# healthcare finance

**June 2016** | Healthcare Financial Management Association

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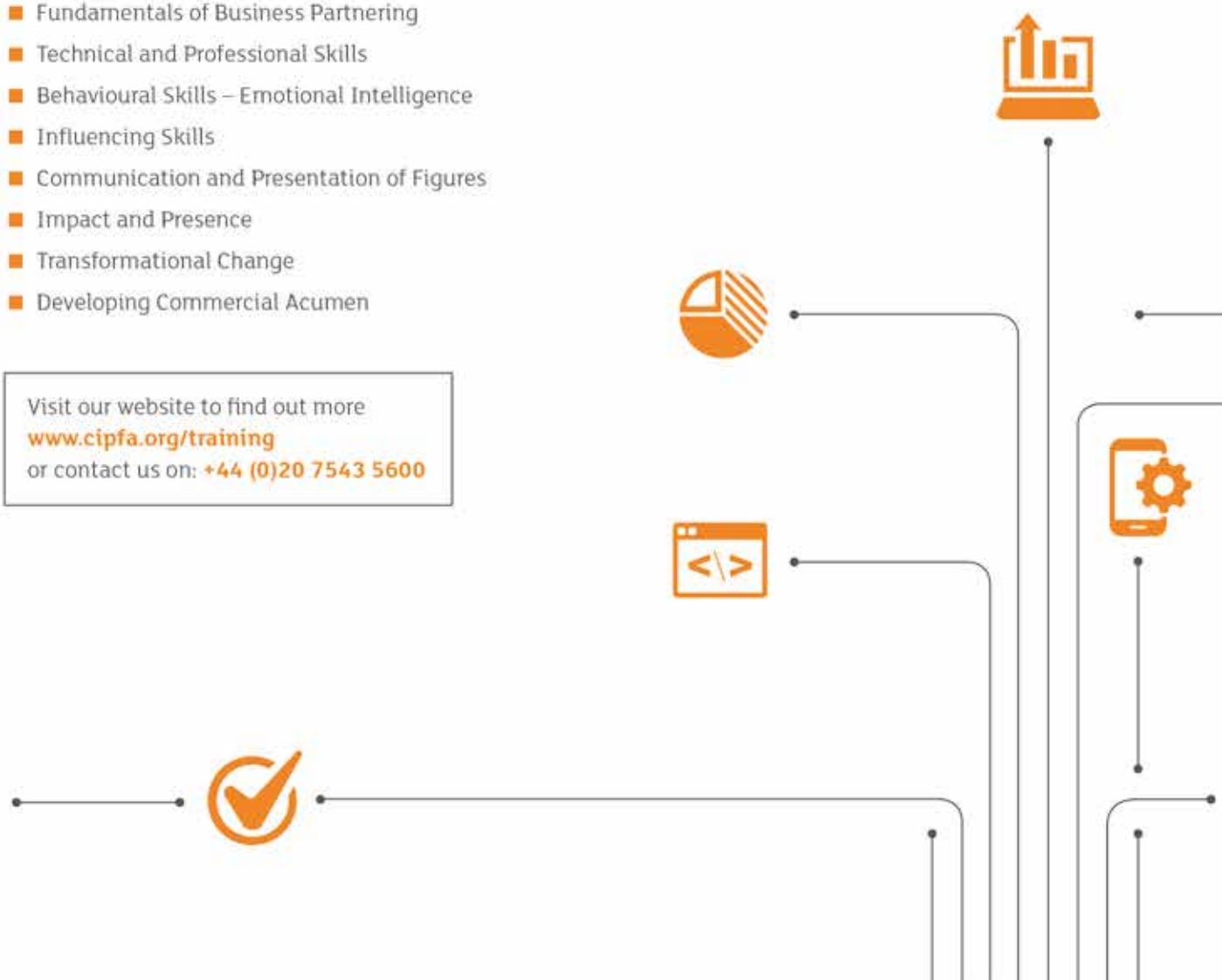


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**ISSN 1472-3379**

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## Features



# JOINING THE DOTS

## Decision Making for a New Era

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The need to professionalise the decision-making process has never been so crucial or so difficult. Organisations, whether public or private, must get better at 'joining the dots' – connecting the most relevant information and people from across the organisation when making decisions.

Rebecca McCaffry, Head of Public Sector Research at CIMA shares her insights into how senior business leaders can improve their decision making procedures.

We're all familiar with complaints that the public sector is overly bureaucratic and fails to think laterally, resulting in decisions that are made either far too quickly, without full consideration of the long-term consequences, or at a snail's pace. But even in the comparatively well-resourced private sector, senior leaders are struggling to make the right decisions at the right time.

CIMA talked to 300 senior business leaders in 16 countries about the effectiveness of their decision making. Bureaucracy, siloed thinking, and breakdowns in trust were all highlighted as problem areas.

**72%**

have had at least one strategic initiative fail in the last three years because of delays in their decision-making process

**42%**

say that they've lost competitive advantage for the same reason.

**29%**

said that organisational silos and bureaucracy are creating coordination problems. This was the single biggest barrier that organisations said they were facing in terms of their decision-making. Close behind this was the need for new skills to make decisions in today's fast-changing business environment followed by the quality of management information and organisational culture not being conducive to swift, effective decision-making.

**70%**

admit there is moderate or significant room for improving active collaboration between leaders and employees.

**65%**

say the same about trust.

## SO WHAT'S THE SOLUTION?

The research suggests that the answer is integrated thinking – a joined-up approach focusing on relationships, resources and value creation over the short, medium and long term. The study found that the organisations who practiced this approach had the most effective decision-making processes.

A significant benefit of integrated thinking to the public sector is its focus on cutting through silos, connecting relevant people and information across the organisation. One example of this is the work of the Future-Focused Finance Close Partnering action area, which, recognising that teams who work better together create better outcomes for patients, recently published a toolkit for leaders which encourages greater collaboration across professional boundaries. Cross-functional working has obvious benefits to the NHS; with no new money available finance and clinical staff must collaborate to improve the productivity, quality and safety of health care.

With increasing expectations of transparency from the public, political leaders and other stakeholders, public sector organisations must find ways of developing a multi-dimensional dialogue which goes beyond traditional corporate reporting. Integrated reporting is an emerging approach which focuses upon organisational dynamics and how value is defined, both by the organisation and its stakeholders. Integrated Reporting in the Public Sector, published by CIMA, provides a roadmap for organisations wishing to take up and reap the benefits of this approach. The report describes the fundamental principles of integrated reporting and provides case studies of public bodies who have already adopted the approach.

Like many of the challenges we face in the 21st century, the road to better organisations in any sector is to be found in behaviour change rather than doctrine. Integrated thinking and reporting facilitate a shift in mindset that opens up leaders to better decision making, greater transparency and a longer-term perspective, all of which are crucial to the sustainability of public services and trust.

For more information on Joining the Dots: Decision Making for a New Era, visit **cgma.org/resources** or contact **cima.contact@cimaglobal.com**

For more information on Integrated Reporting in the Public Sector, visit **www.cimaglobal.com/thought-leadership**

# News

## Baumann: commissioners to target 3% efficiencies

By Seamus Ward

Commissioners will have to deliver significantly higher levels of efficiencies in 2016/17 than in previous years to ensure the NHS in England has sufficient flexibility to cover risks that arise in year, NHS England chief finance officer Paul Baumann has said.

He said 2016/17 was a critical year, in which the NHS had to use the £3.8bn real-terms increase in funding to create financial stability and balance across the whole of the service and to pick up the pace of transformation.

At the national commissioning body's May board meeting, he said achieving this balance was proving challenging for three reasons. First, the provider sector 2015/16 deficit was £650m higher than the £1.8bn sustainability funding targeted to help the sector get into financial balance in 2016/17.

Second, commissioners had to ensure they had enough financial flexibility to deal with any risks arising in year. To achieve this, they had set aside a risk reserve of 1% of budget.

'This has in turn required commissioners to draw up plans for significantly higher levels of efficiency gains through reducing demand or commissioning more cost-effective ways of delivering care, as opposed to the operational efficiencies that providers are accountable for. In 2016/17 commissioner efficiencies will need to be running at 3%, whereas in previous years it was closer to 2%. That's a big concentrating factor in the plans of commissioners.'

**"In 2016/17 commissioner efficiencies will need to be running at 3%, whereas in previous years it was closer to 2%"**
**Paul Baumann (above)**

In 2015/16, commissioners planned to deliver QIPP savings of £2.2bn and by year-end £1.9bn had been realised.

The third factor was to ensure enough activity was commissioned and funded to clear operational backlogs.

Most contracts had now been agreed. 'CCG and NHS England operating plans show a balanced financial position, with a 1% risk reserve set aside as planned,' said Mr Baumann. 'But I have to say, with a level of risk, particularly with regard to the level of efficiencies, that is significantly higher than in previous years. It will require us to build on the vigilance of our monitoring, particularly the speed of our support and intervention where individual organisations show signs of deviation from plans.'

NHS Improvement was working with providers to produce an overall balanced position in 2016/17. NHS England chief executive Simon Stevens told the board: 'Over the next three to four weeks, NHS Improvement will be having conversations with trusts about what their control totals need to be. That's not a straightforward exercise. We have seen substantial cost growth over the last 12 to 24 months and we will have to tackle that at source.'

Mr Baumann said the commissioning sector had an overall underspend of £599m in 2015/16. Clinical commissioning groups recorded an aggregate deficit of £16m – 62 had underspends against plan, totalling £122m, while 39 CCGs had overspends against plan of £151m.

However, the overall position was offset by a £13m underspend on the quality premium. The May board papers added that 31 CCGs finished the year with cumulative deficits, 10 of which were unplanned.

The overall sector position was bolstered by a small underspend in specialised commissioning (£14m) – the first in recent history. However, within this sector, the cancer drugs fund (CDF) overspent by £126m (37%), despite actions taken during the year to limit spending. A new CDF scheme begins in July, which NHS England hopes will ensure that spending remains with the agreed £340m budget.

There were significant underspends in central programme costs (£242m) and other central budgets (£219m). The former included reduced redundancy and transition costs, the freezing of contingencies and unplanned rent rebates. Most of this is non-recurrent and the recurrent elements have been reflected in reduced budgets for 2016/17, Mr Baumann said.

*See Hard times, page 8*

## Finance programme aims for savings

A national financial improvement programme is targeting £50m of savings in its first year.

NHS Improvement has selected 16 trusts from 80 volunteers to receive intensive financial support, in particular to help them realise some savings identified in Lord Carter's review of NHS productivity.

NHS Improvement said trusts were chosen on the basis of where the support would have the most impact. The full list includes eight NHS trusts and eight foundation trusts – acute, mental health and ambulance.

Jason Dorsett, senior responsible officer for the programme, said: 'We will support trusts to tackle the more difficult savings that previous cost improvement programmes have been unable to reach,' he said. 'It will also share innovative approaches, tools and lessons learnt with the rest of the NHS.'

NHS Improvement said the programme was likely to cost £25m, but would save twice this in the first year. Payment for the teams of experts brought in to support the trusts will be partly related to savings achieved.

A second wave of the scheme will be launched later in the year.

Imperial College Healthcare NHS Trust, one of the trusts in the programme, said returning to a balanced budget was a 'top priority'. Chief executive Dr Tracey Batten said: 'The [programme] provides a great opportunity to use the skills and capacity of external experts to boost our existing cost saving work and help secure our financial position for the future.'

# Efficiency plan a priority to achieve £22bn savings

By Seamus Ward

The NHS in England is 'substantially off target' on efficiencies and needs a comprehensive plan to achieve savings, according to Health Foundation research and economics director Anita Charlesworth.

Ms Charlesworth was responding to a briefing from NHS England, which breaks down the estimated £22bn of efficiencies needed by 2020/21. The briefing, written for the Commons Health Committee, said local NHS services will have to deliver £15bn in efficiency savings.

Conventional provider productivity would deliver about £9bn of these local efficiencies – indicating a 2% annual efficiency requirement for providers each year.

Activity-related efficiencies, such as care redesign, would deliver £4bn; £1bn had already been secured from non-NHS providers and clinical commissioning group running cost reductions. A further £1bn would come from other commissioning efficiencies.

With the aggregate underlying provider deficit some £1bn higher than anticipated, providers would have to make extra savings. As the higher deficit was in part due to agency staff use, NHS England is assuming providers can achieve at least a £1.2bn reduction in agency spending this year. The £7bn of national savings would come from areas such as the 1% pay cap and reducing NHS England central budgets and admin costs.

NHS England insisted most of the reductions were not cost reductions but actions to moderate spending growth.

The briefing outlines central modelling of NHS funding needs up to 2020/21. These include how the £30bn funding gap was calculated and the funding required based on three scenarios. In the first – 0.8%, mirroring the NHS average productivity gain – funding of £21bn would be required. In the 1.5% efficiencies scenario, £16bn would be required. The spending review opted for 2% average efficiencies, implying an efficiency requirement of £22bn.

Ms Charlesworth pointed to the need for £15bn of local savings. 'But by its own estimate, the NHS delivered savings of just £1bn towards this last year, confirming that the health system is substantially off target with its efficiency plan. At its heart this reflects fundamental weakness in the approach to efficiency in the NHS – too much reliance on one-off savings,' she said.

'What is now crucial is a comprehensive plan with clear accountability for how these savings can be achieved in reality. Patients and the public also need assurance these savings will be genuine efficiencies, not simply reductions in quality.'

## Funding levels

NHS England has published indicative allocations for the £3.8bn sustainability and transformation fund to 2020/21. The place-based funding will help local areas develop their sustainability and transformation plans (STPs), it said.

The allocations to each of the STP footprint areas include their fair share of sustainability funding, primary care access and transformation funds, as well as other funding such as for modernising technology. NHS England is also allocating £112m to 47 vanguards testing new models of care. The remaining three, in Greater Manchester, are part of the devolution deal.

