healthcare finance

April 2016 | Healthcare Financial Management Association

www.hfma.org.uk

Setting the standards

Patient-level costing approaches key milestone

A game-changer for NHS finance

Efficiency savings are the name of the game in the NHS.

Ensuring your people understand how the money flows, how services are paid for and how to obtain the best value is therefore crucial if the best financial outcomes are to be achieved.

The Operating Game enables you to do just that.

It's a highly effective, interactive training tool that transforms the way clinicians and non-clinicians interact in their daily decision-making, increasing financial awareness through the power of game-play.

The board game is team-based, enabling players to solve problems and respond to typical workplace scenarios together so they can be more effective in their day-to-day roles.

It's a real game-changer that can help build a more sustainable, effective NHS for the future.

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

Patricia McAuley
Programme Co-ordinator
Health Education West Midlands

To find out more call **0117 938 8358**
or email **alex.wood@hfma.org.uk**

hfma

Contents

April 2016

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

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

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

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

Subscriptions and membership
Sally Oakaby
0117 938 8343
sally.oakaby@hfma.org.uk

Production
Wheal Associates
020 8694 9412
kate@whealassociates.com

Printer
ESP Colour Ltd

HFMA
1 Temple Way,
Bristol BS2 0BU

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

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

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

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

ISSN 1472-3379

News

Comment

Professional lives

Page 12 **Manchester rising: an insight into how devolution is progressing in the northern capital**

Features

hfma

HFMA South West Branch
Annual Conference 2016

Now open for bookings
20% discount to members

Thursday 22nd - Friday 23rd September 2016
The Bristol Marriot Hotel City Centre

Speakers include:

Clifford Mann, President at the Royal College of Emergency Medicine
Cormac Torbin, Managing Director of Celesio
Shahana Khan, Director of Finance at George Eliot Hospital, HFMA President
Simon Weston, OBE, CBE, Falklands War Veteran

HFMA ANNUAL
CONFERENCE 2016

hfma

Step Up!

7th - 9th December 2016
Hilton London Metropole

Contact **Camilla.godfrey@hfma.org.uk**
for further details

New look for www.hfma.org.uk

The HFMA launched a new look website last month. The revised site aims to raise the profile of – and provide fast access to – the HFMA's extensive range of policy and technical work.

Visitors can simply look at the full range of the association's work – from guidance and briefings, through events and e-learning and onto news and analysis. Or they can choose what the HFMA has done in a specific area – 11 categories include governance and audit, payment systems, financial management and costing.

The overall aim is to make the range of work more visible. So when a visitor accesses a specific page – looking at a publication or news story, for example – they will receive suggestions of other HFMA work or news that may be of direct relevance and interest.

The fully searchable site continues to provide a platform for the association's popular news alert service, while a new 'top stories' section will provide analysis of the week's events and a blogging area will provide a platform for views and opinions.

Some sections of the site remain for members only – with the same password details that worked with the old site.

News

Board view is key despite 'unusual' review of accounts

By Steve Brown

A decision by the Department of Health to send accounting firms into a sample of NHS organisations as part of 'additional due diligence work' on the annual accounts has been described as highly unusual by the HFMA.

HFMA policy and technical director Paul Briddock said the move 'doesn't seem to place much confidence in the assurance mechanisms already in place to ensure reasonable financial estimates and judgements are being made'.

Healthcare Finance understands that 20 organisations were identified to take part in the 'transactions review'. A letter to selected organisations said the exercise was about understanding the financial position of the whole Department of Health group, with a focus on 'ensuring that we understand that items have been treated consistently across the health group'.

The work was due to examine the application of accounting policies and to 'investigate various transactions where guidance could be misinterpreted or where assurance is needed that changes to guidance are being applied consistently across the group. The participant organisations were chosen to provide a 'representative view of the system'. And the Department said the purpose was to 'support the group accounts' and not to 'critique your local financial statements', which would continue to be audited in the usual way.

The move comes amid concerns that the Department is close to breaching its spending limit for 2015/16. NHS providers' quarter three figures suggested their combined year-end deficit could be as high as £2.8bn, compared with a control total of £1.8bn.

A January letter from Monitor and the Trust Development Authority (now merged into NHS Improvement) set out a series of measures that providers should consider to improve their financial positions. These included 'removing prudence' from the balance sheet, reviewing provisions and reviewing asset lives, which could have an impact on depreciation charges.

Some reports labelled the move as 'desperate' and a few finance directors suggested it sat uncomfortably with the requirement for finance directors to use their professional judgement in taking a view on provisions and other issues. It also follows concerns raised by an anonymous finance director in a letter to the Public Accounts Committee about finance directors being pressured 'into taking the wrong judgements'.

'Ultimately it is for the board of directors to make these estimates in the draft accounts, which are then assessed independently by auditors to ensure that they are reasonable and that the organisation's accounts properly reflect its financial position,' said Mr Briddock.

He added that the reviews could cause 'significant difficulties if differences of opinion arise and people feel that their professional judgement is being compromised'. 'Directors of finance and chief financial officers need to work within their professional boundaries and guidelines and use accounting standards appropriately when making financial judgements and estimates,' he said.

'In reporting their financial position, finance directors and their boards need to be completely transparent about any non-recurrent measures, and work closely with their auditors in the preparation of accounts. They should not be unduly influenced outside of that process.'

In wider media coverage, Sally Gainsbury, senior policy analyst at thinktank the Nuffield Trust, described the measures trusts are being asked to consider – such as 'being clever about when you book income and when you book expenditure' – as falling 'into the area of fiddles'.

In a statement to *Healthcare Finance*, she said: 'NHS finance directors know better than anyone that the sort of accounting manoeuvres that have been uncovered are simply not a sustainable long-term solution, particularly when the financial pressures on trusts are becoming greater by the week.

'Just last month, out of the blue the Budget added on what we estimate could be an extra £650m pension costs for the NHS in 2019/20. It is becoming increasingly unclear in this climate how the health service is going to be able find £22bn of efficiency savings by 2020.'

"This doesn't seem to place much confidence in the assurance mechanisms already in place"
Paul Briddock (pictured)

Warning over activity lag as underspend remains on track

By Seamus Ward

The commissioning sector in England will underspend by £500m in 2015/16, but a backlog in specialist activity could put pressure on referral to treatment targets and commissioner finances in 2016/17.

At the March NHS England board meeting, chief finance officer Paul Baumann said the month nine projected underspend was £413m, but at month 10 the forecast had improved to show an underspend of almost £440m in year. Once risks and mitigations were accounted for the figure rose to £478m.

'These are relatively small but welcome movements,' he said. 'Equally important is that the financial performance of CCGs and direct commissioners has been very stable following the in-depth review we undertook at month nine.'

He added that an early look at month 11 figures had shown the performance had continued, with a net £494m underspend after risks and mitigations.

Mr Baumann was confident the year-end position would be an underspend of about £500m. 'This is critical because it further strengthens our contribution to the strenuous efforts across the whole health economy to offset the position in the provider sector in 2015/16.'

NHS England chief executive Simon Stevens said commissioners received real-terms funding growth of £2bn in 2015/16, with £1bn immediately transferred to the better care fund. NHS England held back £500m 'as non-recurring but tightly managed underspend' to help the Department of Health offset rising acute trust overspends. This meant commissioners managed the year 'with less than £500m extra real terms purchasing power', said Mr Stevens.

He added that efforts to constrain demand were having some effect but lack of capacity in some specialties, including more complex surgery, meant a 'bulge' of activity would be pushed into 2016/17. This could be a big pressure on referral to treatment targets in 2016/17.

Mr Stevens insisted commissioners recognise this in their plans and that providers match this with capacity. If necessary, there must be 'an upfront discussion about alternatives to enable patients to get timely care', he added.

Mr Baumann gave a 'health warning' on the figures going forward into 2016/17 as much of the £500m potential underspend is non-recurrent. He said roughly £200m came from an underspend in legacy continuing healthcare

Month 10 position

NHS England's forecast of a year-end underspend of almost £440m includes:

- A forecast CCG overspend of £21m
- Direct commissioning underspend of £65m
- A £373m underspend in programme and running costs
- With technical and ring-fenced adjustments (£23m), the forecast outturn is £439.3m
- Risks and mitigations result in an adjusted forecast underspend of £479m at month 10
- 29 CCGs are forecasting a cumulative deficit, eight unplanned
- Emergency hospital admissions are up by 1.5% – less than commissioners planned for and funded at the beginning of the year
- Elective day cases are up 4.7% but elective inpatients down 1.9% in the year to date. This could push RTT pressures for complex surgery into 2016/17
- Inpatient bed days are 'flat-to-negative' despite delayed transfers of care and other flow constraints in the system.

Providers hit out at 'counter-productive' fines

NHS provider leaders have hit out at the 'short-sighted' system of fines that has seen providers pay about £600m in 2015/16, exacerbating hospital deficits.

Analysis by representative body NHS Providers revealed the £600m figure – an estimate of the sums withheld from providers for breaching waiting time and other key performance targets during the year.

This represents almost a quarter of the £2.8bn deficit forecast at quarter 3 across the provider sector.

In previous years, a number of commissioners chose not to levy fines or, where money was generated in fines, it was often reinvested back into providers to help them address the causes of the breaches.

However, NHS Providers highlighted changes in 2015/16 that have hit provider finances.

First, the ability for commissioners to waive fines was removed. And in January this year (with effect from October last year), commissioners were told the fines should be retained to improve their year-end position. This had resulted in increased provider deficits and delayed patient care, according to NHS Providers.

Hopson: 'Fining trusts for circumstances beyond their control is counter-productive'

'NHS trust chief executives tell us they are intensely frustrated by these fines and see them as short-sighted, counter-productive and reflecting a sense of denial about how serious the problems facing hospital, community, mental health and ambulance services really are,' said Chris Hopson, NHS Providers chief executive.

'Imposing fines or refusing to pay the full cost of treatment makes no sense at all in this situation and does nothing to address the underlying reasons for trusts missing their performance targets.

No-one is arguing that trusts should get a free pass – they should be accountable for how they perform – but fining them for circumstances beyond their control is counter-productive and leads to worse patient care and even bigger financial problems.'

The lobbying group called for system leaders to suspend fines for 2016/17.

"The financial performance of CCGs and direct commissioners has been very stable following the review we undertook at month nine"
Paul Baumann, above

claims, but these have to be funded over time. The funds set aside for continuing healthcare had been reduced in 2016/17, so there would be less headroom. Similarly, underspends in programme costs also contributed around £200m to the overall underspend, but there will be a 10% reduction in this budget in 2016/17.

The NHS England financial position had also benefited from unplanned rates rebates in 2015/16, but further rebates could not be factored into 2016/17.

Hamilton backs plans for NI structural reforms

By Seamus Ward

Northern Ireland health minister Simon Hamilton (pictured) has confirmed he intends to press ahead with the abolition of the Health and Social Care Board as part of 'ambitious and radical plans' to restructure local health and care services.

Following a consultation, he acknowledged there was concern about future responsibility for commissioning – only 24% of respondents agreed trusts were best placed to assess local needs and should be given greater responsibility for planning local services.

More than 60% of respondents said the proposed changes would not streamline and simplify the health and care system. The Department of Health, Social Services and Public Safety acknowledged there was insufficient detail in the consultation for respondents to come to an informed opinion and promised further stakeholder engagement. Almost nine in 10 respondents agreed that a full competitive commissioning system was too complex and transactional for an area as small as Northern Ireland.

Mr Hamilton believed the response to the consultation – which backed reducing complexity in the system, support for innovation and performance management measures – endorsed his case for implementing his reforms.

However, although he still wants trusts to take on more responsibility for care in their areas, he stepped back from the initial plan to give trusts responsibility for planning care.

He said: 'I am still convinced that we have too many layers of bureaucracy in our system. So, with the objective of eliminating bureaucracy and aiding innovation, I confirm that the board will go, with system-level strategic planning and decision-making for the bulk of health and social care services passing to the Department rather than our trusts.'

A directorate would be established in the Department to performance manage trusts and improve lines of accountability, he added. It would ensure they meet targets and that trusts take responsibility if they underperform.

However, with elections to the Northern Ireland Assembly scheduled for May, it is unclear whether the plans will be carried forward.

In March, Mr Hamilton announced two further initiatives – a £30m transformation fund and an e-health and care strategy. He said the transformation fund would boost innovation, prevention and collaboration. The e-health strategy will use £1m from the fund to develop an electronic health and care record.

Scottish boards get 5.5% boost

Territorial health boards in Scotland will receive a 5.5% resource increase in 2016/17, which will allow an extra £250m to be invested in the integration of health and social care and build the capacity of community-based services, the Scottish government said.

Health secretary Shona Robison (pictured) said the overall funding increase of £500m would take health spending in 2016/17 to almost £13bn. The 14 territorial boards will receive revenue uplifts of between 4.5% (Shetland) and 6.6% (Grampian). Eight special health boards, which include arm's length bodies such as National Services Scotland, will receive a total increase of 3.8%, with the ambulance service receiving the biggest rise (5.4%).

The funding for the integration of health and social care will be split between the new health and social care partnerships, launched in April.

Capital investment will increase by £292m to £495m, with £352m held centrally to support projects such as the new Edinburgh Royal Hospital for Sick Children. She said it would also allow work to begin on a network of diagnostic and elective treatment centres.

Ms Robison said the government was committed to transforming care.

