healthcare finance

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Time for finance to **step up**

News
Providers urged to hold 2015/16 deficits to £1.8bn

Comment
Benchmarking and data central to Carter success

Features
Improving workforce productivity with e-rostering systems

Features
How Alder Hey's costing approach adds up for clinicians

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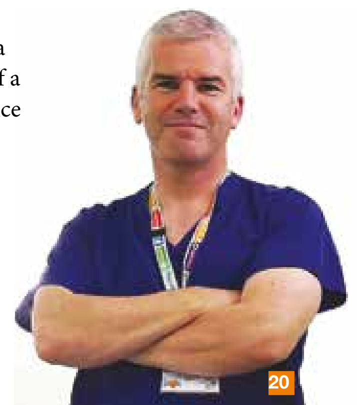

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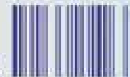

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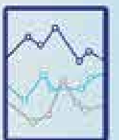

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News

Q4 measures needed to rein in provider deficits

By Seamus Ward

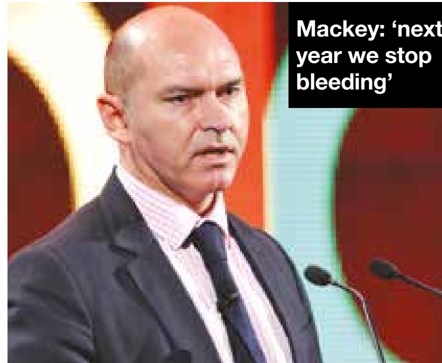
A package of measures, including capital to revenue transfers and accounting adjustments, will be needed to help NHS providers achieve their required aggregate deficit for this year, according to NHS Improvement chief executive Jim Mackey.

NHS providers in England have been told they must limit their aggregate year-end deficit to £1.8bn as a condition of getting access to the sustainability and transformation fund (STF) in 2016/17. The STF was announced in the planning guidance for 2016/17, published before Christmas. It will target £1.8bn primarily at providers of emergency care to help them move to a sustainable financial footing.

The STF has two parts: a general element to be distributed to all providers of emergency care, with each trust eligible only if it has met agreed control totals; and a targeted element to support efficiencies and longer-term sustainability. Full details of the latter have yet to emerge.

There are several conditions for access to the general fund (see box), but senior NHS figures were challenged about the likely 2015/16 outturn by Commons Public Accounts Committee chair Meg Hillier. In a hearing on the sustainability and financial performance of acute trusts, she said an acute trust finance director had written to her predicting the 2015/16 outturn would be between £2.5bn and £2.8bn.

Mr Mackey conceded that, before trusts implement measures that will be required in the final quarter, this may be true. 'To get the figure of £1.8bn, the provider system will end up at a higher number, and then there are other things that will come into play, such as capital revenues transfers and some other accounting adjustments that we will make in the final quarter.'


Mackey: 'next year we stop bleeding'

Curbs on agency spending would also improve the financial position during the final quarter, he added. 'I understand where that finance director is coming from, and it does look like it is heading towards £2.5bn or perhaps even north of that, but then there are a lot of adjustments that will kick in.'

Monitor and the NHS Trust Development Authority have written to trusts requesting they examine the scope for savings in a number of areas in the last few months of 2015/16. These include local capital to revenue transfers; a review of provisions at month nine; no non-medical agency cover for short-term sickness; compliance with agency spending policy; removing prudence from balance sheet estimates of accrual, deferred income, injury cost recovery and partially completed spells; ensuring maximum VAT reclaim; and asset revaluations.

While the 2015/16 deficit and other historic deficits will have to be dealt with at some stage, NHS Improvement expects the provider sector as a whole to achieve a balanced financial position at the end of 2016/17. Individual trusts may still record a deficit, set as their control total.

'The important thing is that next year we stop bleeding,' Mr Mackey told the committee. 'We will have a transformation fund and a more reasonable efficiency ask and, importantly, providers will then have a bit of breathing space to start thinking about future years.'

HFMA policy director Paul Briddock said the proposed package of improvement measures was a sign of the challenges facing the NHS. 'Local bodies are already working flat out to minimise the forecast provider deficit for 2015/16,' he said. 'The ability to clear deficits next year will clearly be affected by how the service ends this financial year. In this context, it is understandable we should explore all options, including local capital to revenue transfers. But this can only be a one-off measure, as failing to invest in our capital estate as it is needed – and to invest in transformation – will be a false economy and simply shift the problem into a future year.'

STF conditions

To access the general element of the STF in 2016/17, providers must:

Deliver agreed control totals
In Q1, they should develop a recovery plan or plan a surplus increase. A control total for 2016/17 and a capital control total must also be agreed. The plans, which should include Carter implementation milestones, should be delivered over the rest of the year.

Improve access standards
In Q1, performance trajectories should be agreed with NHS England and NHS Improvement, then delivered in Q2 to Q4.

Begin transformation In the first three quarters, providers must work with commissioners to develop local sustainability and transformation plans – to be agreed with NHS England and NHS Improvement in the final quarter. Funding will also be linked to the NHS making progress on seven-day services.

PRU

Khan makes PAC appearance

In January, HFMA president Shahana Khan appeared at the Commons Public Accounts Committee inquiry into the sustainability and financial performance of acute trusts.

During a short session, she answered a range of MPs' questions, including queries about efficiency savings. She told MPs that the HFMA had predicted that 2015/16 would be a 'crunch year' for NHS finances, particularly because of rising demand, increased costs and a squeeze on funds.

Broad welcome for tariff proposals – but directors highlight efficiency concerns

By Seamus Ward

The NHS has welcomed the proposed net tariff uplift for 2016/17, although finance directors have warned that some trusts will have to make efficiencies in excess of the planned 2% efficiency factor.

The planning guidance proposed a net 1.1% uplift in prices, made up of a 3.1% cost inflation uplift and an efficiency factor of 2%. Adjustments to specific prices would reflect an anticipated 17% increase in clinical negligence scheme contributions.

Monitor confirmed that 2.2 percentage points of the 3.1% overall cost uplift relates to pay – representing a 3.3% increase in pay and pension costs. The marginal rate for emergency admissions will be 70%, mirroring the enhanced tariff option (ETO) taken by 80% of providers in the current year.

According to Monitor, the current approach to the market forces factor will continue. The formal inclusion of a marginal rate (or risk share) for specialised services has been delayed. Formal consultation on the tariff proposals is expected to open this month.

HRG4+ delay confirmed

The planning guidance confirmed that the introduction of the more granular HRG4+ currency has been postponed until 2017/18. This means that other changes will also be delayed by a year, including the move to new top-ups for specialised services. Monitor and NHS England said they would continue to analyse the changes in the run-up to using the new currency and 'if necessary mitigate the effects'.

HRG4+ makes three big changes, introducing greater granularity to better reflect complexity; more age splits; and grouping patients according to better clinical logic. The move to HRG4+ was proposed by Monitor and NHS England last summer and was supported by 80% of respondents, including 70% of providers. Subsequently, however, the service raised concerns that the impact of the redesigned currency was not known. Monitor and NHS England decided to postpone the implementation.

At the Commons Public Accounts Committee hearing in January, NHS Improvement chief executive Jim Mackey said: 'It presented a risk that there might be financial instability as a result.' The two bodies were contemplating creating a formal shared team or shared resource to work together on pricing, particularly incentivising out-of-hospital care, he said.

NHS Providers chief executive Chris Hopson welcomed the tariff announcement, which follows a net reduction of 1.9% in 2015/16. The tariff, together with the £1.8bn sustainability and transformation fund and a move to three-year planning, represented a positive step.

'This turns a previously impossible looking 2016/17 task into one that looks just about deliverable, albeit extremely challenging. But this extra early investment is only temporary and comes with conditions attached,' he said.

'Trusts and foundation trusts will have a year to turn around their finances, develop long-term efficiency savings plans and identify the long-term changes their local health and care system need. All this must be delivered

Commissioners striving to help NHS to balanced position

Measures being taken by NHS England and the Department of Health will 'just about' offset the expected £1.8bn overspend in the provider sector, according to Paul Baumann (pictured), NHS England chief financial officer.

He said NHS England is 'actively seeking' to increase its underspend in 2015/16 to help the overall financial position at year-end.

The month eight figures, presented to the NHS England January board meeting, show a forecast year-end underspend of £145m across its budgets. However, risks and mitigations identified by CCGs and NHS England indicated the forecast underspend will rise to £207m. And a first look at month nine figures showed the year-end underspend could be closer to £400m.

'This is in part due to the positive response of CCGs and direct commissioners,' Mr Baumann told the meeting. Providers were aiming for a £1.8bn deficit and 'that can just about be offset by our underspend and measures in Department of Health budgets. But the provider sector will have to pull out all the stops and sustain it into next year,' he added.

The month eight figures show forecast overspends of £51m in clinical commissioning groups and £2.5m in direct commissioning at year-end. The latter reflects the cost pressures in specialised commissioning, particularly in the Cancer Drugs Fund, though this is offset in other areas of direct commissioning.

Overspends in CCGs and direct commissioning are forecast to be offset by a number of measures, including underspends in NHS England central spending, such as running and programme costs, and a release of continuing healthcare contingencies.

However, Mr Baumann warned that many of the measures used to improve NHS England's year-end position this year were one-off cost reductions and would not be available in 2016/17.

"Restoring short-term stability must lead to long-term sustainability"
Chris Hopson, NHS Providers, above

while continuing to deliver outstanding care to a million patients every 36 hours. Restoring short-term stability must lead to long-term sustainability.'

Provider finance directors welcomed the move, but questioned whether the 'real world' efficiency factor would be higher than 2% for some. If a trust did not meet its control total for 2015/16, its 2016/17 plans must address this with higher efficiency levels to ensure it achieves its control total. 'Very few organisations will get away with just doing 2%,' one director said.

NI trust finance warning

Concerns have been raised in the Northern Ireland Assembly over local health and social care (HSC) trust finances after underlying pressures were uncovered.

In a report on the health and social care sector, the Assembly Public Accounts Committee said all but one of the five trusts broke even in 2014/15 – the Western Trust with a £6.6m deficit. But the committee said this masked an underlying funding gap totalling £131m. Overall, the five trusts have a £4bn budget and the committee said in recent years they have relied on significant in-year funding to avoid deficits.

Committee chair Michaela Boyle said health and social care bodies were facing an unprecedented financial squeeze, though they had been more generously funded than other parts of the public sector, and demand was rising.

'Putting the HSC trusts on a sustainable footing is a major challenge unless there is a significant change in funding or transformation of services. One significant problem the trusts face is they are unable to carry forward unused funds from one year to the next, impeding their ability to undertake longer term financial planning.'

The decline in financial stability was mirrored by widespread breaches of key waiting times for elective, emergency and outpatient care.

Health minister Simon Hamilton (pictured) said the report confirmed the need for far-reaching reform 'if we want to create a world-class health and social care system and, importantly, put it on a sustainable financial footing'.

Monitor sets 2017/18 target for MH payment

By Steve Brown

Monitor has confirmed that plans to adopt new payment approaches for mental health services will now go ahead in 2017/18 – a year later than originally proposed.

Monitor and NHS England consulted on the two options – paying either on the basis of episodes of treatment/year-of-care or using a capitated payment approach – in October. The consultation was held on the basis of the new approaches starting in 2016/17.

However, a pricing update presented to the Monitor and NHS Trust Development Authority board in January said that the change would now go ahead in 2017/18.

A spokesman for Monitor said this was in response to feedback from the service. While commissioners and providers had supported the payment options, they asked for more time to prepare.

A new survey by the HFMA's Mental Health Finance Faculty underlines that 2016/17 would have been overly ambitious. This found that just over a quarter of a sample of 26 mental healthcare providers were proposing to adopt one of the new approaches in 2016/17, although organisations were clear that this was the likely direction of travel.

In the meantime, the survey confirmed that block contracts would remain in place in many health economies. Some trusts said they planned to shadow year-of-care tariffs in the coming year as a step towards implementing the new currencies. Others suggested episodes of care would be used as a stepping stone to introducing capitated models.

Reinforcing the national decision, one trust was clear that a 'year-of-care approach is not possible in 2016/17 due to timescales and information quality'.

Other trusts highlighted the importance of linking future payment to outcomes and of ensuring the costs of care are covered – supported by cost and performance data collected by mental health clusters and produced using patient-level cost models.

The HFMA survey follows earlier work by the faculty in 2015 that fed into the Monitor/NHS England consultation on payment models. That also highlighted a lack of confidence in meeting the earlier introduction of the new approaches.