**"There is too much reliance on one-off savings"**
**Anita Charlesworth, Health Foundation**

# HFMA launches 2016 awards programme

**The HFMA has launched its 2016 awards programme, which aims to celebrate excellence in NHS finance and governance across eight categories.**

**The categories include Costing, Accounts Team, Governance and Innovation, as well as the Havelock Training and the Finance Director and Deputy Finance Director of the Year awards.**

**The Working with Finance – Clinician of the Year Award, now in its 10th year, completes the line-up. Initially this was given to organisations for their work on clinical engagement. But since 2009 it has sought to recognise an individual clinician who has taken financial responsibility for their services, led efficiency or improvement programmes or provided an example for other clinicians by engaging with the financial management agenda.**

**Phil Thomas, a consultant urologist at Brighton and Sussex University Hospitals NHS Trust, who won the award in 2010, urged clinicians with a track record of financial engagement to enter.**


**Mr Thomas became the trust's first clinical chief of finance in 2008 and is stepping down to concentrate on his clinical duties. The trust is advertising for a successor.**

**'You are not really recognised in this role and people don't really understand it, so it was nice to get national recognition for me and the finance team I worked with,' he said. Clinical-financial engagement was tricky, but could make a difference, he added.**

**The deadline for entries is 30 September and for the first time entries can be submitted through an online portal. The software allows you to save your submission at any point and return to it later; edit your entry after it is submitted, up until the deadline; download a copy; and use the 'copy' feature when entering multiple categories.**

**A shortlist for each category will be published at the end of October. The winners will be announced at the gala awards ceremony on 8 December, during the HFMA annual conference.**

**More details at www.hfma.org.uk**

# Commission backs payment change for specialised care

By Seamus Ward

An expert commission has recommended a shake-up in the specialised services payment model and urged action to create a deeper understanding of the costs of the services.

Former health minister Lord Warner convened the commission to mark the 10th anniversary of the Carter review of specialised commissioning.

Lord Warner's report called for the services, including spinal injury, cancer and rare diseases treatments, to be delivered by networks of providers, including accountable care organisations and lead provider models. These would provide end-to-end services for patients' entire care, enabling them to minimise use of expensive and overstretched hospital resources, the Specialised Services Commission said.

New models of remuneration would be needed to underpin the networks. The national tariff covers about a third of specialised services payments. While it worked well for acute activity, the tariff did not align well with the future evolution of specialised providers – offering no incentive to share the care of an individual between appropriate providers.

The commission recommended moving to capitated payments, closely linked to outcomes, on a multi-year basis. It insisted that a clear understanding of costs and outcomes was essential to assess the value of specialised services and to improve prioritisation and decision-making.

Costs and outcomes would also be fundamental to inform the debate on which services the NHS should fund. According to the commission, specialised services must improve their efficiency, but without further funding it was unlikely that this alone would be sufficient to avoid hard choices on rationing care.

Lord Warner said: 'The commission favours more efficient joint working through networks, making patients rather than hospitals the hub of care. The current danger is that chronic deficits will progressively impede the range and quality of what the NHS can afford to do.'

Hopson: welcomed recommendations

Chris Hopson, NHS Providers' chief executive and commission member, said: 'We strongly welcome this new report's recommendations on working towards a deeper understanding on the costs of delivery services. It tackles the broken payment model for specialised services that has seen financial risk passed from commissioners to providers and developing a national strategy that takes better account of which services should be designed and commissioned nationally, regionally and locally.'

## Finance directors worried about quality

The NHS faces a 'Herculean' challenge in 2016/17 to improve performance and eliminate deficits, according to the King's Fund.

According to the fund's latest quarterly monitoring report, almost two-thirds of NHS finance directors and more than half of clinical commissioning group chief finance officers believe that quality of care deteriorated in 2015/16.

The survey results were backed by the fund's analysis, which showed that performance had reduced in a number of areas, including elective waiting times and the four-hour A&E waiting target.

More than half of trust finance directors expect to end 2016/17 in deficit and the fund estimated that this could reach £1.4bn in the provider sector as a whole. Almost a fifth of CCGs expected to overspend this year.

King's Fund chief economist John Appleby said: '2016/17 is a watershed year for the NHS in which it has been tasked with eradicating deficits and improving performance.

Appleby: '2016/17 is a watershed year for the NHS'

'Despite significant additional funding and a huge effort to contain deficits, it is clear that this is going to be a Herculean challenge,' he added.

*Finance and quality in the red, page 10*

# Fresh hope for junior doctor deal

There is new hope for an end to the junior doctor contract dispute after the British Medical Association and employers agreed a new contract. Full details were not available as *Healthcare Finance* went to press, but once published, the BMA will ballot its junior doctor members.

There are a number of changes to the contract that the government intended to impose from August and that led to juniors taking all-out industrial action for the first time.

Payments for unsocial hours have been rewritten to allow more pay to be given to those working the most weekend shifts. The salary enhancement for unsocial hours is now 37%. Unsocial hours will be from 9pm to 7am every day of the week, ending the distinction between weekend and weekday unsocial hours. However, if a junior starts a shift of at least eight hours after 8pm but before midnight, and that shift finishes before 10am the next day, they will receive the 37% enhancement for all the hours worked.

Enhancements for weekend working, paid as a percentage of basic salary, will depend on the ratio of weekends rostered, with a 10% rate paid to those who work one weekend in two. Basic salary will rise by 10% or 11%, depending on modelling.

Health secretary Jeremy Hunt said the contract would be cost-neutral and reduce by a third the marginal cost of employing juniors at weekends.

BMA junior doctors' leader Johann Malawana said the deal was good for juniors and would ensure they can continue to deliver high-quality care to patients.

# News review

## Seamus Ward assesses the past month in healthcare finance

**While the potential solution to the junior doctor contract dispute and the NHS financial position dominated headlines in May, NHS operational performance briefly grabbed the newspaper column inches. Operational and financial performance can, of course, follow a similar pattern and it seems this was the case in 2015/16.**

According to NHS England figures last month, the NHS in England missed performance targets in A&E, cancer, elective procedures and ambulance times in 2015/16. It recorded the worst performance against the four-hour A&E metric since the target was introduced in 2004, with 91.9% of patients being seen within the time limit in all types of A&E department. More than 2 million patients attended A&E in March – the highest monthly figure recorded. Ambulances responded to two-thirds of the most serious calls within the eight-minute target. Though the NHS carried out 4% more routine procedures than the previous year, by March 8.5% of patients had been on the waiting list for more than 18 weeks.

There were yet more signs of deteriorating performance. The parliamentary and health service ombudsman reported that poor planning, communication and co-ordination between hospital staff and community health and social care services was compromising patient safety and dignity. In a report on discharge from hospital, ombudsman Julie Mellor said there had been a 36% increase in investigations relating to hospital discharge in the past year. Deaths and suffering could have been avoided had hospitals carried out the right checks before sending patients home, she added.


General practice is also coming under increasing strain. GP consultations have increased by 15% since 2011, according to King's Fund research. Its report, *Understanding pressures in general practice*, found that casemix is becoming more complex and intense, with, for example, a 13% growth in face-to-face consultations and 63% more phone consultations. The biggest rise in consultations was in the over-85 age group, who are more likely to have more than one chronic condition.

MPs have called for an urgent review of NHS clinical staffing in England. The Commons Public Accounts Committee raised concerns about supply, budgeting, agency costs and leadership in a report, *Managing the supply of clinical staff in England*. The committee warned that 'no coherent attempt' had been made to assess the headcount implications of major policy initiatives such as the seven-day NHS.

The health and social care system's management of discharging older patients from hospital does not represent value for money, according to the National Audit Office. Longer stays in hospital have a negative impact on older people's health and add financial pressure. In *Discharging older patients from hospital*, the spending watchdog estimated it cost the NHS £820m a year to keep older patients in hospital when they no longer needed acute care. 'Without radical action, this problem will worsen and add further strain to the financial sustainability of the NHS and local government,' said NAO head Amyas Morse.


The NHS should expand the skills of nurses and other staff to develop a workforce for the 21st century, according to the Nuffield Trust. Its report, *Reshaping the workforce to deliver the care patients need*, said that though

## The month in quotes

'Health and social care leaders must work harder to uncover why 10 years of guidance to prevent unsafe discharge is not being followed, causing misery and distress for patients, families and carers.'
**Parliamentary and health service ombudsman Julie Mellor**

'We need a sustainable system, flexible enough to ensure that the best cancer drugs can routinely benefit NHS patients. As the prime minister who introduced the cancer drugs fund, we believe that you want these things as well – please do not allow the assessment of cancer drugs to be consigned to a last-century methodology.'
**Cancer charities' letter to David Cameron**

**'It is a health service with a revenue larger than the GDP of many countries but which would struggle to get a credit rating; which suffers from debt, but is crippled by denial.'**
**BMA chair Mark Porter**

**'Our research shows that reshaping the NHS workforce can offer huge opportunities – for patients, through improved health outcomes, and for staff, through more rewarding roles and better career pathways. But we stress in our report that this is not simply a "nice to do", it is urgent – and essential.'**
**Candace Imison, Nuffield Trust director of policy**

FLICKR

this would be tough in the current financial environment it should be considered a 'must do' for trusts. The report, commissioned by NHS Employers, backs advanced practice roles for nurses, training support workers such as healthcare assistants to carry out basic checks and a new physician associate role.

Following assembly and parliament elections in Wales, Northern Ireland and Scotland, new governments have been forming. As *Healthcare Finance* went to press, the power-sharing government in Northern Ireland was still being discussed, but there was little change in the other devolved nations as the incumbent parties were returned to office.

**Shona Robison (above) is still Scotland's health secretary; Vaughan Gething became secretary for health, wellbeing and sport in Wales**

In Scotland, Shona Robison remains cabinet secretary for health and sport. Announcing her new cabinet, Scottish first minister Nicola Sturgeon said Ms Robison would build on her achievements and oversee the government's 'strong record of investment in and reform of the NHS in Scotland', as well as health and social care integration.

In Wales, Vaughan Gething was promoted to cabinet secretary for health, wellbeing and sport from junior health minister. Predecessor Mark Drakeford has been named cabinet secretary for finance and local government.

Thirty organisations wrote to the Welsh first minister calling on the new government to articulate a long-term vision for health, social care and wellbeing. They wanted a commitment to services being 'properly resourced, including the required level of planning and investment in the future workforce to ensure that the needs of patients are met'. The group – members of the Welsh NHS Confederation challenge 2016 policy forum – said there should be seamless, person-centred care, driven through further integration across the public sector.

Cancer charities have called on the prime minister to review the drug appraisal process used by the National Institute for Health and Care Excellence (NICE). In an open letter, 15 charities said leaving the methodology unchanged would mean innovative cancer drugs would not be approved for use under the cancer drugs fund. Reforms could include introducing flexibility for price negotiation or allowing patient experience to play a more significant role in the final decisions on drug approval.

Before rapprochement was seemingly reached on the junior doctors' contract, British Medical Association leader Mark Porter called on the government to end its denial of the funding crisis facing the NHS. He said that while the NHS had revenue larger than the GDP of some countries, it would struggle to get a credit rating. The service was 'crippled' by a government denial that there was a funding problem. The projected £22bn of efficiencies needed over the five-year spending period would not be achieved, he said.

The Department of Health called for evidence in its review of Public Health England (PHE), including whether the arm's length body is efficient and provides good value for money. The review will also look at PHE's governance and functions and whether these are delivered effectively. The deadline for responses is 24 June.

NHS Employers has created a finance director guide to the flu vaccination CQUIN (commissioning for quality and innovation), outlining the importance of the flu vaccination programme and ways to support their local flu fighter campaign. The guide has been published alongside one for flu leads, which includes ideas to present to their teams and finance directors.
*See page 16 for more on this year's CQUIN scheme*

## in the media

**With NHS finance coverage dominated by the trust 2015/16 year-end figures, the HFMA was approached for comment by national newspapers, as well as those aimed at staff in health organisations or public sector accountancy.**

HFMA policy and technical director Paul Briddock told *The Guardian* the £2.45bn deficit was so large that the Department of Health may have trouble balancing its budget. Mr Briddock said that though the figures were broadly as expected, they were still 'distressing' and 'incredibly worrying'.

**The figures, published by NHS Improvement, exceeded the forecast position and followed the same downward pattern of previous quarters of the financial year, he told *Public Finance*.**

The joint survey on NHS mental health funding, undertaken by the HFMA with NHS Providers, attracted a lot of attention in early May. Reports relayed the survey finding that half of providers received funding increases in the last year. Only a quarter of provider finance directors were confident their commissioners would increase the value of their contract in 2016/17.

**Mr Briddock told *Mental Health Today* that providers and commissioners had to work together to bridge the gap between physical and mental health provision.**

# News analysis

## Headline issues in the spotlight

# Hard times

**Providers may have improved their year-end position compared with earlier forecasts, but their outturn figures for 2015/16 still make for distressing reading. Steve Brown reports**

It is hard to put a positive spin on providers' year-end financial figures, which showed a deficit of £2.45bn for 2015/16. NHS Improvement did flag up that things could have been worse – the run rate earlier in the year suggested a full-year deficit as high as £2.8bn. But in reality the 'improved' position masks a number of one-off measures, without which the problems would have been even more stark.

Providers may have been happy with the public tone of NHS Improvement's announcement. It stressed that providers had 'risen to the challenge of record-breaking demand', seeing an 'unprecedented 21 million emergency patients last year' while making £2.9bn in efficiency savings.

At the end of May, it was still too early to say if providers' improvement against mid-year projections had been enough to help the Department of Health stay within its global budget. But Jim Mackey, NHS Improvement's chief executive, was determined to look for the positives.

'When we consider where we were six months ago, NHS providers have done a great job in reducing the planned deficit,' he said. 'The key now is for us all to work together to make the necessary improvements in 2016/17, to reduce any variations in the quality of care for patients, and to bring the NHS provider sector back into financial balance.'

However, the figures make for undeniably difficult reading. Some 157 trusts reported a deficit, including 58 NHS trusts and 99 foundation trusts. Three quarters of these were acute bodies.

'Distressing' and 'incredibly worrying' was how HFMA director of policy Paul Briddock summed up the figures, confirming most people's expectations. He also highlighted a survey by the King's Fund released just ahead of the provider figures, which revealed finance directors were increasingly concerned about the impact of the financial situation on patient care.

'With 65% of all providers and the majority of acute trusts wrapping up the year in deficit, the challenge for the coming year may push the NHS to its financial limit,' he said.

Operationally, there are increasing signs that demand for services is outstripping funding. The 21 million accident and emergency attendances marked a 2.9% increase on the previous year. But in March, attendances were 7.5% higher than the same month in 2014/15.

## Target pressures

The result has been that just 91% of A&E patients in aggregate were seen or admitted within four hours compared with the 95% target.

For Q4, this dipped to under 87% – the worst quarterly performance since the standard was introduced. There were also increases in four-hour-plus trolley waits, problems meeting ambulance response times and a failure to achieve the 92% referral to treatment target – again on the back of a 15% rise in the number of patients waiting to start treatment.

