healthcare finance

December 2016 | Healthcare Financial Management Association

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Comment
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KeyMed House, Stock Road, Southend-on-Sea, Essex, SS2 5QH, UK

OlympusMedicalEurope

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

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

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

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

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

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

Production
Wheal Associates
020 8694 9412
kate@whealassociates.com

Printer
Pureprint

HFMA
1 Temple Way,
Bristol BS2 0BU

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

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

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

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

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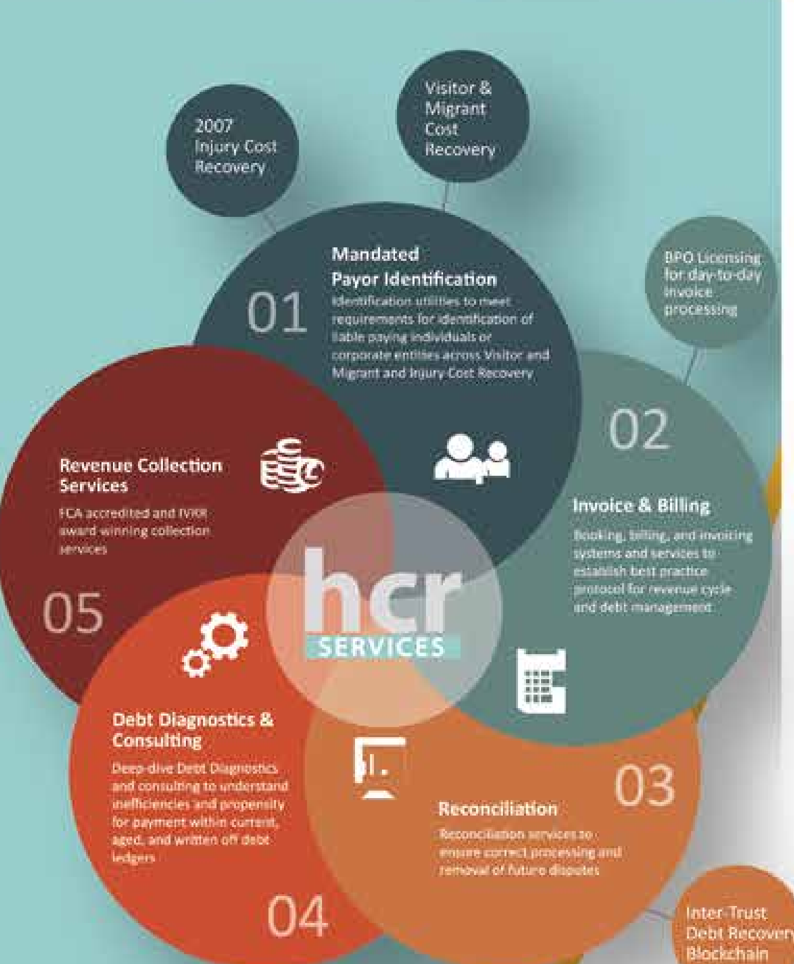

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News

Pressure set to grow as extra funding fails to materialise

By Seamus Ward

Health and social care leaders were dismayed by chancellor Philip Hammond's decision not to allocate additional funding to the sectors in his autumn statement.

There were repeated calls for additional funding to be handed to social care in the run-up to the November statement. Bodies such as NHS Providers and the King's Fund said shortfalls in social care funding were increasing demand at A&E and general practices and contributing to delayed transfers of care out of hospital.

HFMA policy director Paul Briddock said: 'Like many others, we were disappointed to see the NHS overlooked in the autumn statement. In a time of unprecedented challenges for the health service, it's a shame that no new financial injections were unveiled by the chancellor.

'Many areas require support at this time, but perhaps the hardest hit – and most in need – is that of social care. With the increase in the living wage, costs are starting to mount for social care providers, and without further financial provisions they will find it even harder. This has a knock-on effect for the NHS as a whole as it tries to reduce the deficit and balance the books.'

In the HFMA's latest *NHS financial temperature check* finance directors said emergency care demand, pressure on social care budgets and increasing demand overall were the biggest threats to financial balance in their sustainability and transformation plan (STP) areas. Respondents backed STPs in general, but there were concerns about governance and leadership.

"Pressures will peak in 2018/19 and 2019/20, when there is almost no planned growth in real-terms NHS funding"
Richard Murray, King's Fund

King's Fund policy director Richard Murray (pictured) said that with no new money, the intense pressure on health and social services would continue to grow. 'The planned increases in health spending are not enough to maintain standards of care, meet rising demand and transform services,' he said.

'In particular, the pressures will peak in 2018/19 and 2019/20, when there is almost no planned growth in real-terms NHS funding.'

The autumn statement came as half-year figures for the NHS in England showed encouraging signs for the provider sector but continuing cause for concern over operational performance.

Revealing providers' quarter two figures, NHS Improvement said it believed the sector can end the financial year with a £580m deficit. At Q2, providers had an aggregate year-to-date deficit of £648m – £22m worse than planned – but the oversight body said the results were positive as 11 fewer trusts reported deficits than in quarter one and 40 fewer than Q2 in 2015/16.

NHS England said at Q2 the commissioning sector forecast a year-end overspend of £10m. This included a £190m forecast overspend in clinical commissioning groups and an £88m pressure due to technical and ring-fenced adjustments (principally due to the release of provisions and lower than expected depreciation charges). These are offset by underspends in direct commissioning (£52m) and NHS England running and central programme costs (£216m).

Operational performance concerns were highlighted in the King's Fund's latest quarterly monitoring report. It said the NHS faced a difficult winter and, as demand increases, performance against waiting times targets and other performance measures was deteriorating.

The proportion of patients waiting longer than 18 weeks to begin treatment rose to 9.4% in September, it said. This was the worst performance since the target was introduced in April 2012. Delayed discharges were at a record level and GPs had seen a 10% increase in the number of patient contacts in the last two years.

• ***See also pages 10 and 19***

Trusts confident of £900m agency cut

NHS trusts believe they are on course to reduce spending on agency staff by £900m this year, according to quarter two figures from NHS Improvement.

The oversight body said 71% of trusts had reduced their agency spending since new rules and caps were introduced last November. And year-to-date spending of £1.5bn was £312m less than the same period a year before. However, year-to-date spending on agency staff still exceeded plan by almost 16%.

Although providers were predicting a full-year reduction of £900m on the 2015/16 spend of £3.6bn, this was £205m above the agency expenditure ceilings. NHS Improvement said 6% of the total NHS pay bill was spent on agency workers at Q2, compared with a planned 5.2%.

The planned year-end total spending on agency staff is just under £2.4bn (4.8% of total pay costs), but at Q2 trusts predicted it would hit almost £2.7bn (5.3%).

NHS Improvement said some trusts had to do more to bring their spending in line with individual ceilings. It wrote to trusts in October setting out the next steps in curbing agency spend, including specific actions for those missing their ceiling.

As part of the measures it named the trusts with the best and worst performance against their agency ceiling and agency spend as a percentage of total pay.

Anita Charlesworth, Health Foundation director of research and economics, said: 'Despite the agency cap, spending on temporary staff is 16% higher than planned, suggesting that the lack of a workforce strategy is still hitting trust finances.'

Connected conference

Delegates at this year's HFMA annual conference will once again be able to use a smartphone app to see the conference programme, view a map of the exhibition and connect with friends and colleagues.

The app also gives fast access to the conference Twitter stream, as well as information on sponsors and exhibitors.

The conference, which is being held in London on 7-9 December, features some of the best-known names in NHS finance, international healthcare and the world of business.

Speakers include NHS Improvement chief executive Jim Mackey, NHS England chief financial officer Paul Baumann, former Sainsbury's chief executive Justin King and Sarah Storey, Great Britain's most decorated female Paralympian.

As always, the conference features the annual HFMA Awards ceremony, when more than 700 guests will celebrate the achievements and best practice of the NHS finance function.

***Healthcare Finance* will be reporting from the event – look out for the latest news in the *Top stories* section of the HFMA website – and delegates can also tweet using #HFMA2016.**

Reference costs criticised again as Costing Transformation Programme accelerated

By Steve Brown

An audit of the 2014/15 reference costs has assessed 49% of audited trusts as non-compliant with costing guidance, NHS Improvement has revealed.

The audit, undertaken this year by PwC, compounds a similarly poor assessment for the 2013/14 costs, which found that 49% of audited trusts had submitted materially inaccurate reference cost returns. All acute trusts have now been audited over the two years.

Data quality was a key cause of non-compliance (see box) but there were specific errors in the initial cost and activity data, in misallocation of cost pools and the use of cost apportionments that did not accurately reflect resource consumption.

A report from NHS Improvement said the oversight body was concerned by the findings, especially given the importance of accurate cost information in addressing current financial challenges – a point underlined by the Carter report on productivity.

'Our findings show that many trusts still treat costing as a standalone regulatory exercise and do not use costing information to make management decisions. As a result, not enough resources are devoted to ensuring that the information is accurate,' it said.

Eleven trusts out of the sample of 79 had no significant areas for improvement and the oversight body said other providers could learn from these trusts.

NHS Improvement – which is taking over responsibility for reference costs from the Department of Health – is leading a programme to transform costing. This will replace current healthcare resource group-level reference cost submissions with more detailed patient-level cost submissions, prepared using mandatory, detailed costing standards.

Speaking to *Healthcare Finance*, NHS Improvement costing director Richard Ford said the reference cost results were disappointing, but many of the problems were known issues. 'It also makes the case and provides greater impetus for the changes we are making,' he said.

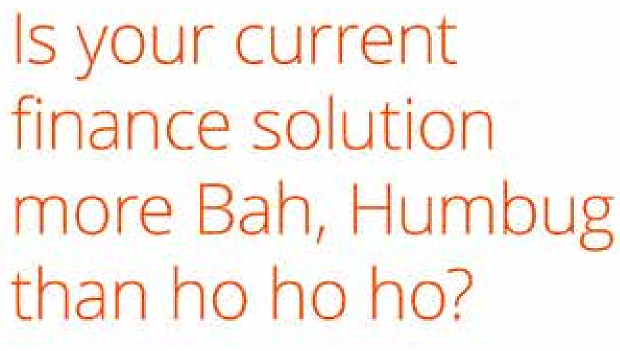
The organisation has just announced a major acceleration to its Costing Transformation Programme (CTP) – see page 15.

In a formal response to the audit findings, the NHS Improvement costing team said work to address the areas of non-compliance in reference costs would now form an important part of the CTP – highlighting actions that could and should be taken to address these areas.

There will also be changes to next year's audit programme on 2015/16 costs, Mr Ford said, which will move away from the 'pass/fail' assessment on the return itself. Instead it will provide an in-year assessment of the quality of the costing process.

Reference cost compliance issues

- Insufficient governance and assurance processes
- Costing inconsistently embedded in day-to-day financial management
- Underlying data quality issues
- Not following guidance



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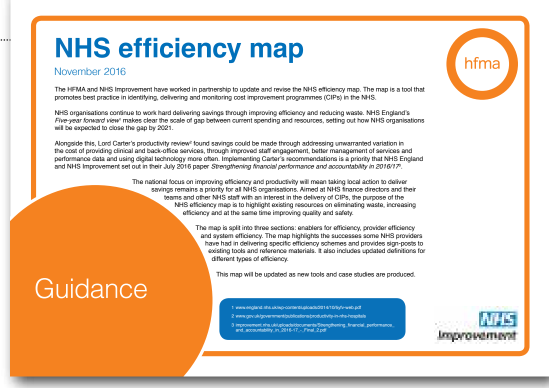


NHS efficiency map

November 2016

The HFMA and NHS Improvement have worked in partnership to update and revise the NHS efficiency map. The map is a tool that promotes best practice in identifying, delivering and monitoring cost improvement programmes (CIPs) in the NHS.

NHS organisations continue to work hard delivering savings through improving efficiency and reducing waste. NHS England's *Five-year forward view*[1] makes clear the scale of gap between current spending and resources, setting out how NHS organisations will be expected to close the gap by 2021.

Alongside this, Lord Carter's productivity review[2] found savings could be made through addressing unwarranted variation in the cost of providing clinical and back-office services, through improved staff engagement, better management of services and performance data and using digital technology more often. Implementing Carter's recommendations is a priority that NHS England and NHS Improvement set out in their July 2016 paper *Strengthening financial performance and accountability in 2016/17*[3].

The national focus on improving efficiency and productivity will mean taking local action to deliver savings remains a priority for all NHS organisations. Aimed at NHS finance directors and their teams and other NHS staff with an interest in the delivery of CIPs, the purpose of the NHS efficiency map is to highlight existing resources on eliminating waste, increasing efficiency and at the same time improving quality and safety.

The map is split into three sections: enablers for efficiency, provider efficiency and system efficiency. The map highlights the successes some NHS providers have had in delivering specific efficiency schemes and provides sign-posts to existing tools and reference materials. It also includes updated definitions for different types of efficiency.

This map will be updated as new tools and case studies are produced.

Guidance

1 www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
2 www.gov.uk/government/publications/productivity-in-nhs-hospitals
3 improvement.nhs.uk/uploads/documents/Strengthening_financial_performance_and_accountability_in_2016-17_-_Final_2.pdf

hfma

NHS Improvement

NHS efficiency map updated

NHS Improvement and the HFMA have updated the NHS efficiency map, which provides finance managers and other healthcare professionals with signposts to efficiency guidance, tools and examples of best practice.

The map promotes best practice in the identification, delivery and monitoring of NHS cost improvement programmes (CIPs). The HFMA said the map would highlight existing resources on eliminating waste and increasing efficiency while at the same time improving quality and safety. There are three sections:

- **Enablers for efficiency** Focuses on good management at all levels of an organisation, including board governance and capability and CIP management
- **Provider efficiency** Looks at areas such as optimising the use of workforce, procurement and non-pay and clinical support services
- **System efficiency** Examines collaboration with local or regional partners on services such as urgent and emergency care to improve quality and safety and achieve cost savings.

Each section looks at a number of potential improvement areas and provides links to improvement tools, case studies and further reading.

The map will be regularly updated and accompanied by new best practice case studies – the first focuses on enhanced nursing care.

• ***To download the Efficiency map, go to www.hfma.org.uk***

HFMA launches qualifications

The HFMA is to unveil its masters-level qualification programme for 2017/18 at the annual conference this month. The programme offers a route to gaining an MBA in healthcare business and finance via a diploma and higher diploma. Candidates must complete three modules to gain the diploma, including a compulsory core module on how NHS finance works, and a further three for the higher diploma. Once the higher diploma has been gained, they can move on to a full MBA.

CCAB- or CIMA-qualified accountants may be eligible to enter the higher diploma directly.

The qualification is aimed at healthcare finance staff; clinicians and clinical professionals; NHS healthcare professionals and managers; and other professionals working in a healthcare-related role.

Those who have worked fewer than two years in healthcare or who do not currently work in the sector can achieve an HFMA Certificate in Healthcare Business and Finance by completing the core module, followed by a further certificate in any of the optional modules. There is then the option to move to the diploma or higher diploma.

Registration to the diploma and higher diploma is open for applicants from 7 December.

• See www. hfma.org.uk

Hunt heralds new era of clinical managers

By Seamus Ward

The health service made 'an historic mistake' in the 1980s by turning to general managers rather than creating a class of manager with a clinical background, health secretary Jeremy Hunt (pictured below) has said.

Speaking at NHS Providers' annual conference, he launched a programme to encourage more clinicians into management. He wanted more clinician chief executives over the next decade and a new generation of clinical and non-clinical leaders, with more women and a greater proportion from black and minority ethnic groups.

While 54% of NHS hospital managers were clinicians, in Canada and the US they accounted for 74% and in Sweden for 94%, he said. Less than half of NHS chief executives were women, though they make up three-quarters of the workforce, while 2% of chief executives are from a BME background (17% of the overall workforce).

'Given that one of the most important roles of a chief executive is to motivate a large number of able, smart but – let's be honest – often quite headstrong clinicians, we should today ask whether the NHS made an historic mistake in the 1980s by deliberately creating a manager class who were not clinicians, rather than making more effort to nurture and develop the management skills of those who are.'

Professional regulation will be changed to encourage more clinicians into management. Health Education England will explore whether doctors can train in clinical leadership as a specialism and the NHS graduate management training scheme will double its intake to 200 from 2018.

Jon Restell, chief executive of health managers union MiP, said the increase in non-clinical management trainees was bold. 'Good for Hunt,' he added. 'It is a vote of confidence in general management, HR, finance and other disciplines in the NHS. We have always strongly supported the aim of growing the number of chief executives from clinical backgrounds and the proportion of leaders who are women and from BME backgrounds. The government must also do more to hold on to existing managers.'