New corporate partners

The HFMA has announced two new corporate partners. They are IntelliCentrics, which provides credentialing services to NHS organisations for both staff and commercial visitors, and Neyber, which enables employees to reduce borrowing costs with access to affordable loans, integrated with payroll, at no cost to the employer.

News review

Seamus Ward assesses the past two months in healthcare finance

While the junior doctors' dispute and Jeremy Hunt's threat to suspend boards that fail to meet financial targets caught editors' eyes over December and January, in the service the focus was very much on how the NHS would end this financial year and what 2016/17 will bring.

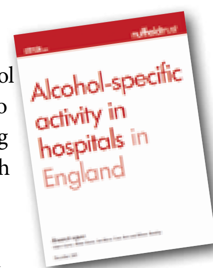
The financial and operational challenges were centre stage at the HFMA annual conference in December. NHS Improvement chief executive Jim Mackey told delegates that the NHS in England had to use 2016/17 to get back into balance, while NHS Trust Development Authority's Bob Alexander said the NHS could expect an 'absolute focus' on finance. A month later, Mr Hunt said his department would take action against trusts that failed to implement efficiency measures. These could include boards losing freedoms and control over key decisions, closer scrutiny from regulators and, ultimately, suspension of the entire board. See the HFMA website (*Healthcare Finance*, December issue) for full coverage of the conference.

Concern was voiced over the current financial position. Research by consultancy EY concluded that small hospitals in England are shouldering a 'disproportionate' burden of NHS deficit in 2015/16. All 20 hospitals with a turnover under £200m are expected to be in deficit, accounting for 8% of total revenues but 11% of the deficit.

Away from small DGHs, Monitor announced it would examine the finances at County Durham and Darlington NHS Foundation Trust. The trust, which provides acute and community services to nearly 600,000 people, has predicted a deficit of £14.7m for 2015/16. The investigation will help better understand the causes of the financial challenge and the support needed. No decision has been taken on whether or not regulatory action will be required.

A lack of substantive staff – and the consequent need to hire agency workers – is one of the main reasons behind trust financial difficulties. But Health Education England is planning an additional 25,000 to 80,000 staff will be available by 2020. The *HEE commissioning and investment plan – 2016/17* says more staff will be trained in every one of the professions where HEE has commissioning responsibilities, and includes growth of nearly 15% in nursing and midwifery.

Health secretary Jeremy Hunt announced six demonstrator sites for the use of the GS1 barcode and PEPPOL communication standards. Each of the sites will demonstrate the benefits of the standards, which can include efficiencies and cost savings, fewer errors and improve patient outcomes and patient safety.



Before the UK health departments updated their alcohol advice in January – saying risks to health were increased by drinking more than 14 units a week in both men and women – the Nuffield Trust warned that the NHS faces a stark challenge in trying to deal with the consequences of harmful drinking. A report, *Alcohol-specific activity in hospitals in England*, said emergency hospital admissions due to alcohol had increased by more than 50% in nine years.

Parliament approved legislation amending the tariff objection mechanism. The amendments have removed the objection based on share of supply and raised the thresholds for the remaining objection criteria.

In January, junior doctors took their first industrial action since 1975, but subsequently suspended planned 48-hour action later in the

The month in quotes

'Over the next decade major health gains won't just come from a few "miracle cures", but from combining diverse breakthroughs in fields such as biosensors, medtech and drug discovery, mobile communications and AI computing. Our NHS test beds programme aims to cut through the hype and test the practical benefits for patients.'
NHS England chief executive Simon Stevens

'We are training significantly more people to work in every healthcare profession than we anticipate retiring or leaving between now and 2020. Between 2012 and 2016, we will have placed an additional 115,000 nursing and midwifery commissions into universities.'
Health Education England chief executive Professor Ian Cumming

'2016/17 is a firebreak year where we at the centre have got to do the best job to create the conditions and environment that give everybody the best chance of success. But you will have to move heaven and earth to get towards that success.'
NHS Trust Development Authority chief executive Bob Alexander

'The NHS and Department for Health have been too slow in tackling diabetes, both in prevention and treatment. The number of people with diabetes is increasing, as is the number of patients who develop complications. It is a very serious condition that can have a huge impact on people's lives. Yet support available to patients and those at risk varies hugely across the country.'
Commons Public Accounts Committee chair Meg Hillier

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In January, junior doctors took their first industrial action since 1975, but suspended action later in the month after progress at ACAS

month after progress was made in discussions at the conciliation service ACAS. Talks continued as *Healthcare Finance* went to press, but a nine-hour all-out strike planned for 10 February could still go ahead. As *Healthcare Finance* went to press, the royal colleges stepped in to urge all sides to reach a settlement.

Trusts were told quality and finance must be considered equally in planning decisions. In a joint letter, NHS Improvement chief executive Jim Mackey and Care Quality Commission (CQC) chief inspector of hospitals Professor Sir Mike Richards, said their organisations would work together to help turnaround trusts with the biggest financial challenges, balancing quality and finance. They will jointly design the framework to be used by the CQC to assess trusts' use of resources. Both organisations will share staffing guidance and use a new care hours per patient day metric to examine trusts' management of staff resources.

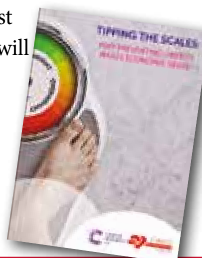
Providers warned a planned increase in CQC fees risked placing additional financial pressure on an already stretched health and care system. In its response to the CQC consultation on its new fees, NHS Providers acknowledged the need for the watchdog to be appropriately funded, but said proposed rises of up to 75% for a provider were 'disproportionate and unrealistic'.

NHS England chief executive Simon Stevens launched a first wave of innovation test beds for the health service. The NHS will work with innovators, including IBM and Philips, in seven pilots to harness technology to address some of the most complex issues facing patients and the health service, he said.

The Welsh government has allocated £2.5m to tackle delayed transfers of care from hospital. It said 435 people had their transfer of care delayed in December. This was fewer than the previous month and the third month there had been a reduction. However, more than half of the delays were caused by late community care assessments, delays in the older people choosing care homes or where they had to wait for a place to become available.

With new year resolutions still fresh, there were two reports on the potential costs of conditions that can be related to lifestyle. The Commons Public Accounts Committee said the costs of diabetes to the NHS would continue to rise without rapid action. In a report on the management of adult diabetes, the committee said some progress had been made, but there were 'unacceptable variations' in education take-up, delivery of recommended care processes, achievement of treatment standards and in outcomes for patients. It is estimated that diabetes costs the NHS £5.6bn a year. Poorly performing clinical commissioning groups should be identified and interventions made to help them improve, the committee said.

Meanwhile, Cancer Research UK and the UK Health Forum said illness caused by obesity could cost the NHS and social care bodies an additional £2.5bn by 2035 if current trends continue. They said almost three in four adults would be overweight or obese in 20 years, leading to an additional 670,000 cases of cancer. *Tipping the scales: why preventing obesity makes economic sense* made policy recommendations including increasing taxes on unhealthy foods, restricting marketing to children and investment in activity.



in the media

Despite the usual lull around the Christmas holiday, the HFMA has been well featured in the media.

Some of the widest coverage was drawn by December's annual conference, which was covered by *The Guardian* and trade press such as *Public Finance* and *Health Service Journal*. *The Guardian* story on a clampdown on overspending trusts included quotes from NHS Improvement chief executive Jim Mackey's speech to delegates. Some trusts would have to 'go through a very painful process', he said.

The HFMA/CIPFA report on the better care fund was well covered in the trade press, which said collaboration was happening but progress was being held back by red tape. HFMA policy and technical director Paul Briddock told *Hospital Doctor* it was positive that six months after the fund began organisations were starting to integrate services, but streamlining and simplification of processes was needed.

The *Huffington Post* contacted the HFMA for an article on trusts needing working capital loans to pay wages and the cost of those loans. The association said there was a balance to be struck between imposing extra costs on organisations in financial difficulty and giving them penalty-free support. The message from the centre was that this was not an easy route to money, it added.

As the dust settled on the spending review, Mr Briddock said in an article for *Public Finance* that NHS finance staff faced the challenge of finding a way to meet short-term financial targets, while ensuring improvements in the future.

HFMA 2015

Highlights from the association's annual conference in December

The conference was a platform for the first announcements about the detailed NHS settlement. Delegates also heard from guest speaker Alastair Campbell (left), as well as (below l-r) Bob Alexander, Paul Baumann, outgoing HFMA president Sue Lorimer and NHS Improvement chief executive Jim Mackey. Also on stage were (bottom l-r) Clifford Mann and Johnny Marshall, HFMA chief executive Mark Knight, Sanjay Agrawal and Paul Briddock

Right: BBC journalist Clive Myrie and finance director of the year Simon Worthington

HFMA 2015 award winners

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Fair shares

Despite financial challenges facing the whole health service, NHS England has made good on promises to move rapidly towards fair share allocations for commissioners. Steve Brown reports

The NHS is built on the principle that everybody should have equal access to good services. The fundamental starting point for delivering on this is to ensure that all areas get a fair share in funding. NHS England believes that this year it has taken a major stride towards getting this core foundation in place.

The NHS has long used a capitation formula to set targets for local commissioning budgets, taking account of the age and need of local populations.

The key word here is 'targets', with commissioners effectively moved from historical allocations towards their fair share target at a pace determined by a 'pace-of-change' policy.

From time to time, formulae have been revised, resetting target allocations. Differential growth, giving a minimum increase to all commissioners and additional growth to under-target bodies, would then move commissioners towards those fair shares. But in times of low overall growth, the pace of change has tended to slow to glacial levels.

In recent years, however, despite the clear financial difficulties facing the service as a whole, NHS England has upped the ante on pace of change. It set a goal of bringing all clinical commissioning groups (CCGs) receiving less than their target funding to within 5% of target by 2016/17.

New allocations published in January not only make good on this, but also give commissioners greater certainty by setting budgets for five years (three years of firm allocations and two years of indicative figures).

The rules governing pace of change for CCGs are complicated. Each CCG should receive a minimum per capita growth (equivalent to real-terms cash growth at average population growth) and minimum cash growth equivalent to real-terms growth plus specific policy pressures, unless the CCG is more than 10% above target (with the cap phased in from +5%).

And this is then further complicated by

There have been changes to further address inequalities – a new sparsity adjustment and a refresh of the emergency ambulance cost adjustment

new 'holistic place-based targets' that take into account both primary medical care and specialised services.

However, the core of the policy is that any CCG that is more than 10% above target receives flat cash bar policy adjustments (with the pension cost increase being the main one). CCGs between 5% and 10% above target receive some growth on a sliding scale.

Mean growth for CCGs is 3.74% with a median (the growth rate received by more than 40% of the 209 CCGs) of 3.05%. There are lower increases for the following three years before an increase again in the figures for year five.

But the focus on bringing all under-target CCGs to within 5% of target means big differences in growth at the local level – with nearly an 8.5 percentage point spread between the lowest and highest growth figures.

Six CCGs will receive the minimum cash growth of 1.39% – Sunderland, Isle of Wight, Camden, Hammersmith and Fulham, West London and Central London. Meanwhile Bedfordshire receives 9.65% and Corby 9.40%.

Bedfordshire CCG welcomed the allocations, which will see it move to its fair share of funding over the next five years. However, the CCG already faces financial challenges. A cumulative £45m deficit reported in 2014/15 led to NHS England placing it under legal directions. The CCG is now on track to meet its financial commitments for the current year but said that 'historic underfunding will have been one of several contributory factors in the financial difficulties we faced last year'.

It pointed out that its starting position – or closing distance from target (DFT) for 2015/16 – was 8% under target, which equated to underfunding of £40m on its £500m budget.

'The benefit of growth next year will help consolidate our financial position so that we can continue to provide good quality healthcare in the future,' a spokeswoman said.