The £2.45bn deficit was almost three times greater than that reported in 2014/15 and £461m worse than the plan that providers started the year with, after they had been asked to revise plans. While the final figure is substantially north of the £1.8bn control total set for the service during the year, it has needed some £724m of 'financial improvement opportunities' to get even get this close. These 'opportunities' included £324m of local capital-to-revenue transfers and one-off technical measures.

NHS Improvement highlighted some of the key pressures driving the overspend. The cost of agency and contract staff was top of its list – as it has been for much of the year. Providers spent £1.4bn more than planned on agency staff, contributing to a £1bn overspend on their overall paybill after underspending on permanent and bank staff. There was not just a failure to deliver a year-on-year reduction in agency costs, but costs were in fact £545m higher than in 2014/15 – with nearly two-thirds of unplanned agency costs attributable to foundation trusts.

This increase in costs was despite mid-year introduced controls on agency spending – including overall spending ceilings, requirements to use procurement frameworks and rate caps. Despite the continued increases, NHS Improvement said the controls had had 'some positive impact'. It has already estimated that the controls have saved £300m compared with what would have been spent (*Healthcare Finance,* May

**Key year-end figures: 12 months ended 31 March 2016**

| | NHS FTs | NHS trusts | Total |
|---|---|---|---|
| **Number of trusts** | 152 | 90 | 240 |
| **Operating revenues (£m)** | 47,213 | 28,488 | 75,701 |
| **Pay costs (£m)** | (30,206) | (18,565) | (48,771) |
| **Non-pay costs (£m)** | (15,942) | (9,782) | (25,724) |
| **EBITDA (£m)** | 1,065 | 141 | 1,206 |
| **Net surplus/(deficit) (£m)** | (1,096) | (1,351) | (2,447) |
| **Net surplus/(deficit) – plan (£m)** | (927) | (1,059) | (1,986) |
| **Variance to plan (£m)** | (169) | (292) | (461) |
| **Number of trusts in deficit** | 99 | 58 | 157 |
| **EBITDA (%)** | 2.3 | 0.5 | 1.6 |
| **Net surplus/(deficit) (%)** | -2.3 | -4.7 | -3.2 |


page 25) and £86m on management consultants. However, these figures take no account of any savings on permanent staff budgets where vacancies have required agency staff cover.

A report to NHS Improvement's board at the end of May said that 'over time we would expect a reduced level of reliance on agency staff as agency controls become further embedded, while providers put in place tighter financial controls, supported by more realistic workforce planning and more robust rostering practices.'

Elsewhere there have been claims that the NHS faces an uphill struggle in achieving compliance with new capped rates. Liaison provides systems to the NHS to help trusts manage temporary staffing. Its latest research on medical locums covering the second phase of rate caps introduced in February estimated that, based on a sample of 56 trusts, English trusts together overspent capped rates by an estimated £26.6m in just nine weeks.

'While we are seeing increased conformance from trusts, particularly during unsocial hours, there is still a long way to go to improve the core rates, which account for 70% of locum hours,' said Andrew Armitage, Liaison managing director. 'Trusts are clearly struggling with negotiating lower rates of pay for certain types of locum.'

A report from the company said that trusts working together and collaborating with a common pool of agencies were having the most success in achieving the capped rates.

NHS Improvement also said that delayed transfers of care cost at least £145m – based on losing a reported 1.7 million bed days (11% more than in 2014/15). However, fully absorbed costs could be much higher – and this is unlikely to capture the real costs of delayed transfers, which Lord Carter highlighted as a 'major problem' facing the NHS.

**"The key is for us to work together to make improvements in 2016/17, to reduce any variations in the quality of care and bring the provider sector back into financial balance"**
**Jim Mackey, NHS Improvement (above)**

Providers spent £143m on waiting list initiative work and outsourced £240m to other providers (including the independent sector). However, they still faced a total of £751m in finance and readmission penalties. Just £253m of this was reinvested directly with providers to improve operational flows, worsening provider's cost pressures by a net £498m. In total non-pay expenses were £1.2bn over plan – a 4.8% overspend.

The £2.9bn of savings delivered through cost improvement programmes was £316m (9.8%) short of plan and £6m below providers' forecast at Q3. More than 78% of the shortfall was due to under-delivery by acute providers. The £316m was made up of a gross shortfall of £403m on pay-related saving schemes and £87m over-performance on planned income generation schemes. Perhaps most worryingly, just 78% of CIPs were achieved from recurrent schemes, well below the planned level of 92%.

Providers' combined deficit exceeds the sustainability and transformation fund that was set at £1.8bn (equivalent to the 2015/16 control total that had been set for providers). Given this was intended to support providers in returning to financial balance, providers will need to deliver higher levels of efficiency in 2016/17 to achieve their set and agreed control totals.

In contrast to their revenue performance, providers' cash position showed continuing month-on-month improvements. The closing cash position of £4.2bn at month 12 was £615m better than plan, reflecting constraint on capital expenditure and management of working capital.

Capital expenditure of £3.7bn was £1.4bn below plan – an underspend that was in line with historic patterns. The underspend also included the £324m transferred to revenue budgets.

NHS Improvement warned that, with capital 'highly constrained' from 2016/17, providers should 'procure their capital assets more efficiently, consider alternative methods of securing assets, maximise disposal proceeds and extend asset lives.'

King's Fund director of policy Richard Murray said there needed to be recognition of the cause of the financial problems. 'Overspending on this scale is not down to mismanagement or inefficiency in individual trusts,' he said. 'It shows a health system buckling under huge financial and operational pressures.'

He added that trusts starting the year with a collective deficit of about £1bn more than planned had 'worrying implications.'

NHS Providers chief executive Chris Hopson put it bluntly. 'This record number of trusts in deficit, with a record overall deficit, is simply not sustainable. We have to rapidly regain control of NHS finances otherwise we risk lengthening waiting times for patients, limiting their access to services, and other reductions in the quality of patient care.'

Following the publication of Lord Carter's report, productivity improvements have been the prime focus. But funding appears to be moving back to the centre stage.

'By 2020 public spending on the NHS is set to drop further to below 7%. This is simply not enough and we need to stop pretending it will be,' added Mr Hopson.

'There is now a clear gap between the quality of health service we all want the NHS to provide and the funding available. What we can't keep doing is passing that gap to NHS trusts – asking them to deliver the impossible and chastising them when they fall short.'

# Comment

June 2016

## Straight talking

**We need a discussion about the balance between funding, efficiency and transformation**

HFMA president Shahana Khan

**You couldn't miss the** media headlines about the NHS provider year-end deficit position of £2.45bn. However, we all know that the underlying position was much worse.

There is no doubt that the NHS can improve productivity and efficiency. The work by Lord Carter provides opportunities trusts must explore to satisfy themselves they are delivering as much value as they can. But a lot of this improvement will take time.

Even where we discover real local opportunities, we can't fix everything overnight. And, as other commentators have said, the current level of overspending in providers is not down to mismanagement and inefficiency in trusts.

Despite the difficult year-end numbers and reliance on technical measures, NHS bodies put in an amazing shift last year to constrain costs. Finance directors and senior finance managers need to keep doing all we can to improve productivity and support transformation. But we also need to maintain our professional integrity and the sovereignty of our boards.

That means continuing to produce plans based on informed assessments of demand and financial flows. And it means plain talking about real savings potential, the impact on services and realistic timescales.

June sees the submission of both sustainability and transformation plans and local digital roadmaps. It is increasingly clear that while these planning tools may have been devised at different times, they are now rightly being linked.

Without the correct technology in place, we simply won't be able to transform services in the way we need to deliver sustainable services.

It is hard to see how we might move to more networked and integrated services without having 'digital, interoperable and real-time patient and care records' committed to by

## Finance and quality in the red

**What are we to make of claims that NHS care quality is deteriorating? Should alarm bells be ringing?**

Healthcare Finance editor Steve Brown

**The Care Quality Commission has** pledged to promote a single shared view of quality. The quality regulator has built its inspection regime around assessing quality using five key questions: is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led?

However, it's new five-year strategy, in which it makes this pledge, says that 'multiple definitions of care quality are still being used'. In response, it wants to work with providers and the public to agree a definition of quality and how this should be measured.

What people mean by quality is important. For example, the King's Fund's latest quarterly monitoring report found that two-thirds of trust finance directors and more than half of clinical commissioning group chief finance officers in their sample say the quality of care in their area has deteriorated in the past year.

The King's Fund said it was the most worrying finding since it started tracking this question back in 2012. And it certainly appears to be something of a tipping point, with a majority of all finance leaders now in agreement.


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**"Without the correct technology in place, we simply won't be able to transform services in the way we need to"**

2020. This programme is about far more than eliminating paper – the roadmaps need to be fully aligned with broader system plans.

These programmes of work are all about future-proofing the service – and they are vitally important.

But in terms of the transformation the NHS needs – revised patient pathways and new models of care – this will also take time. It is the right thing to do – eliminating variation, ensuring patients are treated in the most appropriate environment, supporting patients to stay well rather than catching them when they fall acutely ill and matching facilities to the right-sized catchment areas.

And there is a good argument for suggesting that more prevention, better quality, less rework and economies of scale will also deliver savings.

But it is still not clear what the financial impact of this transformation will be. Will it fill the gap between expected healthcare spending (if no changes are made) and current levels of committed funding?

There is also an argument that holding the level of funding to what has been announced and then establishing sustainability and transformation plans to review services is really an exercise in rationalisation.

Analysis shows that UK public spending on health has fallen in recent years and, comparing planned additional spending to expected growth in the economy, will reduce to below 7% of gross domestic product by 2020.

It is not straightforward. Comparisons with other countries need to take account of both public and private spending on healthcare, and the link between changes in GDP and health spending is not completely clear. But it provides a good check on general funding levels.

Both NHS Providers and CIPFA have recently questioned whether current funding as a proportion of GDP – behind many European countries – is really where the UK wants to be.

One thing is certain. The balance between funding, efficiency, transformation and service rationalisation is a topic that demands discussion by politicians, within the NHS and by the public.

*Contact the president on president@hfma.org.uk*

But what do finance directors mean by quality in this context? Access and waiting times (singled out as the most vulnerable aspects of quality by finance directors in a survey for the last HFMA *NHS financial temperature check* – with new figures out next month) are perhaps what come to mind first – given that they are monitored against national targets.

In this interpretation of quality, how could finance directors say anything different? Performance against the key access targets has fallen.

Or do they mean some broader definition of quality including clinical outcomes, patient-reported outcomes, patient experience and core patient safety?

An understanding of quality in its fullest sense is vital if you are looking at the impact of investment or cost reduction activities on services.

There have been concerns over the years about the relative priorities of quality and finance. And earlier this year NHS Improvement and the CQC wrote to the service saying that 'success is delivering the right quality outcomes with the resources available' and that 'quality and financial objectives cannot trump one another'.

These are nice words, but not particularly helpful for organisations making tough choices at the frontline – particularly when both quality and finance are in the red.

Perhaps what is more galling for providers is that they are being penalised despite their best attempts to achieve this quality-finance balance. Providers reported a £2.45bn deficit in 2015/16 and NHS Improvement said that providers spent £143m on waiting list initiative work to avoid breaches in waiting time targets, as well as outsourcing some £241m of work.

Increases in agency costs will also have been caused in part by striving to meet access targets. But providers still faced net fines and readmission penalties of nearly £500m.

NHS Improvement recognises significant increases in demand – with A&E departments having their busiest year on record and a big jump in the number of people waiting for elective care. So we may have a situation where there are insufficient funds in the system to meet access targets for current levels of demand and then providers being financially penalised for missing these targets.

**"It may well be time to assess whether what the NHS is being asked to deliver right now is in fact achievable"**

There is no disagreement about the general principle that everyone should strive for the highest possible quality within the resources available and this should be underpinned by national standards. And there is broad support that transformation of patient pathways and how services are delivered offers the best prospect for creating sustainable services.

However, even accepting that improved efficiency has a role to play, it may well be time to assess whether what the NHS is being asked to deliver right now is in fact achievable.

And if that is the case, we need to start having a more nuanced discussion about quality and its various dimensions.

3M Science. Applied to Life.™

# Improving data quality to deliver more accurate reimbursement

An NHS Foundation Trust in the East of England that provides acute hospital and community care services to around 280,000 people has taken steps to deal with significant financial pressures and a requirement to maximise value for money with the available resources. 3M's Health Information Systems (HIS) business enjoys a strong working relationship with the Trust's clinical coding team, which uses 3M™ Medicode™ Clinical Encoder as its primary clinical coding tool.

## Project requirement

Complete, accurate clinical coding is essential in NHS Trusts. The Payment by Results framework means that a Trust's revenue is dependent on its coding quality. The Trust had previously engaged an external firm to review the quality of its coded clinical data, however this had resulted in a significantly increased workload for the senior coding team, as the suggested changes were often inappropriate and had to be reviewed carefully. The Trust's Clinical Coding Manager contacted 3M's HIS team to see how it could help the Trust to better use its resources to improve data quality.

## Identified needs

3M's HIS team quickly recognised three key insights.

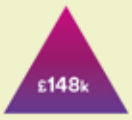
Firstly, it was important to build on the coding team's existing knowledge of Medicode clinical encoder. Secondly members of the existing senior coding team were best placed to identify and assess anomalies in their own data. Thirdly it was necessary to reduce data to a manageable quantity by screening out activity that did not require review.

The addition of three new 3M Medicode modules was proposed to improve the coding process, optimise data quality and maximise the capacity of both the clinical coding auditor and clinical coding trainer:

One of the modules was the 3M™ Data Quality Analytics Solution (DQA) which reviews all coded episodes and reports against the national clinical coding standards, alerting the user to potential errors. Target review areas are identified effectively and efficiently at episode level. DQA fits into the daily coding process where alerts can be reviewed by people trained to recognise the impact of errors.

## The results

**Financial benefit**




A more accurate data submission has led to an income improvement of £148,000 in the first six months, meaning an average of £24,000 per month increase in appropriate reimbursement.

**Increased data accuracy**

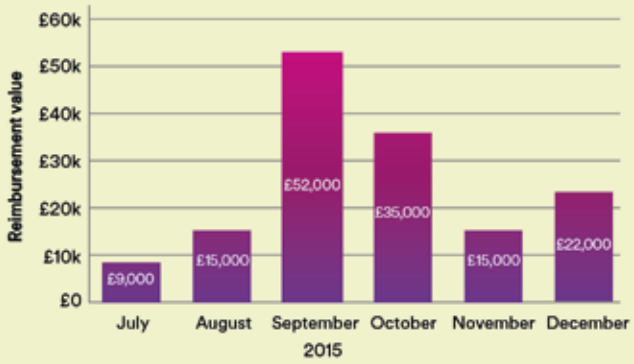
The new modules have led to improved accuracy and quality of data for both internal and external use.