NHS Providers published a survey showing that trust leaders are worried about the number, quality and skill mix of their staff. The providers' organisation said many trust chiefs worried more about staffing than finance.

News review

Seamus Ward assesses the past month in healthcare finance

Health news in November centred on the many calls for the chancellor to allocate extra funding for health and, in particular, social care when he delivered his autumn statement. Pressure groups and think-tanks said a shortfall in social care funding was placing additional pressure on the NHS in the form of increased activity and delayed transfers of care. But ultimately it was fruitless as Philip Hammond did not even mention health or social care, never mind give them additional funding.

A related argument broke out over just how much extra funding the government had given to health. In late October, Commons Health Committee chair Sarah Wollaston wrote to the chancellor to criticise the government's continued claims that it had increased health spending by £10bn up to 2020/21. She said this did not stand scrutiny as the money was allocated only to NHS England and the £10bn figure could only be reached by adding an extra year to the spending review period. The increase was funded by cuts in other parts of the Department of Health budget and, taking into account the spending review period only (2015/16 to 2020/21), overall health spending will rise by £4.5bn in real terms, she said.

Mr Hammond hit back, defending the government funding record and insisting the £10bn figure was correct. He said the money had always been intended for the NHS, not the Department as a whole, to ensure additional funding was prioritised for frontline services. The £10bn figure had been calculated using the 2014/15 baseline, which was also used as the baseline year in the *Five-year forward view*. In line with the service's request, £6bn of the additional £10bn would be given to the NHS by the end of 2016/17, he added.

While this seemed, increasingly, like an argument for economic anoraks and Whitehall obsessives, the British Medical Association and MP Jonathan Ashworth asked the UK Statistics Authority for clarification. It concluded that both were correct, though it acknowledged there was some confusion over the figures. It said the NHS England budget will rise by £10bn between 2014/15 and 2020/21 (£8.4bn over the spending review period). However, it estimated that in constant 2015/16 prices, the Department of Health budget will rise by £4.5bn in real terms over the spending review period. The authority said it would ask the Treasury to investigate whether it can in future present estimates for NHS England and total health spending separately. It would also work with officials to explore other ways of producing the figures to ensure greater clarity on sources, time periods and what is being measured.

Rising demand is one of the key reasons behind the calls for additional funding and, according to the latest monthly figures, activity in the NHS in England continued to rise in September. Emergency admissions were up 2.6%, diagnostic tests 3.8% and A&E attendance 4.9% compared with the same month in 2015. Consultant-led treatment over the last 12 months was 4% higher than in the preceding 12 months. NHS Constitution standards were not met in A&E, referral to treatment, diagnostic tests and the 62-day target for urgent GP referral to treatment for cancer. In A&E, 90.6% of patients were treated within the four-hour target, below the 95% standard.

The Northern Ireland Audit Office called on the local Department of Health to provide ongoing support to health and social care providers to avoid unnecessary hospital admissions and delayed discharges. A report

The month in quotes

'While the Department of Health has been open when asked about the nature of estimated real-terms increases in health spending and its split between NHS England and the Department's overall budget, total health spending figures are much less frequently referred to by government and may be less readily accessible.'
Ed Humpherson, UK Statistics Authority director general for regulation

'Better self-management could make a huge difference to a person's physical and mental wellbeing. Instead, the lack of knowledge among the general population about how they can do this is placing a huge burden on surgeries and hospitals. Rather than an add-on, self-care should be a central part of how we care for patients.'
LGA community wellbeing board chair Izzi Seccombe calls for greater self-care

'There is no ban and no blanket policy – people who do not wish to access the support services or fail to meet the criteria will not be denied their operation. Decisions about what is in the best interests of their health will be made on a case-by-case basis.'
Vale of York CCG clinical lead Shaun O'Connell reacts to reports that it had banned obese patients and smokers from having elective operations

'The NHS will receive £50m this year to sustain performance and meet the increased demand placed on services going into the winter period. We are investing in the NHS, but everyone in Wales can play their part by choosing well.'
Wales health secretary Vaughan Gething says patients can help reduce the pressure on services this winter

FLICKR/DFID

Chancellor Philip Hammond did not even mention health or social care in his first autumn statement

from the auditors said progress had been made on avoiding admissions in recent years, but that emergency admissions were costly and frequently avoidable. In 2015/16 Department figures suggested that 16% of emergency admissions may not have been necessary.

The Local Government Association argued that more care should be moved out of formal healthcare settings altogether. In a report, *Helping people look after themselves,* it called for a 'new culture of care' with individuals with minor ailments looking after themselves rather than visiting their GP or A&E. The LGA said 57 million GP consultations and 3.7 million A&E attendances were for minor illnesses, costing the NHS more than £2bn a year. These included 5.2 million GP visits for blocked noses, 40,000 for dandruff and 20,000 for travel sickness. Some 19% of all A&E visits were for self-treatable conditions, the LGA said, and self-care could save GPs an hour a day and reduce the pressure on social care.

The devolved governments in Cardiff and Edinburgh announced winter funding to support services during the traditional rise in demand. The NHS in Wales will receive £50m, though health secretary Vaughan Gething and head of NHS Wales Andrew Goodall urged patients to choose the right service to save time and to reduce pressure on emergency services. The Scottish government announced funding of £10m to support improvements in waiting times for first outpatient appointments. The funding will provide an estimated 40,000 additional appointments over the next few months, easing the pressure on outpatients in the winter months, the government said.

The government also announced an additional £3m to help health boards prepare for winter by improving patient flow and supporting people back to their own homes as quickly as possible.

Vale of York Clinical Commissioning Group insisted it had not imposed a blanket ban on surgery for patients with a body mass index (BMI) of 30 or higher. It is introducing new criteria asking patients whose BMI falls into this category to reduce their BMI to less than 30 or lose 10% of body weight, or postpone their elective surgery for 12 months. Smokers would be asked to quit for at least two months or postpone their elective surgery for six months. There would be support for patients and a number of exclusions, with a draft list including those requiring emergency surgery or with clinically urgent need and patients receiving surgery for cancer or suspected cancer.

NHS England outlined three actions it will take in the wake of the Court of Appeal ruling on the funding of the HIV-preventative drug PrEP. The court ruled that NHS England had the power to fund the drug – NHS England had previously insisted local authorities should fund PrEP (pre-exposure prophylaxis) due to their remit for preventative healthcare. NHS England said the court had decided it had the power but not the obligation to commission the drug. However, it would now formally consider whether to fund the drug, discuss with local authorities how it could be administered and seek to lower the cost.

in the media

November was another busy month for the HFMA, with responses to reports in the run-up to the autumn statement, including the provider sector Q2 figures and a story on the potential effect of the UK decision to leave the European Union.

HFMA policy director Paul Briddock talked to *Public Finance* about the Q2 figures from NHS Improvement. These showed a year-to-date deficit of £648m, £22m worse than planned, with the overall position boosted by the addition of sustainability and transformation funding. Mr Briddock hoped the figures marked the start of an improved position, adding that the financial performance was 'a testament to the incredibly hard-working staff in the NHS'. But the battle to tame NHS deficits was far from over, he added.

Mr Briddock spoke to the BBC about the potential effect of a weakening pound on the NHS in the wake of the EU referendum. Radio 4 reported on fears that the cost of supplies would increase. Mr Briddock said that the NHS would have to react to an expected rise in the cost of imported goods by, for example, making savings in other areas.

The HFMA also contributed to an *HSJ* report on maximising the contribution of non-clinical staff. Mr Briddock said finance staff were frustrated at working in silos. He added that highly skilled workers were needed to deliver the Carter recommendations, while good-quality information would help drive value.

News analysis

Headline issues in the spotlight

Sustainability questions

Respondents in the latest HFMA financial temperature check survey back sustainability and transformation plans – but have concerns about the process. Seamus Ward reports

Sustainability and transformation plans (STPs) will provide the NHS with an effective lever to gain acceptance of proposals for changing local services, according to the latest HFMA *NHS financial temperature check*. But there was concern over governance of the regional bodies and caution over the levels of savings they can achieve quickly.

The HFMA received responses from 128 provider finance directors (54%) and 73 clinical commissioning group chief finance officers (35%). Finance directors completed the survey in late October and early November.

Survey respondents broadly supported the STP process and 46% said relationships between commissioners and providers had improved.

Almost 60% of respondents said they could see clear and effective STP leadership in place. However, only 20% felt relationships were strong enough in their STP to make the necessary changes across organisational boundaries.

There were fears over the scale of expectation and the consequent financial risk. Respondents did not believe there was enough clarity on accountability for implementation and 72% were concerned about STP governance.

A majority of finance directors (62%) would prioritise their own organisation's obligations ahead of the STP's objectives if there was a conflict between the two. This may reflect the lack of clarity on the authority of STPs and how they relate to boards' statutory duties and financial control totals.

Many finance directors believed the financial goals set for the STP process are too optimistic and only 54% believed that the financial risks associated with STPs have been fully recognised. While accepting that STPs are young organisations, more than a quarter of finance directors questioned whether the STP financial objectives could be delivered. Though most thought it too early to say, 6% of trust finance directors and 17% of CCG finance leads were confident that organisational and STP financial goals would be delivered.

The chief concerns were on the pace of change required and the high-risk nature of the plans. Respondents also questioned whether local politicians would back the necessary changes.

The HFMA said local finance leaders were appealing for realism, with only 5% feeling adequate risk management processes were currently in place. Respondents had highlighted a number of risks to their STP, many of which they also regarded as threats to their organisations, including increases in emergency care activity; the impact of financial constraints on social care; rising demand; slippage in cost savings programmes; and delayed discharges.

According to the survey, 82% of finance directors favoured a change in the regulatory regime to support STP delivery, with 79% backing changes to the financial regime, and many questioning the value of tariff funding.

'Although STPs were met with enthusiasm and positivity when they were introduced, there is scepticism from finance directors that the STP frameworks can work in practice,' said Paul Briddock, HFMA director of policy.

'It is encouraging to see reported improvements in collaboration and some strong leadership in place, but when operating in a "club versus country" framework, where there are conflicting priorities between individual organisations and footprint areas, the lack of clear governance can cause angst.

'Given that it is early days, many organisations are yet to strike the right balance and there are clearly still issues that will need to be worked through, but doing this in an open and transparent manner will be key to achieving the success we need to see across NHS finance.'

The survey also asked trust and CCG finance leads about the financial position of their organisations. In the quarter two figures from NHS Improvement, the provider sector reported a combined deficit of £648m, having received £900m from the sustainability and transformation fund. In their half-year figures, CCGs had a year-to-date overspend of almost £236m against plan.

"Although STPs were met with enthusiasm when they were introduced, there is scepticism from finance directors that STP frameworks can work in practice"
Paul Briddock, HFMA

The HFMA said organisations in all sectors of the NHS are facing significant financial pressure. While the problems in the provider sector are well established, CCGs are also now forecasting an overspend of £190m, according to Q2 figures.

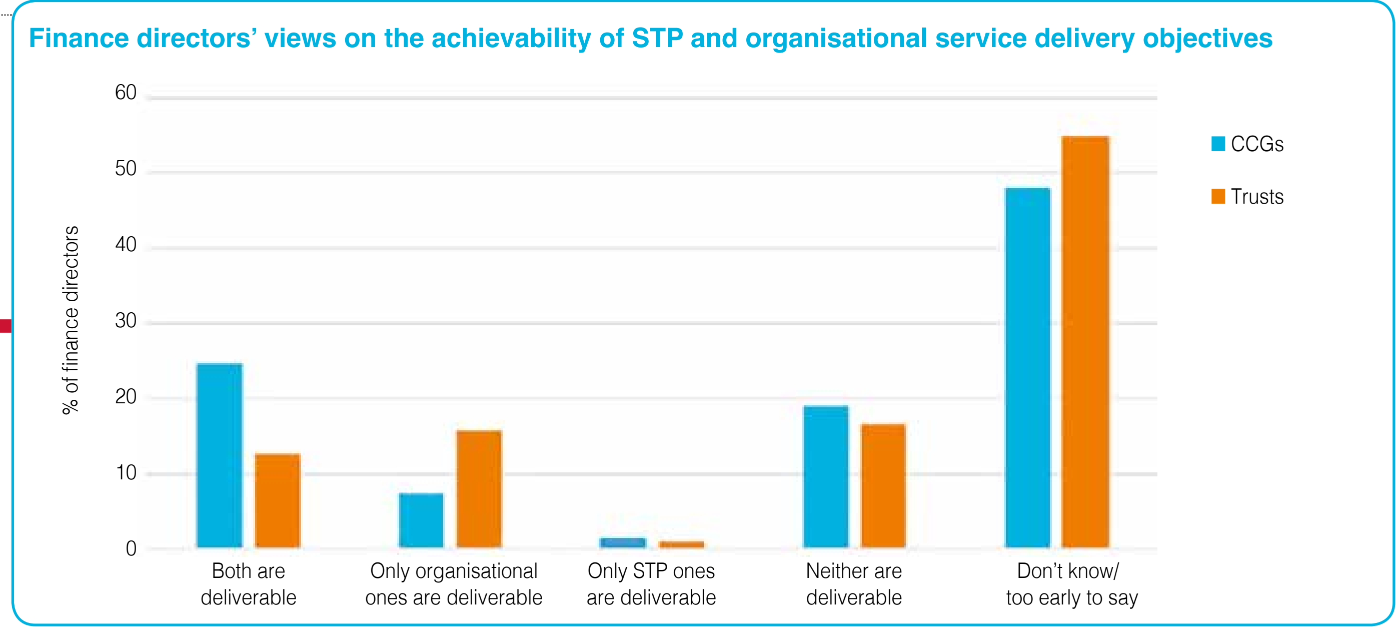
The temperature check survey showed 52% of trusts forecast a deficit this year – NHS Improvement expects 50% (118 trusts) to end the financial year with a deficit. This would be an improvement on 2015/16, when 65% recorded a deficit. The provider sector is, of course, planning for an overall deficit this year, with some organisations also planning for a deficit.

In the HFMA survey, more than half of CCGs (56%) forecast a surplus at year-end, 21% a deficit. They are required by NHS England to make a minimum surplus of either 1% of allocation or their 2015/16 surplus less agreed drawdown, whichever is greater. Some 51% of CCGs told the HFMA that their 2016/17 forecast would reduce their brought-forward surplus.

The HFMA survey said that while most NHS bodies expect their year-end position to be the same as or better than planned, 22% of trust finance directors and 35% of CCG finance officers believe it will be worse.

And 31% of respondents did not expect to keep within their control totals. Some 85% of finance directors did not believe the financial reset, launched in the summer, would return the NHS to financial balance in the short term. Some commented that the plan would cut the deficit, but it was felt that the underlying deficit

Finance directors' views on the achievability of STP and organisational service delivery objectives



was too large to return to balance in the short term. The NHS needed longer to address the challenges of increasing demand, reducing the cost base and balancing the financial position of commissioners and providers.

Finance directors' confidence on being able to meet their control totals was tempered by the lack of headroom in the current financial year. They said forecasts were tight and their delivery depended on the severity of winter pressures, the achievement of cost improvement programmes, inter-organisational agreements and the use of non-recurrent funds. They noted the need to balance the agreed financial position with consequences for services to patients.

In the survey, 57% of CCG chief finance officers and 39% of trust finance directors considered the level of risk to be high. At the same time, confidence in their organisations' ability to deliver planned recurrent savings was low. Finance leaders had more confidence in their non-recurrent savings plans (see table).

Achieving planned savings have proved elusive and was the main factor contributing to a rise in provider costs – 61% of trust finance directors identified underachievement of planned savings as a key cause of variance between their forecast and plan. According to the Q2 figures from NHS Improvement, providers delivered £1.2bn of savings in the first six months of 2016/17, but 75% (£894m) was based on recurrent savings – they had planned recurrent schemes to deliver £1.17bn in the first half of the year.

An increase in agency staff costs was another reason given to the HFMA for provider forecasts varying from plan (34%), along with rises in planned non-pay costs (24%) and increasing fines, challenges and deductions.

NHS Improvement said 71% of trusts have cut their agency spending since new rules to curb temporary staff expenditure were introduced last November. At Q2, agency costs were £312m lower than at the same point 12 months earlier. However, the pay bill was £71m over plan, drugs and clinical supplies overspent by £62m each.

The HFMA said CCG finance chiefs were most concerned about acute hospital contract costs (82%), the cost of funded nursing care (74%) and the underachievement of planned savings (also 74%).

The biggest threat to in-year financial balance is believed to be the increasing emergency admissions, together with other rises in demand and the financial constraints in social care. CCGs also said loss of access to their non-recurrent reserves would threaten their financial balance.

The temperature check report said welcome steps had been introduced to help the NHS achieve financial sustainability and improve its operational performance. These included the £1.8bn sustainability and transformation fund, the two-year planning guidance for 2017/19 and the planning timetable being brought forward.