Analysing the figures

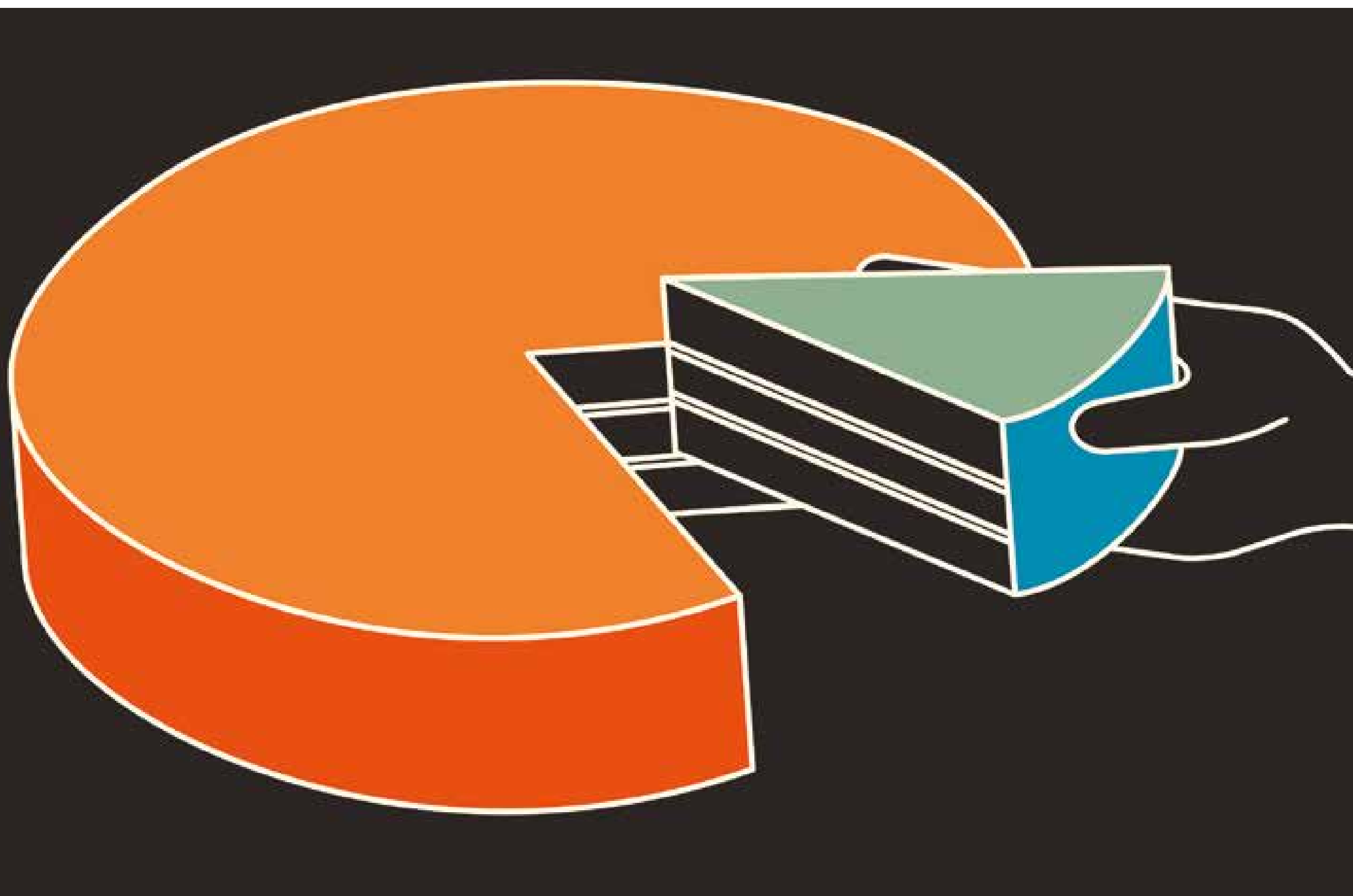
Many CCGs contacted by *Healthcare Finance* during January said they were still analysing the figures. That's understandable. The underlying data in the formula has been updated, with activity data brought forward by four years and model parameters re-estimated.

There have also been changes to further address inequalities – in particular a new sparsity adjustment and a refresh of the emergency ambulance cost adjustment. And a CCG's population growth relative to the average will also have an impact on annual allocations. All in all, it is a complicated picture.

And all CCGs face challenges in agreeing contracts. For example, NHS Kernow, covering

What's not in the allocations

CCGs told *Healthcare Finance* they were also trying to understand what wasn't included in the allocations. For example, funding for GP IT support, which was previously commissioned by CCGs but paid for on a non-recurrent basis by NHS England, looks like it may now fall on CCG budgets. One CCG also identified the lack of 'enhanced tariff adjustment' as a pressure. This was paid this year to CCGs to 'offset some of the pressures arising' from the enhanced tariff option following rejection of the original tariff by providers. Reduced flexibility on how the 1% non-recurrent expenditure can be used is also adding to the pressure.



SHUTTERSTOCK

Cornwall and the Isles of Scilly, is already forecasting a deficit this year and is working with NHS England to develop plans to improve the position. Its growth for 2016/17 equates to an increase of £21.6m.

'Nevertheless, the current level of spending, and the likely increase in future demands and costs for services, mean that setting and agreeing our financial plan for next year will be challenging,' said CCG chief finance officer Simon Bell.

'In addition to the financial plan for next year, we will be working with local providers, the councils and other stakeholders to develop a community-wide five-year sustainability and transformation plan that will co-ordinate our ideas across the system to deliver local healthcare for the future.'

Sunderland is one of the six CCGs facing minimum growth – courtesy of its above 10% DFT. In fact, the changes to the allocation formula moved its 2015/16 closing DFT from 12% to 18.6%.

And while it had been planning on the basis of limited financial growth for the next three years, it said it was disappointed with 'one of the biggest negative shifts in distance from target in the country'. Most CCGs, bar those affected by the rurality adjustment, saw changes of 1%-2%.

It receives slightly more than minimum growth for primary care. However, a spokesman said that with the hybrid DFT at 13.9%, it was still looking at being over the 10% minimum

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Simon Bell, NHS Kernow

growth ceiling for the next five years. 'As such, we will be the only CCG outside London to receive real-terms cuts in funding,' he said. He added that the CCG had begun working with NHS England to understand the shift in target and that it was 'appreciative of the support received to date'.

A January board paper suggested that the reduced allocation growth, combined with the reduced provider efficiency in tariff and anticipated demand increases, would require 'an additional £20m of allocative efficiencies over the next three years'.

'The CCG does hope that, given the significant financial challenges facing commissioners and providers in Sunderland, our sustainability and transformation plan will be viewed positively by NHS England,' the spokesman added.

The introduction of a sparsity factor in the formula results in an adjustment for six CCGs in relation to eight hospital sites. According to NHS England, the adjustment totals £31m, with a range across the six CCGs of £2.6m to £14.2m. The impact on actual allocations in any year is dictated by the absolute DFT and pace of change.

Cumbria was highlighted by NHS England as one of the areas to benefit from the decision to factor in the unavoidable pressures of rurality and sparsity.

However, the impact is complicated. The CCG's DFT has reduced from a closing DFT of 6.5% (using old formula) to a recalculated 2% with the new.

Thirteen different issues contribute to the change, moving the target in both directions. The single biggest impact is from the refresh of the formula regarding need and commissioning patterns. The new sparsity adjustment equates to 2.1 percentage points of the 4.5% reduction, with a refresh of the emergency ambulance cost adjustment also benefiting the county.

While still over target, the reduction in DFT brings the CCG down into median growth territory. Its DFT stays below the key 5% over-target threshold for the five years.

However, with estimated flat population growth, compared with an average of around 0.7%, its DFT creeps back up to a final closing DFT of 4.3%. It may be complicated, but the recognition of sparsity is seen as a breakthrough for areas with remote populations.

The allocations mark a major step towards the allocation of fair shares. An updated formula, new sparsity factor and an aggressive pace of change policy all move money around. Full understanding of what the allocations mean for 2016 and the years ahead will take some time yet.

Comment

February 2016

Time to step up

Best foot forward in an era of transformation

HFMA president Shahana Khan

You may have heard by now – or read elsewhere in this issue – that my theme for the year is 'step up'. This call to action is aimed at the centre, local NHS bodies and the finance function collectively and also at individual members of finance teams.

This in no way undermines the valuable contribution that finance staff have made to date. Far from it – finance has played a significant role in recent years in setting up new commissioning organisations and meeting heroic efficiency requirements built into tariff and non-tariff contracts.

But the NHS continues to face unprecedented challenges. The new money announced as a result of the spending review – and the sensible decision to frontload this and to target those early resources on sorting out provider deficits – is to be applauded. But no-one is pretending these steps have dissolved the challenge facing the NHS.

The only way we will meet this challenge is if we do things radically differently, including redesigning services to meet the needs of an ageing population with a growing level of long-term conditions.

It can't be the 'same old same old'. If we are to stand any chance of success, we will need the finance function to play a leading role. It is easy to say this, I know, but it is nonetheless true. Finance professionals have the skills – an understanding of the clinical and financial sides of healthcare, a reliance on evidence-based decision-making, problem-solving capabilities and attention to detail – that will be vital if we are to transform services.

We need to see this leading role as an opportunity and an obligation – making a lasting contribution to the delivery

Data key to Carter success

Data, benchmarks and transparency should be the real benefits of productivity review

Healthcare Finance editor Steve Brown

The final Carter report is imminent. By the time you read this, it may even have been published. However, it is already close to the top of many finance practitioners' agendas. This is not surprising given we have already seen a preliminary report, supported by various conference presentations. And there has been substantial media coverage both about what Lord Carter and his team have already said and speculation about what they plan to say in the final report.

January saw separate stories about Carter's 'new' adjusted treatment index (ATI) being based on discredited data, while the month closed with leaks of apparent plans to cap hospital management costs and to push much wider use of shared services for back office functions.

It is true that reference costs lie behind the ATI, but it is hardly news, as Carter's first report made this perfectly clear. And discredited? Few in finance would champion the detailed accuracy of reference costs and the last audit found material inaccuracies in half of a sample.

But no-one is claiming absolute accuracy. As Lord Carter told the HFMA conference in December, the numbers (in the ATI

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of sustainable healthcare services for the future.

Of course this would be challenging at the best of times. But the here and now demands our attention too. I doubt the current planning round – even with the extra resources – could be any more demanding. The timescales are shorter than ever – planning guidance was only released at the end of December and we still don’t have the official section 118 consultation document on the new tariff or the 2016/17 national contract, even if we basically know the core details.

Trying to produce a one-year plan and a five-year system plan within a few months is going to be daunting, given that organisations are still shuffling for places within their system footprint and trying to understand what that really means.

But the reality is that we simply have to find the time to support these contract and planning deadlines – producing meaningful long-term and operational plans. We have to continue to manage the day job – ensuring the smooth running of the financial engine room and delivering the agreed bottom line that will be statutorily reported. But somehow we also have to find time to raise our eyes to the horizon.

That means getting involved with transformation projects, bringing ideas to the table and brokering patient-focused transformation across organisational boundaries whatever the implications for individual organisations. It means getting our cost data and financial modelling fit for purpose so they can be the drivers for change.

And it means working right alongside our clinical colleagues – supporting them and challenging them – to really help understand clinical variation and where standardisation of practice can deliver better value.

Within this challenging context of balancing the money and the quality, the NHS needs us more than ever. Are you ready to step up? Somehow I already know you are.

Contact the president on president@hfma.org.uk

and savings targets) may not be spot on, but they are good enough to provide reliable indications. And they should help organisations to ask questions – and perhaps help them to prioritise where to look for opportunities.

Anecdotal feedback from the 32 trusts supporting Carter’s work is positive. They see value in the work and welcome any tools that might help them in their endeavours to improve productivity. So, for example, the requirement for trusts to publish their receipts on a monthly basis for the top 100 items, such as bandages and rubber gloves, has to help NHS bodies avoid overpaying. Procurement – and taking advantage of the service’s collective buying power – is far from straightforward but few would argue that the NHS is already delivering optimum value in this area.

More data, benchmarks and greater transparency have to make sense. Boards should see this as helpful even if subsequent local discussions confirm local costs as appropriate.

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To date, Carter has all been about the power of data. ‘Compare, challenge, explain, copy or change’ appears to be the mantra. The imposition of crude one-size-fits all caps or mandatory service models for support functions would appear to be out of step with this approach – although it will be interesting to see the tone of the final report.

The last question around Carter has to be capacity for delivery. There will inevitably have to be a process of prioritisation, especially as support services such as finance have a huge role in supporting the broader transformation of care models. The data provided by Carter should help in this process, giving local managers the information they need to isolate their best opportunities to deliver better value.

Can Carter deliver its £5bn savings target? Many would say much of that figure will get lost in the translation of theoretical potential into practice. But if it really leads to more data shared across the service and better understanding of relative costs and spending, it has to be a step in the right direction.

Sharper focus

A recent HFMA conference for provider finance directors heard how efficiency remains a top priority. Seamus Ward reports

Efficiency and productivity will remain the watchwords for the NHS in England over the next few years and significant opportunities remain to find savings or avoid costs. This was the key message from the HFMA Provider Finance directors' forum in January.

The theme was prominent in a speech from Lord Prior. Setting the scene in a keynote speech, the NHS productivity minister acknowledged the challenges ahead. But the government would help by frontloading some of its promised additional *Five-year forward view* (FYFV) funding – £3.8bn in 2016/17. With six-month figures forecasting a £2.2bn deficit at the end of the current financial year, 2016/17 would be 'tough, but doable', he insisted.

