to reduce the agency staff bill are working, according to financial and workforce services provider Liaison.

NHS Improvement has already said the caps are working, saving £600m in the first year, but trusts have reported that the locum medical bill is particularly tough to crack.

Now, Liaison's latest quarterly *Taking the temperature* report has found that for locum consultants the proportion of hours that exceeded pay caps dropped from 84% in quarter one to 64% in the second quarter.

The analysis, which looks at four medical grades (consultant, ST3, FY2 and staff grade), is drawn from information generated by its workforce management services, which is used by 60 trusts.

Hourly rates across the medical staff groups remained above caps. The overall locum average hourly pay and commission rates rose in the second quarter of 2016/17, but this was due to an increase in the total number of hours worked. However, commission paid to agencies rose by 1.5% during the quarter.

Andrew Armitage (pictured), Liaison's managing director, said: 'Although total hourly rates paid by trusts across the four main grades of staff remain higher than the price caps, it is positive to see average pay rates for consultants have decreased for the second quarter.

'It is also worth noting that we are seeing progress in hours worked over the NHS Improvement price caps in comparison to last quarter with 64% of total hours worked exceeding the caps as opposed to 84% in quarter one.'

• *See Banking on it, page 26*

OECD highlights healthcare waste

It is likely that around a fifth of healthcare spending makes little or no difference to good health outcomes, according to the Organisation for Economic Co-operation and Development (OECD).

Its report, *Tackling wasteful spending on health*, said it was alarming that such a significant proportion was at best ineffective and at worst wasteful at a time when public budgets were under great pressure around the world. It identified waste in clinical care, including procedures of low value; operational waste (such as in procurement) and governance-related waste.

'Governments could spend significantly less on healthcare and still improve patients' health. Efforts to improve the efficiency of health spending at the margin are no longer good enough,' it added.

The report said high numbers of patients in OECD countries were unnecessarily harmed at the point of care. And more than 10% of hospital spending was on correcting preventable medical mistakes or infections caught in hospital.

It said there was a range of opportunities to spend less on pharmaceuticals, including not throwing away unused drugs. It pointed to a 2010 study that estimated the annual cost of drugs discarded at home by patients in England was £200m. The UK could also make large savings on biosimilar medicines – eight key products are scheduled to lose their patents between 2016 and 2020.

The OECD summed up strategies to reduce waste as:

- Stop doing things that do not bring value – for example, unnecessary surgeries and clinical procedures
- Swap when equivalent but less pricey alternatives of equal value exist – for example, by encouraging the use of generic drugs, developing advanced roles for nurses, or ensuring patients who do not require hospital care are treated in less resource-consuming settings.

See Timescale key to cutting waste, page 12

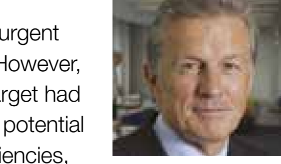
Demand hits ambulance services

Ambulance services across England are struggling to cope with rising demand for urgent and emergency services, the National Audit Office said.

In a report, *NHS ambulance services*, the auditors said new models of care, such as resolving calls over the phone, had helped. But signs of stress remained, including weakening response time performance – in 2015/16 only one ambulance trust met all three targets.

But there was a consensus that commissioners, regulators and providers placed too much importance on response times and this could be undermining efficiency.

For example, in most cases there was no clinical benefit from ambulances arriving within eight minutes in Red 2 calls (the second most urgent call). However, this target had led to potential inefficiencies, such as sending multiple ambulances and standing down those that do not arrive first.



Delays in transfer of care at A&E departments were also hampering efficiency, with around 500,000 ambulance hours lost because turnaround took longer than the expected 30 minutes.

NAO head Amyas Morse (pictured) said ambulance service efficiency depended largely on other parts of the health system. 'Until clinical commissioning groups see ambulance services as an integral part of that system it is difficult to see how they will become sustainable and secure consistent value for money.'

Standards put NHS on path to better costing

By Steve Brown

New costing standards to underpin NHS Improvement's accelerated Costing Transformation Programme were due to be released at the end of January.

Published after *Healthcare Finance* went to press, the oversight body's new *Approved costing guidance* was set to include firm costing standards for acute trusts and draft standards for both mental health trusts and ambulance trusts.

Draft standards for acute trusts were initially published last April. But Richard Ford (pictured), NHS Improvement's costing director, said the standards had been through significant refinements as a result of detailed engagement with six acute 'road map partners' and feedback from costing practitioners in general over the last year.

'We are very proud of the standards and we couldn't have done this without the support of costing practitioners,' he said. 'They've really helped us to stress test the approach.'

One of the key changes generally in the approach taken by NHS Improvement is to require costs to be mapped to different resource types and then allocated to different activities. The initial resource-activity matrix has now been rationalised to make both submission and collection of costs more manageable.

In general, Mr Ford said, the standards had been made more flexible and pragmatic compared with the draft version. For example, some organisations can split pathology costs by individual tests and by pay and non-pay. In other trusts – where pathology is outsourced, perhaps –w trusts use simple weightings to allocate costs across tests. The standards now allow for both approaches.

A first group of 'about 80' acute early implementers will use the standards to make a patient-level cost submission in July.

Mr Ford said the hope was then to take a second cohort through a submission in the second half of the year, by which time an announcement to mandate use of the standards from April 2018 is expected to have been made. The first mandatory collection for acute trusts will cover costs for the 2018/19 year, submitted in summer 2019.

Draft mental health and ambulance service standards will now go through the same stress testing approach with sector-specific road map partners.

Mr Ford said these represented the first patient-level costing standards for non-acute services across the world and that a number of countries were closely following progress. There is a recognition that both mental health providers and ambulance trusts are coming at the new process from a lower starting point, with fewer systems and data feeds in place.

News review

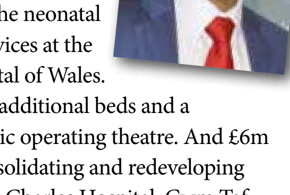
Seamus Ward assesses the past two months in healthcare finance

While stories of an NHS in disarray dominated many news bulletins in early January (see news analysis, page 10), we learnt in the previous month that local authorities would be given greater flexibility to raise funding for social care. Lack of resources in social care is believed to be one of the chief contributing factors to the climbing attendances at A&E – which in turn increases waiting times – and delayed transfers of care of patients well enough to be discharged from hospital but who do not have a package of care in the community.

In mid-December, communities and local government secretary Sajid Javid said social care would get extra funding in the next two financial years. Changes to the council tax precept for social care and savings from reform of the new homes bonus could boost social care spending by almost £900m by 2019, he said. The social care precept can now be raised by 3% rather than the current 2%, providing a potential additional £208m in 2017/18 and £444m in 2018/19. The new homes savings would amount to £240m. But he warned that variations in social care must be tackled and it was 'vital that we finish the job of integrating our health and social care systems'. And NHS Providers warned there were limitations on the new money. It said that while councils would have the freedom to increase the precept by up to 3% in the next two years, they would be unable to raise it by more than 6% over the three-year period set by the original precept conditions.

Meanwhile, NHS Providers reported that cuts in community beds and other services are hampering acute trusts' attempts to cope with rising demand. In its survey, *Delivering care in every setting*, more than half (52%) of chief executives, chief operating officers and finance directors who responded said it had become more difficult to deal with demand for community-based services over the last two years. Despite the direction set by the *Five-year forward view*, they said there were significant reductions in community beds because of lack of funding, staff shortages and a reduction in capacity.

The Scottish government is also pressing for greater health and social care integration, saying it will invest an additional £107m in the next financial year. It said the funding would ensure people were cared for safely in their own homes and would help avoid unnecessary hospital admissions. As outlined in the government's draft Budget, the £107m will transfer from the NHS to health and social care partnerships in 2017/18. It is in addition to the £250m added in the current financial year, which will be part of the baseline from 2017/18.



In Wales, health secretary Vaughan Gething announced a £31m funding package to improve neonatal and obstetric services in two hospitals. More than £25m will be invested in redeveloping the neonatal and obstetric services at the University Hospital of Wales. This will include additional beds and a dedicated obstetric operating theatre. And £6m will be spent consolidating and redeveloping services at Prince Charles Hospital, Cwm Taf, with extra neonatal beds and maternity facilities.

Staying in the principality, employers in Wales have reiterated their commitment to improving medical engagement. The pledge followed publication of a survey that showed engagement was patchy in NHS bodies across the country. For the first time, doctors were invited to take part in the survey – known as the medical engagement scale – which

The month in quotes

'Knowledge is power. Not only does this provide us with a level of data and insight to better challenge clinical practice and variation, it helps to safeguard our patients from avoidable harm. In the event of a product recall, we can easily track an affected product to the right patient.'

Tim Wells, consultant cardiologist at Salisbury NHS Foundation Trust, on the Scan4Safety barcoding

'2017/18 is a crucial year for the vanguards, in particular how we further spread their work across the wider NHS and care services. This funding, as well as the support we offer to them, will help them to continue to move at pace.'

Samantha Jones, director of the new care models programme at NHS England, says vanguards are developing quickly, helped by new funding

'Not only does it ensure patients can receive more treatment in their communities but it also reduces demand for acute hospital usage by reducing avoidable admissions, lengths of stay and delayed discharges.'

Scottish first minister Nicola Sturgeon on why her government has committed a further £107m for health and social care integration

'It is vital we finish the job of integrating our health and social care systems. We know this can improve outcomes and make funding go further, helping people manage their health and wellbeing and to live independently for as long as possible.'

Sajid Javid says new social care funding must be accompanied by reform

SHUTTERSTOCK

Lack of resources in social care is believed to be one of the chief contributing factors to rising NHS pressures

revealed some examples of good engagement and others where significant improvement was needed. A joint statement from the Welsh NHS Confederation and BMA Cymru Wales said improving medical engagement was a priority. The bodies will work together to achieve this over the next three years, when the survey will be repeated.

The NHS Confederation has appointed Niall Dickson as its new chief executive. Mr Dickson, a former BBC social affairs editor and chief executive of the King's Fund and the General Medical Council, will join the confederation on 1 February.

Barcoding of patients, medical supplies and equipment has the potential to save lives and up to £1bn over seven years, the Department of Health said. Highlighting initial findings from its £12m Scan4Safety project, it said barcodes were helping track patients and their treatment. Faulty equipment could be traced and patients identified, even if the fault came to light years later, it said. Early results from six pilots showed lives and money would be saved through reducing waste, the Department added.

NHS Improvement has been asked to prioritise an increase in the average tenure of NHS provider chief executives. In a remit letter to the oversight body, health minister Philip Dunne set out NHS Improvement's objectives for the current year and the rest of the Parliament. NHS Improvement must also strengthen the pipeline of chief executive, finance director and chief operating officer applicants through proven talent management approaches and succession planning. The organisation announced a new aspiring leaders' talent pool at the HFMA annual conference in December. The remit sets objective in five areas:

- Budget
- High-quality care
- Operational performance
- Five-year forward view
- Leadership.

It sets out NHS Improvement's role in supporting the roll-out of seven-day service standards and delivering improved patient-level costing.

Just over £100m in new funding has been allocated by NHS England to support and spread the work of the new care model vanguards. In addition, the vanguards will continue to receive support from NHS England and other national bodies to implement their plans, including how they harness new technology such as apps and shared computer systems. They are also receiving help to develop their workforce so that it is organised around patients and their local populations. The total funding allocated equals that of 2016/17 and will be matched by funds and resources from the vanguards themselves.

in the media

December and January were busy months for the HFMA, with the publication of the latest *NHS financial temperature check*, the annual conference, the launch of the new qualifications and the winter pressures faced by the NHS.

The latter led to an appearance on BBC Radio 5 Live's *Wake up to money* by HFMA policy director Paul Briddock. He said the NHS financial position had been deteriorating for two to three years. He explained how the estimated £30bn gap in NHS funding would be bridged, with an extra £8bn in funding and £22bn in efficiency savings. Asked if NHS managers should be doing more to deliver services within budget, he said the service had been asked to achieve relatively high levels of efficiency since 2010 – historically such levels had not been sustained in the NHS or in other healthcare systems.

The temperature check attracted a lot of media attention, including Onmedica, a website for health professionals. Mr Briddock said finance directors were initially enthusiastic about sustainability and transformation plans (STPs), but the temperature check showed scepticism that they can work.

Health Service Journal reported on NHS Improvement chief executive Jim Mackey telling the annual conference that finance directors should not bow to pressure to hide the true financial position. And, in January, *Public Finance* published an article from Mr Briddock outlining the need for all staff to understand finance and introducing the new HFMA qualifications.

HFMA 2016

Paul Baumann

Highlights from December's conference

The HFMA annual conference heard from a number of leading speakers in healthcare. NHS England chief financial officer Paul Baumann asked finance managers to address four questions:

- Are they maximising value?
- Are risk management strategies adequate?
- Can they quickly capitalise and build on improving partnership working?
- Can the finance function ensure it has the capability and leadership to deliver transformational change?

A development programme for aspiring finance directors and chief finance officers was launched at the December event. At one of a couple of interactive panel sessions, NHS Improvement director of resources and deputy chief executive Bob Alexander said significant numbers of senior finance posts were filled on a shared or interim basis and the development programme would help address this.