'The integration of health and social care is the most significant reform of our health and social care services since the creation of the NHS and our investment of £250m will help health and social care partnerships improve people's experience of care,' she added.

News review

Seamus Ward assesses the past month in healthcare finance

Health news in March was dominated by a Budget that appeared to add costs to the NHS, concern over the year-end financial position of providers (see p8) and the ongoing junior doctor dispute. While health measures in the 16 March Budget appeared to focus on reducing child obesity and supporting some NHS children's services, chancellor George Osborne also increased employer contributions to public sector pension schemes from 2019. Figures from the House of Commons Library suggest this will cost the NHS an additional £650m a year.

Mr Osborne also announced the introduction of a sugar levy, as well as funding for school sport and after-school clubs. Funds generated by the LIBOR inter-bank lending fines will be used to support children's health services in Manchester, Sheffield, Birmingham and Southampton. Central Manchester University Hospitals NHS Foundation Trust will receive £1.1m, while £700,000 has been allocated to Sheffield Children's Hospital Charity for the provision of a helipad and a 3T MRI scanner, respectively. University Hospital Southampton NHS Foundation Trust will receive £2m to build a paediatric emergency and trauma department. Birmingham Children's Hospital Charity will be allocated £700,000 to support its fundraising to transform the hospital's eye department and create a centre for children with rare and undiagnosed conditions.

NHS staff across the UK received a 1% pay rise from 1 April after governments in the four countries accepted the recommendations of the health service pay review bodies. In addition, staff not at the top of their pay band will be eligible for increments. Those in Scotland earning less than £22,000 will receive a £400 top-up to their pay. In Wales, 7,000 of the lowest-paid staff will also get an uplift to account for the rise in the minimum wage from £7.85 to £8.25 an hour. This will be backdated to 1 January and the Welsh government estimated the total cost of the increases would be £40m a year.

The Department of Health said junior doctors in England will receive the 1% rise and this has been factored into the new contract, beginning in August. However, the doctors still oppose the deal. The British Medical Association said industrial action would escalate, with a full withdrawal of labour for 18 hours on 26 and 27 April in response to the government's decision to impose the new contract. The Department said the action put patients at risk.

The medical royal colleges called for the action and contract imposition to be suspended and for both sides to resume negotiations. NHS Employers published the new contract in March, with extended pay protection for some junior doctors. The BMA also launched its judicial review challenging the lawfulness of the decision to implement the contract without agreement.

The government desire for a move to seven-day services and how it would affect juniors' pay and working patterns underpins the dispute. The BMA believes more doctors are needed for a seven-day service and Royal College of Physicians president Jane Dacre raised concerns that trusts are struggling to fill existing physician vacancies and gaps in rotas were emerging. RCP research found four in 10 advertised vacancies were unfilled last year, while one in five consultants reported gaps in junior rotas.

Concern was also voiced over GP numbers. The Commons Public Accounts Committee called for a review of general practice in England amid concerns that recruitment and retention problems mean there are not enough GPs to meet demand. The committee said demand had outpaced capacity over the last decade and access was too dependent on where patients lived.

The month in quotes

'Operating theatres are expensive to run and there is a lot more health boards can do to ensure their theatre capacity is used efficiently and effectively. Achieving this will have benefits for patients and health boards with fewer cancelled operations and better performance against waiting time targets.'
Wales auditor general Huw Vaughan-Thomas

'There is a looming crisis in general practice. For too long staffing levels have failed to keep pace with the growth in demand and too little has been done to close the gap.'
Meg Hillier, chair, Commons Public Accounts Committee

'I feel sorry for NHS trusts, I really do. They have created a raft of new posts to meet the rising demands for patient care, only to find there is no one to fill them. If we have neither enough trainees nor consultants to run the service now, how are we going to implement a safe seven-day service?'
RCP president Jane Dacre

'As the largest employer in Europe, the NHS needs to practise what it preaches by offering better support for the health and wellbeing of our own 1.3 million staff. A good place to start is by tackling the sources of staff sickness absence, including mental health and musculoskeletal injuries, while doing our bit to end the nation's obesity epidemic by ditching junk food and sugary drinks in place of tasty, healthy and affordable alternatives.'
Simon Stevens, chief executive, NHS England

FLICKR

Southend University Hospital NHS Foundation Trust is to receive additional support to help turn around its financial position, Monitor said. Following an investigation into the trust's finances, the regulator said it was facing a £19.5m deficit. Monitor said the trust would set out how it will recover its position in the short and longer term. The trust has also agreed to develop an action plan to improve its cost recording following a separate investigation.

Two other FDs are to receive support to recover their financial position. Monitor said Liverpool Women's NHS Foundation Trust would need help to tackle its predicted £7.3m deficit. The regulator recognised the trust's work to address its financial problems, but support was needed to recover its position and continue to provide quality services to patients.

The regulator is also helping Doncaster and Bassetlaw Hospitals NHS Foundation Trust to improve its financial management and develop its long-term plans for financial sustainability. Monitor said the trust's financial position had deteriorated rapidly since last October, when it discovered it had incorrectly reported its financial position for at least 12 months.

The government introduced legislation to allow the Care Quality Commission (CQC) to raise fees for its comprehensive inspections. The decision follows a consultation that ended in February. The move will allow the CQC to move to a full cost recovery model from 1 April.

Funding of £10m will be available for the next stage of plans to transform urgent care in Scotland. The delivery plan will be published in the autumn, the Scottish government said, and build on work at eight pilot sites that are testing new ways of delivering out-of-hours services. The funding includes £400,000 for an out-of-hours technology system across Scotland.

The Department of Health has published guidance for clinical commissioning groups and NHS trusts on appointing auditors. From April 2017 the bodies must select their auditors and directly manage the contracts for their audits. The guidance is designed to help with the initial appointments, to be made by the end of this calendar year. It sets out the legal requirements, the National Audit Office code of audit practice and auditor eligibility and a core specification. There is also advice on procurement options and the use of frameworks.

There is 'considerable scope' for Welsh hospitals to improve theatre use, reduce late starts and minimise cancellations, according to a report from the Wales Audit Office. The report, *Operating theatres: a summary of local audit findings*, made a number of recommendations, including improving the reporting of theatre performance, greater visibility of theatre data and introducing a national forum for theatre improvement.

There were developments in *Five-year forward view* implementation. Details of 44 'footprint areas' where health and social care leaders, organisations and communities are being brought together were published. NHS England also announced moves to keep staff healthier – a key plank of the forward view. NHS providers will be able to earn a share of a £450m incentive fund by helping frontline staff stay healthy. NHS England chief executive Simon Stevens said they must offer these staff a range of support – offering workplace physio and mental health services; taking action on junk food on NHS premises; and increasing staff flu vaccine uptake.

in the media

A Commons Public Accounts Committee (PAC) report on the sustainability of NHS finances brought several requests for an HFMA comment. Policy and technical director Paul Briddock told *Hospital Doctor* the report echoed something the association had been advocating for some time – a recovery plan that was faster than the current rate.

Additional funding was welcome as it gave providers breathing space, but it did not provide solutions. This would only come through collaboration over a sensible timeframe and with realistic targets. The HFMA supported the PAC call for better data collection to inform more pragmatic target-setting and backed calls to solve wider workforce planning issues instead of the 'quick fix' of focusing on agency staff costs.

The HFMA staff attitudes survey was picked up by *Accountancy Age* and *Financial Director*. The latter reported the finding that only 5% of NHS finance staff feel appreciated by the public, but despite this 64% of NHS financial professionals wanted to spend the rest of their careers there. Mr Briddock told the publication: 'The need for talented finance staff to help their organisations deliver high-quality services with restricted financial resources has never been higher. In the midst of these financial pressures, those in the NHS finance function are dedicated and ready to meet the challenges head on.'

News analysis

Headline issues in the spotlight

Crunch time

A difficult financial year has come to an end, but there is plenty of debate about the year-end financial position and its causes, as Seamus Ward reports

The crunch financial year for the NHS has ended, but perhaps only now the fallout will begin as the true financial picture for 2015/16 emerges in the next few months.

With forecasts at the beginning of the final quarter pointing to a provider overspend of up to £2.8bn, the service had a mountain to climb to meet the £1.8bn deficit control total set by the Treasury for the NHS as a whole. So much rests on achieving this figure, including the service's ability to meet its 2016/17 control totals, and national bodies seem determined to pull out all the stops to make it happen.

For several months, Monitor and the NHS Trust Development Authority (the chief constituents of the newly launched NHS Improvement) have urged trusts to explore every legitimate avenue to reduce their deficits. These include technical measures such as accruals, bad debt provisions and capital-to-revenue transfers. But while no one would expect the general public to understand these technical measures, the mere mention is enough to arouse suspicion that the NHS is 'hiding' its true deficit.

This suspicion increased when it emerged that the Department of Health had decided to send 'small teams of accountants' to a number of trusts to examine their application of accounting policies and to scrutinise transactions to ensure guidance has not been misinterpreted.

The paradox of hiring external consultants when cost-cutting is limiting trust consultancy spending was not lost on finance managers.

In a letter to the trusts selected for the visits, the Department said that the purpose was to support its group accounts and not to critique the trust financial statements. These would continue to be audited by their external auditor.

However, suspicion remained – one commentator described the moves as fiddling the figures by, for example, booking income in 2015/16 and pushing expenditure into 2016/17. The HFMA said the additional due diligence was highly unusual and could cause significant difficulties if differences in opinion arise.

The financial difficulties enveloping the NHS – and the need for action – are not in dispute. But turnaround will be complex, a fact highlighted in a Commons Public Accounts Committee (PAC) report last month. The committee expressed its deepening concern about the financial future of the NHS and said it was not convinced the government had a convincing plan to close the expected £22bn efficiency gap over the spending review period.

Unrealistic targets

The requirement for trusts to make 4% efficiency savings across the board in 2015/16 was unrealistic and had done long-term damage to trust finances, the committee said. And it added that the reference cost data used by the Carter efficiency review to estimate trusts' potential savings was 'seriously flawed'. NHS Improvement must set out how it will work with trusts to improve the quality of cost data in 2016/17, it said.

All trusts in deficit should have realistic recovery plans in place by the beginning of the 2016/17 financial year, the committee said. And, as a matter of urgency, NHS England and NHS Improvement should set out how they will

Integrated opportunity

While NHS acute providers struggle to contain their aggregate overspend in 2015/16, the King's Fund believes they could avoid some costs through better integration of physical and mental health services. Lack of integration between physical and mental healthcare is costing the NHS £11bn a year, it said, and integration could improve outcomes for patients and save money.

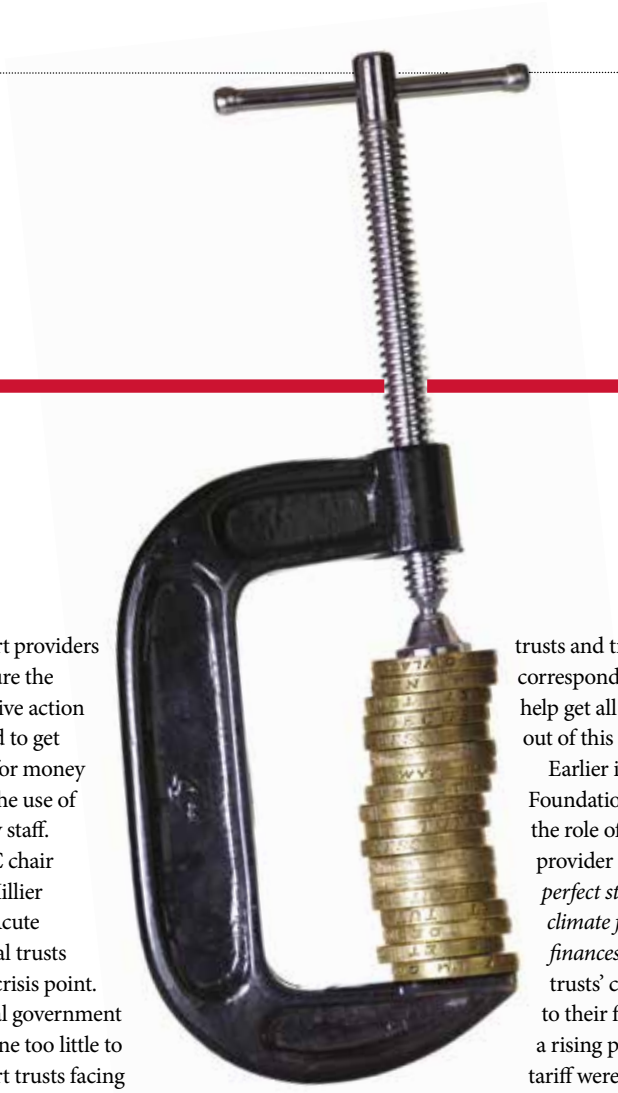
The £11bn cost is the result of several factors: high rates of mental health issues among patients with long-term conditions such as cancer and heart disease; limited support for the psychological aspects of physical health issues – for example, during and after pregnancy; and poor management of medically unexplained symptoms such as tiredness or pain with no obvious cause.

It added people with mental illness live 15 to 20 years less than the general population, largely as a result of physical ill health.

The King's Fund report, *Bringing together physical and mental health: a new frontier for integrated care*, identified 10 areas where mental health input could be enhanced in acute and primary care settings while also improving physical health assessments in mental health inpatient facilities.

