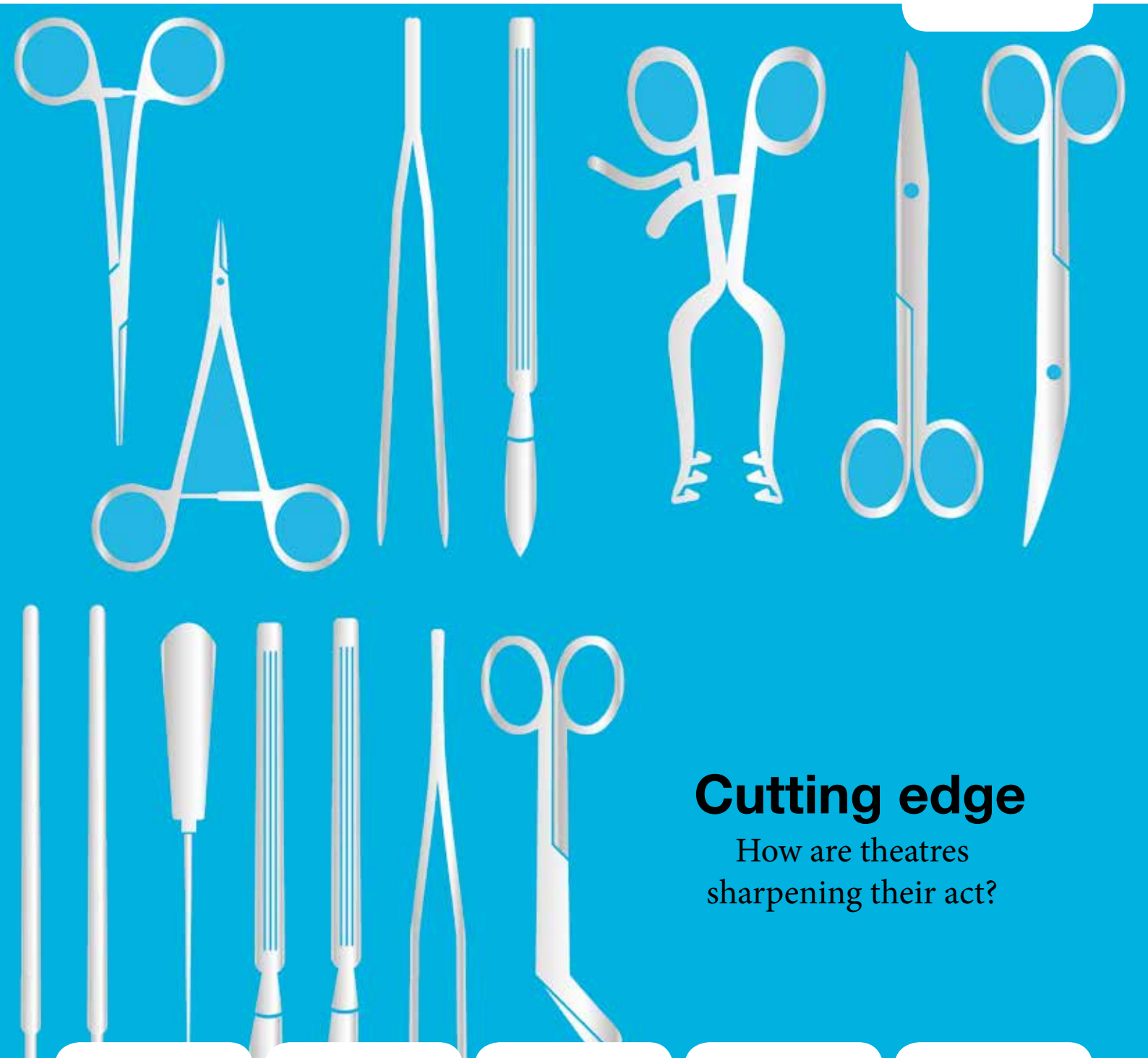
healthcare finance

July/August 2016 | Healthcare Financial Management Association

www.hfma.org.uk



Cutting edge

How are theatres sharpening their act?


Accelerating intelligent everything
Hewlett Packard Enterprise and Intel® are pushing the Internet of Things forward by building a new class of systems that computes and analyzes data where it lives — everywhere.
WEATHER ALERT
Accelerating next
Hewlett Packard Enterprise
intel
Learn more at hpe.com/iot
Intel and the Intel logo are trademarks of Intel Corporation in the U.S. and/or other countries.
© 2016 HPED LP

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

Production
Wheal Associates
020 8694 9412
kate@whealassociates.com

Printer
ESP Colour Ltd

HFMA
1 Temple Way,
Bristol BS2 0BU

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

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

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

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

ISSN 1472-3379

Contents

July/August 2016

News

Comment

Professional lives

Page 26 **The Bolton health economy's alternative to the national tariff is helping to transform services and improve efficiency**

Features

CIPFA The Chartered Institute of Public Finance & Accountancy

Post Graduate Certificate in

finance business partnering

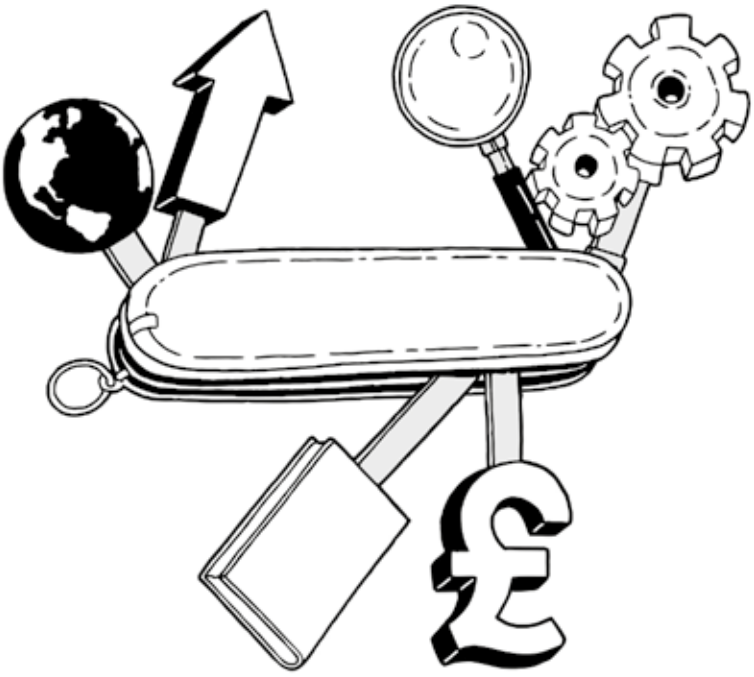
Finance professionals in the public sector have developed their role by evaluating how they can best support their organisations in a strategic as well as operational sense.

To support the development of this role, CIPFA is offering a Post Graduate Certificate (Level Seven) in Finance Business Partnering. Upon completion, delegates are eligible to apply for CIPFA affiliate membership.

Modules covered include:

- Fundamentals of Business Partnering
- Technical and Professional Skills
- Behavioural Skills – Emotional Intelligence
- Transformational Change
- Influencing Skills
- Impact and Presence
- Developing Commercial Acumen
- Communication and Presentation of Figures

Visit our website to find out more
www.cipfa.org/training
or contact us on: **+44 (0)20 7543 5600**



News

Mackey: swift action needed to secure financial position

By Seamus Ward

The provider sector must aim to get its aggregate deficit down to around £250m by year-end by prompt action in three areas, NHS Improvement chief executive Jim Mackey has said.

Mr Mackey said that, following the agreement of control totals in all but 19 providers and the implementation of the £1.8bn sustainability and transformation fund, the aggregate planned deficit stood at around £550m.

The final rules for access to the sustainability and transformation funds were due to be published at the beginning of July.

While the planned deficit represented significant progress compared with 2015/16 (when the total provider deficit was £2.45bn), there was still work to do. In a letter to foundation and NHS trusts, co-signed by NHS Improvement chair Ed Smith, he added that the level of deficit made the management of the overall financial position risky. To address this, and ensure the service had the financial resilience to live within its means, he set out three areas where movement was expected by the end of July – pathology and back office consolidation; pay costs; and unsustainable service consolidation.

The measures on back office and pathology will see the implementation of the Carter review recommendations – overseen by NHS Improvement's newly appointed director of operational productivity and Carter implementation lead Jeremy Marlow.

Mr Mackey said back office services had not been consolidated as they have in other sectors. He asked all sustainability and transformation plan (STP) leads to produce proposals to consolidate back office and pathology, initially across their STP area, but in the longer term over a larger footprint.

"Significant inroads can be made to help bring providers more in line with the sector as a whole" Jim Mackey (pictured)

While 2016/17 plans showed the provider sector was looking to actively manage and reduce costs, some providers were planning higher levels of pay cost growth. Also, some trusts had higher pay costs growth in 2015/16 than their peers. NHS Improvement would work with the trusts to determine where planned growth could be eliminated and 2015/16 increases reversed.

Mr Mackey acknowledged this work would be complex, but added: 'Significant inroads can be made to help bring these providers more in line with the sector as a whole and other providers with a similar general profile. We will do this work in close collaboration with CQC colleagues to ensure that any adjustments are in line with our commitment to patient safety.'

Pay growth changes and outline plans for consolidation of back office and pathology services should be agreed by the end of July.

The letter said direct savings as well as indirect savings, such as deflating the locum market, could be achieved by consolidating planned acute services that depend on temporary staff.

Mr Mackey said these services should be identified, together with how they could be consolidated, changed or transferred, and the potential operational and financial impact, by the end of July.

The renewed focus on savings came as the latest HFMA *NHS financial temperature check* revealed provider concerns about delivering control totals – 63% of organisations surveyed had agreed control totals at the time, but only 60% said they would meet all the conditions set.

HFMA head of policy and technical Paul Briddock said: 'NHS Improvement is right to acknowledge the significant progress the service has made in moving from an underlying deficit of around £3bn at the end of 2015/16 to a current plan of a £550m deficit utilising the £1.8bn STP funding. However, our *Temperature check* shows provider finance directors believe there is high risk associated with this year's financial plans.

'We note the three areas for a renewed focus, including back office consolidation. The NHS must continue to examine all areas of frontline and back office activity to ensure it delivers maximum value from every pound. But there is a huge management agenda. Finance staff will play a crucial role in addressing these three areas, ensuring smooth implementation of the new Carter metrics and data requirements, facilitating service transformation and delivering day-to-day financial management.'

See News analysis, page 8

Stepping up in the US

HFMA president Shahana Khan addressed the US annual national institute – the US HFMA's annual conference – in Las Vegas in June. The event brought together 5,000 healthcare professionals from across the US for a conference on 'thinking out of the box'. Ms Khan briefed delegates on the current challenges facing the NHS and explained her theme for the year – 'Step up'.

New finance risk metrics will focus on resilience and efficiency

By Seamus Ward

NHS Improvement has outlined proposals for a unified oversight framework to replace risk assessment and accountability frameworks.

Finance and use of resources is one of five areas in the framework – the others are quality of care, operational performance, strategic change and leadership and improvement capability.

Based on assessments in all the areas, trusts will be grouped into four categories: no concerns; emerging concerns/minor issues; serious issues; and critical issues. Support from NHS Improvement will be based on these categories – organisations with serious and critical issues will be given mandated support.

The finance and use of resources assessment (developed with the Care Quality Commission) will be used, as now, to identify early signs of financial problems. But it will usher in a greater focus on efficiency using the recommendations of the Carter report. At first, there will be seven metrics, with four implemented immediately:

- **Capital service capacity** – headroom over interest or other capital charges, such as private finance initiative payments
- **Liquidity** – days of operating costs held in cash or cash equivalents
- **Distance from control total or financial plan** – year to date actual position against trajectory in providers with control totals; in those without, year to date actual I&E surplus against year to date planned I&E surplus
- **EBITDA margin** – EBITDA divided by total revenue

A further three will be introduced in shadow form in 2016/17 – tracked, but not included in the financial rating:

- **Cost/weighted activity unit –** the change in the Carter efficiency metric, cost

Financial rating metrics

	Metric	Score			
		1	2	3	4
Financial sustainability	Capital service capacity	>2.5x	1.75-2.5x	1.25-1.75x	<1.25x
	Liquidity (days)	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	EBITDA margin	≥5%	3%-5%	0%-3%	≤0%
	Change in cost per weighted activity unit (WAU)*	≤1.1%	1.1%-2.1%	2.1%- 3.1%	>3.1%
Financial controls	Capital controls*	<5%	0%-5%	5%-15%	≥15%
	Distance from control total or financial plan	≥0%	(1)%-0%	(2)%-(1)%	≤(2)%
	Agency spend*	≤0%	0%-25%	25%-50%	>50%

Scoring a 4 on any metric caps the overall rating to 3 at most **Shadow form in 2016/17*
Brackets indicate negative numbers *Source: NHS Improvement*

Baumann calls on service to 'demythologise' £22bn savings

The health service must 'demythologise' the required £22bn savings, which are to a large extent about more effective use of resources rather than cost reductions, according to NHS England chief finance officer Paul Baumann (right).

Speaking to the HFMA annual commissioning conference in June, he said the spending review assumes £7bn of these 'savings' will be delivered nationally through wage restraint and other mechanisms.

The 2% annual efficiency requirement on providers would account for £9bn, with much of this achieved through delivery of the Carter report savings. This left £6bn for commissioning, which would be delivered by a combination of local action and national initiatives.

Mr Baumann broke down the £6bn further, with an estimated £4.3bn being delivered through activity-related

savings. The RightCare programme is expected to support some £1.7bn of this, with new models of care and urgent and emergency care reform each contributing a further £0.9bn.

'We need every health economy to grasp each efficiency programme and embed it into their plans for the future through the STP process,' he said.

Mr Baumann suggested that the end of June deadline for submission of sustainability and transformation plans (STPs) could be extended to ensure they are robust and financially balanced.

But, recognising relationships were better developed in some areas, Mr Baumann said he wanted robust plans that can stand up to external scrutiny.

'The question is not whether health economy spending can be made to balance within the resources but how,' he said. 'We need not to waste each other's time submitting plans that either don't balance or assume someone else will come to our rescue locally or nationally with additional resource.

'It is more of an egg and spoon race than a 100-metre sprint. I would rather have a fully developed and perfectly balanced golden egg in September than a sticky mess on the grass at the end of June.'

He said commissioner plans for 2016/17 were 'undoubtedly the most risky I have seen in my 10 years in the NHS'. The common financial platform across CCGs had contributed to increasing the 'financial grip' on commissioner finances, but the sector needed to improve its intelligence and early warning systems and clear the 'commissioner-provider fog'.

"We are keen to follow how the statutory duties of Monitor and the Trust Development Authority translate into practice in this fresh approach"
Miriam Deakin, above

per weighted activity unit (WAU)

- **Capital controls –** distance from capital control total
- **Agency spend** – distance from agency cap.