There were opportunities in all trusts to increase efficiency by reducing variation in performance, NHS Improvement chief executive Jim Mackey told the conference. Eliminating variation would help build the case for further funding increases. He called for greater positivity, but added that he did not expect accountants to agree to report figures with which they were uncomfortable.

In a motivational session to close the conference, Paralympian Dame Sarah Storey described the challenges and successes in her career to date.

The HFMA national awards were held during the conference, which saw Bolton Clinical Commissioning Group chief finance officer Annette Walker named as Finance Director of the Year. She was praised for a range of work, but particularly on the pioneering partnership with Bolton NHS Foundation Trust, which led to their aligned incentives contract.

- See more conference coverage at www.hfma.org.uk (top stories)

Paralympian Dame Sarah Storey

Jim Mackey

Outgoing president Shahana Khan

HFMA AWARDS 2016

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www.hfma.org.uk

Annette Walker named top director

Anita Charlesworth, Health Foundation

Accounts Team of the Year

Nigel Edwards, Nuffield Trust

Panel Session with Shahana Khan, former HFMA president Sue Jacques and CIPFA chief executive Rob Whiteman

Professor Tim Briggs, *Getting it right first time* initiative

Bob Alexander

New president Mark Orchard

CONFERENCE PHOTOGRAPHY: THEODORE WOOD

News analysis

Headline issues in the spotlight

Bleak midwinter

Fears over the impact of rising demand at a time of financial difficulty appear to have come to a head this winter. Seamus Ward looks at how the NHS and politicians have reacted

That winter 2016/17 would be tough for the NHS was not up for debate. As statistics showed the usual summer lull in demand being replaced by activity levels similar to those seen in previous winters, it seemed inevitable that this winter would be particularly difficult. The health service will be grateful for the relatively mild winter so far, though it remains wary of a prolonged cold snap and the ever-present threat of norovirus, but clinicians say December and the first half of January saw unprecedented levels of demand.

Clinical leaders raised concerns about the quality of care the service can provide and urged the government to re-examine NHS and social care funding. In January, the Royal College of Physicians wrote to the prime minister saying the increase in need was outpacing resources. High demand was paralysing hospitals, preventing their transformation; there were too few qualified staff; and services were 'struggling or failing to cope'. It called for 'the reinvigoration of social care services and urgent capital investment in infrastructure'.

The British Red Cross went one step further, saying the situation in A&E was nothing short of a humanitarian crisis and its staff were helping out in 20 emergency departments.

Its chief executive, Mike Adamson, said: 'We see people discharged from hospital to chaotic situations at home, falling and not being found for hours, not being washed because there is no carer to help them. These are people in crisis, and in recent weeks we have started talking about this as a humanitarian crisis. We don't say this lightly.'

The claim was strongly refuted by both health secretary Jeremy Hunt and the prime minister, Theresa May. She said: 'We recognise the pressures that the NHS has been under over the winter – this is not unusual. There are always extra pressures for the NHS over the winter period.'

Mrs May agreed to meet House of Commons select committee chairs to discuss their call for all parties to reach a consensus on health and social care funding. However, she is said to be unimpressed by NHS England chief executive Simon Stevens. At a Commons Public Accounts Committee hearing, he appeared to contradict the government's position that the NHS is getting more than the £8bn it asked for in the *Five-year plan*.

It's a highly charged and politicised atmosphere, but what do we know about what's happening at the frontline? Official figures show pressure is growing. NHS England weekly performance figures for 2-8 January show bed occupancy rates between 93% and 96% – well above the 85% recommended level.

A recent National Audit Office highlighted growing demand for ambulance services – averaging 5.2% a year since 2011/12. Though it pointed out potential efficiencies, NHS ambulance services said funding had not matched rising demand and it is likely future settlements will be tougher.

The Scottish service turned in a similar performance to last year, with around 88% of patients seen within four hours in the first week of January. However, this was achieved with 3% more attendances.

In Wales, for all types of A&E unit, the figure

Long-term problem

Hospital admissions have increased by 3.6% a year since 2003/04, outstripping rises in the NHS budget, according to the King's Fund.

In an analysis of hospital activity and funding, it said health service budget rises averaged 4.8% a year in real terms between 2003/04 and 2010/11, but they have fallen to 1.2% a year since then.

Emergency admissions from major A&E departments have increased by an average of 4.3% a year since 2003/04. Planned activity has also risen – outpatient attendances have increased by an average 3.8% since 2007/08, while elective admissions have gone up an average of 4.3% since 2003/04.

The fund added that the rise in hospital treatments could jeopardise the *Five-year forward view*, This assumed growth in hospital activity would be reduced to 1.3% a year, when in the first six months of 2016/17 it rose by 3% compared with the same period in 2015/16.

King's Fund chief executive Chris Ham (pictured) said: 'The NHS is treating more patients than ever before, which is a tribute to the hard work and commitment of its staff.'

But he added: 'With the gap between funding and hospital activity set to grow over

the next few years, the NHS needs to do everything it can to moderate demand for hospital care.

'We know that some of this demand can be avoided if alternative services are available – the challenge is to provide the right care in the right place at the right time and to ensure that hospitals are only used when necessary and appropriate.'

Downing Street suggested that GPs could do more to relieve pressure on A&E by opening during the day and extending opening hours to 8pm, seven days a week

was 81% in December 2016 (81.5% a year earlier), though there were fewer attendances than the previous year.

The figures in England particularly prompted stories of an NHS crisis. HFMA policy director Paul Briddock said the NHS had seen this winter's difficulties coming and had been working hard to limit its impact.

'Finance directors have been warning for some time about the impact the current financial situation would have on the quality of services,' he said. 'Reports of waiting times and missed targets are the ongoing signs of a decline in quality for patients across the UK.'

He added: 'In July and December last year, the HFMA's *NHS financial temperature check* showed that more than one in five finance directors believed the quality of patient services would deteriorate in 2016/17.'

And before this, in November 2015, some 43% said they didn't think the NHS could continue to deliver the current levels of quality within the increased funding currently promised.

'This was not media scaremongering but a reality check on the pressures the NHS is under and expected to deliver against.'

Some sections of the media, which are perhaps looking for causes of the current problems beyond those already well rehearsed – the ageing population and funding squeeze, particularly in social services – have turned their attention to the role of managers in the planning and delivery of services. Are managers to blame, they ask.

Care Quality Commission chief inspector of hospitals Mike Richards said the NHS as a whole was under tremendous strain. It needed both strong management and additional funding to relieve the pressure.

'Management is part of the solution, though there's also the increased activity that ultimately will need more funding. You can't go on doing more and more with the same funding, so it's a combination of the two. But we are seeing that those hospitals with strong leadership are doing better in difficult circumstances than others.'

Speaking to Radio 4's *Today* programme, he added: 'I believe the government is going to need to put more money in over time. As and when that does happen, as I hope it will, we need to use it wisely.

'I think there have been previous occasions when money has gone into the NHS and it has not been used wisely. That's when the good leadership, the transformation and greater integration is going to be all-important.

'Social care is at a tipping point. We do need more funding for social care – there is no doubt about that in my mind – but it is not the whole of the problem. We are seeing increased attendance rates at all ages in hospitals, not just at old age. There are more call-outs for ambulances, more pressure on A&E departments, more admissions. It is a big problem of increased activity, not just about discharge, although that's important too.'

According to the government, the failure of many GP surgeries to open during normal office hours is adding to the pressure on A&E.

A National Audit Office report, *Improving patient access to general practice*, found that 46% of practices in England closed at some point during core hours – between 8am and 6.30pm. Practices are not required to be open during these hours, but must provide essential services to meet their patients' needs.

"We are seeing increased attendance rates at all ages in hospitals, not just at old age. There are more call-outs for ambulances, more pressure on A&E, more admissions"
Mike Richards, CQC

The NAO found that 18% of practices closed at or before 3pm on at least one weekday. However, three-quarters of those practices received additional funding to provide access to out-of-hours care. And patients registered to practices that open for fewer than 45 hours a week attend A&E more often – on average 22 more attendances per 1,000 patients.

Armed with this report, Downing Street suggested that GPs could do more to relieve pressure on A&E by opening during the day and extending opening hours to 8pm, seven days a week. In future, extended hours funding would be linked to GPs offering appointments at the times patients wanted.

Doctors were furious, with the British Medical Association claiming the government was attempting to 'scapegoat overstretched GP services when the cause of this crisis is that funding is not keeping up with demand'.

NHS Providers called for a wide-ranging review of how winter pressures are managed, including whether the service should revert to dedicated winter funding. It said many trusts believed mainstreaming the funding into the overall NHS budget has led to the loss of winter capacity. The review should also look at the effectiveness of cancelling elective operations and access to primary and social care.

This was always going to be a tough winter for the NHS, but can the service continue to keep muddling through?

Comment

February 2017

Mind the gap

Let's keep perspective and a focus on ending 2016/17 in the best possible financial shape

Unless you were hiding under a rock, you will have been unable to avoid the early January media frenzy. Even the British Red Cross chief executive – a society that has a long and valued history of working with the NHS – stood by his description of a 'humanitarian crisis' gripping the NHS.

The pressures facing the health and wider social care system continued to dominate the news until the focus gave way to Donald Trump's inauguration as US president and the continuing story that is Brexit.

In the NHS, the story behind the headlines was indeed remarkable. However, reporting is all a case of perspective. Reports chose to focus on the longest waiting times in A&E for over a decade, patients cared for on trolleys, cancelled operations and hospitals declaring major alerts. An alternative reading – albeit less dramatic – would be that NHS staff, through dedication and hard work, are coping remarkably well in the circumstances.

We also need to beware of simplistic assessments of why demand is rising so persistently. The infamous 'graph of doom' provided a simple illustration of how a financial gap would open up as demand rose faster than funding, and we have now very definitely entered the gap years.

Again, we need to avoid overly simplistic conclusions about the sustained increase in demand. It is too easy for commentators – including those in the service – to oversimplify 'the problem' as being one that can be solved by the public being encouraged to choose services wisely.

The pressure on A&E departments, ambulance services, acute mental

HFMA president Mark Orchard

Timescale key to cutting waste

The OECD says about a fifth of health spending adds no value, but eliminating waste takes time

Wasteful healthcare spending is common, according to a new report from the Organisation for Economic Co-operation and Development (OECD). The report – *Tackling wasteful spending on health* – suggests that, despite health budgets being under pressure across the world, about one fifth of health spending 'makes no or minimal contribution to good health outcomes'.

The finding should come as no surprise. Don Berwick, former chief executive of the Institute for Healthcare Improvement in the US, famously suggested, several years ago, that the US healthcare system was wasting at least that figure across six categories. There was no reason to think other health systems were any different.

The OECD report backs up its assessment with various examples covering wasteful clinical care, operational waste (including poor targeting of hospital care) and governance-related waste. On the clinical care side, these include repeated diagnostic tests or services and patients receiving low-value care or even care that causes

Healthcare Finance editor Steve Brown

SHUTTERSTOCK

"We need to exit 2016/17 in the best possible financial shape. Anything less would seriously damage our ability to create a platform for transformation"

health and primary care has more to do with a sustained increase in the complexity of cases – a factor of an ageing population – than large numbers of 'trivial' patients accessing services via the wrong door.

While local government has faced major financial pressure, demand for social care is driven by similarly complex drivers.

Efficiency will take us part of the way – there is so much more we can do – but on its own, this won't forever bend the two plotted lines on the graph.

Transformation will also make its contribution – though more preventative activities and services delivered in the community is, in any case, the right way to go.

But we also need to fully understand the challenge we face. For example, official estimates suggest by 2039 more than one in 12 of us living in the UK will be over the age of 80, broadly double the current level.

With such demographic pressures, it is hard to see how the country could avoid a simple national choice between increased health and social care funding or changing the services currently delivered free at the point of need for all.

Those of us working in the service may argue that is an easy decision, but it certainly lends weight to calls for a cross-party review of future NHS and social care needs.

So what does all of this mean for the average jobbing finance professional, today?

Right now, we need to exit 2016/17 in the best possible financial shape. Anything less would seriously damage our ability to create a platform for transformation over the next two years.

With just a small handful of exceptions, all inter-NHS contracts have been agreed up to March 2019. With an implied acceptance that we now need to make the money go around, our immediate focus has to be on working with clinical and operational colleagues across all parts of the service – removing any and all barriers that get in the way – to maximise our collective ability to continue to deliver for patients and service users in our local settings.

Everyone counts, and we all have a part to play, in a year that will set the direction for the NHS as it approaches its 70th birthday and beyond.

Contact the president on president@hfma.org.uk

serious complications. Looked at alongside high-profile reports of the current pressures on the NHS, this could lead people to believe that the solutions to the health service's financial problems are entirely within its own hands. All it needs to do is eliminate its waste and redirect the resources to meet the real demand.

But identifying waste (real and potential) is one thing, eliminating it is not so simple.

It is not that it can't be done, but it will need time and energy. And they are two things in short supply right now with clinicians and support teams stretched to breaking point to meet unprecedented demand.

What seems simple – taking procedures of limited clinical value off the treatment menu, for example – is rarely straightforward. An item on Radio 4's *Inside health* programme in January demonstrated this perfectly. The incision of meibomian eyelid cysts is typically not funded by clinical commissioning groups and regarded as 'by exception only' treatment. But an eye surgeon on the programme said this was a false economy, even suggesting that the cost of asking for exceptional funding exceeded the cost of treatment.

