healthcare finance

November 2016 | Healthcare Financial Management Association

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News

Association calls for debate on scale of NHS funding

By Seamus Ward

The HFMA has called for a public debate about whether taxpayers are willing to pay more to fund the NHS and backed a mechanism to link overall NHS funding to a proportion of GDP.

In its submission to the House of Lords' enquiry into the future sustainability of the NHS, the association said it was the right time to have an honest debate about the appetite for higher taxes to pay for the NHS.

If not, the debate should move to deciding the level and range of universal services that should be provided by the health service.

The HFMA told the Lords committee holding the enquiry that NHS bodies were struggling to meet demand and balance their books. Though quarter one figures for 2016/17 were more positive, this was only achieved with the sustainability and transformation fund.

Without this, the underlying position was similar to that a year earlier and in the HFMA *NHS financial temperature check* survey, finance directors had reservations over whether estimated efficiency requirements were realistic.

HFMA policy director Paul Briddock said: 'If demand for NHS services continues to increase, the pressure will continue to build. Even now, NHS finance staff – and other healthcare managers – find themselves with the seemingly impossible task of cutting costs while activity increases. This position is not sustainable.'

"NHS finance staff find themselves with the seemingly impossible task of cutting costs while activity increases"

Finance directors have previously told the HFMA that additional funding, over and above that already promised, was the their preferred action to return financial sustainability while maintaining clinical service quality.

The HFMA noted the Organisation for Economic Co-operation and Development (OECD) figures, which showed UK health spending stood at 8.5% of GDP in 2013.

This included public and private spending on healthcare. UK spending was about the same level as total spending in Finland and Italy, but less than the average across the 30 OECD countries (8.9%) and France and Germany (both around 11%).

'We believe it would be helpful for the government to commit to a fixed percentage of GDP to fund the NHS during a spending review period,' Mr Briddock said.

'We must be sure we are counting like with like. However, it is clear we are out of step with other countries and we think setting health spending as a proportion of GDP would be a step in the right direction.'

Paul Briddock: fixed GDP percentage call

The HFMA also looked at workforce, calling for a review of how doctors are educated and trained and how this is funded.

Against the backdrop of high locum spending levels, some HFMA members had suggested that medical training should be loan funded. However, the value of the loan could be reduced over a number of years as the doctor spent time working for the NHS. This would avoid the situation where public funds are used to train doctors who then go on to work outside the NHS.

In October, health secretary Jeremy Hunt said he would consult on measures that would introduce a minimum period of service for NHS-trained doctors. Those who worked less than this would have to repay some of their training costs.

• *See 'The demand puzzle', page 16*

All-commissioner shortlist for FD award

The 2016 HFMA Finance Director of the Year will come from the commissioning sector in England after an all-commissioner shortlist was announced. The four shortlisted chief financial officers are:

- **Annette Walker**, Bolton Clinical Commissioning Group
- **Carl Usher**, Midlands and Lancashire Commissioning Support Unit
- **Claire Skidmore**, Wolverhampton Clinical Commissioning Group
- **Paul Brickwood**, Knowsley, St Helens and Halton clinical commissioning groups.

The North West is again well represented, with two candidates on the finance director shortlist and Salford Royal NHS Foundation Trust shortlisted in five of the nine categories. This includes the Working with Finance – Clinician of the Year Award, where two of its clinicians – Claire Mason and Tara Kearney – have been shortlisted. The trust is also in the running for the governance, innovation, deputy finance director (Diane Morrison) and accounts team awards.

Wrightington, Wigan and Leigh NHS Foundation Trust has been shortlisted for the Accounts Team of the Year Award for the fourth year – the trust took the award in 2014.

Cwm Taf University Health Board, North Staffordshire Combined Healthcare NHS Trust, North Tees and Hartlepool NHS Foundation Trust and Yorkshire Ambulance Service NHS Trust have all been shortlisted for the Costing Award.

• **For the full shortlist, see inside back cover**

Oversight framework 'lays bare' pressure on NHS providers

By Seamus Ward

The shadow categorisation of NHS trusts under the new single oversight framework shows the enormous pressure they are facing, according to NHS Providers.

Last month, NHS Improvement published its initial findings under the new framework. Around 40% of NHS providers in England were categorised as requiring improvement support.

The initial segmentation is the first under the new single oversight framework. NHS Improvement said 141 providers were in the top two categories – maximum autonomy or targeted support. The others require mandated support for significant concerns (74 trusts) or are in special measures (22 trusts).

The new framework assesses trusts in five categories – quality of care; finance and use of resources; operational performance; leadership and improvement capability; and strategic change.

NHS Providers head of policy Amber Davenport said the segmentation highlighted the hard work of trust leaders with the majority of trusts in the top two categories. But she added: 'What the figures do lay bare is the enormous pressure the acute sector is facing. While the new [framework] marks a significant shift from NHS Improvement, as it places much greater emphasis on improvement and support, it is difficult to separate the segmentation from the difficult context in which providers are operating.

'This is one of increasingly challenged finances, a social care system that has reached a tipping point and rapidly rising demand.'

NHS Improvement said a further three NHS providers have been put into the separate financial special measures, taking the total to eight. The body said the three organisations – East Sussex Healthcare NHS Trust, Gloucestershire Hospitals NHS Foundation Trust and Brighton and Sussex University Hospitals NHS Trust – were forecasting a combined deficit of £73m and had failed to keep up with their agreed control totals.

But NHS Improvement chief executive Jim Mackey said the five trusts in special measures since the financial reset in the summer had responded well and had identified around £100m extra in savings.

Amber Davenport: 'Social care has reached a tipping point'

NHS Improvement said some of the original five trusts would be released from financial special measures in a few months, once they have demonstrated continued delivery of their plan and achievement of key milestones. But Mr Mackey added: 'The three providers going into financial special measures are causing significant concern. They've agreed savings targets locally but are a long way from meeting them.'

Tough challenges await Scottish health boards

Scotland's NHS boards struggled to achieve financial balance in 2015/16 and may find it difficult to deliver 'unprecedented' savings in 2016/17, according to Audit Scotland.

According to the auditor's annual report, although services had improved, funding was not keeping pace with demand. The total health budget in 2015/16 was £12bn, a real-terms increase of 2.7% on the previous year, yet many boards had to use short-term measures to break even.

Costs were rising – drug costs increased by 10% between 2012/13 and 2014/15, for example. The boards delivered savings of £291m in 2015/16 and plan to save £492m in the current financial year – an average of 4.8% compared with 3% in 2014/15.

The report also highlighted staff issues. It said the NHS had an ageing workforce and experienced difficulties in recruiting and retaining staff in some areas. Boards were spending more on agency staff – agency nursing and midwifery spending increased by 47% compared with 2014/15. Agency doctor spending rose by a third.

The auditor recommended the Scottish government consider giving NHS boards greater financial flexibility. For example, three-year rolling budgets rather than annual financial targets would facilitate longer-term planning.

It added that the government should model the cost of its clinical strategy and how it will be funded, including the capital investment that will be needed.

It should share best practice on health and social care integration, including governance and budget-setting.

Auditor general Caroline Gardner (pictured) said major challenges lay ahead for the NHS in Scotland.

'The Scottish government has had a policy to shift the balance of care for over a decade, but despite multiple strategies for reform, NHS funding has not changed course,' she said.

'Before that shift can occur, there needs to be a clear and detailed plan for change, setting out what the future of the NHS looks like, what it will cost to deliver and the workforce numbers and skills needed to make it a reality.'

Control total deadline

NHS Improvement has told trusts they must agree financial control totals for 2017/18 and 2018/19 by 24 November.

Agreement and delivery of the control totals are conditions for accessing the sustainability and transformation fund (STF), which is worth £1.8bn in each of the years.

NHS Improvement said the STF will be divided into a £1.6bn general fund and £200m targeted fund for high-performing trusts.

Most of the general fund (£1.5bn) will be allocated to emergency care providers, which face the most significant financial and operational pressures, it said. The remaining £100m will be allocated to ambulance, mental health and community trusts according to revenue.

The King's Fund was critical of the use of the STF so far. In a review of the *Five-year forward view*, it insisted too much of the fund was being used to reduce deficits and the five-year plan could be undermined if more is not allocated to transforming services. Much remained to be done, including the development of new payment mechanisms.

Birmingham and Solihull and other sustainability and transformation plan (STP) areas have published their plans. The Birmingham STP will seek to transform health and social care and create efficient organisations and infrastructure. The latter includes plans for back-office services for the four main acute providers to be provided by University Hospitals Birmingham/ Heart of England foundation trusts.

CNST safety incentive

The NHS Litigation Authority (NHSLA) will 'enhance and refine' its approach to Clinical Negligence Scheme for Trusts (CNST) pricing following a review.