Providers will continue to be scored 1 to 4 on each metric, but reversing the current risk assessment framework – 1 the best score, 4 the poorest. Providers scoring a 3 or 4 in the overall financial assessment will trigger a potential concern, as will a 4 on any of the individual metrics. Scoring a 4 against the three shadow metrics will not trigger action in 2016/17.

NHS Improvement chief executive Jim Mackey said: 'The framework will shift the emphasis away from regulation and performance management and towards identifying how we can best help providers make the improvements they want to make for patients.'

Miriam Deakin, head of policy at NHS Providers, said the single framework had potential to align regulation with the Care Quality Commission, and to ignite sector-led improvement.

She said: 'We welcome the greater emphasis on improvement and tailored and voluntary support. However, it is important that all trusts are judged objectively against clear criteria and we are keen to follow how the statutory duties of Monitor and the Trust Development Authority translate into practice in this fresh approach.'

The consultation closes on 4 August.

Stevens unveils technical tariff

There will be a new payment mechanism for medical technical innovations such as devices or apps that have been shown to save costs or help patients with supported management, NHS England chief executive Simon Stevens (right) said.

Speaking at the NHS Confederation annual conference last month, Mr Stevens said the new tariff introduced in 2017/18 would 'diffuse' innovations more quickly and remove the need for local price negotiations. Hinting at pass-through arrangements similar to those for high-cost drugs and devices, he said the tariff would guarantee automatic reimbursement when an approved innovation was used.

NHS England would bulk purchase the technologies to get the best value, he added.

In a wide-ranging speech ahead of the EU referendum, he warned

that the NHS should not assume it will receive extra funding beyond that in the spending review.

'I do not believe it would be prudent for us to assume any additional NHS funding over the next several years, not least because there is a strong argument that, were extra funding to be available, frankly we should be arguing that it should be going to social care,' he said.

The NHS faced three challenges this year. It no longer had 'the luxury of time' implementing the Carter recommendations.

The same was true for clinical commissioning groups and RightCare. The NHS must deliver key national priorities such as the forward view and 'land' the sustainability and transformation plan (STP) process.

Cost report shows PLICS potential

By Steve Brown

NHS providers have made progress with their patient-level information and costing systems (PLICS) data over the past three years, but data quality issues still remain, NHS Improvement has said.

In a publication summarising analysis of patient cost data submitted as part of a voluntary collection covering 2014/15, NHS Improvement said the findings 'continue to demonstrate the need for improved and more prescriptive standards and a wider, mandatory PLICS collection from all providers'.

A new costing methodology is being introduced as part of the organisation's Costing Transformation Programme.

Submitted data was 'relatively clean', but the report drew attention to issues to be considered for the next collection – the selection of dominant procedures in an episode, the inclusion of implausible figures in some data feeds and the submission of invalid healthcare resource groups.

While costing data submitted using the new methodology in the future will realise more benefits, the report said the current data showed the power of being able to analyse cost data vertically (down to patient level) and horizontally (by components of costs currently collected in cost pool groups).

The 2014/15 data showed that the three biggest contributors to total acute care costs were wards (24%), overheads (19%) and medical staffing (16%). Operating theatres (not including medical staffing) contributed a further 9% of costs.

The analysis also shows that other cost types can be major contributors in specific areas of care. For example, in episodes involving the use of critical care services, the critical care component accounted for 29% of all costs.

The report said that medical staff and ward costs had increased as a proportion of all costs over the past three years, possibly as a result of improved costing, while overheads had reduced. It also found that cost breakdown changes across provider types, with overheads and critical care costs accounting for a greater proportion of all costs in specialist providers, while ward costs proportionally were smaller.

Showing the potential for further analysis, the report also highlighted wide variation in theatre times even for the same HRG, point of delivery type and dominant procedure.

www.hfma.org.uk

ONLINE THIS MONTH

Matthew Cripps, national director NHS RightCare, blogs about emerging successes in the first wave of clinical commissioning groups involved in RightCare and the plans to roll it out to the rest of England.

Healthcare Costing for Value Institute members can access videos of speeches from June's value masterclass. Go to the HC4V section of the HFMA website and click on 'resources'.

News review

Seamus Ward assesses the past month in healthcare finance

The referendum on European Union membership and the fall-out from the subsequent vote to leave has wide implications. These reverberated through Whitehall, with both the Conservatives and Labour facing leadership elections as *Healthcare Finance* went to press. Health was no different. The exit decision and the uncertainty at the heart of the government will be disconcerting for the NHS on many levels.

NHS Confederation chief executive Stephen Dalton summed up the mood when he said the service had broadly benefited from the UK membership of the union and the full implications of exit were yet to be clearly understood. NHS organisations would be anxious to see how it would impact on recruitment, economic stability, transformation of services and legislation. NHS Employers said it was important EU nationals working in the NHS know they will continue to be valued and welcome – a message reinforced by NHS England and health secretary Jeremy Hunt.

The NHS in England awaits a new government in the autumn, but earlier in June those in Scotland and Northern Ireland

heard more of their new administrations' plans. New Northern Ireland health minister Michelle O'Neill (left) welcomed an extra £72m for health and social care, allocated as part of in-year adjustments to budgets. But she insisted the focus must remain on long-term reform. Only structural reform would secure an efficient and effective health and social care service. An expert panel on the reform of health and social care had told her service delivery must change. She added that the in-year funding would be spent across the system, including unscheduled care, additional social care provision and ICT.

Scottish health secretary Shona Robison said primary, social and mental health care will be given 'an increasing share' of the NHS budget. In advance of the first health debate of the new Scottish parliamentary term in early June, she pledged to increase funding for frontline services each year. Ms Robison also announced a government review of NHS targets to ensure they are delivering better outcomes for patients and best use of resources. The review will look at targets in the context of the shift in delivery of care from hospital to the community, she said.

In Wales, new health minister Vaughan Gething welcomed a survey that shows high overall patient satisfaction with the local NHS. The Fundamentals of care survey found 99% of patients felt they were treated with dignity and respect, while 98% said they were given help to be as independent as possible. Some 95% of patients said they were given full information about their care, while 98% said they were made to feel safe. Mr Gething said the findings were positive, though he acknowledged that there was work to be done – for example, to ensure patients got enough sleep.

Concern over the NHS financial challenge is not going away, but, according to Nuffield

Trust chief executive Nigel Edwards (left), it may be obscuring a problem that is at least as serious – a crisis in the NHS workforce. While he accepted finance was a major issue, Mr Edwards said inter-related workforce problems included low morale, bullying and a looming shortage in some specialties. The thinktank's survey of 100 health leaders reported rising concern about staff morale and the role of deteriorating finances in this. Increased workload was the number

The month in quotes

'We simply cannot sustain our current model – either in qualitative or financial terms – and we must focus on delivering the change necessary to build a sustainable health service for this and future generations.'
Northern Ireland health minister Michelle O'Neill

'With the increasing financial challenge, we have seen an inevitable increase in focus on the finances. For many staff, the perceived move away from a positive focus on system redesign and improving care to a cost-saving environment has been demotivating.'
CCG leader speaking to the Nuffield Trust

'[The A&E] figures show the NHS struggling to meet many key performance targets in the face of rising demand and huge financial pressures. At a time of year when we should see performance figures starting to fall back in line with targets, instead we see a worrying picture of the extreme pressure hospitals are under.'
King's Fund chief economist John Appleby

'The NHS continues to face unprecedented demand and challenging financial circumstances. Against this background, we need to make sure we are utilising all the collective resources of a "place" to benefit our local communities. There is now a real urgency to deliver on this ambition. Our priority now must be to turn rhetoric into action.'
NHS Confederation chair Stephen Dorrell

NHS Employers said it was important EU nationals working in the NHS know they will continue to be valued and welcome

SHUTTERSTOCK

one cause of declining morale, exacerbated by staff shortages and pay restraint, Mr Edwards said. These have combined to fuel staff interest in agency work.

The transformation of services and greater integration are two responses to the funding challenge, and health and social care leaders warned faster integration was needed. The NHS Confederation, Local Government Association, Association of Directors of Adult Social Services and NHS Clinical Commissioners said unprecedented pressure on funding has put at risk plans to improve patient care and raised questions over the sustainability of the health and social care sectors. Their report, *Stepping up to the place: the key to successful integration*, described how a fully integrated, transformed system should look. Their recommendations included a call for national leaders to redress funding shortfalls, particularly in public health and community services. Locally, managers must look beyond individual organisations to ensure integration and transformation happen quicker.

Research examining the reorganisation of stroke care in London and Manchester kept the focus firmly on service transformation. The work, funded by the National Institute for Health Research to draw out lessons for major system change, said service standards linked to financial incentives should be used to ensure major reorganisations deliver the best possible care. *Explaining outcomes in major system change* said ongoing achievement of service standards should be linked to financial incentives. It said new service models should be simple and understood by staff and the public.

Manchester should have a single acute NHS provider covering the city, according to a recommendation in a review of hospital services. The new provider would bring together Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester along with the services provided on the North Manchester General Hospital site by Pennine Acute NHS Trust.

NHS Employers published the terms and conditions of service and indicative pay summary for the new 2016 doctors and dentists in training contract. The contract remains subject to a referendum of relevant British Medical Association (BMA) members. Under the proposed deal, doctors in training will be paid for all work done, with an average increase in basic pay of 11%. Pay for extra hours worked will include enhanced rates for unsocial hours, a weekend allowance for those who work more than six weekends a year, on-call availability allowance and pay for hours worked on call.

The NHS in England failed to meet access standards in A&E, elective care and ambulance response times in April, despite rises in activity. Summary figures published by NHS England showed six of the eight elective cancer standards were achieved, but others were missed. Activity was up compared with 12 months earlier – emergency admissions rose by 3%, diagnostic tests were up 6.4%, A&E attendances 2.3% and consultant-led treatment 3.9%.

in the media

EU referendum purdah meant there was little NHS finance news to respond to in June. But *Clean Energy News* covered the Sustainable Development Unit report on the NHS and the environment, carried out for NHS England and Public Health England and supported by the HFMA. It said the NHS and wider health sector could save up to £414m a year and cut a million tonnes of carbon emissions a year by 2020 (see p20).

HFMA Environmental Sustainability Special Interest Group chair Sandra Easton told the online news site the NHS had to exploit the financial opportunities of becoming environmentally sustainable. It was important for the health service to identify opportunities where it can save money and ensure sustainability.

The association's parity of esteem report, produced jointly with NHS Providers, was picked up by primary care practitioner magazine *GP*. The report raised provider concerns that they had not received promised uplifts in mental health funding.

Paul Briddock, HFMA head of policy and technical, took part in a *Health Service Journal* inquiry into the importance of the NHS non-clinical workforce. Mr Briddock said the skills of these staff would be needed to deliver the Carter efficiency programme. He also highlighted the recent finance staff census data, showing that only 10% of finance staff felt valued by government and 5% by patients.

News analysis

Headline issues in the spotlight

Risk assessment

The latest HFMA survey of NHS finance directors spells out heightened concerns about the delivery of financial plans this year. Steve Brown reports

NHS finance directors and chief finance officers are reporting the most challenging contracting round they have experienced, and have raised major concerns about their ability to deliver financial plans in 2016/17.

The HFMA's latest *NHS financial temperature check* pulls together reported financial information with a detailed finance director survey undertaken at the end of May and early June. The report summarises the out-turn position for 2015/16, in which providers reported a £2.45bn deficit – three times larger than in 2014/15 – and clinical commissioning groups overspent by £16m compared with planned levels.

The current year was supposed to see the NHS provider sector return to overall balance on the back of a targeted £1.8bn of sustainability and transformation funding. Providers have been asked to agree to centrally set control totals as a precondition to accessing the additional funding.

In the HFMA sample, some 63% of trusts had signed up to their control totals. However, of these organisations, only 60% expect their organisation to meet the conditions set.

NHS Improvement reported that 157 trusts out of 240 (65%) reported a deficit in 2015/16. However, in the 105 trusts in the *Temperature check* sample, only 70% of those reporting a surplus or breakeven in 2015/16 expect to repeat the feat. And among trusts making a deficit in 2015/16, only 39% expect to return to a positive financial outturn. The sample is not completely reflective of the surplus-deficit split across the sector in 2015/16, but it does not look like the major turnaround in providers' financial positions that was being planned.

This chimes with recent confirmation from NHS Improvement that the aggregate planned provider deficit currently sits at about £550m. This has been driven by a worsening of providers' financial position in the last few months of 2015/16, beyond the £1.8bn originally set as a maximum deficit. It also reflects the fact that the £2.45bn deficit was only achieved using

'financial improvement opportunities' including capital-to-revenue transfers and one-off technical measures.

The feedback is that this has been the most challenging contracting round that finance directors have experienced. Service affordability and protracted negotiations about reducing activity levels and QIPP savings were the main issues. Two-thirds of CCGs and nearly half of trust respondents reported a high degree of risk associated with achieving their organisations' 2016/17 financial plan. Just 3% of finance directors were confident in their plans enough to label them as low risk.

There were no surprises in what finance leaders saw as the main risks. In providers, these included (in order) slippages in cost-saving programmes, agency staff spending and the knock-on impact of social care financial constraints as well as increased demand.

For CCGs, the most widely flagged risk was from funding increases in emergency care activity. But continuing healthcare, rising demand in general and slippage in cost savings were also regularly highlighted.

Achievement of savings is clearly crucial to achievement of overall plans. In 2015/16 commissioners delivered £1.9bn of a planned £2.2bn of QIPP savings. Providers similarly fell short of planned levels, with their aggregate £2.9bn of savings failing to meet the planned level in cost improvement programmes by £316m. Providers had planned for 92% of these savings to be from recurrent schemes, but in fact recurrent savings accounted for less than 80% of all savings.

Keeping a post vacant might deliver a non-recurrent saving, eliminating the position would make the saving recurrent. Failing to deliver recurrent savings makes subsequent years' saving programmes even harder to achieve as their underlying financial position is worse than reported.

Trusts' and CCGs' savings plans ranged from a modest 1% to a more eye-watering 9% as a percentage of turnover or resource limit, although 63% of trusts and 68% of CCGs had savings plans in the range of 2.5% to 4.5%.