So you need a common definition of waste and sensitive access controls put together by clinicians and managers. There's no simple flick of a value switch.

The OECD report is a useful reminder that there is in general significant potential to get better value for money out of existing healthcare resources. But the danger is that it could get seen as an excuse to justify current funding levels.

All organisations carry waste in them. And the NHS is no different. (Or perhaps it is different in having greater scrutiny put on it.)

There are lots of good initiatives that aim to tackle this waste – atlases of care providing opportunities to compare variations in activities and vanguards looking to revise pathways, in part to ensure patients are treated in the best, most cost-effective way.

Of course, more could be done. NHS Improvement's Jim Mackey called for increased focus on the 'incredible variation across the provider sector and within

"You need a common definition of waste and sensitive access controls put together by clinicians and managers. There's no simple flick of a value switch"

organisations', when he addressed December's HFMA annual conference. But it is hardly as if clinicians or managers are twiddling their thumbs wondering what to do with their time. The reality is that there is a significant amount of waste in the NHS *and* it needs more funding. It needs this funding to meet the huge demand it is currently facing while it looks to redesign more efficient pathways.

By all means, there should be downward pressure on budgets to create a sense of urgency in the pursuit of greater productivity. But expecting a miraculous and unrealistic conversion of existing 'waste' into usable resources will undermine any attempts to put the service on a sustainable footing for the long term.

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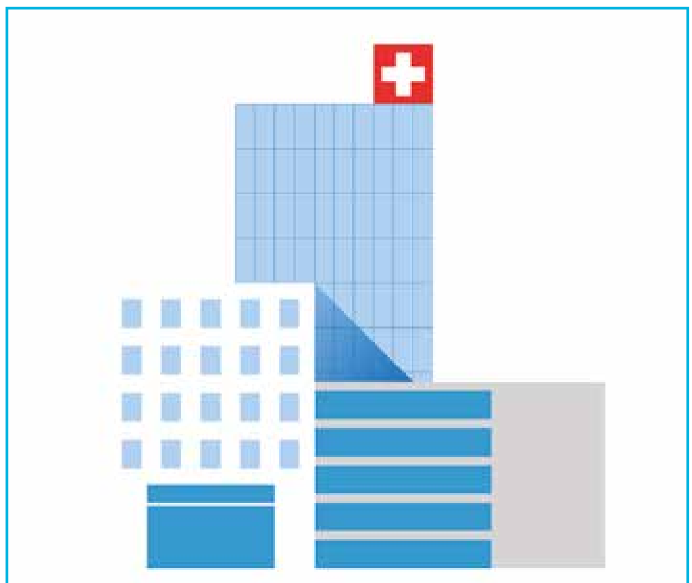
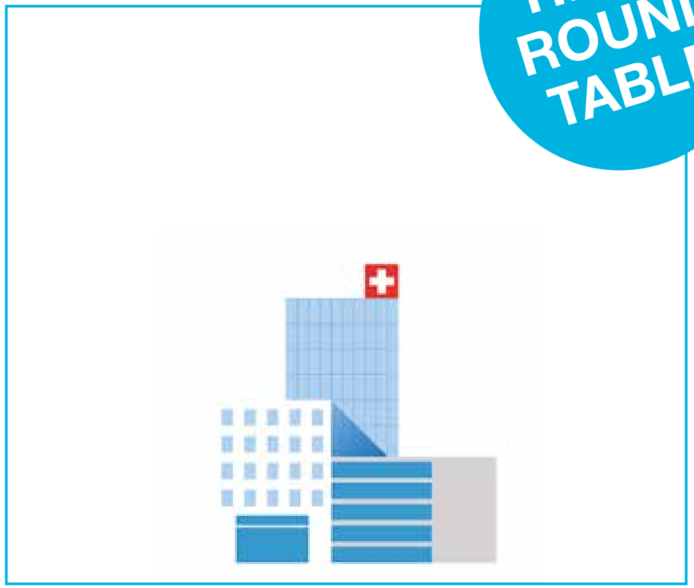
Sizing it up

A recent roundtable looked at the issues facing small hospitals and how they can adapt to create a sustainable future. Seamus Ward reports

HFMA ROUND TABLE





Small hospitals have been a concern for a number of years. Can they be clinically sustainable, offering services that are of expected quality, while balancing the books? Can they remain viable at a time when much of secondary care is either moving into larger, specialised centres or being devolved out of hospital and into the community?

A recent HFMA/Grant Thornton roundtable sought to set out the issues faced by small hospitals and plot a course for their future. Before it became part of NHS Improvement, regulator Monitor defined small hospitals as those with fewer than 700 beds or less than £300m income. And, as discussions opened, it quickly became clear that while small hospitals experience similar problems as those in their larger counterparts, the impact of the issues can be disproportionately greater.

HFMA policy director Paul Briddock said the association had completed informal research on the financial position of 40 small to medium-size hospitals at the end of 2015/16. This showed the majority were in deficit, and this was in line with the position outlined in the quarter three report for 2015/16 issued by Monitor.

Clinical staffing is a major issue for all hospitals, but the roundtable participants agreed that it is difficult for small hospitals to recruit and retain doctors and other clinicians. This had a knock-on effect of increasing the need for agency staff, but even temporary staff were difficult to attract at capped rates.

Rebecca King, deputy director of finance at Dorset County Hospital NHS Foundation Trust, said it can be a struggle to keep up staffing ratios. The trust has challenges in recruiting to some key medical posts and medical locum costs are high. Although it was determined to hit its agency cap, it was hard to get staff to come to the trust at capped rates.

'We have to have them, as otherwise we couldn't run a safe service,' Ms King said. 'Being small, we have some services that are single-handed or run by two consultants, so it can be a struggle for them to run on-call rotas. This puts pressure on costs and is something that is not reflected in the tariff.'

In a small hospital, with some services run by one or two consultants, on-call services can be difficult to arrange without locums. The same is true for absences or if one consultant decides to take a post elsewhere.

HFMA immediate past president Shahana Khan, who is finance

Roundtable participants

- Clive Andrews, associate director of finance, Wye Valley NHS Trust
- Paul Briddock, policy director, HFMA
- James Cook, director, Grant Thornton
- Karen Edge, deputy director of finance, Mid Cheshire Hospitals NHS Foundation Trust
- Shahana Khan, finance director and deputy chief executive, George Eliot Hospital NHS Trust
- Rebecca King, deputy director of finance, Dorset County Hospital NHS Foundation Trust
- Mark Stocks, partner, Grant Thornton

HFMA ROUND TABLE

director and deputy chief executive at George Eliot Hospital NHS Trust, said medical sub-specialisation was exacerbating the issue. This added to the complexity of potential solutions, such as sharing clinical posts across different organisations.

Ms King agreed – a doctor was more likely to pick a whole-time contract in one hospital over a role shared across hospitals. 'Unless they have a link to your location, or it's where they want to live, they won't want to work across two or maybe three hospitals when they can be whole-time in another,' she said.

Clive Andrews, associate director of finance at Wye Valley NHS Trust, said that as well as financial issues, his hospital had experienced diminishing flexibility as it ran at almost maximum capacity all year – a difficulty felt more acutely in a small trust than one with more beds.

Despite these issues, the roundtable highlighted areas of good practice, and solutions to problems faced by small hospitals. Chief among these was the need to collaborate and integrate. Collaboration could mean contracting out services to another provider or working with others to allocate activity to the most appropriate hospital. Though the roundtable stressed the need for this to be clinically led and in patients' best interests, practitioners also pointed out that transferring services can leave trusts facing stranded costs.

Karen Edge, deputy director of finance at Mid Cheshire Hospitals, said difficulties often lay in medical specialties. Sometimes changes needed a push, such as in the national vascular consolidation work. 'It was a catalyst for clinicians and it is better for patients, but we ended up with a £500,000 loss on the vascular changes,' she said. 'We needed to lose 1.5 ITU beds and six surgical beds – you can't dispose of those costs easily, but you do lose all the income. This can be a particular problem for small hospitals.'

Also, in considering new arrangements, roundtable delegates said trusts should be aware that sometimes patients are comfortable receiving care in their local hospital and simply do not wish to travel to another town or nearby city to get the care they need.

Grant Thornton partner Mark Stocks said trusts were using different models of collaboration. Clinical pathways were being examined to allocate work to the best placed provider or to deliver elective care – by moving large parts of the elective workload to specialist facilities or satellite hospitals, say, leaving the main site to focus on emergency care.

Role of STPs

But with sustainability and transformation plans (STPs) highlighting the need for collaboration more generally, could they have a role in helping small hospitals increase their sustainability? While the roundtable agreed it was early days for STPs, Ms Khan said some small hospitals were already pushing ahead with different models.

Other participants were implementing networking or collaborative arrangements, sharing staff or facilities. The Mid Cheshire trust buys in consultant time from other trusts under different models. So, in haematology and cardiology, 'bought in' consultants from another provider see inpatients at trust premises. But, as it is unable to fill weekend ENT rotas, the trust offers a 24-hour weekday service until 5pm on Fridays. The weekend service is then provided at University Hospitals of North Midlands NHS Trust. However, Ms Khan and others cautioned against wholesale shift of activity to larger hospitals. Many services in small hospitals have excellent outcomes, while some larger providers struggle to cope with the demand they face, she said.

For a small hospital with good-quality services and spare capacity, it made sense to understand opportunities available to provide services locally and to have a more joined-up approach across the system.

Wye Valley 's Clive Andrews said STPs were the best way forward for the service as it develops medium- to long-term strategies. 'They will help plan some of the changes that will undoubtedly have to happen and bringing all the health organisations and local authorities together has got to be helpful. But we have to get the public on board – that's the big issue we are going to face.'

Merger questions

While many of the potential solutions to clinical and financial sustainability lie in working with external partners, Ms Khan said this did not necessarily mean mergers and acquisitions. Grant Thornton director James Cook agreed. He said: 'We have seen that mergers haven't always worked. However, trusts are looking at vertical integration with primary care or with social care to see where they can get synergies.'

Ms Khan's trust is looking to build sustainability on three concentric circles. She said: 'The first is that we need to drive through more efficiencies internally, through tackling waste and waiting etcetera. The second is around collaboration with our partners, such as pharmacy services and other non-frontline services. In the third circle we are looking at building a health and care hub because we have the opportunity to gain a better return from the physical estate.'

The hub could potentially include the third sector, social services step-down centre and key worker accommodation. 'We are talking to several organisations. So the future of the hospital site isn't necessarily just as a hospital – it's as a health and care hub.'

It is not alone in looking at integrating services. Ms King, from Dorset County Hospital, said it was developing plans for an integrated care hub with step-up and step-down beds.

Mid Cheshire Hospitals recently acquired community services, which it hopes will help improve issues over delayed transfers of care. It is working on plans to redesign pathways and integrate the workforce to create community teams, pulling patients out of hospital.

Mr Andrews said Wye Valley manages community services and has some community beds on three sites. 'The trust's priority remains avoiding delayed transfers of care to aid pressure on acute beds. We are looking to use our existing bed base as flexibly as possible.'

Mr Briddock wondered if small hospitals would need capital funds to adapt their estate to provide integrated services. However, Ms Edge suggested it might not be needed. 'Community services can operate from anywhere. You are supporting the patient to be at home and wrapping services around them.' If funds are needed, Mr Cook said, some had been identified in the *General practice forward view.*

His Grant Thornton colleague, Mark Stocks, said funds could come from local government following the announcement of increased funding at the end of 2016. 'Local authorities are thinking about how to invest their social care money and there's a chance to have a conversation about step-up and step-down teams,' he added.

While it is clear small hospitals face similar issues to their larger counterparts, these can have a disproportionate impact. But, as the roundtable demonstrated, they have identified the issues and are seeking to address them through collaboration, integration and innovation.

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> **"There is more we can do at the HFMA to facilitate learning and sharing across all four nations. We will find practical ways of making that happen during my year"**
> **Mark Orchard**

Collaborative solution

The Dorset health economy – with three district general hospitals, a community and mental health provider and a single clinical commissioning group – faces all the same challenges as the UK health system as a whole.

At Poole hospital (right), Mr Orchard has worked with local NHS leaders to devise a system approach to these challenges. The Dorset sustainability and transformation plan (STP) estimates that, with no change, the system will have a £229m deficit by 2020/21. Its proposed solution has three strands: prevention at scale; integrated community services; and a single acute network with, potentially, significantly revised roles for the county's three district general hospitals.

But more fundamental than this, Mr Orchard says there needed to be a system-wide recognition of the near-term reality of the financial position – there is no additional money – and that old transactional-based contracting arrangements would no longer work.

Instead, the Dorset STP translated this into a financial framework for the next two financial years, enabling the bodies involved to focus on planning for operational delivery within available capacity from next year.

Mr Orchard says a new two-year single collaborative agreement, starting in April, for the first time 'contractually commits individual organisations to work in the joint interest of the whole system in terms of funded capacity and demand management'.

It committed to initial programmes of work, requiring delivery in January and February, so that the collective system will be best placed to deliver in the years ahead. All agreed actions will be tracked on a system scorecard, with transparent key performance indicators to enable system partners to hold each other to account and take corrective action where needed.

This will be reported at appropriate intervals to the Dorset system leadership team. The information will also form the basis of how delivery will be reported to NHS England and NHS Improvement.