**Increased capacity for audit**

The introduction of the new modules has meant that all coded data can now be audited internally using existing resources.

**Development of people skills**

DQA has allowed the existing team to optimise its efficiency and initiate a cycle of continuous learning and development.




**First six months all saw improved reimbursement results, with £52,000 generated in September 2015 alone. Data on file with the Trust's Clinical Coding Department 2015.**

*"Twice-weekly running of DQA means that the coding team has immediate feedback, in more detail. Our month-end checks are fewer and completed nearer to the time of coding, meaning that we are able to quickly correct errors and feed back to the coders."*

Clinical Coding Manager

For more information on the 3M DQA Solution:
Freephone **0800 626578** or email **help.his.uk@3M.com** or visit **www.3M.co.uk/his**

Financial results were produced by processing six month's data and amending codes, i.e. using a more specific code and also adding codes where DQA highlighted a potential error and on further investigation where extra codes could be added. Data on file 3M and Medicode are trademarks of the 3M company. 

# Carrying on

**Continuing healthcare demand and costs are increasing and commissioners are feeling the strain. Seamus Ward examines why**

It is fair to say that continuing healthcare (CHC) has not always had the highest profile in the NHS. In the past, it may have been regarded as a small, if contentious, element of commissioners' budgets, a hangover from primary care trusts or, in NHS acute providers' case, largely an irrelevance, because the care is delivered either in patients' homes or in privately run nursing homes. Yet its profile is rising.

Several times in the last year NHS England has highlighted how underspends in provisions for legacy CHC claims – for care delivered before April 2012 – have helped increase the overall commissioner underspend and offset provider sector deficits.

Providers are increasingly worried about delayed transfers of care – some of which are caused by slow assessment of patients' eligibility for CHC. With new claims seemingly on the rise and a deadline looming to process legacy claims, CHC looks set to play a bigger role in the national conversation on finance and the services that are delivered by the NHS.

CHC is a package of health and social care commissioned and funded solely by the NHS. This covers patients who are over 18 and require physical and/or mental healthcare outside hospital – which could be in their home or a nursing home – as a result of a disability, accident or illness. To be eligible, the patient must be assessed as having a primary health need. This is assessed using a framework, which was first introduced in 2007 and includes an initial checklist to see if a patient may be eligible for CHC, followed by a more detailed decision-support tool (see box right). A fast-track tool can also be used for those in the final stages of life. If a patient is deemed eligible, a review should take place after three months and annually thereafter.

It is a complex and emotive area, and the waters are muddied by the fact that there are new claims (those made since the inception of CCGs) and legacy claims (those passed on by PCTs when they were abolished).

Retrospective claims, also known as previously un-assessed periods of care (PUPOC), cover the period from April 2004 to March 2012, and are made by patients hoping to be reimbursed for the care they paid out of their own pockets. With many patients now dead, these claims are often made by relatives.

PUPOC payments should restore the patients to the financial position they would have been in if CHC had been funded at the time. The settlement should not result in the individual or the CCG gaining a financial advantage. Nationally, about 59,000 PUPOC claims were made and by March 2015, 27,500 were waiting to be processed.

The health and parliamentary ombudsman has complained about the slow speed of progress and NHS England expects CCGs to make an initial assessment of all claims by March 2017 at the latest. It has asked CCGs to complete outstanding assessments by September to allow a six-month contingency. This does not include time for appeals.

While CCGs have the legal responsibility for the legacy claims and must make provisions in their accounts, NHS England holds the funds. The funds are gathered through a risk pool to which all CCGs contribute each year – it is these funds that have been

**"With new claims seemingly on the rise and a deadline looming to process legacy claims, CHC looks set to play a bigger role in the national conversation on finance"**

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underspent in recent times, with NHS England returning a proportion of CCG contributions. In 2014/15, the underspend on the risk pool meant that all CCGs were given back about 50% of their contribution – £156m was returned nationally. According to the latest NHS England figures, at year end in 2015/16 the underspend against expected legacy claims was £192m.

While the return of a proportion of contributions has been helpful, it's not all positive. As NHS England chief finance officer Paul Baumann has pointed out, this is merely deferred spending and the funds will be needed in the next few years as claims are settled.

CCGs say the remaining legacy settlements could be higher than those already processed because outstanding claims tend to involve patients who needed more complex care.

The assessment of a PUPOC claim is similar to that outlined in the box, but can be complicated by the fact that the patient may be dead and it can be difficult to get hold of the care records needed to complete the review. In addition, claimants must prove how much they paid for their care. One CCG estimates that the cost of reviewing its PUPOC claims will be more than £200,000. This is paid by CCGs and is not offset against the contribution to the risk pool, which is typically between £1.5m and £2m a year.

**"One CCG estimates the cost of reviewing its PUPOC claims will be more than £200,000. This is paid by CCGs and is not offset against the contribution to the risk pool"**

According to Health and Social Care Information Centre figures, just under 22,000 patients were newly eligible for CHC at the end of the first quarter of 2013/14. Over the next 10 quarters the number of newly eligible patients rose and by the end of the third quarter of 2015/16 it stood at more than 25,000.

In the same period, the overall number of patients eligible for CHC increased from just under 57,000 to 62,000. Although a relatively modest increase, costs can soon add up. Needs vary, of course, with an individual with significant health needs perhaps costing £5,000 to £6,000 a week while an older person who perhaps needs a little support through regular nurse visits could cost a few hundred pounds.

## Increased pressures

Kernow Clinical Commissioning Group ended 2015/16 with a £17m deficit against a planned surplus of £500,000. A spokesperson for the CCG told *Healthcare Finance* that it overspent its CHC budget by just over £11m. The CCG says pressures on CHC are mainly due to the increased population of over-65s living in Cornwall and the Isles of Scilly and increased life expectancy. It is working closely with NHS England to develop robust plans to improve its financial position. It is also working with its CHC providers as part of the recovery plan.

'Continuing healthcare is a big issue for the NHS and it has grown massively over the last 10 years,' says Ray Hart, managing director of Valuing Care, a consultancy that helps NHS bodies establish the true costs of the care they are commissioning. In some cases, he says, it has saved 10% to 20% on the cost of individual care packages.

'The growing area is around older people who are eligible for CHC, taking up quite a proportion of people in care homes,' says Mr Hart. 'Most people think social services pay for this population, but a proportion – 10% to 20% in any given area – could be CHC clients. It needs to be commissioned based on the cost of the placements, but it is not always seen as a priority.' He believes that there is a greater awareness of CHC, adding that in the past many of these patients would have been cared for in cottage hospitals, which are now largely gone.

Commissioners are looking at different ways of solving that problem and getting better value from ever-increasing demand, he says.

'For older people, CCGs have on the whole used council rates and added extra services on top. But providers are questioning council rates. Some commissioners have used banding and not always accurately. We have seen huge variation around bands, with some providers claiming they don't cover their costs, while others are quite happy. Bands speed up the process and make billing easier. 'On the flip side of that, if you are trying to cost every single assessment and placement – looking at how many staff are needed per shift, for example – that's a lot of work.'

One CCG told *Healthcare Finance* that it had introduced more consistency into the assessment process it had inherited from its predecessor primary care trust. Instead of assessments being undertaken by district nurses, there is now a dedicated nursing team for this purpose and a more rigorous assessment process. It has also commissioned 'discharge to assess' beds for hospital patients. There was a recognition that an assessment undertaken at the 'direct discharge' stage could lead to under- or over-estimating a patient's needs, but the initiative allows clinicians to get an accurate assessment of the support that will be required when they leave hospital. Patients are moved to these beds for a week or more, until they are stabilised, and then an assessment is made.

The CCG has seen a 12% fall in the number of patients being funded for CHC, funded nursing care or joint packages of care. And within this overall reduction, there has been a shift away from CHC towards joint funding and funded nursing care. The CCG attributes this to its better and more consistent assessment, but the savings have been counterbalanced by rises in nursing home costs and care costs in other sectors – driven in part by the rising cost of staff in these services.

CHC is a complex area and in many parts of the country it is becoming a pressing financial matter not only in terms of legacy claims, but also new claims as the population ages.

## The CHC process

Initially, a health or social care worker will identify a patient with a potential need. In some areas this can involve the completion and submission of a checklist to the CCG.

At the next stage, a decision support tool is used to determine the patient's eligibility. This is a document with more than 50 pages and is filled in by a nurse assessor.

Once gathered, the information is discussed by a multidisciplinary team, which assesses the level of need across multiple domains to decide if there is a primary health need in an individual's care needs. This covers areas such as breathing, mobility and whether they need help with eating and drinking.

The assessment has four possible outcomes:

- **The patient is eligible for CHC** – the cost of all their care, including accommodation if appropriate, is picked up by the CCG.
- **The patient requires funded nursing care** – this care is delivered only in nursing homes and is funded by the CCG. In one CCG spoken to by *Healthcare Finance*, this amounts to around £113 a week, with the balance possibly funded by social services. If a patient decides that they want to be in their own home and their needs can be met in the community, no payment is made, because universal services such as district nursing can provide this level of nursing care.
- **The patient needs a joint care package (health and social care)** – the CCG and the local authority agree to contribute to the cost of the patient's care, which can be delivered in a care home or the patient's own home. As is often the case with local authority social care funding, CCGs would typically cap the cost of services delivered at home at a point close to the cost of supporting that patient in a care home.
- **The patient has only social care needs**.

# New role with HFMA - Policy and technical assistant

## Secondment/ fixed term opportunity for a band 7 accountant

The HFMA is looking to second a Policy and Technical Assistant to support the work of the technical editors. For more information about the role visit jobs.hfma.org.uk

To apply please send your CV and covering letter setting out why you would be suitable for the role to **sarah.moffitt@hfma.org.uk** by 5.00pm on 15 June 2016. Interviews will be held in London on Wednesday 29 June. Initially, this is a one year opportunity. Applications for part-time hours will be considered.

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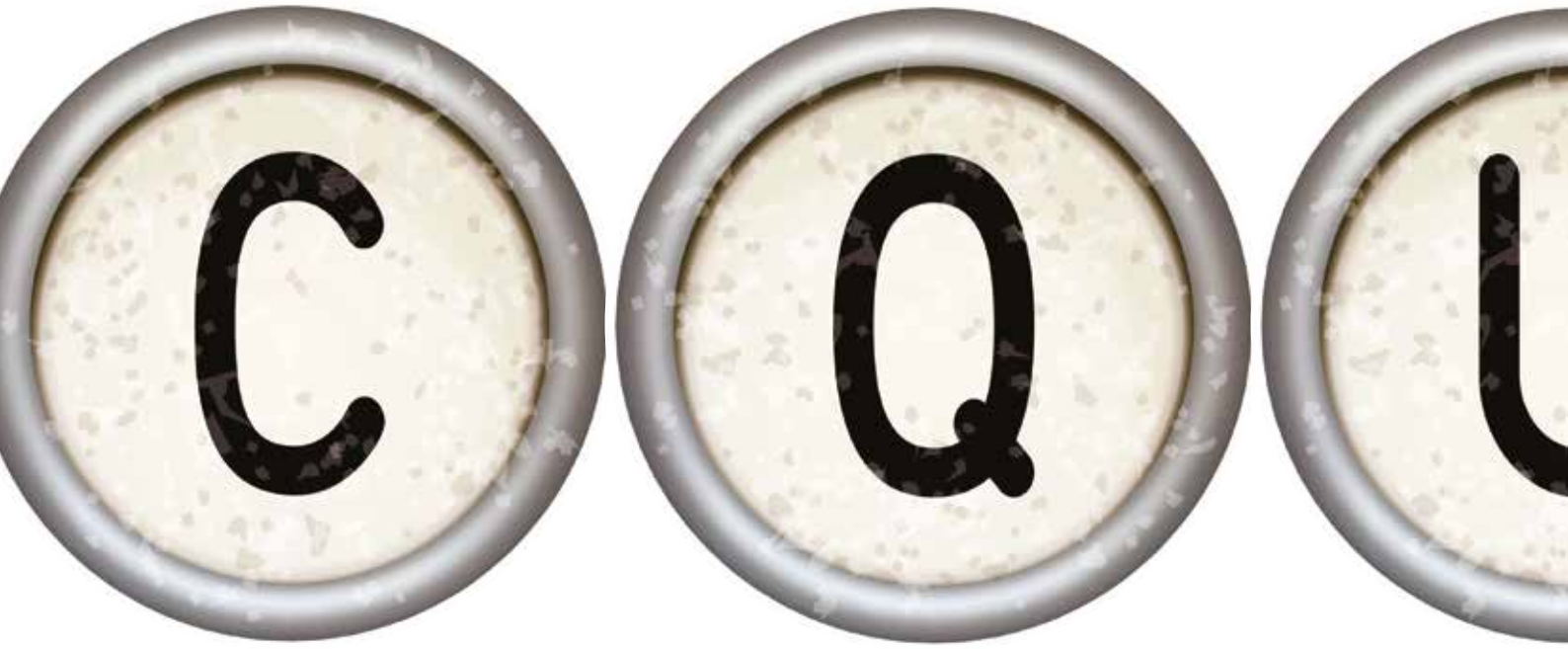


# Press for change

**Providers have complained this year's CQUIN incentive scheme has departed from the original focus on quality, but commissioners say they are merely implementing the NHS forward view. Seamus Ward reports**

As reforms of the tariff go, commissioning for quality and innovation (CQUIN) was relatively uncontroversial initially. When it was introduced in 2009/10, there was wide support for paying a percentage of contract value to incentivise providers to improve the quality of care.

But in recent months it has turned sour, with the late publication of some 2016/17 CQUIN guidance, changes to the amounts to be paid for specialist CQUINs and disputes between local commissioners and providers that have reportedly held up the signing of contracts.

With speculation over its future, providers have told *Healthcare Finance* that they believe the initiative has lost its way.

In 2016/17, as in previous years, there are national and local CQUINs as well as CQUINs for specialised services. NHS England says this year's scheme is designed to support the *Five-year forward view* and, when aligned with sustainability and transformation plans, will be a powerful lever to deliver better quality care through clinical and service transformation. There are four national goals: staff health and wellbeing; identification and early treatment of sepsis; improving the physical health of patients with severe mental illness (PSMI); and antimicrobial resistance. Schemes must include goals applicable to the sector.