The NHSLA said the new approach to pricing would be less backward looking, while also enhancing safety. Recognising concerns in consultation responses, the changes would be phased in.

Starting with maternity contributions, the NHSLA intends to phase in a pricing approach that relies less on a body's previous claims and more on indicators of recent safety improvements.

Notification of 2017/18 prices has been brought forward to help CNST members with their financial planning – general and provisional maternity fees for 2017/18 were due to be set in October.

The maternity contributions are provisional initially because the NHSLA intends to explore safety indicators as part of a refined approach to exposure.

Where robust indicators can be found, the provisional price will be adjusted in December, but changes will be limited to 5%.

It then intends to review the general contribution to refine its approach to exposure, starting with 2018/19 pricing.

An early notification model for very-high-value incidents will be introduced from April next year. This will also give the NHSLA discretion to withhold indemnity for non-reporting.

The moves are part of a package of measures to reduce clinical negligence costs.

Wales plans 2.5% funding increase

By Seamus Ward

Spending on health, wellbeing and sport in Wales will rise to around £7bn under draft proposals for 2017/18 – a 2.5% real terms increase.

However, in its draft Budget published in October, the government said the Department of Health, Wellbeing and Sport's capital funding will drop by 10% to around £245m.

In a report issued before the Budget, the Health Foundation said long-term sustainability was possible for the NHS in Wales, but it would require greater efficiency and funding growth. It said that if funding grew in line with the NHS in England – an average of 0.7% a year – there would be a £700m shortfall by 2019/20. However, 1% efficiencies a year plus savings in pay growth would reduce the gap to £150m.

Responding directly to the Health Foundation analysis, the draft Budget document said the position was challenging, but an additional £240m will be spent on the NHS in 2017/18. This would allow NHS organisations to: meet the rise in costs and demand, including pay awards; deliver more care in primary and community settings; maintain investment in new therapies; and ensure high-quality care, it said.

The government said agreement had been reached on a number of measures with the second biggest party Plaid Cymru. The parties had agreed spending of more than £40m for some specific services, including £20m of the additional £240m for mental health services, £15m for diagnostic equipment and £7m for clinical education.

Anita Charlesworth (pictured), the Health Foundation's director of research and economics, said the additional funding was a welcome recognition of the pressures on the health service.

But she added: 'The NHS faces long-term challenges, and public finances in Wales will be under considerable pressure for the rest of this decade. It is therefore essential that this additional money is used to support the transformative change and improved efficiency that will help the health service in Wales to continue to meet patient needs. Alongside funding, the NHS in Wales needs a comprehensive workforce strategy.'

HFMA AGM

The HFMA's annual general meeting will be on 9 December at 9.15 in the London Hilton Metropole. Details will be available on the HFMA website soon.

News review

Seamus Ward assesses the past month in healthcare finance

Paradoxically, October's biggest health story stemmed from the parlous state of social care in England. The Care Quality Commission's annual state of care report, which looks at both health and social care, highlighted the fact that funding cuts and rising demand in adult social care is having an impact on those who rely on the services and putting more pressure on the NHS. Greater demand for NHS care was in turn affecting trusts' ability to meet their performance and financial targets, the Care Quality Commission (CQC) said (see 'The demand puzzle', page 16).

In its annual *State of care report*, the CQC said the adult social care market was fragile, with independent providers handing back contracts to local authorities and bed numbers static. About 1 million older people were living with unmet social care needs in 2015, and 81% of councils had cut social care spending in the past five years. There was much good and outstanding care in the NHS, it said, despite the financial challenges. But too much acute care was rated inadequate, especially in urgent care and medical services.

The pressure on social care and its knock-on effect on the health service is well known, of course, and NHS England chief executive Simon Stevens has said that any additional funding over and above that already promised by the government should go to social care. Some political commentators had wondered if chancellor Philip Hammond would find some additional cash in his first autumn statement on 23 November. However, according to reports, prime minister Theresa May has told Mr Stevens there will be no more money.

The Academy of Medical Royal Colleges published a list of 40 treatments of little or no value to patients. The treatments, from across 11 specialties, include putting a plaster cast on small wrist fractures in children – the academy said they heal just as quickly with a removable splint. The list is part of the academy-led 'Choosing wisely' campaign, which aims to inform discussions between doctors and patients and to challenge the belief that more is always better in the case of medical intervention.

Trusts could phase in the new junior doctor contract from October, though the British Medical Association asked them to hold off on implementation. BMA junior doctors' leader Ellen McCourt said some trusts had decided against implementation in October. Not enough preparation time had been allowed and she urged trusts not to rush to meet a 'politically imposed deadline'.

Workforce is a growing issue. During the dispute, which the BMA maintains is ongoing, the government promised a seven-day service would not spread the current doctor cohort more thinly. The lack of clarity over recruitment and retention of European clinical staff following the vote to leave the European Union has created further uncertainty. And more than four in 10 doctors who graduated nine years ago are planning to practise abroad, according to the BMA's latest report in a 10-year study of the career paths and attitudes of 430 doctors. Its tenth and final report said one in 10 had taken steps to obtain a certificate of good standing to send to overseas regulators and employers. Doctors said work-life balance, shortage of doctors and paperwork caused most stress.

Measures to combat doctor shortages have been announced. Health secretary Jeremy Hunt

The month in quotes

'We rely heavily on doctors from overseas – who do a fantastic job but are often taken from developing countries that need them – as well as expensive agency staff. By dramatically expanding our supply of home-grown doctors, we will ensure the NHS always has the doctors it needs.'
Health secretary Jeremy Hunt announces funding for an additional 1,500 medical student places

'We have been saying for some time that morale among doctors is at an all-time low and these figures show, once again, that doctors are on a knife edge. They are reaching their limit, and if stretched any further, they will walk.'
Ellen McCourt, chair of the BMA's junior doctors' committee, warns that one in 10 doctors who graduated nine years ago has taken steps to work overseas

'We will increase spending on primary care services to 11% of the frontline NHS budget. That's what doctors have said is needed, and it is what we will deliver. By 2021, an extra £500,000 will be invested in GP practices and health centres.'
Scotland first minister Nicola Sturgeon shifts funding to primary care

'What distinguishes many of the good and outstanding services is the way they work with others – hospitals working with GPs; GPs working with social care; and all providers working with people who use services. Unless the health and social care system finds a better way to work together, I have no doubt that next year there will be more people whose needs aren't met, less improvement and more deterioration.'
CQC chief executive David Behan says collaboration is the key to better care

HIMAGES PICTURE AGENCY

According to reports, prime minister Theresa May has told Simon Stevens there will be no more money for the NHS

said he would fund an additional 1,500 medical training places from September 2018. He said he would lift the cap on the number of students the schools can take – currently 6,000 a year. He would consult on implementing the proposals, along with a plan to increase the return for the taxpayer by requiring a minimum period of service in the NHS – any less and a doctor could have to pay back a proportion of their training costs.

Northern Ireland health minister Michelle O'Neill launched a 10-year plan to transform care. She said that if nothing was done, health would consume 90% of the Assembly government budget in 10 years. In the short-term, she promised a plan to tackle waiting lists, but there will also be clinically led service reconfiguration reviews, new structures to reform planning and administration and more care moved into the community.

Pay rises are unlikely to be a weapon to recruit or retain doctors, given the importance of keeping the pay bill down to deliver the £22bn efficiency savings by 2020/21. This was underlined in NHS Employers' evidence to the pay review bodies, which said employers support giving the same percentage increase to all staff within the average 1% cap set by government.

The Scottish government promised a further £500m will be invested in primary care by the end of this Parliament. It will mean half of frontline NHS spending will be allocated to community health services, it said. This reflected its policy of moving more care out of hospital. The funding will support the development of a multidisciplinary approach, more staff and investment in GP services and health centres, first minister Nicola Sturgeon said.

NHS England also announced a boost to out-of-hospital services, saying its estates and technology transformation fund will support almost 300 schemes. In addition, clinical commissioning groups will receive £11m this year and £24m next year to offer psychological therapies to patients with long-term illnesses. Some £5m will be allocated to support GP indemnity costs, where they work in out-of-hours and unscheduled services, including NHS 111, to boost services in the winter period.

Researchers at the University of York Centre for Health Economics said new drugs for hepatitis C should be held in reserve when treating most types of the disease. The new drugs should be held back as second-line treatment for those not cured by the standard therapies, they said. There have been concerns about the cost of the new drugs, which ranges from £25,000 to £70,000 per treatment course but have the potential to cure more patients than the standard treatment.