'Clearly, the significant work begins now, but our joint ambition is that by working together we will be able to continue to deliver services across Dorset that best meet the needs of our local patients and service users,' he says.

For Poole this means a sizeable 4.7%, or £11m, cost improvement programme during 2017/18.

All parties recognise how demanding this efficiency is – for example, exceeding Poole's current year CIP target of 3.9%.

But there have been upsides to the new collaborative

Everyone counts

Everyone in NHS finance has a role to play in the current challenges and the HFMA needs to target support at all its members, says new HFMA president Mark Orchard. Steve Brown reports

Mark Orchard, HFMA's new president, wants the HFMA to become a one-stop shop for its members. That's the core of his theme for the year – *Everyone counts*. He is clear that the demand on NHS services has never been greater. And with austerity creating specific challenges for the 20,000 strong NHS finance community, he says the association needs to ensure it provides support across its whole membership.

Mr Orchard, director of finance at Poole Hospital NHS Foundation Trust, took over the presidential role from Shahana Khan at the HFMA annual conference in December. The conference programme included all the key system leaders and health service commentators and left delegates in no doubt about the scale of the current challenge.

Put simply, rising demand coupled with inflation is outstripping increases in healthcare funding. Mr Orchard says he is well aware of the challenges facing the NHS and the finance community. The service is already struggling in 2016/17 with spending review resources frontloaded (a 3.7% real-terms increase in England). But from April, increases become far less generous (1.3% in 2017/18 and 0.3% in 2018/19) as the service enters the so-called funding 'u-bend'.

These pressures are being felt across the whole NHS. Although local contexts can be different – depending on historical funding and structures – the challenges are similar. In Dorset, for example, – Mr Orchard's local health economy – the health system is aiming to rebalance acute and community services to close an estimated £229m deficit by the end of 2020/21 (see box below). It requires change and productivity improvement on an unprecedented scale.

The finance function will need to be at the heart of meeting this challenge and will be under significant pressure to deliver. That's why Mr Orchard wants to make sure the HFMA is providing the right support across the whole function and the whole UK health service. That support cannot just be at director level, or focused on just the English service; it needs to be at all levels of the function and UK-wide.

'Given the challenges we face, the association and its members need to support everyone across our unique network, irrespective of: which bit of the devolved NHS they work within; whatever level they are working at; whether qualified or unqualified; and certainly irrespective of gender and ethnic background,' he says. Every member of the function has a role to play and he is determined that 'every single member feels valued'.

He insists the HFMA is ideally positioned to help finance teams share best practice and solutions to common problems. In particular, he thinks the four UK health systems can do more to learn from each other.

'Northern Ireland and Scotland have very different, but equally valid, experiences of integrating health and social care,' he says. 'Wales has moved beyond the NHS internal market we still cling to in England, despite a new emphasis on system collaboration. England has made some great progress on costing. So, despite our different starting points, I believe there is more we can do at the HFMA to facilitate learning and sharing between and across all four nations. We will find practical ways of making that happen during my year.'

The approach to commissioning is a good example. The activity – understanding the needs of local populations and ensuring services are in place to meet them – remains vital and each UK health system has to undertake this. But it is achieved in a variety of ways. Has the English approach become too transactional? Does the lack of a direct link between activity outcomes and payment outside of England undermine initiatives to improve cost at service line level?

There will be pros and cons to each approach, but Mr Orchard believes the association, with branches and members in all four nations, is well placed to 'facilitate learning' and discuss the relative merits. Different approaches to health and social care integration is another

approach. 'We've never before had the certainty of agreeing the financial parameters that early in the year [October], and that really focuses the mind quickly on the actions needed,' says Mr Orchard.

'By the time we submitted our draft plan at Poole, clinical directorates had already identified £5.4m CIPs and by the final plan, we had another £2.6m of pipeline schemes. But this still leaves a significant £3m of CIP unidentified and a scale of challenge that this hospital has not seen historically.'

The whole system is now focused on addressing demand – and ensuring it is met by services at the right time and in the right place. The plans are based on activity being contained within the forecast 2016/17 levels, despite the trend suggesting increases effectively across the board (over 4% for elective and non-elective inpatients, for example).

The flat activity target relies on quick wins – delivering best practice in referral management, reducing low value procedures and implementing *RightCare* and the *Getting it right first time* orthopaedic programme.

Mr Orchard believes the collaborative approach offers the best chance of success – and early progress has been good – but he says achievement of the efficiency targets will be demanding. The full-year effect of significant reductions in agency staff costs – from £526,000 in April (well above the £370,000 monthly spend implied by the trust's agency staff cost ceiling) to £263,000 in November provides a good start.

The STP also anticipates a reduction of time in beds across the county's hospital sites. With current demand trends, new models of care will need to be up and running and effective fast – being explored (and consulted on) in Dorset as part of an acute care collaborative vanguard.

THEODORE WOOD

Mr Orchard acknowledges that while the move to more community services is the right thing to do, it is a 'leap of faith' in terms of its cost impact. But there are no other options. 'There is no plan B,' he says.

Underlining the challenge, Mr Orchard says 'exiting 2016/17' with the best financial results possible is vital to the health economy's longer term goals – especially with major reductions in the amount of real-terms growth in the NHS settlement over the next few years.

The X-factor

Mark Orchard claimed a first as he made his inaugural speech as president to the HFMA annual conference in December. 'I am your first president to be born in the 1970s, so I guess that makes me a generation X president,' he said.

With vague definitions on when generation X began, earlier presidents may contradict this claim. But Mr Orchard is without doubt the first president to launch his year with a rap. His brief excursion into hip-hop (pictured) – which he tested first with his two children – was well-received, demonstrating perhaps a determination to be noticed and to prove that working in NHS finance can still be fun despite the very serious financial context and current pressures.

An economics graduate, Mr Orchard started his accountancy training in the private sector in Abergavenny before joining an NHS-hosted audit consultancy, where he gained his ACCA qualification.

Mr Orchard moved to England in 2003 for a further brief role in audit, at Winchester and Eastleigh Healthcare NHS Trust, before starting on a career path in commissioning.

He held deputy finance director positions at South and East Dorset and then Bournemouth and Poole primary care trusts, advancing as commissioning was restructured, before gaining his first director role at Bournemouth in 2009.

Here he oversaw the transfer of community services to a local provider, led the HFMA Accounts Team of the Year (2010) and chaired a South West director group to put all local commissioners on the same ledger and payroll platform.

As the commissioning structure continued to change, in 2011 he became finance director of the PCT cluster comprising NHS Bristol, NHS North Somerset and NHS South Gloucester.

In 2012, he became finance director of NHS England (Wessex), overseeing the creation of nine local clinical commissioning groups and the demise of the local PCT cluster.

While here, he also played a leading role in establishing the Future-Focused Finance NHS finance development strategy, leading initially on the strategy's *Foundations for sustained improvement* action area.

He moved to his first senior role in the NHS provider sector in May 2015 as finance director of Poole Hospital NHS Foundation Trust. Prior to this appointment, he had been preparing to take the HFMA president's role for 2016.

However, in order to enable him to focus on his new appointment, he deferred his presidential year.

Shahana Khan, finance director at George Eliot Hospital NHS Trust, was originally due to be president in 2017 but brought this forward to enable the switch.

"I will prioritise my HFMA time with a bias towards getting out to the branches"

potential area that could benefit from more comparative analysis and discussion. While determined to improve communication and cross-fertilisation of ideas across the four nations, he also wants to build on the association's links with the US and Australia. But he wants to explore how technology could help connect core memberships of healthcare finance bodies, rather than relying on presidential engagement.

All HFMA presidents face a busy HFMA programme alongside their senior substantive roles. And Mr Orchard is pragmatic about what he can do over the next year. 'Let's be absolutely honest – I've got a day job and that comes with a control total and a whole bunch of other things to deliver on. And that's no different to any other finance director in the service,' he says. 'So my prime focus has to be ensuring that, in my case, the Dorset system continues to deliver for local patients and service users. That said, when it comes to my HFMA year, I will prioritise my HFMA time with a bias towards getting out to the branches.'

Branches are the 'lifeblood' of the HFMA, he says. The association benefits from widespread contributions from members, sitting on committees and special interest groups, for example. But for many members, the branch represents their whole direct engagement with the HFMA. Mr Orchard wants to ensure branches get the right recognition and he'll contribute to this by ensuring he visits every branch in 2017.

While getting around the country, he wants to listen to and learn from members – how is the association supporting members locally and what more could it do centrally to support local activity? – and feed this back into the support programme the association provides.

HFMA members are also likely to be more aware of the association's national board, which will be more visible, says Mr Orchard. New additions will cement links between the HFMA and the Future-Focused Finance (FFF) initiative. Mr Orchard was national lead for the improvement programme when it was set up three years ago (while he was finance director for NHS England's Wessex area team). The initiative owes a lot to Mr Orchard's vision and drive and it is no coincidence that his theme for the year as HFMA president – *Everyone counts* – closely resembles the FFF overall aim of *Making people count*.

Caroline Clarke, finance director at the Royal Free London NHS Foundation Trust and senior responsible officer (SRO) for the FFF value workstream, has joined the HFMA board. And so has Sanjay Agrawal, SRO for FFF's close partnering work. A consultant respiratory intensivist at University Hospitals of Leicester NHS Trust, Dr Agrawal also represents the HFMA's first ever clinical member of the HFMA board.

The HFMA has long championed clinical-financial engagement and Dr Agrawal's appointment is a further demonstration of this commitment, underlined by plans to establish a new HFMA clinical forum alongside a new social care faculty (in partnership with CIPFA).

With plans for an HFMA app to deliver member services and the start of the association's qualifications programme (see page 22), there's a busy year ahead. And Mr Orchard is determined to make it count.

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Good education

With very few options for gaining an accredited qualification in health finance, the HFMA has launched two masters level diplomas that either stand alone or provide a pathway to a full MBA in healthcare business and finance. Steve Brown reports

Pilot lessons: Loraine Penman
Senior information officer, NHS Education for Scotland
Module, C1: How finance works in the NHS

Loraine Penman qualified with CIPFA back in the 1990s while working at Leeds Teaching Hospitals NHS Trust, but her career has also involved working in local government and the private sector, providing consultancy services to the NHS.

More recently, she has worked in Scotland, with her latest position providing temporary cover at NHS Education for Scotland. Her role heading management information means she covers reporting (including finance and cost data) as well as systems support.

She is a keen supporter of training and development and sees her piloting of the *How finance works* module as a good way of helping the association to develop a worthwhile programme. She admits that, given her career and experience, she is up to speed on a lot of the content – although it provides a good refresher and there are always new things to learn.

Ms Penman admits she is viewing the assessment with some trepidation, given the gap since her last formal academic activity. But recognising the assessment requires a 'different frame of mind' and skills that she doesn't typically use in the workplace, she is also looking forward to the challenge. She adds that the live discussions are really useful – she has been particularly interested listening into some of the issues raised by commissioning staff in England – and that the discussion forums could be really helpful once they are more populated with students using them more often.

'There is a noticeable lack of qualifications in the healthcare finance arena,' says HFMA director of education Alison Myles. 'If you have your professional accountancy qualification, what else can you look at to develop your studies further, alongside your day job, or help yourself prepare for a next career move? And for those people currently in healthcare who want to understand more about the financial side, without actually becoming an accountant, there are precious few options.'

In fact, when the HFMA undertook some research into the area, it found just one foundation-level (pre-degree) qualification that dealt directly with healthcare finance, but without going down the pure accountancy route. For accountants, there were plenty of MBAs and many specialising in healthcare management – but none that provided specific opportunities to tailor studies around healthcare finance.

So it decided to fill the space itself. In December, the HFMA launched two masters-level qualifications. The HFMA diploma and higher diploma provide good qualifications in their own right. But successful completion of both diplomas (each worth 60 credits) would entitle the student to move on to an MBA top-up programme (worth a further 60 credits) being developed by the HFMA's partner BPP University. A

programme will shortly be put to BPP's School Review Board for formal validation.

The new qualifications represent a natural progression for the HFMA. The association is an authority on NHS finance and governance issues – with a focus on technical detail and providing practical support to finance practitioners. It runs a successful and well-regarded events programme, but in recent years it has also established itself as a leading provider of e-learning.

These e-learning modules have been particularly popular with newcomers to NHS finance teams and with non-accountant budget holders – providing short (typically up to 2.5 hours) introductions to key financial topics such as budgeting, business cases and costing. Completion of five modules led to an *Introductory award in healthcare finance*.

But the new diplomas take the HFMA to a completely different level in terms of qualifications, providing higher level accredited qualifications (all three modules of the qualifications lead to masters or level 7 awards). But the qualifications do build on the approach at the heart of e-learning by providing a flexible, online study route that is designed to suit students working full-time in the NHS.

The diploma and the higher diploma each require the completion of three 20 credit modules (60 credits in total for each diploma). One module within the diploma is mandatory (*How finance works in the NHS*), with all other modules optional. To access the diploma, candidates must have two years professional experience in the NHS, otherwise they will first be required to take the mandatory module before being able to register for the wider diploma. Successful completion of this diploma will enable entry to the higher diploma.

Professionally qualified accountants (CCAB or CIMA) with at least two years' post-qualification experience in healthcare may be eligible to gain 60-credit transfer and gain direct entry to the higher diploma.