Payments are made based on the actual annual value (AAV) of the relevant contract. This is the aggregate of all payments made to the provider for services delivered under the specific contract during the year, not including CQUIN and other incentive payments, and after any deductions or withholdings. Payments can be in part or in full based on the achievement of milestones or targets.

The national indicators are worth different amounts and, when added to local CQUIN, total 2.5% of AAV. This year, the staff indicator is worth a minimum of 0.75% of AAV. The others are worth at least 0.25%. Commissioners and providers may agree to increase these amounts and the remainder is available for local CQUINs. For example, if an acute trust agreed CQUINs at the minimum level for sepsis (0.25%), staff wellbeing (0.75%) and antimicrobial resistance (0.25%), 1.25% of AAV would be available for local CQUINs.

CCGs have worked with NHS England to develop a menu of local CQUINs for 2016/17, based on CCG priorities. The menu has seven priority areas and 30 indicators. The priority areas include productivity, integration and urgent and emergency care. The local schemes are flexible, allowing for local targets and payments to be set.

## Key concerns

One provider director of contracting has concerns over the direction CQUIN has taken. 'To me CQUIN has lost its way,' he says. 'Our CQUINs are worth £12m, so we cannot afford not to have it, but then again we can't afford to sign up to anything too risky and could lose us money. Because of this we have to restrict what we do to CQUINs that are safe, which means we are not doing what we are supposed to do.'

NHS England says the national CQUINs are aligned to its strategic priorities and support delivery of the government's mandate in areas such as antimicrobial prescribing and resistance rates.

Several providers have told us of their concern that the achievement

of some CQUINs is outside their control – the health and wellbeing CQUIN, for example, a third of which is based on healthier food for patients, staff and visitors (see box overleaf).

A persistent gripe from providers is that changes to CQUINs each year can pull the financial rug from under services they have developed under the initiative.

Central Manchester University Hospitals NHS Foundation Trust director of contracting and income Lee Rowlands says CQUIN can be seen as a pump priming tool, but when funding is taken away to invest in a new and different CQUIN the following year, the providers can still be left with a recurring cost.

'You can earn CQUIN payments each year, but they're usually different ones each year. You therefore get a payment that will cover the costs in the first year but the risk is that you are then left with the costs on your books going forward.

'There is a danger that commissioners see broadly the same level of CQUIN payments as a "new" resource each financial year, when actually you might only be able to earn the same CQUINs annually (say £10m), but over the course of three to four years the recurrent costs may then exceed this,' he says.

'CQUIN has worked best where it incentivised genuine changes or advances in clinical practice (such as VTE monitoring). When this was a multi-year CQUIN, the payments were genuine pump-priming enablers and then, over time, VTE monitoring became part of standard practice and the costs absorbed as part of normal day to day running costs.'

NHS England points out that it does not change all national CQUINs from year to year. This year, for example, is the third year for the mental health CQUIN, while the sepsis CQUIN is in its second year. 'Specialised commissioners have developed a greater number of multi-year CQUINs, as well as including in scheme design explicit considerations for how changes will be sustained after the CQUIN is retired,' it says.

Commissioners should make it possible to achieve local incentive targets over a number of years, it adds, particularly where there is a shift to new models of care or outcome-based payment that will require several years to deliver. 'However, CQUIN is a dynamic scheme and will change in response to national and local priorities so we suggest that commissioners should avoid agreeing binding CQUIN schemes with the providers that cover the period beyond the duration of the CQUIN scheme – which is currently 31 March 2017,' a spokesperson adds.

**"There is a danger that commissioners see broadly the same level of CQUIN payments as a 'new' resource each financial year"**

**Lee Rowlands, Central Manchester NHSFT**

SHUTTERSTOCK

## Action on Hepatitis C

Specialist CQUINs have also come under scrutiny. In March, specialist providers claimed that changes in specialist CQUIN schemes would hamper their attempts to get back into financial balance.

Much of the focus has been on the CQUIN for new hepatitis C treatments. Providers say the goalposts moved as late as mid February, when NHS England published details of the specialist CQUINs. To accommodate the additional cost of new Hep C treatment, it announced that the 23 trusts that are national Hep C providers will be able to receive CQUIN payments of 2.8% of contract value. To accommodate this, the maximum specialist payment for other providers was reduced to 2%. Trusts had assumed specialist CQUINs would be paid at 2.4% and agreed control totals based on this.

Even though the Hep C providers have access to 2.8%, some of the 23 trusts told *Healthcare Finance* they were not happy. One trust said it does not have a 'clear line of sight to earning 2.8%'. Payment of the full amount relies on all the providers remaining within budget.

'This is a budget management tool and we will not know our income from this until the end of the year. We could break even on the budget, but if any of the other Hep C providers overspend we will suffer the consequences and vice versa,' the trust adds.

NHS England states: 'Since it is only relevant providers themselves who can clinically manage the expansion of patient treatment volumes in line with the legally mandated NICE guidance, we make no apology for providing positive incentives to support them in doing so. The undesirable but unavoidable alternative – given the NICE legal funding mandate – would have been to top slice from available specialised

## Healthy CQUIN

Some tabloids may have dismissed NHS England's focus on staff health and wellbeing as frivolous or screamed with incredulity about Zumba classes for NHS staff, but staff welfare is something to take seriously. As NHS England says, happier staff can reduce costs – whether through higher retention of staff or reduced sickness absence, which is put at £2.4bn a year.

Staff health and wellbeing is encapsulated in a new, three-part national CQUIN. Overall, the CQUIN is worth 0.75% of AAV, with each of the three parts worth 0.25%.

There are two options in the first part, with only one to be selected. Commissioners and providers should choose between achieving a five percentage point improvement in each of the staff survey questions on health and wellbeing or introducing a range of physical activity schemes (such as exercise classes), improving access to physiotherapy services and introducing mental health initiatives.

The second part relates to food sold in hospitals. A range of initiatives are required, including banning price promotions on sugary drinks and ending advertising of sugary drinks and food high in salt, fat and sugar. Healthy options should be available for staff working night shifts. There is also a mandated data collection on existing contracts with food and drink suppliers.

The final part of the CQUIN relates to flu vaccination of frontline clinical staff, with a target of 75%.

Payments are made against achievement of milestones. For example, in the staff survey option a 2% improvement will lead to payment of a quarter of the weighting associated with this option. Nothing will be paid for improvement of 1% or less. In the flu vaccination element no payment is made for achieving 64% or less; 50% for uptake of 65%-74% and 100% for 75% and above.

NHS England makes no apology for prioritising the staff health and wellbeing indicator by making it worth three times more than the other national indicators.

'Given that its workforce is often put in high-pressure situations, and is responsible for helping to care for the health of England's population, the NHS has a responsibility to take care of its own staff,' a spokesperson told *Healthcare Finance*.

One finance manager closely involved in contracting asked how trusts can achieve the targets on food and drink when they cannot control what's sold in concessions in their buildings. 'Good luck negotiating that with Costa Coffee,' he says.

NHS England says the CQUIN emphasises the health service role in leading the battle against obesity and lifestyle-related illnesses.

'Provider trusts are significant and influential organisations, and have a major role to play in delivering a changed culture. NHS England will be hosting discussions with the major food suppliers and franchise holders to the NHS to help trusts make progress in the four areas outlined in the CQUIN. Practical steps have already been taken. So, for example, the Royal Voluntary Service has recently sent out a letter to each trust, covering 440 stores, outlining how they will meet the CQUIN measures during 2016/17.'

Liz Preece, workplace health and wellbeing specialist at The Healthy Worker, a company that helps employers develop and deliver staff health and wellbeing strategies, says the CQUIN is a landmark in NHS staff welfare. Two of the staff survey questions on health and wellbeing relate to musculoskeletal problems and stress – two of the primary causes of staff absence, she says. 'If you can improve these, there's an opportunity to make a significant difference,' she adds.

'Finance teams need to be part of the solution, supporting trusts to move forward and not seeing staff health and wellbeing as "a nice to have" any more. Part of the purpose of the CQUIN is to push that thought process – there's a return on investment from it.'

provider income growth a national reserve of up to several hundred million pounds to cover risk of excess provider spending on Hep C.

'Delivering this carefully targeted CQUIN scheme will have negligible, if any, costs to specialised providers themselves, while also giving them extra income and helping protect available funding growth for all providers of specialised care. The vast majority of contracts for Hep C lead providers are agreed.'

NHS England adds that non Hep C providers that were on the default tariff rollover tariff in 2015/16 did not earn any CQUIN last year so are moving from 0% to 2% for specialist CQUINs. 'The change moves around £20m gross income earning potential from over 170 providers – an average income change of a little over £100,000. Given the costs providers need to incur to earn these sums under the CQUIN scheme, which over recovers costs by 25%, the effect on bottom line financial balance is substantially less.'

Trusts say a lot of work – possibly a disproportionate amount – goes into negotiating and verifying CQUINs. 'I think CQUIN has become too important in contracting,' one trust director says. 'When it was first introduced you could see why it was being done – to improve quality and pathways – but it's getting more difficult.'

This year, local disagreement and discussion has contributed to delays in signing some contracts. NHS England acknowledges this. 'We do know that, in some cases, NHS commissioners and providers have struggled to reach timely contract agreements for 2016/17, and in some instances the local element of CQUIN has been one issue on which they have been unable to agree,' a spokesperson says.

'We recognise that technical discussions on the design of local CQUIN indicators can take time, and we do recommend that commissioners focus on agreeing a manageable number of local indicators relative to the value of the overall contract. This is why this year we have collaborated with CCGs to design a new comprehensive menu of local CQUINs that CCGs can adapt for local use.'

For very small-value contracts, where the effort of designing local CQUIN indicators would be disproportionate to the benefit obtained, national CQUIN guidance allows flexibility, so the commissioner can agree simply to pay the 2.5% in full, the spokesperson adds.

### Call for review

Some providers would like the initiative to be reviewed. 'I'd like a stock-take of whether CQUIN should still be considered a fundamental part of the payment system or if the resource should be diverted into other parts of the payment system instead,' Mr Rowlands says. 'It should be a two-part process, in that if it concludes we should stick with CQUIN, we should also go back to the original principles behind it, to incentivise quality improvement – CQUINs should also be properly thought through, consulted upon and published early so we can all plan properly.'

Many providers will sympathise with this view, but commissioners – both national and local – may feel using the initiative to drive forward service transformation while making quality improvements in targeted areas is equally valid.

# HCL transformation team saves Trust £1.2m

## Challenge

Following the successful implementation of a HCL master vendor (MV) solution in 2014, the Mid Yorkshire Hospitals NHS Trust (MYHT) sought to further reduce its dependency on off-framework agency medical locums, increase direct engagement conversions, improve service delivery and realise operational and financial efficiencies.

**100%**
**locums supplied on-framework**

## Solution

In August 2015, HCL's experienced team of advisors conducted a five day on-site diagnostic. Resulting recommendations included:

1. Centralise booking team to manage rotas, bank and agency – An inconsistent approach to rota planning meant locum requests were often given to staffing co-ordinators last minute and decisions were service driven rather than cost driven.
2. Relaunch Direct Engagement (DE) programme under HCL master vendor solution – The Trust's DE take-up target of 80% would be more easily achieved through HCL as the Clarity technology would give the team the ability to influence and control the supply of locums.
3. Transfer off-framework spend through the MV agreement – HCL Clarity put together a transition plan to completely remove off-framework supply of medical locums at MYHT. All locums supplied off-framework were instructed to register with the MYHT in-house staff bank or with an approved agency if they wished to continue to work at the Trust. No services were disengaged without a viable alternative to ensure safe delivery and continuity of patient care.


## Outcome

- New centralised medical staffing structure ensures clarity and visibility on all bookings Trust-wide.
- Access to real-time management information and transparency on workforce data. This enables cost savings through more efficient scheduling and faster identification of skill gaps and high spend areas.
- Off-framework suppliers have been migrated through the MV, ensuring all medical locums are supplied via approved rates and compliance standards.
- The relaunch of DE at the Trust is expected to create savings of £1.2m per annum.

"I would highly recommend HCL to any NHS organisation. The team surpassed all expectations and helped the Trust formulate a clear improvement plan that will create circa £1.2 million of annual savings."

**Neil Bowman**, *Head of Business Delivery*, Mid Yorkshire Hospitals NHS Trust

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# The way forward

**The Virginia Mason Medical Center in Seattle (pictured below) has won wide-ranging plaudits for the safety and quality of its healthcare. Now a programme in the NHS aims to help five trusts learn from its expertise. Steve Brown reports**

The challenge facing the NHS is easy to articulate. Deliver higher quality within restricted resources. While many may subscribe to the theory that higher quality equals lower cost, turning this into practice across wide-ranging services is a daunting prospect. What they need is a tried and tested toolkit that they can use to drive quality improvement.

One such toolkit is the Virginia Mason Production System (VMPS). A scheme was launched last year by the then NHS Trust Development Authority to support five NHS providers to adopt this approach across their organisations.

The basic approach of the VMPS, which is built on the Toyota lean management system, works on the assumption that it is staff who know what the problems are and have the best solutions. It then uses a number of observation and data analysis tools to describe how patients experience the service. This helps staff identify how to improve the patient's journey. This is tested and, where appropriate, implemented – with the aim of standardising processes wherever possible.

These tools include established quality and lean management techniques such as process mapping, 5S (sort, simplify, sweep, standardise, self-discipline) and SMED (single-minute exchange of die). And they are put to use by multi-disciplinary improvement teams (from consultants down to the most junior members of staff) brought together in rapid process improvement workshops (RPIWs).

**"It is about looking at services inch wide but mile deep … to use narrow terms of reference to achieve a level of depth"**
**Julian Hartley, Leeds Teaching Hospitals**

Leeds Teaching Hospitals NHS Trust was one of the five trusts selected as part of the TDA initiative, now supported by NHS Improvement. With a recognition that processes need to be adapted to local context, the trust has styled its take on the VMPS as the Leeds Improvement Method.

Julian Hartley, chief executive at the Leeds trust, says that the difference with the Virginia Mason approach, as opposed to earlier NHS improvement initiatives, is the structure. 'There is an absolute focus on patients and respect for people and an incredible rigour and discipline in the system's methodology, which is all about achieving a level of standardised work to reduce waste and increase value.