He conceded some trusts may have felt: 'If we are going to lose £40m, why not £50m and pull it back the following year'. This was dangerous, because having lost its financial discipline, a trust can find it difficult to convince staff that tight financial management is important again.

'With staff groups, particularly medical staff, if you lose individual discipline it makes your job incredibly difficult. But on the other side of the equation, in a financial crisis you may be able to do things that you couldn't before. I know a lot of hospitals are looking at joining up with other hospitals; rationalising service lines; and looking to do deals outside hospital. People are looking at things differently because there is a recognition that we can't drag ourselves out of it just by our own efforts. We shouldn't waste a good crisis.'

Efficiency push

Lord Prior told *Healthcare Finance* the £5bn of productivity and efficiency savings identified by Lord Carter in his review was achievable. 'The £5bn is based on trusts getting to the average. It takes in a whole range of clinical specialties and all their activity, but it is not a stretch target,' he said. He did not underestimate the scale of the challenge and in some trusts it would be more difficult than others. 'I am conscious of the fact that it can't be done overnight. It's not going to be easy, but it is possible.'

The money did not have to be saved in the first year, he insisted, but over the five years of the FYFV process. Away from these savings, other changes such as new care systems – accountable care organisations, MCPs and PACS – will take time to establish and begin delivering savings.

Lord Prior dismissed claims that efficiency targets were invalid because the reference costs on which they are based are inaccurate. 'What else have we got? The spread of patient-level information and costing systems will improve them,' he told *Healthcare Finance*. 'I've been working closely with Lord Carter over the past few months and I think the methodology he has developed should be very helpful. It's not perfect – the reference costs are not perfect and the market forces factor is not perfect – but it should provide you with a methodology for looking at variation within and across your organisations.'

Carter's adjusted treatment index (ATI) gives the health service a currency to examine and improve efficiency and productivity. 'Carter is providing people with the methodology,' he said. 'It will help finance directors and all the board.'

Chiefly, it would help trusts answer the question 'Are we good?'. Lord Prior said this was difficult to answer – should it be based on outcomes, infection rates, value for money or other factors?

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Procurement savings are a key element of the Carter efficiencies. Lord Carter told the HFMA annual conference in December that NHS procurement was a 'shambles' and, speaking after the directors' conference in January, Lord Prior agreed. 'It reflects the disaggregated, fragmented structure of the NHS. When every hospital is isolated, it is hard to get economies of scale in purchasing. We have a national supply chain but less than 40% of supplies goes through it. It's disaggregated and we don't think about economies of scale.'

The Department's new procurement strategy, outlined in January, would allow a greater degree of aggregation, he added. A new return would require trusts to publish receipts on a monthly basis for their top 100 purchased items, such as bandages, needles and rubber gloves. This would allow hospitals to compare costs and drive down prices.

The directors' conference heard how the introduction of GS1 barcodes can increase efficiency and improve patient care. Derby Teaching Hospitals NHS Foundation Trust director of finance and performance Kevin Downs outlined some practical examples of the benefits for his trust. It has introduced barcode scanning at point of use in a number of areas, including general surgery and cath labs. The information not only feeds into its supplies system for reordering and audit, but also into its finance system.

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For example, the trust can produce a 'cost of operation' sheet, listing costs such as consumables and staff time. These can be compared at an aggregate or individual level to identify and address variation.

The system meant the trust did not suffer from some of the procurement weaknesses outlined in the interim Carter report. 'We don't have different departments buying the same product at a different price,' Mr Downs said. 'That's controlled by the e-catalogue. At no point is there manual intervention apart from overseeing the level of stock held.'

As well as procurement, Lord Prior said transforming care and driving down agency staff spending were fundamental to meeting the £22bn funding shortfall identified by the FYFV. 'We have a huge property estate that is under-utilised in hugely expensive areas. There are lots of areas where we could do quite a lot better,' he said.

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Benefits of devolution

Representatives from the Greater Manchester devolution project insisted, however, that the city's new structure offered a fresh opportunity to tackle the causes of ill health and reduce demand. Greater Manchester health and social care devolution project chief finance officer Sarah Senior added this would take time.

Tameside Hospitals NHS Foundation Trust finance director Claire Yarwood said Greater Manchester had worked with NHS England and the Treasury to create a transformation fund, on which the national £1.8bn transformation fund was based. 'The fund allows us to do things differently,' she said. 'We have had to be quite radical and stretch our ambition and it's been a challenge for the directors of finance in commissioners and providers.'

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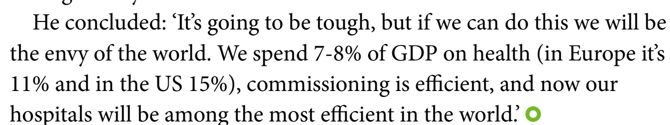
And he had a stark message on the future of district general hospitals. 'The age of the DGH is behind us. They must integrate [with other providers] or join in some sort of chain.'

While barriers to change remained, he was optimistic because the NHS had a widely supported narrative for reform in the FYFV, while NHS Improvement's focus on development, not just finance, was a 'huge step forward'. New technology and transparency of information would drive improvement. 'Transparency is the closest thing we can get to a market without having a market,' he said. 'It is better than the other interventions of the past 10-15 years. We've tried targets, tried top-down performance management, but transparency is a better way to self manage the system.'



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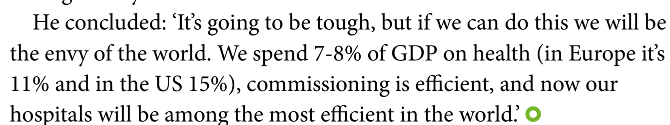

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step change

Despite welcome new funds, the NHS still faces a long-term challenge to deliver sustainable services into the future. New HFMA president Shahana Khan believes the finance function can step up to the challenge and help shape transformation. Steve Brown reports

The NHS finance function needs to exert its influence more as the NHS looks to address its significant financial challenges and transform services to meet rising demand and patient expectations.

This is the message from new HFMA president Shahana Khan as she challenges the profession, individual finance practitioners, organisations and the broader NHS to 'step up' in the year ahead.

Ms Khan welcomed the new investment – more than £8bn by 2020/21 in real terms – promised in the government's recent spending review announcement. 'It is badly needed as we know the system is currently in financial meltdown,' she says.

The frontloading of this investment – £3.8bn in 2016/17 – and the initial focus on addressing provider deficits is the right approach and absolutely necessary, she adds. However, she remains concerned about the long-term sustainability of services in the face of a rising and ageing population and growth in the prevalence of long-term conditions.

While the £8bn investment is in line with the sum NHS England asked for in its *Five-year forward view*, it assumes the NHS can achieve some £22bn of productivity improvements over the same timescale to bridge an estimated £30bn funding gap.

Ms Khan says that maximising value – considering quality in terms of outcomes and experience and factoring in costs – makes complete sense. And she believes Lord Carter's productivity work should be welcomed in supporting local organisations to challenge local efficiency, locate best practice and implement change where appropriate.

Echoing Lord Carter's presentation to the HFMA annual conference in December, she says the efficiency targets being set using the 'new' adjusted treatment index may not identify the exact efficiency opportunity, but they should help organisations to focus on areas where savings could be realised.

However, much of the productivity improvement will need to come from transformation projects, with vanguard sites working up wide-ranging new models of care around the country. And it is here where Ms Khan has some concerns.

She says that testing the new approaches makes sense and there is the potential for significant learning to be shared across the whole service. The projects are clearly focused on optimising care for and integrating care around patients.

But the financial implications of these new models are less clear. 'In many cases, the projects hope to deliver financial efficiencies as well as service improvements, but we have not tested the transformation model in terms of how it will deliver on the efficiencies we are looking for or over what timescale,' she says.

Leading the debate

She wants politicians and the service's senior leaders to lead the debate on the need for new models of care – and the changes patients and the public will see as a consequence, especially in terms of potentially reconfigured services.

But she also wants them to be open about how the service could react if transformation doesn't achieve all the desired financial benefits. In effect, she is keen that any contingency planning is made more public.

Organisations also need to step up, says Ms Khan. In particular, she would like to see an end to providers and commissioners 'fighting over the same pound'. 'We've got to get away from a simple focus on the contract,' she says. 'At times, this gets in the way and we need to move forward on a local health economy basis.'

She includes wrangles over fines and how activity is being counted as key parts of the distractions that prevent local organisations coming together to find joint solutions to health economy-wide problems. Different systems of performance measurement and management may be needed.

The recently published shared planning guidance makes moves in this direction with the requirement to develop five-year sustainability and transformation plans across whole health economies. 'We need to focus on system solutions instead of organisational boundaries,' she says, suggesting that

“Understanding costs is important for any business, but if we are serious about improving NHS efficiency and productivity, good cost data is essential”
Shahana Khan

organisations and their leaders will need to demonstrate courage in doing so.

Changing the status of the contract as the bridge between commissioners and providers might have implications for the national tariff. ‘We may need to rethink how we use the tariff differently,’ she says, adding that the HFMA and the finance profession need to play a big part in these developments.

She recognises it is difficult territory. ‘We have to avoid the tariff getting in the way of delivering great care in the right setting and at times the incentives haven’t aligned with the way health economies want to provide services. So it needs to change,’ she says. ‘But the tariff has also brought huge benefits in getting a focus on accurate coding and classification and improved costing.

‘Understanding costs is important for any business, but if we are serious about improving NHS efficiency and productivity, good cost data is essential. It is through the use of cost data – and particularly patient cost data – and service line information that we can really get into the drivers of cost. And increasingly that is how we can work with clinicians to understand where clinical variation is appropriate or where changes in practice could improve services and reduce costs.’

Staffing challenges

National and local organisations also need to step up in getting to grips with the current staffing challenges. Nationally imposed caps on agency rates and requirements to stick to framework contracts are useful, but organisations still face operational pressures to staff rotas. Agency staff are often only available on non-framework contracts.

Ms Khan wants organisations to ensure that staff roles are built around the needs of patients and to explore the potential for new staffing models – developing physician associates and advanced nurse practitioners, for example, or broadening the roles of therapists.

The core problem, says Ms Khan, is a shortage of available staff, making it difficult to recruit to some substantive positions and driving up agency rates, especially in some specialty areas such as theatre practitioners.

For the long term, she believes the service needs to improve its workforce planning. She is interested to see if the removal of NHS funded university places for nursing and other health degrees will lead to an increase in available staff downstream. In the short term she wonders if the centre could take more of a role in co-ordinating the recruitment of clinical staff from outside the UK – with increasing numbers of providers including this in their staffing strategy and making separate arrangements. Organisations also need to do more to understand how they can improve staff retention.

Being more vocal and influencing policy development is one of the ways Ms Khan

THEODORE WOOD

thinks the finance profession can step up – on issues such as the importance of costing and the remuneration system.

This is not simply a matter of talking up the financial challenges facing the service. Instead, it is about continuing to work professionally and in an evidence-based way with the national bodies and the Department of Health. This will ensure there is a good understanding of the pressures in the system and how policies are playing out in the field, she says.

Ms Khan believes the finance voice was key in paving the way for the spending review increase in health spending. But she thinks there is room for improvement.

'The finance profession knew for years that 2015/16 was the crunch year when the NHS was facing a cliff edge and yet we were not able to influence an earlier change of direction,' she says. Now, with the new investment, she suggests 'all eyes' will be on the finance community to ensure the extra investment delivers financial balance and service improvement. 'It is time for the finance profession to step up and be counted,' she says.

Her final challenge is to individual finance practitioners. She knows finance staff have worked hard in recent years, but believes their 'skills, determination and passion' will be needed even more as the service pushes ahead with transformation.

Future focus

And she believes practitioners need a subtle change in focus, away from the past and onto the future – less 'looking through the rear view mirror' and more providing of solutions to known problems.

The HFMA will be looking to support practitioners in maximising their individual and collective potential. Its programme of events, development opportunities and policy and technical work will continue to do this. And Ms Khan says that the association will specifically showcase 'how we can all step up in our day jobs' as well as achieving a key milestone with a new educational programme elevating the HFMA to 'awarding body' status.

'We need to get more on the front foot, be more forward-looking and solution-oriented,' says Ms Khan. 'For example, we know we need to get the debate going beyond organisational boundaries. I'm sure we can be the transformational people who make those discussions happen.'

Finance staff already have a relevant skillset, but with this adjustment she is convinced they can become game changers for the NHS. She argues that the current challenges really represent an 'opportunity' for finance practitioners. All they need to do is 'step up'.

Career path

Shahana Khan joined the NHS in 1991, just after the major reforms that split the commissioning of health services from the provision of care. She undertook her accountancy training in the public sector as part of the Ministry of Defence's fast-track scheme, before leaving to become chief financial officer of an international software company.