Completion of the higher diploma will enable students to register for the full MBA – which is likely to involve either a 60-credit dissertation or a 30-credit work-based project and two further modules.

This will be a significant undertaking by anyone taking on the qualification. Each module is led by a tutor with direct experience of working in NHS finance at a senior level and is expected to last 15 weeks, with 10 weeks of teaching and five weeks working on an assignment. Students should expect to set aside 200 hours in total per module – averaging about 13 hours a week for study, including up to two hours for a 'live' webinar, and completion of assignments. Each week's topic comes with a recommended reading list and exercises to demonstrate understanding of the subject. Students will also have access to discussion forums to raise specific questions or talk around the subjects.

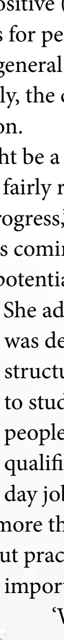
The first formal intake of students will be in May 2017, and there will be five optional modules to choose from as well as the mandatory (for the diploma) *How finance works in the NHS* module. Fifteen healthcare staff have been testing out two of the modules to help the HFMA make any final tweaks ahead of the first intake – some looking at the mandatory core module and others taking the optional module on value (*Creating and delivering value*). Early feedback from this pilot exercise has been very positive (see 'Pilot lessons').

Mrs Myles says the qualification caters for people with lots of different backgrounds – clinical, non-executive, general management and administration – but that, at least initially, the core interest is expected to come from the NHS finance profession.

'We anticipate a typical candidate might be a qualified accountant with a few years' experience. They've studied fairly recently and are looking for something to support their career progress,' she says. However, early interest is coming from a broad spectrum of potential candidates.

She adds that the association was determined to produce a structure that enabled people to study flexibly – recognising people would be looking at the qualification alongside busy day jobs that often require more than nine-to-five hours. But practical content was also important.

'We wanted the content to be relevant to the



"We wanted something that might support people to think through issues and then be better prepared to put the principles into action"
Alison Myles, HFMA

Pilot lessons: Andy Bell

Acting finance director, London Ambulance Service NHS Trust
Module O4: Creating and delivering value

A former graduate of the national financial management training scheme, Andy Bell has always taken CPD seriously and was already starting to think about an MBA when the HFMA announced its own qualifications. Volunteering to test a module was immediately appealing, especially as it has been 10 years since he completed his accountancy qualification. 'It was an opportunity to test if the qualification was worthwhile and whether I could manage it alongside a busy day job,' he says.

The time commitment – estimated at 13 hours a week – is a big consideration for any masters student undertaking studies alongside a full-time job. Talking to *Healthcare Finance* four weeks and four topics into the course, Mr Bell says it has proved to be manageable and he is impressed by the quality of the content. 'The value model is strategic and ties in well with what I do at work – perhaps even more so having stepped up from deputy finance director to acting director,' he says. 'There is a direct connection with the issues I am dealing with in my organisation and across the local system.'

The online portal and activity e-book approach is really helpful, he says. Beyond that it is about good time management – having material loaded on his ipad to read on his daily commute and getting in the habit of doing additional reading in the evenings.

Early release of the final module assessment – undertaken in weeks 11 to 15 – has also helped Mr Bell to target his learning appropriately. 'I was worried I might be getting into something completely academic, but it has proven to be the polar opposite and is aimed at providing real practical support,' he says. He will see how the module goes, but will definitely consider taking the full higher diploma with a view to moving onto the MBA.

Pilot lessons: Chris Probert

Finance manager, Aneurin Bevan University Health Board
Module, C1: How finance works in the NHS

Chris Probert is impressed with the quality, depth and range of the content in the diploma's mandatory module. And he is attracted by the idea of gaining a further qualification to support his career development.

'There is very little in further education that is directly relevant for a qualified accountant or just someone wanting to get a recognised qualification in healthcare finance,' he says. While experience is important, he is keen to supplement this with a further recognised qualification. And he was instantly drawn to something that was directly relevant to his day job rather than just having a generic relevance.

And although he has also fed back some comments about the slight English focus of the module, he has been interested to understand more about how systems work outside Wales.

However he says would-be students should be prepared to put the hours in that the diploma requires.

Mr Probert qualified with ACCA in 2011, but admits that it has been 'hard getting back into the studying habit' – especially as it now has to be fit around a busy day job.

'It works out at around two hours a day,' he says, and you need to be disciplined to prevent falling behind. He suggests that at some points in the year – year-end and working towards submitting costing returns – work pressures would make it hard to find enough time. 'If I was doing this for real, rather than as part of a pilot process, I would want to talk to my employer about how they might support me in making the time,' he says.

"We are convinced these qualifications will help professionals to develop the right skills and attributes to make this transformation a success"
Mark Knight

issues that people are dealing with,' she says. 'The NHS faces major challenges in the coming years as it looks to transform services around new models of care. And given the financial context, it has to maximise value – measured in both quality and cost. So we wanted something that might support people to think through these issues – for example while studying our value module – and then be better prepared to put the principles into action back in their organisations.'

The 'practical support' approach can also be seen with plans to add a further optional module on costing. With NHS Improvement leading a major Costing Transformation Programme – backed by Lord Carter's review of productivity – the association is in discussion with the oversight body about developing this module. This is seen by NHS Improvements as part of a package of measures to raise the profile of costing in the NHS, increase the costing function and broaden its skills.

Paul Assinder, a former national president of the HFMA, is one of six tutors who will support students through their study, leading discussions and tutorials. With more than 20 years' experience as a finance director in the NHS, in commissioning and provider bodies, he also has senior-level private sector experience, currently as a management consultant. And he is also no stranger to academia, teaching on a finance MBA as a visiting lecturer at Wolverhampton University's business school.

He was instrumental to creating, and now teaches, the *Creating and delivering value* module. He says that, on top of a rigorous and assessed development process, this final refinement step – with the pilot students – helps get the content right. 'I've been really impressed by the commitment of the pilot cohort,' he says. 'They are doing a real service to the association.'

He believes the HFMA qualifications are distinct from other offerings. 'We are trying to apply some of the more esoteric and academic content you might find in similar programmes to the day-to-day needs of individuals working in the NHS,' he says.

Managers today need to be more general business professionals, as well as specialists in their own field, and the qualifications recognise this context.

He insists the HFMA's position as an authority on NHS finance – with a recognised position as a producer of quality publications, events and training – means students will end up with a qualification that carries weight across the NHS. He believes the programme will prove attractive to finance professionals and other NHS staff outside the finance circle – and that studying in a group of finance and non-finance professionals will lead to rich discussions and more practical value.

His value module takes an 'unashamedly economics perspective', he says – for example, looking at efficiency requirements, investment planning and national allocation policy through the lens of health economics. 'The aim is to give the students a different perspective on what they are often doing on a daily basis,' he adds.

HFMA chief executive Mark Knight is excited by the new qualification. 'We've put a lot of time and planning into this qualification and it is a key landmark in the development of the association. We've listened to what our members have told us about what they and the

Find out more about the qualifications on the HFMA website at hfma.to/qualifications

broader community want and need to support their further development as healthcare professionals.

'It is an opportunity for professionals to enhance their skills and career. But it will also serve the NHS well. The content will not only deliver a more qualified and informed workforce in future, but we believe it will help people better address the challenges they face on a daily basis.

"The whole finance function and the wider workforce will need to develop new skills and different perspectives as the NHS looks to transform the way it delivers services. And we are convinced these new qualifications will help professionals to develop the right skills and attributes to make this transformation a success.'

This is an exciting development for the association and it could lead to the award of a first MBA in healthcare business and finance within the next two years.

"The aim is to give the students a different perspective on what they are often doing on a daily basis"
Paul Assinder

Pilot lessons: Michelle Gilmour

Directorate accountant for planned care, NHS Fife
Module 04: Creating and delivering value

It has been 12 years since Michelle Gilmour finished her ACCA qualification and she had already started to think about an MBA as a next step. 'Supporting the HFMA in testing the new qualification was a great opportunity and a perfect way to find out how I would cope with the workload on top of my day job,' she says.

She says her life has changed since she was last in serious study mode – she is now married and has two children. The course comes with an estimated 13 hours a week time commitment and she says you need to be structured and organised to fit it all in.

This has meant early mornings at the office, using lunchbreak and even listening to recordings on her walked commute to work. 'The reading is the most demanding part of it – the recommended list is quite extensive,' she says.

However she's enjoying the material. Value is on everybody's agenda at the moment, so it is no surprise to hear she finds the content sits comfortably alongside her day job in supporting planned care. She admits she has even picked up some specific ideas from the sections on improvement techniques and cost improvement programmes. Weekly tutorials have proved challenging to get to – frequently clashing with unavoidable work meetings. But she says the ability to catch up in your own time on-line is really convenient.

As a relatively small test group, she says interaction in these sessions hasn't been huge, but imagines this would increase dramatically with a full-sized study group once the qualification goes properly live.

Has the workload put her off taking her MBA aspirations forward? No, but she says she would have to think carefully about the time needed to do a whole diploma and to think through her next career steps before making any long term commitment to the full qualification.

Banking on it

A roundtable discussion on continuing efforts to reduce agency spending identified opportunities to improve internal solutions to staffing problems. Steve Brown reports

HFMA ROUND TABLE

In many ways, the health service's recent performance on the use of agency staff is a success story. At the half way point in the current financial year, providers had spent more than £300m less on agency staff than in the same period last year. And they were at that point forecasting a £900m full-year reduction in agency costs. This represents a major turnaround considering the trend up to this point has been for significant year-on-year increases.

However, winter pressures have further challenged trusts agency budgets and temporary staffing costs remain a major concern for NHS providers across all four UK nations. The challenges are short and long term – sustaining reduced rates paid for nursing staff and making similar in-roads into medical locum costs, while also fixing underlying problems forcing temporary staff spending. In January, the HFMA, supported by staff bank management provider Bank Partners, brought finance directors from English providers together for a roundtable discussion about key issues and to share local solutions.

The event began with a brief reminder about the key causes of the growth in temporary staff spending. Following the 2013 Francis report on problems at Mid Staffordshire NHS Foundation Trust, providers looked to increase establishments to ensure safe staffing levels. Insufficient availability of staff – a result of training too few new staff in previous years – drove trusts to agencies.

The continued short supply pushed rates higher and higher, which attracted some permanent staff out of substantive roles to become agency workers, compounding the staffing shortages facing trusts.

Roundtable delegates said it was not just safety issues that increased agency spending. 'Historically, there were specialties – acute medicine, for example, and accident and emergency – that were increasingly under pressure,' said Jonathan Stephens, until recently director of finance at Alder Hey Children's NHS Foundation Trust and now at NHS Improvement. 'Some of these roles have been difficult to recruit to, with staff shortages in what are challenging and essential roles driving up the need to bring in agency locum appointments.'

Jonathan Stephens

Sandra Easton

These roles continue to be a problem, but there are a growing number that providers are struggling to recruit to. Examples round the table included histopathologists, theatre practitioners and consultants and nurses in children's mental health services – and a more surprising challenge with the more specialist roles among administration and clerical staff (see box overleaf).

Safety and quality continue to be big drivers of the use of temporary staff. Tools to support safe staffing decisions and monitoring have been produced – first by the National Institute for Health and Care Excellence and, more recently, by NHS Improvement. But providers report that decisions are often taken on the back of individual clinical assessment, rather than based on trend or data analysis. If a chief nurse or medical director says staff are needed, few managers will disagree.

John Graham, finance director at Royal Liverpool and Broadgreen University Hospital

ILLUSTRATION: SHUTTERSTOCK

NHS Trust, said there were mixed messages coming out of the centre about the extreme pressures facing hospitals – and accident and emergency departments and non-elective admissions in particular. 'NHS Improvement recognises we are in a very challenging time and says we need to sort things out clinically,' he said. 'On the other hand, we are also being asked to deliver on the financial balance side.'

Operationally, this message is being translated into prioritising accident and emergency, ensuring rotas are filled to cope with demand and sourcing staff where they are available – often through agencies. 'What is the real priority?' asked Mr Graham.

While higher than expected activity is driving the need for additional staff, trusts continue to struggle with high levels of vacancies in their core establishments – as high as 17% in one of the trusts present. Trusts recognise that this issue needs to be fixed from both ends – sourcing new permanent staff and improving retention rates to reduce staff churn.

Sandra Easton, chief finance officer at Chelsea and Westminster NHS Foundation Trust, said the trust had introduced 'remain' interviews. 'We have these as well as the more traditional "exit" interviews to help us understand what has worked and is continuing to work for them,' she said. It is hoped this means staff get an opportunity to air grievances or difficulties in time for them to be addressed if possible – rather than forcing them to move to get a better fit.

Other trusts have similar initiatives. Don Richards, chief financial officer at West Hertfordshire Hospitals NHS Trust, said the trust's 'reconnect' programme, introduced by its human resources department, had similar ambitions. As in many trusts, executive directors are involved with staff induction programmes, but in Hertfordshire, directors come back to meet staff 10 weeks and 20 weeks post-induction. He said this helped 'build up a relationship' with the organisation and retention rates had improved.