Chris Naylor, senior fellow at the fund, said: 'Traditionally physical and mental health have operated as distinct, separate systems in terms of treatment and funding. That is no longer affordable financially or acceptable clinically. The government has set the goal of parity of esteem, meaning mental healthcare should be "as good as" physical healthcare. We argue that there is an even greater prize at stake – that mental health care should be delivered "as part of" an integrated approach to health.

'When we spoke to patients they told us they wanted to see healthcare professionals who recognised all of their care needs. What's more, at £11bn a year, the disconnect between treating physical and mental health is costing the NHS greatly and isn't meeting patient needs.'



SHUTTERSTOCK

"The 'front-loaded' investment will help but there must be concern over the back end of this parliament, when the funding increases will be much lower"

Chris Hopson, NHS Providers

support providers to secure the collective action needed to get value for money from the use of agency staff.

PAC chair Meg Hillier said: 'Acute hospital trusts are at crisis point. Central government has done too little to support trusts facing financial problems, with the result that overall deficits are growing at a truly alarming rate. Crude efficiency targets have made matters worse. Without urgent action to put struggling trusts on a firmer financial footing there is further serious risk to services and the public purse.'

She added that it was unacceptable for senior government officials simply to point to excessive agency costs as a source of trusts' difficulties; they must address the underlying causes.

'There is a long way to go before the taxpayer will be convinced that there is a workable and properly costed plan in place to secure the future of our health service,' she said.

The committee expects the Department, NHS England and NHS Improvement to report on progress in September.

System focus

NHS Providers chief executive Chris Hopson said the committee had echoed reports from the front line. 'This report confirms what our members have been saying for the past 18 months: the financial crisis in NHS hospitals and other providers is due to the fundamental mismatch between what NHS providers have been asked to deliver and the resources they have been given,' he said. 'It is not a function of the performance of individual foundation trusts and trusts. Therefore, we need corresponding system-wide action to help get all frontline NHS providers out of this crisis.'

Earlier in the month, the Health Foundation had also highlighted the role of system pressures in provider deficits. Its report, *A perfect storm: an impossible climate for NHS providers' finances?*, said pressures beyond trusts' control were contributing to their financial troubles. It said a rising pay bill and the national tariff were among the driving forces behind the overall deficit position in acute hospitals in England. Poor-quality care was often associated with deficits. Acute and specialist trusts found to be inadequate by the Care Quality Commission were more likely to be in deficit than other trusts.

Foundation research and economics director Anita Charlesworth said the NHS faced another five years of austerity. Productivity improvements were needed to ensure patient care did not suffer. 'The financial challenges facing our hospitals are not the result of weaknesses in the management of individual organisations,' she said.

'They stem from poor workforce planning and fundamentally an unrealistic expectation of efficiency improvement in the NHS. Providers are now between a rock and a hard place. Training places for nurses have fallen 20% over the last decade, while demand rose due to rising activity levels. Demand for nursing staff further increased in the wake of the Mid Staffs Inquiry. Far from mushrooming, nurse to patient bed day ratios have now only returned to 2011 levels and the need for staffing increases could have been foreseen.'

"Central government has done too little to support trusts facing financial problems, with the result that overall deficits are growing at a truly alarming rate"

Meg Hillier, Public Accounts Committee

Deficit warning

While the MPs on the PAC were putting together their report, their colleagues on the Commons Health Committee were hearing that it is unlikely trusts in England will eliminate their aggregate deficit by the end of 2016/17.

In evidence to the committee's inquiry on the spending review settlement for health and social care, NHS Providers said its current best estimate was that providers would reach the end of 2016/17 with an overall £500m deficit.

The evidence added that clarity was needed over funding for government policy commitments and it warned large-scale transformational change could take decades.

Mr Hopson acknowledged the NHS had received a relatively good settlement in the spending review, but added that it was in the middle of the longest and deepest financial squeeze in its history.

'The "front-loaded" investment over the next two years will help to ease the pressure, but there must be concern over the back end of this parliament, when the funding increases will be much lower,' he said.

The annus horribilis is over, although the final position remains on a knife edge, and 2016/17 looks brighter. Guidance and policy aim to rebalance trust finances – through the sustainability and transformation fund and a higher overall tariff uplift. However, finance directors will be nervous about their ability to recover their financial position while maintaining staff morale and the quality of patient services.

Comment

System solutions

The NHS needs to focus on whole systems not individual organisations

HFMA president Shahana Khan

A report on the sustainability of acute hospital trusts was published by the Public Accounts Committee in March. It was informed by an inquiry to which the HFMA gave evidence. It was great to be able to talk about how the financial challenges feel at the coal face and our regular temperature check results meant we could back up our comments with evidence.

There is increasing recognition that the problems facing the NHS – and pushing providers further into deficit – are systemic rather than due to the failings of providers.

Some organisations will have responded better to the pressures than others – and there remain significant opportunities to drive further efficiency and to spread best practice. But it is good to see recognition of circumstances the service already understands.

Efficiency targets have been unrealistic in recent years, the payment system needs an overhaul and wider workforce planning issues need to be resolved alongside measures already introduced to reduce agency spend.

We increasingly need to take a system focus – and fix the system – rather than expecting organisations to deliver against unrealistic individual targets. That is not to say the NHS and individual bodies shouldn't be challenged. We should. And the recent Carter report is a good example of an initiative that both challenges us and offers us tools to improve. But the challenges need to fair and the expectations realistic.

The sustainability and transformation planning process – and the work to establish health economy-wide footprints – demonstrates a sensible approach to work as whole economies to address the current challenges. We need to ensure that politics and 'old system think' does not

Costing is the plan

Patient costing can provide the 'where' and the 'how' as the NHS looks to improve value

Healthcare Finance editor Steve Brown

The Public Accounts Committee last month slammed NHS system leaders for having no 'overarching and convincing plan for where and how the £22bn savings needed by 2020/21 will be made'.

The 'where' and the 'how' are the key words. Identifying 'transformation' as a solution or insisting 'higher quality should be lower cost' is all very well, but it hardly pinpoints how organisations can first make the step change in value delivery and then continue to drive down costs.

There is, however, a tool that should help organisations do just that and this month it will get thrust back into the spotlight – as NHS Improvement's Costing Transformation Programme reaches a significant milestone with the publication of new draft standards. The PAC's missing plan could be as simple as prioritising the introduction of patient costing, using a common methodology.

To be fair, the importance of good cost data is not lost on the PAC. It raises concerns about the 'material inaccuracies' within reference cost data used to set savings targets for providers as part of Lord Carter's work on improving NHS productivity. But its view of

"We need to ensure that politics and 'old system think' does not get in the way of tackling some real knotty issues"

get in the way of tackling some real knotty issues.

Commencing local procurement exercises for local services at this time makes it difficult for stakeholders to work together, leads to less transparency and adds a further level of complexity into a process that will be complicated enough. Our system leaders will need to give a clear steer on this.

The planning guidance for 2016/17 and beyond hints at taking this system-wide approach to another level with NHS England and NHS Improvement identifying a willingness to explore a 'single financial control total across local commissioners and providers'.

In many ways this is appealing. How often has one provider's poor financial position been related to the underfunding of its commissioner, or a provider's poor finances undermined the performance of its commissioner? Yet this will not have stopped these organisations facing scrutiny or sanctions for issues partially out of their control. This often leads to inefficient spending to address short-term issues rather fix the long-term problem.

Taking a system-wide view has to make sense. We have been moving (slowly) towards a system based on complete transparency. Yet this is not always how things have worked, with central or local commissioner support for local providers – or different approaches taken on sanctions and incentives.

This has only masked the true underlying financial positions of organisations.

A system-wide approach would in theory enable a simpler approach with system-wide balance being the common goal.

Yet how would this operate? A system approach would require complete openness around shared data and a rethink of the contracting framework and tendering requirements. And what would happen to tariff?

And we mustn't lose the good work that has come out of the existing systems. The HFMA has a big role to play in helping to think through how such a system would work and what governance arrangements might look like. It is a major undertaking, but it must be explored – and soon.

Contact the president on president@hfma.org.uk

costing is as a way of improving the accuracy of these targets.

In reality, robust and detailed patient cost data not only indicates what is achievable, but tells you where to look and often how to achieve the improvement. If properly used, it should provide the foundation for continuous value improvement across the health service.

Clinicians like good cost data – a point likely to be made in NHS Improvement's *Case for change* publication this month (see page 16). But they often need convincing. After dealing with years of crude averages, clinicians are likely to start off disbelieving the data, challenging the overheads and pointing out every error.

Once a tipping point is reached, however – where cost differences reflect the treatment differences they observe between individual patients – they can become cost converts and the ones that drive the pace on costing improvement.

Addressing unwarranted variation is a big part of meeting the £22bn challenge. And patient cost data provides the microscope for first of all spotting variation (where it is leading to cost differences), considering its appropriateness and then drilling down into exactly where the variation is occurring.

Armed with this information, clinicians can change or refine clinical processes to optimise value. This can be informed by what is being achieved in other organisations, confident in the knowledge that cost differences are down to clinical processes, not costing methodology.

It is not just about being cheaper. A shorter stay in hospital that leads to higher readmissions is clearly a false economy, but you need accurate costs to understand how costs are driven across the whole pathway.

Cost data also needs to be at the heart of the transformation programme. The NHS cannot afford to enter into new ways of delivering services without understanding the impact on costs. That doesn't mean it shouldn't implement reforms just because the costs go up – again the decisions need to be about value measured in outcomes and cost. But it at least needs to plan for this impact – otherwise it will be firefighting financial problems for years to come.

There are two real challenges. The first is getting everybody on board. The NHS has made some good progress with patient-level costing over the past decade (see page 21), but it's been slow and patchy. Then it is about timescales. The ambitious NHS Improvement Costing Transformation Programme would see a first comprehensive (all sector) patient-level cost collection for 2020/21 data, with submission in September 2021.

"Patient cost data provides the microscope for first of all spotting variation, considering its appropriateness and then drilling down into exactly where the variation is occurring"

That may not be ambitious enough to make a massive contribution to the £22bn for all organisations. However, benefits should start to accrue from day one and can really accelerate once practices are embedded.

The NHS needs this more granular cost data. The centre, provider boards and NHS finance teams need to commit properly to the journey and then set a demanding pace to implement as quickly as possible.

SHUTTERSTOCK

Manchester rising

A recent HFMA event heard how Greater Manchester devolution is being put into practice. Seamus Ward reports

Built on the site of the Peterloo Massacre to commemorate the repeal of the Corn Laws, the Manchester Free Trade Hall (pictured) has been linked to many political and cultural events. A legendary punk gig held there is said to have spawned many of the city's best known bands and a heckler in its audience famously branded Bob Dylan 'Judas' when he went electric. Last month, plans for an overhaul of health and social care in the city were outlined at the venue – plans that, in time, could be viewed as equally significant.

The devolution of powers to Greater Manchester is well known. But with the project going live at the beginning of this month, the HFMA Provider Finance faculty conference gave a timely insight into how it will work and how it aims to improve the health and care of local people.

Katy Calvin-Thomas, Greater Manchester health and social care team director, said there were some obvious reasons for devolution, local decision-making being one. But her team wanted to make local health and care services clinically and financially sustainable. 'I'm not saying we couldn't do it without devolution, but it creates a real sense of control and being in charge,' she said.

Health and social care could also contribute to the wider local economy by helping people back into work. The local economy contributes around £20bn to the Exchequer, but consumes £27bn, including £6bn in healthcare spending that has now been devolved to the area. 'There is something about how we as a community get our economy back into balance,' she added.

Statistics made the argument for devolution compelling. More than two-thirds of local premature deaths are the result of behaviours that could be changed. And a fifth of 55- to 64-year-olds are out of work mostly due to ill health. 'If we could bring the employment rate up to the UK average, we would lift 16,000 children out of poverty,' Ms Calvin-Thomas said. Across the city, £1bn a year is spent on long-term conditions related to mental illness and life expectancy for this group is 10% to 15% shorter than the rest of the population. By 2021, 35,000 people will have dementia and just under a third will have severe symptoms requiring 24-hour care.

Ms Calvin-Thomas acknowledged that it could take 10 or 15 years to change some of these outcomes, but they could not continue providing services as they do now. She said: 'If you look at our outcomes for the last 10 to 15 years, they have not moved. They are still as bad as they were and we have got to do better.'

But in addressing some of these issues, local health and social care bodies would have to take a more holistic view that cut across organisational and sector boundaries.

She acknowledged this would be difficult. For example, a focus on improving the social and emotional development of children in the run-up to school age – currently four out of 10 five-year-olds are not ready to start school – would not produce direct savings for health and social

ALASTAIR WALLACE / SHUTTERSTOCK

"The transformation fund is non-recurrent – it will not be used to prop up deficits; it's to get you to a place where you don't make a deficit"
Sally Parkinson

care, but would have a knock-on effect on educational attainment and benefit the local economy.

'Health and social care devolution can contribute to the wider devolution work that will lead to the creation of a community that is growing economically, vibrant and thriving and able to look after itself,' she said. 'The health and social care work is an important place to start.'

On the other hand, health and social care would benefit from more people being in work, as those with jobs tend to stay healthier than those without work. 'We can't sort it all out, but we can help people to be healthy and stay in work so that the other things flow from that.'

Terms of engagement

In February 2015, the 37 local statutory health and social care organisations plus NHS England signed a memorandum of understanding underpinning the devolution of the £6bn health and care budget on 1 April this year. The 37 organisations have a governance framework, with a strategic partnership board on which each body has a representative.