The Care Quality Commission (CQC) proposed to increase its fees for most providers in 2017/18 to meet its requirement for full chargeable cost recovery. For NHS trusts with a turnover between £125m and £225m, this would mean this year's fee of just under £137,000 would rise to slightly over £202,000 in 2017/18. The CQC said it was conscious of the impact of the proposed increase in fees on providers and it would continue to examine its costs.

in the media

***Hospital Doctor* and *National Health Executive* covered the HFMA response to NHS Improvement's measures to tackle agency staff spending. Director of policy Paul Briddock told *Hospital Doctor* the HFMA supported the body's previous and new measures to manage agency spend. Despite the previous measures, he said trusts were still paying a premium on agency staff, which was adding to cost pressures. This could only be partly resolved by price caps – longer term, the HFMA would like to see more resources spent on increasing the NHS workforce and redesigning services across wider geographical areas.**

Mr Briddock spoke to *National Health Executive* about the two-year operational guidance from NHS England and NHS Improvement. He welcomed NHS England's decision to listen to the NHS finance community by dropping plans to move all outpatient follow-up appointments to a single block payment. Though the HFMA welcomed the planning guidance, there was no easy fix to the health service's problems, he said.

In an article for *Health Business* on mental health funding, Mr Briddock said an HFMA/NHS Providers survey found only half of English mental health trusts had received a real terms funding increase in 2015/16 and only a quarter of providers thought commissioners would increase funding this year. He also highlighted a lack of clarity over parity of esteem.

News analysis

Headline issues in the spotlight

Temporary fix

There are increasing signs that price caps and controls aimed at curbing agency staff costs are starting to have the desired impact. But continued pressure is needed, particularly with medical staff. Steve Brown reports

The NHS has saved more than £600m in just one year as the result of measures to curb spending on agency staff, according to NHS Improvement. But before anyone gets too self-congratulatory, agency spending is still a problem, and the oversight body is introducing a further series of measures to clamp down on expensive temporary staff.

Let's recap the problem. In 2014/15, NHS providers spent £3.3bn on contract and agency staff – 31% more than the previous year. For foundation trusts (subject to separate reporting at the time), this compared with plans for a 44% cut in these costs. Again for FTs, agency costs were 6.4% of total staff costs, up from 5.2% in 2013/14.

Jump forward another year to the end of 2015/16 and a similar picture of rising costs can be seen. Total agency spending across all providers was £3.6bn – now accounting for 7.5% of trusts' and FTs' collective total pay costs. This was again above plan – by £1.4bn and despite an intention to cut agency costs. In 2015/16, the first agency controls were also introduced.

These included an initial ceiling on overall agency nurse spending for each provider, and requirements to use only approved frameworks to source agency staff, followed by caps on the actual hourly rates paid by providers to agencies.

Phased cap

The capped rates for medical staff were lowered in three steps and from the beginning of April this year, the spending ceiling was extended to cover all agency staff, not just nurses. There are now also wage caps setting the maximum amount an agency worker can be paid per hour by an agency.

Back in April, NHS Improvement declared itself happy with the progress – saving £290m from October to February compared with expected spending. It has now given an update on the impact of the agency controls a full year after they were introduced – putting the updated savings figure at £600m.

'The progress we have made in a single year is really promising and trusts have responded well to the caps,' said Jim Mackey, NHS Improvement chief executive. 'They've worked hard to cut these bills and, in many cases, improved the way they manage their workforce. But there's much more to be done, especially to reduce how much trusts pay for medical agency staff and bringing staff back into the NHS.'

More on the additional measures soon, but let's stick with the figures. The £600m reduction is compared with what would have been spent if the controls had not been introduced in October 2015 (based on previous trends). The Q1 figures published by NHS Improvement at the end of August actually showed a £10m underspend on the total paybill – although a £72m overspend against plan on agency staff was masked by an £82m underspend on permanent staff. More encouragingly the Q1 agency spending was just 6.1% of the total pay bill – back to just below the 2014/15 full-year proportion – and £100m down on the same quarter in 2015/16.

Backing up the impact of the controls, NHS Improvement said that sample data showed an 18% reduction in nursing agency prices and 13% cuts in medical agency staff prices since October 2015. And monthly agency spending figures do appear to show that reductions have been maintained. Average monthly spend in the first five months of 2016/17 of £254m compares with an average of £304m in the first five months of 2015/16. And the August 2016 spend of £252m was 19.5% less than the same month last year.

'The vast majority of trusts – 73% - have reduced their agency spend since the same time last year,' NHS Improvement economics director Chris Mullin told *Healthcare Finance*. 'Agency spend is at about 20% below the equivalent month last year and over half those trusts have reduced spend by more than a quarter.'

Compared with agency spend growth in recent years of 25%-30%, he said this was 'quite a turnaround'.

However, NHS Improvement sees significant potential for further reductions. It has been monitoring price cap overrides, which continue in their tens of thousands each week. The most recent figures show some 47,000 cap overrides in the last week of August. At this level, a reduction in the rate paid for each shift above cap of just £1 would save £19.5m across a full year. A staggering £51m could be saved just by reducing the medical and dental shifts above cap by £5 per hour.

There is still an issue about reducing the overall reliance on temporary staff. For example, the Royal College of Midwives said last month that the more than £72m spent in 2015 on agency, overtime and bank midwives could

Going metric

NHS providers' performance against their agency spending ceiling has become a formal part of their finance and use of resources assessment as part of the new single oversight framework introduced in October. Actual data reported in monthly returns will be used to award a 1 (good) to 4 (poor) score based on preset performance thresholds:

Score	Distance from agency cap
1	≤0%
2	0%-25%
3	25%-50%
4	>50%

Agency ceilings for providers for 2017/18 and 2018/19 were due to be agreed by late October, ahead of draft financial and workforce plans being submitted towards the end of November. NHS Improvement has warned providers not simply to divide their agency ceiling by 12 and enter it into their agency line; it needs to be phased to match forecast hotspots as performance through the year against agency spending will affect segmentation.

have employed 3,318 midwives – effectively solving the current midwife shortage in England, estimated by the college to be 3,500 midwives.

Improving use of bank staff should also reduce overall costs. A special report from NHS Professionals in June identified a range of options, including never cancelling a bank shift – certainly not in favour of agency staff. And it may seem counterintuitive, but increasing bank pay rates – closing the gap with agency rates – can increase bank-filled shifts and reduce overall temporary staff spend.,

Bringing staff back into the NHS and better use of bank staff are also on NHS Improvement's agenda, but its main focus at the moment is reducing the costs of agency staff when the NHS does need to use them.

Medical locums costs – a third of the overall agency bill – are the biggest concern. While there are similar numbers of nursing and medical cap overrides (each making up just under 20,000 of the 47,000 total), the number of nursing overrides has been falling throughout this year. In contrast, the overall trend for medical and dental is rising. Mr Mullin said that some of this increase is a result of better data and reporting.

'When we started this process, a number of trusts didn't know what they spent on medical locums or how many times they were overriding the cap,' said Mr Mullin. Nursing directors ' got a grip relatively quickly' with overrides falling and, where they are exceeding the cap, they are only doing so by a small amount. He believes the better data is a sign that medical directors are also improving their grip.

"A number of trusts didn't know what they spent on medical locums or how many times they were overriding the cap"
Chris Mullin (above)

Liaison, which provides a workforce management system and service to NHS providers, has been monitoring use of medical locums closely for the past year, publishing a series of *Taking the temperature* reports. Drawing on data from 58 trusts, it highlights a significant increase in the hours booked by its sample in 2015/16 (2.3 million) compared with 2014/15 (around 1.5 million). There were spikes – an increase of 435% for ST2s, 69% for consultants and 162% for staff grade – and associated costs rose from £100m to £160m.

Reducing costs

While pay rates increased across all grades of staff in 2015/16 compared with 2014/15, the rate caps introduced during the year did have an impact – with a 1.5% drop in overall average pay rates between Q3 and Q4. This continued into the new financial year, according to the latest *Taking the temperature* report. 'Overall average pay rates fell from £62.64 in Q4 to £62.49 in Q1, while average commission fell by 1.6% to £6.86,' the report said – the third consecutive quarter in which rates have fallen.

It also shows a 5% fall in core hours pay rates between January and June for consultants and ST3 grades. But it exposes the clear potential for significant further savings – making NHS Improvement's talk of £5 rate reductions not seem that ridiculous.

Across the sample, the average rate paid for an ST3 was £58.80 compared with the average national framework rate of £41.08 – but the highest rate paid was £105 an hour. For a consultant, the average rate paid was £91.68, compared with a framework rate of £60.67 and a highest rate of £147 an hour.

Mr Mullin identifies a range of reasons for continued problems with medical rates – shortages in particular specialties, market conditions, individual doctors determined to keep rates high and a few agencies that are 'still out to make a lot of money out of the NHS'.

"There's much more to be done, especially to reduce how much trusts pay for agency staff and bringing staff back into the NHS"
Jim Mackey (above)

To encourage trusts to focus even more on this issue, NHS Improvement plans to publish league tables of agency spend on best and worst performing trusts. It is also collecting anonymised information on the 20 highest earning agency staff in each trust and on long-standing agency staff. Providers will also have to tell NHS Improvement about any shifts that cost over £120 an hour. Interim senior managers who charge more than £750 per day will also be subject to an approval process.