She says that former HFMA chairman Bob Dredge played a major role in bringing her into the NHS by giving her the opportunity to join Wolverhampton Health Authority, where he was finance director, 'despite me not having an inkling what an accountant did for the NHS'.

This was followed by a number of further positions in trusts before becoming deputy finance director of Good Hope Hospital NHS Trust in 2005 and then in the bigger Heart of England NHS Foundation Trust in 2006. Her first finance director role followed soon after in 2007, when she moved to head the finance team at Walsall Healthcare NHS Trust. She stayed there for nearly six years.

A short spell as finance projects director for NHS England in the Birmingham, Solihull and Black Country Area Team was followed by a return to the provider sector at the end of 2013 as director of finance and performance at George Eliot Hospital NHS Trust.

Having assessed that it was unlikely to achieve foundation trust status on its own, the trust was given approval to seek a strategic partner to secure a sustainable future for services in 2013. However, on the back of improved performance and quality, the procurement process was stopped in May 2014. This improvement also led to the trust being taken out of special measures, which had been imposed on the trust following the Keogh review of trusts with higher than expected mortality rates in 2013.

Ms Khan says staff at George Eliot really rallied together as a big family when facing these huge challenges. The trust was now continuing to explore a long-term solution to the provision of sustainable local services and examining how to use its estate in bringing different services together in a possible campus-style model.

Ms Khan, an HFMA trustee since 2011, became its president in December, taking over from Trust Development Authority business director Sue Lorimer.

"I'm sure we can be the transformational people who make discussions happen"

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making the system sweat

SHUTTERSTOCK

Trusts in England will be required to adopt electronic rostering, but some already have systems and are not making the most of them. Seamus Ward looks at how trusts can maximise the benefits of e-rostering

One of the concrete early signals from the Carter review of efficiency was that the NHS in England would be expected to adopt electronic rostering to allocate staff shifts. It would improve efficiency and productivity by ensuring the right staff were in the right place at the right time to suit patient needs, But don't most NHS trusts already have e-rosters? Yes, but, as Lord Carter explained to the HFMA annual conference in December, many do not use them well.

When the NHS first adopted e-rostering seven or eight years ago, there was much excitement. They would save ward managers from having to spend days poring over huge sheets of paper to create a roster. No longer would they eye each new Post-It note on their computer monitor with suspicion, hoping it was not another written request for days off or particular shifts. They would have more time to nurse and manage, as rosters would be produced at the touch of a button.

By linking with financial systems, payroll would be more accurate, while managers would be able to keep track of leave and ensure all contracted hours were worked. Sadly, this Shangri-La has not been reached in many trusts, with reports that paper rosters are still the norm, even among those with e-rostering systems.

Lord Carter aims to change this. Ahead of the publication of his final

report, the Department of Health said all trusts will be required to adopt e-rostering and use them well to ensure they are getting maximum use of staff – their single biggest expense. In his interim report, Lord Carter said a 1% increase in workforce productivity could avoid costs of £400m.

But how can trusts make the most of e-rosters? Some trusts are going through the process of learning to make the most of their e-rostering software, years after it was installed. In many cases, this requires a system reboot.

Northern Lincolnshire and Goole NHS Foundation Trust has used an e-roster system for five years, but director of finance and business support Marcus Hassall believes it is only in the latter years that it has begun to harness the full power of e-rostering.

'For the first three years, we didn't get it properly embedded. It was an add-on to what roster creators were doing before, making up the rosters on paper. We didn't have their understanding on e-rostering to deliver the maximum benefits for patients.'

Some roster managers were creating rosters on paper and then inputting the information into the software. This could take some staff up to three days. 'It doesn't generate the benefits you can get from e-rostering,' he says.

Derek Conlon, e-rostering and central bank staff manager, adds: 'In the past it was thought that e-rostering was more about finance than patient safety, but our key message was about linking it to better nursing and quality of care.'

An e-rostering system – Smart's Rosterpro – has been installed at the Royal Devon and Exeter NHS Foundation Trust for a number of years, covering the working hours of nurses and associated healthcare staff, such as healthcare assistants. But deputy chief nurse Tracey Reeves acknowledges it has not always been operated successfully.

'When it was brought in, it was not done terribly systematically – in a way that would maximise the benefits and staff buy-in,' she says. 'We weren't using all the functionality.'

As in other trusts, staff continued to work out rosters on paper before inputting the information into the e-rostering software.

System reboot

Both trusts are now turning the situation around. To reboot its e-rostering system, the Northern Lincolnshire trust called in its rostering software provider, Allocate, to examine how its use of the Healthroster system could be improved. This led to the trust looking at several areas.

Helen Clark, matron and the clinical lead for e-rostering, says she worked on getting staff to 'own' their working hours. One of the incentives used to get staff to use the system was moving the booking of requests, such as annual or study leave, onto the system. In turn, this helped the trust to influence when staff could take leave. For example, it could ensure every shift had an experienced, substantive staff member who was able to take charge.

Roster managers were urged to use the auto-roster option in the software. Mrs Clark says the release of version 10 of the Allocate software has encouraged this – it is now web-based, greatly speeding up the process, she says. 'On average we have gone from 8% auto rostering to more than 40%. That's still not huge, and not where we want it to be, but it is being facilitated by the speed of processing now.'

The time taken to create a roster – which used to take three days – is now down to five hours in some wards.

The position at the Royal Devon and Exeter has changed markedly. About five years ago, Ms Reeves led work that aimed to standardise shift times. Though it was not linked directly to the trust's e-roster, the project had a significant impact on getting the most out of the system.

'This allowed us to begin to build the foundation for better rostering. We redesigned all the shifts so we had the same starting and finishing times trust-wide. These are predominantly long days, which will not suit everywhere, but it's what our staff told us they wanted.'

Initially, they set a target of having 60% of staff working these long, 12-hour shifts, particularly in inpatient areas. Currently, about 80% are working these shifts across most wards, making auto-rostering more straightforward.

Before it refocused efforts on its e-roster, the system allowed many individual requests for flexible working. But it is difficult to accommodate large numbers of requests in a standardised system.

'We are a classic example of a trust that thought [e-rostering] would be the solution, but staff didn't particularly like it,' says Ms Reeves. 'But when we started thinking about using the auto-roster element of the software, we couldn't get it to work – there were too many requests. We had to go back to basics.'

The e-rostering system now allows flexible working, where necessary, but without compromising the balance of skills and numbers required. 'If too many people on one ward are making requests, then we may think of moving one to another ward,' Ms Reeves says.

With increases in its nursing establishment the trust decided to rebuild its rosters from the bottom up – deciding what skill mix and numbers were needed for each shift. This allowed the trust to set rules for each shift in the e-roster programme.

"Across 10 wards, we could evidence savings averaging £60,000 per ward. But we have also improved patient care by using our restricted resources better and getting more from it"
Marcus Hassall, Northern Lincolnshire and Goole NHS Foundation Trust

Ms Reeves adds: 'We had to manage annual leave, so we introduced rules in the e-roster on the maximum levels of people on leave at any one time. At the same time, we made sure staff understood we needed to have some people on leave to eliminate peaks and troughs.'

Further steps were taken to entrench e-rostering. 'An internal audit suggested rostering was not as well managed as it should be,' she says. 'It was possible that there were some overpayments to staff and there was a lack of tracking of hours. At that point, two years ago, we brought in a project manager to get on top of e-rostering and to make sure we are using the system properly. We then started to eliminate the risk of over- or underpayment.'

The onus is on the matrons who create the trust's rosters to fill them six weeks in advance (the trust has 90% compliance currently). This means at peak holiday times, such as Christmas, senior managers and matrons can be assured they have the correct skill mix and numbers of staff for each shift. 'The system links to our internal bank, so those people know work is potentially available,' says Ms Reeves. 'Our fill rate from our internal bank has improved.'

While he would not claim the Northern Lincolnshire trust is seeing the full benefits, Mr Hassall believes it is 'getting there'. He says: 'The difference we have made in the last two years is that we have tried to be more explicit about the rules in the system. This gives you the ability to drive efficiency in terms of the use of the roster.'

Rules now state the skill mix for a particular shift, as well as numbers of staff required.

Mr Hassall believes the financial benefits are significant, but they are not limited to finance. 'We tested the impact over a year across 10 of our wards, and could evidence savings averaging £60,000 per ward. But we have also improved patient care by using our restricted resources better and getting more from it. We are reducing agency spend and increasing

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quality as agency staff often do not have the skills or local knowledge to work as effectively as substantive staff.'

The bulk of the saving is made up of ensuring all contracted hours are worked and avoiding paying for additional hours through overtime or additional staff, with a smaller amount from avoiding agency spending.

The Northern Lincolnshire trust has increased its nursing establishment, but just over a year ago it went through a period where nursing vacancies rose from 7% to 12%. At any other time it might have faced a huge increase in nursing agency spend, but it was able to minimise the impact of the vacancies using e-rostering.

Mrs Clark said at one point the trust had lost 40 whole-time equivalents, but managed to maintain fill rates for shifts without markedly increasing the amount of agency staff. The increased visibility in the e-rostering system allowed it to optimise the use of substantive staff – getting them into the right shifts.

'With the rostering system in place we were able to monitor our spending and do a good job in filling the gap by using the system to deliver improved rosters,' Mr Hassall says. 'It was a great success in terms of cost avoidance.'

Mr Conlon adds that transparency of information has been a boon for staff. 'Managers get reports on who works the most weekends or bank holidays or who has the most requests granted. The visibility and availability of the information for staff is very democratising for them.'

Allocate's Healthroster solution is used by more than 60% of NHS trusts. Simon Courage, the firm's director of product development, says e-rostering is needed to solve the complex equation of staffing an NHS organisation.

'If a manager is creating rosters on a piece of paper, there is no visibility to the organisation; there is no overview,' he says. 'But Carter says there needs to be an overview so you know where the pinch points are. You cannot know where staffing might be problematic without an electronic source of all that information.'

Mr Courage says the software providers can help trusts maximise the benefits of their e-roster by keeping in touch after they make their sale. Allocate has a user group that meets annually, as well as regional groups and an online forum. It also has Allocate Insight, a range of services that assess a trust's performance on the use of rosters, benchmarked against its customer base.

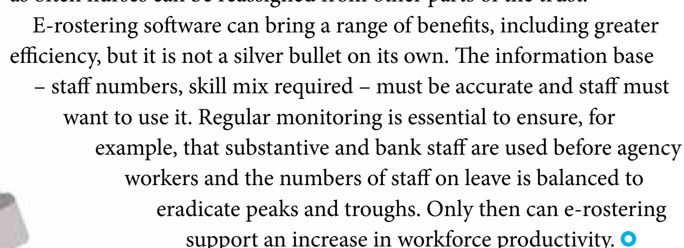
Everyday life

The e-roster has become central to everyday life at the Royal Devon and Exeter, Ms Reeves says. It is making the trust more efficient, particularly by avoiding costs – from reducing the use of agency staff to improving recruitment and retention.

Ms Reeves admits the trust was fortunate to have carried out actions that proved the building blocks for better e-rostering – the standardisation of shift starting times and rebuilding its shift numbers and skill mix from scratch. But she adds that ensuring the system continues to provide all its benefits is largely about good housekeeping.

The clear information about each shift delivered by the e-roster helps matrons keep on top of staffing needs. Senior nursing staff meet each week to ensure upcoming rosters are robust. If a gap is identified, they will use their experience to judge whether it needs to be filled to maintain patient safety. Or, in the case of a specialist post, such as in theatres, they may judge an agency worker is needed. But by booking an agency nurse in advance, they are more likely to be hired on a framework and at a better rate.

This process is repeated daily, to account for short-term absences, such as for sickness. This is helping control the trust's use of agency staff, as often nurses can be reassigned from other parts of the trust.



E-rostering software can bring a range of benefits, including greater efficiency, but it is not a silver bullet on its own. The information base – staff numbers, skill mix required – must be accurate and staff must want to use it. Regular monitoring is essential to ensure, for example, that substantive and bank staff are used before agency workers and the numbers of staff on leave is balanced to eradicate peaks and troughs. Only then can e-rostering support an increase in workforce productivity.

Surgeon Simon Kenny (second right) with operating department practitioners

Catching the clinical eye

Improving quality will often reduce costs and Alder Hey's new way of presenting cost data to clinicians aims to identify these win-wins. Steve Brown reports

Alder Hey Children's NHS Foundation Trust has taken the potentially dry subject of healthcare costing and made it about patients. This has helped to deliver benefits for patients, but in the process they have already realised recurrent financial benefits of more than £1m.