Andrew Lee, director of finance at mental health provider 2gether NHS Foundation Trust, accepted it was about making people understand they were valued and 'doing the normal things right'. 'It is simple things like trying to ensure everyone has their appraisal – not just 70% of staff – so you are picking up issues raised by the whole workforce,' he said.

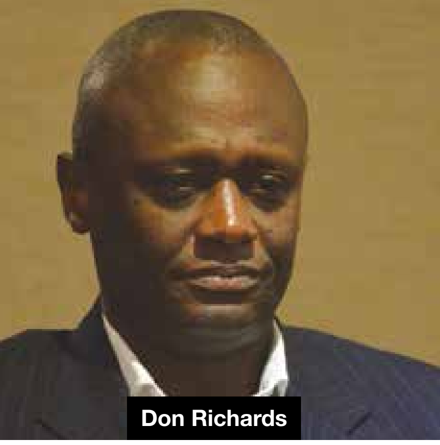
University Hospitals Coventry and Warwickshire NHS Trust has also been exploring how it might develop some form of retention package for hard-to-recruit-to areas, according to its finance and strategy director Susan Rollason. However, the trust was clear that it needed to balance any such incentives with its treatment of existing staff.

'We are still thinking this through as we don't want to send the wrong message to the people already there,' she said.

Other participants – some also exploring similar schemes – agreed that care was needed with such packages. Shahana Khan, finance director of George Eliot Hospital NHS Trust, also warned that such approaches could have unintended consequences. 'You need to be careful not to escalate rates and simply end up with organisations poaching staff from each other,' she said.

Participants

- Gary Boothby, director of finance, Calderdale and Huddersfield NHS FT
- Paul Briddock (chair), policy director, HFMA
- Sandra Easton, chief finance officer, Chelsea and Westminster NHS FT
- John Graham, finance director, Royal Liverpool and Broadgreen University Hospital NHST
- Martin Innes, agency intelligence team manager, NHS Improvement
- Shahana Khan, finance director, George Eliot Hospital NHST
- Andrew Lee, director of finance, 2gether NHS FT
- Don Richards, chief financial officer, West Hertfordshire Hospitals NHST
- Jonathan Stephens, NHS Improvement (formerly with Alder Hey Children's NHS FT)
- Susan Rollason, finance and strategy director, University Hospitals Coventry and Warwickshire NHST
- Bank Partners: Kate Harris, Antony Mann and Steve Twelftree


Don Richards

Sue Rollason

Flexible working

Improving flexible working arrangements was seen as one way of improving retention and attracting staff. Kate Harris, Bank Partners' commercial and marketing director, said the NHS was 'not particularly good at offering flexibility'. 'We are working with trusts to look at how we can enable staff to work in ways that fit around their lives,' she said.

Different lifestyle aspirations for younger staff – the millennial generation – were also cited as a cause of recruitment difficulties.

'We now have a "global" generation,' said NHS Improvement's agency intelligence team manager Martin Innes. 'We saw it in the Brexit debate: it is not just that people see themselves as European rather than British; many see themselves as global residents.'

So for a lot of staff, working abroad is part of their career plan. The NHS needs to ensure it is not pushing people into taking these decisions and work to bring similar-minded foreign health workers – also looking to work abroad – into the NHS on a larger scale.

Patient acuity and dependency is also a major driver of temporary staff in some areas. 'Some of the demand is to do with clinical need,' said Mr Lee. 'We will fairly regularly take in service users with requirements beyond what we are normally contracted to do.'

This might be an under-18 – possibly in a prison cell – needing an inpatient mental health bed but with none available via NHS England. Or it could be someone who would otherwise need to go out of county.

'We have to special them to ensure safety and this is often two (staff) to one, and in some cases three to one,' said Mr Lee. 'Commissioners will pay for this, but while it may not cost the trust any more, it does cost the health economy. So it is not just quality and safety, but clinical need.'

It was agreed that specialling was a driver of temporary staff costs for most trusts, with establishments either not taking any account of specialling requirements or only allowing for average levels. For many wards, temporary staff

are seen as the correct solution for short-term specialling requirements – though some trusts have piloted full-time 'floating' nurse teams to support enhanced care requirements.

Increasing numbers of trusts are introducing a more structured approach to decision-making for enhanced care arrangements (see *Healthcare Finance* November 2016, page 23). This can involve using a standard assessment to 'score' patients – ensuring more consistency and leaving an audit trail for decision-making.

University Hospitals Coventry and Warwickshire said such an approach had helped it take out around £1m in cost across its wards. 'It is not just about having an enhanced care team – that isn't the solution by itself,' said Ms Rollason. 'You need clarity on when someone needs specialling and what specialling actually involves.'

Spending ceilings

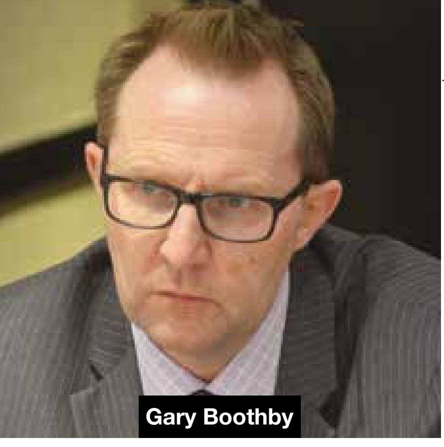
The roundtable discussed the impact of the overall agency spending ceilings and the individual rate caps. In a survey by Bank Partners, and facilitated by the HFMA before the roundtable, only a handful (6% of more than 100 participants) said the new controls hadn't helped. More than 70% thought the measures had either been instrumental in reducing costs, added control but not reduced spend, or helped but also led to some unintended consequences.

NHS Improvement has already reported savings from the new controls, but Mr Innes said forecasts suggested total agency spending would hit just under £3bn this year compared with more than £3.6bn in 2015/16 – a saving of almost £700m. Many trusts were spending below their ceiling, others above their ceiling but still down on the previous year's spending.

There was a broad consensus that the rate caps had been effective – although finance directors said it was important to look at overall pay costs, including increased use of bank and substantive recruitment – not just focus on agency spend. 'When you add back in superannuation costs and other extras, the costs can be more similar than you think,' said Ms Rollason. She added that new rules from Revenue and Customs around paying self-employed medics could change some of this.

Mr Innes agreed the overall picture was important and said that the total paybill was down this year. But he admitted this would get harder as trusts eliminated rate cap breaches. This is not surprising as the 155% agency cap level was chosen to reflect substantive rates plus add-ons – creating a level playing field.

All attendees agreed that securing medical locums at anything close to cap was far more demanding than with nursing staff. In part


Gary Boothby

Steve Twelftree

this reflected greater mobility of the locum workforce, with doctors in general happy to travel further for shifts or interim work at better pay.

Gary Boothby, director of finance at Calderdale and Huddersfield NHS Foundation Trust, said rate caps presented different challenges for trusts in different locations. The trust is forecasting a relatively significant breach of its spending cap, but took a deliberate decision to maintain safety and access. He said that bigger city trusts had more options for filling shifts that weren't realistic in their smaller town-based sites. Others suggested that whole-health economies needed to hold a common line on not breaching rate caps for the capping policy to be effective and to guard against grade inflation.

Where temporary staff are needed, trusts are agreed that the first port of call should be their own internal banks. The pre-roundtable survey had found that nearly four in every five trusts had increased their use of bank staff, compared with agency, to help save money on temporary staffing. Yet trusts have widely varying success rates in meeting their additional staffing requirements from their own banks.

Steve Twelftree, Bank Partners' managing director, said this was no surprise. 'I can guarantee that you are all underinvested in your banks,' he said. When Bank Partners goes into a trust to talk about delivering services, it typically finds that the bank is looking for substantive staff who can work extra shifts. Failure to do this means an almost immediate call to an agency. Instead he suggested that the separate banks run for its eight clients boasted bank fill rates as high as 85% (nursing) and 90% (both locum and admin and clerical).

This was achieved by having more than 180 staff involved in running these contracts. Bank Partners business development manager Antony Mann said half these were focused on recruitment, rather than shift placement. 'The average database we inherit is 90% substantive staff and 10% bank-only workers,' said Mr Twelftree. 'One of our key performance indicators is to move the mix to 50:50.'

His colleague, Ms Harris, added that trusts needed help to focus on reducing the time to hire – both for new substantive staff and for staff working through the bank. 'It takes, on average, over 90 days to get someone through the recruitment process,' she said. This has a number of consequences. For a start, with permanent staff, it potentially creates more demand for temporary staff to fill vacancies. For bank staff, it reduces the capacity to fill shifts internally.

Mr Boothby said Calderdale's local health economy was talking about creating a standard local passport. 'In our locality, the majority of turnover, certainly among nurses, is between the different provider organisations. If we can agree the standards we are all working to – the checks we need and the governance – we can cut the time to hire.' He said this could go beyond basic recruitment checks to consider common training requirements.

Hire times

Mr Innes said NHS Improvement was keen to support improvements in hire time – flagged up as a concern in Lord Carter's productivity review. 'Why does it take two weeks from resignation to advertise a post and why do you need a four-week window to advertise or interview four weeks after that?' he asked. 'There is so much time before you even offer the post let alone undertake individual checks.'

He said the oversight body would start 'monetising the process' showing organisations what any delays in their recruitment process was costing them so it could support them to improve in this area.

Mr Innes also called for greater collaboration between trusts in running banks. Mr Twelftree agreed this had to be the way forward, but also suggested that trusts tread carefully. He referred to one such discussion involving neighbouring trusts. 'The trust with the highest bank fill rate had the lower bank pay rate,' he said. Bringing the banks together

Admin challenge

The almost complete focus in the past year has been on reducing medical and nursing agency workers. But admin and clerical temporary staff account for a key component of overall agency spend and there are growing calls for trusts to tackle these costs.

Sandra Easton said that, along with allied health professionals, admin and clerical counted for a third of Chelsea and Westminster's overall agency spend. And NHS Improvement's Martin Innes pointed out that 'price cap overrides in London for admin and clerical now exceed those for nursing'

While trusts might argue that patient safety forced their hand in using agency staff to fill shifts, could the same argument be made for admin and clerical, he asked. 'The use of agency to source IT consultants is an issue, particularly in London,' he said. 'Are these roles patient critical? We are now seeing an issue in IT and with temporary executives – even junior executives.'

West Hertfordshire Hospitals' Don Richards said the NHS had appropriately moved from a 'job for life' culture but maybe too far towards a 'hire and fire' approach and that this had led to an interim culture. 'In some ways, we have created our own problem,' he said.

Mr Innes suggested anecdotal evidence indicated that younger staff – millennials – were increasingly interested in flexibility. They wanted to only stay for a short time in a specific job and many were keen to work abroad.

He acknowledged that the NHS was often competing for admin staff with the private sector, which could pay better. Band 7 to band 8 accountants, for example, could often earn more working with major accounting firms.

Delegates agreed that specialist roles were driving use of agency staff for admin and clerical. 'Agenda for Change doesn't always work for specialist roles,' said Calderdale's Gary Boothby. 'There are some areas where, to get the right people, Agenda for Change hasn't kept up.' And for some areas, such as implementing electronic patient records, the temporary market seemed the right place to go. Coders and costing accountants were two other areas seen as pressure areas where trusts were struggling to recruit.

'Operational managers is another pinch point forcing us into the market,' said Susan Rollason. 'As a big acute, University Hospitals Coventry and Warwickshire has no problem with general admin and clerical, but in finance, specialist posts can be an issue. With sustainability and transformation planning, there is growing demand for people who can run a long-term financial model.'

Jonathan Stephens, formerly with Alder Hey, defended the use of the interim market for some senior executive roles in certain cases. 'General management jobs or board positions are tough roles and if you have a vacancy, you need to fill it almost immediately or there can be ramifications for leadership and operational service delivery. It is, of course, essential that the NHS ensures these sorts of interim appointments are at a rate that represents value for money,' he said. Others agreed that, because of the level of difficulty and responsibility, recruitment was not simple.

Bank Partners' Steve Twelftree said that, in general, admin and clerical was the easiest staff category to recruit to within its banks across eight clients in and near to London. 'We have a 90% fill rate in all our banks for admin and clerical,' he said. But he admitted that specialist roles such as coding and IT were more difficult.

Despite the difficulties, Mr Innes said more attention was needed – there had been cases of very senior managers charging excessive rates and this needed to be addressed. A revised VSM framework requiring approval for managers appointed on more than £750 a day would help, he said, but trusts should tackle the issue locally.

Mr Stephens suggested the service had over the past year or so been 'focusing on nurse agency, and we probably haven't done enough on other areas of agency use across our workforce, including non-clinical staff'.

could have a negative impact in terms of the fill rate and/or the rate that needs to be paid. Instead, he said, trusts could initially explore using each other as a 'first port of call or first tier' response when they can't fill a shift from their own bank.

Currently, substantive staff in one trust may be working agency shifts in the neighbouring trust. So this 'first tier' approach would 'slow the agency market down overnight'.

Some finance directors said they were looking to establish medical banks too. But all suggested they were much harder to establish than more common nurse banks. 'Most people think these are too hard to even attempt,' said Mr Twelftree. 'But doctors do join banks.'

He added that they had seen significant successes with medical banks, with high fill rates and reduced agency rate breaches. 'It can be done but it needs investment,' he added.