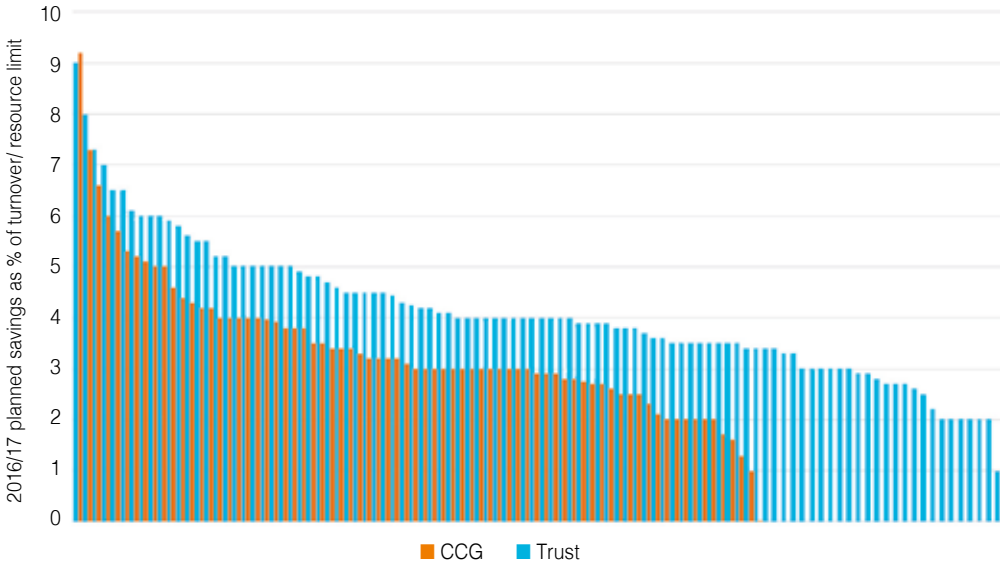
Respondents had more confidence in being able to deliver non-recurrent savings than planned recurrent savings. Nearly 80% of trust directors said they were confident of delivering their planned non-recurrent savings – a slightly higher level than CCG directors. But this falls to 39% and 33% respectively for recurrent savings – raising concerns about the ability to achieve control totals and required financial positions.

Transformation remains the main perceived solution to at least meeting some of the current service and financial challenges. CCGs are planning closer integration or redesign of pathways and eliminating unwarranted clinical variation – raising quality and reducing waste.

Primary care investment is also a big priority for many commissioners – again moving investment to earlier in the pathway or even to prevention and supported self-management models. Transformation is also on trusts' agendas, but they are also looking to target agency staff costs, improve procurement value and rationalise estates.

The impact of financial challenges on the quality of services is difficult to analyse. Defined

2016/17 planned CIPs and QIPP programmes as a percentage of income



in terms of key measured access targets, there have been undeniable dips in performance. In May, NHS Improvement reported that 'the sector as a whole continued to underperform against a number of national healthcare standards'. In aggregate, providers missed the 95% four-hour target in accident and emergency and the 92% referral to treatment target. They also failed to meet the 85% 62-day urgent cancer referral to treatment target in each quarter.

In reality, quality is a more rounded issue, taking account of access, outcomes and patient experience – and the *Temperature check* has always used this broader definition when examining quality of services. In previous surveys, finance directors have given a relatively rose-tinted view of quality. Last November's report, for example, found that 88% of finance directors did not expect service quality to reduce in 2015/16, while just 9% of directors thought quality would actually deteriorate.

However, the latest survey finds pessimism on the increase, with 21% of CCG chief finance officers and 23% of trust finance directors expecting a deterioration in quality in 2016/17. A third of trust directors believe quality will be hit in 2017/18.

Drilling a bit deeper, the survey found that directors see waiting times, access and the range of services offered as the most vulnerable as a result of financial pressures.

But patient safety was considered the least likely area to be affected.

The *Temperature check* also looked at the sustainability and transformation planning process, with the requirement to produce plans having been introduced since the last survey. There was broad support for planning across areas, with the process seen as providing benefits for collaboration and the reshaping of services.

However, there were some concerns about the governance arrangements for large 'footprints' (44 in total). There were also concerns that pressure on individual organisations to meet their own financial targets under pressure from regulators might take precedence over partnership aims.

There was further concern that the pressure for such a fast pace of change might place a strain on newly forming relationships. And only 35% of respondents thought the relationships between commissioners and trusts in their footprint were strong enough to deliver the required cross-organisational changes.

Even those with a good track record of collaboration felt the challenge was substantial. Most respondents (71%) believed it was too early to say whether the new plans would result in a fair sharing of financial risk between the organisations in their footprint. Just 16% of directors in the sample declared themselves very or quite confident that the organisations in their footprint could deliver a connected strategic plan for the period up to 2021.

"There is a clear message from the finance community that it is full square behind the need to transform services and develop new models of care"
Paul Briddock, HFMA

There was almost unanimous backing for transformation of services in organisations and across areas. Many areas are already working on this, but directors highlighted the difficulty of taking this agenda forward while also maintaining business-as-usual and delivering on-going cost improvement programmes.

There is also a continued question mark over the sufficiency of current NHS funding.

HFMA policy and technical director Paul Briddock said the financial position was tough and the outlook was extremely challenging. 'There is a clear message from the finance community that it is full square behind the need to transform services and develop new models of care.

'These are the right things to do – whatever the financial situation. Looking to support more people in the community and focus increasingly on prevention are the right approaches, but they also give us the best chance of ensuring services are sustainable.

'But there is no financial headroom – as can be seen by the £2.45bn deficit recorded by providers in 2015/16. And finance directors are clear that they see significant risks in the plans they are looking to deliver in 2015/16.

'There are also increasing concerns about the impact on service quality and how quickly the sustainability and transformation plans are expected to deliver more integrated services.'

Comment

July/August 2016

Even greater intensity

The UK's vote to leave the EU adds yet another layer of complexity to the finance picture

It is perhaps difficult to see past the enormity of last month's referendum decision. Whatever your stance on remain-leave, everyone (I think) would accept that the decision to leave the European Union will have an impact on the NHS. It is the extent of that impact that is hard to judge right at this moment.

Both sides in the campaign were guilty of using scare tactics and exaggeration, but no-one in NHS finance will expect to see leave campaigners' pledges of spending our EU contribution on the NHS come to fruition.

The economy is crucial to current health spending commitments and to any settlements the service might hope to receive in the future. As the Institute for Fiscal Studies pointed out, any impact on national income is likely to dwarf the UK's current net EU contribution.

So how markets and businesses respond beyond the inevitable initial nosedive will almost certainly have implications on health and social care funding.

And we can only guess at the impact on staffing – in terms of continuing to source much needed healthcare workers and in terms of changes to regulations such as the working time directive. Any impact on research funding will also need to be understood.

Perhaps of most immediate concern is that we may well find ourselves in something of a planning blight. There will be so much work to do on the divorce proceedings and in appointing a new prime

HFMA president Shahana Khan

Single vision

A new oversight framework will look familiar to finance managers but offers some changes for the future

There are no big surprises in the publication of NHS Improvement's 'new' single oversight framework – and in particular its finance and use of resources assessment. But there are clear moves towards a broader assessment of finance and an increasing interest in efficiency.

A revised framework was always going to be necessary. NHS Improvement's responsibility covers oversight and the provision of support for both foundation trusts and NHS trusts – previously overseen using the similar but separate risk assessment and accountability frameworks. NHS Improvement is also working towards a joint approach to assess use of resources with the Care Quality Commission.

And, to complete the motivations, Lord Carter also called for NHS Improvement to develop an integrated performance framework to ensure a single set of metrics for reporting performance.

The overall framework covers five areas: quality; finance and resources; operational performance; strategic change; and leadership.

But finance managers will inevitably be drawn to the proposed assessment on financial performance. The immediate changes are very minor and are mostly about formally harmonising the regime for both trusts and foundation trusts – using the old FT system as its model.

Providers will have to get used to aspiring to a 1 rather than a 4 as the scoring system has been flipped on its head. But other than that finance managers will be very familiar

Healthcare Finance editor Steve Brown

"Having completed six months as HFMA president, I am struck by how nothing has changed and yet everything has changed"

minister that political focus may inevitably be drawn elsewhere.

These challenges will add layers of complexity to what are already the most significant challenges the health service has faced since its creation. Most organisations (as I write this) have signed up to control totals for 2016/17. But there can be no doubt that, with agreement being the key to unlocking sustainability and transformation funds, some organisations have felt caught between a rock and a hard place.

The HFMA's latest *Temperature check* (analysed on page 10, with the full report included in this issue) underlines this. Two-thirds of commissioner chief finance officers and half of trust finance directors rate their own financial plans for 2016/17 as high risk.

It is sensible NHS England has increased the time available to produce health economy-wide five-year STP plans. This recognises that footprint relationships are starting from different levels of maturity. More time won't of itself deliver the robust and balanced plans that are demanded, but it suggests a degree of understanding of the severe challenges facing economies.

Even before the EU exit decision, we were warned to expect a 'reset on the money'. So we know the pressure will only increase. Having completed six months as HFMA president, I am struck by how nothing has changed and yet everything has changed. In many ways we are still having the same discussions – about transformation, about Carter, about staffing costs – and facing the same pressures in keeping services operating. Yet we have also come a long way in terms of the detail we are talking about. This has to continue and, if anything, the intensity has to increase despite the impact of Brexit.

There are good examples of new models of working emerging, but this has to become wholesale across the NHS. Transformative change has to come out of discussion and into practice. And finance staff have a major role in making this happen.

Contact the president on president@hfma.org.uk

SHUTTERSTOCK

with the metrics. Capital service capacity and liquidity measures use the same definitions and the same thresholds between ratings as in the old risk assessment framework. The 'variance from plan' becomes 'variance from control total' to recognise the new regime of control totals, but is effectively the same measure.

And there is a focus on EBITDA margin rather than I&E margin – perhaps as it is seen as focusing more on operational efficiency than overall efficiency. There is also a welcome and clear indication that this is a building block to providing a single assessment of use of resources across NHS Improvement and CQC – ensuring a common basis for future assessments.

There is perhaps more of interest in proposed new metrics that will be run in shadow form this year with a view to inclusion next year. These metrics will not influence an organisation's actual rating for the next 12 months. Measures on capital controls (distance above control total) and agency spend (distance from cap) are simply an extension of heightened central interest in these issues.

But a new (shadow) metric assessing a provider's average cost increase for an average episode of care – or the change in its cost per weighted activity unit – delivers on Carter's call for a greater focus on unit costs and productivity.

Finance managers – with support from their costing experts – will want to get their heads around the new reference cost-based cost per WAU metric in general and the change in cost that is the specific measure used in the use of resources assessment.

It is a key change and practitioners will welcome the decision to not jump straight in with a live indicator.

Before, an organisation's efficiency or productivity was only measured indirectly. Poor efficiency would impact on margin, capital service capacity and liquidity – but this puts productivity and efficiency directly under the spotlight.

A side effect of the new cost metric could well be to raise the importance and profile of cost data and costing processes among provider boards. This is a seen as a key enabler for NHS Improvement's separate costing transformation programme. The fact that a reference cost based indicator could stimulate greater regulatory scrutiny may bring costing back on to the table in some organisations.

"The key issue is what NHS Improvement does with the overall scores generated using its finance assessment"

Really, the key issue is what NHS Improvement does with the overall scores generated using its finance assessment – produced using a familiar method of averaging and rounding. It claims it is focused on support – some available to all, some targeted but voluntary and some mandated. The usefulness of this support and how quickly it is triggered using the new metrics will be key to finance managers' longer term reaction to the new system.

Operating theatres are at the heart of acute trusts, but they are expensive resources that, like any other, must be efficient. Seamus Ward asks trusts how they are sharpening their operating practices

surgical precision

If, as is often said, A&E is the front door of acute hospitals, operating theatres could be seen as their foundations. Surgical patients are the source of much of the income they receive. And operating theatres account for almost 9% of acute care costs (not including medical staffing) – 19% of total costs where theatre costs are present – according to patient cost data published by NHS Improvement last month. A recent Wales Audit Office report (see box) put the direct cost of operating theatre time at £14 per theatre per minute. With pressure on finances, this is clearly an area where trusts will hope to improve productivity and efficiency.

Not surprisingly, theatre efficiency featured in the Carter report earlier this year – he said delayed transfers of care resulted in the sub-optimal use of clinical resources and treatment delays for other patients. The resultant loss of income cannot be offset, as costs are still incurred for clinicians, theatres and other overheads, the report added.

Unwarranted variations in theatres were also highlighted. Carter said deep wound infections for primary hip and knee replacements ranged from 0.5% to 4% of cases. If all hospitals achieved 1% infection rates, the NHS would transform the lives of 6,000 patients and save £300m a year.

Two years ago, NHS Providers carried out a benchmarking exercise on theatres, finding three key challenges that continue to resonate with operational and financial managers:

- **Effective planning** On average, participants scheduled 35 hours of operating activity per theatre per week, of which 10% was cancelled, though the best performing trust managed to cancel only 3%.
- **Preventing last-minute changes** Cancellation of procedures was not always under the control of the department – patient cancellations accounted for 39% of all last-minute procedure cancellations, while hospital cancellations due to clinical reasons accounted for 34% and the remainder were due to non-clinical reasons.
- **Efficient patient flow in the department** Trusts wanted to reduce the theatre time wasted due to late starts and early finishes, which overall accounts for 18% of theatre hours used.

NHS Providers head of analysis Siva Anandaciva says trusts continue to focus on maximising the effective utilisation of theatres. 'Providers are doing this by improving the effectiveness of how operating lists are scheduled, building more responsive and flexible work plans for consultants, and minimising delays to patient flow to and from theatres.

He adds: 'However, operating theatres are part of an interdependent system and their efficiency will always be reliant on general hospital patient flow. We are now seeing even the most effective providers struggling with increasing waiting lists, as the demand for emergency surgery and inpatient beds displaces planned elective operations.

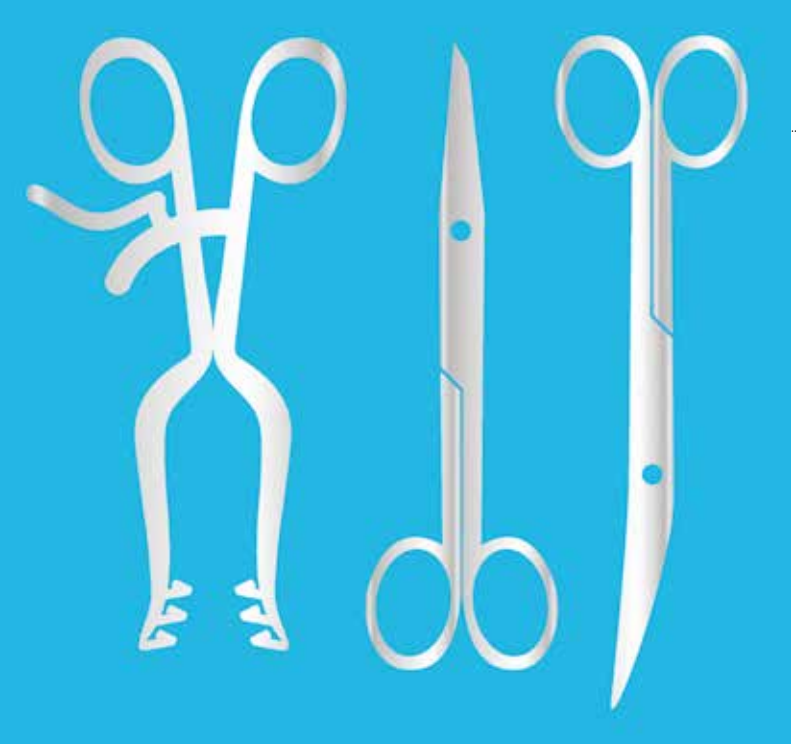
'For these reasons, providers are now looking at alternatives to transform the ways in which they work by consolidating surgical services, either across different sites within the same trust or across trusts to form specialty centres, as part of service transformation initiatives to improve theatre efficiency, safety and patient care.'