The trust's work on costing was recognised at the end of last year, when it won the HFMA Costing Award for 2015. This work has built on good cost data and a philosophy of continuous improvement. But the real key has been to drive clinical engagement by focusing on quality and service improvement.

The trust has prioritised costing for several years. An early adopter of patient-level information and costing systems (PLICS) with its Healthcost costing system, the trust has taken costing improvement seriously. In 2013, a self-assessment using the HFMA's materiality and quality scoring (MAQS) system gave its costing processes a silver rating – in the top five highest scores in England. Running the same assessment a year later, on the 2013/14 data, turned silver into gold and gave the trust the country's second highest MAQS score.

Further improvements are ongoing. For example, the trust has targeted the use of acuity measures on wards to help inform the allocation of nursing costs to individual patients and move away from simplistic time-on-ward approaches. The work involved significant nurse engagement – as nurses input the relevant data – and simple changes to the patient administration system.

There have also been changes to improve allocation of costs in theatres, particularly around the allocation of downtime. And the trust wants to improve the allocation of its medical staff costs too.

But while the trust has put a lot of effort into improving costing and cost data, it has not waited for perfect data before starting to use it. Patient-level cost data has underpinned the trust's approach to service line reporting in recent years. Jason Dean, costing accountant at the trust, says 'getting the data out there' is key to the improvement of the data as the process is necessarily iterative.

However, although cost data was already being used, there was recognition more could be done to engage the clinical workforce with this data source. 'We were aware we were only seeing the tip of the iceberg in terms of how cost data could be used to improve services and performance,' says Mr Dean. 'There is no point producing wonderful information and then not using it for the benefit of the hospital and patients. We've had some good wins, but there is so much more that can be achieved.'

In October 2014, it launched a costing strategy – which it called its 'treasure map'. It identified several milestones for the past 18 months – all of which have been met – but its aim was: to listen to what clinicians wanted; provide easy-to-read, visually appealing reports; and identify opportunities to improve services and finances. Treasure hunt training sessions have even turned data analysis into a game, with attendees asked to find the total overhead for cardiac surgery or locate a patient's biggest deficit-making episode.

'The focus has been to get people using the data – talking to people so they understand better what the opportunities are and we understand what they need,' says Mr Dean.

Out have gone old-style spreadsheets providing massive amounts of detail and a 'helpful' smattering of clinician-baffling acronyms such as 'EBITDA'. In have come graphic-based interfaces and infographics that pull-out the service and cost improvement opportunities, without making clinicians go hunting for them. This comes in two forms. First is the main interactive interface with the service line reporting system, which now provides a simple summary of the overall trust performance, broken down into its five clinical business units – medical specialties;

Savings account: endocrine

Patient cost data was used to back up a business case for expansion of the endocrine service. The service was not meeting clinical standards or regional demand and was arguing for increased investment despite making a significant deficit.

The patient data revealed variation in the number of patients seen by different consultants and suggested nurse-led attendances were more cost-effective for appropriate cases.

The trust decided to train more nurses to take care of straightforward cases and the focus of attention also led to an increase in consultant contacts.

The service has seen a sustained reduction in cost per case – producing a total saving of £160,000. It is now in surplus, meeting both clinical standards and existing demand, and has been able to hire an extra consultant to meet the increasing demand.

integrated community services; neurosciences, musculoskeletal and specialist surgery; surgical, critical care, anaesthetics and cardiac; and clinical support. Separate tabs show the bottom line performance of each business unit, identifying deficits and surpluses by relevant specialties. For each specialty there are tabs by healthcare resource group and by clinician – and users can drill down to patient level.

The second approach to help clinicians understand the financial and service improvement opportunities uses infographics to show the cost of quality and performance issues, using benchmark data from other providers or previous year comparisons. Launched in the trust as 'value intelligence for patients' or VIP (see below), it uses a set of static infographics. In future, it will enable the user to drill into more detailed infographics on each subject and into patient-level data in most instances so users can track the causes of outlier performance.

It uses metrics, chosed by clinicians, that show the performance of key aspects of different services right alongside the total cost of that performance. The infographic might show a CBU's readmission performance alongside the cost of the readmissions. Or it might show the number and cost of hospital-acquired infections broken down by the service areas where the infections are occurring.

'The aim has been to tie this into the quality strategy not the cost improvement programme,' says Mr Dean. 'We want the focus on quality … and finance to be the follow-on.' It has proven a good starting point for clinical engagement.

VIP value

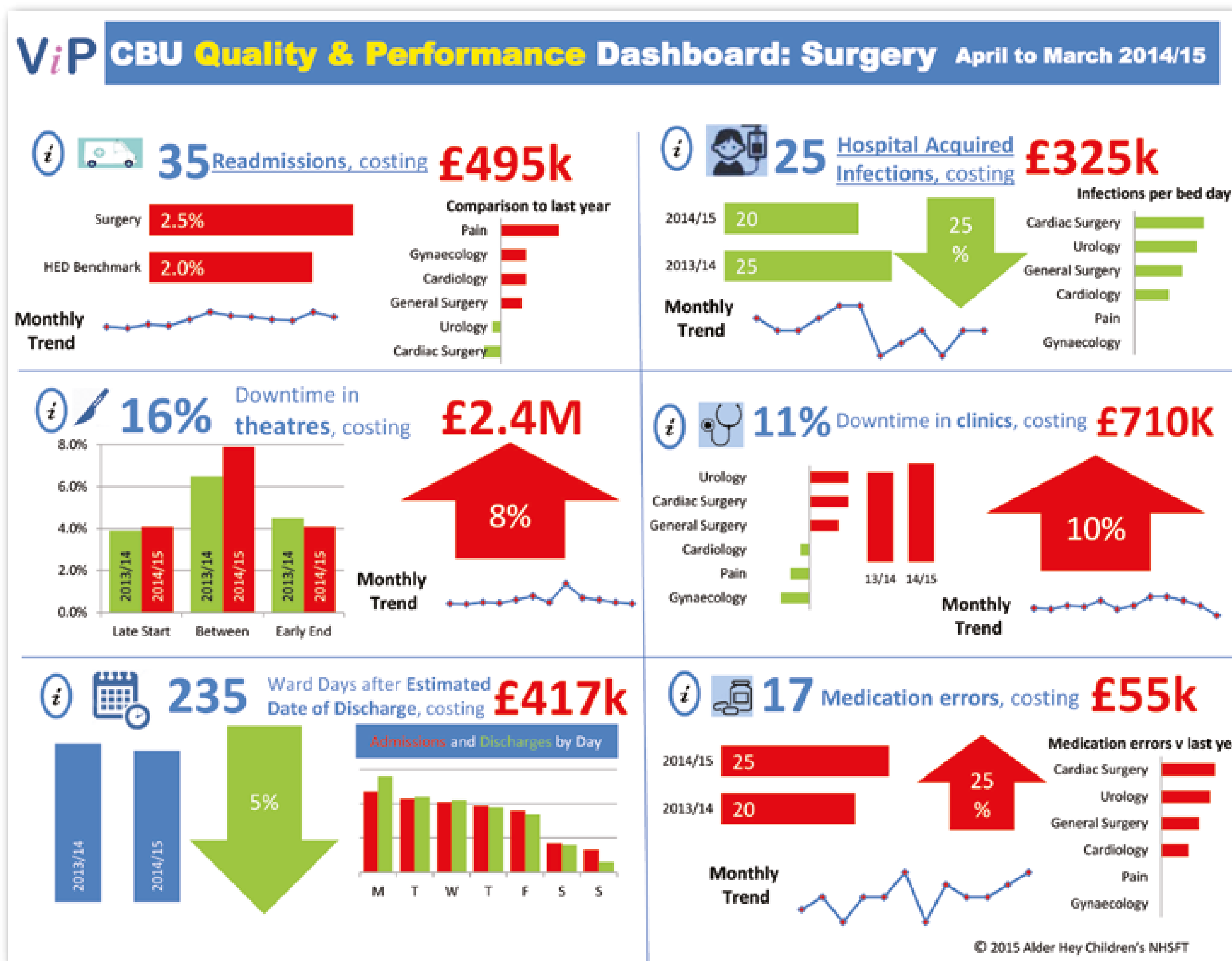
The trust is about to launch the VIP across all its specialties and clinical business units, although costing data has already shown its value in a number of pilots and deep dives.

Improvements and financial gains have been made in several areas. By using the PLICS system to drill down into the biggest loss-making patient in one business unit, the trust discovered the loss was mainly due to drug expenditure. Further investigation showed the drug was eligible for refund but was not being flagged, along with other drugs on the pharmacy system. Fixing this increased income by £90,000 and procedures have been put in place to ensure full coding occurs in future (see boxes for further examples).

The trust has used the data to identify opportunities to improve services and reduce costs and to identify previously unpaid activity. Mr Dean recognises that from a system-wide perspective, finding ways to take out real cost offers the greatest benefits. However, he says that correcting coding and classification processes also has system-wide benefits in understanding casemix and activity that go beyond any income corrections.

Perhaps the best example of how the detailed cost data has been used to inform service change is appendicectomies. Paediatric surgeon and clinical director Simon Kenny says: 'We identified the appendicectomy HRG (FZ20C [1]) as the biggest loss-making HRG in general paediatric surgery at Alder Hey.'

Outcomes – for example, measured in



[1] *FZ20c is the under-19 appendicectomy HRG under default tariff rollover arrangements – the currency changed for the 2015/16 enhanced tariff option*

terms of readmissions – were good in comparison with other providers, but costs looked higher, certainly compared with district general hospitals.

The biggest gap was in length of stay, and analysis by consultants has shown clear variation, both in terms of how quickly different consultants get children into theatres and how long they stay in hospital.

Mr Kenny says looking at variation in costs by different consultants suggested there were potential savings of £220,000 if all moved to the performance of the seemingly most efficient. 'Some surgeons wanted to keep their patients in an extra day,' he says.

This is fine when appropriate, but there are benefits for patients in getting them home as soon as they are fit for discharge. Having the data has enabled clinicians to discuss the variation and eliminate it where it makes sense.

'[The work] has allowed us to focus on reducing delays in decision-making prior to surgery and to tackle variation in different surgeons' approaches where they haven't followed the pathway,' says Mr Kenny.

Another cause of the apparently higher costs was Alder Hey's earlier use of intravenous antibiotics for complex patients. This approach has been highly successful – and a key reason for the trust's low readmissions – but it does explain some of the longer lengths of stay. The trust is examining the potential to deliver the drugs via an outpatient parenteral antibiotic therapy (OPAT) service.

Deputy finance director Claire Liddy says the trust has attempted to provide its financial data in the context of the patient journey. 'Before, when we were only talking in terms of EBITDA and profit and loss, it didn't inspire clinicians or hit the right notes.'

The response to the new visual approach has been very positive. 'Clinicians haven't suddenly decided it would be a good idea to reduce infections, for example,' she says. 'We had good data about harm and readmissions and everyone wanted to minimise these events.

'But it was not until we ran this through the costs system that we really knew and could see the true cost of not achieving these quality aspects.

'It gives us a shared purpose. Not only can we see where we want to raise quality, but we can see the financial benefits of doing so. We can unite around a win-win. Clinicians can also see how this supports our long-term financial sustainability.'

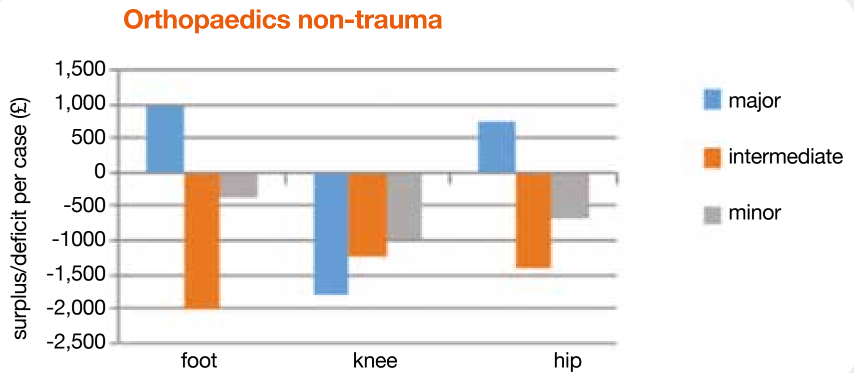
The use of costing data has already delivered service and financial benefits for Alder Hey. But the real hope with the new approach is that clinicians, services and business units will be able – and keen – to drive some of these changes themselves using the costing system as a support tool.

'We're a relatively small trust,' says Mrs Liddy. 'The senior leadership team can't know the intricacies of every service, so we have to inspire individual consultants to be leaders. Our VIP system will be the platform to take this forward.'