A number of trusts are implementing best practice ideas to fill shifts, particularly with nursing. These include using social media to communicate with bank staff, paying weekly to match agency benefits and using self-service booking systems. A number are also auto-enrolling new staff on bank databases. But Ms Harris added that trusts should also routinely sign up leavers to the bank –increasing the bank's capacity beyond a trust's own workforce.

2gether NHS Foundation Trust has had some success with a novel solution – offering nursing undergraduates a fixed monthly income in return for committing to shifts as healthcare assistants. While these shifts may be more concentrated in holiday periods, the trust provides a steady monthly payment. This has proved popular to date, but the trust also hopes it will have a further payback by encouraging some of the students to come back to the trust once they have qualified.

Lateral thinking

Ms Khan said the NHS should tackle staffing shortages more laterally. 'If you look across the NHS, there are patients there who don't need to be in hospital. We've changed a ward into a step-down facility and approached the care sector to staff it – using a housing association,' she said. The trust discharges patients to this service rather than retaining overall control. 'Perhaps we need to look at doing something like this on a larger scale.' Ms Easton said Chelsea and Westminster did something similar – but there had been a tendency for patients to get stuck in the step-down facility.

The roundtable participants agreed there was still more that could be done to increase bank use and reduce agency costs. But they were also clear that some of the problems could only be fixed by an increase in the number of nurses, doctors and other staff in the overall market. 'There is a fundamental problem in some roles of actual shortages in the number of staff available,' said Ms Rollason.

John Graham agreed. There were process improvements that could and should be made, and good practice that wasn't yet being followed across all providers. But in a seller's market – with too few staff available overall and major shortages in key areas – there was a danger that NHS providers were simply 'robbing Peter to pay Paul'.

Alongside better recruitment and administration of temporary workers, the service needs national solutions to get training numbers correct so that there is a sustainable and affordable temporary staff market.

HFMA annual costing conference 2017 – forward together

06 April, London

The HFMA annual Costing Conference aims to provide costing practitioners with the latest developments and guidance, and provide their colleagues with a greater awareness of the role of costing in the NHS.

The day will include interactive workshops, case study examples, policy updates and the chance to network with over 200 of your costing colleagues.

This event also provides a crucial opportunity to raise the profile of costing within your organisations and health economies. The conference is therefore aimed at both costing professionals and those not in a costing role but with an interest in the costing agenda.

For more information, please email Jonathan.Richards@hfma.org.uk

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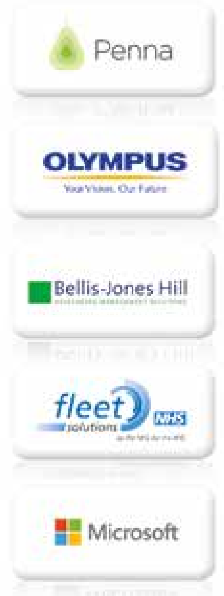

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hfma professional lives

Events, people and support for finance practitioners

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Consultation sets out plans for new, broader use of resources assessment

Technical update

The ink on the single oversight framework is barely dry. Yet just a few months on, we have another finance assessment being proposed for NHS providers. This 'new' use of resources assessment would again be undertaken by NHS Improvement and used to inform its oversight of trusts. But it would also be submitted to the Care Quality Commission for consideration and then published as part of the CQC's overall reporting and rating of provider performance. Under current plans, it would appear as a separate rating alongside the familiar quality ratings.

To be fair, although the new consultation is hot on the heels of the recently published finance assessment and single oversight framework, the new assessment's development has been well trailed – with the health secretary first asking the CQC to add resources to its inspection checklist in early summer 2015.

Subject to joint consultation by the CQC and NHS Improvement, it will in any case build on the single oversight framework assessment, rather than completely replace the metrics.

A quick recap on the single oversight framework (SOF) is probably helpful. It identifies providers' support needs using triggers and metrics in five themes – the pertinent one in this context being finance and use of resources. This includes five financial metrics: capital service capacity; liquidity; I&E margin; distance from financial plan; and agency spend. Further metrics (cost and capital) were already under consideration for 2017/18.

The use of resources assessment expands the definition of resources beyond simple financial performance. In this context, resources now refer to four areas: finance; clinical services; people; and operational productivity.

The finance metrics in the SOF would continue to support the pure finance assessment within use of resources. But several metrics are being considered in the other areas: emergency readmissions (clinical), vacancy rates (people) and estates costs (operational), for example.

Area of use of resources	Key lines of enquiry	Indicative metrics
Finance	How effectively is the trust managing its financial resources?	• Capital service capacity • Liquidity • Income and expenditure margin • Distance from financial plan • Agency spend (performance/ceiling)
Clinical services	How well is the trust maximising patient benefit, given its resources?	• Pre-procedure non-elective bed days • Emergency readmissions • Cancelled operations • Proportion of beds occupied by those with an average length of stay >7days
People	How effectively is the trust using its workforce to maximise patient benefit?	• Vacancy and staff turnover rates • Sickness absence
Operational	How well is the trust maximising its operational productivity?	• Purchase price index • Estates cost per square metre • Pharmacy spend: quarter-on-quarter change

The proposed metrics are 'for illustrative purposes' and 'not the final shortlist'. And context will be used alongside the metrics – local intelligence and locally used metrics and other additional data from the oversight body's model hospital programme. In keeping with the CQC approach, the broader use of resources assessment will assign trusts to one of four categories: outstanding; good; requires improvement; inadequate.

The consultation says it is important to distinguish between a trust's finance and use of resources score (measured monthly in the SOF), its SOF segmentation and its annual use of resources assessment rating.

Providers will continue to receive a monthly finance and use of resources score – based on the five metrics – and this will contribute to the decision on segmentation, triggering different levels of provider support.

However, when the trust has a broader use of resources assessment, which will coincide with a broadly annual inspection by the CQC, this new resources assessment will be used as the finance and use of resources score for that month (with good translating to a 1 score and inadequate to a 4). This will remain in place until NHS Improvement is satisfied improvements have been made, indicated by continuing monthly assessment using the five metrics and by the achievement of milestones set out in any improvement action plan.

Finance managers told *Healthcare Finance* the language – with finance and use of resources referring to separate but related assessments – was confusing. But they have until the middle of February to let the oversight bodies know what they think in detail.

Technical review

The past two months' key technical developments

All the key financial guidance documents covering reporting and accounting in the NHS were published during December and January. The Treasury's *Financial reporting manual* introduced a new requirement to include a summary in the overview section of the annual report and more detailed integrated performance analysis. It also introduced a change to the definition of salary and allowances to include any severance payments for loss of office. These were formerly disclosed separately but not included in the remuneration table. The Department of Health's *Group accounting manual 2016/17* was also published in December. A series of eight frequently asked questions (FAQs), included in additional guidance, describe the latest amendments and this will be updated as additional FAQs arise through the year – keeping all additional guidance in a single document. The package of guidance was completed in January with the release by NHS Improvement of the *Foundation trust annual reporting manual*.

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

All appointments to posts defined as 'office holders' should be on payroll, regardless of the expected duration of the appointment, according to new guidance from NHS Improvement. This means that PAYE should be deducted at source and office holders not engaged using a personal services company, an employment agency, consultancy or other intermediary vehicle. Earlier guidance had allowed accountable officers to sign off on exceptional temporary circumstances and capped the duration at six months, but now this can only happen where the off-payroll engagement is to cover an office holder who is temporarily unable to perform duties. Existing office holders should move from off-payroll to on-payroll engagements, or be replaced by alternative on-payroll candidates, at the end of their engagement or by 30 April 2017.

The proposal to introduce an administration levy for the NHS Pension Scheme will add a further cost pressure that has not been included in the 2017/19 two-year tariff, according to the HFMA. Responding to the Department of Health consultation on the planned measure (which closed in January), the association noted the reasoning for the proposed change – the Department believes it will increase employer engagement and opportunities for innovation. However, the HFMA said its members also believed the proposal would shift costs from the Department to the wider NHS, including GP practices. These costs would come alongside costs levied by the Care Quality Commission and NHS Litigation Authority, as well as changes to the tax regime relating to salary sacrifice and off-payroll arrangements.

At the end of 2016, NHS Improvement set out the provisional timetable for the submission of costing data for 2016/17.Timescales depend on whether a provider has signed up to be an early implementer of patient-level costing. Acute early implementers will have to submit patient-cost data, as part of the Costing Transformation Programme (CTP), by the end of July, with reference costs submission (including and net of education and training) due by the middle of September. Mental health and ambulance road map partners will face a September submission deadline for both patient-level and reference cost data (despite earlier indications of a July deadline for the patient data). All other providers face an earlier – end of July – deadline for both their reference costs submissions. The differential deadlines aim to help early implementers to make progress on patient costing as part of an accelerated CTP (see *Healthcare Finance*, December 2016).

Improving antimicrobial stewardship

Antimicrobial stewardship refers to an organisational or healthcare system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness. Services are commissioned by local authorities and clinical commissioning groups (CCGs). Providers are prescribers, primary care and community pharmacy teams, and childcare and education providers.

New NICE guideline NG63 offers best practice advice on antimicrobial stewardship and aims to reduce inappropriate antimicrobial demand and use, and prevent infection. It covers making people aware of how to use antimicrobial medicines (including antibiotics) and the dangers associated with their overuse and misuse.

It also includes measures to prevent and control infection that can stop people needing antimicrobials or spreading infection to others.

Implementing the guideline is anticipated to be a cost saving overall because of:

- Reduced prescribing of antimicrobials
- Reduced treatment costs as a result of fewer infections that are resistant to antimicrobials and fewer infections resistant to multiple drugs
- Fewer infections requiring hospital admission.

Savings for England cannot be accurately quantified, but are likely to be significant.

For example, a reduction in adverse events associated with use of antimicrobials such as clostridium difficile infection (CDI) may save the NHS around £10,000 per case. Each non-elective admission for gastroenteritis costs the NHS between £760 and £8,240, and a non-elective admission for respiratory infection costs between £960 and £5,570.

Preventing 1% of non-elective hospital admissions for these two common infections could save around £2.8m a year in England.

Diary

February
2 B London: quiz, London
7 F Mental Health Finance: mental health costing forum
9 F Chair, Non-executive Director and Lay Member: forum, London
9 N Integration summit, London
9 B North West: annual quiz, Manchester
15 B Northern: pre-accounts planning, Durham
16 B London: London student conference
20 B KSS: NHS introduction to finance, Crawley
23 B North West: what is your risk appetite? Liverpool
28 I HC4V: value masterclass, London
30 B Eastern: introduction to NHS finance, Fulbourn

March
1 B West Midlands: financial governance – getting it right plus Annual reports: what good looks like, Birmingham
3 B Northern Ireland: final accounts workshop, Newtownabbey
9 I HC4V: introduction to NHS costing – regional networking and training (North), Leeds
14 N NHS operating game 2017, London
15 B KSS: HFMA/TIAA accounting standards technical update, Gatwick
16 F Provider Finance: technical forum

April
6 I HC4V: annual costing conference
19 F Commissioning Finance: forum

May
11 B South Central and South West: developing talent conference, Bristol
17 F Chair, Non-Executive Director and Lay Member: forum, London
18 F Provider Finance: directors' forum

June
12 B London: annual conference, London
15-16 B South Central: annual conference, Reading
22 B West Midlands: annual conference, Wolverhampton
29-30 B North West: annual conference, Blackpool

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

B Branch N National
F Faculty I Insitute

Implementing NICE's guideline may result in additional costs in the short term by:

- Introducing approaches to reducing inappropriate antimicrobial demand and use (for example, providing resources on self-limiting infections)
- Introducing approaches to prevent and limit the spread of infection (for example, providing information on hand washing)
- Producing written information for prescribers, primary care and community pharmacy teams to share.

Nicola Bodey, senior business analyst, NICE

Events in focus

Getting capital when times are tough
16 March, 110 Rochester Row, London

Capital funding is in short supply in the NHS, with national funding cut in the current spending review period and capital funds transferred to revenue at national and local level to reduce provider deficits. It is widely believed that capital will be needed to support transformation of services under the *Five-year forward view* and it has been reported NHS Improvement is examining the feasibility of NHS bonds to raise funds.

Capital is not just a technical issue; it can also have an impact on service quality – being used to replace outdated clinical equipment, for example. Many providers have turned to alternative sources of financing, such as leasing and managed equipment schemes and off-balance sheet PFI.

Against this backdrop, the HFMA Provider Finance Faculty will hold this half-day event in March. It is busy completing the programme and has already confirmed Chris Cale, NHS Improvement assistant director of capital and cash, as a speaker. It is also seeking two case studies funded through innovative ways of getting access to capital or other means.

- Please get in touch with **keith.sykes@hfma.org.uk** if your organisation is willing to share its experiences.
- Faculty members can book a place at the event by emailing **grace.lovelady@hfma.org.uk**

Northern Ireland branch final accounts workshop
3 March 2017, Newtownabbey

This annual day-long event includes a technical update from University of Ulster's associate professor of accounting and finance Robert Kirk, as well as speakers from the Department of Health. The event is aimed primarily at individuals involved in the year-end accounts process, as well as providing essential CPD hours for all qualified staff. It provides a valuable networking opportunity for the finance community as well as a kick-start to the year-end planning process.