TPOT scheme

While individual trusts are targeting operating theatre efficiency, in England there is no national initiative. Around eight years ago, the then NHS Institute for Innovation and Improvement launched The Productive Operating Theatre (TPOT, pronounced 'teapot'), which included efficiency and value as one of its themes – the others being team performance and wellbeing, safety and reliability, and patient experience and outcomes. It was adopted in hospitals across the UK.

An evaluation of the scheme, published in 2013, said the six organisations it studied, including four from the English NHS, had made significant savings. It suggested an average hospital with 16 theatres could save £7m a year, much of it on a recurrent basis.

A modular scheme, TPOT aimed to help staff identify and resolve everyday issues and frustrations using Lean principles. It included 13 modules, focusing on areas such as prompt starting times, patient turnaround to minimise gaps between operations, scheduling, organisation of theatres and ensuring that operational status can be understood at a glance.



Although the evaluation was positive, TPOT as a national scheme is no more, partly due to the institute's closure in March 2013. But the materials for the scheme are still available through the institute's legacy website, and finance and theatre managers say the best ideas – on making performance visible to all staff, for example – have become mainstream in most trusts.

Colchester Hospital University NHS Foundation Trust, for example, ended its scheme around three years ago. That does not mean individual elements or ideas have been abandoned. Wendy Hobbs, practice educator and theatre training lead at the trust – but previously in charge of TPOT there – says it has retained the scheme's pre-session briefings.

'Each theatre team meets before the list starts in the morning to discuss the individual patients from a surgical and anaesthetic perspective. They arrange the order of the list and discuss things such as whether specific instruments will be needed for particular patients. It's an exercise in safety first, but also efficiency.'

At University Hospitals Bristol NHS Foundation Trust, TPOT and other earlier theatre efficiency initiatives had resulted in improved theatre efficiencies. But in 2014, finance director Paul Mapson recognised a new approach to theatre efficiency was needed. This led to a new trust-wide theatre transformation project to provide sustained improvements in efficiency.

The trust has 33 theatres on six different sites, covering adult and paediatric elective and emergency surgery. Jan Belcher is its theatre transformation project manager. From her diagnostic work, the project identified seven themes to be pursued:

- List structure and organisation
- Starting on time
- Turnaround time
- Patient flow in and out of recovery
- Integrated team working
- Data quality
- Performance management.

Recognising the importance of local ownership of improvement work, each theatre suite identified a lead practitioner representative and, following listening events and consultation, each suite identified its priorities within the seven themes. All departments were involved in the work to improve data quality and performance management and appointing departmental leads. Suites' areas of focus were later confirmed, with good-quality data to support the need for action and to track improvement against agreed trajectories.

A broad range of projects have subsequently been implemented, including increased pre-operative assessment and a transfer nurse role to move patients from recovery to their ward, leading to better patient experience. There was also a focus on trauma list efficiency, using a team approach to the 'golden' first patient – the first patient on the surgical list is decided in advance and can be prepared and ready for the start of the session – and the implementation of an electronic display board to manage this cohort of patients.

Specialty rewards

A specialty approach also reaped rewards, particularly with ENT surgery, through improved scheduling and a focus on productivity. The team did not take a one-size-fits-all approach, Ms Belcher says.

Starting on time is a major challenge, and lack of available ward beds is one main cause of delays. The golden patient initiative is being rolled out to appropriate specialties to address this. Where possible, the norm will be that all golden patients are day cases unless otherwise indicated, though this is not feasible in many situations.

Team engagement and project ownership have been key to success and sustainability, and these remain critical factors in planning for theatre efficiency. Communications to keep staff informed are part of this, and information has been provided in a simple format to provide updates about progress and achievement.

'Staff are, rightly, focused on quality, and safety and efficiency may be lower in their priority list. However, theatre efficiency dashboards showing performance over the previous week and months are shared with all theatre staff on notice boards, as well as through the intranet,' says Ms Belcher.

Measures such as available theatre session uptake, start time, turnaround times within 15 minutes and recovery transfer delays are regularly reported and RAG rated for understanding at a glance. Progress and performance are regularly reviewed.

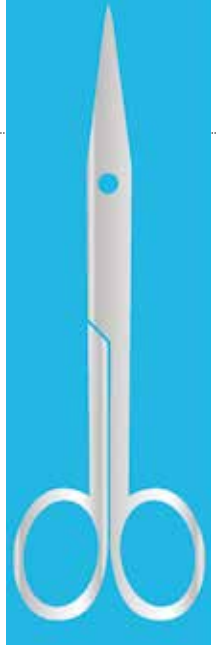
More recently, the key challenge across theatres has been around staff recruitment and retention, as without a stable workforce efficiency improvements are difficult to sustain. The programme organised a week-long staff engagement event, focusing on supporting teams to identify and address barriers to delivering quality care in a timely fashion.

Ms Belcher says: 'It also provided a means to recognise and celebrate the amazing work that takes place in our theatres every day, and the efforts of staff to make this happen. The event proved very successful in engaging staff and refreshing energy for the next phase of improvement projects.'

Chris Kennedy, general manager for perioperative, critical care and pain at Guy's and St Thomas' NHS Foundation Trust, says it is using cost data to improve efficiency.

'With help from the finance team, we worked out how much it cost per minute to run a theatre. Then, using the theatre management system, we worked out how much downtime there was across all theatres because of early finishes, delayed turnaround and cancellations. We were able to look at this by specialty and by theatre team and multiplied the downtime by cost per minute. We worked out we were wasting £15m a year. Because it was done using a financial model it allowed us to focus on the specialties where we were losing the most.'

"The demand for emergency surgery and inpatient beds displaces planned elective operations"
Siva Anandaciva, NHS Providers



The trust was able to develop a self-help tool and provide direct support for those specialties that needed more help. It quickly emerged that one of the key issues in high-turnover procedures was getting the patients through quickly enough. The reason was not enough staff to ensure an even flow of patients and optimise use of the theatres.

The trust's solution is to create two teams for some lists. The trust cannot blindly throw additional resources at the issue, though; it has to be sure it is financially viable and the additional activity covers the cost.

'Finding the staff is a challenge and there is an effort to reduce temporary staff costs, but as long as the additional activity covers the costs, I don't think there is a problem with doing this,' says Mr Kennedy.

Rolling out the initiative

The initiative is currently running in orthopaedics and gynaecology lists, as well as paediatric MRI. It is also to be trialled in urology.

'If a session regularly has a turnover of four or five cases and an extra team would add a fifth or sixth case, we would ask if the extra investment of getting the additional staff justifies the cost,' he says.

'For some, we are looking at just doing this first thing in the morning – getting extra staff to do a relatively uncomplicated case first thing. It can take an hour or hour-and-a-half to anaesthetise some of our patients, so we can do this while the first patient of the day is in surgery.'

In this case, there would be two anaesthetists – one with the more complex patient, the other taking the less complex case from the anaesthetic room, through surgery and onto recovery. Similarly, for minor procedures such as in gynaecology there are two anaesthetists working in tandem to bring patients through and maximise theatre use.

If casemix suggests that a session could be made more productive by adding staff – either for the first procedure or for the whole session – it will be discussed with the appropriate surgical or theatre teams, costed and trialled for around a month. If it proves viable, additional staff will be made available for that session every week.

At Colchester, theatre manager Shelagh Lissone says the trust is taking steps to increase efficiency and safety in its theatres. Safety is a particular focus after the Care Quality Commission raised concerns recently. The theatre team monitors start and finish times, following up on reasons for delays and feeding back to clinicians.

It also hopes to try walking patients to surgery accompanied by a nurse this month, rather than on a bed pushed by a porter as it currently does – which relies on porters being available to get the patient in theatre on time.

Colchester is exploring reorganising its theatre schedule – arranging more all-day lists so it gets an extra hour of operating time (the all-day list is nine hours; the traditional schedule is two four-hour lists per day).

Despite efforts to minimise cancellations, they do occur. A theatre support manager chases the rescheduling of cancelled operations so the trust is not fined under the 28-day breach rule. This has improved the position, and there were no breaches in May.

At Guy's, Mr Kennedy is the operational lead for the trust's overarching work stream on surgical productivity, which looks at the whole patient pathway. He previously led the trust's TPOT work, which was merged into the trust's own theatre efficiency project.

In the past six years, he says, elective activity in the trust's 44 theatres has increased from an average of 900 cases a week to 1,300. This is partly the result of extra hours – elective work is now scheduled for Saturdays – but there have been incremental gains from increased efficiency. Elective theatre use is about 90% and cancellations (due to the hospital and to patients not attending) have fallen from 9% to 7% in the past 18 months.

Theatre management is complex. Efficiency measures can have consequences for many parts of a hospital, including staffing and bed use, income and costs. Equally, decisions made in other parts of a hospital can have an impact on what theatres can achieve. Successful solutions will require the precision of a scalpel.

Welsh audit report

According to the recent Wales Audit Office report *Operating theatres: a summary of local audit findings*, theatres are under-used and the national and local focus on theatre efficiency has waned in recent years

Though there was a lack of data, the auditors said the prevalence of late starts is a good barometer for theatre productivity and they found this is common in Wales. While the reasons for cancellation of operations vary, almost half were because the patient cancelled or did not attend.

The WAO said there are a number of barriers to efficient theatres – including concerns over quality of theatre data and how it is used; difficulty finding beds; low staff levels; and fragmented accountability for the surgical pathway. Lack of good-quality data meant health boards struggled to dispel myths about the true causes of inefficiency.

The report made a number of recommendations:

- A renewed national and local focus on theatre efficiency
- Clarity of responsibility and clinical leadership along the pathway, with 'robust executive oversight'
- The Welsh Risk Pool Service was unable to provide details of the cost of surgical litigation and the WAO said the service should work with the Welsh government to regularly analyse the costs and causes of litigation. They should aim to identify themes, spread learning and prevent issues arising in future
- Health boards should risk assess their current investment programme for renewing and replacing theatre equipment
- The government and health boards should agree a method of benchmarking staffing and skills levels in theatres to ensure safe and sustainable staffing
- Through a new national theatre forum, the government and health boards should agree a new dataset of efficient, productivity and safety measures to support comparison and learning. It is likely these would be a set of core measures, supplemented by some speciality specific measures
- Board meetings should regularly consider theatre efficiency and safety using data such as patient experience, use of theatre time, start and finish times, turnaround times and cancellations
- Up-to-date performance and safety information should be visible in operating theatres.

Syncera®
Powered by smith&nephew

Adapt to a different kind of operation

Unique Interactive Digital Solutions designed to help reduce unwarranted perioperative variation and optimise operating theatre efficiency.

Streamline where it's needed

- Customisable and surgeon-specific training
- Efficient tray inspection and tracking can result in up to 61% fewer instruments and up to a 60% reduction in processing costs[2]

Connect where it's disjointed

- Up to 85% reduction in implant related waste[1]
- Reduced incidence of 'near miss' events[1]
- Error-free ordering and automated product replenishment
- Documentation of assembled cases and trays – shows available or missing

Personalise where it matters

- Designed to reduce staff orientation time by up to 40%[2]
- Helps increase surgeon confidence in staff by providing scoring, instant feedback, and rapid improvement with real-time metrics[2]

Visit uk.syncera.com

GS1 UK

1. Ast M; et al. The Reduction of Implant-Related Errors and Waste in Total Knee Arthroplasty Using a Novel, Computer Based, e.Label and Compatibility System. Journal of Arthroplasty. Article in Press. 2013. **2.** Hensell MG, Pirris J. Virtual BackTable. Reducing Cost of On-boarding. Presented at the AORN Surgical Conference and Expo 2015.

headli

Capitation-based budgets are seen as the best way to drive integrated services and underpin new models of care being developed in vanguard sites. Steve Brown reports

Work in Mid-Nottinghamshire to transform its model of care got underway long before the area was awarded vanguard status by NHS England. However, the central support and profile has helped to accelerate development and put in place key strands of its new integrated care system. It is also one of the areas to have made most progress with a new capitation payment system to underpin the new way of working. In fact, it is just one of a number of sites that will run capitation systems in shadow form this year.

Mid-Nottinghamshire (or, to be precise, the population covered by Mansfield and Ashfield and Newark and Sherwood clinical commissioning groups) started developing its new model approach as part of its 'Better together' programme three years ago. Patients, the public and clinicians had identified a reactive system that operated in silos, was difficult to navigate and where referral times and waits could be lengthy. It was also recognised that the system was simply not sustainable – heading towards a funding gap of £140m (estimated at the time) within 10 years as a result of a rising and ageing population.

The collaborative approach, including an alliance of local providers, the two CCGs and the county council, is now an NHS England integrated primary and acute care system, one of nine so-called PACS sites among the 50 vanguards.

New models of care are being implemented across all of the programme's focus areas – proactive (long-term conditions) and urgent care; planned care and women's and children's care – although the most eye-catching changes so far have been for proactive and urgent care.

Integrated community network

At the heart of the new model is an expansion of integrated community services across Mid-Nottinghamshire. Using risk profiling, the top 2% of the population at most risk of hospital admission are identified and supported by multi-disciplinary integrated teams (and crisis support). The aim is to avoid admissions and improve levels of self-management.

In urgent care, GP and accident and emergency services have been integrated so that there is now a single front door to both primary care and emergency care services at local accident and emergency and minor injuries units. Combined with changes to processes at Sherwood Forest NHS Foundation Trust and changes in how patients are discharged, this has been a huge success. The trust moved from the bottom five in terms of the A&E four-hour wait to top quartile in about nine months.

Marcus Pratt, associate chief finance officer for both CCGs involved, says you need the care model in place before you can turn attention to payment. 'Otherwise you are just shifting financial risk around the system,' he says. But payment is an important component to making the system work and the vanguard is one of six sites leading the way in developing new payment systems. These sites (see box) will shadow-run their funding mechanisms during this year, with some potentially starting 2017/18 with the new payment systems in place.

Current incentives do not support the changes the health economy has made or wants to make to care delivery. If the new model works, there should be a shift of care out of hospital and into the community. Yet in some instances, tariff continues to incentivise increased acute activity. 'And in the community sector under a pure block contract, the incentive can be to look solely at internal organisational efficiencies as much as possible and not necessarily focus on what the best outcomes are for the system,' says Mr Pratt. 'So, as a system, we want to create a payment mechanism that gets everyone working together for the same goal and takes away those potential perverse incentives.'

The alliance, involving the commissioners and their seven provider organisations, is crucial. Commissioners continue to have contracts with individual organisations for the delivery of services, but a new alliance contract (based on the NHS England standard alliance contract) brings everyone together around common goals and sets out the payment approach. With one element of the new payment approach live in 2016/17 (an outcome-based payment), individual organisation contracts effectively point to the alliance contract for this payment.