Agreement between providers to work together has been one of the most significant steps forward. They have formed a provider federation, which Ms Calvin-Thomas said was 'critical'. 'They are talking to NHS Improvement about having a Greater Manchester licence with an additional condition on working with the federation, but they are not waiting for that [before moving on]. They don't agree on everything, but they have clear risk and gain share – part of their work is to look at that transparently.'

Sally Parkinson, Greater Manchester health and social care devolution associate chief financial officer, said the risk and gain share agreement was crucial. 'It has always been the stumbling block – everybody needs to gain and everybody needs to take risk,' she said.

The GM strategic partners developed a five-year plan underpinned by a financial framework to help give the plan credibility, Ms Calvin-Thomas said. 'We started with a high-level assumptions-based plan. This was quickly embedded in our 10 localities so that, over time, rather than being assumptions-based, it will become a real plan.'

This would help address the forecast £2bn shortfall in funding by 2021. 'Creating a financially balanced and sustainable system underpins everything else we are doing,' she added.

Ms Parkinson said additional NHS funding and protected social care money would contribute £700m to closing the funding shortfall.

The team of three finance staff who put the framework together had identified opportunities for savings. Locally driven work, supported by integration, payment reform and GM-wide digital transformation, could deliver almost £400m by preventing ill health. 'These were the easy things to talk about because everyone understands they are the right thing to do,' Ms Parkinson said.

A further £158m could be made in provider savings through better care – reducing lengths of stay, for example. The biggest single element identified was in provider cost improvements, aided by workforce transformation. This came to savings of £736m, although Ms Parkinson said this would change as the model was run before the announcement of the sustainability and transformation fund and associated control totals.

Provider reconfiguration could provide a further £139m and collaboration between providers on estates and the provision of back office services could deliver a further £120m, but there would be additional capital costs of £200m. The GM team was working with local government colleagues to minimise this cost and talking to the Department about keeping the receipts from the sale of surplus estate.

Localities were asked to show how they would realise these potential savings in their local plans. These were put together using commissioner and local authority plans, together with providers' five-year plans for Monitor/NHS Trust Development Authority, to give a picture across Greater Manchester.

'It's no surprise that in year one the level of transformation is limited and the impact on activity, outcomes and finance is not going to be massive,' Ms Parkinson said.

But Ms Calvin-Thomas added that the locality plans were crucial when it came to discussions on funding with the Department of Health, Treasury and NHS England.

She said that they also looked for quick wins – often initiatives that had been planned or were even in progress, such as seven-day GP access or creating a single public health system for Greater Manchester.

The team believed they needed £500m to front-load transformation. Greater Manchester was able to secure a total of £450m of transformation funding. Ms Calvin-Thomas said they want to use this funding to reimagine services across the whole care system. It was focusing on five areas for transformational change:

- **Population health** investing in services that will make the biggest difference to the population's health and wellbeing
- **Community-based care** a new care model delivered closer to home and driven by local integration and multispecialty community provider work. Groups of GPs are rethinking primary care delivery.
- **Standardising acute and specialist care** reducing variation by creating best practice specifications, enabled by standardised information management and technology.
- **Standardising support services** providing clinical support and back office services at scale. Ms Calvin-Thomas asked why each trust, council and NHS England office needed their own IT department, for example.
- **Enabling better care** including creating new payment models, ways of commissioning and contracting to incentivise working the city.

Using the funding

Ms Parkinson said the transformation fund was a 'spend it or lose it' fund and would stand at £60m in year one. She did not anticipate many localities would need transformation funding in the first year.

'What's critical is that it is non-recurrent – it's to fund things like double-running costs while we put the new system in place and it will not be used to prop up deficits; it's to get you to a place where you don't make a deficit. We have requested a return of 3:1 on the transformation funds, but that's for the whole locality, not just the providers.'

The team has set up five pan-city provider efficiency programmes, each with its own director of finance lead:

- Procurement
- Pharmacy
- Pathology and radiology
- Back office
- Estates.

Greater Manchester has already made some procurement gains in the past few years, Ms Parkinson said. But she added: 'Every organisation

Providers including The Christie NHS Foundation Trust have signed up to the federation

still has its own procurement team. There has got to be some benefit from looking at a cross organisation approach.'

A high-level model had shown opportunities in addressable spend to deliver savings of £100m over a five-year period. Standardisation is key. 'There is a wide variety of product choice even within organisations, she said. 'That can't be right and we should challenge that. Doing it as a GM partnership we will be able to do more.'

Many of the potential gains in pharmacy are in procurement and ideally there would be a central pharmacy store for the city. The pharmacy workstream will build on the model hospital work in the Carter review, she added. A change in mind-sets is needed for the pathology and radiology programme to succeed. 'Who's going to give up their pathology department?' Ms Parkinson asked. 'We need to do it more effectively than we do at the moment and use technology better. People are probably aware of what can be done, but we need to get to the point where trusts are comfortable with pathology not being on site.'

Back-office focus

While shared services are not a new idea, there is potential to achieve greater efficiencies in the back office, she said. This could be up to 25% of costs, made, perhaps across CCGs, providers and local authorities. Transactional elements of finance and HR could be put into a centralised shared service for Greater Manchester.

A high-level assessment of estate utilisation showed huge variations, Ms Parkinson continued, and the aim of this workstream is to use public sector property as a single resource across the city.

'We anticipate activity growth of about 9% over the period, so if we do nothing we would need 9% more beds. However, in the solution to the £2bn problem we are doing two things that will bring that down – we aim to reduce acute activity, which will bring the number of beds needed down by 15%, and use beds better through reducing lengths of stay. That will account for another 15% – an aggregate of 30%. So we think we can have a 20% reduction in beds. It's a massive ask and some hospitals have private finance initiative estate where they are tied in for 20 years. There are a lot of issues that mean we just can't take out 20%.'

There is much to do in a short space of time – the Greater Manchester team will face pressure to deliver results in five years even though some of their programmes could take 10 or 15 years to bear fruit. But if they succeed, their work could go down as revolutionary.

Tameside action

The conference heard how one area plans to tackle a financial shortfall, clinically unsustainable services and a complex public health challenge under the umbrella of GM devolution.

Jessica Williams, programme director for integration at Tameside and Glossop health and social care, said the area – on the east side of the city – had some of the worst healthy life expectations in the country. In some wards, the average healthy life expectancy was 57 years.

Its local hospital, Tameside Hospital NHS Foundation Trust, was one of the Keogh trusts, but it came out of special measures last September having improved practically every aspect of its performance. But the health and care system around it was poor and as a consequence it rarely hit the 95% A&E target, she said.

Finances were difficult. The contingency planning team from Monitor – sent in to address issues at the trust – identified a potential £70m shortfall in the local health and care economy by 2020.

The situation had to be addressed quickly. 'We need to push integration using GM devolution where we can, but we cannot allow GM devolution to slow us down,' Ms Williams said.

'Our vision of integration is about bringing down silos, stopping unnecessary duplication, achieving standardisation and economies of scale. People should only go to hospital when they need to.'

The work is complicated by the fact that Glossop is in the Derbyshire County Council area, but she said they aimed to ensure continuity of services whether in Glossop or Tameside.

The Tameside and Glossop local plan is known as the 'Care together' programme and it has two pillars – the creation of a single commissioning function for health and social care and an integrated care organisation (ICO) to deliver health and care services as efficiently and effectively as possible. The first pillar was scheduled to go live on 1 April with a budget of £420m.

'We are going to have one finance director for commissioning and one for providers. These people are going to hold the ring. From 1 April, contracts will be more or less block, with a floor and ceiling, but we are moving to capitation outcomes-based contracts,' Ms Williams added.

"Our vision of integration is about bringing down silos, stopping duplication, achieving economies of scale. People should only go to hospital when they need to"
Jessica Williams

The ICO – the first in the country – will be created by April 2017. This will sub-contract some services to other providers. Tameside and Glossop has bid for GM transformation funding to support its plans.

Healthcost

Leading healthcare to deliver change

What are you getting from your current costing model?

Are you able to identify clinical variation and daily resource consumption?

As efficient costing is now becoming a central point of focus for all organisations, the need for a transparent and intuitive costing model is of paramount importance. **Healthcost** are the industry leaders in the provision of ***daily*** **PLICS** outputs and SLR reporting.

We are costing specialists who provide expertise, support and training to the Healthcare sector. We currently support over 25 NHS healthcare providers, including Alder Hey Children's NHS Foundation Trust who are the recent winners of the **HFMA Costing Award 2015/16.**

Our reporting applications help to identify and improve the quality of source information as well as identify the cost of every clinical resource within a patient's pathway. Designed using clinical input, they are simple and intuitive without the difficulties associated with the traditional healthcare analytical reporting.

Healthcost are sponsors of the HFMA Healthcare Costing for Value Institute

hfma Corporate Partner

W: www.healthcost.co.uk T: +44 (0) 1628 855 3621 E: info@healthcost.co.uk

Cost centre of attention

The new costing director at NHS Improvement is determined to raise the profile of NHS costing as the service moves to put the focus on patient-level costs. Steve Brown reports

When Monitor launched its plans to transform costing across the English NHS back in December 2014, it promised a business case to support its planned switch to more granular patient-level cost data. But while that report is still due to be published later this month, the regulator's new head of its costing initiative believes in many ways the case is already made.

Richard Ford, became director of costing for NHS Improvement, which brings together Monitor and the Trust Development Authority, at the beginning of February. He is determined to establish a higher profile for costing in general and the regulator's Costing Transformation Programme (CTP) in particular. But he says that discussion is now around 'how' and not 'if'.

'The idea that we need to wait for the value for money report to justify a move to a costing approach – that agenda has moved on,' he says. 'Patient-level costing is going to happen. We have the backing of our board, Lord Carter, the *Five-year forward view* and the BDO report [consultancy report that underpinned the CTP]. The case for change has been accepted while we've been developing the value-for-money report.'

A value for money paper, *Patient-level information and costing systems – case for change*, will be published this month, although Mr Ford says it will be less about identifying exactly how much patient-level costing can save in total and more about helping local organisations to make their own cases locally.

'It is hard to extrapolate an exact cost-benefit from the case studies we have looked at. But it is clear the benefits easily outweigh the direct costs of costing practitioners and systems. It is also clear that the benefits grow exponentially once costing conversations become embedded, when the finance manager starts to put down the cost centre report and picks up a costing report. By year three, providers have typically recouped their costs and by years three to four in some cases they are getting a three-fold or more return on investment.'

"The benefits grow exponentially when the finance manager starts to put down the cost centre report and picks up a costing report"
Richard Ford

The report will describe the journey on which providers need to go and provide a business case template for providers to take to their own boards.

One thing is clear – the value for money report is no longer being seen as the key trigger for a decision to mandate patient-level costing or new costing standards.

'The goal is 100% submissions and 100% compliance with a common approach,' says Mr Ford. He is hopeful the majority of providers will opt to adopt, given the strength of the business case, but recognises that mandating the standards is part of the picture. But he sees the timing of any decision to mandate as being more about what would help trusts most.

While the NHS faces unprecedented financial challenges now and over the coming years, the 2016/17 settlement is relatively better than the later years covered by the spending review. Early mandation – rather than being a tool to push laggards – could actually help trusts take the plunge sooner rather than later, the NHS Improvement director suggests.

Costing pedigree

Mr Ford does not come with a specific NHS costing background. This is in keeping with Monitor's aim not to populate its central costing team by asset stripping the NHS costing function, which will need to retain and build on existing skill and staffing levels to deliver the programme.

However, he moves from Nottingham University Hospitals NHS Trust, which is in the vanguard of trusts to have implemented patient-level costing and is actively using the data to drive improvement. And his business transformation role at the trust sets him up well for the fundamental overhaul being planned for NHS costing.

He says transformation in the NHS has to be based on delivering better value, measured both in terms of quality and cost. If comparison and benchmarking are to flourish in the way the Carter report envisages, cost data has to be reliable. 'We are the denominator,' he says. 'While we are still working to measure and quantify quality, it is even more important we have costs compiled and reported on a consistent basis across all trusts. It is the one constant we can guarantee.'

And he stresses that the objectives of better costing are to improve reporting and decision-making within trusts, to support benchmarking and to inform pricing. The order is important. NHS Improvement and NHS England's pricing role demands robust costs, but this is not the prime reason for costing to the patient level.

There has been some solid progress in recent years, but it has been slower than many would have wanted – in part a result of the voluntary approach to adopting patient costing. There is now growing impatience at the centre, as well as rising demand at trust level and a shared recognition that the pace needs to pick up.

Lord Carter's productivity report has put data and sharing information at the heart of the transformation agenda. His model hospital envisages whole swathes of data and metrics to support improvement activities and assurance. There are new specific cost metrics – the adjusted treatment cost and the cost per weighted activity unit (see 'Measure by measure', *Healthcare Finance*, March 2016, p20) – but in reality good cost data forms the foundation of the approach.

The CTP even gets a specific mention, with the report recommending 'every effort is made to deliver the programme by the 2020 deadline'. Lord Carter has called for all trusts to be using a 'standard patient-level costing system by April next year and fully integrated and utilised by October 2018'. Mr Ford admits this is ahead of the CTP timetable and presents 'ambitious challenges'. Discussions are ongoing.

There has been some wider kickback about the use of reference costs to create these new metrics – given that an audit showed there were material errors in 49% of a sample of cost submissions for the 2014/15 reference costs used. But Mr Ford says Carter is clear that the cost metrics and savings opportunities fed back to trusts are to help them ask questions. And he hopes that overall, the new metrics and Carter spotlight will encourage providers to accelerate their adoption of patient costing.