Looking into 2017/18, just over half of trust finance directors predicted their organisation will be in deficit and the proportion forecasting a 2017/18 surplus was 35%, compared with 45% in 2016/17. A quarter of CCG chief finance officers are forecasting a deficit in 2017/18.

There is uncertainty about control totals for 2017/18 and 2018/19. A third of those accepting totals believe them to be achievable and 19% unachievable, while 48% did not know. Some finance directors were concerned the control totals were unrealistic and did not reflect the scale and pace of change needed to enable significant transformation programmes across a number of organisations.

Concern remains over quality of care, with 25% of trust finance directors and 22% of their CCG colleagues believing it is deteriorating in the current financial year. Almost half (47%) of trust finance directors and nearly a third (32%) in CCGs said it will decline further in 2017/18. While few directors believed clinical outcomes or patient safety were at risk, they were concerned about access to care, waiting times and rationing.

Mr Briddock said the NHS was in a difficult position – discussion was needed on its finances and expectations had to be more realistic.

'Finance directors are calling for more realism across the sector, and a frank discussion as to what services are affordable in future. The current numbers don't add up and are merely a sticking plaster on a much bigger problem. Despite the NHS agreeing that initiatives such as STPs provide the platform for achieving a more financially balanced NHS, further conversations and collaboration are needed.'

Finance director confidence in delivering 2016/17 savings programmes

	Recurrent savings		Non-recurrent savings	
	CCG	Trust	CCG	Trust
Too early to say	1%	3%	6%	1%
Not at all	32%	24%	8%	4%
Not very	42%	40%	20%	12%
Quite	24%	30%	51%	58%
Very	1%	3%	15%	25%

Comment

December 2016

Step change

A whirlwind year has seen finance managers step up to the challenge

Wow, what an eventful year! I was warned that my year as HFMA president would fly by – and that has proved to be true. But I couldn't have predicted the whirlwind of events – outside and inside the health service.

My year started on a personal sad note with the death of my mother. This meant I missed my own inauguration as association president. So a heavy heart and no glitz and glam. And it meant I then had a baptism of fire in January when I took up almost my first duty for the association: giving evidence to the Public Accounts Committee's inquiry into NHS sustainability.

HFMA president Shahana Khan

A clear message I picked up from members as I visited branches was to be the finance function's voice and 'say it as it is'. I've tried to be true to this from that first very public engagement, continuing it in regular meetings with system leaders and within the pages of this magazine.

Under my theme for the year, I challenged the finance function to 'step up' and there is clear evidence that it has done just that.

The association saw its influence strengthen further with strong input to the national planning framework changes. System leaders also stepped up in listening to grass roots' call for changes.

The system is not perfect yet, but the recognition of the importance of moving away from an annual focus and planning earlier should be applauded.

We all now have the responsibility to make things work and, as a knock-on benefit, the planning changes also give us some headroom for much needed progress in areas such as patient-level costing (as you can read

Agreeing to differ

It is hard to reconcile 'no new funding' decisions, given the current pressures

Healthcare Finance editor Steve Brown

Sometimes you wonder if we are all being shown the same footage. The United States' population appears to have voted for a new president, despite a widely broadcast series of comments and viewpoints that many people found objectionable. Were they all watching and listening to the same speeches? In many cases, voters' decisions had been made and no amount of 'evidence' or analysis would persuade people to change their minds.

Is something similar going on with health and social care funding in the UK? Is the government seeing something other than the apparently clear evidence of a service in financial distress? This would appear to be the case, given the clear decision not to respond to calls for additional funding in last month's autumn statement.

Few realistically expected actual additional funds for the NHS – having being afforded 'special' protection in recent years relative to other spending departments. Pre-statement lobbying had focused on the need to supplement social services budgets

PRESS ASSOCIATION

> **"Despite the challenges we face, I am heartened by our members – there is no shortage of enthusiasm "**

in this issue) and service reform.

The association has had another strong year with a series of well-attended events and its new international value symposium standing out in particular. But it steps up again this month as it reaches another major milestone with the launch of qualifications leading to an MBA.

There are signs that we have all stepped up too in the financial results. The half year figures suggest a service working incredibly hard to constrain a deficit in the face of unrelenting activity pressures and the very real impact of cuts in social care spending. Clearly there is more work to be done and the second half of the year is going to be much tougher, but we should acknowledge the work that has been undertaken.

Outside the NHS, we have seen a vote to leave the European Union, which led directly to a new prime minister. A weaker pound already means higher costs for some imported goods, but we don't yet know what the full impact of that vote will be; with challenging times ahead no doubt.

Perhaps even greater uncertainty surrounds the impact of the election of a new president in the US. There could clearly be an impact on the global economy, which could have knock-on effects on UK inflation and interest rates.

I also can't help wondering that if I had been HFMA president next year, would I have faced even closer scrutiny as I went through passport control to visit the US HFMA annual national institute?

Our temperature check (see page 10) gives an insight into the very real pressures facing finance directors, their teams and organisations right now. There is no denying that times are hard out there and that there are very legitimate concerns about funding. But I cannot help notice the amazing attitude of finance staff as I've met them throughout the year.

Despite the very real challenges we face, I am heartened by our members – there is no shortage of enthusiasm or lack of community and there is a clear determination to do the right thing for services and patients. This is surely the very definition of a service that has stepped up.

Contact the president on president@hfma.org.uk

and end cuts to public health, which would in turn relieve pressure in the NHS. Even the politically neutral Care Quality Commission had talked of 'approaching a tipping point'.

There was a definite anticipation that the government would listen to these calls and recognise the acute funding problems facing social services.

But continuing a year of incorrect predictions, it would appear the government sees a different story when it looks at health and social care. It recognises the financial challenges of delivering services in such a difficult wider economic context. But it is not persuaded enough to divert scarce resources to ease those pressures. It maintains transformation plans can still be delivered within the already committed additional resources, ignoring subsequent cost and activity pressures.

Yet the evidence of a service pulling out all the stops to meet rising demand and growing pressures continues to mount. Stubborn provider deficits and signs of stress in commissioning, as local bodies attempt to deliver unprecedented efficiency demand, are undeniable evidence.

Current provider forecasts suggest a £669m deficit by the year-end. CCGs are also forecasting an overspend within a small forecast underspend for commissioning as a whole.

The HFMA's latest *NHS financial temperature check* underlines the significant risks even within these plans. Nearly 60% of CCG and 40% of trust finance directors say there is a high risk associated with achieving their plans for the year. Achieving recurrent savings are – not untypically – proving a particular challenge, potentially making next year's efficiency requirement even harder. So no let-up there then.

Perhaps what gets missed in all the hand-wringing about the size of the deficits is how well the service is delivering amid these challenges. NHS Improvement said a second successive quarter of 'positive financial performance', reported in its quarter two report, came despite 'continued unprecedented growth in demand'.

> **"The evidence of a service pulling out all the stops to meet rising demand and growing pressures continues to mount"**

This performance – masked in the understandably negative coverage of financial deficits and funding shortages – should not be overlooked.

Most people agree that the long-term solution is transformed care – meeting current demand in different ways and providing more general support and fewer acute interventions for the long-term ill. NHS Improvement chief Jim Mackey and chancellor Philip Hammond have hinted the Treasury is aware of sustainability and transformation plans' need for capital. But for the time being, it seems the service and the government will have to disagree about the level of funding needed by the NHS and social care before these transformed arrangements can be put in place.

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

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fast track

With growing impatience about how long it could take to deliver patient-level costing in the NHS, NHS Improvement has responded by hitting the accelerator on its transformation programme. Steve Brown reports

Next year there will be a major acceleration of the NHS Costing Transformation Programme (CTP) as NHS Improvement looks to use a window opened up by the setting of a two-year tariff to make a big step forward in patient-level costing.

The tariff for 2017/18 and 2018/19 has been derived from the 2014/15 reference costs. This creates capacity at the centre and reduces the urgency for the 2016/17 reference costs, which would normally be submitted in July 2017, creating the potential for trust costing teams to make more progress with patient-level costing implementation. So NHS Improvement has decided to go for it. 'The two-year tariff gives

us the opportunity to see if we can accelerate patient costing and get it into the next tariff calculation process – using patient-level costs rather than reference costs or patient costs to supplement reference costs,' says Richard Ford, costing director at NHS Improvement.

'Next summer we don't need reference costs to be all submitted in July, so the aim is to get a cohort of trusts using patient-level information and costing systems (PLICS) to submit patient costs to us.'

If successful, this would be a significant step forward for the costing programme – under the previous timetable, the first tariff to be informed by new acute patient-level cost data would have been for 2021/22. This recent push would potentially gain the service two years on those original plans.

This would be welcome. A recent audit of NHS reference costs has again underlined the poor state of existing healthcare resource group-level costing across England. And while the transformation programme has received broad support, there is a general feeling that it could or should be delivered quicker.

Lord Carter's report on productivity called for 'the use of a standard patient-level costing system in all trusts by April 2017' – substantially ahead of actual programme requirements. And the Public Accounts Committee has called for rapid improvements in the quality of cost data.

So this is the fast-track plan. More than 60 acute trusts have volunteered to be in the fast track. This already includes 31 of the 36 trusts that are vital – in terms of healthcare resource group coverage – for tariff-setting. So the other five 'vital' trusts have been asked to get involved too. These nearly 70 trusts will be supported through a rapid implementation plan starting in February and leading to a patient-level cost collection in July.

There will be monthly deadlines and each of four regional groups of trusts will be supported by its own account manager.

NHS Improvement is also putting together a central specialist team to support the whole cohort and provide intensive support where needed. There will also be a programme of webinars.

It is a big undertaking. This point is underlined by this year's patient cost submission by NHS Improvement's roadmap partners – six acute trusts that implemented the new costing standards early and went through a test submission. 'The six partners were some of the best in the sector but, despite their best efforts, there were still inconsistencies in the data they submitted,' says Mr Ford.

Roadmap lessons

There have been lots of useful lessons from this roadmap process. For a start, the standards have changed (see box), but it has also underlined the importance of whole organisations committing to costing transformation, not just the costing team.

'Ultimately this is about the quality of people and how engaged the whole organisation is – how supported the costing team is,' says Mr Ford. Some organisations simply ran out of time to implement all the standards, he adds. 'There has to be a readiness to do the hard miles.'

He wants NHS providers to understand this. There are significant benefits – for organisations and the NHS more broadly – from better, more granular cost data. But it is not something that can be achieved in a half-hearted way.

To make room for these organisations to concentrate on patient costing and the new submission, they will face a relaxed reference cost submission timetable. Trusts outside the early implementers will face the normal timetable. In fact, in a step up from last year, they will have to submit an integrated reference costs return – including both their standard reference costs and their education and training costs – in July.

In contrast, the patient cost trusts will have until September to submit their reference costs. To ease the burden for all providers, there will be no reference costs spell return for 2016/17 costs – with the return being focused on finished consultant episodes.

"The aim is to get a cohort of trusts using patient-level information and costing systems (PLICS) to submit patient costs to us"
Richard Ford, NHS Improvement

The ambitious aim is to have patient-level cost data delivered to the tariff creation team by the end of 2017 to be fed into the tariff creation process for 2019/20 (which starts with engagement with HRG expert working groups). The current expectation is that the patient data will inform prices, rather than directly set them, and there are likely to be support arrangements to enable a smooth transition to what could be quite different prices.

For the costing transformation to work, a number of issues need to be addressed. 'The biggest issue for us is that the actual complement of costing practitioners across the service is in the upper 200s,' says Mr Ford. 'We need it to be 500-plus and maybe up to 700.'

This message – that the costing function needs to grow in size and capabilities – has been consistent since Monitor (as it was) launched its transformation plan at the end of 2014. Now, however, NHS Improvement has tried to put in place some of the mechanisms that will support this growth and development.

The HFMA is launching two diploma qualifications at this year's annual conference, which will provide a pathway to an MBA in healthcare business and finance. NHS Improvement is in discussion with the association about developing a costing module or modules as part of these diplomas.

It believes these modules (whether as part of the full diploma or not) will provide existing costing practitioners with opportunities to expand their skills and to get their costing credentials formally recognised.

For new or non-costing practitioners, NHS Improvement is developing a foundation course to provide an introduction to costing

for more general finance managers and perhaps technician-level accountants. Mr Ford believes this will help expand interest in and understanding of costing and 'help bring the converts in and increase the cohort of costing practitioners'.

Even if this increases the pool of appropriately qualified, potential costing practitioners, there will still be a requirement for boards and finance directors to back the programme by increasing the costing budget to enable teams and skills to be expanded.

'First, we recognise that we need to talk to directors of finance and chief executives and promote the programme,' says Mr Ford. 'But we are also working with NHS England to explore and develop a best practice tariff for costing.'

Investment incentive

This could be in place for 2019/20 and the incentive for trusts is that if they make the necessary investment in systems and costing function now, they should be well placed to receive that new tariff payment if it gets the go-ahead.

Mr Ford says this is not dissimilar to the approach used in Germany to support the costing expenses of providers involved in a pool of organisations that submit patient costs to support tariff-setting. The difference is that all NHS hospitals would have the potential to earn the best practice tariff.

A smaller incentive will see providers that are in deficit (but still under their control total) able to invest in a costing system (again remaining within the control total) that nominally increases their deficit.

November's audit report on NHS reference costs for 2014/15 (see news, page 4) showed that 49% of acute trusts were non-compliant with the *Approved costing guidance*.

This follows a similar conclusion the previous year, when 49% of trusts were found to have submitted materially inaccurate costs. Given that the whole acute sector has effectively been audited over the two years, this is pretty damning.

The report concluded that 'many trusts still treat costing as a standalone regulatory exercise and do not use costing information to make management decisions' and that 'not enough resources are devoted to ensuring that the information is accurate'.

Mr Ford said it was a disappointing assessment, but in many ways the poor consistency in reference costs and the low priority given to it by providers were known issues. 'But it also makes the case and provides greater impetus for the changes we are making,' he says.

The audit report is a reflection of underinvestment in costing. But it clearly has the potential to demoralise costing practitioners and undermines arguments for greater use of cost data in decision-making. NHS Improvement is determined this will change.

The acceleration of its transformation programme is perhaps the best possible response.

First submissions

Six roadmap partners submitted patient-level costs in September and October, becoming the first real users of the new draft costing standards published in April. A report will be sent back to these organisations towards the end of the year, but Paul Howells, costing transformation lead at NHS Improvement, believes that, even with just six providers involved, useful information is emerging.

'We've been able to track a patient across a number of the [London-based] partners across the financial year in different care settings,' he says. 'One patient had close to 20 outpatient appointments at one trust, three inpatient episodes at another and also attended a third accident and emergency department.

'We can track the patient across care settings and see what has happened – how much time in critical care, how much time in theatre, how many tests they had – and we can break down the cost of each element.

'And when we bring in mental health, ambulance and community data, we will be able to link up across the whole spectrum – and that could have ramifications for the tariff in the future and for regional decision-making.'

This 'whole pathway' view of patient costs may not have been the prime purpose of patient-level costing, but it could be a powerful additional benefit.

Using the standards has also led to them being revised. Perhaps the key change is a reduction in the number of components into which each patient's costs have to be broken down for submission to NHS Improvement. The initial requirement was for providers to map costs from the ledger to approximately 80 resource types and then to allocate these resource costs across more than 120 activities.

With practitioner input, this has been rationalised down to a 20 x 50 matrix (resources x activities), with major rationalisation around how overheads are reported.

Some trusts found it difficult to categorise all their costs across the original wider range of components, which also created collection challenges. Some file sizes submitted were as large as 100 gigabytes

"We've been able to track a patient across the financial year in different care settings. One patient had close to 20 outpatient appointments at one trust, three inpatient episodes at another"
Paul Howells, NHS Improvement

and the total database for six trusts was 747 million lines. Compare this with an estimated 12,000 lines of data in a reference cost submission across six trusts and the step change in detail becomes clear.

These revised standards for acute services are part of NHS Improvement's *Approved costing guidance*. This will also include first standards for mental health and ambulance services, details of a new costing assessment tool (CAT) and the traditional reference costs collection guidance.

The CAT aims to help practitioners and boards understand how good their costing is, how closely they are following the standards and where they should focus improvement efforts. An early version has been revised following practitioner feedback and now takes more account of materiality. All early implementers will complete the assessment next year.

There are also plans to develop a portal, providing NHS providers with a way to compare their own detailed costing data to that of peer providers. A similar tool has been used to good effect in Australia (see *Healthcare Finance*, July/August 2016) and there are clear links with NHS Improvement's wider model hospital project, which could see reference costs replaced by patient costs when possible.