Savings account: orthopaedics

Income per case for orthopaedics work was behind plan. Drilling down into the detailed cost data showed that, for feet and hips work, the trust was counterintuitively making money on major, complex cases and losing on intermediate work. It became clear this was the result of undercoding, having lost a specialist orthopaedic coder.

Collaboration between surgeons and the coding team has clarified what coders need to see to code correctly and what surgeons need to provide, underpinned with a proforma. This identified £58,000 of extra income in the first three months.



Savings account: neurology

Drilling down into the data behind the neurology service – which was making a 21% deficit – highlighted a lot of therapy work being done unpaid post-discharge. Further analysis revealed 51% of the loss was from just 10 patients – each with a length of stay of more than 55 days. The patients were typically receiving intensive therapy that was not covered by the excess bed days rate.

Looking across the whole trust, the data showed just 123 patients accounted for 26% of bed days, so the trust decided to take a detailed look at rehabilitation. 'This was a staggering statistic and these patients were spread across different wards and not necessarily cared for on a consistent basis,' says costing accountant Jason Dean. 'In the acute world, hospitals might have neurology rehab wards, but this model hasn't developed in paediatrics.'

This led the trust to develop a specialised rehabilitation team working from a dedicated ward in its recently opened hospital. It means patients in the rehab stage receive the right attention and care earlier – typically intensive support from occupational, physio and speech therapists.

The aim is also to introduce a second step in the rehab process, similar to the adult pathway, where patients and their families are coached in preparation for going home. Practitioners work with the family and patient to develop a joint plan for post-discharge care, with willing parents empowered to provide as much care as possible. There are clear benefits for the child and family and typically a reduced length of stay, which reduces cost.

Alder Hey is in talks with commissioners about financial support to cover the costs of the work, with a proposal for rehab to form part of the Cheshire and Mersey Women's and Children's vanguard work.

The trust believes the changes have the potential to release up to 6,000 bed days for acute tertiary patients, though the main benefits should be felt at a much wider scale, massively reducing lifelong health and education costs.

Mr Dean cites a recent case of a child able to enter mainstream schooling as a result of the more focused, intensive therapy.

Looking to share your healthcare finance experience?

HFMA are currently working in partnership with BPP University to develop a set of post-graduate qualifications in healthcare business and finance, aimed at finance and non-finance professionals working in healthcare across the UK, including devolved nations.

We're recruiting a number of module leader/tutor roles to accommodate the new post graduate Certificate and Diploma qualifications in Healthcare Business and Finance. We are looking for highly motivated individuals with a strong background in healthcare finance to bring module leadership and high quality teaching to HFMA.

Closing date for applications 12 February.

Visit hfma.to/tutor for more information or contact Emily Osgood, Head of Skills Development and Education at HFMA, emily.osgood@hfma.org.uk

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

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professional lives
Events, people and support for finance practitioners

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IFRS 16 sets deadline to move leased assets on balance sheet

Technical update

Eight years after the first discussion paper was launched, the International Accounting Standards Board (IASB) published its leasing accounting standard, *IFRS 16 Leases*, in January. The implementation date for the standard is accounting periods starting on or after 1 January 2019. The standard must gain EU endorsement before then and, for NHS bodies, it must be reviewed by the Treasury and included in the *Financial reporting manual*.

The standard makes minimal changes to the definition of a lease and for accounting by lessors, but completely changes the way that lessees account for lease arrangements.

All leases, with two exceptions, will be accounted for in the statement of financial position (SOFP) from the date the standard is applied. They will be shown on the SOFP as an asset (reflecting the right to use the underlying leased asset) and a lease liability (representing the obligation to make lease payments). The exceptions are leases of less than 12 months' duration and leases for underlying assets of low value, such as computers and tablets.

The lease liability will be the present value of the lease payments not paid on the commencement date. This will be calculated using the interest rate implicit in the lease or, if that is not known, the lessee's incremental borrowing rate – the amount the lessee would have had to pay to borrow over a similar term an asset of similar value in a similar economic environment. This rate will therefore be specific to the lease being considered.

The value of the right to use the asset will be measured at the start date as the amount of the initial measurement of the liability:

+ any lease payments made on or before the commencement date
– any lease incentives received
+ any direct costs incurred
+ an estimate of any costs that will be incurred by the lessee at the end of the lease for dismantling and removing the asset.

The new standard will affect the statement of comprehensive income (SOCI) and the cashflow statement. Under the current arrangements, operating lease rentals are an operating expense, but these will be replaced under IFRS 16 by depreciation and interest charges.

The total cost of the lease over its life will not change, as it will be the total amount paid to the lessor. But rather than the current straight line rental charge, the new interest costs will be higher at the start of the lease period than the end. Depreciation will probably continue to be

As always, the standard included new disclosure requirements. Some will require judgement because the standard requires disclosures to be made to give users of the accounts enough information to assess the effect of leases on the entity's financial position. To assist with implementation of the standard, there is a choice of transition arrangements, including entities implementing the standard requirements at the transition date rather than retrospectively restating all prior periods. It is likely HM Treasury will direct public sector bodies on which transition arrangements to follow.

Tuberculosis guideline: more tests

NICE update

England has one of the highest tuberculosis (TB) rates in Western Europe – in 2013 there were about 7,300 new cases.

TB is a curable disease spread by inhaling droplets containing the bacterium coughed by someone with infectious TB. Once inhaled, the bacteria reach the lung and grow slowly. In more than 80% of cases, the infection clears, but in a small number, a defensive barrier is built round the infection and the TB bacteria lies dormant. This is called latent TB. Some with latent TB go on to develop active TB.

NHS England and Public Health England have been working to reduce the harm of TB. As a notifiable disease, clinicians must notify local authorities or a local Public Health England centre of suspected cases.

An expanded NICE guideline (*NG33*) covers preventing, identifying and managing latent and active TB in children, young people and adults. It aims to improve ways of finding people with TB and recommends everyone under 65 with latent TB should be treated. The guideline recommends changing the age criteria for testing contacts of people with active TB for latent TB and the criteria that signify a positive test result for latent TB. Current practice for diagnosing latent TB is to use a Mantoux test in people aged 18 to 34.

Those testing positively for latent TB also receive an interferon-gamma release assay test. Those aged 35 to 65 receive a chest X-ray to test for active TB. The guideline suggests offering Mantoux testing alone to

In brief

An updated frequently asked questions document on the Department of Health 2015/16 *Group manual for accounts* is now available. This has added FAQs about profit or loss on disposal of non-current assets and changes to the accountability statement.

The Department of Health has updated directions on payments made to local authorities and other bodies in connection with property. The directions relate to payments made under sections 256 and 257 of the *NHS Act* 2006.

Guidance on the 2015/16 accounts governance statement has been published by the Department of Health. The annual governance statement is available from its online group manual for accounts.

Financial directions to NHS England for 2016/17, which accompany its mandate, are now available. The mandate sets out NHS England's total revenue resource limit of £106bn and total capital resource limit of £305m for 2016/17. The directions set out additional controls, including expenditure sub-limits to which NHS England must adhere, based on Treasury budgetary controls.

calculated on a straight line basis but, overall, the impact of lease arrangements will be higher costs at the start of the lease period than at the end.

Metrics such as earnings before interest, tax, depreciation and amortisation (EBITDA) will be affected – operating lease rentals will no longer be included in this calculation. And in the cashflow statement, the cost of leases will be shown as financing rather than operating costs.

In terms of application of the new standard, it is not expected contracts will have to be reviewed to identify whether they include a lease or not, but work will be required to identify the interest rates implicit in each lease and to understand the impact on the financial results and performance metrics.

Debbie Paterson is an HFMA technical editor

For all the latest technical guidance, log on to www.hfma.org.uk/news/newsalerts

diagnose latent TB in people aged 18 to 65 who are close contacts of a person with pulmonary or laryngeal TB.

The changes mean more outpatient appointments and tests, more positive results for latent TB and more tests for active TB. This means more staff needed to care for the test and treatment. The extra annual cost of diagnosing latent TB once the guideline is implemented is put at £1.8m for England.

Nicola Bodey, senior business analyst, NICE

Diary

February
- **5-6** B North West Branch: annual conference, Blackpool
- **9** F Chair, NED and Lay Member forum, Manchester
- **23** B London Branch: what makes a good business case, London
- **24** B Northern Branch: pre-accounts planning, Durham

March
- **8** F Mental Health forum, Birmingham
- **9** B North West Branch: data analytics and focus on health and social care integration in Manchester, Manchester
- **17** F Provider Finance forum: Devo Manc, Manchester
- **17** B London Branch: student conference, Rochester Row
- **22** B South West Branch: #connect Dorset event

April
- **21** N Annual costing conference
- **27** F Commissioning Finance forum

May
- **11** F Chair, Non-executive and Lay Member forum, London
- **12** F Provider Finance: directors' forum, London
- **19** N Innovate, integrate, motivate, annual mental health finance conference, London
- **24** N CEO forum

June
- **9** B West Midlands Branch: annual conference
- **13** B East Midlands Branch: team building event, Beaumanor Hall
- **17** I HC4V: value masterclass
- **22** F Commissioning Finance: faculty dinner, Stratford-upon-Avon
- **23** N Spending wisely, annual commissioning conference, Stratford-upon-Avon
- **27** B East Midlands Branch: team building event, Beaumanor Hall
- **28** B London Branch: annual conference, Rochester Row

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

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

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

Event in focus

Costing conference
21 April, London

As well as keeping delegates up to date with costing policy and guidance, this practical event will include interactive workshops and case study presentations, as well as networking opportunities. It is open to costing professionals and those interested in NHS costing. Monitor's costing transformation programme will have a significant impact on costing and is sure to be a central part of many discussions. Speakers include Sarah Butler (left), deputy director – performance insight team at the Department of Health, who will discuss preparing for the 2015/16 cost collections. Others will address issues such as the 2016/17 clinical costing standards and the role of patient-level information and costing systems in supporting clinicians' evidence-based decisions.

For details, visit tinyurl.com/j2dcne2 or email sophie.rowe@hfma.org.uk

Full steam ahead

Association view from Mark Knight, HFMA chief executive

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

As always, there's plenty going on in the association. We finished 2015 with one of the better annual conferences in recent years, according to feedback, so onto the next one… Places for early booking will be available shortly. We greatly value your support for events like this and I was impressed by the mature debate at the conference as we sought to question speakers.

We also held a commissioning forum and provider event in January, both of which were well attended and received. And our annual chairs' conference also proved popular.

At branch level, we have three events in January/February, with conferences in South Central, North West and Yorkshire/Humber. So it's been a whirlwind start to 2016.

We also have a new president, Shahana Khan who has started off with the usual round of presidential visits and an appearance at the Public Accounts Committee – just to keep her on her toes. This wasn't a very long session, but she put her points across well and even got a mention in Roy Lilley's blog – fame indeed.

I'm looking forward to working with Shahana this year. Not only have I known her for a long time, but also because I think her theme of 'Step up' is a great encouragement to us all.

We have two major preoccupations this year – a new membership strategy, because we want to 'step up' the number of members we have, and launching our qualification.

Our membership strategy is to be discussed at the February board. We'd like to develop membership in a number of different ways. First, we want to make it easier to pay and easier to join. So we will be looking at how payment can be handled monthly and by different methods. And on the joining side, we are looking to develop a champions' scheme. Pioneered in the Welsh Branch, it's about getting a focal point in each organisation with someone who can champion our cause. We'll also be looking to develop materials to support membership.

We are planning to improve member benefits, including a better platform for our webinars. It is important members feel special, so a number of changes will be made to member access. Places at the annual dinner in December will be reserved for members first before others can book, and branch meetings will be exclusively for members (though some will charge for non-member attendance). We are also looking at whether we can offer very junior staff and students an ultra-low rate.

HFMA chief executive Mark Knight

"It is important members feel special – places at the annual dinner will be reserved for members first before others can book"

All these initiatives will be the responsibility of a membership manager we will be appointing in the next few weeks.

Our second focus this year is on our suite of qualifications. I can't tell you much this month, but we will unveil something very special in the near future encompassing certificates, a diploma and an MBA. I'll explain more in the next issue.

For now, we are working on our bid to Ofqual to be given awarding body status, which will be a big step forward in the long history of the HFMA – and a very tangible response to Shahana's call to 'step up'.