Mr Pratt says having a forum for senior finance leaders to come together through the alliance has been key to driving the programme forward. 'The alliance members have been keen to ensure the payment mechanism is co-designed by all parties to ensure full sign-up and to keep a focus on what's best for the system,' he says.

However, the full capitated payment approach will have three elements. The first is a fixed element for each provider based on planned activity and commissioner spend. This is adjusted for inflation, population changes, efficiency and the impact of shifts in resource usage from, say, acute to community as a result of the new delivery model.

The second – unique to Mid-Nottinghamshire and not reflected in

ne act

national models – is a variable element the vanguard believes will support patient choice. 'In our alliance, we have multiple acute providers and we need to acknowledge some money should follow patients if they choose treatment by one provider rather than another, because of preference or the perceived quality of services at those providers,' says Mr Pratt.

So this is not just a marginal element for any additional activity above the activity assumptions in the fixed payment, but something to fund changing patient flows – for example, due to patient choice. The actual mechanism had not been finalised as *Healthcare Finance* went to press, but it could involve payments linked to changes in the percentage share of activity of the acute providers, perhaps operating with a cap and collar mechanism.

A third element will link payment to outcomes and is already live in 2016. The stand-out feature of this payment is that it is an all-or-nothing mechanism. Either all of the partners receive it, if the outcomes are achieved, or no-one receives it. This provides a financial incentive for all partners to work together to plan and implement initiatives and meet the system outcomes.

The scheme was co-designed by all alliance members and is set at 1.8% of contract value for each alliance provider. It is paid on the achievement of a set of outcomes and in this year is a variation to the CQUIN incentive scheme. This gives all alliance members a direct interest in the achievement of the overarching system goals and activity targets – reducing the potential for parochial financial self-interest.

Overarching this whole three-part payment is a risk and reward mechanism that attempts to align financial incentives across the whole health economy to ensure alliance members are acting in the best interests of the patient and the system as a whole. (National models for

Linked data benefits

Tower Hamlets Clinical Commissioning Group has been working towards more integrated services for several years. In September 2013, it set up local integrated community health teams to support high-risk patients – those with the most complex needs were a key focus for attention, often older adults with long-term and multiple conditions.

Its planning document for 2013-2016 said these patients accounted for about 80% of the CCG's spend on hospital care, often the result of avoidable emergency admissions. These patients were also frequent users of GP, community and social care services.

More integrated care was identified as a way of improving the response for this group. The CCG's involvement in the multispecialty community provider vanguard to create an integrated provider partnership is a way of accelerating these developments. The vanguard – 'Tower Hamlets Together' – also includes Tower Hamlets GP Care Group Community Interest Company, Barts Health NHS Trust (acute and community services), East London NHS Foundation Trust (mental health and community) and London Borough of Tower Hamlets (social care), although the aim is to broaden this to include local voluntary and community sector organisations.

The integrated model includes initiatives to improve continuity and patient-centredness, such as the use of care navigators (embedded in multi-disciplinary community teams), rapid response and discharge support to support the area's high-risk patients. CCG strategic development manager for payments and incentives Mary Mulvey-Oates says the model works well, but adds: 'We have got to a certain point, but one barrier to progress is how the payment system works.'

The vanguard is helping NHS England and NHS Improvement think through how payment

arrangements can be put in place to support new care models. While the centre has been thinking through creating capitation budgets based on whole populations, Tower Hamlets has begun shadow testing a baseline budget for a specific cohort of patients.

This creates extra challenges. While it is fairly straightforward to identify acute spend at patient level, this can be harder for community, mental health, social care and primary care spend.

It is early days, but the vanguard has the advantage of a well-developed patient-level linked data set, which includes detailed primary care data such as appointment types.

This opens up the possibility of breaking down overall commissioner spend into spend on different patient cohorts, which might provide a way forward for setting a budget for the integrated partnership. Key decisions have yet to be taken and the CCG is keen to engage further with its clinical community to develop its approach.

SHUTTERSTOCK

capitation include risk and reward as one of the three elements alongside fixed and outcome-based payments.)

The CCG has invested in the integrated community teams in its contract with its community and mental health service provider, Nottinghamshire Healthcare NHS Foundation Trust. Under old rules (and during the transition this year), the CCG is taking the risk of the upfront investment (supported by vanguard funding). If the investment does not lead to the expected reduction in acute emergency admissions written into acute contracts, it will continue to pay for the 'extra' acute activity undertaken by its acute providers (under existing marginal rate rules). But there is also risk in the acute sector where marginal tariff income may not cover the increase in planned costs.

Shared risk

In future, the costs of exceeding the planned levels will be shared. 'If the model fails, we will share the risk across all the alliance partners that can influence the planned target – in this case, the acute providers, the community provider and the CCG,' says Mr Pratt. This will be done in a planned way rather than using an arbitrary marginal tariff percentage.

Another good example is with high-cost drugs. With current pass-through payment arrangements, there are no financial incentives for acute providers to minimise the use of high-cost drugs where there are more cost-effective generic drugs available. The hit is taken by the commissioner, but all the influence lies with the acute provider. But new risk and reward plans could see savings made from increased use of appropriate generics shared between the provider and commissioner.

With the planned payment mechanism nearly finalised, a big task has been calculating the right capitated budget to start with. This is a whole population budget – preferred by NHS England and NHS Improvement over budgets targeted at specific sub-segments of population as they are seen as offering 'greater opportunities to integrate care and incentivise prevention' and because they 'mitigate the impact of random cost variations, which cannot be controlled by the budget holder'.

For Mid Nottinghamshire, population – the combined registered populations for the two CCGs – is relatively straightforward. There have had to be adjustments with social care (who have services in scope of the payment mechanism) as the boundaries are not quite co-terminus with the local authority.

In terms of delivery of health and social care in Mid-Nottinghamshire, all services are in-scope and there is a desire to bring as much as possible into scope of the payment mechanism over time. In the short-term the local priority has been identifying a subset of services based on urgent and proactive care that will form a shadow capitation budget from July.

"Even those without linked data can come to a view on their WPB and then increase their understanding of population and activity"
Alex Guite, NHS Improvement

For acute services, Mr Pratt says identifying current payments on the population was straightforward, thanks to the tariff system. The spend on new integrated teams to deliver community services was also easy to identify and adult social care has been included with the exception of personal budgets. Continuing healthcare is currently not in scope due to commissioning and risk-sharing arrangements across the whole county, which is a wider population than the vanguard.

Prescribing is seen as critical as different levels of prescribing could affect acute activity – optimum prescribing could avoid admissions or reduce length of stay. While the vanguard remains keen to bring it in scope in future, it remains out for purposes of shadow running. This is because although primary care has a seat at the alliance table, it is not a formal part of it. Also, there is a lack of detailed data at patient level.

In general, primary care is seen as central to multispecialty community

Capitation explained

'There's lots of international evidence that outcome-linked capitation budgets are a reliable form of payment to align incentives for integrated care,' says Alex Guite, pricing development lead at NHS Improvement (right). 'That makes them particularly relevant to multispecialty community providers (MCPs) and primary care acute care systems (PACS).'

It comes in two flavours – with budgets covering a whole population or targeted at a specific sub-segment – and it is a whole population approach that NHS Improvement and NHS England are focusing support efforts on. A draft payment systems handbook says whole population budgets (WPBs) offer 'greater opportunities to integrate care and incentivise prevention and mitigate the impact of random cost variations that cannot be controlled by the budget holder'.

WPBs are the preferred approach for anyone making new moves towards capitation budgets, but the two bodies are happy for local areas already pursuing the more targeted budgets to continue.

A whole population budget covers the population of an area – rather than a particular age group or pathway. This leaves the task as identifying the services that are in scope and their related funding, rather than trying to carve funding up between different parts of a population.

Most people's contact with capitated budgets would be with commissioner allocations, where budgets (or at least target allocations) are created using a weighted capitation approach – each area's population is weighted to reflect its make-up in terms of age and relative need, then each 'weighted' head attracts the same proportion of the total national allocation to CCGs.

But whole population budgets come at capitation from a different starting point. You still get a budget to provide the agreed services – though they may be defined in broad terms – for a specified population, with the baseline budget initially created on the basis of existing spend on the services deemed as 'in scope'. What differentiates this from a block contract are elements of payment linked to outcomes (typically for the whole health economy) and a mechanism to share financial risk across all the commissioners and providers involved.

In contractual terms, this may involve a contract between a commissioner and a lead provider and sub-contracts between the lead provider and other providers. Or, as in Mid-Nottinghamshire (see main feature), it could involve a contract with a provider alliance, underpinned by commissioner-provider contracts.

Identifying spend for a WPB is relatively straightforward for in-scope acute services as spend on the secondary uses service database can show relevant activity and this can be calculated at current prices. Block contracts for community, mental health and social care services – and identifying the spend on in-scope primary care services – can be more challenging. It may involve estimates, weightings or the use of provider costs. NHS Improvement and NHS England's WPB handbook will contain guidance on identifying in-scope spend when it is published in the autumn.

So there is no per capita amount as such – and 'the policy direction beyond WPBs is not set yet', says Mr Guite. But he expects commissioners and providers to challenge the appropriateness of historical spend levels and make adjustments for efficiency and inflation.

Patient-level data sets – linked across different providers – will play an important role, but the lack of them shouldn't be seen as a barrier to progress. 'Sites with better data can make faster progress and make more nuanced, granular and robust approximations and forecasts for their budgets,' says Mr Guite.

'But even those without that linked data can make progress and come to a view on their WPB and then increase their understanding of population and activity over time. In fact this better understanding of population and services is a good initiative in itself.'

providers and integrated primary and acute systems. However, at the moment in Mid-Nottinghamshire, core primary care services are outside the scope of the budget, but enhanced services are in. The vanguard is also keen to include mental health services.

However, it is not straightforward to deconstruct the existing block contract to identify those services that directly align with urgent and proactive care. The work done around clusters has provided a way in and so certain clusters have been included, even though there is recognition that this doesn't fully align with the intended scope. For example, all dementia services have been included.

In total, around £100m of services are expected to be in the shadow budget – nearly 20% of the combined CCG (£450m) and social care (£100m) budget. Mr Pratt says the shadow running will provide insight into how the system can work together to deliver shared goals. He admits that the current finances in the NHS add to the challenge.

The capitated budget is set on the basis of commissioner spend not provider costs – as this represents the money available to the health economy. But he says the reality locally and across the country is that there are widespread deficits, particularly in the acute sector. So there may need to be some form of transition to a truly capitated budget to ensure financial sustainability in the short and long-term – and everything has to align to the overarching sustainability and transformation plan.

Mr Pratt says the financial position also provides extra incentive. 'It is a burning platform,' he says. 'We clearly need to do something differently to cope with pressures now and those that will arise from demographic change in the future. By working across organisations and aligning the system and incentives around the same goal, we have the best shot at delivering the right services and reducing cost.'

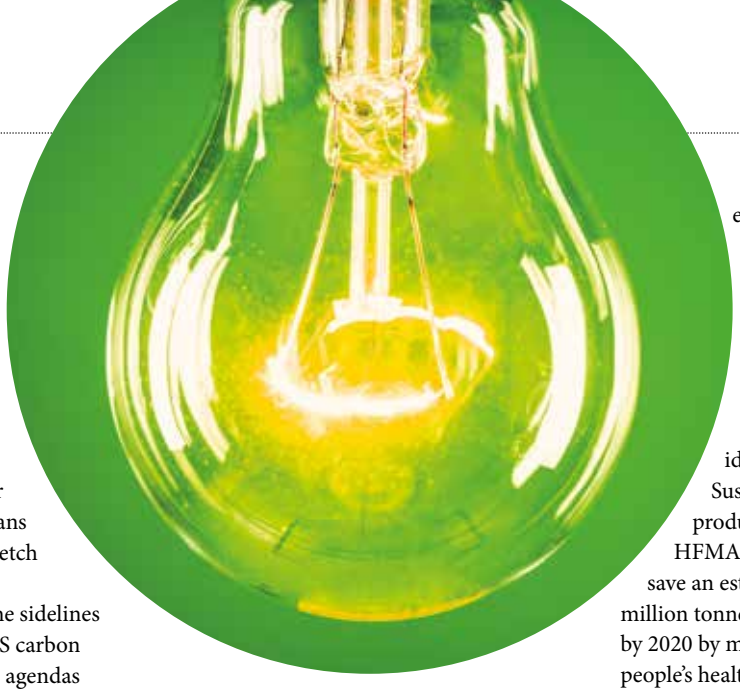
Intensive payment sites

Multispecialty community providers

- Tower Hamlets Integrated Provider Partnership
- Dudley Multispecialty Community Provider
- Encompass (Whitstable, Faversham and Canterbury)

Integrated primary and acute systems

- Mid-Nottinghamshire Better Together
- Northumberland Accountable Care Organisation
- My life a full life (Isle of Wight)



lightbulb moment

Ensuring services are environmentally and socially sustainable can also improve the financial position. New HFMA sustainability group chair Sandra Easton talks to Steve Brown

The financial challenge facing the NHS, and the need to transform models of care, can seem all consuming. It is both immediate – NHS providers ended 2015/16 £2.45bn in deficit and this year looks equally tough – and likely to get worse in future years. Rising demand, driven by a rising and ageing population with greater levels of long-term conditions, means restricted growth funding must stretch even further.

This can push other goals into the sidelines – contributing to reducing the NHS carbon footprint, for example. But the two agendas are linked and a report in June highlighted opportunities to cut carbon emissions that would also ease NHS financial pressures.

'The reality is that we only have limited resources – financially and environmentally – and we simply need to make the most of them,' says Sandra Easton, chief financial officer of Chelsea and Westminster Hospital NHS Foundation Trust (see page 32) and chair of the new HFMA Environmental Sustainability Special Interest Group. 'We increasingly have to see things in terms of a triple bottom line – planning and accounting in terms of the financial, environmental and social impact of service delivery – and understand the interconnectedness of these agendas.'

Ms Easton says the new HFMA group has been set up at an opportune moment, given the recent move towards whole health economy planning through the sustainability and transformation planning process. The group includes a representative from the Prince of Wales' Accounting for Sustainability project, which aims to inspire finance leaders to adopt sustainable and resilient business models. It also involves accountancy body CIPFA and the Sustainable Development Unit.

An early task for the HFMA group was to survey finance managers about sustainability. It found that few people felt on top of the agenda. Many saw it as important but either struggled, or were reluctant, to take on responsibility. Some felt it was a distraction and there were more pressing issues to focus on.

The survey also identified a split in the NHS, with commissioners often seeing the agenda as more relevant to providers – the major users of energy and direct contributors to the service's carbon footprint.

However, it unearthed an appetite to understand how to make progress. Helping to embed current good practice – as opposed to cutting edge activity – will be a major focus for the group. Ms Easton also wants organisations to move more towards private sector practice in reporting their performance in terms of their environmental and social impact as well as their finances. (Social sustainability is about taking decisions that help build and sustain healthy and liveable communities by supporting equity, diversity, quality of life and individual responsibility.)