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NHS Improvement describes the Q2 results as the service being one-nil up at half time. Now Bob Alexander wants providers to maintain this performance for the second half. Steve Brown reports

HALF TIME LEAD

THEODORE WOOD

NHS providers are doing well financially in extremely trying times – and finance teams are playing a major part in this performance. So says Bob Alexander, director of resources and deputy chief executive at NHS Improvement. But he now wants those finance teams to lead a further push to contain this year's aggregate deficit within planned levels and to enable the service to start 2017/18 as close to run-rate balance as possible.

Mr Alexander, who will address the finance function at the HFMA annual conference this month, spoke to *Healthcare Finance* just after the oversight body had published financial figures for the first six months of 2016/17.

NHS Improvement claims the figures show a sector 'continuing its financial recovery'. While the overall year-to-date position was £22m over plan (compared with £5m under plan at Q1), the oversight body and regulator says the number of providers in deficit has reduced for a second consecutive quarter. And the monthly run-rate has seen 'significant improvement' compared with the same period last year.

The full-year forecast at the half-way mark is for a sector deficit – taking account of provider deficits and centrally held resources – of £669m. This would be £89m over the planned level of £580m, although NHS Improvement says it believes this plan could still be achieved. There is no longer any talk of reducing the current year overspend to £250m – the ambition targeted as part of the financial reset at the beginning of the summer. But this appears to be recognition of what the regulator accepts as 'continued unprecedented growth in demand for NHS services'.

'This is not positive spin,' he says. 'We are being realistic. But without a shadow of a doubt, organisations are working tremendously hard to keep to the financial plan – and at Q2, broadly the provider side is on plan and that is a really good effort.'

NHS Improvement chief executive Jim Mackey put it another way. 'Thanks to a phenomenal effort by staff across the NHS, we're one-nil up at half time.'

Mr Alexander acknowledges there are variations to forecast and that some cost improvements are loaded into the second half of the year – and this will require a redoubling of cost improvement effort. But while overall providers are behind plan in terms of cost improvements, the level of cost improvement in 2016/17 is ahead of last year. So, in summary, good work but more to do. And he is clear that NHS Improvement is determined to help providers meet their targets, not just berate them for under-performance.

Taking control

'We want to support finance professionals and their organisations more broadly in delivering the financial plan for the year and demonstrate to stakeholders that operational financial control exists against unrelenting demand pressure,' he says.

Mr Alexander says that while all providers face this pressure, some are struggling more, whether because of more severe pressures, historical context or other reasons. Providers' financial performance is underpinned

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Model hospital

Lord Carter's final report on productivity called on NHS Improvement to develop a model hospital. This information system would bring together key metrics to describe 'what good looks like from board to ward' and enable trusts to compare themselves to national averages or peer organisations.

Six compartments of the model hospital are now live: hospital pharmacy and medicines; estates and facilities; headline finance metrics; visitor cost recovery; nursing and midwifery; and a test

workforce analysis.

Further expansion is expected soon, following testing with a small cohort. This will add three modules: emergency medicine; trauma and orthopaedics; and allied health professionals.

New metrics are also being added to existing modules and data will be refreshed with the latest 2015/16 reference costs.

NHS Improvement has also recently launched a purchase price index and benchmarking tool, which is refreshed monthly with trusts' purchase order data. NHS Improvement says that in total it includes £8bn of spend information with about £2bn matched on the price comparison tool. One trust has already made a £150,000 saving on pacemakers and implantable cardioverter-defibrillators as a result.

by £1.8bn from the sustainability and transformation fund (STF). Nearly £1.5bn of this is currently reflected in providers' forecast outturn position, which is a collective £1,067m deficit (offset by £327m of undrawn STF and a technical adjustment of £71m to produce the overall forecast of a £669m overspend).

The deficits in seven of the eight providers in financial special measures add up to more than a quarter of the overall provider deficit of £1bn. And there are 16 providers on the overseer's financial improvement programme (albeit with three organisations on both lists). Trusts on the initiative bring in outside help to help them deliver more difficult saving opportunities.

Mr Alexander is clear that no-one wants to be under financial scrutiny. But he says the way both these programmes have been delivered demonstrates NHS Improvement's 'support' credentials. He insists that improvement programme trusts have found it helpful, and the approach with special measures, involving other NHS professionals and organisations, seems to be working well with recipients. While three trusts only entered special measures in October, the initial entrants 'are all in a better place now than when they were put in', he says.

Decision-making

Despite significant pressure to keep costs down, he says the overarching requirement is to ensure organisations properly think through big decisions that have implications for resources. Some turnaround programmes in the past have been criticised for being short sighted – delivering financial targets at the expense of services, for example. But Mr Alexander says the current pressure to contain costs is not a simple 'swing of the pendulum'. 'We used to worry about this and now we are worried about something else.'

For example. the new agency controls come with 'break glass' arrangements that enable trusts to breach caps where required to deliver services. Mr Alexander says that is characteristic of the approach in general.

'We are looking for more control and more advance thinking about decisions – that feels like an okay place to me,' he says.

Agency staff costs are a good example of the challenges for providers. As they struggle to fill substantive positions, and demand pushes activity above planned levels, some drivers are outside providers' control. However, NHS Improvement says caps and other controls are helping to contain these costs.

While agency spending at Q2 remains ahead of plan by some £200m, it is £300m less than in the same period last year. And this is against a trend of year-on-year increases – 25% in the three years up to the introduction of the controls. NHS Improvement has already highlighted differences in the success of the caps to date on temporary nursing and locum doctor spending (*Healthcare Finance*, November 2016, page 8).

It suggests some of the difference is down to better data and faster response by nursing directors in getting to grips with both reporting and cost reduction.

But there are other factors behind the continued high spending on locum doctors. 'The challenge around medical locum expenditure is more difficult than with other clinical staff,' says Mr Alexander. 'This brings us back to sustainable services and services in some locations that are propped up by medical locums. There needs to be some honest conversations around that,' he says.

He adds that these conversations need to be as much about the quality and safety of services as the costs of delivery. 'It is not just the provider that has to make the argument, there is a big commissioning responsibility in this too,' he says. 'There is also a big primary care responsibility in thinking about how local services that are run by predominantly locum staff do the right thing by their patients.'

The publication of highest and lowest spenders on agency staff (compared with agency spending ceilings and as a percentage of total pay) is not just to put pressure on the poorer performers but to demonstrate where organisations may be getting to grips with the issue. It is an approach that NHS Improvement is keen to expand and its Carter-commissioned model hospital is already giving trusts comparative data in a range of areas (see box).

Mr Alexander points out that despite very real system-wide pressures, 120 providers forecast a surplus for the current year (118 forecast a deficit) and many will enter next year in run-rate balance. Some of this will be about good financial management and best practice in service delivery. The challenge remains to spread best practice where appropriate.

Efficiency map

An updated *NHS efficiency map,* produced by NHS Improvement and the HFMA, was published in November to support best practice in cost improvement (see page 7). The map is split into three sections: enablers for efficiency; provider efficiency; and system efficiency. It signposts existing tools and reference material to support cost improvement and includes case studies about specific improvement projects.

NHS Improvement has also called on the finance function to make a direct contribution to improved efficiency by exploring the potential to share financial services across local health system providers. The financial reset called for the consolidation of back office services across local sustainability and transformation plan (STP) footprints. 'As a minimum, organisations should be able to demonstrate why they have got the back-office arrangements they have,' says Mr Alexander. But in reality, he believes providers could and should be more ambitious. 'Some parts of the

country are having productive conversations in this area,' he says.

Given current pressures, it seems a tall order for the service to enter 2017/18 with an aggregate underlying run rate balance. But Mr Alexander refuses to rule it out.

'We'll test that through the operational planning for 2017/18 and 2018/19,' he says. The parameters have been set to encourage aggregate balance and there has been an agreed approach on expected activity pressures, but he acknowledges that local health economies need to factor in the impact of this year's activity increases as they develop plans.

This recurrent balance would provide the foundation for the next two years (underpinned by a two-year tariff to provide some provider stability) and for local health systems' STP plans. Entering this period with an underlying run-rate deficit will make the challenge even harder.

These system-wide plans aim to deliver services that will be sustainable over the medium to long-term – with many targeting a shift of care from acute into local care settings.

There have been concerns that a shortage of capital to support this transformation might undermine plans. But Mr Alexander insists

this is not an issue for all areas. 'We have to recognise that capital availability is a challenge within the settlement,' he says. 'Some STPs need capital, though many remain a work in progress. And some of the STPs that are most developed are relatively capital-light, because the best STPs are an articulation of a journey that's been going on for some time.'

That said, NHS Improvement chief executive Jim Mackey has floated the idea of a new bond to provide an alternative source of capital funding. Mr Alexander says the idea is still in the very early stages. But he calls on local systems to engage with local authority partners, which have a little more flexibility around capital.

'Some areas could be a bit more joined up with how they deal with existing infrastructure, sharing more and possible capital receipt opportunities. Some systems are in dialogue and in others this could be a real opportunity.'

Regulation call

The move to a greater system focus has led to calls for regulation to be focused on systems rather than organisations. Mr Alexander accepts that oversight bodies and regulators must be sensitive to the fact that local organisations 'stand or fall in this together', though it is not clear how regulation could work at a system level. He accepts that systems control totals are a simple addition of provider and commissioner targets and don't yet offer any broad flexibility. 'But we have said we are open to that conversation,' he says.

There would be two issues for NHS Improvement and NHS England: what are the reasons for the change and what is the confidence that the shared arrangements would be strong enough to deliver? With tight financial control so important within such a difficult settlement, it seems unlikely there will be any major change in this area over the next 12 months.

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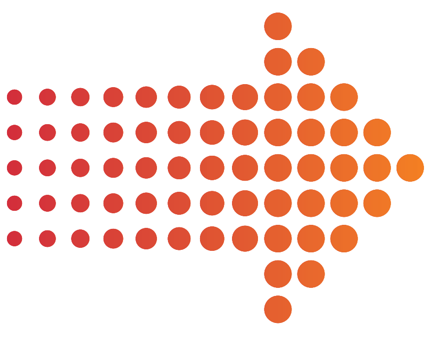
Striving for excellence



The HFMA president and chief executive's report, 2015-16

In what has been a particularly challenging year for our members HFMA continues to strive to listen and support the membership in every way it can.

This is particularly the case in policy and educational terms where HFMA continues to fulfil its mission and objectives as articulated in our 2014-17 strategy.

For the fourteenth straight year, we are pleased to report HFMA has delivered a surplus of £225,000, slightly down from £303,000 in 2014/15. However, it should be noted that this year we started on the very exciting development of our own Qualification which has resulted in 'exceptional' costs of £183,000 which if adjusted for would mean our surplus would have been £408,000.

Our turnover has also increased from £7,592,000 to £8,516,000 which is one demonstration of the continuing growth in activity at HFMA.

Our conference facility, 110 Rochester Row, is now really 'bedding in'. Not only does it continue to provide us with a focal point in the centre of London but it contributed £230,000 to our bottom line. We were able to plough this surplus back into the policy and technical work of the Association. That figure represents a 6% return on investment as well, before consideration is given to the increased capital value.

We would also like to thank our friends on the corporate partner programme – all 25 of them. These organisations provide us with valuable resources without which we would not be able to run our central infrastructure. HFMA does not endorse products or services but we work with clients to help them get their message across. We would also like to thank all of our commercial supporters whether they be national or local businesses. Together they provide substantial resource for the Association to operate on the scale it does.

Our reason for existence is to support our members so HFMA is delighted to be able to say that by the end of the year the target of 10,000 members has been beaten by 1,675 to bring this class of membership to a total of 11,675. Although more challenging, we have also managed to have a small increase year on year in our paying membership. A major objective for 2016-17 is to develop new ideas to attract more finance professionals into membership.

Paul Briddock has continued to spearhead our policy and technical programme and act as principal spokesperson for HFMA. The two financial temperature check surveys were amongst the highlights of a busy year and the whole media campaign generated 188 pieces of coverage which is way above the target of 75 that was set.

The health system is under significant pressure and over the past year HFMA has been able to support members and others in the NHS through:

- 105,402 hours of CPD provided during year (on average 11 hours for each full member)
- 155 local and national events
- 37 webinars providing 7,633 hours of CPD
- 42 briefings and publications.

This amazing amount of activity does not 'just happen'. HFMA is blessed to not only have a very professional and dedicated team of some 80 staff but also a magnificent and growing group of volunteers who work so hard in their free time whether they be committee or branch members or Chairs or of course our Trustees. We are truly blessed to have such busy senior people in the NHS working so hard to make HFMA the success it is.

Sue Lorimer was the president for the first half of the year whose theme 'Stronger together' was a great success with 28 courses commissioned and run by our branches. We would like to thank Sue for the steady and effective way she led HFMA in her year in office, we would also like to thank Andy Hardy and Stephen McNally, two trustees who are stepping down at this AGM.

The theme for the second half of the year, launched at the 2015 annual conference in December 2015, is 'Step Up'. A theme that has captured the imagination of the service and once again, with each branch running at least one event, has proved a well-supported initiative.

During 2015-16 we continued to host and be recognised as prime partner for Future-Focused Finance ('FFF') and committed £100,000 of our resources to support the initiative. HFMA are proud to be at the heart of FFF.

HFMA is always looking to do more and develop new services to support the membership and ensure the sustainability of the Association into the future. Two major steps in the development of HFMA are; the development of the qualification, which we are expecting to launch in 2017 and the long held desire for a Royal Charter which is proving to be a longer process than we first envisaged.

We continue to strive for excellence in all we do and to grow the reach and depth of HFMA activities. We recognise a strong Association is good for the finance community as our members grapple with the unprecedented change and financial challenge within the NHS.

Thank you for reading this annual review if you think you might want to get involved please do not hesitate as there are always spaces for more willing volunteers!

Shahana Khan
President

Mark Knight
Chief executive

HEA.FIN.009 Annual Review 4pp - Draft 5.indd 1 10/11/2016 14:22

An increased membership

Total number of HFMA members:

11,675

(exceeding target of 10,000)

Expanding our

Learning and development

Supporting members and others in the NHS through organising:

37 webinars providing **7,633 hours of CPD**

155 local and **national events** held across the UK

42 briefings and **publications**

1,300 delegates at regional conferences

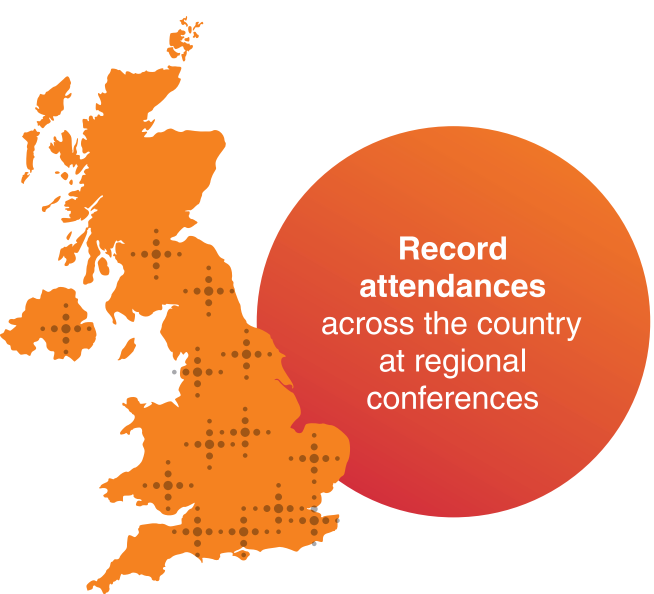
98% of e-learning feedback was **excellent/good**

93% events feedback was **excellent/good**

105,402

hours of CPD provided during year (on average 11 hours for each full member)

Active in all regions



Fantastic participation in our wide and varied programme of events across the UK

340 delegates in **West Midlands** listened to **Roy Lilley** as the keynote speaker

London hosted a joint event with McKinsey whose speakers received reviews of **'excellent' from 92% of the audience**

Record numbers of 200 at **Northern Ireland's** annual conference

40% increase on **attendance** in **South West** for the Developing talent conference

East Midlands' 'Stronger together' day on **maximising your impact** and **boosting your confidence** and **resilience**

200 delegates attended the 2 day conference in **Yorkshire and Humber**

207 delegates at the conference in **Wales**

174 attended a 24hr event organised by **KSS (Kent, Surrey and Sussex)** 'When the going gets tough'

Eastern launched **quarterly director of finance/ deputy meetings**, a newsletter and hosted 100 delegates at their conference

Scotland's high profile conference, with **John Swinney, deputy first minister**, as one of an impressive speaker line up, attracted 104 delegates

128 delegates attended the conference and membership numbers increased in the **North West** branch

Northern's annual conference was attended by **195 delegates** with highlight sessions by **Jim Mackey** and **Pat Oakley**

South Central's 'Step Up' day **boosting your team's resilience** and coaching people out of their comfort zones

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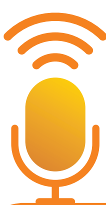


A valued voice

100% **positive media coverage** from 188 media items

110,000 website visits

Gold standard

Sally Gunnell OBE,
Olympic gold medallist closed the Annual provider conference 2016

Flagship venue for members

Dedicated conference facility in London
110 Rochester Row

Finances

Healthy financial position with a **surplus** of

£225,000

Turnover increased from

£7.6 million

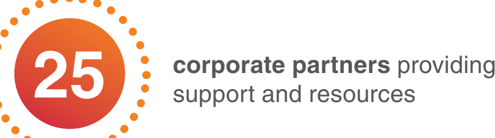
to £8.7 million

Net assets

£4.7 million

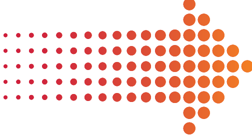
built up over many years to ensure sustainability for the future

Commercial allies



25 **corporate partners** providing support and resources

All of our events, across the UK this year have been very favourably received with **superb feedback** across the board. The range of subjects covered has been more varied than ever, with content tailored to the needs of the members attending.