- To book, email **kim.ferguson@northerntrust.hscni.net**

Demanding times

Association view from Mark Knight, HFMA chief executive

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

"I'm very excited about our new qualifications in particular"

My HFMA

Welcome back to *Healthcare Finance* for 2017! It's our first edition of the year, but it already feels like so much has happened. You'd have to be travelling from some sort of deserted island to not be aware of the unprecedented pressure the service has been under. While financially it looks like we might just make it through to the end of March, the English NHS has seen some of its worst performance data, with overheated accident and emergency departments and social care bottlenecks.

We're all aware of the need to become more efficient, but the future settlement for the NHS looks extremely challenging. I personally feel there will at some point be movement on current funding plans. However, the government seems to be determined at the moment to stick to its guns – although events could force its hand in the coming years.

Much of the 'savings' are predicated on a workforce of over one million people receiving 1% pay rises. Yet we know, with Brexit and other pressures in the world economy, inflation could exceed 3% next year. How realistic are 1% pay rises in the face of this? And this is just one of the pressures on that meagre future increase.

We at the HFMA think, like others, that there should be some mechanism to take health and social care out of politics. We're starting to talk to other organisations about whether a guideline proportion of gross domestic product (GDP) could be set which the chancellor would have to take account of on a yearly basis.

We're told that our international obligations are to spend 0.7% of GDP on overseas aid. Similarly, the price for staying in NATO is 2% spend on defence. Each year, these figures are explicitly mentioned when the chancellor delivers the budget. So why couldn't a figure – say 9.5% of GDP – be set for health or a higher percentage for health and social care? It takes those items out of the political mix because everyone has agreed what needs to be spent.

The disadvantage is that it ties the health and social care budgets to GDP, which can go down. So there would need to be some protection mechanism built in. No-one is pretending that the solution is simple. However, it is becoming increasingly clear – particularly given the ageing population – that we need to have a funding mechanism that fully recognises the demands being placed on the huge public priorities of health and social care.

HFMA chief executive Mark Knight

At the HFMA, we will continue to represent your views through our policy documents, social media and through the very good work that our policy director Paul Briddock is doing with the media. We will continue this year to provide the best networking and training events to enable you to be at the top of your game.

I'm very excited about our new qualifications in particular – see page 22 for more details. If you are thinking of doing it, please get in touch or complete the relevant forms. It may well be worth talking to your organisation about any support they can give you.

We think we have developed a unique product that will support individuals in pursuing their career goals, while also enhancing the skills available to the NHS to meet the current and future service and financial challenges.

Member news

HFMA's AGM announced:

- Alex Gild and Bill Gregory were elected vice-presidents.
- Caroline Clarke, Lee Outhwaite, Dr. Sanjay Agrawal and Owen Harkin joined the board of trustees
- All annual subscriptions remain unchanged: monthly subscriptions paid by direct debit for ordinary members £5; £3 for abated members.

Faculty/committee chairs:

- James Rimmer, Audit and Finance Committee chair
- Tom Jackson, Commissioning Faculty chair
- Jonathan Stephens, chair of Prescribed Specialised Services Committee
- Paul Stefanoski, chair of Mental Health Finance Faculty
- David Bacon, chair of the Accounting and Standards Committee
- Shahana Khan, FFF representative

Branch appointments:

- Neil Kemsley, director of finance at Plymouth Hospitals NHS Trust, has taken over from Sarah Brampton as **South West Branch** chair, while Kate Wycherley becomes skills development co-ordinator, succeeding Leanne Lovelock.
- Owen Harkin, director of finance at Northern Health and Social Care Trust, has taken over from Stephen McNally as **Northern Ireland Branch** chair. Business Services Organisation FD Wendy Thompson is vice-chair.
- New **Wales Branch** student representatives are Matthew Land and Chelsie Skerritt from Betsi Cadwaladr University Health Board. Ceri Lewis, Hywel Dda University Health Board will look after sponsorship.

Laura Ffrench, Wales Branch skills development co-ordinator, is to climb Mount Kilimanjaro in support of Emmaus Bristol, a charity that runs a residential community of former homeless men and women. If you'd like to donate go to goo.gl/ferWpF

Member benefits

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

Branch focus

West Midlands Branch

The West Midlands Branch is one of the few HFMA branches to have its own formal research and development committee. Chaired by David Melbourne, the committee comes together to work on projects that reflect policy issues. This can lead to the publication of reports, such as *The newbies guide for reference costing* and *Choosing wisely – the organisational and cultural changes of clinical resource stewardship.*

'The branch has always had a strong focus on helping equip finance professionals in the NHS with the knowledge and skills they need to provide great support to the clinical front line,' says Phil Jones (pictured), director at Grant Thornton and a member of the branch.

Collaboration is key not only to the committee but to the branch as a whole. *Competition to collaboration* is this year's branch theme, inspired by the need to put patients at the centre of the system. It also highlights the branch's work on sustainability and transformation plans.

Reflecting the collaborative message of this year's theme, the branch is working with CIMA, and a joint event, *Financial governance: getting it right and annual reports,* will take place in March, hosted by Grant Thornton. A joint event with the Healthcare People Management Association is also in the calendar for this year.

The branch is working on the development of a local pool of talent. The regional finance management training scheme run by the branch currently has 10 graduates and two apprentices.

As with other branches, the branch annual conference is the highlight of the year. This year the event is taking place on 22 June at Wolverhampton Racecourse. Chris Ham, chief executive of the King's Fund, and Bob Alexander, deputy chief executive of NHS Improvement, have been confirmed as speakers. Places can be booked via the HFMA website.

'The annual conference is always a great experience, attracting 300-plus professionals to an informative event, addressed by leading speakers in the field,' says Mr Jones.

- For more details on the branch events, please visit the West Midlands Branch pages on the HFMA website or email **clare.macleod@hfma.org.uk**

branch contacts

Eastern kate.tolworthy@hfma.org.uk
East Midlands joanne.kinsey1@nhs.net
Kent, Surrey and Sussex elizabeth.taylor@wsht.nhs.uk
London nadine.gore@hfma.org.uk
Northern Ireland kim.ferguson@northerntrust.hscni.net
Northern lynn.hartley1@nhs.net
North West hazel.mclellan@hfma.org.uk
Scotland alasdair.pinkerton@nhs.net
South West kate.wycherley@hfma.org.uk
South Central alison.jerome@hfma.org.uk
Wales laura.ffrench@hfma.org.uk
West Midlands clare.macleod@hfma.org.uk
Yorkshire and Humber laura.hill@hdft.nhs.uk

Appointments

Iain Stoddart (pictured) has been appointed chief finance officer at Knowsley and St Helens clinical commissioning groups. He currently shares the role with **Paul Brickwood**, who will be retiring later this year after over 30 years in the NHS. Mr Stoddart was previously chief finance officer at North Staffordshire and Stoke-on-Trent clinical commissioning groups. He is succeeded by **Alistair Mulvey**.

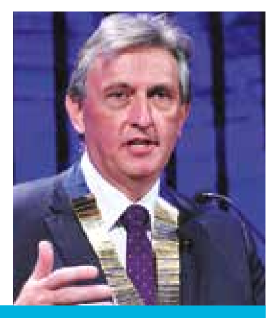
Hannah Witty (pictured) is the new finance director at Royal National Orthopaedic Hospitals NHS Trust. She was acting director of finance and estates at the UK Home Office. She succeeds **Jonathan Wilson**, who is now director of finance at Homerton University Hospital NHS Foundation Trust.

Ismail Hafeji is now director of finance at Greater Manchester Mental Health NHS Foundation Trust – created from the acquisition of Manchester Mental Health and Social Care Trust by Greater Manchester West Mental Health Foundation Trust on 1 January. Mr Hafeji was previously director of finance at the latter. He has more than 30 years' experience of working in the NHS. **Sam Simpson**, who was director of finance at Manchester Mental Health and Social Care Trust has moved on to be director of finance for Cheshire and Wirral Sustainability and Transformation Plan.

North Lincolnshire and Goole NHS Foundation Trust has appointed **Paul Corlass** (pictured) deputy director of finance. He was previously head of finance at Hull and East Yorkshire Hospital NHS Trust.

Norfolk and Norwich University Hospitals NHS Foundation Trust has appointed **James Norman** chief finance officer. Mr Norman was deputy group finance director at Network Rail and has spent more than 15 years working in finance in the construction, utilities and transportation sectors. He takes over from **Sheila Budd**, who was acting director of finance at the trust.

Former HFMA president **Tony Whitfield** (pictured) has announced he will retire at the end of March from full-time work in the NHS, following a serious health issue in 2016. Mr Whitfield joined the NHS in 1983 and spent 25 years as a finance director. After 11 years as finance director at Salford Royal NHS Foundation Trust, he joined Leeds Teaching Hospitals NHS Trust, also as director of finance, at the beginning of 2014. Mr Whitfield plans to take up a non-executive role in the local NHS.



> **"You need to contribute to how the service is run. It's your responsibility as a finance professional and also as a user or potential user of the service"**
> **Graham Nix**

Finance stalwart Nix retires

Former University Hospital Bristol finance director Graham Nix has retired after more than 40 years in the NHS.

With such a long career, it's no surprise he has many highlights, but he picks out two. 'The work I am most proud of is when I was project manager for the Bristol Royal Hospital for Children – the first purpose-built children's hospital in this country for well over 100 years.'

A substantial amount of the funding for the hospital was raised through a charity. 'It was tremendous and gave me access to some fantastic people. I met royalty and the families of hospital patients and I had the opportunity to go to the United States and Europe to look at their children's hospitals.'

He is also proud of his legacy in the form of past trainees who have built careers in the NHS. 'Someone said to me recently that if they are speaking to finance people in the South West they will say, "I was a trainee of Graham Nix". I always saw helping people develop as a major part of the job,' he says.

Mr Nix started his NHS finance career in 1974, working in planning and providers, as well as at district and regional health authority levels. But, when the purchaser-provider split was introduced in the early 1990s, he became the finance director of what was then United Bristol Healthcare NHS Trust.

He later combined the role of deputy chief executive with the top finance post at the trust and spent some time as its interim chief executive in 2001/02.

For the past 10 years he has been a non-executive director on the board of North Somerset Primary Care Trust and its successor clinical commissioning group.

Looking back to 1974, he says, finance trainees spent almost 12 months on a Cook's tour, not just visiting and observing frontline services but also taking part in their delivery – portering or helping fill out a needs assessment, for example.

He enjoyed working alongside frontline health professionals and believes the insight was invaluable. 'To be a really good finance director or finance professional in the NHS you need to understand the service. And if you do, you need to contribute to how it's run. It's your responsibility as a finance professional and also as a user or potential user of the service.'

A staunch supporter of the HFMA and one of its first honorary fellows, he gave crucial backing to the organisation, including temporary office space when the association moved from London to Bristol. Mr Nix also chaired the South West Branch and helped organise the national weekend schools.

His career has not all been positive. 'It's fair to say I've dealt with some difficult issues, including the paediatric cardiac surgery in Bristol, which led to a public inquiry and General Medical Council hearings,' he says.

'I left University Hospital Bristol in 2005 so, in effect, this is my second retirement,' he jokes.

Initially, he concentrated on helping the trust's charity, Above and Beyond, fundraising efforts as a trustee. Later, he joined the board of the Brook sexual health service for young people and chaired the Avon St John Ambulance – also sitting on the St John Ambulance national finance committee.

He says he has retired 'for good this time'. The decision follows his being diagnosed with cancer 18 months ago but, following treatment, Mr Nix has been given the all-clear. He is determined to enjoy his retirement, spending more time with his grandchildren and cycling with his wife.

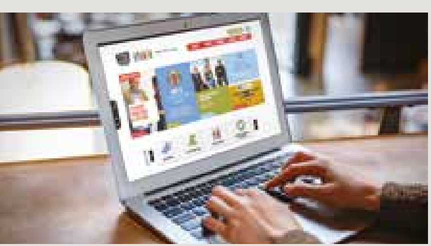
Mr Nix adds: 'I had a fantastic career in the NHS and all is positive for the future.'

FFF launches refreshed website

The NHS Future-Focused Finance (FFF) team has launched its new website, *writes David Ellcock*. The site – still at www.futurefocusedfinance.nhs.uk – has been given a complete overhaul. As well as a fresh design, a huge amount of useful content has been added.

Each of FFF's six action areas now has its own dedicated page on the site. You can find out all about the work being done in each area, along with useful documents and links to the people leading on individual pieces of work.

A new section of the website is dedicated to toolkits developed by FFF in recent years.



The *Decision effectiveness tool*, the *Crossing professional boundaries* toolkit, process maps for hire-to-retire and procure-to-pay, the *Four strengths framework* and others are all now easily accessible and can be downloaded from a single page.

You can quickly find out which value makers and finance and clinical educators are based in your area of the country using the redesigned map.

You can still write your own blogs and read others' thoughts in the blog section, which has been refreshed and updated.

All previously registered site users need to log into the new site and change their password – security protocols mean previous passwords could not be carried over to the new site. If you have problems with this, please contact the team at futurefocusedfinance@nhs.net.

Comments and suggestions for the site can be sent to the same email address.

David Ellcock is FFF's programme director

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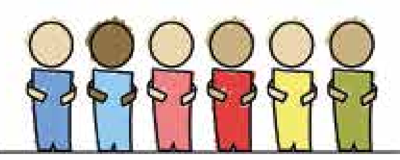

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