In terms of good practice, Ms Easton says many organisations will have looked at the obvious quick wins in reducing carbon and energy costs – replacing lightbulbs with energy efficiency LED bulbs, for example. 'But there are lots of other things you can do and that's what we want to get some profile for – environmentally sustainable choices that support an organisation's financial position.'

Just 35 such interventions – identified in a report from the Sustainable Development Unit, produced with the support of the HFMA sustainability group – could save an estimated £414m and cut one million tonnes of carbon emissions a year by 2020 by making changes that also benefit people's health (see box). Measures range from reducing packaging on theatre kits in hospitals to replacing asthma inhalers with non-propellant versions.

'It is about raising awareness of the easy-to-do things and making sure everyone is starting from a standard platform,' says Ms Easton. 'For example, ensuring we all have LED lights. The list of 35 things in the SDU report move us beyond this but are things we all could do. This is the standard we all should have.'

There are some who would argue that sustainability is an estates issue, that the only financial role should be approving an estates' business plan – for example, replacing existing boilers or generators with combined heat and power plant. But Ms Easton insists that finance managers need to become more proactive in helping to lead and supporting the move towards greater sustainability.

Finance role

'Yes, it must be led by the estates department – they will change the lightbulbs or put in the combined heat and power plant,' she says. 'But one barrier we've had is that people haven't known how to translate an idea into a business case that a finance director understands. This is where finance needs to get involved.'

For some changes, Ms Easton says, the business case is straightforward – those lightbulbs again. Here's the cost; here are the payback period and savings. 'But for the things that are harder to quantify, and are more speculative in nature, estates may need help in

making a solid business case,' she adds.

Finance also needs to start challenging estates about what they are doing in certain areas. 'Then they can work it up together and see if it flies,' says Ms Easton. 'Some things will be difficult to cash and to identify the benefit. They won't be as easy as saying the electricity bill will be 10% cheaper. And as we think about pushing the boundaries on reducing our carbon footprint, we will need to have finance leading the charge so that we can get a detailed understanding of the benefits.'

It boils down to a joint responsibility for the finance and estates team, with the list of 35 interventions providing a handy checklist for initial discussions. 'What do we already do and what could we do?' says Ms Easton.

HFMA toolkit

The HFMA group is putting the list at the centre of its own work programme, she says. 'We will take a handful of the 35 and develop a toolkit – this is what a business case would look like; these are the things you need to consider. We want to make it as easy as possible to help people move into a world where you consider the environmental impact as well as the financial.'

She says there is a good alignment with the recent Carter report on productivity, which also highlighted savings from energy consumption. However, the Carter report also suggested £700m could be saved from better procurement. In the past there has been tension between whether some financial savings on procurement could come at the expense of the environment, with cheaper prices offset by the higher carbon emissions released in greater transport distances where products are sourced from further away.

Ms Easton thinks better procurement can deliver on both fronts. 'Greater use of hubs can be part of the solution – you don't have 10 lorry journeys from a national depot travelling to 10 hospital sites; you have a lorry going to the hub and 10 smaller journeys from the hub.'

But she admits that the NHS needs to look beyond the simple financial impact in considering the sourcing of its supplies. 'It will be a balance between lowest possible cost and buying locally,' she says.

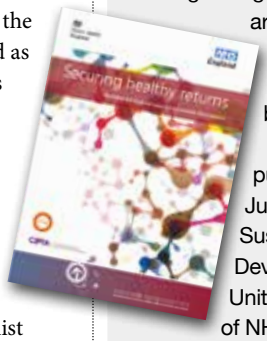
She accepts that, given the financial environment, the focus will be on interventions that deliver on both fronts – reducing carbon footprint and reducing costs. But there are also changes that can be made without incurring additional cost. 'For example, one of the measures on the list of 35 is to prescribe non-propellant inhalers for asthma,' she says. 'That doesn't cost the NHS anything but the carbon saving is the biggest on the list.'

This brings Ms Easton to a further misconception she wants to address – that reducing carbon emissions is a challenge for providers not for commissioners. Clearly, the non-propellant inhaler opportunity for appropriate cases demonstrates where commissioners can have a direct impact. But Ms Easton says that commissioners could do far more through the contracting process, moving beyond the lip service paid to the issue in the NHS standard contract. She suggests that the CQUIN mechanism would provide one way to incentivise interventions to improve the environmental impact. Commissioners may not have direct control of some of these issues, but they have levers that can be used. 'Some of the barriers are actually just perceived rather than real barriers,' she says.

'We need to get sustainability firmly on board agendas,' says Ms Easton. As well as providing practical tools to support this, the group hopes to show leadership and so encourage more finance directors to take a leading role in their own organisations.

• *Reporting requirements, page 28*

Mapping out savings



Securing healthy returns estimates the health sector could save up to £414m a year and cut one million tonnes of carbon emissions every year by 2020 by making changes in 35 areas, many of which would have patient benefits too.

The report, published in June by the Sustainable Development Unit on behalf of NHS England and Public Health England, was supported by the HFMA Environmental Sustainability Special Interest Group. It identifies a 'clear proven financial case for sustainable development' and a 'critical role for healthcare finance professionals'.

It asserts that health bodies do not need to choose between saving financial resources or protecting the environment. 'Indeed the most effective investments can often save money, improve health now and safeguard the environment on which all future health depends'.

The report focuses on 35 interventions that could deliver the savings, hoping this will support local investment decisions. But it says the list is not comprehensive. Prevention, waste (especially pharmaceuticals), new models of care and staff behaviour are identified as offering the most dramatic absolute savings financially and environmentally.

In the report's foreword, NHS Improvement chair Ed Smith says finance professionals have a critical role to play 'through supporting development of local leadership, governance arrangements and organisations' plans and reporting'.

The report adds: 'Finance professionals are crucial to realising and reporting savings from sustainable development management plans by ensuring they are valued and integrated into cost improvement programmes and given sufficient coverage in annual reports.'

It highlights eight 'top opportunities' for finance professionals. These include ensuring annual sustainability reports include financial savings and non-financial indicators, such as carbon reduction; staff mileage claims; use of finite natural resources; and social value indicators.

Finance staff should also look to 'identify opportunities for sustainable development investment from outside the health sector through match funding, partnerships and collaboration'.

HFMA
AWARDS 2016

National Healthcare Finance Awards

Rewarding healthcare finance innovation and achievement for over 10 years

- **Accounts Team of the Year Award**
- **Innovation Award**
- **Working with Finance – Clinician of the Year Award**
- **Finance Director of the Year**
- **Costing Award**
- **Governance Award**
- **Deputy Finance Director of the Year Award**
- **Havelock Training Award**

Nominate now to recognise excellence and celebrate success in your organisation. All applications will now be submitted through our new online, easy to use system

Deadline for applications: Friday 30 September 2016

For more information please visit
hfma.to/awards or contact **awards@hfma.org.uk**

PORTAL POWER

Building on its activity-based funding system, New South Wales has had major success implementing a portal that feeds cost data back to clinicians and general managers. Richard Edwards talked to programme leader Alfa D'Amato

Good cost data is essential to running healthcare services. But it only becomes really valuable once it is used – ideally by clinicians – to support decision-making or to inform the elimination of waste or the improvement of services.

Alfa D'Amato, deputy director of the Activity-Based Funding Taskforce in New South Wales, Australia, understood this early in his career. The point – and his interest – is to transform costing data into clinical insight.

Having trained as an accountant in Italy, Mr D'Amato started his career in Australian healthcare in the middle of the last decade. He soon found himself leading a project to implement 'episode funding' for a group of 18 hospitals. He saw the task as improving transparency in his part of the state health system. But it forced him to improve costing data to the point where clinicians would accept it without raising concerns about casemix complexity and without explaining why the data did not apply to them.

This recognition that the clinical workforce is the key audience for cost data has stayed with him throughout his subsequent career.

He joined the Ministry of Health in 2011 to help implement the National Health Reform Agreement, which required all Australian states and territories to introduce a consistent activity-based funding (ABF) methodology.

Initially, Mr D'Amato felt the department did not properly appreciate the opportunities activity-based funding (ABF) could bring. Historically it had relied on population-based funding. But that 'didn't lend itself to the level of transparency that enables the system to gain very quickly a level of efficiency that open, shared data can provide,' says Mr D'Amato.

He now leads the state's ABF taskforce, which in a few short years has re-engineered patient-level costing across New South Wales and developed an activity-based management (ABM) portal to feed back cost information to clinicians and general managers. A timetable has been agreed to roll out the ABM portal nationwide in Australia.

There are huge parallels with the English health service, whose own casemix funding system (albeit based on healthcare resource groups rather than diagnosis-related groups) predates that in New South Wales. In England too – belatedly some might argue – the NHS is now embarking on a mandatory service-wide implementation of patient-level costing using a common methodology. And NHS Improvement already provides a patient-cost benchmarking tool to voluntary contributors to its patient-cost collection – a forerunner to a future more sophisticated analysis tool.

Hear more

Alfa D'Amato (right) will be among speakers to address the HFMA Healthcare Costing for Value Institute's first international symposium looking at the growing international movement towards value-based healthcare. The 12 October event will give institute members – including finance leaders and clinicians – a chance to hear in more detail how New South Wales implemented patient-level costing across the state to underpin a cost and activity data portal to support local improvement. **(See page 29)**

Back in New South Wales, Mr D'Amato says the programme's rapid success was down to its structured approach. In year one, the focus was on investment in standardising the IT infrastructure to collect reliable data. In years two and three, he concentrated on maximising data quality so that it could be used for decision making. Now the focus is on using the data and reaping the rewards of the ABM portal. The aim is to extract as much value as possible from the data by making it available to as wide an audience as possible.

The portal allows clinicians and general managers to access the costing information, giving a 'helicopter view' of the data at local health district level. IT should mean users can see very quickly where their clinical costing information is an outlier compared with similar hospitals. The data is also submitted to set the 'national efficient price' for services in Australia as well as state-wide prices. Mr D'Amato adds that the benchmarking data creates 'huge competition' to be seen as the most efficient hospital.

As well as the standard metrics the ABM portal provides, such as average cost and length of stay, it allows analysis of 'cost buckets'. '[It is] so users can see at a particular hospital how the medical staff cost compares to a similar hospital treating similar patients. This allows questions about how to allocate financial resources such as workforce mix between medical, nursing and allied health costs, or to know if it is critical care or theatre costs that need to be examined,' he explains.

The ABM portal effectively allows users to drill down into the data to identify clinical variation. He says this allows for a much better quality of conversation between managers and clinicians, with clear data and complicating factors such as casemix complexity removed

SHUTTERSTOCK

by comparing similar hospitals. He adds that clinicians 'love' the portal because they are naturally competitive and relish the opportunity to showcase how efficient their services are.

There are four uses for the ABM portal: benchmarking service costs; identifying and reducing unwarranted clinical variation; reducing the number of high-cost, high frequency patients; and costing patient journeys across sectors and financial years.

Clinicians, managers and finance staff can now 'benchmark their services across the state in a way they have never been able to before'. Mr D'Amato says two things make this possible. 'Firstly the data is very transparent, everyone can see everyone else's data,' he says 'and secondly because of the timeframe. Previously it took a couple of years to consolidate all of the data and distribute it, whereas now it is much easier. The most recent benchmarking data was turned around in four weeks from final submission to being available in the data portal'.

Mr D'Amato believes the portal is already a success. 'We can see the average costs of services are not increasing at the same rate as in the past,' he says. 'We're already bending the curve, which is significant given New South Wales is the biggest jurisdiction in Australia.' He says the portal has helped identify high-cost patients at risk of multiple hospital admissions, enabling appropriate services to be provided to reduce their overall pathway costs.

It has also allowed the Ministry of Health to demonstrate its efficiency to the state Treasury and other central agencies. The state's health system is not facing the relentless efficiency and cost improvement requirements of the NHS, but is not immune to the expectation that every dollar will provide the greatest value.

'Ultimately we want to link our data with patient outcomes data and work towards improving the value of the healthcare we provide, so we can invest in the right areas for the best outcomes.'

The work is rooted in the academic basis of professors Porter, Kaplan and others – which argue for value-based decision-making in healthcare – but combines it with a typically Australian pragmatism for getting the job done. 'Unless you are able to demonstrate a direct link with health activity on the ground, it is very difficult to describe what value-based healthcare means to clinicians – is it value for the patient or value for the clinicians?' says Mr D'Amato.

The mechanics of the data collection that underpin the ABM portal provide some interesting contrasts with infrastructure and practice in the NHS. Mr D'Amato says New South Wales 'benefits' from a state-wide, centralised financial ledger system and a similarly centralised approach to patient administration. This has paid dividends in supporting consistent collection of comparable data. 'The financial and staff time burden of improving data collection are significantly outweighed by the return to patients and improving clinical practice,' he says.

The ABM portal is also available across all health sectors, including community and mental health. This may seem alien to the NHS based on past payment systems, where such transparency may sometimes have been seen as undermining local negotiations and local pricing arrangements. (However, there are some moves towards open book arrangements in new NHS sustainability and transformation planning footprint areas).

The ABM portal gives clinicians a window on cost and activity

Mr D'Amato says the cross-cutting approach is essential. 'Often commissioners don't appreciate the relationships between the services,' he says. 'Now they see the relationship between length of stay in acute and mental health services and the provision of sub-acute and community services, for instance.' Critically, they can see when the overall patient pathway costs less. This is data commissioners have struggled to obtain in the past and, for Mr D'Amato, it is one of his biggest achievements.

As well as seeing benefits across whole patient pathways it has helped relationships between separate parts of the health system. Once the data is transparent and no longer has the potential to cause dispute, the negotiation moves on and costs can be addressed based on the evidence. Mr D'Amato insists there are better conversations to be had between funders and hospitals than arguing about the validity of data. He sees this as a major benefit.

The HFMA's July NHS financial temperature check survey of finance directors (see page 8) found that only 35% of respondents believe the relationships between organisations in their STP footprint are strong enough to deliver the cross-organisational changes that are required. Given the 2016 contracting round was seen by some as the most challenging in recent memory, how much would newly forming relationships benefit from the kind of data available in an English ABM portal?

Behind the scenes of the portal is a data validation exercise that is crucial to its success. The ABF taskforce provides templates for data collection to ensure consistency, but the audit and assurance of data quality takes place locally, carried out by hospitals' internal audit teams. Some investment is required, but the pay-off is that data is ready for use almost immediately.

The ability of the ABM portal to benchmark data across the state and, soon, the whole of Australia, is what makes it a game changer, according to Mr D'Amato. Clinicians are having conversations about efficiency, facilitated by finance data and there are genuine improvements to clinical practice and patient outcomes. Funders are having better conversations with their providers.

His message is that this can be done in the UK and the benefits of a goldmine of data for providers and funders will outweigh the short-term pain of setting up data collection systems.