'It is about looking at services inch wide but mile deep,' he continues. 'We are not trying to take on too complex a process, but use narrow terms of reference to achieve a level of depth.'

And he insists it is about changing the way Leeds does business, not about completing an initiative. 'Virginia Mason has been at this for 15 years, it is not about overnight success. But the aim is to, inch-by-inch, get through broken operating processes and redesign those processes by applying standard work.'

## Focus of improvement

Leading the way at Leeds has been work on elective orthopaedics – with a focus on total hip and knee replacements – an area highlighted by Lord Carter as offering potential for productivity improvements.

The trust was keen to focus on the day of admission and surgery and staff had set reducing patient waits on the day as a key priority. But it was soon realised that to have maximum impact on this, the team would have to look earlier in the process – at the way theatre lists were constructed and then managed up to the day of surgery.

At the beginning of May, an improvement team made up of nurses, managers and consultants gave its 90-day 'report out' – its third feedback event giving an update of work done to date and lessons learnt since its RPIW at the end of January.

The sense of staff enthusiasm and engagement at the lunchtime event was clear – although they were also open about the challenges they had faced and continued to face. And there was a definite sense that they were fixing things that had both frustrated staff and had had a negative impact on patient experience of services.

## The road to Virginia Mason

Virginia Mason Medical Center is a non-profit organisation providing integrated healthcare across Seattle in the US. It has won various awards for clinical quality – making various lists of America's best hospitals for several years running.

Behind these awards and widespread recognition for delivering safe, high quality care is an ambitious system-wide change programme launched back in 2002. It adopted the basic principles of the Toyota Production System, renaming it the Virginia Mason Production System (VMPS).

The programme effectively targets the perfect patient experience, free from errors and defects. It recognises that staff know what the problems are and have the best solutions – so it supports them to identify and implement improvements.

It uses lean management techniques to continuously improve quality and safety, eliminating waste and reducing costs. The benefits are patient-focused – more value-added time spent with providers, less delay waiting to see doctors or waiting for tests, and safer services. Some figures suggest that nurses have increased the average time spent on direct patient care from 35% to 90%.

On launching the NHS link up with Virginia Mason last summer, health secretary Jeremy Hunt insisted he wanted 'to make the NHS the safest healthcare system in the world, powered by a culture of learning and continuous improvement'. He described the achievements at Virginia Mason over the last decade as 'truly inspirational'.

Sixty-two NHS trusts applied to be part of the programme but just five were selected: Leeds Teaching Hospitals; University Hospitals Coventry and Warwickshire; Barking, Havering and Redbridge University Hospitals; Surrey and Sussex Healthcare; and The Shrewsbury and Telford Hospital.

NHS Improvement medical director Kathy McLean says the focus of the five-year programme is on improving quality and safety. 'But we firmly believe that it will lead to efficiencies as well,' she says. 'We know it takes time. You don't do these things sustainably over a very quick period of time. The experience in Seattle shows that this can take years to really embed.'

The selected trusts are being supported by the Virginia Mason Institute (VMI), set up by Virginia Mason to support the application of its approach across other healthcare bodies. They receive intensive training in the method and support from a VMI 'sensai'. But the aim is for the trusts to be able to deliver the training to their own staff and build a sustainable culture of continuous improvement.

Dr McLean admits that 'over time it is hoped the NHS cohort can help others to learn from them' – becoming exemplars of the approach. However the five trusts are not the first to adopt the Virginia Mason methodology in the NHS.

A previous system-wide partnership in the North East was set up in 2006. Although it was hampered by some structural changes when the strategic health authority was abolished, a number of local organisations have had success with the system. Tees, Esk and Wear Valleys NHS Foundation Trust is one example (see *Healthcare Finance* September 2013, page 13) and the North East System Transformation team continues to be hosted by Gateshead Health NHS Foundation Trust.

Dr McLean says other trusts around England have also worked with Virginia Mason – including Western Sussex, which recently became one of only three acute trusts to be rated as outstanding by the Care Quality Commission - or have used the approach to some extent.

A recent King's Fund report – *Improving quality in the English NHS* – called for a 'coherent and integrated strategy' on quality improvement. This would need capability to be built in all NHS organisations with support provided regionally and nationally. The NHS Improvement programme may not deliver at this scale, but it is a good step in the right direction.

The RPIW on theatre list order changes was a direct reaction to the realisation that about 80% of the operation scheduling team's time for these procedures was taken up with dealing with patient cancellations – often in the week running up to the scheduled procedure. This would leave the scheduling and pre-assessment teams making multiple calls to line up a replacement and sort out the necessary pre-assessments.

In some ways, this wasn't surprising given the process in place. The decision to operate would be taken at an outpatient appointment, at which point a patient was put on the inpatient waiting list. This then effectively became an administrative task of finding an available timeslot that complied with national referral-to-treatment targets.

Adhering to internal policies, a letter was then sent to the patient three weeks before their operation date. For many patients this was simply too little notice, leading to cancellations in some 10% of cases.

### Consultant diaries

One of the ideas hatched in the RPIW that the improvement team was keen to test was for consultants to take their surgery diaries into outpatient consultations and to give patients a date for their operation immediately.

This has been a significant success. Patients are now typically getting six weeks' notice and of 120 patients 'dated' by the beginning of May, 39 had had their surgery and just three had cancelled. Building slowly, the approach has been rolled out to involve nine consultants.

This small change has already had a major impact on the scheduling team. With list churn minimised, it is now spending just 10% of its time on rescheduling patients. This frees up time to spend more proactively preparing surgeons' diaries ahead of outpatient clinics. And the scheduling team can also pay more attention to future lists. Draft lists reflecting the proposed optimum order are put together by the scheduling team and then reviewed

Leeds Teaching Hospitals NHS Trust's Chapel Allerton Hospital

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Improvement work led to seven trays of surgical instruments in theatre for knee replacements (left) being reduced to four (below), and work is under way to create a single instrument pack for a given procedure

by the relevant surgeons and anaesthetists a week, or even several weeks, in advance. This leads to patients being allocated in advance more definite timings for their time in surgery, which can have major implications for the fasting regimes that patients have to follow.

'Previously, people might have been asked to fast from the evening before an operation but not operated on until the following afternoon,' says Helen Gilbert, Leeds Teaching Hospitals' kaizen promotion officer, who is leading the improvement work.

'Now a patient may be able to have a light meal the evening before or a drink of water in the morning if they are guaranteed to be the last on the list.'

This not only impacts on patient experience but can help recovery time, if patients avoid unnecessary dehydration.

The team is now looking to progress further improvements. For example its aspiration is to undertake patient pre-assessments on the same day as the outpatient appointment at which the decision to operate is taken.

To take this forward, the trust needs to find a fixed location to do the pre-assessment, but a half-way house has seen patients leave their hospital outpatient appointment with both a date for surgery and for their pre-assessment.

There may have been financial benefits from the work – avoiding spaces in theatre lists due to cancellations – and reassigning staff onto more value added work. Certainly the volume of activity has increased.

But Ms Gilbert stresses that this is not the goal. 'Our philosophy is that cost improvement is a consequence, not the point of our work,' she says. 'It is about spending the money we have more wisely.'

**"Cost improvement is a consequence, not the point. It is about spending the money we have more wisely"**
**Helen Gilbert, Leeds Teaching Hospitals**

This 'quality first' approach is underpinned by deliberately keeping the improvement work separate from the trust's cost improvement programme. 'We haven't had a CIP target imposed on us,' she says – an approach that appears to have been adopted across other trusts in the programme (see box page 24).

If cost savings are identified and delivered, they may contribute towards a unit's cost improvement target – but that is not the over-riding goal.

## Inventory focus

A second RPIW in March looked at theatre inventory for total hip and knee replacements, including the implants, theatre trays and loan kit. In particular it aimed to examine the potential for rationalisation of the various instruments used and to reduce the time taken to get these instruments ready to use for each operation.

The RPIW was instrumental in helping different parts of the theatres' team to understand each other's roles and to challenge parts of the process. For example, there was little awareness among the surgeons that picking the surgical instrument trays (seven in total) along with additional individual instruments to meet the needs of the surgical team took nearly 20 minutes. Preparing those trays and instruments for use – opening packs, counting the instruments in and quality checking – took a further 29 minutes.

Yet orthopaedic surgeon Campbell Maceachern admitted that 'some of these instruments I have never seen before and wouldn't know what they were used for.'

Theatre staff reviewed the instrument requirements of all the surgical team and specified new trays – reducing the number needed from seven to just four. And then the stock room was redesigned, creating dedicated aisles for different procedures along with a 'basics' section.

These combined actions slashed the tray

Leeds improvement teams at a recent 'report out' with Julian Hartley (centre) and Helen Gilbert (right)

## Find out more

NHS managers can hear more about the Virginia Mason story at an HFMA value masterclass on 17 June. The masterclass will focus on outcomes for patients and populations and be addressed by Suzanne Anderson, executive vice-president, Virginia Mason Health System, and president, Virginia Mason Medical Center. It is open to finance director and chief finance officer members of the HFMA Costing for Value Institute, with members also eligible to bring a clinical colleague with them. For more details visit **www.hfma.org.uk/education-events/**

picking time by 19 minutes – with just 55 seconds now needed to select the right trays. Preparation time has also been cut by more than 20 minutes.

More ambitious plans to create a single instrument pack for a given procedure are under development – the necessary instruments are not all available currently from the same supplier.

With theatres being one of hospitals' most expensive resources, reducing turnaround time between patients is a valuable prize – which ultimately could enable more patients to be treated within the same session.

There are quicker paybacks too. There could be a saving in the instrumentation the trust needs to stock, but certainly in its sterilisation costs, which have already been reduced.

Once the process is locked down – the focus to date has been on the use of one particular knee joint – then it can be applied more widely across orthopaedics, and then lessons learned across other surgical departments.

## Challenging agenda

There are challenges. While the improvement work (at Leeds and elsewhere) may not operate under its own cost improvement targets, it is not immune from the current financial challenges.

Staff at the Leeds report outs talked of the time pressures. One spoke of their frustration about not being able to advance the improvement work faster because of the pressures of 'the day job'.

The current financial climate does not allow for backfilling of staff tasked with the improvement work. And while the eventual plan is for the Leeds Improvement Method to become business as usual, for now there remains a steep and time-consuming learning curve for all staff.

IT is also a common obstacle – or lack of relevant data to inform optimum decision-making. Some changes will inevitably need capital or revenue investment, which can be difficult in a climate of significant cost improvement requirements.

And inevitably some staff will be opposed to the changes that will emerge from the process, even if these might be short-lived.

Both Ms Gilbert and Mr Hartley accept these challenges, but say that moving to a rigorous system of continuous improvement is simply the right thing to do. And the Leeds Improvement Method is not about quick fixes, it is about introducing sustainable improvements. These improvements may take years to materialise in some areas or in terms of some national indicators, but it makes sense to start the journey as soon as possible.

## Discipline is the key

'We didn't want to apply for the Virginia Mason initiative because we thought we should,' says Andy Hardy, chief executive of University Hospitals Coventry and Warwickshire NHS Trust – one of the five trusts selected to demonstrate how the continuous improvement methodology can be applied in the NHS. 'We'd already launched a five-year organisational development strategy in 2014 called *Together towards world class*.

'There are two streams – covering patient experience and services – which fit perfectly with the Virginia Mason aims. And we reasoned this could help us get there quicker.

'We want to be the best we can be and this gives us a set of tools to do that,' he says, identifying standardisation of processes as crucial to the elimination of waste and potential harm.

'Discipline is the really key word – doing things as you planned, as you said you'd do them and in a defined way.'

Initial work has focused on ophthalmology, with two rapid process improvement workshops looking at the booking of outpatient appointments and at how clinics are run.

The first has resulted in a 'massive change', with the 'complete removal of partial bookings' – patients now leave clinics with follow-up appointments booked in. 'This is great for patient experience, eliminating the potential for people to be lost in the system, and led to efficiency on staff side.'

The subsequent RPIW looked at how clinics are run and has led to standardisation on how they are set up and the numbers of patients seen, as well as requiring all patients to be booked in.

**"You can't do everything at the same time; you do things steadily and let it build"**
**Andy Hardy**

Mr Hardy acknowledges that some clinicians – those not directly involved in the RPIW – have kicked back against some changes. 'We were told to expect that,' he says. 'You just need to work through it – we are doing this because it is best for patients.'

As with Leeds, UHCW's approach is to keep the Virginia Mason work separate from cost improvement programmes.

'Virginia Mason chief executive Gary Kaplan talks about how the path to low-cost healthcare is the same path to high-quality healthcare,' says Mr Hardy. 'And we have deliberately not attributed any cost savings to this programme, although we know it will drive efficiencies.'

But if the improvement work identifies savings that can be realised, service units can use these against their cost improvement targets. 'It is that way around,' Mr Hardy says.

The trust has three value streams – ophthalmology, incident reporting and theatres – and expects to undertake six or seven RPIWs this calendar year, spreading learning across the trust where it can. Other areas are keen to get involved, with services such as maternity pitching to be the next value stream.

Mr Hardy says: 'A clear message from Virginia Mason is that it is very disciplined. You can't do everything at the same time; you do things steadily and let it build. At the end of five years, not every part of the hospital will have been directly involved, but every part of the hospital will have been affected.'

# How much is financial stress costing the NHS?

by Neyber Co-founder Monica Kalia

At Neyber we have just released the findings from our groundbreaking new report, "The DNA of Financial Wellbeing", which puts the financial wellbeing of the UK's workforce under the microscope. The wide-ranging survey of 10,000 UK employees (including over 1,000 health and care services employees) has examined, for the first time, what the financial impact is on organisations whose workers are worried about their own personal finances.

We found that although financial stress is impacting workers across the UK, regardless of industry, region and age group, one of the sectors most badly affected is health and care services.

In line with the recent report by the Royal College of Physicians (RCP), entitled "Work and wellbeing in the NHS: why staff health matters to patient care", which set out why it is in the best interests of both patients and NHS organisations for the health, wellbeing and engagement of the NHS workforce to be prioritised, our findings highlight that action in this area is a financial imperative.

In an era where budgets are hard to balance, as much as 14% of payroll spend is being wasted due to lost productivity, absence and the stress related illness that results from financial stress. All this adds up to a substantial cost for employers to bear. We have calculated that the lost productivity and increased absence and employee turnover associated with financial stress costs UK employers in the region of £120.7 billion every year.