'Lord Carter wants us to move at pace because everyone agrees that reference costs have their limitations,' he says. 'At the moment, reference costs is the only game in town, but there is no doubt patient-level costing is the future. Lord Carter is right to push us and the service and what is particularly helpful is that he is putting the conversation into the right forum and getting clinicians involved.'

Carter also called for a common chart of accounts to be introduced across England in advance of the costing changes.

However, Mr Ford says he has talked to Lord Carter, who is happy that the CTP approach – translating each trust's general ledger into a consistent format within a cost ledger with the quantums in both fully reconciled – achieves the same goals.

Progress report

So where is the transformation programme up to? The development of completely new and detailed standards is on schedule, with publication (primarily for roadmap partners) this month alongside the value-for-money report. 'This has been a massive exercise and very much a bottom-up initiative,' says Mr Ford. 'The sector has been fully engaged with finance staff building the standards up from scratch to align with how the BDO report advised costing should work.'

There are 25 in total. Among these are two information requirements, nine costing processes, nine costing methodologies and five costing approaches. For example, one of the costing process standards covers allocating overheads. A methodology standard looks at costing within theatres. An approach standard sets out the costing approach within a specific service area – chemotherapy is an example. And the information requirements examine what source data is needed and how it should be treated. But Mr Ford says they are 'all standards', will be compiled in a single costing manual style document and form the basis for any future audit and enforcement. The absolute intention is to allow less room for interpretation and less opportunity for trusts to do things their own way – something the service has called for in earlier consultations.

Mr Ford says NHS Improvement is definitely in listening and collaborating mode. 'Feedback from the sector suggests the revised approach may in fact be too prescriptive now,' he admits.

For example, there have been issues with the sheer number of resources and activities being dictated by the centre – meaning that patient cost spreadsheets extend to hundreds of thousands of lines. There are question marks over the value of such detailed analysis and the ability of systems to cope. 'The point is that we are listening and we recognise we need to find a practical happy medium – a good compromise,' he adds.

Mr Ford suggests this is in keeping with NHS Improvement's attempt to position itself as a provider of support to trusts and foundation trusts and not just a regulator.

On the systems front, original plans had been to accredit software to give providers the assurance that existing or new systems were fit for purpose. 'I've asked why we can't go further and create a preferred supplier database,' says Mr Ford. 'Then anyone who needs a new system doesn't need to undertake a separate procurement process.' This may take longer at the outset than putting an accreditation system in place, but it will save time overall.

If providers and patients are the main

Milestone

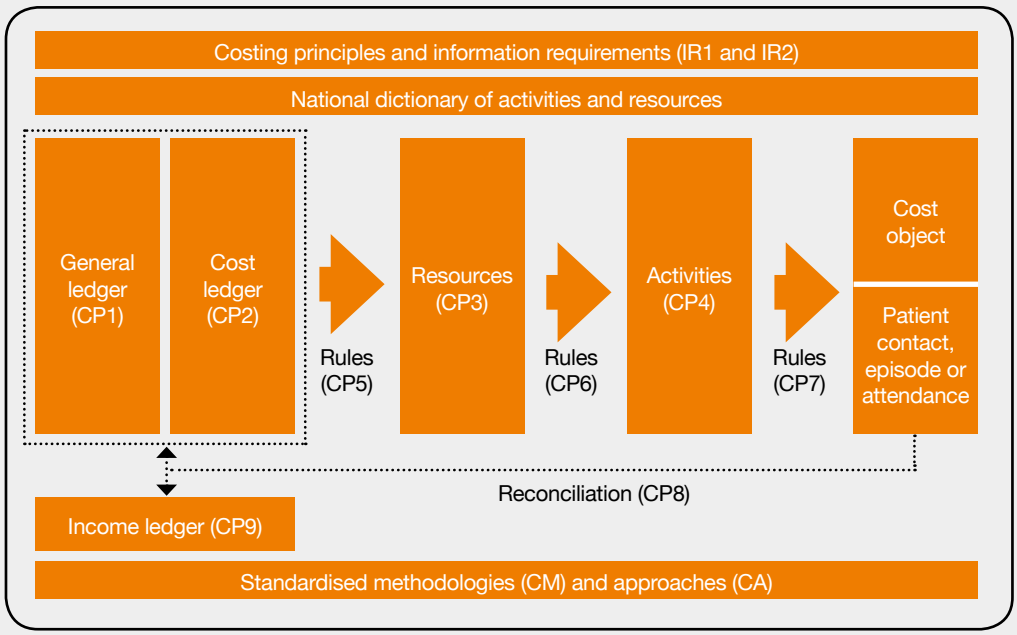
The Costing Transformation Programme will reach a key milestone this month with the publication of its *Case for change* report alongside draft acute care costing standards, a Q&A paper, minimum standards for software and resource and activity lists. Mr Ford will also address the HFMA's costing conference on 21 April.

The new approach

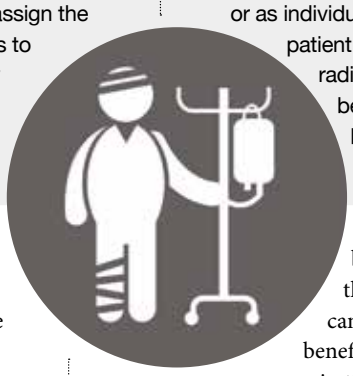
Monitor's original costing proposals (December 2014) talked about mapping costs from the general ledger into 'nationally standardised resource categories' to ensure a common starting point.

In reality there is an intermediate step – creating a cost ledger. This will typically use a combination of cost centre and subjective codes and may involve some disaggregation – for example, breaking down specialist nursing costs into the costs incurred for different types of specialist nursing.

With full reconciliation between the general ledger and standardised resources, this is believed to offer the same benefits as having a common chart of accounts. This has been agreed with the Carter team as achieving the requirements of its recommendation for a standard chart of accounts.



The costs from the cost ledger are then assigned to standard resource categories – covering both direct costs (for example, covering different types of staff in different specialties) and overheads. Resources are then mapped to activities such as ward, outpatient or theatre care. The final stage is to assign the costs of activities to the patients they relate to, either in groups (such as groups of patients receiving general ward care from nurses) or as individuals (a patient receiving radiotherapy or being visited by a district nurse).



beneficiaries of better costing, then NHS Improvement wants to help providers to help themselves. Some of this is about getting the whole service onto the same page in terms of recognising the benefits of better costing. And some of it is about ensuring it has the capability to compile and use better cost data.

'The HFMA is a key partner in this,' says Mr Ford. 'Our planned engagement strategy will target boards, clinicians and finance staff. Trusts not yet bought into patient costing (literally) will have to demonstrate that their boards have discussed the issue. And where trusts have purchased but not developed their costing systems, we need to get these trusts to the point where they can submit meaningful data. The HFMA has well established networks and we are in the process of identifying and working with partners to help deliver our agendas.'

NHS Improvement is talking directly to the royal colleges about why cost data is a tool for clinicians to deliver better value. And it also wants to support costing practitioners to expand their skills, finance managers to develop costing skills and for the whole finance function to place more value on costing in general.

'Another key deliverable is the need to grow costing talent. We don't have nearly enough costing practitioners to deliver our ambitions, so we need the finance community to develop costing talent,' Mr Ford says.

"We don't have nearly enough costing practitioners to deliver our ambitions, so we need the finance community to develop costing talent"
Richard Ford

'The HFMA is developing a programme as part of its institute to help deliver this. The change comes when trusts are using costing reports in discussions with clinicians, not just cost centre reports. We need to get financial managers doing this, which will get them more interested in costing – and change the perception of costing within and outside the profession.'

There are examples of trusts around the country that are already reaping benefits from patient-level costing. But NHS Improvement believes even these organisations can see greater benefits once all organisations are on board and working to a consistent methodology.

The ability to benchmark is a central theme of Lord Carter's recommendations, with its calls for the development of a 'model hospital' matrix of metrics and indicators. NHS Improvement recognises that cost data is fundamental to this approach. Cost data is already being fed back to participants in Monitor's voluntary patient cost collection. But the vision is for comprehensive, service-wide information to be provided to all trusts – effectively bringing all organisations into a 'free' nationwide benchmarking club.

The ultimate step has to be to put this cost data alongside agreed and consistently measured outcome information – giving a real insight on value. That may still be some time off. But getting the cost data right is an important first step.

See 'Costing is the plan', page 10

Powerful Insights for Exceptional Performance

Financial Analytics

- Patient-Level Costing
- Patient Cost Benchmarking
- Integrated Service Line Reporting
- Data Management & Quality Reporting

Health Analytics

- Care Pathway Analytics
- Benchmarking
- Variation Analysis
- Quality & Outcomes

- 130+ NHS Customers Across All Offerings
- Predictive Analytics & Consulting Services
- Locally Deployed and Managed Service Options

From definitive data and advanced analytics to high value, tailored consultancy services, IMS Health Albatross has the tools, technology and trusted expertise to help you meet your ever growing efficiency targets with a focus on enhancing patient outcomes.

Financial, operational and clinical functions all rely on the power of our proven solutions to drive significant performance improvements, including:

- **Consistent, compliant Patient-Level Costing delivered as a Managed Service**
- **Compelling, comprehensive National Patient Cost Benchmarking**
- **Comparative, capacity-releasing Care Pathway Analytics**

Find out how to focus on the insights

To discover the freedom of faster, more informed decisions based on actionable insights that are trusted at the highest level and to increase efficiency and performance, contact nhssolutions@uk.imshealth.com or 01785 238009

imshealth™
Albatross

IMS Health • 210 Pentonville Road, London N1 9JY, UK • www.imshealth.com

Costing clarity

Having championed patient costing nearly a decade ago, Tony Whitfield is disappointed there hasn't been faster progress across the NHS. But he remains committed to the need for better cost data to underpin decision-making around transformation. Steve Brown reports

Back in 2007, Tony Whitfield – then finance director at Salford Royal NHS Foundation Trust – called on the NHS to move beyond the crude averages at the heart of NHS reference costs and start 'costing for business' by costing down to the patient level. Nearly nine years later, has the NHS taken up his challenge?

The short answer is probably 'no' – or at least not as quickly as he or many others would have liked. But the prescription for change remains the same. The NHS needs a far greater understanding of what it costs to treat patients, the different components of those costs and how costs vary from one patient to another. What has changed is that there are a lot more people making the same argument and championing patient-level costing. And there is now a national programme – likely to become mandatory at some point – that aims to get the whole service costing individual patients using a common methodology.

Mr Whitfield was one of the early pioneers of patient-level costing and led the HFMA's early work in the area, including overseeing the initial production of voluntary clinical costing standards. His belief that finance and clinicians needed to understand each other's business better – with costing providing a perfect meeting place – underpinned his 'knowing the business' theme while he was HFMA president in 2013.

Scale of the task

Now at Leeds Teaching Hospitals NHS Trust, he is in a different environment from Salford. The trust is more than twice the size, for a start. Many of its clinical service units – cancer, cardio and respiratory and the Leeds Children's Hospital – are as big as some freestanding NHS trusts or foundation trusts.

The NHS is also in a completely different financial place than it was eight to nine years ago. Back then, the service overall was in surplus and tariffs were increasing year-on-year. But Mr Whitfield says the current widespread financial challenges make an even stronger case for having a forensic understanding of costs.

Deficits and recovery plans may put all but essential spending off limits, but Mr Whitfield remains clear that investing in better cost data is essential. It is part of the solution and not a way of exacerbating the current financial position.

And Mr Whitfield can back up his words with actions. Leeds Teaching Hospitals NHS Trust delivered a £24m deficit in 2014/15 against a planned £50m – the improvement largely thanks to non-recurrent income support from the Trust Development Authority and depreciation savings following a major asset revaluation. The challenges have continued into 2015/16, with the most recent board reports forecasting a year-end deficit of £31m, again using non-recurrent support to improve on a planned £37m deficit. Achieving this would keep the trust on course for its planned 'return to sustainable break-even' in 2017/18.

But even given these pressures, replacing finance systems – including the ledger, costing and contracting systems – was a priority when Mr Whitfield joined the trust in January 2014. Although the trust had nominally been pursuing patient-level costing, Mr Whitfield says he found a good costing team struggling with poor systems, which compromised the quality and the usefulness of the cost data produced.

Cost data was poorly regarded in the organisation and in reality the trust's sole focus was the annual reference cost return. 'It was my decision that we needed a new costing system,' says Mr Whitfield. 'But I wanted the team to decide on the actual system we would use.'

So that's what happened with the costing team, after a proper competition, selecting the Healthcost patient-level costing system.

The contract was signed in March 2015, giving the costing team just 20 weeks to implement a new system and meet the 2014/15 reference cost submission deadlines. 'Our costs were compiled to a degree of granularity that hadn't been achieved previously and we were starting to produce useful data,' says Mr Whitfield.

He openly admits that there is a huge improvement programme stretching out ahead of the costing team – the trust is probably close to being in the same position as Salford back in 2007. But he credits his costing team with making 'amazing progress' in what has been a

Tony Whitfield (right) and Leeds Teaching Hospitals' head of costing Vinod Bassi

'fabulous start'. Delivering detailed patient costs requires clinical engagement, new feeder systems and an iterative process improving data and the allocation methods employed. This can't be achieved overnight, but if you don't start the process, you will never achieve the end goal.