Introductory Guide

Twelfth Edition

PRE-ORDER NOW

For more information:

www.hfma.org.uk/publications

publications@hfma.org.uk

0117 938 8340

HFMA's Corporate Partners are:

ASTERAL · LIAISON · OLYMPUS · Newton · Bellis-Jones Hill

Penna · CIVICA · NHS Supply Chain · CIMA · software europe

Roche · Syncera · celesio · MAQUET GETINGE GROUP · Healthcost

Grant Thornton · advanced · NHS Shared Business Services · Hewlett Packard Enterprise · intel · fleet NHS solutions

neyber · CBS VAT Consulting · CIPFA

For more information about the benefits of our Corporate Partners, please contact Paul Momber **E paul.momber@hfma.org.uk T 0117 938 8972**

HFMA does not endorse products and services supplied by these organisations.

In place of strife

The Bolton health economy has opted for an alternative to the national tariff that is already transforming services and improving its efficiency. Seamus Ward reports

It's been a bruising period for those in NHS finance and contracting. With concerns over finances, quality and safety, and the need for efficiencies and service transformation, it is perhaps not surprising that the last two contracting rounds have been tougher than ever. In some areas, professional relationships have broken down and meetings have been thunderous. Commissioners and providers say the national tariff, or payment by results (PBR) as some still call it, makes contracting adversarial, but Bolton NHS organisations believe they have a solution.

'It's no secret that over the past two years we've had quite a challenging relationship financially,' says Simon Worthington, finance director and deputy chief executive of Bolton NHS Foundation Trust.

'The trust was in financial difficulty and had to get the best out of the contract we could, while the CCG had to manage its own position. That tension was starting to affect the clinical conversation, especially around CQUINs. We had to put a stop to that and transform the discussion.'

Bolton Clinical Commissioning Group chief finance officer Annette Walker adds that, with the focus on legal, financial and contractual issues, there was little time to look at transformation. The Bolton health economy faces a £64m shortfall by 2020 across health and social care, including £39m at the trust and £15m at the CCG.

The 2016/17 contract was signed before deadline, and while the benefits of removing the potential for confrontation cannot be underestimated, the Bolton initiative isn't simply a case of two sides getting on better. Both parties wanted to change local contracting and the 2016/17 planning guidance gave them the opportunity. Mr Worthington says the guidance opened the door by allowing NHS bodies in an area to apply for a single control total. While the Bolton bodies haven't formally applied, they think of the area as a single financial entity. This is embodied in the 'Bolton pound' and the agreement that a financial problem in one organisation is an issue for both.

With this single control total in mind and using the stability of the local health economy following turnaround work over the past few years, Bolton was able to take the next step – moving away from the national tariff. Broadly speaking, the new arrangements give the provider a minimum income, with incentives to reduce costs.

Over the past 18 months, the Bolton health economy has been doing a lot of work on effective use of resources and eradicating procedures of limited clinical value. Mrs Walker says under the national tariff reducing this activity potentially has an adverse effect on the provider. And although Bolton had reduced levels of limited clinical value procedures to the average for Greater Manchester, more could be done.

'We both came to the realisation that traditional contracts were not going to lead to the transformational changes needed,' Mrs Walker says.

The partners wanted to do something radical, but the tariff mechanism was all they knew. And they didn't want the new arrangements to be complex, though they had to be sufficiently sophisticated to allow for risk management. The partners have developed an aligned incentives approach comprising four elements:

- Allowing for transformation – so hospital activity could fall with the right incentives and conditions in place
- Reducing costs of pass-through items
- Stability in areas where there is little financial risk and costs are controllable, such as CQUINs
- Cost risk share in A&E, critical care and non-elective care.

The first focuses on services where activity can be reduced or shifted into different settings or modes of delivery. These include elective services, outpatients, unbundled diagnostics, secondary care therapies and direct access radiology and pathology. The trust's income in these areas is protected, removing the disincentive that prevented activity being delivered differently – for instance, by converting follow-up appointments to telephone clinics where possible. Over time, resources can be moved if Bolton decides to invest in other services.

The second element focuses on pass-through costs – for high-cost drugs or devices, for example – where there is no incentive for the provider to reduce costs.

'We used to just send the bill to the CCG,' Mr Worthington says. 'It's surprising

how many tens of millions of pounds are dealt with on that basis. But now we have people poring over spending to take costs out.'

Payment is based on 2015/16 levels and, for an agreed period, if costs are lower – driven by better procurement and ensuring prescribing is clinically appropriate, for example – the trust will be able to keep the savings. If costs are higher, the CCG will be liable but because the trust now has an incentive to reduce the costs, the risk of this is much lower.

"People are spending significant amounts of time working together to do more value-adding activities. It would not be credible to go back to PBR"
Simon Worthington

In the third area – risk share in A&E, critical care and non-elective care – a minimum level of income is guaranteed. Taking a single place-based approach, if activity rises above plan, the CCG and foundation trust will jointly manage the risk and agree funding to support the additional costs from a local sustainability fund of £1.5m. If the fund is not needed to manage risk, it will be used for FT-led transformation schemes. This creates a strong incentive to reduce this type of activity.

The fourth area groups services where activity and costs are relatively stable or controllable. The payment level is fixed and includes services such as those in the community, best practice tariffs, CQUIN and the maternity pathway. The final agreement takes up two pages of A4 paper.

Mrs Walker says: 'As a commissioner, we had got to the point where we'd done as much as we could, but under the new contract the provider is incentivised to take that further where clinically appropriate. In the past, where savings would have accrued to the commissioner, they now accrue to the provider. We've already identified system savings opportunities of at least £2m – savings we wouldn't have been able to make under the old style of contracting.'

Specialist roll-out

While specialist services remain on the tariff, Mr Worthington hopes to convince specialist commissioners to move to the new local arrangement. He believes it's important other CCGs that commission activity at the trust are on a similar deal to the one with Bolton CCG. 'From an operational point of view, it would be very difficult to manage changes so that just the Bolton patients got the transformed service.'

Though the contract includes large elements of fixed payments, both finance leads insist it is not a block contract. 'It's anything but,' says Mrs Walker. 'We will continue to monitor activity flows in and out and looking at the impact of recommendations from NICE, for example, that may trigger a decision on the contract based on cost.'

Costing will underpin payments to the trust, including how they will flex when circumstances change. Working groups carrying out the detailed strategy, planning and implementation sit underneath a newly formed local sustainability and transformation group, which will oversee performance and transformation.

And if a clinician proposes a change to improve quality, for example, management accountants will look at the costs and assess whether it will make savings. 'It's not a question of agreeing a contract number. We will make sensible decisions around whether that amount needs to flex, based on joint understanding,' adds Mrs Walker.

She explains that the risk of activity rising is more 'theoretical' as the provider is incentivised to reduce activity and costs.

'Some would say it's going back to the old days, by just asking, "How much does it cost?"' says Mr Worthington. 'If the change saves money and quality is maintained, that's fantastic. The new approach also makes it clear to clinicians that developments have to be financed from within the existing Bolton pound.'

A key element of the new way of working has been breaking down the organisational boundaries. For example, Mr Worthington has been speaking to local GPs about the contract and Mrs Walker has attended divisional meetings at the trust. Collaboration is not confined to the executive level. The CCG and foundation trust finance teams are working more closely, particularly in the costing working groups, and being more transparent about their organisations' finances.

However, Mrs Walker says they are not merging their finance departments. 'Rather than performance managing from the side-line, commissioners are working with the service delivery people to improve services, reduce costs, increase clinical sustainability and address workforce issues. We have some individuals seconded to the trust and we are looking to expand that model,' she says.

Mr Worthington adds: 'People are spending significant amounts of time working together to do more value-adding activities. It would not be credible to go back to PBR.'

Key achievements

There have been immediate benefits. For example, Mr Worthington says service changes previously believed to be unachievable, such as co-location of GP out-of-hours services and A&E, have now been made. 'There was a feeling that the trust would use co-location to draw more patients into hospital, but since we no longer have an incentive to do that, they are now co-located,' he adds.

Bolton is within the Greater Manchester devolved area and all localities have plans in place for their health and social care system. In Bolton, the new contracting arrangements are seen as the means to implementing its local sustainability and transformation plan.

'We have rapidly redesigned our locality governance on the back of the new contract. We have a sustainability and transformation group that will draw its members from across the system and oversee the delivery of the locality plans and the transformation required,' Mrs Walker says.

Sitting above this group, a committee of chairs and chief executives will respond to STP requirements and work to deliver the wider Greater Manchester plan. The model for organisational delivery has not been settled, but Mrs Walker and Mr Worthington are relaxed about this. They believe it is better to get the contracts and services sorted out first and the organisational models will follow. Indeed, NHS Improvement chief executive Jim Mackey recently said Bolton was a good example of how localities can get on with transformational change.

The Bolton partners believe they have removed the financial barriers to transforming services and now there is no going back.

Annette Walker and Simon Worthington

hfma
professional lives
Events, people and support for finance practitioners

Page 29
Full details of upcoming HFMA events

Page 30
Brexit considered, plus members' many fundraising efforts

Page 31
Network focus on the Commissioning Finance Faculty

Page 32
Sandra Easton steps up at Chelsea and Westminster

Understanding the requirements on sustainability reporting

Technical update

The Sustainability Development Unit's *Securing healthy returns* report says the 'requirement for sustainability reporting as part of annual reports is emphasised by the Department of Health and in guidance from Treasury'. In reality, the wording is anything but emphatic, *writes Steve Brown*.

Up to 2015/16, there have been two rule books for trust and foundation trust accounts – the Department's *Manual for accounts* and what was Monitor's *Annual reporting manual*. While both allow for environmental reporting, neither could be said to have been particularly bossy about it.

In a section on performance analysis (paragraph 2.15), the *Manual for accounts* says that organisations should provide information on its key performance measures. There are no direct requirements for sustainable development reporting, though the Department says requirements for such reporting would be advised of in frequently asked questions. There was no mention of sustainability in any of the FAQs issued by the Department in 2015/16.

The *Annual reporting manual* goes a little further, but not much. 'The annual report may, at the NHS foundation trust's discretion, include additional reporting covering sustainability, equality, and the NHS Constitution,' it says in paragraph 7.7.

In 2016/17, there will be a single group accounting manual covering the accounts of all NHS bodies. And on the face of it, a tougher stance does seem to be emerging. The consultation draft says helpfully: 'Reporting entities are expected to comply with mandatory sustainability reporting requirements. It is envisaged that such reporting will be integral throughout the annual report and accounts and not a separate standalone report.'

This begs an obvious question: what are the mandatory reporting requirements? The place to look is the Treasury's *Financial reporting manual* (FReM). Both the 2015/16 and the 2016/17 FReMs (paragraphs 5.2.10 and 5.2.11) repeat the 'comply with mandatory requirements' call and underline that reporting should be integral and not separate from the annual report.

It adds that 'entities falling within the scope of reporting under the *Greening government commitments*' should also report performance against sustainability targets.

An annex flags up environmental and sustainability guidance, but even the most recent version of this guidance states explicitly that NHS bodies are not covered by the requirements. It adds that the NHS has its own carbon reduction strategy and also assesses performance using the 'Good Corporate Citizenship tool developed with the Sustainable Development Commission'.

The lack of clarity – or at least detail – appears to have influenced actual practice. Analysis undertaken by the SDU shows that only one third of annual reports for CCGs and NHS providers included a good sustainability report in 2014/15.

However, there are specific requirements for NHS bodies to report on sustainability. CCG annual reporting guidance for 2013/14 – and still live on the NHS England site – confirms this for CCGs, while, for NHS providers, the requirement comes from the terms and conditions written into the NHS standard contract. A provider must 'demonstrate progress on climate change adaptation, mitigation and sustainable development' and, importantly, 'provide a summary of that progress in its annual report'.

Providers looking for further details are pointed in the direction of Sustainable

Go ahead for GreenLight prostate treatment

NICE update

NICE has recommended GreenLight XPS to treat benign prostatic hyperplasia (BPH) in non-high-risk patients (medical technology guidance MTG29), *writes Nicola Bodey*. It provides another treatment option for benign BPH alongside monopolar and bipolar transurethral resection of the prostate (TURP). NICE estimates 13,600 people with BPH are eligible to have GreenLight XPS, with uptake anticipated to be 50% from year two onwards and around 6,800 people having the procedure each year, either as an elective inpatient or day-case procedure.

This guidance is a cost saving for the NHS. The level of savings depends on how many procedures are done as day cases and the cost of the GreenLight XPS fibres.

NICE anticipates more people will have day-case procedures with GreenLight XPS than with TURP. This will reduce the number of bed days needed by people with BPH, allowing providers to better utilise beds.

The reduction in bed days is a non-cash-releasing saving, with additional day cases generating increased income for providers due to the day case uplift for these procedures.

An annual commitment to purchase fibres above a minimum number secures provision of a GreenLight XPS console at no extra cost. The average cost per fibre is £550.

The approach is also expected to reduce the number of adverse events associated

In brief

NHS RightCare has published four more commissioning for value packs to help clinical commissioning groups identify opportunities for improving value. The packs cover cancer and tumours, mental health and dementia, maternity and early years, and musculoskeletal, trauma and injuries.

NHS Improvement has published details of regional workshops that will look at the 2017/18 tariff. Four events will take place in July and one in August in Birmingham, London and Leeds.

NHS Employers has published the detailed technical requirements for commissioners and practices that hold a general medical services contract (GMS) under agreed GMS contract changes for 2016/17. It also issued the requirements for practices offering enhanced services and vaccination programmes.

NHS Improvement draft guidance for providers on local stakeholder engagement is a helpful reminder of the importance of good governance, especially in the current financial and operational environment, the HFMA said. In its response to the draft, it added that all local organisations must take a similar approach.

Development Unit guidance on sustainable development management plans. This does suggest that marginal abatement cost curves could be used in annual reports to explain environmental performance. But that is the only mention of annual reports. For those putting reporting into practice, the SDU produces detailed reporting guidance and provides checklists and reporting templates.

The 2016/17 group accounting manual is currently out for consultation. *Healthcare Finance* understands that the SDU has been in discussions with the Department about strengthening the clause in paragraph 2.15, and there is an expectation that this will happen.

There is a good argument that sustainability can help organisations meet existing financial challenges. But improving the clarity around reporting requirements would be a good first step.

with treatment. Savings range from £1.3m when 36% of procedures with GreenLight XPS are done as day cases, to £3.2 million when this reaches 70%. Based on 53% of GreenLight XPS procedures being done as day cases, the guidance is estimated to save the NHS around £2.3m per year (or £4,200 per 100,000 people). This technology is commissioned by clinical commissioning groups. Providers are NHS hospital trusts.