Publishing and informing

The Policy and Technical team:

Produced
25
briefings and publications

Carried out
16
pieces of research

Developed or significantly updated
12
new e-learning modules

Responded to
11
consultation papers

Faculty events reached over
1,000
delegates

The continued support and expertise of our committees, who contribute to the thought leadership of the association, allows us to **inform a wider audience through our publications**. Titles updated this year include: the NHS finance function, guidance on audit panels and a costing guide, as well as a series of briefing documents, surveys and the development of clinical costing standards for acute and mental health services. Our policy team continued the debate at national level with their timely responses to 11 consultation papers. The Healthcare Costing for Value Institute also took the work in patient level costing further, by publishing the first PLICS toolkit for acute services.

The reach and depth of HFMA networks provide us with invaluable expertise and knowledge, adding value to our **collaboration with a wide range of partners:** our committees contributed to the survey on mental health parity of esteem working with NHS providers, and a number of NHS finance career stories, with Future Focused Finance.

The Provider Finance Faculty took finance directors from across the UK to see GS1 barcodes in action at Derby Teaching Hospitals, the first trust in the country to adopt the new technology.

The Commissioning Finance Faculty has seen more than 500 delegates benefit from the forums held across the UK, and the Healthcare Costing for Value Institute continues to evolve and bring real benefits for members, both commissioners and providers, attracting wide attendances at Value masterclasses, the Annual costing conference and the launch of the Annual technical costing update, reaching a total of over 480 delegates.

Our work in education continues to develop in line with the needs of our members and the wider healthcare community

The Institute also offers world wide **networking and learning opportunities** with high profile input from the internationally renowned Virginia Mason Institute, Seattle, at one of the masterclass events and an international symposium on value in healthcare, with speakers from the UK as well as Germany, Spain, Australia and the Netherlands, offering new insights.

Our work in education continues to develop in line with the needs of our members and the wider healthcare community, with 12 new and updated e-learning modules being added, by the policy and technical team.

Faculty events offer a focused environment for information sharing and education, for example, the events organised by the Chair, Non-Executive Director and Lay Member Faculty have provided a unique, educational and collaborative setting for a total of 130 delegates. Events have addressed issues of concern to members and have aimed to equip them with the skills and knowledge they need in the challenging and ever changing landscape of the NHS.

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health and safety

SHUTTERSTOCK

The NHS Litigation Authority hopes changes to the CNST will incentivise safety and cut the cost of clinical negligence. Seamus Ward reports

Each year there are lurid headlines about the amounts the NHS pays out in clinical negligence damages, with the totals climbing every 12 months. Last year was no exception, with £1.4bn paid out compared with £1.1bn in 2014/15.

So it's not surprising the NHS Litigation Authority (NHSLA), which administers the risk pooling clinical negligence scheme for trusts (CNST), is exploring ways of reducing the negligence bill. There are three main elements of the work – supporting trusts to learn from errors; changing the way member contributions are calculated to better reflect their recent safety record; and tackling costs, including legal fees.

Helen Vernon, the NHSLA chief executive, says the number of new claims are levelling off – now around 850 a month compared with a historic high of 1,100 a month – but they are still too high.

A number of drivers are increasing the cost of clinical negligence. These include a rise in claimant legal costs, which are often paid by the NHSLA. Claimant costs have risen disproportionately to the value of claims, particularly in relatively low value claims.

'There is some excessive charging by claimant lawyers and we are challenging them robustly,' Ms Vernon says.

The amount of compensation given in high-value claims has gone up. She adds that the rise in NHS activity in recent years has potentially contributed to the increase in numbers of cases. With the NHS treating more patients, the number of claims would be expected to rise proportionately.

Ms Vernon says the authority has shifted its emphasis to helping members reduce incidents of negligence. Historically under the CNST, trusts were assessed against risk management standards. In return for achieving these standards, they received a discount on their contribution – 10% for level one, 20% for level two and 30% for level three.

'We found the assessment was creating a large bureaucratic burden on the member trusts. It involved a lot of investment of their time and resources to achieve the standards. And there wasn't a great progression through the levels – many trusts got to level one and stayed there rather than investing to get to a higher level.'

There was also concern about a lack of evidence of a correlation between the achievement of the risk management standards and improvement in a provider's claims history.

Learning from claims

In place of the risk management standards, Ms Vernon says the NHSLA has chosen to support members so that they learn from incidents and focus on the causes of their claims to reduce claim volume and value.

'We are also encouraging candour and transparency. Clearly, when something goes wrong, these are critical and if you do this, you are more likely to prevent a claim,' she adds.

'We are working closely with trusts to help them get to grips with their claims. The rising cost of claims, combined with our closer working relationship has seen many trusts getting to grips with their claims data in a way that perhaps hadn't previously been the case.'

Scorecards, distributed to members over the last year, have highlighted where claims are coming from in terms of numbers and value for each organisation. These are interactive tools that allow members to drill into their claims data. 'It allows them to focus on high-value and high-volume areas, because we need to tackle both,' Ms Vernon adds.

It is also moving to early reporting of very-high-value claims, allowing

the NHSLA to help the trust learn from the incident and help manage the legal process.

The NHSLA has also brought trusts together to examine their ideas to address the causes of claims. Last year it distributed more than £18m to support the national *Sign up to safety* campaign. It approved 67 bids – trusts were able to bid for a one-off payment of up to 10% of their CNST contribution to fund a safety scheme. The NHSLA intends to publish the outcomes of these initiatives in the new year.

It's also changed the pricing methodology for CNST following a consultation this year. The changes seek to support the objective of incentivising service improvement, she says.

In its consultation response, the NHSLA signalled a shift to a pricing approach that is more focused on recent experience (see box). For 2017/18 the focus of the changes is on maternity – the area with the highest claims value, hence the greatest impact. 'We are looking at the available maternity outcome measures, working with the royal colleges, NHS Improvement and others to see the potential to link some of these outcome measures to pricing so we can incentivise improvement.'

Work has already begun, with CNST prices published in October – two months earlier than in previous years to aid planning for 2017/18. With work ongoing on outcome measures in maternity, the maternity figures were provisional and the NHSLA will produce final prices this month. It has promised to cap changes in the provisional maternity component to +/-5%.

Ms Vernon says the new system is 'less backward looking'. 'In very-high-value claims, such as brain damage at birth, it can take several years from the incident to the claim being reported to the NHSLA.

'So, when assessing a trust's contribution, the high-value claims will probably have happened years ago and is not necessarily representative of their current efforts on safety. We are trying to make the scheme more forward-looking, so we can incentivise and respond to improvements organisations are making.'

Concerns over the cost of claimant legal fees led the Department of Health to announce its intention to consult on introducing fixed recoverable costs for low-value clinical negligence claims. It is understood the consultation is imminent.

"We are trying to make the scheme more forward-looking, so we can respond to improvements"
Helen Vernon, NHSLA

The Litigation Authority backs fixed costs, pointing to its experience in employers' and public liability indemnity (the Liabilities to Third Parties Scheme, LTPS), where fees are fixed. Ms Vernon says the reduction in non-clinical legal costs contributed to a 10% cut in its LTPS contributions this year.

In 2015/16 the greatest number of resolved clinical negligence claims were in the damages range of £25,000-£50,000. But these 2,500 claims generated disproportionately high claimant legal costs – 135% of the value of damages in this range in 2015/16.

The same is true for lower value claims. Is there an opportunity to resolve these claims quicker to minimise the legal costs?

'It's a key objective for us to resolve claims as quickly as we can and ensure that where damages are due to be paid that we do so promptly. But at the same time, where there is no liability, we repudiate claims robustly and we have seen an increasing number of claims where we don't pay damages.'

Appropriate payments

Sometimes claims are higher than the NHSLA valuation of damages, she adds, and negotiations on this can take time. 'Clearly, the quickest way to resolve a claim is to pay out what's being asked for, but that's not necessarily the right outcome. We have to ensure we are making appropriate payments because we are dealing with NHS funds.'

Equally, the NHSLA will not seek to avoid paying damages where a member has been negligent. 'We have an obligation to the taxpayer to ensure we are repudiating cases of no merit. But we also have an obligation to make payments where compensation is due, and act fairly in relation to the patient.'

Given the rise in CNST fees, is she concerned that foundation trusts may leave the scheme and seek a commercial insurer? She mounts a robust defence of the scheme, saying it is the best possible value in clinical negligence indemnity. It's underwritten by the state and costs are low because it does not attract insurance premium tax and brokers' fees.

'We don't have to collect money up front to hold as a reserve to fund future claims, so money is not diverted from the frontline of the NHS – we only collect what we need to pay out.'

CNST calculation

The CNST is by far the largest of four schemes that the NHSLA manages to resolve clinical negligence liabilities in England. A not-for-profit membership scheme, it aims to spread and smooth the cost of post-1995 liabilities over time. It provides indemnity cover to 536 members – NHS trusts, foundation trusts, clinical commissioning groups and 89 independent sector providers.

The CNST is funded through member contributions on a pay-as-you-go basis. Members pay a contribution towards the estimated costs of claims each year.

A member's CNST overall payment is determined by splitting the total to be collected between members according to their relative size, activity levels, recent contributions and claims history.

Maternity contributions are calculated separately and new safety indicators may be introduced for 2017/18, adjusting the maternity element of the price by no more than +/-5%.

First, contributions are calculated as a weighted average of three elements:

- **A risk-based exposure element based on staff and activity levels, with each speciality allocated a risk weighting. The NHSLA is to review whether staffing levels are an appropriate measure of risk next year. The risk-based contribution for maternity is based mainly on number of births, though staffing levels can adjust the contribution by +/-10%**
- **A contribution based on paid claims experience for the previous five years**
- **A contribution based on known outstanding claims.**

In the new method, incidents older than 10 years have been stripped out, rebalancing the weighting to recent safety improvements rather than past claims. Each member's contribution is adjusted to limit the percentage change in contribution from the previous year, to help stabilise prices.

NHS Supply Chain

Driving savings in procurement

How working together to change procurement habits can help save the NHS millions

There is rarely a day that goes by without a headline about the financial pressures faced by NHS Trusts. The combination of increasing demand and budget pressures has seen NHS Trusts end 2015-2016 "£2.45bn in the red, with 65% of providers in deficit," says Chris Hopson, the chief executive of NHS Providers.

Given this unprecedented financial challenge, delivering efficiencies from non-pay spend has become essential. Previously overlooked, procurement is an area that commands high spend and still has huge savings potential. Lord Carter's report "Operational productivity and performance in English NHS acute hospitals: Unwarranted variations, published in February 2016 identified £700m of potential savings from procurement.

Identifying sustainable long term savings

In March 2016 NHS Supply Chain and the NHS Business Services Authority reached their target of delivering £150 million in cash releasing savings back into the NHS. Cash releasing savings' refers to the recovery of funds that can be reinvested in patient care, usually achieved through net price change, commitment discounts and using alternative quality products which offer better value'. David Pierpoint, managing director of customer engagement at NHS Supply Chain explains, "To support the delivery of savings we worked closely with the NHS Business Services Authority and both suppliers and procurement and clinical teams in NHS trusts to identify where and how savings could be made."

Commenting on the savings achieved, Sir Ian Carruthers, chair of the NHS Customer Board, which also played a role in delivering the savings said, "Identifying sustainable long term savings is fundamental to driving value for the NHS and by focusing on sustainable cash releasing savings means that not only do prices remain low but it prevents price hikes or supply shortages that could happen if prices were slashed to unsustainable levels."

David Pierpoint continues: "With over £150 million of these savings delivered, our journey doesn't end here." NHS Supply Chain and the NHS Business Services Authority are targeting a further £150 million in cash releasing savings from the two-year extension to NHS Supply Chain's service contract with DHL by September 2018.

£300 million savings target

NHS Supply Chain and the NHS Business Services Authority are continuing to work with NHS trusts to maintain momentum and to aggregate demand, rationalise and standardise their use of consumable products to deliver savings and achieve the £300 million overall target by September 2018. Key to this is the implementation of NHS Improvement's Nationally Contracted Procurement programme (NCP). Launching in 2017, the programme will look to NHS Trusts to commit to purchasing a core set of products through NHS Supply Chain to reach the volume necessary to achieve the economies of scale required.

In addition to the NCP programme, other savings programmes include:

- NHS England Excluded Devices programme – a single national approach, operated by NHS Supply Chain, for purchasing and supplying high cost medical devices for specialist services
- Compare and Save – allows trusts to review potential comparative product savings
- DH Consumables Fund –achieving price reductions on high usage product lines through national volume commitment
- DH Capital Fund – maximising savings through bulk purchasing deals on capital equipment
- Price Ranking – at a glance price ranking sheets have been developed so that supplier pricing can be reviewed with ease
- Product Rationalisation – product range has been reduced from over 600,000 product lines down to 316,000 product lines
- Facilitating price decreases by suppliers.

Finely balanced

A tough commissioning year reaches the half-way mark with challenges emerging but a forecast for the overall position broadly on plan. Steve Brown has the details

It was always going to be a tough year financially for NHS commissioners. There was a smaller provider efficiency requirement built into tariff, compared with recent years. And on top of this, they were asked to set aside funds to offset wider system overspends. Commissioner figures at month six show how the sector is squaring up to this challenge.

After last year's major overspend by NHS providers of £2.45bn – and a bigger underlying deficit – the focus in 2016/17 has been to move providers back towards balance. To this end, the £1.8bn sustainability and transformation fund has been focused on providers. But the broader business rules for the year also put an extreme burden on commissioners in helping to address provider overspends.

First, the efficiency requirement built into tariff prices was set at 2% compared with 4% in previous years. While this is almost certainly a more realistic assessment of what providers can be expected to deliver, it inevitably puts pressure on commissioner budgets compared with previous years' tariff uplifts. This might have been hard enough. But commissioners have also been required to set aside 1% of allocations (worth about £800m) to cover any further system overspends. NHS England has always acknowledged that it was asking a lot of commissioners in 2016/17 – needing a 3% savings requirement compared with the 2.2 % in the previous year.

With providers currently forecasting a year-end deficit of £669m, commissioners' set-aside may well need to stay uncommitted. Month six analysis shows that, overall, NHS England is reporting a £168m (0.3%) overspend in the year to date. This comprises a £236m overspend (0.6%) by clinical commissioning groups, a £27m overspend on direct commissioning budgets and a £95m underspend on central budgets.

The direct commissioning overspend is itself made up of a £49m overspend on specialised commissioning, offset largely by just over a £21m underspend on primary care, dental and public health budgets.

These figures take no account of the half-year value of the commissioner risk reserve, worth about £400m. Taking this into account equates to a net underspend for commissioning as a whole of £231m.

However, NHS England says the forecast for the full year remains broadly in line with plan – an overspend of just £10m, representing less than 0.1% of total budgets (within NHS

Central view

Speaking to *Healthcare Finance*, **NHS England chief financial officer Paul Baumann** (right), assesses the challenge facing commissioners and the NHS and progress in 2016/17.

'In 2016/17 we committed ourselves to stabilising the financial position of the NHS while taking the first steps towards the implementation of the *Five-year forward view*. We always knew this was going to be tough, and indeed the year is throwing up very significant challenges for commissioners and providers alike, as we seek to ramp up the level of efficiency – of all types – to secure financial balance in this critical first year of the spending review cycle.

'As things stand, we have a line of sight to delivery of this all important marker of our credibility as a service – and of our professional "grip" as a function. Providers up and down the country are taking resolute action to bear down on cost – notably in reversing the recent trend of burgeoning agency costs – in order to get as close as possible to the £580m deficit plan they set for themselves.