Trust head of costing Vinod Bassi says the final contract signing had been later than planned, leaving less time than they'd wanted to implement the system. 'But this pushed us to get out in the trust and validate our results as we went along,' he says.

He is also delighted with the new system. 'It used to take 26 hours to do a run of data and it often fell over. Now it takes four hours and it is much more transparent about where it encounters any blockages.'

Mr Bassi suggests the trust had been in a 'costing wilderness'. 'We were just focused on filling in the statutory returns,' he says. 'No-one used the cost information. There was no validation or clinical engagement. It has been a renaissance.' There is now renewed enthusiasm in the team, much greater professional satisfaction and ambition to do more – supported by an active costing system user group – and make a difference to patient care.

Mr Whitfield says this is exactly the right reaction. 'I want them to be proud of being advocates of great care, not spreadsheet warriors,' he says. And he remains convinced that all providers need to be pursuing similar approaches.

The Jubilee Wing of Leeds General Infirmary

Pace of change

In general, Mr Whitfield says he is disappointed with how long it has taken the NHS as a whole to get behind patient-level costing. 'The service hasn't embraced costing at the level it should have. And in general terms, it is not where our best people aspire to work – that is still something that has to change,' he adds. Too often when good people end up in costing, they feel they have to move on – into financial management more generally – to further their careers. 'This has to change,' he says.

Cost data often provides the best way of examining variation in clinical practice – or even just spotting where attention could best be focused to find improvement. 'And there is increasing consensus around the need for new models of care to deliver services going forward,' he says. 'But we can't move into these new models without understanding their affordability – or if they cost more; we need to understand the value they deliver. Accountants can't describe the new models we need to deliver, but we can and have to be part of the decision-making process by ensuring tha we are factoring in an understanding of what will happen to costs.'

Mr Whitfield says that cost data is important for tariff-setting – with new tariffs and payment mechanisms needed to underpin the new models of care. But, echoing comments from NHS Improvement (see page 16), he insists the prime reason to improve costing is to understand how services are delivered and inform decision-making.

'It has a major role in supporting clinical groups to highlight unwarranted variation. A first step might be to ask if we can deliver services for the tariff price. If we can't, perhaps other providers should be taking on the work. And if we can, we need to ask if anybody is doing it more cost effectively. If so – and the outcomes are good or comparable – what can we do to improve?'

However, important decisions such as these can't be taken if people – finance practitioners and clinicians – don't buy into the cost data and believe what it is telling them.

Despite a new system and approach at Leeds being barely 12 months old, there have already been early wins. The trust has been able to evidence underpayment for some specialised abdominal surgery.

However, Mr Whitfield is clear that the key benefits need to come from using the data to reduce costs, not increase income. 'With the spending squeeze, it may feel as though we have no money to spend, but in reality we are spending £3m every day. The question is: are we using it to the best effect?'

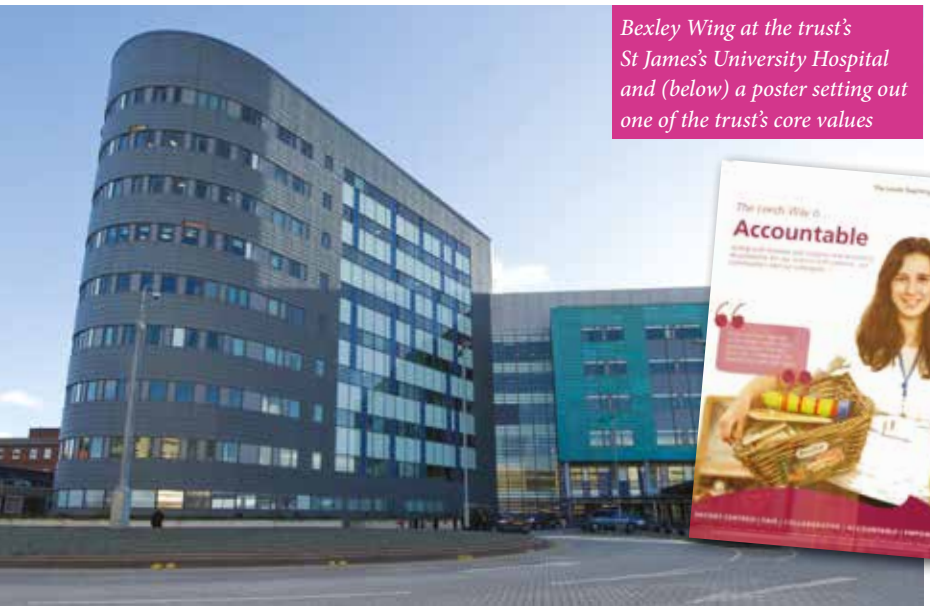
Patient cost dashboards – with a specific version targeted at clinicians – are now available to all the trust's clinical service units. And data is now refreshed on a monthly basis rather than just twice a year, as before. Unassisted take-up of the data and use of the dashboards is limited, but the trust has done some more detailed work with some pilot areas under the guidance of clinical costing champion Dr Stuart Murdoch, chair of the trust's patient-level information and costing board.

This has included orthopaedic surgery, where work is being undertaken to identify waste and inefficiency – part of an initiative called the Leeds Improvement Method, developed with the Trust Development Authority and the US Virginia Mason Institute. While the focus of the work is around eliminating errors and never events and reducing waste, Mr Whitfield is clear that the trust also wants to demonstrate it is reducing unit costs – making accurate cost data vital.

He says the danger is that over recent years, clinical units may have slid into financial unsustainability with the central finance team doing what it can to deliver the financial position.

'This has been hugely disengaging for clinicians and there has been no narrative about how to get back into financial sustainability – just imposed cost improvement programmes. This has been characterised by very top-down approaches such as vacancy freezes. The new leadership team has brought these blunt measures to an end.'

The trust's values include empowering



Bexley Wing at the trust's St James's University Hospital and (below) a poster setting out one of the trust's core values

staff and holding them to account. 'But you can't hold people to account for a financial plan without clarity about the data they need to deliver the plan,' says Mr Whitfield. 'That means giving them the absolute performance numbers and showing them where the opportunities are for maximising value. That is where the cost data comes in.'

The trust has big plans to improve costing. It currently has no acuity system, although it has created a bespoke system to weight catheter laboratory minutes for different procedures – helping to produce more meaningful costs for its cardio-respiratory department. It is about to launch a new data warehouse, to bring all its data in one place. And it is keen to start putting cost data alongside outcome measures – there are plans for a specific project looking at cancer trends.

Barcode pilot

But perhaps its biggest project involves a move to adopt the GS1 'barcode' standards – it is one of six formal GS1 pilot sites. The focus of the work is to improve procurement and stock control (and enhance safety), giving far greater visibility over what trusts use and what they pay for goods and services. But a knock-on benefit is the ability to trace consumption of specific resources to individual patients, eventually doing away with whole swathes of cost apportionment and allocation approaches.

'It is really exciting – we'll have the ability to scan patients, staff, blood, consumable and OPCS codes – the possibilities are huge,' says Mr Whitfield. 'But it will make our ability to identify, analyse and understand variation so much greater.' He maintains that it takes 'about five years before patient-level costing is business as usual', with the benefits accumulating each year of the journey. It might be frustrating not to be able to access all the benefits immediately. But the important thing is to take the first step.

- *Costing is the plan, page 10*
- *Cost centre of attention, page 16*

Eyes on the prize

Carter review trusts tell Seamus Ward about their experiences and how it has helped their drive for greater productivity and efficiency

The final Carter report on efficiency and productivity left acute trusts with many questions, and there is a feeling in the NHS that its publication may have been rushed to show that action was being taken in the face of projected deficits. However, there is also a belief that Carter has left plenty for trusts to get their teeth into.

Certainly, that's the message coming from some of the trusts with some experience of the Carter process. The review initially included 22 acutes, later increased to 32, which engaged with the Carter team to discuss performance data and identify and codify what good looks like.

This led to a set of benchmarks and indicators, including the creation of new metrics such as care hours per patient day, to form the basis of a model hospital.

But what of the process itself and do these trusts have any pointers or best practice to hand on to acutes that are now getting to grips with Carter?

Door to savings

Simon Worthington, Bolton NHS Foundation Trust's deputy chief executive and director of finance, says the Carter work is challenging, but has opened the door to savings (see box, page 26).

'Trusts now have individual reports setting out how much they can save. It might say they can save £70m – they might challenge that, but the potential savings are not going to be nothing. There are definite opportunities.'

Often, the Carter work turned up little that was new for the Bolton trust. This is hardly surprising, as it had already identified a variety of savings opportunities through extensive benchmarking as part of its financial turnaround.

'It confirmed things we had already identified,' says Mr Worthington, 'but if trusts have not done the work that we did, there will be things identified that they will not have known about.'

With a reference cost index of 92 and with much of the Carter work based on reference costs, it is not surprising that savings

SHUTTERSTOCK

Procurement progress

University Hospitals of Leicester NHS Trust head of procurement Ben Shaw says the focus of its local procurement work is on delivering cost savings and improving the procurement processes, such as purchase order compliance and use of its e-catalogue – both identified in the Carter review.

Training and better staff communication are the main elements of this work. Mr Shaw says staff often did not know the correct processes, so the trust is using an e-learning tool and newsletters to correct this.

The trust also has an exception list, highlighting invoices that come in without a purchase order. This can lead to contact with suppliers to let them know they must provide a purchase order number on their invoices.

The next step is price benchmarking. The trust already has a benchmarking system, which allows it to compare with about 70 of its peers. But Mr Shaw says extra savings will be seen when all acute trusts are involved – he is helping the Department of Health specify a national benchmarking tool, due in May.

'The Carter team ran a benchmarking exercise in

identified at Salisbury NHS Foundation Trust are relatively small. Carter believes the trust could save £10m, but director of finance and procurement Malcolm Cassells thinks this may be overstated. 'We think it is possibly nearer £3m,' he says.

However, he is fully behind the Carter work and says the process has helped the trust question whether it is as efficient as its management and staff believed.

'When the data was originally produced for the 22 trusts, we looked, in the main, pretty good, though we were looking like an outlier for qualified nurse staffing,' says Mr Cassells. 'We thought that was odd and worked with the Carter team – that work has shown we are not an outlier on this measure.'

Data opportunity

The issue lay in the data. 'The focus on qualified nurse staffing enabled us to work in more detail on our e-rosters and, more widely, on how rosters can be used better. It hasn't resulted in huge savings, but going forward there might be some savings as we get better reports off our rostering system.'

Mr Worthington adds that the 32 trusts and the Carter review team have done a lot of groundwork, creating a fantastic resource for the NHS. Even so, he detects a level of defeatism in some trusts, which believe they have done all they can

He believes this cannot be the case and the detailed Carter work will help trusts manage their businesses more effectively. They must use the information and tools they have already – such as e-rostering systems to ensure nurse shifts are safe and the nursing resource is being used efficiently.

University Hospitals of Leicester NHS Trust joined the Carter process in the second tranche of 10 trusts. Chris Benham, director of operational finance, says there were many data analytics requests from the Carter team.

December with about 90 trusts and the results were far more accurate than we had been getting previously. This exercise potentially identified further opportunities to reduce costs and we are looking forward to the roll-out of a national solution,' says Mr Shaw. 'With between 150 and 200 organisations involved, we will have even better data. It will be a really positive development, allowing us to look at the spending and make sure we get the best deal possible.'

The trust is also focusing on the national procurement work. It has been part of the Carter procurement workstream since last summer. While it has been one of the more challenging workstreams in terms of obtaining data, Mr Shaw says good progress has been made.

The group has been working on the national procurement standards, set to be rolled out to the service in the next couple of months.

'That's a really positive development as the standards will include all the measures of performance,' he says. 'We are committed to driving this forward and in some ways it has already made a difference as we are more focused on the metrics.'

'Some of these followed the principles and spirit of reference cost data collection to come up with the adjusted treatment cost metric,' he says. 'There has been quite a lot of dialogue between the Carter central team and the partner group to work out what it means.'

Mr Benham is not sure the work with Carter has made a great deal of difference to the trust so far in terms of identifying productivity and efficiency improvements.

But he adds: 'It does give indicators that make you think slightly differently – direct clinical time per whole time equivalent is probably something we wouldn't have looked at when doing the normal process of looking for efficiencies. That can put some fresh challenges into organisations about where the potential efficiencies are to be found.'

Moving forward, the Leicester trust is keen to mainstream the Carter activity. 'We are keen that it doesn't create a separate workstream and becomes part of what we do, both in our day-to-day work now and in one or two years.'

While the trust is working through the 15 recommendations in the final Carter report, it

Transfers problem

Salisbury NHS Foundation Trust's Malcolm Cassells (pictured) says many of the Carter recommendations will lead to trusts examining 'bite-size chunks' of their spending, but highlights one area that could produce large amounts of savings – delayed transfers of care.

Indeed, the final Carter report is clear that it is one of the big issues facing providers and an enabler for increased productivity. While NHS England statistics showed delayed transfers had increased to 5,500 patients a day, information from trusts showed the problem could be much larger. Carter estimates that up to 8,500 acute beds are blocked by medically fit patients on any given day.

'It was useful Lord Carter pointed out that a lot of savings are not achievable unless there is a national approach to dealing with this. It hasn't happened yet,' Mr Cassells says.

He says local authorities are not incentivised to 'pull out all the stops' to enable clinically fit patients to be discharged from hospital, often into care homes or nursing homes. The daily cost of keeping a patient in hospital could be £300, but the penalty charged to local authorities for delayed transfers is only £100. At present LAs may even save money by leaving patients in NHS hospitals.