The further 'clampdown' is not because the original controls are not working, but because 'we want to give trusts as much support as possible', according to the oversight body. Mr Mullin insists what the measures have done to date is to 'give negotiating strength to trusts and empower finance departments and human resource departments to take on agencies'.

'Controls also sharpen the level of management focus on finances and agency spend – that has been a big factor behind the improvement we've seen, not only the price cap per se,' he said.

The hope is that with greater transparency of data and spend levels, providers will collectively be better able to hold the line against unreasonable rate demands from temporary staff and agencies.

Comment

November 2016

Doing the right thing

Despite a frustrating planning schedule, finance directors must stick to their professional judgement

What is the secret of good planning? Timing. NHS sustainability and transformation plan (STP) footprints across England will all have submitted their system-wide plans for delivering sustainable services over the next five years. But with last-minute changes in national requirements – combined with the order of submissions – this has been a somewhat frustrating process.

HFMA president Shahana Khan

We've all been working on system-wide STP five-year plans over the summer. It has been in most cases a rather top-down process using the best available assumptions and benchmarks, to support improvement in key areas. While numbers have been submitted at the STP level, a set of yearly organisational numbers are implicit in this.

Late on in this process, we have had NHSI control totals issued for each provider for 2017/18 and 2018/19, which have to be agreed by end of November. In how many cases will these control totals reflect the numbers included in the STP submissions?

To top this, there is a real issue of having a third set of organisational numbers for the next two years. These are based on the traditional organisational bottom-up approach, taking into account individual local nuances, contracts, costs pressures and savings.

Regulators are making it clear that an organisation's issued control total can only be amended if another organisation within the footprint is willing to make an equal and opposite amendment. I can't see many volunteers stepping forward to take on another's debt – especially in health

Finding time for value

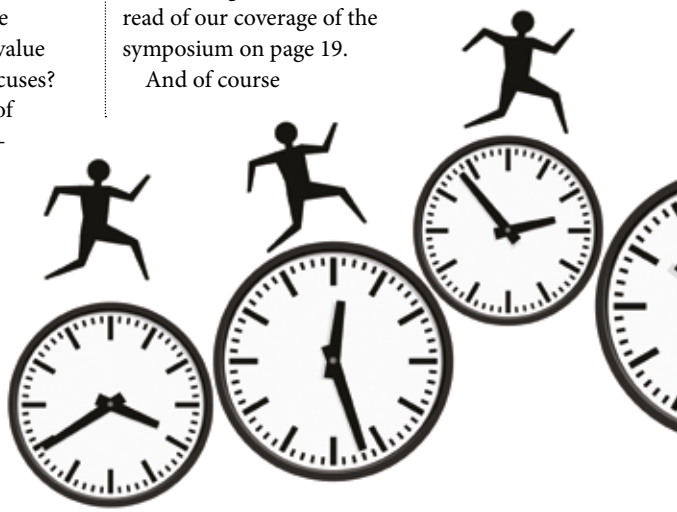
Finance professionals need to find time to further the value agenda despite immediate pressures

Healthcare Finance editor Steve Brown

There are things we know are good for us, though somehow we don't have the time or resources to make them happen: getting fitter; learning or practising an instrument; changing utility supplier or insurance provision. Is there a danger that the value agenda is falling victim to similar excuses?

Few would argue with the theory of value-based healthcare. In a funding-limited system, all decisions should be focused on getting the best value from all decisions and treatment approaches – best value in terms of outcomes and patient experience and in terms of cost.

There is a growing consensus across the NHS that this is where we need to be. And we are in good company – many international health systems are on a similar journey. The HFMA Healthcare Costing for Value's brilliant recent international symposium – its first such international gathering – provided a fascinating insight into some of the work going on in the UK and across the globe to further this agenda. There were real examples where value principles had been applied either at an individual service level or across whole local health economies with some great results. Have a read of our coverage of the symposium on page 19.



And of course there are lots of examples of organisations improving value, even without giving it an official 'value' label. Read the case studies on page 23 to see how some trusts are improving both quality and cost in the provision of one-to-one nursing care.

"Professional ethics must prevail where the right numbers will be the right numbers"

economies, where providers and commissioners are facing extreme challenge or already in deficit.

We do, however, need to recognise that our system leaders face a similar headache. The relentless pressure to deliver financial balance within quality constraints has led to this hard-line approach.

It is clear though that professional ethics must prevail, where the right numbers will be the right numbers, and we need to do the right thing.

The challenge is, of course, to make all this align. No-one would disagree that all the plans should – must – be based on a shared understanding of activity flows. This must take account of recent demand trends and a realistic assessment of the impact of any mitigating actions or pathway changes.

The challenges we face in the NHS can only be met if we face up to them as whole systems.

The solutions are likely to mean the re-provision of existing services in different ways, the involvement of different providers and some restructuring of services across broader geographies.

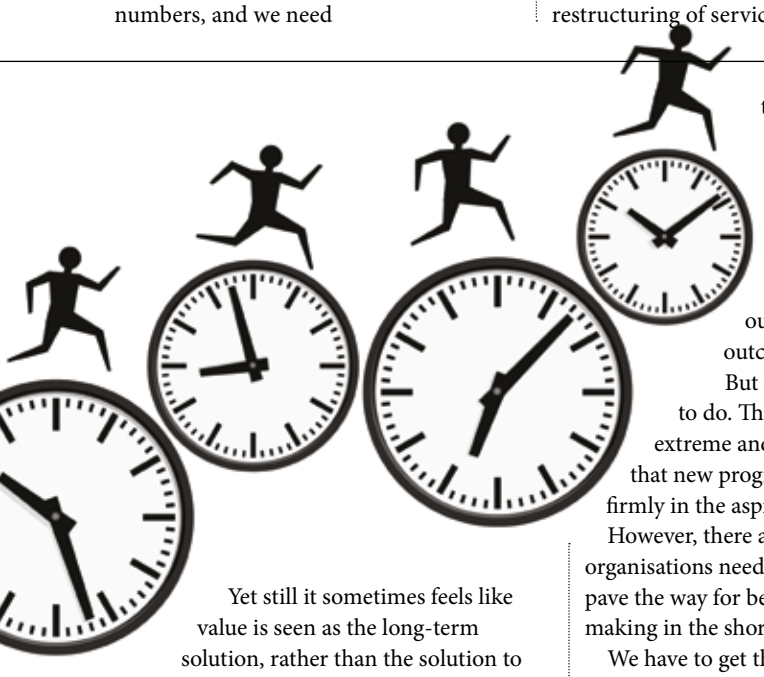
These are not quick wins and will involve several stakeholders, not least local politicians who are already demanding a role in this.

In the meantime, we need to get on with the day job. Our financial performance this year will also impact on the scale of the challenge next year. And while Q1 and early signs around Q2 are encouraging, we all know that much of the efficiency ask is back loaded in 2016/17. So the second half of the year presents the greater financial and operational challenge.

Many areas face rising pressure as a result of stretched social service budgets, adding further costs and affecting patient flow. My trust at the weekend had to admit two elderly people, not because they were ill but because they were physically unable to cope. Admitting was the safest and right thing to do – but there should have been better, more cost-effective options.

There is more of this to come, so we cannot afford to put all our time into 2017-19 and beyond, thinking this year's financial targets have been achieved. As ever, we must do the right thing.

Contact the president on president@hfma.org.uk



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Yet still it sometimes feels like value is seen as the long-term solution, rather than the solution to the current problems. Or people are too busy meeting the near impossible demands of today to have the time to pursue new 'initiatives' – however well regarded.

Value-based healthcare isn't – or at least shouldn't be – viewed as an 'initiative'. It has to become the way we do business – a constant process of improving value and then cranking the handle again to improve further; scrutinising pathways and eliminating unwarranted variation that adds no value but may add cost; checking that the outcomes you deliver are the outcomes that patients want.

But that is easy to say and hard to do. The current agenda is so extreme and staff are already so busy that new programmes or approaches stay firmly in the aspirational tray.

However, there are things that all organisations need to be doing right now to pave the way for better value-based decision-making in the short, medium and long term.

We have to get the data right. That means activity data, outcome data and cost data. For finance people, we have a major responsibility (though not sole responsibility) for the latter. NHS Improvement's Costing Transformation Programme must seem like a distraction for finance directors at the moment. But getting robust, patient-level cost data – derived in a consistent way – is vital. This is not just for any future tariff-setting approach but, more importantly, to inform local decision-making.