'Meanwhile, commissioners are on track to deliver the highest ever level of QIPP efficiencies, which will maximise the availability of the system reserve we took at the beginning of the year and deliver an overall commissioner underspend to square off the overall NHS financial position. This delicate balance is by no means "in the bag", but with single-minded focus over the remaining months of the year it can still be done.

'Moving forward, finance teams in local health economies have a key role to play in building on the strategies and partnerships created in the sustainability and transformation planning process. They are already working hard to create credible and affordable plans for the equally challenging middle years of the spending review and will also need to ensure that we get the best possible value from the crucial choices we need to make over the coming months as to how to invest the substantial, but distinctly finite, revenue and capital resources we have available for the transformation the NHS needs to achieve clinical and financial sustainability.

'More than ever before, this calls for a finance function that is resilient, joined up and equipped to play at the top of its game - which is, of course, the vision we set out in the Future-Focused Finance programme. Bob Alexander and I are greatly encouraged by the way in which our profession is stepping up to this challenge, and we are deeply grateful for the tireless efforts of finance teams across the country. We look forward to exploring with colleagues gathering for the HFMA annual conference how we can continue to work together for maximum success in tackling the challenges and opportunities of the critical years ahead.'

NHS England says the forecast for the full year remains broadly in line with plan – an overspend of just £10m, representing less than 0.1% of total budgets

England's revenue departmental expenditure limit, or RDEL, allocation).

This forecast position would leave commissioners' risk reserve intact and available to offset deficits elsewhere in the system. But the overall £10m overspend would mask a forecast £190m deficit across CCGs and £88m of pressure resulting from 'technical' adjustments. These adjustments include the elimination of benefits included in the headline numbers from an anticipated release of provisions (£64m) and lower than budgeted depreciation charges (£24m), neither of which can be included when reporting against the core non-ringfenced RDEL measure.

Offsetting these overspends are forecast underspends on central running costs (£216m) and direct commissioning (£52m). This latter forecast underspend would be thanks to a continued underspending on primary care and an expectation that the specialised commissioning overspend can be eliminated.

There are signs of pressures having a real impact at local level. The year-to-date deficit for CCGs has increased by £77m between month five reports and month six figures. CCGs' forecast outturn has also worsened by more than £100m between the two reports.

Some 84 (40% of all CCGs) are reporting year-to-date overspends – with nearly 50 of these being greater than 1%. Most of these expect to recover their financial position by the end of March. But 35 CCGs are forecasting a position worse than plan, with 11 of these forecasting an unplanned cumulative deficit.

Efficiency gains

Efficiency gains – as expressed in reported commissioner QIPP savings – are expected to be 40% higher than 2015/16, but are currently expected to fall short against the ambition of a 65% increase. Some of this can be attributed to rising activity, although there is a view that activity rises are not across all types of activity and a greater understanding of trends in specific service areas is needed.

CCGs clearly had ambitious plans to bend the normal growth trends downwards. Their efficiency gains suggest they have had only partial success and not yet delivered the full impact needed to meet their plans.

NHS England has been reporting the higher level of risk being carried this year – reflecting the higher level of ambition on efficiency. But it says 'an increasing amount of risk' is now crystallising into forecasts – a progressive increase as more data and activity figures become available as the year progresses.

It assesses the net risk position reported by CCGs and direct commissioning teams, after available mitigation has been applied, to be £299m – reflecting the difficulty in delivering full-year commissioner efficiency plans, managing activity risks and absorbing the cost of increases in funded nursing care. This is partially offset by central mitigations of £20m – reducing central costs – giving an overall net risk position of £279m.

The assessment excludes the £800m of uncommitted funds held by CCGs and commissioning teams. Decisions on whether this can be used (or how much of) will be taken 'later in the year' as it becomes clear how the financial performance of commissioners and providers is developing.

NHS England does not expect all identified risks to materialise. Its summary position, as things stand, is that commissioners are on course to balance their combined budget for 2016/17 as a whole, while contributing a managed underspend to fully offset the planned £580m net deficit in the trust sector.

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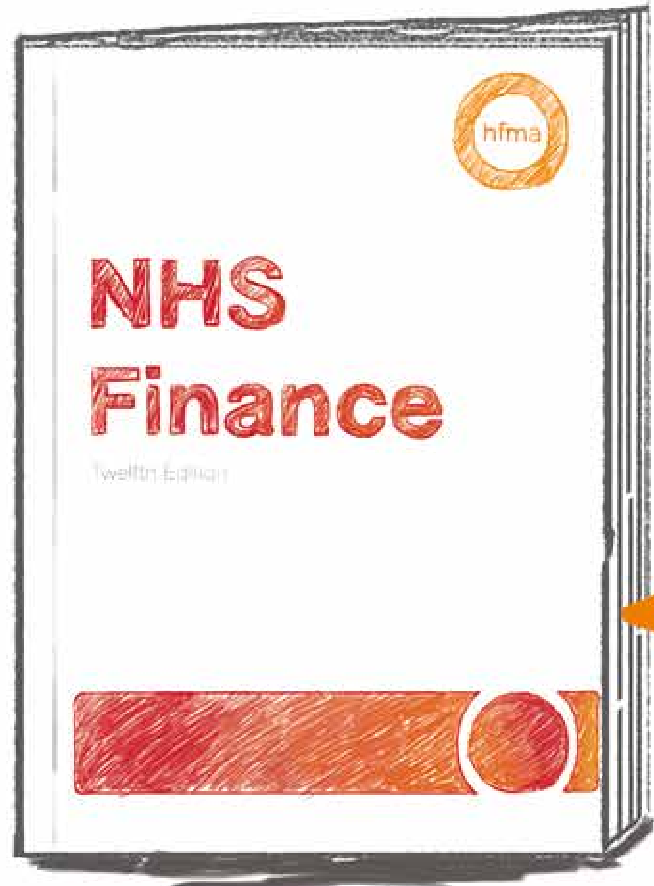

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Forging ahead

An evaluation of the first two years of Future-Focused Finance has demonstrated both progress made and areas that it should address. Seamus Ward reports

Nearly three years into the programme, NHS Future-Focused Finance (FFF) has become part of the health service lexicon and a highly visible presence, particularly on social media. It's a wide-ranging programme, taking in everything from what it's like to work in NHS finance, to the skills needed as the NHS changes under the *Five-year forward view*, to clinical engagement and how to achieve best value and lean systems.

FFF recently commissioned an evaluation of progress over its first two years. It concluded that some advances had been made and it also highlighted there was more to be done.

FFF was launched in February 2014 as a five-year programme for all members of finance staff. It is led by the Department of Health, national arm's length bodies such as NHS England, NHS Improvement and Health Education England, together with the HFMA – all under the auspices of the Finance Leadership Council. The HFMA provides hosting arrangements for FFF budgets and contracting. The arm's length bodies provide funding for a small central team to deliver day-to-day support for the programme.

The initial objectives boiled down to putting resources to the best possible use, reflecting changing demography, and increasing clinical-finance engagement. Individual finance staff members would be equipped to drive and adapt to change, while ensuring finance teams see how their contributions matter. Six action areas were developed to deliver these objectives:
- Best possible value
- Great place to work
- Close partnering
- Efficient processes and systems
- Skills and strengths
- Foundations for sustained improvement.

Programme director David Ellcock says any assessment of FFF should take into account the fact that it is a mix of tangible traditional outputs, such as reports and tools, and others that are more difficult to measure, though no less important.

'There's an interesting contrast at the heart of FFF,' he says. 'There's an understandable desire from a lot of people for published product they can see – if things come out of FFF then it is seen to be delivering and therefore providing value. Products are important, but so is the social movement that is winning hearts and minds, such as the value makers and working closely with clinicians.'

Best possible value

The *Best possible value* workstream was an early example of a tangible output. FFF worked with management consultancy Bain to deliver a best value decision-making framework, which was launched early in 2015. Mr Ellcock says it has been used by NHS England to aid the delivery of the *Five-year forward view*, in assessing whether organisations should be granted vanguard status and funding, for example. However, to date its use has not been as widespread as hoped.

'NHS England made reference to the framework in guidance on commissioner financial planning, but we haven't seen individual organisations take it up in significant numbers. Having said that, we recently launched a campaign to get people to use it and it has generated significant interest.'

Mr Ellcock says the *Great place to work* action area has delivered a range of outputs. These include coaching and mentoring seminars with the HFMA. The association also worked with FFF on the *Career stories* project – a large piece of work that profiled a range of NHS finance staff at different stages of their careers. 'This piece of literature always

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generates a fantastic response,' he says.

The FFF work on the attributes of finance directors is due to be published soon, he adds. 'A large piece of work on developing a national finance leaders' talent pool and regional talent networks, supported by the arm's length bodies and delivered in conjunction with the HFMA, will be launched in December.'

FFF encouraged finance directors to show their support through declarations – by July 2016, 260 of the 500 organisations' directors had signed the declarations and FFF is looking to increase this. Mr Ellcock believes the declarations are important for the whole initiative. 'I think that not only are they saying FFF is a good idea, but also it demonstrates that finance directors are telling their staff they can be involved in FFF. Giving their staff permission to play a role is as important as saying they like the idea of FFF.'

He concedes there is more to do in some areas, including diversity. 'It's a massive task. We are doing better, but it's a drop in the ocean compared with what could be achieved.'

The *Foundations for sustained improvement* workstream includes what some have referred to as the beating heart of FFF – the value-maker programme. This was an early initiative, which built on the London Olympics games maker concept – value-makers are local champions of FFF, sharing best practice and resources. By July this year, 190 value-makers had been recruited.

Mr Ellcock says: 'The value-maker programme's been a real success in terms of engagement. The report is clear about this: a significant number of value-makers have been closely involved in the work nationally and the evidence suggests a group of value makers are working hard locally without always bringing this to the national team's attention. We need to work more closely with them to showcase their work and to better understand the support they need. We know that inevitably a few will drop away, but where it's worked, it has worked very well.'

The *Close partnering* workstream and the *Finance and clinical educator* (FACE) programme (see *Healthcare Finance*, November 2016) have been built on the value-maker network. Both initiatives seek to improve finance engagement with clinicians.

'This is a network of people sharing best practice and working with colleagues to get messages across finance and clinical boundaries, in both directions. There's no point in people sitting at the centre saying: "This is the way we do things". This is where the social network is really important. But how do you put a value on that?' Mr Ellcock asks.

Mr Ellcock insists progress is being made on clinical engagement. 'This is what FACE is about. I think we had hoped a lot more clinicians would be involved in FFF, but when we realised that wasn't going to happen the emphasis changed – finance staff are going out to work with clinicians. However, there is still a lot of work to be done.'

"We deliberately set out not to make FFF a project that simply churns out huge printed documents that no-one has the time to read"
David Ellcock (above)

Moving on, Mr Ellcock admits the *Efficient processes and systems* workstream has not yet achieved everything it set out to achieve. It began with purpose, with the launch of a benchmarking tool two and a half years ago. This month, the FFF team plan to relaunch it as a fully online tool. Organisations taking part will be able to input their data and compare with other organisations. It plans to update the data every six months. 'The action area also produced two process guides on procure-to-pay and hire-to-retire systems, which have gone down very well with practitioners and are available via the FFF website,' says Mr Ellcock.

The potential to create a clearing house for intra-NHS financial transactions – an idea floated soon after the FFF launch – is also being examined. 'We are exploring the possibility of this on a much smaller scale than initially proposed and are looking to develop this with colleagues in a single patch,' he says.

The *Skills and strengths* workstream has produced the *Four strengths framework*, which highlights the skills finance staff will need to help the NHS through the next stages of its five-year plan (*Healthcare Finance*, November 2016). This is being used in several organisations for formal and informal assessment, including annual appraisals. It is also working on an e-learning project with the HFMA and Health Education England.

The need for better communication is a recurring point in the report and is one area of focus for the *Foundations for sustained improvement* action area. 'One of the things I now know is that we didn't spend enough time thinking about how we would communicate our activities,' says Mr Ellcock candidly.

'This is particularly true because there is always so much going on. We are always looking forward and deliberately set out not to make FFF a project that simply churns out huge printed documents that no-one has the time to read.'

Website updates

He accepts the report's assessment of the FFF website – that the site needs to be 'more engaging and active'. He says it relies on the efforts of value-makers and other supporters of the initiative to create much of the content. 'Though the blogs they produce are of a high standard, they are sporadic as they can only be produced when individuals can take time away from their day jobs to write them. FFF is planning a new version of the website that's less reliant on users but will still provide a place for individuals to add content.'

The evaluation report concludes that it is the right time for FFF to review and refresh its initial aims and objectives to ensure they are clear. Mr Ellcock says this is 'entirely appropriate' as FFF goes into the second half of its five years. The landscape has changed, with two sponsoring bodies – the NHS Trust Development Authority and Monitor – now merged into NHS Improvement, for example. 'With these changes, we need to look at the aims and objectives again,' he says.

So if a similar evaluation were to take place in two-and-a-half years, what would it show? 'I am confident we will have delivered the things we are required to do and these will be useful to the finance function,' says Mr Ellcock. 'We will have delivered a wide range of useful products and created a social movement within the finance function to help finance staff make the most of their networks.'

As with any interim evaluation, the assessment of FFF's progress has highlighted areas that must be addressed. Mr Ellcock points out, much has been achieved by volunteers and a handful of central staff. But he knows that FFF must now kick on to fully achieve its objectives.

Digital Transformation enabling dramatic cost reduction for the Public Sector:

Industry voice: Council places itself on course £29m savings programme with Microsoft at the core of new digital platform.

The NHS and local government are feeling a similar type of pain. Financial resources are not keeping up with the demands on their services, and the need for long term cost savings are high up the agenda for both.

They could also learn lessons from each other. One of the transformation leaders in the public sector, the London Borough of Enfield has laid the ground for significant savings, stretching into the next decade, with a change in approach for its digital operations. It has made a difference for the council in a way that could make a difference for a healthcare organisation.

Enfield has had a sharp eye on the bottom line with its transformation plans. In 2014 it set out to save £29 million up to 2020, following a consultancy exercise that led to recommendations that are often heard in the public sector – make better use of digital technology, move to cloud solutions and break down the information silos with a major restructure.

Two years later it is close to completing the restructuring, and according to Rocco Labellarte, the council's interim assistant IT director, is on course to hit the savings target by the end of the decade.

"We've been able to achieve that because previously the organisation was built on a paradigm of inefficiency, not wilfully but through old ways of doing things, and by changing our approach we are achieving great results" he says.

Those changes have involved an extensive restructuring of the IT estate, with Microsoft providing the single core for customer interactions.

Enfield has used Microsoft at the core of their platform for creating a new citizen account. This is linked with its website to provide a single view of the citizen and for the citizen to have a single view of all their dealings with the council.

It has been able open the account solution provided by Microsoft to internal customer services staff, with an 'On behalf of' function they could authorise actions, and design a data model around the activities that were important to measure, such as response times to service requests and spending.

Anytime access

"If you talk digital, and about what people want to do, it's about having access to anything, anytime, anywhere, whether it's about a complaint, or paying council tax – all commercial businesses do that through a customer account," Labellarte says. "So our focus has been on using the Microsoft Dynamics platform to create that customer account then build a single view for the customer, and for us of the customer."

Alongside this the council has consolidated the use of Office 365 as its day-to-day productivity tool, giving employees access to the range of applications – such as Word, Excel, Skype for Business and SharePoint – that fulfil routine functions and support collaboration. And it has used Microsoft Azure in a move to the cloud, shifting about 75% of its applications and storage onto the platform while keeping the rest on premise.

The platform links into various line of business systems for the back office, but Labellarte says Enfield's decision to build around the Microsoft stack has been a key element in the success of the restructure.

"It was a smart move because you avoid all the problems you have when you try to integrate a multitude of systems that don't quite talk to each other," he says. "It means there is one set of developers, one set of requirements and one system to build.

"Having that integration with things like Skype for Business, which they've done tremendously well, and the fact you can access the council's systems from any device securely to PSN (Public Services Network) standards all within that Microsoft environment, is very close to perfection in digital terms. It brings all our problems and solutions into a one stop shop, so if we have a problem we know what it is and know we have the people who can give us a solution."

Projected savings

The building of the platform and application around it have made it possible to reduce the council workforce by about 600 and are laying the ground for cumulative savings of about £16 million up to 2020. Further savings to meet the council's target are expected to come from the development of a procurement and commissioning hub.

Labellarte says there is still some work to do on the digital restructuring, largely in adding features to meet requests from various departments in the council, and upgrading other systems to cloud solutions where possible. "It's building the digital platform first, then fixing stuff around the edges," he says.

The council also faces the challenge of changing the mindset of staff so they accept the use of the tools within the Microsoft package as the default way of working. He cites webchat as a prime example, for dealing with the public and each other.