'I think trusts will look much closer at expenditure as a result of Carter, but the biggest potential savings come from issues such as delayed transfers of care, which must be solved at national level,' he says.

'We need a approach that would transform the situation in hospitals across the country. We are talking about significant savings through better use of the resource and through reduced administration by not having to keep chasing social services to get patients into more appropriate care settings. Local authorities need incentivising to ensure this is resolved.'

Carter believes the cost to NHS providers could be £900m a year and elective operations cancelled as a result of bed blocking could be contributing to the growing use of non-NHS providers for routine operations.

In addition, the pressure on beds caused by patients who do not need to be in hospital drives the need for expensive agency staff.

"Carter indicators can put fresh challenges into organisations about where efficiencies can be found"
Chris Benham, University Hospitals of Leicester NHST

accepts local circumstances will affect its ability to deliver them.

'Every organisation will have to work out what they can do in the short term and what is more transformational – what will have to be done beyond the 12-month time horizon,' says chief financial officer Paul Traynor. 'Some things can't just plug into the next cost improvement programme. Some of this will be about resources, some about capability and some will be structural. For example in estates it takes time to get rid of surplus land and buildings, while big projects, such as pharmacy transformation – as we have here – don't just happen overnight.'

The new limits on administration costs has prompted the Salisbury trust to look at its coding for occupational groups within the electronic staff record. Mr Cassells says it is clear that the occupation code data in ESR and the way it was being extracted was flawed across the NHS and work has not been undertaken to try and improve its accuracy. It is only when such data is being used nationally that there is an incentive to get it right.

There were some relatively small savings – Salisbury discovered that moving from soluble prednisolone to a tablet form would save £23,000 per annum, and other benchmarking in pharmacy has helped to reduce the use of Diclofenac. But Mr Cassells says a large proportion of potential savings lie outside trusts' direct control – the biggest is addressing delayed transfers of care (see box, page 25).

Mr Worthington insists accountability over the delivery of Carter is crucial and finance teams have a key role here. For example, they can ensure the production of month-end budget reports is slick and timely.

'We must be focused on giving people the tools to solve any problems – you can't performance manage someone if you don't give them the appropriate tools. If you don't, you can end up with people becoming disengaged from the process of improvement.'

He adds: 'Carter is exposing improvement opportunities and by doing that is removing the excuse that there aren't any opportunities. It's management by removal of excuses. Our role as a finance profession should not be "explain why the Carter numbers are wrong", but to use them to drive improvement.'

The Bolton model

Bolton NHS Foundation Trust's Simon Worthington Is keen to understand what is meant by the model hospital and his trust is working with NHS Improvement to develop the idea and test out how it works in a real world setting. 'It's a very good idea, but getting it to operate will mean a lot of hard work,' says Mr Worthington.

Trusts have been told they have savings opportunities, but this is at a high level – the next stage in the development of the model hospital is to drill down into the detail.

'If you take a geographical area, you know its size and activity, so you can say how much you need to spend on orthopaedics, for example. You will have some idea how this s broken down – you need this many doctors and nurses, say.

'The Carter work hasn't really got to that level yet. That's where we need to get to and what we're working with them on.'

He continues: 'You might be told there's a

£2m savings opportunity in orthopaedics, but it doesn't tell you the details. Because of this, the immediate reaction might be that it's rubbish, but we have to get beyond that. It's like peeling away the different layers of an onion and at the moment we're only at the top layer.'

He adds that the model hospital will not help if it is used as a stick to beat those that fall short of metrics. It must be used in a more constructive way, to identify opportunities for continuous improvement.

The Bolton trust has set up its own model hospital project and is currently focusing on the acute specialties. 'We are going from first principles to establish how much we think that specialty could cost under certain assumptions. We produce a report for the clinicians, saying we can take this much out of costs by doing these things differently. They may say that's wrong and then we're into a dialogue with them.

'It gives you something to grab hold of – you could say we have a £2m saving in orthopaedics or we could say something more impactful, like we think there's an issue with theatre throughput or length of stay.'

Reports on each specialty take four weeks to prepare and another four for the clinicians to respond. The reports are prepared using existing staff with management accountants moving away from transactional duties to working in a business improvement team.

The trust has nine specialties and reports on all were due to be completed by the end of the 2015/16 financial year. Once discussions with clinicians are complete, it aims to drive efficiencies in at least 80% of its acute services over the next year.

"It's like peeling away the different layers of an onion and at the moment we're only at the top layer"

Simon Worthington, Bolton NHS FT (above)

Looking to share your healthcare finance experience?

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

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

Closing date for applications 12 February.

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

hfma

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

hfma

HFMA
ONLINE
ACADEMY
A hub for finance training

Courses you'll click with… HFMA's Online Academy

The largest and most advanced hub for finance training in the NHS encompassing e-learning modules across a wide range of subjects, including **Introduction to NHS Finance, Introduction to NHS Budgeting, Introduction to NHS Governance and Introduction to how NHS services are paid for.**

Over **200 NHS organisations** currently subscribe to our Online Academy and over 192,000 CPD hours have been delivered since it launched in 2006 – with good reason.

For more information visit hfma.to/onlineacademy or contact:
Alex Wood, Business Development Manager
E: Alex.Wood@hfma.org.uk T: 0117 938 8358

hfma

professional lives

Events, people and support for finance practitioners

Planning for a year-end with no surprises

Charities guidance on www.hfma.org.uk

Technical update

The big issue for this financial year is the actual outturn position for the NHS and its impact on the Department of Health's overall spending limit, *writes Debbie Paterson*. There has been a focus on the estimates and judgements used in getting to that position, with the Department looking to review the consistency in how guidance is being implemented as part of additional 'due diligence work'.

This is a novel move and has prompted some discussion and a statement from the HFMA (see page 3). However, putting this issue to one side, the main message coming out of the HFMA's pre-accounts planning conferences in January was that there should be no surprises.

In recent years, the outturn reported pre-audit has not changed materially as a result of audit and the expectation is that this year will be no different. The way to achieve this is to discuss all potentially difficult issues with external auditors as soon as possible. Ideally, this will already have happened.

While the various accounting manuals have been available for some time, more recent guidance was issued in the last weeks of March. Monitor, for example, issued an update to its *Annual reporting manual*. This makes amendments to the disclosures in relation to 'on-balance sheet' service concessions, internal audit expenditure, merger support monies and income as a result of capital-to-revenue transfers. The update also confirms there are no changes to the fair pay multiple or off-payroll disclosures.

The Department was also planning to issue another FAQ on the pensions disclosures made in the accounts. The narrative disclosure relating to the NHS pension scheme has been amended and has been issued to trusts and clinical commissioning groups. Foundation trusts should have received this or will do shortly.

Foundation trusts and trusts will be required to include the single total remuneration table in their consolidation schedules this year. However, this should not cause any additional work as the information is reported in the remuneration report; it is simply to avoid another central collection.

The Department also issued the month 12 agreement of balances guidance, and it is worth checking for changes. This year, for the first time, income and expenditure with a year-to-date balance of more than £2m will have to be agreed at year-end. The contact lists have been updated and section 7 and the appendices provide guidance on how to make sure you are agreeing balances with the right part of NHS England. A large proportion of mismatches result from failing to identify the appropriate part of NHS England to agree balances with.

The only new accounting standard to come into force this year is IFRS 13 – *Fair value measurement*. It is expected to have a limited impact on NHS bodies. As a result, the valuation of surplus assets, which are not in use and have no restrictions on their sale, has changed.

The better care fund is expected to be

Sickle cell treatment patient and cost benefits

NICE update

About 13,500 people have sickle cell disease in England – they have a mutated variant of haemoglobin that causes red blood cells to form a distinctive sickle shape, *writes Nicola Bodey*. These red blood cells do not flow easily and can cause blockages – vaso-occlusive crises. These are most serious when they restrict the blood flow to major organ systems.

NICE guidance (MTG28) states that the case for adopting Spectra Optia Apheresis System (Spectra Optia) for automated red blood cell exchange in people with sickle cell disease is supported by the evidence.

Spectra Optia is an apheresis and cell collection platform that can be used for automated red blood cell depletion and exchange in adults or children with sickle cell disease, who are on a long-term or temporary/medium-term transfusion regime. It is faster to use and needs to be done less often than manual exchange and should be considered for people who need regular transfusion.

Some 700 people in England with sickle cell disease will be eligible for Spectra Optia and an estimated 570 people will have it from year five, when a steady state is reached.

The annual saving associated with implementing the guidance for the population of England is £12.9m from 2020/21 (about £18,100 per 100,000 population).

A Spectra Optia machine costs about £62,400 and maintenance costs are estimated to be £4,600 per year. It is anticipated there will be savings if commissioners and providers work together

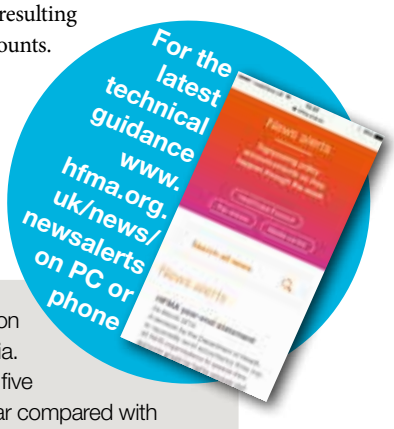
In brief

- **Monitor and the NHS Trust Development Authority have updated their NHS provider inflation assumptions for the period 2016/17 to 2020/21. They recommended providers use these when planning and forecasting activities, while also taking account of local circumstances, opportunities and pressures.**
- **Monitor issued updates to its financial accounting guidance – the month 12 foundation trust consolidation template and updates to the two optional accounts templates.**
- **The Department of Health has updated the templates for recovering costs of care from visitors and migrants. The templates, applicable from 6 April, take in updates to *Overseas chargeable patients, NHS debt and immigration rules: guidance on administration and data sharing*.**
- **The HFMA has issued briefings on charitable funds' year-end and changes in financial reporting standards and guidance. The former reminds NHS charities to follow the new statement of recommended practice for 2015/16 annual accounts; the latter highlights the changes that could affect NHS organisations' annual reports and accounts. pressures.**

a critical issue for CCGs. The HFMA understands that auditors are looking closely at these arrangements and will expect that the accounting treatment for the fund has been determined based on an assessment of the signed agreements. It is particularly important to identify whether host bodies are acting as principals or agents in the agreement as this may be the determining factor in whether accounting is on a gross or net basis.

Finally, this is a big year of change for charities with the adoption of a new statement of recommended practice and resulting restatement of the 2014/15 accounts. There is a briefing on year-end reminders available on the HFMA website.

Debbie Paterson is an HFMA technical author



to reduce the need for chelation therapy by using Spectra Optia.

There will be a reduction of five hospital appointments per year compared with manual or top-up transfusion. Each attendance will be shorter by about four hours as a result of the more efficient transfer.

This will reduce the impact of transfusion therapy on education and work for people with sickle cell disease.

Nicola Bodey is senior business analyst at NICE

Diary

April
21 (N) Annual costing conference
26 (B) East Midlands Branch: financial governance, Castle Donington
27 (F) Commissioning Finance forum
27 (B) West Midlands Branch: contracts and legal framework

May
11 (F) Chair, Non-executive and Lay Member forum, London
12 (F) Provider Finance: procurement forum, London
19 (N) Mental health finance conference, London
25 (N) Payment systems, Rochester Row, London
26 (B) East Midlands Branch: FFF/FSD/HFMA roadshow, Nottingham
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

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

July
7-8 (N) Creating synergy, annual provider conference, Warwick
12-19 (B) Wales Branch: personal impact skills, across Wales
19 (B) KSS Branch: introduction to NHS finance, Crawley

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

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

Event in focus

National payment system conference
25 May, Rochester Row, London

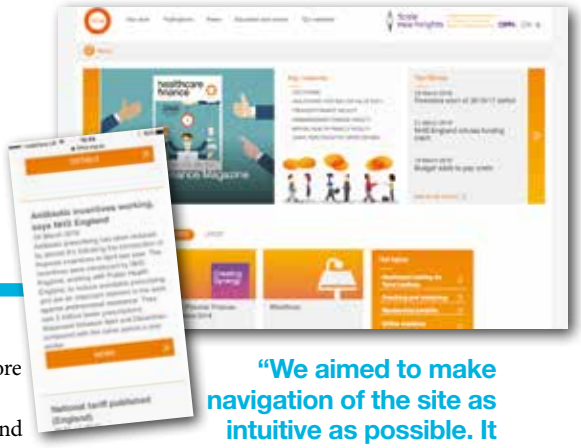
The development of the payment system for 2017/18 to support the implementation of the *Five-year forward view* will be the focus of this year's conference. Aimed at finance directors, deputies and finance managers in providers and commissioners, the event offers technical discussion, an overview of policy, a question and answer session and a series of workshops. Speakers include NHS Improvement executive director of resources and deputy chief executive Bob Alexander, who will look at the challenges ahead. NHS England head of pricing Martin Campbell (pictured) and Monitor pricing director Toby Lambert will outline priorities for local and national pricing in 2017/18. Workshops will focus on issues including locally determined prices, lessons from pricing development in mental health and the future of best practice tariffs.