Member news

Several key decisions were taken at the 30th HFMA AGM on 11 December 2015:

- All subscriptions remain at the same rates.
- George Eliot NHS Trust finance director Shahana Khan was elected president.
- Mark Orchard and Alex Gild were elected vice-presidents.
- Bill Gregory, James Rimmer and Huw Thomas joined the Board of Trustees

Chairs of several committees and technical issues groups were appointed for three years:

- Keely Firth, Audit Committee
- Robert Forster, Provider Technical Issues Group
- Tom Jackson, Commissioning Technical Issues Group
- Ian Moston, Policy and Research Committee

A total of £7,000 was raised for KIND at the HFMA's 2015 conference gala dinner. The charity has worked for some 40 years helping disadvantaged children and families in Liverpool and Merseyside.

Chris Brown, an HFMA executive coach, is runner-up in the executive coaching category of the Coaching Academy's inaugural International Coach of the Year Awards. A qualified coach, he is also a former NHS finance director and deputy chief executive.

NHS South East finance skills development manager Stuart Wayment (pictured) has raised £700 for tumours charity PLANETS by swimming the Solent. In 2012, he was diagnosed with a tumour and began long treatment. "The swim was a challenge I probably wasn't fit enough to do even before I was unwell. I want to prove to myself and other patients that you can get back stronger," he said.

Member benefits

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

Branch focus

President visits
Valued network

The HFMA presidential schedule can, at times, be a formidable whirlwind of events and meetings, ranging from a faculty forum in London to the US HFMA annual national institute during the summer months.

Branch visits – usually to branch annual conferences – make up some of the biggest time commitments in the presidential diary, but these are occasions that presidents look forward to.

While conferences are spread throughout the year, there are peaks, particularly later in the year, when the Scotland, Wales and Northern Ireland branches hold their annual conferences.

However, by the end of January, new HFMA president Shahana Khan will have attended two of the 13 branch conferences – at South Central and Yorkshire and Humber.

And within a week of this month, she will have attended a third such event – the North West Branch conference.

Yorkshire and Humber chair Nigel Booth (pictured) said: 'Branches are an important part of the HFMA structure and this is recognised by the fact that presidents regularly attend the branch conference.

'It allows them a chance to speak to local members and non-members and it gives the local health community a chance to meet the national president and put a face to the name. It goes a long way to cementing the links between the national and regional HFMA.'

HFMA chief executive Mark Knight added: 'HFMA presidents have a busy calendar, but they all make the time to visit as many branches as they possibly can. It's good for them to go out and meet members who may not come to national events, particularly more junior members of the finance function.

'Past presidents have said that going out to the branches was one of the duties that they most looked forward to. When their year is complete, they look back on them as some of the most enjoyable times of their year.

'The HFMA values its branches and the work they do, and this is reflected in the time presidents give to supporting them and their events.'

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Yorkshire and Humber laura.hill@york.nhs.uk

Appointments

Ian Baines (right) has become director of transformation at Stafford and Surrounds; Cannock Chase; and South East Staffordshire and Seisdon Peninsula clinical commissioning groups. With more than 20 years NHS experience, he has held senior posts and board-level positions at NHS acute and mental health trusts and CCGs. His last position was chief financial officer at South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group. **Paul Simpson**, who was director of finance and deputy chief executive at Stafford and Surrounds and Cannock Chase CCGs, is now also director of finance and deputy accountable officer at South East Staffordshire and Seisdon Peninsula CCG.

Jon Cooke has been appointed director of finance on an interim basis at South West Yorkshire Partnership NHS Foundation Trust. He was previously chief finance officer at Yorkshire and Humber Commissioning Support. **Alex Farrell**, who was director of finance and deputy chief executive, will now focus solely on the latter role before stepping down from her full-time post at the end of May.

Ray Davey has become interim chief financial officer at Ashford Clinical Commissioning Group and Canterbury and Coastal Clinical Commissioning Group. Previously, he held the same position at Luton Clinical Commissioning Group. The move follows the departure of Ivor Duffy.

John Dowell (left) has been appointed chief finance officer at South Devon and Torbay Clinical Commissioning Group. He has held senior positions in the Devon NHS system, most recently as Eastern Locality chief financial officer at Northern, Eastern and Western Devon Clinical Commissioning Group. He succeeds **Simon Bell**, who has moved to Kernow CCG.

Tim Barlow is now chief finance officer at University Hospital of South Manchester NHS Foundation Trust. He was Warrington and Halton Hospitals NHS Foundation Trust's director of finance and commercial development. Before joining the NHS, he worked in the private sector, including as UK finance director for Thomas Cook and My Travel.

Andrea Chadwick has been named director of finance and commercial development at Warrington and Halton Hospitals NHS FT. She was director of finance and information at Calderstones Partnership NHS FT.

Danielle Cecchini (right) is the new finance director at Lincolnshire Community Health Services NHS Trust, succeeding interim Kieran Lappin. Ms Cecchini was senior business consultant at the NHS Trust Development Authority.

New year honours

Two leading members of the NHS finance community were awarded OBEs in the new year honours list. Lorraine Bewes (below right), chief financial officer at Chelsea and Westminster NHS Foundation Trust, and Jane Tomkinson, chief executive of Liverpool Heart and Chest Hospital NHS Foundation Trust, both said the awards were a surprise.

'I am thrilled, astounded, delighted and humbled in equal measure,' Ms Tomkinson said.

'I am incredibly proud of what it means in terms of what has been achieved at Chelsea and Westminster,' Ms Bewes said. As she prepares to take a career break, prioritising family commitments, the award marks the end of her time at the trust.

Several NHS finance directors have received awards before, including national NHS finance directors Colin Reeves (CBE), Richard Douglas (CB) and David Flory (CBE). Finance directors from local bodies who had become chief executives – such as David Stout (OBE), North East Strategic Health Authority, and Keith, Ford (OBE) Mayday Healthcare NHS Trust – have also previously been honoured.

The Department of Health is seeking nominations for 2017 new year honours by 24 February. For further information, visit tinyurl.com/kud5gos

Ms Bewes and Ms Tomkinson have been awarded OBEs for services to NHS financial management. It was important to recognise NHS finance at a time when finance teams were under pressure to support organisations' financial positions, said Ms Tomkinson, who had a successful career in NHS finance before moving into general management.

'It is positive for the profession and raises the profile of the contribution it makes, particularly with the challenges we face in the NHS,' she said.

Ms Bewes added: 'I think it has meant a lot to the profession. The award is for my colleagues – people who work incredibly hard and are passionate about achieving success in their organisation to support their clinical counterparts.'

HFMA CNL Faculty chair Heather Strawbridge, who is chair of South Western Ambulance Service NHS Foundation Trust, also received an OBE.

Obituary: Martin Davies

I am sad to announce the death of Martin Davies, *writes Paul Taylor*. Martin was a well-known, hugely respected and liked member of the West Midlands finance family.

In his younger days he rose from deputy treasurer at Bromsgrove and Redditch Health Authority to become deputy managing director at the West Midlands Regional Health Authority from 1988 to 1992.

He founded Provex Consultancy in 1994 and forged a successful career as the 'go-to man' in the region for strategic financial advice and business planning. He assisted in the successful build of many health and hospital facilities in the West Midlands, including a number of new large acute hospitals, community hospitals and primary care facilities.

He grew the Provex brand over the 21 years of its operation and his legacy continues in the work of a number of companies in the Provex group of companies.

He died suddenly and unexpectedly, aged 59, on Friday 8 January 2016, leaving his wife, two daughters and two grandchildren.

He will be sadly missed by family, friends and colleagues alike, and will be remembered as an intelligent, kind, good-humoured and professional man.

Paul Taylor is associate director of Provex Consultancy and head of finance for the new care models programme

February launch for teamwork toolkit

A toolkit to improve NHS team working has been commissioned by Future-Focused Finance (FFF). *Crossing professional boundaries – a King's Fund toolkit for collaborative teamwork* aims to get clinical and financial staff working together to address their common challenges. It encourages staff to consider how they work together, providing a step-by-step guide to reflecting on others' point of view. Clinical and financial leaders work through the approach together.

A recent FFF-commissioned Ipsos MORI survey highlighted variable engagement between clinicians and finance staff. More than half of respondents agreed they listened to each other's concerns and had shared goals, but only 29% said they spent sufficient time together and only 24% reflected on how they were doing as a team.

Professor Michael West of the King's Fund said: 'Healthy working relationships are critical to an organisation's ability to create a culture in which organisational teamwork can thrive in order to deliver better patient care within the resources available.'

FFF's Dr Sanjay Agrawal agreed. 'Most teams in the NHS do not take the time to stop and reflect. It's seen as a luxury. We're saying it's a basic requirement of well-functioning teams.'

Twenty-two NHS organisations piloted the toolkit, which was independently reviewed by CIPFA, and it had significant impact on clinical engagement and team working. The toolkit will now be adapted to take in feedback and fully launched on 19 February.

For more information on *Crossing professional boundaries – a King's Fund toolkit for collaborative teamwork* go to tinyurl.com/KFtool

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"For someone with a lack of knowledge of NHS finance, I found the day very insightful and a springboard for learning which I hope to put into practice."

Patricia McAuley
Programme Co-ordinator
Health Education West Midlands

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or email **alex.wood@hfma.org.uk**

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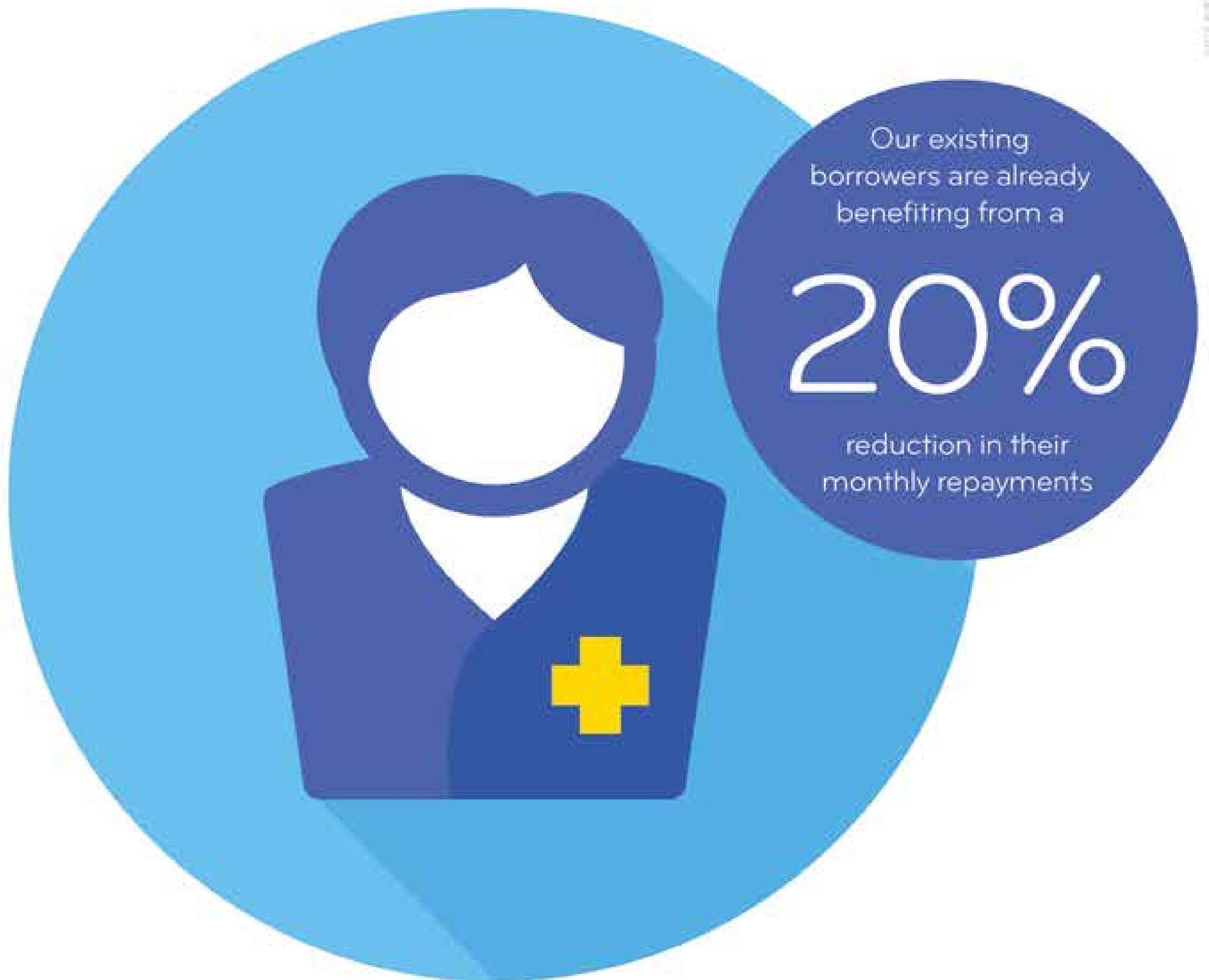

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