We estimate that 68% of NHS staff are affected by financial stress, with a staggering 91% of those on a salary of £30,000-£39,000 admitting that they have been impacted in the past 12 months. The majority of workers (53%) said that being under financial pressure affects their ability to perform their job, rising to as much as 71% for 18-24 year olds.

Our findings also underlined the lack of a savings safety net should health workers face any unexpected financial outlays. For example, 36% of those in England have less than one month's savings to sustain their lifestyle should their income cease.

There's no doubt the figures are very worrying. But they also present a vital opportunity for us to begin to address individuals' need for greater financial resilience and provide the support they need to achieve this. The good news is that the majority of health and care services workers (58%) would value their employer facilitating support to help them improve their financial situation, and in turn their health and productivity.

# Stepping up

**Finance directors have a key role to play in NHS transformation and Future-Focused Finance wants to ensure aspiring directors get the right support to step up when the time comes. Steve Brown reports**

The NHS is looking to transform healthcare services so that they remain sustainable within finite resources in the years and decades to come. But it also needs to deliver service and financial targets in the short term. Taken together, these challenges make finance director roles some of the most important to the continuing success of the NHS.

There have been concerns in recent years about shortages of candidates for some finance director roles – particularly in some of the more challenged health economies – or about the shortage of experience among candidates. So what is the finance function doing to ensure it has the right people ready to step into these roles as the opportunities arise?

Enter the Future-Focused Finance initiative. As part of its 'Great place to work' work stream, it is looking specifically at succession planning in NHS finance and in particular how it can ensure staff arrive at their first finance director position armed with the right skills and experience to do the job – and give their employer confidence they will be able to do it.

Karen Berry, director of finance and information at Lincolnshire Partnership NHS Foundation Trust (right), is examining how the function can do more to enable mobility for finance staff as they navigate their careers. There has been a long-held perception that finance staff can get stuck in sector-specific tracks – certainly in England.

So someone working in commissioning finance will stay in commissioning finance – partly because providers might be looking for provider specific experience to appoint at any senior level, let alone finance director. But finance staff can also get stuck in tracks within their sector – so a costing accountant won't be exposed to a broader financial management role, for example. Secondments are one way to fix this. As long ago as 2009, in an HFMA survey of aspiring leaders, deputy finance directors were calling for secondments to fill a perceived experience gap – both to gain experience of different sectors and to gain a more strategic focus. But secondments that do take place seem to do so on an ad hoc basis.

As part of its work on succession management, FFF has looked at how it might support and encourage secondments. But it has had to refocus from its original target – deputy finance directors – to slightly less senior staff. 'We've found that directors can be reluctant to let deputies go on a secondment – nervous about the impact of losing such a key member of staff temporarily, or perhaps even permanently, and of who they might get as backfill for the position,' says Ms Berry. She believes organisations can manage their staff development so that they don't become so dependent on individuals.

At the Lincolnshire trust, for example, there has been a deliberate attempt to make no-one indispensable. This has involved shadowing of roles and detailed descriptions of each role and tasks undertaken. This makes it easier to fill vacancies as they arise and tackles concerns about how a role might be filled if someone did leave or take a secondment.

Ms Berry also believes recent developments in the NHS have created a more secondment-friendly environment. 'While in principle we support secondments as an excellent way to develop staff, in the past there might have been suspicion about a provider taking in someone from its main commissioner or vice versa,' she says.

SHUTTERSTOCK

This could mean they get 'inside knowledge' of local costs, for example, which might lead to additional pressure in local contract negotiation. 'However the sustainability and transformation planning process is changing this,' she says. 'All the place-based systems of care work is pushing people to work together and across organisations. In Lincolnshire, for example, we have a system-wide approach including open book accounting that's helping to reduce those barriers, so it removes any suspicion that people might have about one side hiding something from another. We need to take this opportunity.'

FFF has supported a secondment pilot in Yorkshire and is aiming to start a further pilot supporting more junior staff, with shadowing and buddying opportunities across Yorkshire and the North East. This second pilot will provide a taster of different roles and functions.

Having spoken to all finance directors across the county about the secondment work, and realising it would be difficult to get off the ground at the deputy level, the focus moved more to facilitating movement for finance staff around the band 7 to 8b level.

## Secondment support

Cathy Kennedy, deputy chief executive and chief financial officer at North East Lincolnshire Clinical Commissioning Group, has led the FFF 'Great place to work' work stream since its inception (see p32). 'It wasn't straightforward identifying the opportunities or the candidates,' she says. 'But with the help of Finance Skills Development, we were able to put together five secondment opportunities and identify a further four that were already underway.' These opportunities were to fill vacancies, to cover for maternity leave and for a couple of fixed term projects.

FFF has asked CIPFA to review the pilot but says the anecdotal assessment is that the pilot has gone well. 'We have had a project manager supporting us and we have stayed in contact with the secondees – and the response has been positive,' says Ms Kennedy. 'Now we want to look at it in more detail.'

She acknowledges that the releasing organisations may feel they get the least out of secondments. She recognises that a secondment may lead to someone actually leaving an organisation or accelerating their departure, but she says many also see the advantages.

**"We have had a project manager supporting us and we have stayed in contact with the secondees – and the response has been positive"**
**Cathy Kennedy**

'Some organisations are keen,' she says, 'because they recognise they have a static workforce. They can see the benefits for the individual in seeing other aspects of the system and when they do come back they often come back with new ideas that will benefit their own organisation.

'There have to be benefits to these experiences,' she adds. 'Increasingly we need finance directors to be system leaders and it has to be harder for them to do this – or for others to believe they are capable of doing this – if they have only worked in one sector.'

Ms Kennedy is also keen to provide support directly to deputies. 'Often the deputy role faces internally so it can be unusual at that point to gain good system exposure. Yet we then expect these same candidates to move into roles where a system focus is one of prime requirements.'

This view is backed up by a new survey by the HFMA on behalf of FFF. Early results from this work reinforce the idea that it is the broader competencies needed to be a director – not technical skills – that most aspiring finance directors think they do not pick up automatically as part of their progression through finance. There are clear concerns about the relative lack of system leadership opportunities. And more than 60% of aspiring directors see this gap in their competencies as having a significant impact on their career progression.

The survey also underlines that respondents see secondments and shadowing – alongside coaching and mentoring – as having the most potential to help them fill this gap. FFF is currently analysing the findings of this further research before deciding its next steps.

# Internal affairs

Nottingham University Hospitals NHS Trust has taken an innovative approach to talent management, succession planning and staff development. The finance department is committed to ensuring its staff are exposed to as many aspects of finance as possible. It has started its own graduate training programme this year with four graduates signing up to a two-year programme. The graduates will rotate every six months across four different business areas – financial management, financial accounting, corporate and strategy and business development and planning.

'We started the programme at the beginning of the year,' says Joanne Brewin (inset), head of financial management at the trust. 'The idea is that we are "growing our own", by training and developing our own staff. For individuals, we are hopeful that opportunities will emerge, and in turn, we will benefit from retaining the talent. While not guaranteeing jobs at the end of the programme, we are committed to the idea of adding value to the wider health economy by investing in managers of the future.' With 123 applications for the training places, the scheme proved popular.

The trust supports all its accounting students with training workshops on a wide variety of NHS finance and business issues, and encourages all staff to attend if they are interested. Ms Brewin says the finance department also attempts to use internal secondments to provide its staff with opportunities to broaden their experience. So if a role becomes available, its first thought might be to see if it would be appropriate for an internal secondment. 'We try to look at what our individual team members would benefit from.'

This is enhanced by a focused review and appraisal system, where all finance staff are encouraged to have a regular one-to-one meeting with their manager, at least once a month – with an extended meeting every three months to focus on progress with personal and business objectives. 'It is important to understand their aspirations and development needs,' she says.

These may range from technical skills to softer attributes. These non-technical skills – negotiating, for example – are particularly important for the business partnering approach being adopted to embed finance in the trust's operational functions. 'We have identified the competencies needed to undertake such a role,' she says, presenting them in an easy-to-read grid format. By comparing staff against these requirements, it hopes to provide a coherent way of prioritising both individual and team development needs for different staff members.

The next steps include the roll out of this process across other staff groups.

hfma

# professional lives

## Events, people and support for finance practitioners



# Call for salary sacrifice reviews

Technical update

NHS bodies should review salary sacrifice scheme arrangements to ensure compliance with new national minimum wage requirements. From April, the new national living wage was introduced for workers aged 25 and over. The rate of £7.20 per hour equates to an annual salary of £14,078, which is under the lowest salaries paid under Agenda for Change of £15,251 – pay point 2 of both band 1 and band 2.

For those aged between 24 and 16, the various national minimum wage rates apply.

Many trusts have introduced salary sacrifice schemes for employees – where the employees give up part of their cash earnings for non-cash benefits such as childcare vouchers or car hire schemes. It is these reduced earnings that would be judged for compliance against the national living wage requirements.

Although there appears to be a reasonable gap between the effective annual national minimum wage salary and the lowest Agenda for Change rates, it actually equates to less than £100 a month. With staff theoretically able to take up to £243 per month in childcare vouchers under a salary sacrifice scheme, there could be issues in some cases.

However, the potential problem goes further than workers employing salary sacrifice to the maximum level. It is also a potential issue for part-time workers – where the salary sacrifice deduction can have a greater impact, particularly if an employee reduces their hours after entering a scheme.

Compliance is also judged on a period-by-period basis. So while annual pay might average out above the required minimum rate, if it drops below the line for even one period then an employer could have problems – even with staff on higher pay rates.

The indications that the national living wage will rise to £9 per hour by 2020 – well ahead of the 1% rises for public pay in general – mean this could become an increasing issue for some employers – especially where employees have already entered, for example, a three-year car contract scheme.

The HFMA Accounting and Standards Committee has heard about one case where an NHS body has already had to stop a payroll payment at the last minute and reissue it without the salary sacrifice to ensure it did not breach the legislation. In this case, the system controls picked up the problem and action could be taken. But it is not clear if all NHS bodies' systems have similar controls.

NHS Employers has called on all employers operating salary sacrifice schemes to 'review their arrangements to ensure compliance with the new minimum income requirements.' On an ongoing basis, it suggests this should include monitoring:

- When an employee joins a salary sacrifice arrangement for the first time
- Where a new salary sacrifice scheme is introduced
- Each April when the national living wage rates are reviewed
- Each October when the national minimum wage rates are reviewed.

The consequences of non-compliance are significant. If a trust pays an employee below the new national living wage, it would be required to make up any shortfall and may be fined up to £20,000 by Revenue and Customs for each non-compliant employee. Perhaps even more damaging is the prospect of being named and shamed for such a breach and facing what is likely to be intense media scrutiny.

The Department of Health has issued the 2016/17 Group accounting manual (GAM)

## Pre-eclampsia test could reduce admissions

NICE update

NICE diagnostics guidance (DG23) considers the use of PlGF (placental growth factor)-based testing to help diagnose suspected pre-eclampsia.

There are about 664,000 births in England each year. Pre-eclampsia is characterised by high blood pressure (hypertension) and proteinuria, which occurs when the kidneys leak protein into the urine. If pre-eclampsia is not diagnosed and closely monitored it can lead to life-threatening complications.

The Triage PlGF test and the Elecsys immunoassay sFlt-1/PlGF ratio, used with standard clinical assessment and clinical follow-up, are recommended to help rule out pre-eclampsia in women presenting with suspected pre-eclampsia between 20 weeks and 34 weeks plus six days of gestation.

It is estimated that about 67,200 women with suspected pre-eclampsia are eligible for testing with the Triage PlGF test or the Elecsys immunoassay sFlt-1/PlGF ratio each year. Around 40,300 women are likely to be tested from year five onwards once uptake of the tests has reached 60%.

There is estimated to be a £7.3m saving from year five onwards comprised of a cash cost of £2.3m for testing equipment and a £9.6m non-cash-releasing saving due to a reduction in bed days from fewer admissions for monitoring where pre-eclampsia can now be ruled out.

## In brief

- **The Department of Health has issued new guidance for primary care staff providing healthcare to European Economic Area visitors, urging staff to help get money back into the NHS. It sets out the rules governing access to treatment and how to reclaim the costs – funds that will go back into frontline NHS services.**
- **The acute patient-level information and costing systems (PLICS) data collection will run from 1 August to 31 October. NHS Improvement said the timing had been moved by a month to allow time to complete the two mandatory reference cost collections first.**
- **The HFMA has produced two briefing papers – one on the disclosure of single total figures of remuneration; another on anticipated changes in reporting standards and guidance that may affect annual reports.**
- **The eMIT tool, which lists prices paid and use of pharmaceuticals by English trusts, has been updated to reflect data for the 12 months to December 2015.**

for consultation. Most of the manual is now applicable to all NHS bodies, the exception being Chapter 2 on the annual report. NHS Improvement will continue to issue separate guidance for foundation trusts on this area.

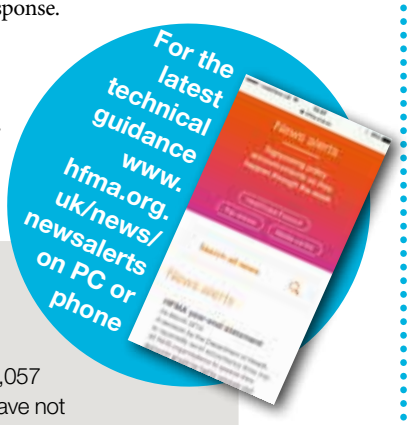
With no new accounting or reporting standards for 2016/17, the consultation focuses on how previously separate guidance is being brought together. Of particular interest to foundation trusts are changes in relation to:

- Directors' remuneration disclosures made under s412 of the Companies Act
- The use of a capitalisation threshold higher than £5,000
- The use of a market rate to measure fair value of future cash flows from financial instruments.

There are also changes to the guidance on the parliamentary accountability and audit report part of the annual report.

Consultation lasts until 1 July and the HFMA will be submitting a response. To provide comments, email debbie.paterson@hfma.org.uk

***This update was written by HFMA technical editor Debbie Paterson and Steve Brown***




There is no anticipated resource impact for commissioners. The standard antenatal maternity tariff of £1,057 will be paid for women who have not previously had pre-eclampsia. Women who have previously had severe pre-eclampsia will be allocated the intermediate tariff of £1,691 (2016/17 national tariff payment system).