Email camilla.godfrey@hfma.org.uk for details or visit www.hfma.org.uk

Virtual new look

Association view from Mark Knight, HFMA chief executive

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



My HFMA

The new HFMA website is live (www.hfma.org.uk). Its development comes on the back of a renewed push for members and I am also delighted to announce that my colleague Flo Greenland is to become our first membership manager. Flo's role will be to drive our growth for new members and implement an ambitious membership strategy, which was agreed by our board in February. She joins our new website manager Sheridan Mossley in a substantial upgrade to our member services.

Our website was last redeveloped in 2008 and while we've refreshed it a few times, we were running on creaking legacy technology. Our new site is run on an industry-standard platform and gives us a lot more flexibility and I believe it reflects where the association is now. The 2008 site had a significant focus on where you could buy something. Now the focus is very definitely on what the association is saying and how it can help you in your day jobs.

Our popular news alerts feature prominently and I feel sure that many of you will choose to access this service via your mobile, on which the new site works well. We are supplementing this signposting service with more news and analysis through the week (our newly entitled 'Top stories') and we are also relaunching a more extensive blogging section.

As you'd expect, social media is integrated and individual twitter feeds are now visible across the different sections – in branches and our faculties, for example. All our content is categorised, so visitors can hone in on everything to do with costing, financial management or clinical engagement, to give a few examples. Our aim is to make sure our work is as visible as possible.

We hope that you like the design – we certainly do. But the main purpose of the new site is to make our wide range of content – from events and webinars to briefings and guides to news and opinions – easy to find. And if you follow one link, we've tried to flag up to you directly relevant other content that you might want to be aware of.

HFMA chief executive Mark Knight

"We aimed to make navigation of the site as intuitive as possible. It has been designed with you – the member – in mind"

We have a clear aim to integrate our communication channels much better. So in future we want this magazine and the website working in tandem, with the magazine highlighting additional online resources, for example. You should literally watch this space!

We aimed to make navigation of the site as intuitive as possible. It has been designed with you – the member – in mind. So let me know what you think of it as we will refine the site as we move forward (chiefexec@hfma.org.uk).

So far, implementation has gone smoothly, but like a duck swimming, there's a lot of paddling going on beneath the surface, so bear with us if there are issues initially.

I'd like to thank my team, led by James Hood, our head of IT and e-learning. We continue to provide you with the services we think you need in this busy period, but please tell us what we should or shouldn't do – we'll look at anything.

Member news

The North West Branch's recent awards ceremony has honoured several finance staff:

- NHS Wigan Borough Clinical Commissioning Group won two of the four categories – great place to work and finance team (pictured). The judging panel was impressed with the team's evidence-based submission and approach to staff development and training.
- Salford Royal NHS FT won the innovation and research award for its innovative dashboard and a project between finance and nursing teams to handle expenditure and deliver care.
- Kim McNaught was named 'unsung hero' for her overall support for the branch and contribution to promoting development opportunities.

Warwickshire North Clinical Commissioning Group deputy chief finance officer Anthony

Chapman is running his 12th London Marathon on 24 April to raise £3,000 for WellChild. He plans to run all 26.2 miles in the charity's 11ft mascot Nessa the Nurse (pictured). It will be Anthony's last London Marathon and his sister Clare will run it with him. Support him at http://uk.virginmoney giving.com/anthonychapmanrunning

Several appointments were made across HFMA networks:

- Laura Ffrench – Wales skills development co-ordinator
- Hamish Hamilton, NHS Lothian assistant finance manager – Scotland Branch committee
- Flo Greenland – membership manager
- John Guest – Charitable Funds SIG Department of Health representative.

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

Business plans
Looking forward

Business plans submitted by HFMA branches show a vibrant network of local bodies keen to listen to members' views and take action.

Perhaps in response to local member feedback and the increasing challenges facing members in their professional lives, branches are adding more events to their calendars. And they are reaching out to members using new platforms, including social media, and old, such as newsletters.

Each branch must hold four events a year, but most are planning more – often double – including events to support HFMA president Shahana Khan's 'Step up' theme.

At the same time, there is a recognition of the financial pressure facing the NHS. This could mean employers are reluctant to allow staff out of the office. But branches are responding. For example, the North West Branch is reviewing the format, timing and content of its annual conference and seeking views from members, local NHS organisations and partners.

All branches are looking to maintain or increase membership Some, such as North West and Wales, have a named person in each organisation to provide a link to their branch committees. Other branches are keen to develop their research work further – the West Midlands Branch research and development committee surveyed members to inform event topics and research projects. Using the results, the committee has devised a work plan and started on seven new projects: clinical engagement; fines regime; stress management; population-based commissioning; a costing guide; procurement; and best practice tariffs.

The Wales Branch has based its plan on five pillars – community; mutual support; development; career-long; and professional profile. Branch chair Huw Thomas (pictured) said these are the result of a member survey and a meeting with its local champions. 'The five pillars are an expression of how we wish to come together as the Wales NHS finance community to support each other throughout our careers,' he said. 'We are the community of healthcare finance colleagues who support and help each other with networking and development opportunities throughout our careers; and through that raise the profile of our profession as a whole.'

Branch contacts

Eastern kate.tolworthy@hfma.org.uk
East Midlands joanne.kinsey1@nhs.net
Kent, Surrey and Sussex elizabeth.taylor29@nhs.net
London taryn.nicolson@hfma.org.uk
Northern Ireland kim.ferguson@northerntrust.hscni.net
Northern lynn.hartley1@nhs.net
North West hazel.mclellan@hfma.org.uk
Scotland alasdair.pinkerton@nhs.net
South West leanne.lovelock@hfma.org.uk
South Central alison.jerome@hfma.org.uk
Wales laura.ffrench@hfma.org.uk
West Midlands georgina.callaghan@hfma.org.uk
Yorkshire and Humber laura.hill@york.nhs.uk

Appointments

Gary Boothby is now deputy director of finance at Calderdale and Huddersfield NHS Foundation Trust. He was deputy director of finance at Mid Yorkshire Hospitals NHS Trust and acting as director of finance following Robert Chadwick's move to Cardiff and Vale University Health Board in November last year. **Jane Hazelgrave** (pictured) has been appointed director of finance at Mid Yorkshire Hospitals NHS Trust. She has been chief financial officer at Bradford Districts Clinical Commissioning Group for the past three years.

Steven Bolam (pictured) has stepped down from his role as director of finance, performance and informatics at St George's NHS Foundation Trust. After more than three and a half years in the post, he is taking a role at NHS Improvement. Mr Bolam has significant board-level experience, having held director roles at various NHS organisations. He is succeeded by **Iain Lynam** on an interim basis. Mr Lynam has experience in corporate and financial restructuring in the NHS and the private sector.

Kevin Smith (pictured) has been named director of finance and commissioning at East of England Ambulance Service NHS Trust. He has been acting director of finance at the organisation since June 2014, stepping up from his substantive position as a deputy director of finance. He has more than 20 years' experience in NHS finance, working in the acute, community, mental health and ambulance sectors, as well as in the construction industry.

Pippa Ross-Smith is now chief finance officer at Brighton and Hove Clinical Commissioning Group. She was previously head of strategic finance and deputy director of finance at Avon and Wiltshire Mental Health Partnership NHS Trust. She sat on the HFMA Mental Health Steering Group and is an associate member of the Policy and Research Committee. Mrs Ross-Smith succeeds Michael Schofield.

Trevor Shipman (pictured), director of finance at Central and North West London NHS Foundation Trust, has retired after more than 25 years in the NHS. He is succeeded by **Hardev Virdee**, who was previously chief finance officer at Wandsworth Clinical Commissioning Group.

Mr Virdee started his career in the NHS as part of the NHS national financial management training scheme and has since held various senior NHS finance roles. He is also a trustee at The Point of Care Foundation – an independent charity working to improve patients' experience of care and increase support for the staff who work with them.

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 need to focus on ensuring we have a smooth year-end process and that the business is fully engaged with delivering our five-year plan"
Colin McCready

McCready makes move to NHS Professionals

On the move

Colin McCready has been appointed chief financial officer of NHS Professionals following the announcement of Rob Clarke's upcoming retirement.

Mr McCready moves from Serco Europe, where he was finance director, working in human resources and other outsourcing services. Previously, he was finance director and commercial manager at Control Risks, overseeing its kidnap response, risk consultancy and security businesses in Europe and Africa.

He started his career at Cadbury Schweppes in Watford and also brings to the new post his experience in investment banking at Dresdner Kleinwort. He joined NHS Professionals last month to enable a full handover from Mr Clarke.

Mr McCready said his new post gave him 'a chance to join an incredibly interesting and successful company at an important time in its development'.

'The role of leading the finance function through its own transformation programme as well as influencing the shape of the business going forward in response to market and technological changes is incredibly exciting,' he added.

His first challenge is 'to understand the business, the market, its clients and current offering,' he said. 'We have an ambitious programme of projects in the pipeline and I will need to quickly get up to speed on these. Thankfully, I am inheriting a great team that is delivering the core financial functions and has robust processes and controls in place.'

He aims to facilitate the speedy and efficient implementation of a number of projects in progress that would deliver significant benefits to the business. 'We are also approaching the financial year end, so clearly I need to focus on ensuring we have a smooth year-end process and that the business is fully engaged with delivering against our 2016/17 budget and our strategic five-year plan.'

Mr McCready hopes that, coming from the independent sector where the bulk of his experience is in professional services and outsourcing, he can bring a different perspective to the business. 'I have also previously led finance transformation projects and ERP system implementations and have the scars to prove it. I am incredibly excited and anxious to get stuck in to all the hard work we have ahead of us.'

Obituary: JR Hindle

I was greatly saddened to hear of the death of our oldest past president, JR Hindle, at the age of 96 before Christmas, *writes HFMA chief executive Mark Knight*. He was president of the Association of Health Service Treasurers from 1971-72 and his day job was treasurer of Preston and Chorley Hospital Management Committee.

In 2009, when Paul Assinder and I decided to celebrate the HFMA's 60th anniversary as part of Paul's year in office, we asked anyone with a history of the association to step forward. Mr Hindle spent a lot of time telling me about his career and how things were when he was at work. We decided he should play a major part in our 'Looking forward, looking back' 60th anniversary year in 2010 – he featured on the special video (still on YouTube) and attended the North West dinner as guest of honour (above).

Mr Hindle was at the first meeting of the HFMA at the Free Trade Hall in Manchester in November 1949. He went on to be treasurer at Preston for many years. He was a Council Member throughout the sixties and editor of the predecessor to this magazine. His descriptions of his dealings with government, managing conferences and being president still resonate today. His advice to me – 'get in with the docs' – was an early message on clinical engagement! When we opened Rochester Row, the HFMA Board decided to recognise the role he had played in our 60th anniversary celebrations by naming a room after him. His memory will be long with us.

Finance support

Future focused finance

Future-Focused Finance, with the HFMA, recently ran a series of six webinars on coaching and mentoring, *writes David Ellcock*. The webinars were instigated by FFF's 'Great place to work' action area, which aims to enable individuals and teams to have rewarding careers in the NHS. Coaching and mentoring are seen as integral parts of the action area – they are seen as key to developing potential at all levels of finance.

The webinars – led by Jonathan Bowyer, HFMA executive coach, and Claire Merrick, HFMA coaching and mentoring services manager – sought to give participants the skills to develop effective coaching and mentoring relationships. They covered a range of topics, from an introduction to the concepts behind coaching and mentoring to encouraging their use in finance teams.

There were sessions on the foundations of effective conversations; active listening and powerful questioning; establishing and building rapport; and creative thinking and problem solving.

Great place to work senior responsible officer Cathy Kennedy, said: 'Finance staff from across the NHS can benefit from being involved in coaching and mentoring, whether they are working with a coach/mentor, using the relevant skills in their day-to-day work or sharing their skills and knowledge by being a coach/mentor. Involvement encourages individuals to take responsibility for finding solutions to issues, which helps find lasting success built on practical solutions. We're very grateful to the HFMA for helping us.'

Catch up with all six webinars for free at www.futurefocusedfinance.nhs.uk/blog/free-coaching-and-mentoring-webinars

• David Ellcock is FFF's programme director

Innovate Integrate Motivate

HFMA Annual Mental Health Conference 2016
19 May - London

For more information or to book visit hfma.to/innovate or email lay.hine@hfma.org.uk

MH FINANCE FACULTY DISCOUNTS AVAILABLE

Spending Wisely

HFMA Annual Commissioning Finance Conference 2016
23 June - Stratford-Upon-Avon

For more information or to book visit hfma.to/spendingwisely or email grace.lovelady@hfma.org.uk

COMMISSIONING FINANCE FACULTY DISCOUNTS AVAILABLE

Creating Synergy

HFMA Annual Provider Finance Conference 2016
7-8 July - Kenilworth, Warwickshire

For more information or to book visit hfma.to/synergy or email grace.lovelady@hfma.org.uk

PROVIDER FINANCE FACULTY DISCOUNTS AVAILABLE

SELECTMORE

Asteral Select – the alternative method for procuring and managing capital assets

Our vendor independent solution provides tailored packages for Cardiology, Radiology and Endoscopy services that allow you to invest in safe, productive services without capital resources.

Asteral Select services include design, build, equipment procurement, maintenance, clinical consumables, IT systems, consultancy and the provision of non-clinical and technical support staff. Helping you deliver the **5-year Forward View**, Asteral Select offers cost and efficiency savings, with clinical choice of subcontractor.

For a more flexible managed service that provides the choices you want, call Asteral on 0118 900 8100

ASTERAL

www.asteral.com