"Value-based healthcare isn't – or shouldn't be – viewed as an 'initiative'. It has to become the way we do business"

Good cost data is also fundamental to engaging clinical staff in the financial management agenda. Cost data that doesn't reflect clinical behaviour – or delivered so late that clinicians can't remember the cases it relates to – is a sure-fire way to disengage the very people who commit the service's resources. Finance professionals have long identified the importance of this engagement and right now what the service needs is the good existing examples of such engagement to be replicated on a grand scale.

With time as precious a resource as money at the moment, finance professionals need somehow to keep pursuing these core foundations for value-based decision-making.

The truth is that without robust data and widespread clinical engagement, value-based healthcare will remain just a good intention.

Assessors required for HFMA Qualification

From 2017 the HFMA will be awarding a new post-graduate level Diploma and Higher Diploma in Healthcare Business and Finance. Both qualifications will be delivered on-line by the HFMA Academy and are aimed at finance and non-finance professionals working in healthcare (or a related area) across the UK.

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To apply, please send your CV and covering letter by Friday 18 November to Natalie Earl at HFMA Academy, natalie.earl@hfma.org.uk

together stronger

A new Future-Focused Finance framework sets out required attributes for finance staff, to bring consistency to appraisals. Seamus Ward reports

It is generally agreed that existing finance competency frameworks are good, but perhaps are only taken off the shelf just before annual appraisals. Even then, anecdotally, finance staff report that appraisals can differ from team to team, organisation to organisation. But NHS Future-Focused Finance (FFF) has released a framework to introduce greater consistency and clarity, highlighting the skills finance staff will need to support the service through the next stages of its five-year plan.

The *Four strengths* framework offers four attributes needed by finance staff – I'm a finance expert; I'm a team player; I drive value; and I make change happen.

David Ellcock, programme director for Future-Focused Finance, believes the statements can be used in formal appraisals or informally. 'If you speak to most NHS finance professionals, a consistent approach to staff appraisals and development plans has been missing for some time. It makes sense for those working in clinical commissioning groups and in trusts to be reviewed in exactly the same way, under exactly the same headings. But at the moment, that's not happening,' he says.

'The *Four strengths* will go a long way to redressing the balance – providing a consistent, universal set of categories that can be used throughout the NHS. We hope that they are a useful tool for all finance teams across the country.'

The framework has been trialled in a number of trusts, including University Hospitals of Leicester NHS Trust. Alistair Fleming, the trust's clinical management group head of finance, says the *Four strengths* system was a good match for the appraisal scheme at the trust. 'We grade people against four quadrants – quality, performance and operations, people and finance. That fits well with what's been developed by FFF – quality equates to driving value; performance and operations to making change happen; people to team player; finance to being a finance expert.

'I find appraisals can be subjective but this is more detailed about what the core competencies are. It makes sense to use it.'

Mr Fleming, who has since moved to a new team, first used the *Four strengths* for his deputy's appraisal. It went well and has been used to appraise the rest of the team. He plans to introduce it for his new team. 'The question on making change happen works pretty well in financial management,' he says. 'In the appraisal, we mapped this back to our performance and operations quadrant. There's a useful element about influencing change as part of the daily job and implementing new ways of working.

'In financial management we are sometimes seen as the numbers guys, but you pick up knowledge of what clinicians tell you works. It would be good to use that to provide that "friendly" challenge to clinicians and operational teams – could we do things differently, in a way that's better for patients and helps the bottom line?

'In difficult times people tend to retreat to what they know best – "We do the numbers and operations is your bag, guys" – but we want to be there providing expert advice and coming up with options from our experience of working in other clinical areas.'

Derek Stewart, associate director of finance – financial services at Northampton General Hospital NHS Trust, started using the tool last month for a team member's appraisal and is speaking to senior managers in the finance department about spreading it more widely.

'It's good because it is clear and fits with our approach. Change is continuous for us and we are always striving to improve. For example, in the financial accounts area, we undertake an annual lessons learnt review of processes to ensure we can make them better for the following year. At first I thought the driving value for patients and taxpayers would be difficult as we are not in a management accounts setting and

I'm a finance expert


I'm a team player


I drive value

I make change happen

I'm a finance expert

I'm a team player

I drive value

I make change happen

dealing with direct patient care. However, we are involved in trying to get equipment replaced and working with directorates to put together replacement plans for capital medical equipment.

'So, in that sense, driving better value in procurement and ensuring best treatment is available for patients by timely replacement of equipment, and also ensuring accurate site valuations are undertaken, means this strength is directly linked to the work we do.'

The team player strength is important to the Northampton General financial accounts team as staff work in a number of small groups, so communication and working together is paramount.

Mr Stewart adds that the finance expert statement aligns with the core competencies for each role. This helps spot training and development needs, not just for individuals but also potentially across a whole finance department. 'Looking across the financial accounts team and the whole department we could see a weakness or learn why people like to work in a particular area. This can help get a consistent approach across the department.'

The tool could help retention of newly qualified finance staff, Mr Stewart suggests. By focusing on achieving the core competencies in the finance expert section, staff could develop within the Agenda for Change bands, making staying more attractive.

'If they achieve these levels, there's an opportunity for them to be paid at a higher grade and for the department to keep staff longer. If you keep staff happy, you keep them longer and the trust has a better return on investment in funding and time.'

He adds that the finance expert section can help identify staff members who would like to move to other areas within the department – helping to pick out the skills and support they will need. 'You can build on their core competencies to prepare them for where they would like to go next, hopefully keeping them at the trust, which helps our succession planning.'

Appraisals – both formal and informal – can help finance teams to identify the skills that their staff need to help facilitate the emerging structure of the NHS and its financial mechanisms. The *Four strengths* could offer a clear and simple way for all NHS organisations to achieve this in a consistent way.

FACE time

A key work stream of the FFF *Close partnering* delivery group is to improve financial awareness and partnership working between NHS managers and clinicians by sharing knowledge through training and engagement. To this end, the finance and clinical educator (FACE) role has been developed, with the aim of establishing a FACE of finance in every NHS organisation. FACE recognises the role non-finance professionals can play in championing clinical-financial engagement.

Pam Kaur, commercial finance manager at University Hospitals Coventry and Warwickshire NHS Trust, and Ben Roberts, head of finance transformation at Bolton NHS Foundation Trust, are leading the FACE network nationally. There are now 190 FACEs, including a number of clinicians. Ms Kaur says that though the educator role is not new, FACE gives them a national title that acknowledges and rewards their work.

At Coventry and Warwickshire, for example, training has concentrated on its 290 budget-holders, though the events have attracted other staff members with an interest in NHS finance. Training has covered skills such as reading budget reports, savings and service line reporting and patient-level costing.

The FACE network was launched at the annual HFMA conference in December 2014 and has gained momentum through workshops and events, as well as less traditional methods, such as Twitter chats.

'We've spent a lot of time over the last six months looking at where we are as a network, developing a vision on where we want to be in the future,' Ms Kaur says. 'Over the next three years we want to build the foundations for a long-term, long-lasting relationship between finance and clinicians of all disciplines and to help people with support and resources.'

Mr Roberts adds: 'The support and opportunities from being part of the network have been amazing. It hasn't just helped me in my own development, but also in my day-to-day role. I was on a conference call with another trust talking about their services recently – if I hadn't been part of the network that call wouldn't have happened.'

Email: futurefocusedfinance@nhs.net or tweet: @k_pam5 @ben_m_roberts_1 @nhsFFF_FACE

• FFF will lead a learning lab at the HFMA annual conference, 7 December

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The demand puzzle

Activity is rising and steps to curb it are an important element of sustainability and transformation plans. But what is fuelling demand and how is the NHS trying to reduce the pressure? Seamus Ward reports

There is growing concern about the rising demand for NHS services. Activity and waiting lists are on the up and the NHS may not be able to live within its means if it is not controlled. Of course, the health service has many demand management initiatives, which in many cases report impressive results, but so far at least they have not been able to quell the rising tide of need.

Given the financial climate, it is not surprising that demand management is a major part of the £22bn of savings set out in the *Five-year forward view* and each sustainability and transformation plan must include a section on addressing demand. However, to address demand it must first be understood.

While demand is not a modern phenomenon in the NHS, the issue came into sharp focus in the last few months. Traditionally, the summer months offer trust A&E departments in England a respite after the high-demand winter. But official figures show that this winter effect is happening all-year round.

This summer's A&E waiting time performance was worse than every winter for the past 12 years bar one. Between June and August, 90.6% of patients were seen in four hours – worse than every winter since 2004 except last winter, when the figure was 89.1%.

In August, NHS Improvement published promising first quarter financial figures for English providers – with a deficit of £461m – £5m better than planned. While this was positive news, it warned that activity continued to rise, with an extra 300,000 A&E attendances compared with the same quarter in 2015/16 and a 6% rise in emergency admissions.

Figures for August see the upward trend continuing with A&E attendances up 4.2% and emergency admissions up 3.8% on the previous year. Outpatient attendances are also increasing (see figure 1). Elective care is also on the rise, with consultant-led treatment 4% higher and diagnostic tests up 5.5%.