But there are more ambitious plans beyond that, reflecting what Labellarte sees as a three-way division of the council's processes. There are those that are high volume and low complexity that can be sanctioned through the simple filling of an online form and are more easily automated; those that are low volume but high complexity, such as responding to care needs for children and adults; and some that are in the middle – medium volume and complexity – such as dealing with enquiries and making decisions on planning permission.

The final group can require more complicated forms, but Enfield is already looking beyond that into the potential of using artificial intelligence (AI) to support the processes. It is talking to Microsoft about its own offerings in the space, and hoping this could provide more efficient services and more savings in the future.

"It's immature at the moment but interesting," Labellarte says.

Overall, Enfield's experience over the past two years provides an example of how a focus on the core demands on an IT estate, and a consolidation within a single technology stack, can provide significant long term savings for a public authority.

Microsoft will be showing how it can help NHS organisations achieve long term savings at the Healthcare Financial Management Association conference in London on 7-9 December 2016.

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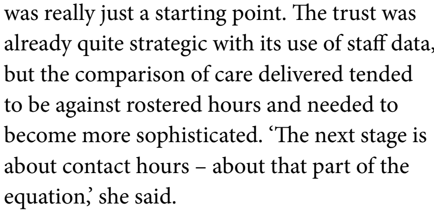
shifting position



Good visibility of staffing data can help trusts better match patient demand with staff levels. Steve Brown listens in at a recent HFMA-facilitated masterclass

The key to more sustainable use of temporary staff is data. As a minimum, providers need to see easily what is driving their current usage of temporary staff and how that matches with the actual demand. But the main goal should be real-time visibility of how they are using their most important resource – their workforce, including substantive and temporary workers.

Centrally imposed caps on individual staff rates and overall budgets have had some success in reducing spend and restricting growth (*Healthcare Finance,* November 2016). But at a recent masterclass facilitated by the HFMA, workforce software firm Allocate Software looked at the problem from a different angle – highlighting the key opportunities for trusts to reduce their need for temporary staff in the first place.

Lord Carter's report on NHS productivity was clear that much of the NHS was only paying lip service to e-rostering as a means of optimising the deployment of staff. 'Even where trusts have invested in such technology, we found trusts were not getting meaningful use of it,' it said.

Finance staff and clinical managers at the masterclass agreed delivering improvement required good data, and e-rostering systems were key to this. But the reality in some trusts is that e-rostering has been more about supporting the payroll department and investment in e-rostering has stopped with the purchase of software.

Hugh Ashley, Allocate's general manager UK and Ireland, said this was changing as organisations realised the potential benefit to staff and the savings for their employers.

Mark Oldham, director of finance and strategic planning at Mid Cheshire Hospitals NHS Foundation Trust, agreed that e-rostering was invaluable, but it was pointless to automate something that didn't work. 'You need to get the policy and culture right, translate that into the right processes and then automate,' he said.

The single overarching benefit of proper e-rostering is the visibility this can give the organisation on how it is using staff, where it has over- and under-supply, and where the opportunities for improvement arise. This converts a system from just an operational tool making the production of staff rosters easier, to one that is strategic. Actual improvements of course only materialise if the data produced is reported and acted upon.

CHPPD move

Lord Carter called for care hours per patient day (CHPPD) to become the 'principal measure of nursing and care support deployment'. Managers agreed this was more about compliance currently, although trusts are starting to get to grips with it. It is generally reported to boards as required, alongside other staff metrics. But non-executives did not always understand what they were looking at.

Daphne Thomas, deputy director of finance (operations) at Milton Keynes University Hospital NHS Trust, said: 'The board could see variation between wards but it wasn't always easy for those without a detailed knowledge of ward acuity to interpret the variation.'

Colin Ovington, chief nurse at Sandwell and West Birmingham Hospitals NHS Trust, said the measure was useful if triangulated with other data. 'We look at early-warning triggers of potential problems on a ward and to see if the CHPPD metric is telling the same story.'

Su Rollason, director of finance and strategy at University Hospitals Coventry and Warwickshire NHS Trust, said the metric was really just a starting point. The trust was already quite strategic with its use of staff data, but the comparison of care delivered tended to be against rostered hours and needed to become more sophisticated. 'The next stage is about contact hours – about that part of the equation,' she said.

To get the maximum value out of the metric, said Mr Ashley, reporting needed to be four-dimensional. Trusts should report their actual CHPPD delivered alongside the planned hours (included in the roster) and the actual required hours (informed by the acuity and dependency data collected on a shift-by-shift basis). This then needs to be looked at alongside skill mix (at least broken down by registered nursing staff and care assistants).

Allocate head of customer success Leigh Malyon said such analysis was becoming 'imperative, not just useful'. By adding in analysis of how actual care hours were delivered (see graph) – by substantive, bank or agency staff – the information could become really powerful in understanding what is driving staffing costs and to flag up quality concerns.

Allocate offered a number of tips on how to minimise temporary staff costs:

- **Roster early** An organisation rostering four weeks ahead has 50% of the agency costs compared to one rostering two weeks ahead. This gives more time to fix issues and avoid unnecessary use of temporary staff.
- **Get the headroom right** In calculating establishment levels for a ward, trusts take account of the amount of time staff will be unavailable for work, through

holiday entitlement, sickness or study leave – typically an uplift of 22%. Getting the calculation right is one thing, but how headroom is managed is also important. Should trusts look to cover all this headroom with permanent staff? Trusts might set an establishment to meet predictable absences such as holidays and rely on temporary staff for unpredictable absences. Keeping establishment down below the level of real headroom was described as a 'false economy'.

- **Get the right balance with flexibility** If established to cover headroom, a ward should be able to manage with average absence levels and average levels of holiday absence without temporary cover. Providers should then be clear what the policy is on taking leave – the number of nurses on leave at any time, say. This could be reinforced through a self-service system for booking leave. A rigid approach to leave needs to be balanced with flexibility, which can be important for staff retention. But flexibility arrangements should be periodically reviewed to check inequitable arrangements and unnecessary roster complexity.
- **Make it easier to book bank shifts** Trusts that offer a facility for staff to book their own shifts use 24% fewer agency staff and leave the bank office able to concentrate on the harder to book shifts.

New approaches

Some trusts have looked at different ways of organising nursing teams to help them respond to changes in demand. The masterclass discussed whether teams could be defined at specialty or directorate level – making it easier to move staff between wards. Mid Cheshire has already introduced fixed contract staff pools – specifically recruited to work in multiple locations as demand requires.

Mr Oldham said current market conditions tended to work against these approaches. 'The shortage of qualified nurses makes it difficult to use this resource flexibly,' he said, with staff often attracted to more substantive ward roles or working through agencies.

Sandwell and West Birmingham was looking at creating a pool for one-to-one care, a significant driver of agency spend. But Mr Ovington said broader changes were needed involving volunteers and family members to support such services (One to one, *Healthcare Finance,* November 2016).

Ms Rollason said that where such arrangements were put in place, it was important to be clear the changes were being made to improve quality. This was acknowledged by the whole group.

However, Allocate said that research showed that paying a premium to staff in these 'float' arrangements was also a success factor.

Some trusts already monitor staff demand in real time using patient acuity and dependency data recorded each shift to inform the movement of staff between wards. It was agreed that this was where all trusts should be headed.

The use of medical locums is arguably a bigger challenge currently than that of temporary nursing staff. Breaches of capped locum rates have not reduced and where there is an 'overpayment', it remains significant.

My Malyon said rostering medics was often complex, but there were big opportunities to improve the deployment of the existing medical workforce, which would have an impact on other staff. The starting point was the job plan. 'You still see organisations trying to do this on paper, limiting the opportunity for analysis. The most opportunity for being more effective is at the planning stage and then delivering on that plan,' he said.

Job plans needed to meet expected service demand and then be completed as intended, he added, underlining Lord Carter's call for greater analysis of job plans.

He gave examples of where job plans could be improved. For example, the company's research suggested that on average programmed activities (PAs) were miscalculated by 0.62PA per consultant, typically due to errors around rota or out-of-hours working. On top of this, there is frequent miscalculation of unpredictable programmed activity for on-call duties. Mr Malyon said this should always be based on objective measurement of typical activity – yet this doesn't always happen and is often overestimated.

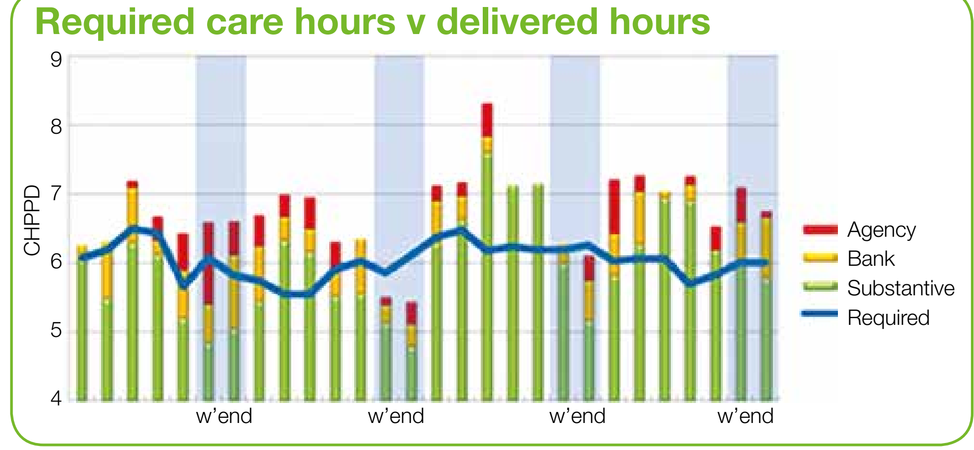
Leave entitlement is widely misunderstood too, with mistakes both in calculating overall entitlement and how much leave is needed for weeks involving on-call duty. This can disadvantage or benefit consultants. But overall, the company estimates that leave is being over-allocated by 10%.

This may not always translate into a cash saving, said Mr Malyon, but might offer opportunities for enhancing services.

He acknowledged it needed to be handled sensitively, recognising the goodwill provided by the medical workforce. But there was also a need to ensure equitable treatment of the whole medical workforce.

The key point was better visibility, from job plans to actual practice. And there were benefits for doctors too, with systems able to show doctors quickly when they are working, when they are on-call and who with, and helping them to manage any swaps process.

These are difficult issues. But addressing the demand for temporary staff – both nursing and medical – is as important as tackling the direct costs of those temporary staff.



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hfma
professional lives

Events, people and support for finance practitioners

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Highlights of HFMA local and national events into 2017

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Mark Knight looks forward as the year comes to an end

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Cathy Kennedy takes regional NHS Improvement role

Agreement of balances remains key focus despite good 2015/16 results

Technical update

As we reach the end of the calendar year, it is time to start preparing for the end of the financial year, *writes Debbie Paterson*. One of the first jobs for the finance team in 2017 will be the quarter three agreement of balances exercise.

The process looks to eliminate any accounting mismatches between different bodies within the Department of Health group.

For example, £500,000 recorded as earned income with a matching receivable in NHS trust accounts, but without matching expenditure in clinical commissioning group accounts, will lead to misreporting.

While Q2 focuses on receivables and payables only, at Q3 agreement is also needed for income and expenditure for the year to date.

The Department of Health has not yet issued its guidance for quarter three (although revised guidance covering Q2 was issued in September) – that is usually a Christmas present. But it has indicated that there will not be much change to the process from last year.

It was pleased with the outcome of the 2015/16 agreement of balances and has concluded that there is not much it can do to the guidance to improve matters.

Despite this, practitioners responding to HFMA's 2015/16 year-end survey put agreement of balances as one of the top three areas needing further support and guidance. In the absence of major revisions to central guidance, finance teams may want to consider some basic steps that might help the process go as smoothly as possible.

Fully engage with the process Prior to 2011/12, NHS provider bodies were not fully consolidated into the Department of Health's accounts. Foundation trusts, in particular, could decide whether or not to engage with the agreement of balances process. When, in 2011/12, provider bodies were brought into the Department's accounting boundary, the option to engage in the process was removed and participation in the exercise became mandatory for all. There is no excuse, six years later, for treating this as an optional exercise.

It is very important to the Department to allow it to prepare consolidated accounts for more than 400 bodies, but it should be an important part of the financial management of all of those NHS bodies involved.

While agreement of a balance may not be an agreement to pay, a mismatch must surely raise concerns that the amounts reflected in one of the body's accounts are not accurate.

Read, disseminate and follow the guidance The agreement of balances guidance changes very little year on year and the Department of Health helpfully provides a summary of the key changes it makes each quarter. At more than 50 pages long, reading all of the guidance may seem poor use of time if you've been involved in the process for some time and you know what you are doing. However, the guidance is well worth revisiting occasionally to make sure that you haven't missed a change – or simply to check your practice against that set out in the guidance.

> The agreement of balances guidance changes very little year on year … But it is well worth revisiting occasionally to make sure you haven't missed a change

It is equally important to make sure that everyone in the finance team reads the guidance and understands how the work they are doing could impact on the exercise. The areas in which problems often arise are: accruals; long-term contracts such as maternity pathways (where, for example, antenatal care is often delivered in two separate years); and deferred income.

Stick to the timetable It is difficult but it makes everyone's life a little bit easier if everyone meets the necessary deadlines.

Keep contact details up If you don't tell people where to send your statements how will they pay you? This is particularly important for large organisations such as NHS England, where there are different contact points depending on the service the statement relates to.

Talk to your counterparties Reading between the lines, a lot of the feedback the HFMA receives is basically 'we are doing it right and they are all doing it wrong'. Perhaps you are frustrated with a particular counterparty that always sends its statements in pdf format. Or perhaps you know that there will be a mismatch with another counterparty because 'there always is'.

In these days of email, it is easy to forget that there is a person at the other end of the process who may well be as frustrated with you.

Before the exercise even starts, see if you can contact the key counterparties to discuss the best way to agree balances between you and resolve the mismatch before the statements are even sent.

Debbie Paterson is an HFMA technical editor

Technical review

The past month's key technical developments

Technical roundup

A meeting of the HFMA's Accounting and Standards Committee in November discussed how the **apprenticeship levy** should be accounted for. There appears to be no obvious solution for any of the nations in the UK. In Scotland, Wales and Northern Ireland, it is clear that there will be an additional expense from April 2017 as the levy is paid. However, the plans for how employers will access that money as they train apprentices are not yet clear.

In England, how funds will be accessed is known, but the accounting is not clear. The amount of levy paid by employers (in respect of employees who live in England) will be held in a digital fund that can be used to pay approved training providers for training and assessing apprentices. The digital fund is a virtual fund for employers so they will not receive cash from it. The committee identified three possible ways to account for the levy and the digital fund:

- Expense the levy paid, do not reflect the digital fund in the accounts at all, as there is no benefit or liability for the employer
- Expense the levy paid and establish a government grant receivable for the amount of training to be purchased only once conditions for accessing the fund have been met
- Do not expense the part of the levy that will be used to fund training but instead hold that as a pre-payment, which is released when the training is provided.

The committee plans to issue a discussion paper setting out these solutions in more detail to support discussions with auditors and colleagues. The Department of Health, NHS England and NHS Improvement are discussing this issue and will raise it with the Department for Education.

NHS improvement ran its consultation on the 2016/17 ***Annual reporting manual*** (ARM) during the first half of November. The manual sets out the requirements for foundation trusts' annual reports, while detailed accounts requirements are set out in the Department of Health *Group accounting manual 2016/17* (see *Healthcare Finance,* October 2016, page 27). Despite the different manuals. Foundation trusts are still required to present their annual report and accounts as one document. Key changes include the staff costs note now being included in the annual report staff report rather than the accounts, with a summarised note remaining in the accounts. Regulatory rating disclosures should also now reflect the new single oversight framework. The manual also now refers to the NHS standard contract's requirement for sustainability reporting.

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

The first full provider segmentation under the new **single oversight framework** (SOF) will be published before Christmas, NHS Improvement has said. This will update the shadow segmentation published in October. The new framework aims to help providers attain and maintain Care Quality Commission ratings of good or outstanding, with providers segmented on the basis of the level of support they need across five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change and leadership
- Improvement capability.

The finance assessment includes five metrics covering capital service capacity, liquidity, income and expenditure margin, distance from plan and agency spend.

NHS Improvement has issued new **capital guidance** to replace all previous guidance relating to the capital regime and investment business case approval process published by the NHS Trust Development Authority or Monitor. It describes the delegated limits and business case approval process for capital investment and property transactions applying to any foundation trust in financial distress and to all NHS trusts. Existing thresholds for reporting and review remain in place for foundation trusts not deemed to be in financial distress. Other useful information includes a business case core checklist for use in the production of business cases and advice on post-project evaluations.