**Nicola Bodey is senior business analyst at NICE**

# Diary

### June

7 (N) Workforce conference, Rochester Row, London
9 (B) West Midlands Branch: annual conference, Wolverhampton
13 (B) East Midlands Branch: team-building event, Beaumanor Hall
15 (B) South West and South Central branches: developing talent conference, Bristol
17 (I) HC4V: value masterclass with Virginia Mason
17 (B) Wales Branch: coaching, mentoring and problem-solving, Cardiff
22 (F) Commissioning Finance dinner, Stratford-upon-Avon
23 (N) Commissioning conference, Stratford-upon-Avon
24 (B) Wales Branch: coaching, mentoring and problem solving, North Wales
27 (B) Eastern Branch: personal development day, Newmarket
27 (B) East Midlands Branch: team-building event, Beaumanor Hall
28 (B) London Branch: annual conference, Rochester Row

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

### July

7-8 (N) Creating synergy, annual provider conference, Warwick
12-19 (B) Wales Branch: personal impact skills, across Wales
19 (B) Kent, Surrey and Sussex Branch: introduction to NHS finance, Crawley
21 (B) Yorkshire and Humber Branch: annual quiz
22 (B) Kent, Surrey and Sussex Branch: student conference

### September

9 (B) Yorkshire and Humber Branch: student event, Leeds
14 (I) Costing regional networking and training event
15 (F) Provider Finance: technical forum, London
15 (F) Commissioning Finance: forum, London
22 (F) Chair, non-executive and lay member: forum, London
29 (N) CEO Forum, Jim Mackey

### October

12 (I) International Symposium
20 (F) Provider Finance: directors' forum, London

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

**Event in focus**

## Step up, HFMA annual conference
**7-9 December, London**

The HFMA has confirmed Justin King (right), the former chief executive of Sainsbury's, as a guest speaker at its annual conference in December. The event, which takes place over three days, is the centerpiece of the healthcare finance year. Proceedings will begin with the HFMA Learning Lab – a series of workshops and opportunities to hear case studies of ideas put into action. Delegates will hear from leaders in health finance, from the UK and abroad, while the HFMA annual awards on 8 December will celebrate the contribution of finance to the efficient, safe and effective provision of healthcare. The association also reminded members that the special discounted rates for the HFMA annual conference ends on 30 June.

*Visit www.hfma.org.uk for details or contact camilla.godfrey@hfma.org.uk*

# Support in tough times

**Association view from Mark Knight, HFMA chief executive**

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

My HFMA

This month may be the most important in our country's history this century with the vote on 23 June on whether we stay in the European Union or not. Not surprisingly, the HFMA has a completely neutral position on EU membership and how you should vote. I'm sure you haven't come to this page to have me set out the arguments of this increasingly complex decision. The scale of victory by either side will be interesting – a narrow 'yes' may embolden 'no' enthusiasts to continue to make the argument; a narrow 'no' could lead to Europe making us another offer. It's hard to see where it will all end.

In matters closer to home, the Q4 provider figures for 2015/16 released towards the end of last month and featured elsewhere in this edition make grim reading and make you wonder about whether the NHS will break the departmental expenditure limit. We shall find out soon as the accounts have to be laid before Parliament before MPs' summer holiday in July.

We will shortly be producing our latest temperature check to review last year and what you think about this year's challenges. We've been meeting other organisations to reflect on what joint policy efforts we can make. It won't surprise anyone that funding is top on the agenda and the feeling that we are marching south in GDP terms from the heady heights of nearly 9% in the mid-noughties.

Our president's theme of 'Step up' is timely and apposite, encouraging members to seize the opportunities as finance remains front and centre of all the NHS does. To support members, we are once again launching free programmes exclusively for them. These are concerned with the development of skills such as negotiation and personal resilience. There are some national programmes and some that are being run by our colleagues in the branches.

In addition, to help support hard working finance staff out in the field, we are aiming to train 100 new mentors. This will provide participants with the skills to take back into their organisations to help staff who need support and development. There will be two parts to the programme – a day on the basics of how to mentor and what it is all about; and, for those who can afford a little more time, a second day when practical skills can be taught and mentors can have a go, albeit in a theoretical way. Nonetheless, it will be high-quality training provided by industry experts.


HFMA chief executive Mark Knight

To help members understand key issues and get up to speed, there are to be a series of webinars and roundtables. So our 'Step up' programme will provide something for everyone in the hope that we can help better equip members for the challenges that arise.

Finally, we will shortly be sending out subscription notices. The HFMA board has decided to allow members to pay by monthly direct debit and this will be introduced this autumn. It's a little more expensive than a £60 a year one-off direct debit fee as it will be £6 per month and £4 for the abated/student rate. However, we hope it may be more attractive to members who want to space out their payments.

## Member news

The HFMA is launching a webinar series to support this year's president's theme, *Step up*. 'Creating value for your organisation' (24 June) and 'Time to step up' (30 June) are the first two, examining areas such as best use of support and career development. Access the webinars via www.hfma.org.uk

The 'Train the trainer day' (pictured), hosted by the HFMA at East Kent NHS FT as part of the trust's subscription to The NHS Operating Game, achieved a record 91% excellent feedback.

Your HFMA membership subscription is eligible for a tax-exempt benefit. You could either claim the exemption when completing your self-assessment tax return form or by contacting HMRC. Find out more at www.hfma.org.uk/our-networks/hfma-membership/faq

HFMA committee and special interest group new members:

- **Accounting and Standards Committee** Gerry O'Brien, Scottish Ambulance Service
- **Commissioning TIG** Louise Nunn, NHS England (Yorkshire and Humber); Karen Parkin, NHS Wakefield CCG
- **Governance and Audit Committee** Paul Tiffen, NHS Protect; Claire Mellons, EY
- **MH Steering Group** Mandy Pady, Abertawe Bro Morgannwg UHB; Suzanne Robinson, North Staffordshire Combined Healthcare NHST; Graham Wareham, Surrey and Borders Partnership NHS FT
- **Environmental Sustainability SIG** Kevin Hewings, Community Health Partnerships; Jo Dolby, Leeds Teaching Hospital NHST; Laura Roberts, Gloucestershire Hospitals NHS FT

## Member benefits

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

## Branch focus

My HFMA

### London Branch
**Capital events**

With its next branch annual conference around the corner, the London HFMA branch committee is preparing to welcome more than 100 delegates who will have the opportunity to network, learn and share best practice with colleagues working in the capital.

The topic is 'The model hospital', inspired by the recommendations in Lord Carter's report to 'develop a model NHS hospital to help providers aspire to best practice across all areas of productivity'.

'We are hoping to achieve a much greater awareness around the key topics being discussed,' says Malcolm Hines (pictured), chief financial officer and deputy chief officer at Southwark Clinical Commissioning Group, who is also treasurer of the branch.

'We also want people to go back to their organisations and say: "The HFMA has run a really good conference – you should join and come to more of the events it organises". It is only through getting involved that people get to network more, make new friends and find out about new topics. They can then apply that knowledge in the workplace.'

Places for the event on 28 June can be booked through the branch page on the HFMA website.

Last year the branch hosted a successful event – 'Improving quality and productivity: challenges and solutions in managing temporary staffing' – in partnership with the Health People Management Association. The demand was so high that the committee has decided to run the event again in September.

Students have a special place in the branch. They are encouraged to set up and run their own training and support networks. Its student conference took place in March and speakers ranged from Alison Campbell, leadership associate at the King's Fund, to Richard Alexander, director of finance, Imperial College Healthcare NHS Foundation Trust.

Social activities such as quiz evenings and football tournaments are also a regular feature of the branch schedule. 'They are about getting people together and giving them a platform to both talk about professional issues and to get to know each other so that they've got people they can turn to when they need help and advice or just need to talk things through,' Mr Hines adds.

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**West Midlands** clare.macleod@hfma.org.uk
**Yorkshire and Humber** laura.hill@hdft.nhs.uk

# Appointments

**John Yarnold** (pictured) is the new interim director of finance at Homerton University Hospital NHS Trust. He has 40 years' experience in the healthcare industry and has spent 24 of them as a director. He has worked in a number of hospitals in North West London, Plymouth Area Health Authority, Plymouth Hospitals NHS Trust, at the Department of Health on secondment and NHS Gloucestershire. More recently, he has undertaken a number of assignments in acute trusts in London and the South West, including project director for the *Building world class finance* initiative in Imperial College Healthcare NHS Trust and project lead for the efficient systems and processes work stream as part of the FFF initiative. Mr Yarnold succeeds **Matthew Metcalfe**, who was appointed on an interim basis in April last year.

**Julie Lawreniuk** (pictured) has been appointed chief finance officer at Bradford City and Bradford District clinical commissioning groups. She was previously chief finance officer at Calderdale Clinical Commissioning Group and Greater Huddersfield Clinical Commissioning Group. She succeeds **Jane Hazelgrave**, who is now director of finance at The Mid Yorkshire Hospitals NHS Trust. **Lesley Stokey** is now acting chief finance officer at the Calderdale and Greater Huddersfield CCGs.

**Jonathan Dunk** is now chief finance officer at Cambridgeshire and Peterborough Clinical Commissioning Group. He was previously director of finance at Milton Keynes University Hospitals NHS Foundation Trust. He is succeeded by **Sophia Aldridge**, who was previously interim director of corporate affairs at the trust.

**Neil McDowell** has been named acting chief finance officer at Wandsworth Clinical Commissioning Group, following Hardev Virdee's move to Central and North West London NHS Foundation Trust.

**Mark Youlton** (pictured) has been appointed chief officer at East Lancashire Clinical Commissioning Group, and replaces **Dr Mike Ions**, who retired at the end of March. Mr Youlton was previously chief finance officer and deputy accountable officer at East Lancashire CCG. He has held a number of finance posts over a 32 year career within the NHS in Lancashire. **Kirsty Hollis**, previously deputy chief financial officer at the organisation, is now acting chief financial officer. She has worked in the NHS for over 25 years. Ms Hollis is also an assessor for the North West FSD Network's *Towards excellence* programme.

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

"I am pleased to be coming back to my old stomping ground – back to where I started as a trainee"
**David Jago, Wirral University Teaching Hospital NHS Foundation Trust**

# Jago returns to Wirral as finance director

**On the move**

A return to Wirral University Teaching Hospital NHS Foundation Trust is something of a homecoming for David Jago. It was where his NHS finance career started as a graduate trainee for the then Mersey Regional Health Authority, rising through the ranks to assistant director of finance. He has spent 14 years of his career in the organisation and, from the beginning of June, he returns as the trust's new director of finance.

'I am pleased to be coming back to my old stomping ground – back to where I started as a trainee,' he says.

'It is a strong, clinically led organisation. I have long held the view that Wirral always had the ability, working with commissioners, community and social care, to pull off the collaborative work that needs to take place in the health and social care system.'

Now it is poised to harness that potential, he believes. 'Wirral's vision and its key strategy around its clinical models and service performance; its potential collaborative working with the South Mersey Acute Alliance, with the Countess of Chester and with Wirral Clinical Commissioning Group on the Healthy Wirral programme are key elements of its plans that really excite me. I want to be part of supporting its delivery.'

It will be challenging – like many of its peers, the trust is in deficit. It ended 2015/16 with a £15.4m deficit and has agreed a breakeven control total for the current year.

Mr Jago says the trust has a clear programme for becoming financially sustainable 'The recovery plan is acknowledged as credible and robust and, in my role as director of finance, I want to ensure the organisation delivers that plan to NHS Improvement.'

He is realistic about what can be achieved in the short term, knowing that full financial recovery will take time, and he insists the collaborations with local organisations will deliver efficiencies. 'It is essential to bring services closer together and create a local health economy that can meet the financial challenges and deliver the high standards of care expected by the local population.'

The trust has improvement trajectories for referral to treatment and cancer waiting times and has recorded more positive results in the latest staff survey. 'We are heading in the right direction with a positive workforce, helping to deliver against the key challenges,' he adds.

Mr Jago moves from Liverpool Heart and Chest Hospital NHS Foundation Trust, where he was chief finance officer. Claire Wilson, who is currently chief finance officer at Bury Clinical Commissioning Group, will succeed him at the specialist trust.

He wants to bring his experience of service-line reporting (SLR) to the Wirral trust. 'One of my challenges is to enhance the existing SLR system to facilitate clinical engagement and, as part of our Carter work, to deliver efficiencies and drive out unwarranted variations.

'I think SLR is a key enabler of that and I want to build on what we achieved at Liverpool Heart and Chest.'

To begin with, this means introducing new governance processes and structures around the Wirral trust's SLR system and recruiting clinical champions to work with the finance team. He also wants to get the organisation to gold level on its materiality and quality score (MAQS).

Building on its high position in the recently published NHS England national digital maturity index, where it came fourth, is a priority. 'It will bring a range of benefits to staff and patients by streamlining processes and improving the quality and safety of care. I am looking forward to being part of a digitally-enabled organisation.'

## Kennedy ends FFF role

**Future focused finance**

Cathy Kennedy has stepped down as senior responsible officer for the NHS Future-Focused Finance (FFF) great place to work and value-maker action areas.

Ms Kennedy, deputy chief executive at North East Lincolnshire Clinical Commissioning Group, has been with FFF since it launched in 2014, leading initially on 'Great place to work' and establishing a group of volunteers tasked with developing 11 workstreams. More recently, she has also led on the value maker work.

She was the driving force behind moves to urge finance directors to sign a declaration of commitment to FFF. She has led the value-maker programme since last year, overseeing the second recruitment round, which attracted 62 recruits.

Bob Alexander, executive director of resources at NHS Improvement and chairman of the NHS Finance Leadership Council, paid tribute to her commitment to FFF in ensuring the interests of commissioning and commissioners were always strongly represented.

Loretta Outhwaite, chief finance officer at Isle of Wight CCG (pictured), is the new 'Great place' SRO. She said it was an honour to lead the action area and she was looking forward to building on Ms Kennedy's work.

'I'm very excited about the work the FLC has asked us to do this year to develop an aspiring finance director/chief finance officer network,' she said. 'As a former work stream lead for FFF's more diverse leadership, I'm passionate about increasing the diversity of the finance community and committed to us making significant progress in this area.' A new value-maker lead will be announced soon.

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# Working together to deliver on the Carter Recommendations

## The countdown to April 2017 has begun

Commissioned to address unwarranted variation in quality and financial management, the Carter Review of Operational Effectiveness puts pharmacy at the heart of NHS transformation. Recommendation 3 calls for Chief Pharmacists across NHS England to review current pharmacy operations to deliver long term sustainable strategies to enhance health and wellbeing, while improving quality and financial stability. Celesio has the experience and capabilities to support your NHS Trust throughout this transformation.

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