David Maguire, economic and data analyst at the King's Fund, says demand has been rising for years across all clinical areas and sectors, creating something of a perfect storm for the NHS to face.

'If you look at activity rates, they have got higher and higher over the past 10 years. Activity in outpatients, elective, non-elective and A&E attendances are all going up.'

He adds that demand is increasing in primary care too, demonstrated in the King's Fund report *Understanding pressures in general practice*, published earlier this year. The study found a 15% increase in GP consultations between 2010/11 and 2014/15, with face-to-face consultations rising by 13% and phone consultations by 63%.

'It shows not only more contacts with GPs, but also the patients had a higher average age and that people were presenting with a greater average number of comorbidities. The ageing population is certainly a factor,' Mr Maguire says.

Around 15 million people in England have a

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long-term condition and, while the number with one long-term condition is forecast to remain relatively stable over the next 10 years, those with multiple conditions is set to increase to 2.9 million in 2018 – one million more than in 2008.

The likelihood of long-term conditions rises with age and by 2034 the number of over-85s is set to reach 3.5 million (5% of the population) – 2.5 times more than in 2009. The King's Fund report said the average number of chronic conditions was 3.27 in patients over 85.

Avoidable problems that lead to hospital admissions are on the rise. For example, malnutrition as a primary diagnosis for admission rose from 544 patients in the period August 2010–July 2011 to 730 in August 2014 – July 2015. Half of the patients admitted in the latter period were over-60.

This ageing population and pressure on primary and social care is having an impact on secondary providers. The latest NHS England statistics show the number of people admitted from A&E is up from 19% of attendances in 2002/03 to 27% last year.

According to Mr Maguire, either people are presenting at A&E in a worse state or clinicians are getting more cautious.

Looking at the latest HES data, there was a 3.8% rise in A&E attendances between April and July compared with the same period in 2015. However, there appears to be some opportunity to reduce A&E attendances (figure 2). The biggest proportion of patients (37%) was discharged with no further need for treatment or advice.

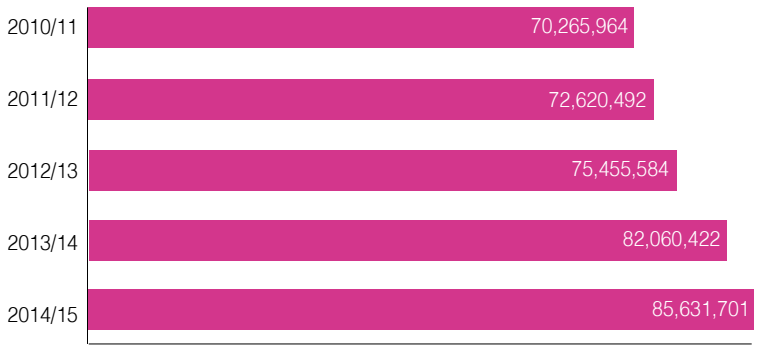
And, while just under a fifth were admitted, a similar proportion were discharged to the care of their GP. This does not mean these groups of patients were wrong to go to A&E in the first instance, but some experts believe it shows patients need better signposting through the system.

It can be difficult to discharge some medically fit inpatients safely, particularly the elderly, with hospitals waiting for care packages to be arranged in the community. These delayed transfers of care are rising and were identified as a threat to NHS efficiency in the Carter report. The latest figures show 188,300 delayed days in August 2016, of which 127,500 were in acute care. A year earlier there were 145,100 delayed days, of which 93,100 were in acute settings – total delayed days in acute care rose by 37% in the last year.

However, NHS England said 59% of the delays in the latest figures were due to the NHS, 33% caused by social care and around 8% due to both the NHS and social care.

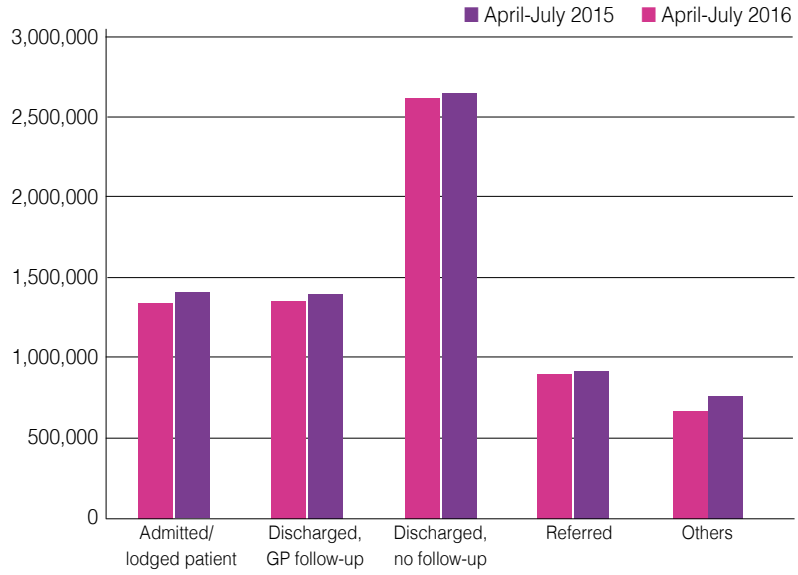
According to Mr Maguire, the funding gap in social care is likely to be at least £2.8bn by 2019 and, combined with the rise in delayed discharge, the pressure on acute providers could only get worse.

FIGURE 1: OUTPATIENT ATTENDANCE GROWTH



Source: Hospital episode statistics

FIGURE 2: A&E ATTENDANCES



Diverting patients away from hospital to care in a more appropriate setting is a key pillar of demand management initiatives. But they encompass a range of actions.

Longer term, it can mean promoting healthier lifestyles now, so people can avoid chronic diseases such as diabetes, cardiovascular diseases and cancers when they get older. This will, of course, do little to address the pressures immediately at hand.

Self-care options

Shorter term, demand management can mean closely monitoring the health of people with chronic illnesses to intervene early before their condition worsens and they require a hospital admission. This can be performed by a clinician, remotely or face to face, or, in the case of self-care, by the individual themselves.

Self-care opens up the possibility of apps that measure or remind the patient to measure vital statistics – blood glucose, heart trace or blood pressure, for example. Its potential to cut costs while improving the patient experience – by making them feel more involved in their care – is generating much excitement among healthcare providers and funders across the developed world.

Linked to this, demand management can mean moving care out of hospital to the community, with care services provided by specialist GPs and nurses, or even peripatetic 'hospital' doctors.

NHS England also believes giving patients full choice in their treatment – whether to self-care, defer treatment or, where the 18-week standard is likely to be breached, an option to choose an alternative provider – is important in demand management. It believes choice can

spread demand across the system – patients who prioritise waiting times will choose providers with shorter waits, for example.

Demand management can also mean tougher referral thresholds or rationing. This year, several clinical commissioning groups have been criticised for plans to limit some types of surgery, including preventing patients with a high body mass index from having hip and knee replacements, for example.

Some CCGs have introduced referral management systems (see box) to ensure patients are seen in the most appropriate setting. The operational planning guidance for 2017/18 and 2018/19 outlines a number of demand reduction measures, including implementing RightCare elective care redesign and urgent and emergency care reform.

Of course, moving care to another setting merely deflects demand to another part of the healthcare system. This has led to warnings that moving care out of hospital and into the community may not reduce overall costs.

Last month, Katherine Checkland, professor of health policy and primary care at University of Manchester, told the Lords inquiry into NHS sustainability that expectations of demand management were too high. 'Part of the problem is that a lot of the expectations of demand management are overblown. There is the idea that by prevention you will save a lot of money or that doing things out of hospital will be a lot cheaper. The problem is expectations have been too high,' she said.

RightCare way

She added that savings could be found in examining the value of clinical interventions and driving out unwarranted variations, particularly through schemes such as RightCare. RightCare works with local health economies to identify variation in geographically similar populations; shift the conversation to population healthcare rather than individual organisations; identify the best opportunities to improve the population's health; and use evidence-based processes to make sustainable change to care pathways and reduce unwarranted variation.

It is working with 65 local health economies and 144 more are to join the programme in December. National director Matthew Cripps says the initiative is well placed to understand the relationship between demand and value.

'Every local health economy involved in wave one of the RightCare programme has identified three to four pathways that offer the largest opportunity for change, using RightCare data as their starting point for understanding opportunities. As the data compares each local health economy to similar populations, demand issues for priority programmes are flushed out early,' he says.