Nicola Bodey is a senior business analyst

Diary

July

7-8 (N) Creating synergy, annual provider conference, Warwick
12 (B) Wales Branch: personal impact skills, Swansea
13 (B) Wales Branch: personal impact skills, Cardiff
15 (B) South West Branch: #ConnectDorset 2016, Bournemouth
18 (B) North West Branch: Step up: evidence-based persuasion, Wigan
18 (B) North West Branch: Step up: secrets of world-class negotiators, Wigan
19 (B) Wales Branch: personal impact skills, North Wales
19 (B) Kent, Surrey and Sussex Branch: introduction to NHS finance, Crawley
21 (B) Yorkshire and Humber Branch: annual quiz, Yorkshire Sculpture Park
22 (B) Yorkshire and Humber Branch: turnaround, Pontefract

September

9 (B) Yorkshire and Humber Branch: student event, Leeds
12 (B) South Central Branch: Step up: evidence-based persuasion, Reading
12 (B) South Central Branch: Step up: secrets of world-class negotiators, Reading
13 (B) Eastern Branch: student conference, Cambridge
14 (I) Costing regional networking and training event
15 (F) Provider Finance: technical forum, London
15 (F) Commissioning Finance: forum, London
20 (B) London Branch: HPMA joint event, Rochester Row
22 (F) Chair, non-executive and lay member: forum, London
22-23 (B) South West Branch: annual conference, Bristol
29-30 (B) Wales Branch: annual conference, Hensol
29 (N) CEO Forum, Jim Mackey
30 (B) South Central Branch: football tournament, Southampton

October

7-8 (B) Kent, Surrey and Sussex Branch: annual conference
12 (I) International Symposium, London
13 (B) East Midlands Branch: annual conference, Leicester
19 (N) Charitable Funds, London

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

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

Event in focus

International symposium, Healthcare Costing for Value Institute

12 October, London

The HFMA Healthcare Costing for Value Institute's first international symposium will bring together finance and clinical professionals to learn about innovative practice in achieving best value around the world. Confirmed speakers include Michael Rabenschlag (right), director of the Department of Economics at the Institute for the Hospital Financing System in Germany; Claude Pinnock, director of the International Consortium for Health Outcomes Measurement; and Alfa D'Amato, deputy director of the activity-based funding taskforce in the New South Wales Ministry of Health, Australia. The symposium is aimed at finance directors, chief finance officers and clinical colleagues, as well as international delegates. Clinicians in institute member organisations are guaranteed a free place if they book by September.

Visit hfma.to/symposium for details or email jonathan.richards@hfma.org.uk

Uncertain times ahead

Association view from Mark Knight, HFMA chief executive

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

My HFMA

So there we have it. After all the electioneering and punditry, the UK has set a course to leave the European Union. For many of us 23 June 2016 will be one of the historically defining days in our lives and it has sharply polarised the country.

The EU has been part of our world for so long, affecting almost every aspect of our existence, and we now have to take hold of any opportunities that present themselves to smooth any economic effects of leaving.

For the NHS, the implications could be very significant. If the consensus view of the economists prevails, the UK will be a poorer place economically, at least in the short to medium term. In that context, appeals for a fair share of gross domestic product to be spent on healthcare, even if heeded, would not necessarily lead to increased spending. After all, 8% of not very much is not very much.

Another uncertainty is over the workforce. Free movement of labour has helped to attract and retain staff from the EU at every level. A significant number of those employed in the social care sector are from within the EU.

There has been talk about an Australian-style points system to control immigration. But again, it is not clear how that would work with some of our caring roles. And what of those who are here already and performing much-needed roles in health and social care. Even if rules do not change, will the statement made by UK citizens encourage some to look elsewhere – Germany, for example – for a more welcoming place to work? These are all considerations, policy makers will need to have in the future.

Even without actual change, the uncertainty surrounding major areas such as reciprocal healthcare arrangements, standards and research could itself have an impact. Many agreements and arrangements are embedded in laws and legal documents, and that will take years to plough through.

However, my main worry lies elsewhere. The UK is a fabulous country. It has traded and taken a leading role in the world for centuries. There is a chance we will recover from this economically and take advantages of opportunities that come our way. I'm more worried about the schism the referendum has caused and the disaffection of young people hostile at the apparent actions of the older generation. England and Wales are both 'leave' places, whereas Scotland and Northern Ireland are 'remain' – although, ironically, the result could trigger further attempts by Scotland to leave the UK.

HFMA chief executive Mark Knight

These are disturbing long-term issues and ones that will need to be handled carefully by our political leaders. But it has a knock-on effect to our own part of the system because day and night our NHS will still need to deliver.

The NHS itself faces an uncertain time. A new prime minister means a new cabinet, which could have implications for the health secretary. And that has implications for the transformation programme in the NHS – which is attempting to deliver a more collaborative, health economy-wide approach to service delivery despite the legislation set out in the 2012 health act.

The NHS is facing its biggest ever challenges. It is hard to see the current political uncertainty easing these pressures in the short-term.

Member news

Sheffield United supporters (above), including Paul Briddock, HFMA director of policy and technical, raised £17,532 for Prostate Cancer UK after cycling from Sheffield to Amsterdam. Also, Royal Devon and Exeter NHS FT deputy chief executive and chief financial officer Suzanne Tracey and colleagues raised more than £5,000 for Crohn's and Colitis UK and the British Heart Foundation by completing a 300-mile cycle ride to Paris.

James Blackwell, the HFMA's head of skills development, will represent Great Britain in the Paralympics in Rio with the national cerebral palsy seven-a-side football team. More details at **tinyurl.com/zft2jam**

HFMA Eastern Branch administrator Kate Tolworthy is running in Cancer Research's Race for Life in July. Support her at **www.justgiving.com/katetolworthy**

University Hospital Southampton NHS FT director of contracting Kevin Ross is taking on the three peaks challenge in October with partner Mandy, a nurse at the trust, to raise £1,500 for air ambulances – **www.justgiving.com/fundraising/MandyKevin**

Nottingham University Hospitals NHS Trust director of finance and procurement Rupert Egginton won the latest HFMA temperature check prize draw and has donated it to his hospital charity.

Worcestershire Acute Hospitals NHST interim FD Rob Cooper has published his debut novel, *From Blackpool to Cabrera*. 'I decided to write it after someone in a meeting said NHS finance staff could only do numbers,' he said.

Member benefits

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

Network focus

My HFMA

Commissioning Faculty

The Commissioning Finance Faculty annual conference in June was attended by 110 delegates and received excellent feedback.

The event is the highlight of the year for the faculty and among the speakers were Paul Baumann, chief finance officer at NHS England, and Matthew Cripps, national director at NHS RightCare.

'It was great to meet people, share ideas and catch up on what is happening,' says Debbie Newton, chief finance officer at NHS Hambleton, Richmond and Whitby Clinical Commissioning Group, who is also a member of the faculty's technical issues group.

The group comes together quarterly to discuss the biggest challenges in the sector.

'We look at things nationally. We work through where issues are and we try to help each other. When something new comes up, we'll talk about it. We'll all have an input into it and we'll look up ways of helping the faculty to get guidelines and other ideas out to the wider financial community,' she adds.

The next event in the faculty's programme is a strategic financial planning forum on 15 September in central London. It will be led by Sam Higginson, director of strategic finance at NHS England.

He will be joined by members of his team, who will provide a national update on the spending review, efficiency agenda and allocations, as well as the latest developments on the sustainability and transformation plans (STPs).

David Chandler (above), NHS Sunderland Clinical Commissioning Group chief finance officer and also a member of the faculty's TIG group, is particularly looking forward to the event: 'I'll be there. Some of the subjects are very close to my heart,' he says.

The faculty's last event for the year – the case study-based forum – will focus on STPs in practice, which will take place on 16 November. The forums organised by the faculty are open only to members of the network.

'I'd encourage more people to get involved in the faculty – especially aspiring chief finance officers. I think they'll find it incredibly valuable and will build up a strong network of connections,' Mr Chandler says.

- Visit http://hfma.to/commissioning for details on the Commissioning Finance faculty

Branch contacts

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

Appointments

Simon Young, director of finance and deputy chief executive officer at Tavistock and Portman NHS Foundation Trust, will be retiring in September. He was appointed director of finance at the trust in 1996. Mr Young trained as a management accountant in the manufacturing industry, working for the National Can Corporation from 1981 until 1987.

Wendy Thompson (pictured) is the new director of finance at the HSC Business Services Organisation in Northern Ireland. She has worked at South Eastern Health and Social Care Trust for 10 years, initially as assistant director in financial services and later as assistant director in financial management. She received an HFMA Key Contributor Award in 2015.

Richard Wheeler has been named finance director at Northamptonshire Healthcare NHS Foundation Trust. The 2012 winner of the HFMA Deputy Director of Finance Award, he has experience as a finance director in further education, regional development and healthcare. Most recently he held the role at East Midlands Ambulance Service. He succeeds **Bill McFarland**, who has retired.

Maria Moore, interim chief finance officer at Oxford University Hospitals NHS Foundation Trust, has become director of operational finance at the organisation. She succeeds **Mark Mansfield** who had been director of finance and procurement since 2010.

Suzanne Robinson (pictured) is now director of finance and performance at North Staffordshire Combined Healthcare NHS Trust. Formerly deputy director of finance at The Christie NHS Foundation Trust, she succeeds interim **Ann Harrison**. **Sarah Lorking** will join Ms Robinson as deputy director of finance, moving from Derby Teaching Hospitals NHS Foundation Trust where she is assistant director of finance.

Sue Hall, director of resources at Avon and Wiltshire Mental Health Partnership NHS Trust, has been named director of finance at Hampton Court Palace. She has worked at the trust since 2012, initially as interim director of finance and then director of business development before becoming director of resources in 2014.

Roy Jackson (pictured) is the new director of finance at Hinchingbrooke Healthcare NHS Trust. He has more than 30 years of experience in the NHS within both the commissioning and the provider sector. He succeeds the trust's interim director, **Ian O'Connor**.

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

"I want to take my experience of an organisation post merger and try to apply the learning at the start of Chelsea and Westminster's journey"
Sandra Easton, Chelsea and Westminster Hospital NHS FT

Transition tops Easton's agenda at Chelsea

On the move

Sandra Easton has been appointed chief financial officer at Chelsea and Westminster Hospital NHS Foundation Trust – a chance, she says, to share her experience of bedding in a trust merger and to learn from one of the top-performing health service organisations.

She joined the trust in August last year – moving from Imperial College Healthcare NHS Trust – taking the director of finance role under then chief financial officer Lorraine Bewes. But, with Ms Bewes stepping down earlier this year, Ms Easton has taken the chief financial officer post, which now includes both roles.

She will play a major role in delivering a smooth transition following the trust's acquisition of West Middlesex University Hospital NHS Trust in September last year.

'I joined the trust two weeks before the merger. In my mind I came in to facilitate that from an organisational perspective as well as merging the finance and information teams and building a world-class department that will support both sites in the new trust,' she says.

Her experience at Imperial will be particularly applicable at Chelsea and Westminster. 'I went to Imperial around two to three years after the Hammersmith and St Mary's trusts merged to form Imperial. But even then there were lots of things that still hadn't been aligned. I want to take my experience of an organisation post merger and try to apply the learning at the start of Chelsea and Westminster's journey.'

Me Easton was also drawn to the trust by its reputation. 'Chelsea and Westminster is a top performer on A&E access,' she says. 'It is an opportunity for me to learn how it maintains that performance, even when going through the merger.'

Like all NHS organisations, Chelsea and Westminster faces a challenging control total this year, planning for a small surplus. Nevertheless, Ms Easton says the trust has a robust in-house team in place to help deliver this. The team is based in its project management office (PMO), set up as part of the acquisition process.

The PMO is working in three areas, two of which are about the here and now. These focus on integration and alignment of processes and policies and service efficiency and improvement. Ms Easton says the latter is 'about the cost improvement work and getting cash out of the bottom line'.

The third area is longer term, focusing on transformation and financial sustainability as well as quality of services.

Ms Easton started her NHS career in 2001 after finishing her degree in financial services, and she has a wealth of experience across acute, tertiary, community and mental health providers. She worked at Imperial for more than four years, holding a number of roles, including one of the trust's heads of finance, one of its business partners and, latterly, deputy director of finance.

'My new role includes information and procurement, which is exciting and challenging,' she says. 'It's a fantastic time to be leading these teams. The information team reports to me because its data is so key to the delivery of the financial position and the Carter recommendations. It's really high profile.'

One of her immediate objectives was to move to a single ledger system and this was scheduled to go live at the end of June. Common reference cost and service line reporting systems were launched in January.

'The next big objective is to build a strong department that can continue to attract the best talent,' says Ms Easton. 'We are refreshing our training policy for finance and starting to work on getting accreditation with CIMA and ACCA. We want to make this a place where people want to come to learn and work.'

FFF seeks new FACEs

Future focused finance

Clinical-financial engagement is a key component of any scheme to ensure the service makes the most of its resources. And NHS Future-Focused Finance (FFF) is keen to support organisations realise this goal by developing a new cohort of finance and clinical educators (FACEs).

There are currently 161 FACEs in the NHS, helping to explain NHS finance for non-finance staff. They aim to develop partnerships with frontline clinicians, understanding their perspectives and promoting value-based decision-making.

Sanjay Agrawal (left), a consultant respiratory intensivist and senior responsible officer for the FFF close partnering work stream, says the programme must become systematic.

'We have fantastic examples of clinical engagement, but hotspots of best practice are not enough. We need every organisation to get the maximum out of every £1 of investment, with the most effective service delivery creating the best-value clinical experience,' he says.

FFF value maker Ben Roberts says the aim is to get one FACE in every organisation, supported by local networks to make the educator work as far-reaching as possible. A launch event was held at the beginning of July and a new 'FACE of finance' tag line was created.

Fellow value maker Pam Kaur says: 'As a finance and clinical educator you are the FACE of finance within your organisation and part of a network of like-minded people who want to add value within the wider NHS and help people demystify finance.'

- **Visit futurefocusedfinance@nhs.net**

celesio

AAH Hospital Services | LloydsPharmacy Healthcare Services | evolution Homecare Services

Working together to deliver on the Carter Recommendations

The countdown to April 2017 has begun

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

Outpatient Dispensing | Repatriation of Homecare | Reducing Stock Holding
Medicines Optimisation | Releasing Capacity | Supply Chain Management | Procurement

Find out how much your NHS Trust could save with our savings estimator:

www.CarterSavingsEstimator.co.uk/HFMA or call us on 02476 432764

OLYMPUS®

Your Vision, Our Future

GUARANTEED PERFORMANCE SOLUTIONS

Service provision and capital product options

Olympus has developed Guaranteed Performance Solutions, a new service in response to the changing health service landscape, to improve patient outcomes through efficiency gains.

Guaranteed Performance Solutions options:

- Capital replacement programme
- Managed equipment service
- Consumable management
- Asset management and budget control
- Multi-vendor service

To investigate potential efficiency gains under an Olympus Guaranteed Performance Solution contact us on **01702 616333** or **strategy@olympus.co.uk** so that we can begin the process of change within your hospital.

OLYMPUS MEDICAL

KeyMed House, Stock Road, Southend-on-Sea, Essex SS2 5QH | Tel: +44 (0)1702 616333 | www.olympus.co.uk