Revised guideline for chest pain

NICE has produced an updated clinical guideline (*CG95*), which focuses on chest pain of recent onset.

The updated guideline includes new recommendations on which diagnostic tests adults with stable chest pain should be offered following an assessment of the type of chest pain and other risk factors.

Chest pain is a symptom of coronary artery disease (CAD). It occurs when the blood supply to heart muscles is restricted as a result of atherosclerosis in surrounding blood vessels. This type of chest pain, known as angina, can affect function and physical ability, as well as quality of life.

If left untreated, it can lead to myocardial infarction (heart attack), which can be life threatening.

New evidence was identified on the use of non-invasive tests to diagnose CAD in people with stable (non-acute) chest pain. New evidence was also identified on clinical prediction models that may lead to improved estimation of the pre-test likelihood of CAD.

Implementing NICE's guideline may result in the more effective use of NHS resources and improved prognosis for adults with chest pain because of prompt and accurate diagnosis.

It may also lead to more appropriate diagnostic investigations and reduced adverse events. Increasing the number of CT coronary angiography scans performed may have resource implications because of the availability of suitable scanners and

Diary

December

7-9 N HFMA annual conference Step up, London Hilton

16 B Northern Ireland: Christmas cracker and AGM, Belfast

January

12 F Provider Finance: directors' forum

17 N Chair, Non-executive and Lay Member: annual chairs' conference, London

18 F Commissioning Finance: financial sustainability forum

19 I HC4V: NHS costing – regional network and training event, South

24 N CEO Forum, London

25 N Pre-accounts planning, Leeds

26 B Wales and North West: leadership and engagement event, North Wales

26-27 B Yorkshire and Humber: Branch conference, Broughton

26 N Pre-accounts planning, London

27 B Kent, Surrey and Sussex: student conference, Maidstone

30 B Eastern: introduction to NHS finance, Fulbourn

February

7 F Mental Health Finance: mental health costing forum

9 F Chair, Non-executive and Lay Member: forum, London

9 N Integration summit

9 B North West: annual quiz, Manchester

15 B Northern: pre-accounts planning

16 B London: student conference, Rochester Row

23 B North West: what is your risk appetite? Liverpool

28 I HC4V: value masterclass

March

1 B West Midlands: Financial governance – getting it right and annual reports: what good looks like, Birmingham

9 I HC4V: introduction to NHS costing – regional networking and training event (North), Leeds

16 F Provider Finance Faculty: technical forum

April

6 I HC4V: annual costing conference

19 F Commissioning Finance: finance forum

May

17 F Chair, Non-executive and Lay Member: forum

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

B Branch N National F Faculty I Insitute

Events in focus

HFMA pre-accounts planning 2017

25 January, Leeds; 26 January, London

The popular preparatory day for the year-end annual report and accounts process returns to Leeds and London. It is aimed at senior NHS finance professionals, those in providers and commissioners responsible for accounts, and finance staff in commissioning support units and shared services providers offering year-end support to NHS organisations.

The event includes plenary and workshop sessions on the 2016/17 accounts process, and discussion on changes to accounting and reporting requirements and planning processes for early submission. The emphasis will be on sharing good practice and learning from the 2015/16 annual report and accounts process. Speakers include Andrew Baigent, director of financial management at the Department of Health; Ian Ratcliffe, head of sector financial accounting (FTs), NHS Improvement; Steve Hubbard, head of financial reporting, NHS Improvement; and Richard Lawton, head of financial accounting and services, NHS England.

• **For further details, email camilla.godfrey@hfma.org.uk**

Step up programme

One year on

This year's presidential theme, *Step up*, has been supported by a range of national, branch and online events, along with coaching and mentoring training, which have offered HFMA members a chance to learn new skills. The programme has focused not on technical skills, but on other skills finance staff will need as the NHS develops under the vision of the *Five-year forward view*.

It has included two national events for senior finance professionals, focusing on leading change, managing teams and developing management skills. There has also been a range of branch workshops, with most presented as 'mixed doubles' – two half-day workshops provided in a day. These have sought to help finance staff develop the leadership, managerial and negotiating skills they will need.

Feedback from members has been positive, with national events scored as excellent or good by all attendees. Delegate feedback has been received for most of the 27 branch events held so far, with most scored as excellent or good by at least nine out of 10 attendees. Similar positive responses were received for the coaching and mentoring and webinar programmes.

appropriately trained professionals.

Any associated resource impact should be considered locally.

Stakeholder comments suggested that limited availability of suitable CT scanners and appropriately trained professionals may affect the speed of implementation.

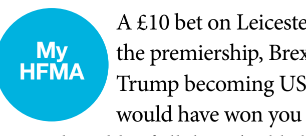
A sample calculation showed that additional savings of £31,500 are possible for a population of 100,000 from year five onwards.

Stephen Brookfield is acting associate director resource impact at NICE

A rock in hard times

Association view from Mark Knight, HFMA chief executive

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



A £10 bet on Leicester City winning the premiership, Brexit and Donald Trump becoming US president would have won you £30m, such were the odds of all those 'unlikely' events. Overall, 2016 has been a year of surprises.

Here in the comparative quiet of HFMA, we've seen relatively few surprises. The pressure on our members has mounted throughout the year and the association has continued to be 'the system' providing support and opportunities for finance professionals to meet.

As we come together in December for our annual conference, I am again reminded that the importance of the role played by the association is magnified when the service faces financial difficulties – a rock in hard times.

I'm very proud we are using the annual conference to launch our own qualifications leading to an MBA, which will start in May. So many members have helped in its development – I must pay tribute to Alison Myles and her team, who have worked so hard to pull it all together. The qualification will offer so many opportunities for us to increase the learning available. It is also central to incoming president Mark Orchard's theme for 2017.

We continue to work hard to develop new services and improve existing ones. At the last meeting of the HFMA board, we agreed that the subscription would be payable monthly – at only £5, a bargain! We also continue to invest in our infrastructure – a new app is due next year – and we are developing ideas for our 2017-2020 strategy. With this, we aim to plot a course into the next decade.

I was recently fortunate to visit our colleagues in Australia, where I extended your good wishes to members there. They have renamed themselves HFMA Australia, which means there are now three HFMAs throughout the globe. I expect much will come out of the learning we undertake together, and we will find new organisations and individuals in other countries who share our desire to learn together.

The problems are common – an ageing population, chronic disease, demographic change and technology advancement. In some areas, the US and Australia are ahead of us, in others they are behind. There are opportunities for mutual learning and sharing and we have a solid partnership in place to facilitate this.

HFMA chief executive Mark Knight

My final comments this year have to be for our president. Shahana Khan has travelled many miles for us this year, representing our interests and promoting our vision. This is despite the significant challenge facing all provider organisations and other commitments in her life. Her simple message of *Step up* has encouraged members and challenged us as staff. In January, she gave evidence to the Public Accounts Committee (above), and followed that up with speeches and presentations up and down the country and at the US HFMA conference, ANI.

I've greatly enjoyed working with Shahana over the past year and in the run-up to her presidency and I know she will continue to contribute to the association. Many thanks Shahana from all of us!

A finance professional's job is never easy, but during 2016 I hope the association has provided you with support and made your life just that bit easier. Let's hope we can do even more in 2017.

Member news

The Northern Branch annual award winners are as follows:

- Accountant of the Year: Peter Robinson, deputy income and corporate accountant, North Tees and Hartlepool NHS FT; runner-up Kirsty McGregor-Towers, finance manager, North of England CSU
- Technician of the Year: Kirstie Saville, senior finance officer, North of England CSU, and Annie Walton (pictured), finance officer, Sunderland CCG
- Large Team of the Year: commissioning team, North of England CSU; runner-up finance, North East Ambulance Service NHS FT
- Small Team of the Year: costing team, North Tees and Hartlepool NHS FT; runner-up financial control team, NHS Business Services Authority

New commissioner members in the National Payment System Group include: James Colledge, Enfield CCG; Gail Fortes-Mayer, Sandwell and West Birmingham CCG; Dan Gilks, Solihull CCG; and Louise Morris, Wirral CCG.

Paul Simpson is now chair of the West Midlands Branch, succeeding Jonathan Tringham. Mr Simpson is director of finance/deputy accountable officer at three CCGs: Cannock Chase; South East Staffordshire and Seisdon Peninsula; and Stafford and Surrounds.

Lancashire Teaching Hospitals NHS FT is the latest provider to host a *Train the trainer* course for the HFMA NHS Operating Game. A subscription enables the trust to run training sessions as often as it likes, enabling participants to simulate decision-making in an acute hospital.

Correction: in the last issue we misspelt the name of East Midlands Branch Unsung Finance Hero Manjit Dharam. We apologise for any inconvenience.

Member benefits

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

Network focus

Healthcare Costing for Value Institute

'Finance managers in the NHS are not the enemy,' says Jean MacLeod, consultant physician in medicine and diabetes at North Tees and Hartlepool NHS Foundation Trust. A member of the Healthcare Costing for Value Institute council, she encourages her colleagues to be more engaged with the trust's finance team.

Bringing clinicians and finance managers closer together is a key aim for the Healthcare Costing for Value Institute. It was established in April 2015 and has 110 member organisations. It provides a platform for support and ideas exchange that will help NHS providers and commissioners to improve patient-level costing and value-based healthcare. The institute organises multiple events during the year and regular briefings.

In October it hosted its first international symposium that allowed practitioners from seven countries to exchange best practice in applying the theory of value-based healthcare in practice. A recurring topic on the day was the importance of clinical engagement.

Duncan Orme (pictured), deputy director of finance at Nottingham University Hospital, attended the event and was particularly impressed with the costing examples from different parts of the world. 'It was good to exchange ideas on how costing information is used to drive value.

'The session by the International Consortium for Health Outcomes Measurement was particularly good. You could see where the world of the clinician is meeting with the world of the accountant in healthcare. Fundamentally, clinicians and accountants come from different perspectives and different cultures when looking at costing.'

Dr MacLeod says one of the biggest challenges for clinicians wishing to engage with costing is the lack of understanding about how money flows in their trust. She first got involved with the institute earlier this year and has since seen a shift in culture. 'We've got more and more clinicians not being scared to talk about cost and efficiencies,' she adds.

The institute is hosting its next value masterclass on 28 February in London. It is aimed at NHS finance directors and senior clinicians to encourage more clinical engagement. The annual costing conference is on 6 April in London. Registration is open to all NHS trusts. Visit www.hfma.org.uk.

branch contacts

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

Appointments

Martin Armstrong is now director of finance, information and IT at East and North Hertfordshire NHS Trust. Previously director of finance at North Middlesex, he has over 18 years' experience in the acute, community, mental health and learning disability sectors. He succeeds **Tony Ollis**, who was appointed in 2014 and has now retired.

Suzanne Tracey (right) has become chief executive at the Royal Devon and Exeter NHS FT. She was chief financial officer, deputy chief executive and, more recently, acting chief executive at the organisation. Before she joined the trust, she was director of finance/ deputy chief executive at Yeovil District Hospital NHS FT. She was president of the HFMA in 2011 and still chairs its Provider Finance Faculty.

Dorset Clinical Commissioning Group has named **Chris Hickson** assistant director of finance. He was head of management accounts, financial planning and primary care at the CCG. Mr Hickson has more than 20 years of finance experience in the NHS and the housing association sector.

John Somers (pictured) has become chief executive at Sheffield Children's NHS Foundation Trust. He joined the trust as chief finance officer in 2014 following six years' experience in senior NHS roles in Rotherham, Lincolnshire and Wakefield. He succeeds **Simon Morritt**, who is now chief executive at Chesterfield Royal NHS Foundation Trust. **Mark Smith** is the new interim chief finance officer.

Nick Dawe is now chief finance officer at Ashford Clinical Commissioning Group and Canterbury and Coastal Clinical Commissioning Group, moving from executive director of corporate services at Westminster City Council and the Royal Borough of Kensington and Chelsea. Mr Dawe succeeds interim **Ray Davey**, who has moved to Shropshire Clinical Commissioning Group as interim chief finance officer, where he succeeds **Andrew Nash**.

Keith Griffiths is the new director of sustainability at East Lancashire Hospitals NHS Trust, moving from Calderdale and Huddersfield NHS Foundation Trust, where he was finance director. **Gary Boothby** is now executive director of finance at Calderdale and Huddersfield, having been deputy director of finance at the organisation.

North Tees and Hartlepool NHS Foundation Trust has appointed **Kevin Scollay** (pictured) deputy director of finance. He was senior finance manager – commissioning finance at North of England Commissioning Support Unit. He succeeds **Caroline Trevena**, who became director of finance at the organisation in February.

"It is the opportunity I wanted, to take a different perspective and also to be able to have a role that's looking at a wider area, across the Yorkshire and Humber footprint"
Cathy Kennedy

System-wide view

On the move

Though long associated with commissioning, Cathy Kennedy will move back into the NHS provider sector in the new year, taking up the new post of business director for the NHS Improvement Yorkshire and the Humber region. Mrs Kennedy is moving from North East Lincolnshire Clinical Commissioning Group, where she has been deputy chief executive/chief financial officer.

Deputy CFO Laura Whitton will become the CCG acting chief finance officer.

Mrs Kennedy has worked in commissioning organisations in North East Lincolnshire for around 16 years, but has a great deal of provider experience behind her.

'The role I've been in over the last 16 years has changed a lot. For the first 11 years the organisation was a provider of community and mental health services so it's only recently that I have not been directly involved in the provider side. Before that I was an acute trust director of finance for nine years so my knowledge may be rusty, but I haven't forgotten it. When I moved from provider to commissioner, I feel I added value and would like to think that, moving back the other way, I will add value again.'

In this respect, her understanding of adult social care – North East Lincolnshire CCG commissions these services, working closely with local authorities – will be important, with pressures in social care having a direct impact on NHS activity.

It is also a broader role. 'It is the opportunity I wanted, to take a different perspective and also to be able to have a role that's looking at a wider area, across the Yorkshire and Humber footprint. It's all about a new challenge, a new perspective and joining a new organisation – helping to shape it and getting it as good as it can be.

'I have worked with a lot of people across the footprint so it's an opportunity to build on those relationships and help the NHS move forward in this challenging time.'

Mrs Kennedy adds that working across sectors helps finance professionals, who increasingly have to adopt a system-wide view. 'I don't think my job will be to take one perspective on the issues. All the challenges we are facing will not be solved by one organisation working by itself.

'We need providers and commissioners to come together and the STPs will bring them together. My role is not about taking a unilateral provider view in trying to resolve problems. I am keen to have a team with different backgrounds.'

The role is new, with NHS Improvement creating a new sub-region tier of management. Her key responsibility will be finance – delivery of control totals, the financial aspects of the single oversight framework and contract sign-off.

With contracts due to be signed this month, her first task on taking up the post in the new year could be to bring together providers and commissioners to resolve disputes.

Mrs Kennedy says the goal is sustainability and the delivery of control totals and contract sign-off are markers along the way to this goal. She insists this will only be achieved through collaboration – among local organisations and between national regulatory bodies such as NHS England, NHS Improvement and the Care Quality Commission.

Though she is no longer senior responsible officer for the Future-Focused Finance (FFF) *Great place to work* action area, she will continue to lead FFF work to support aspiring finance directors. And, though standing down as chair of the HFMA Commissioning Faculty this month, she remains committed to the work of the association and will remain president of the Yorkshire and the Humber Branch.

FFF gears up for annual conference

Future-Focused Finance (FFF) will be launching three products at this year's HFMA annual conference. The first is an accreditation process for NHS organisations, which will allow them to demonstrate their commitment to the development of finance skills across their workforce. The Finance Leadership Council has given its full support to this process, which is based on the long-standing and highly regarded North West skills development team's *Towards excellence* scheme.

The National Aspiring Finance Leaders Talent Pool will be the second product to be launched. The talent pool is designed to support those senior finance colleagues who are deemed to be ready to apply for their first finance director post within 12 months.

The talent pool has the backing of Bob Alexander, executive director of resources at NHS Improvement, and Paul Baumann, chief financial officer at NHS England, and will be run in conjunction with the HFMA. The pool will support 50 to 60 candidates per year, include a robust selection process and provide an individually tailored development programme for its participants.

FFF will also announce the launch of its redesigned website, which will go live in the first week of the new year.

FFF programme director David Ellcock said the team had listened to feedback from across the service and worked with web designers to come up with an exciting new look. He said the redesigned site would enable much better navigation and easier links to FFF's action areas and products.

'We are delighted to be launching these products, which we believe will improve the quality of the finance function in the NHS and so facilitate the delivery of better care for patients,' he says.

• ***Visit www.futurefocusedfinance.nhs.uk***

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* Source: Neyber report, 'The DNA of Financial Wellbeing' 2016