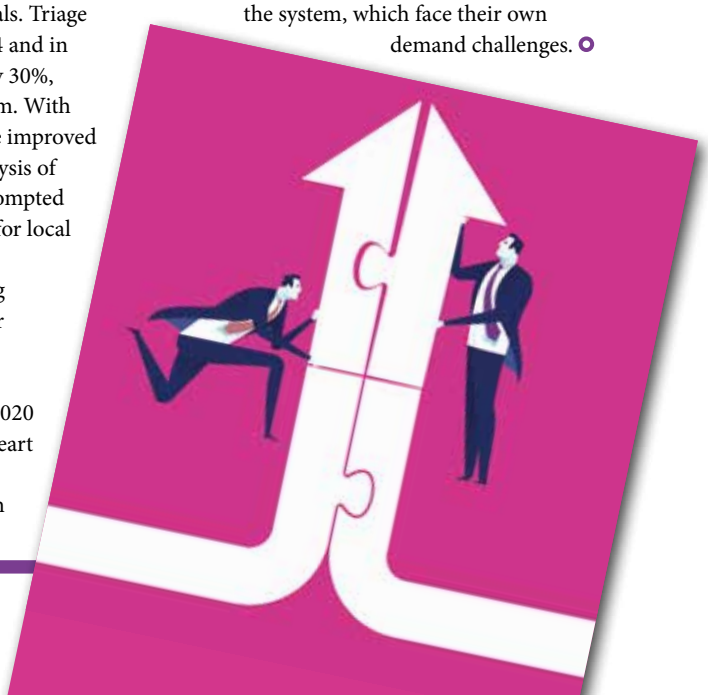
'Local health economies involved in piloting and early implementation of the RightCare approach provide good examples of how powerful the programme can be in addressing two aspects of demand management – both making sure the patients reach the right setting and prevention being utilised effectively to reduce overall demand.'

Professor Cripps gives two examples of how the RightCare approach is aiding demand management. Using RightCare principles – where to look, what to change, how to change – two clinical commissioning groups, Ashford CCG and Canterbury and Coastal CCG, identified the need for a triage service for musculoskeletal referrals. Triage was introduced in December 2014 and in the first 12 months referrals fell by 30%, producing an annual saving of £1m. With fewer referrals, waiting times have improved and the detailed comparative analysis of referrals and interventions has prompted plans for a new integrated model for local orthopaedic services.

Bradford Districts CCG is using RightCare to tackle cardiovascular disease, the leading cause of death locally. It aims to reduce cardiovascular events by 10% by 2020 – including 150 strokes and 340 heart attacks over the period.

Taking the population approach of RightCare, it has identified 7,000 patients with a more than 10% risk of stroke and given them statins to reduce their cholesterol levels. A further 6,000 already taking statins have been prescribed a more effective form of the drug. Almost 1,000 people with abnormal heart rhythm have been given blood thinners to cut their risk of stroke, while 38,000 have joined a new programme to monitor and control their blood pressure.

The nature of rising demand is complex and the response to it equally so. True reduction in demand can only come in the long term – the outcome of successful public health programmes. But until this happens, demand management will mean deflecting care away from hospitals to more appropriate parts of the system, which face their own demand challenges.



Referral cuts

North Tyneside Clinical Commissioning Group has seen significant reductions in referrals to secondary care. Commissioning and performance manager James Martin says this is in part due a new referral management service.

'One of the big drivers is to reduce variation between practices in terms of referrals and to standardise the way things are done,' he says. 'There can be differences in GPs' clinical knowledge and how comfortable they are about making decisions.

'GPs refer patients through the e-referral system, with their cases reviewed by consultants. There are several outcomes to the review – the patient is listed for an outpatient appointment; the patient is referred back to primary care with a care plan; or the consultant requests further information.

In the latter scenario, the GP may not have carried out steps outlined in the referral protocol, such as diagnostic tests.

Mr Martin accepts referrals back into the community and managing patients through the process has meant extra work for GPs, but he adds: 'The patient needs to be seen somewhere – this is about ensuring they are seen in the right setting.'

Initially the focus was on the specialties with the biggest volume of referrals – orthopaedics, ophthalmology, ENT, dermatology and gynaecology – before being rolled out to others. 'We have also had two facilitators work with the practices with the biggest level of variation to make changes that will reduce that variation.'

The work, along with the CCG QIPP scheme, meant that in May, across all referrals, numbers were down by about 10% compared with 12 months earlier. Or, looking only at GP referrals, they were down 13.4%.



Added value

At the HFMA's first international symposium on value, clinicians and managers agreed on the importance of good data and a common language as the core foundations for value-based decision making, Steve Brown reports

Data quality and the need for a common language between clinicians and finance staff. These were mentioned time and time again as the key ingredients for moving to value-based healthcare at the Healthcare Costing for Value Institute's first ever international symposium on value.

A mixed audience of clinicians, finance and other managers were brought together in London in October to hear speakers from across the world and the UK talk about progress towards using the delivery of value – taking account of quality and cost – as the primary goal for healthcare services.

Setting the scene, Dr Paul Buss, medical director at Aneurin Bevan University Health Board, said there was growing evidence that better outcomes cost less and that changing clinical behaviour was key to closing the growing 'value gap'.

He stressed that an evidence-based approach – understanding cost-benefit ratios and measuring clinical outcomes – was fundamental to unlocking this change in behaviour. In terms of the use of patient-level and activity-based cost data, he said clinicians had to start demanding 'why aren't we doing this?' rather than 'why are we doing this?'. Four questions needed answering, he said – 'Can we develop costing systems that influence clinical behaviour? Can we develop systems where the cost element is used as an early marker of poor performance? Can we use costing to close the value gap? And can we develop costing mechanisms that accurately portray our clinical activity?'

Jason Neil-Dwyer, a plastic surgeon at Nottingham University Hospitals NHS Trust, is one clinician who has seen the potential of cost data. The trust was an early implementer of patient-level information and costing systems (PLICS). While clinicians initially responded negatively to a first cut of the granular cost data for his division, pointing out errors, he also saw how more robust data could support improvement in the way services were delivered. But first, finance practitioners and clinicians needed to develop a common language.

'There is an inevitable clash of worlds,' he added. 'It can be a case of P-values [measures of statistical significance] versus £-values.' Finance tended to be 'linear, hierarchical and deal in absolute values', said Mr Neil-Dwyer, while clinical care was 'networked, interdependent with inherent variability'. A core example was the healthcare resource groups used as the currency to show clinicians their costs for various activities. Describing the HRGs for plastic surgery as 'not obvious', Mr Neil-Dwyer said they were 'our work as imagined by someone else'.

The first task was to create a shared mental model of work done. This involved clinicians acknowledging the starting point was that there was a £3m deficit on the departmental budget. For finance it meant presenting costs in something other than HRGs. 'We needed to express the financial concerns in a clinical "work as done" context,' he told the conference.

Refocusing exercise

For plastic surgery at Nottingham, this meant initially examining procedure codes grouped in a way that made more sense to the clinicians and then focusing in on the areas where most difference could be made. Examining the 30 codes where the service made the biggest absolute losses and where it exhibited the biggest unit cost deficits helped the team to identify trauma and skin cancer as the agreed areas to target for improvement.

'Now my colleagues could see the cost in terms they recognised and finance understood the clinical pathways generating the costs,' he said.

Using quality improvement methodologies and with clinicians now welcoming the PLICS detail, the department looked at areas including the costs involved in single prolonged stay cases, complex breast reconstruction and skin cancer pathways.

For example, in breast reconstruction, it identified that more than 80% of costs were in theatre, with an operation time (7.5 hours) significantly above the international gold standard. This has led to improvements, with an extra consultant on each case helping to bring down theatre time – two cases can now be undertaken in a lengthened 9.5-hour theatre session. It has also helped mount an evidence-based challenge to the current tariff rate set for the procedure.

Pictured l-r: Jean MacLeod, Alfa D'Amato and Paul Buss

Duncan Orme, deputy director of finance at the trust, said that with the trust still making a significant underlying loss, the work in plastic surgery and other areas had to be expanded to other parts of the trust. 'The theory is beginning to set,' he said. 'We have half a dozen examples of senior clinicians leading motivated teams in using good information [to drive value]. We now have to make that the norm in our hospital, not the exception.'

There was support for ensuring a focus on quality as a means of engaging clinicians. However, Dr Buss said the trick was to 'bring money into the room and discuss it in a clinical context'. Mr Orme added that making sure data was published regularly was also important. 'If you produce cost data once a year, clinicians will probably have forgotten the patients concerned, but if it is six weeks after discharge then they are more likely to be able to remember specific details.'

There was agreement that focusing on value in acute and community services was a good starting point – with a focus on improving safety, flow and starting to build links with wider quality and outcome data. But there was also recognition that in future the focus should broaden to include primary care, enabling clinicians and managers to target best value across the whole patient pathway.

The importance of 'using the same language' was raised again in a workshop led Dr Jean MacLeod and Stuart Burney from North Tees and Hartlepool NHS Foundation Trust. They said the integrated trust was still trying to improve communication across its sites, almost a decade after taking on community services, which itself had followed an acute merger. 'So clinicians talking to finance is just another layer,' said Dr MacLeod, a consultant physician and the GP liaison officer at the trust.

However, clinical teams and the finance department have worked well together to put in place and build a business case for a completely revised chronic obstructive pulmonary disease pathway. The traditional model saw patients with exacerbations of COPD being frequently admitted to hospital – often at some distance from home and with poor transport links. Oversight was often by generalist teams rather than specialists and, as part of the admission, the patients would typically have a chest X-ray and numerous blood tests. Average length of stay was just over six days.

Hospital at home

The aim under a new hospital at home model was for patients to be cared for in their own homes, with guaranteed specialist input and no travelling for them or their relatives.

With the commissioner only committing to a one-year contract for

Data processing

Prescription has played a big part in creating a foundation of meaningful patient cost data compiled using a consistent approach in Germany. **INeK** (the Institut für das Entgeltsystem im Krankenhaus) is the body that oversees the hospital remuneration system. Its head of economics **Michael Rabenschlag** (inset) gave symposium delegates an insight into the country's 15 year journey to improve costing, creating what is now a leading example of a large scale diagnosis-related group costing/pricing system.

The organisation is in fact responsible for more than just costing – collecting inpatient activity data, maintaining the currency, setting coding rules and producing grouping software as well as overseeing the patient costing and tariff setting process.

While the hospital inpatient activity collection is mandatory for all hospitals, cost data is submitted on a voluntary basis. Nearly 250 hospitals are part of this costing sample and they are paid for their efforts, covered along with InEK's running costs by a €1.15 surcharge on all invoices submitted by hospitals. For larger hospitals, Dr Rabenschlag said the funding could be enough to cover three people working on producing the costing data. And with InEK-focused work only taking about half their time, this left hospitals with a paid resource to get value locally from the cost data.

Echoing comments from other speakers, he said that data quality was vital – with data of insufficient quality rejected from the sample either partially or wholly. Some basic data checks are built into the submission system, such as missing costs in cost centres and comparisons with previous years, while more sophisticated checks look at coherency and variation, for example, ensuring appropriate prosthesis costs are included for a hip replacement.

Cost data is collected in a matrix covering 11 cost centres (such as wards, intensive care and theatres) and 10 cost types (arranged in three broad groups covering staff, consumables and overheads) and the allocation methods for each cost type in each cost centre are mandated.

The Australian healthcare system has long collected patient-level cost data, using the data to inform an activity-based funding system for hospitals. But in the last few years, the state of New South Wales has stepped up a gear and made firm moves towards using the data to support real activity-based management. This has been underpinned by a portal that enables clinicians and managers to analyse and compare activity and cost data across health districts.

Deputy director of the state's **Activity-based Funding Taskforce Alfa D'Amato** told the symposium that the state was taking the use of patient data 'very seriously' now and that the portal had helped to embed patient-level costing across the system, with single submissions of data now being put to multiple uses. He said there were four key stages in the journey: improve the data; improve the process; have an impact in terms of better care; and then deliver improved patient outcomes.

Mr D'Amato described the portal in detail in *Healthcare Finance* (July/August 2016 p23), but he told the symposium that getting data fit for purpose was key. Without this, it would be difficult to get the all-important clinical engagement. There is extensive data validation, with the data submission platform open for four weeks and hospitals encouraged to submit improved data in response to any issues flagged by the system. A 'reasonableness and quality' app scores the data quality to support practitioners with these submissions. The data is also subject to local audit as part of the internal audit programme.

New South Wales has already started to see a reduction in the rate of increase of average costs – and believes the portal has played a part in this improvement. It recognises it still has a way to go before it has fully embedded value-based decision making in local hospitals – however it is clear that system leaders see huge benefits in the approach and the portal and approach has now been expanded to the whole of Australia.

the revised service (as part of a local block contract), the challenge has been to demonstrate the new model works both for patients and financially for the commissioner and provider – and that has meant closer working between clinicians and finance.

Dr MacLeod said the original business case was based on a number of assumptions and predictions for the impact of the revised service. 'There were no concrete examples we were copying and nowhere with a comparable set-up to the trust,' she said, adding that the trust had targeted an ambitious 50% reduction in admissions over two years.

With five months' real data since starting the service in April, over the summer the trust started to build its business case for continuing with the new model. By the end of August, it had counted 176 avoided admissions along with more than 50 early discharges made possible by the enhanced home support. In both cases the numbers are trending upwards month by month.

'There is no doubt this is the right clinical thing to do, but now we have to make the business case as well,' said Dr MacLeod.

Even on the early numbers while the service was still taking hold, projections suggest there will be a 26% reduction in admissions (compared with 1100 previously) over the full year. This translates to a reduction of nearly 1,700 bed days, and reductions in both the number of blood tests ordered (£3 per patient) and chest X-rays (£35 per patient). There are also unanticipated savings from reduced use of tiotropium inhalers. While new inhalers often had to be handed out in hospital settings, seeing patients at home means they can access their existing inhalers (and get them checked). Clinicians were largely unaware that these inhalers cost around £32 per patient. In total, the trust is confident it will save at least £450,000 over a full year.

Multiple benefits

The biggest benefits are for patients – avoiding unnecessary admissions and greater control over their condition. But the financial case is also stacking up. However, the trust is keen to examine other metrics that it should be collecting to help reinforce the case and to improve the service.

For example, Dr MacLeod said the trust wanted to build in patient experience and link test results with the data set, in part to verify exactly how many of the ordered blood tests are looked at.

Head of contracting income and costing Stuart Burney accepted that the trust would lose out in net terms from losing the income tied to admissions, even with the new community service being separately funded. However, he said the trust needed additional acute capacity, and the changes would support this. 'So although we may lose income, we will be more cost-effective,' he said.

"We have senior clinicians leading motivated teams in using good information. We now have to make that the norm in our hospital"
Duncan Orme

Capitation and outcomes

With the NHS now exploring accountable care models, **Santiago Delgado Izquierdo,** described how the model was delivering benefits in Valencia. The **Ribera Salud** Hospital System has been on a journey towards more integrated care for more than 15 years and is now seen as a pioneer of capitated payment approaches in healthcare.

Mr Izquiero said the hospital was no longer the centre of the system and the culture was now one of financing health, not healthcare. 'Capitated payment gives predictability for the government and makes us accountable for the healthcare outcomes of the population,' he said. 'And it incentivises providers to take on greater financial risks and invest in preventative care and treatment in the most appropriate settings.'

Thomas Kelley, a vice-president at the International Consortium for Health Outcomes Measurement (**ICHOM**), told the symposium that health systems needed to get better at measuring what really mattered to patients for specific conditions. Structural indicators (is there a stroke unit?), process measures (was an intervention performed in a certain timescale?) and clinical measures are important – but what the patient wanted to achieve is also vital. For prostate cancer patients, this might mean continence or sexual function, not just survival. ICHOM now has 21 agreed standard outcome sets and is overseeing international benchmarking pilots in two service areas – cataracts and hip and knee osteoarthritis.

Erasmus Medical Center in Rotterdam was an early adopter of ICHOM outcome standards and is a good example of an organisation putting value-based healthcare theory into practice.

By mid-2017 it plans to have outcomes in place for 36 service areas, some adopted from ICHOM standard sets, some self-developed. Chief medical information officer **Jan Hazelzet** said that value-based healthcare was written into the hospital's strategy. Outcomes – including before and after questionnaire responses – are now part of normal practice and always discussed in consultations.

He also encouraged finance managers to investigate the data currently held by clinical audit teams. 'We submit over 300 sets of audit data,' he said. 'Everything we do [through our PLICS system] is based on data that is already there. Go and talk to your clinical audit and effectiveness teams and present this data alongside your PLICS data,' he said.

One thing was clear, all international health systems face similar challenges. And many recognise a focus on value – rather than simply cost or quality – as the best way to approach them. The HFMA's symposium is likely to be the first of many.

• *For details about the HFMA Healthcare Costing for Value Institute, see 'our networks' at www.hfma.org.uk. Institute members can also access videos from the symposium*

Pictured l-r: Jason Neil-Dwyer and Duncan Orme

Digital health and technology forum

15 November, London
HFMA Provider Finance Faculty

This session will examine the current digital landscape in health and will showcase the benefits of using digital technologies in trusts and across STP footprints following the Carter recommendations. The event will include both keynote speakers as well as an opportunity to share learning through smaller, focused case-study sessions. The day will give you an opportunity to get an understanding of the concept of 'meaningful use' and focus on benefits of, and ways in which digital tools can improve efficiency, quality, and contribute towards the financial savings target.

PROVIDER FINANCE FACULTY

Book now by visiting **hfma.to/digitalhealth**

For more information contact **grace.lovelady@hfma.org.uk**

HFMA Provider Finance Faculty member organisations get one free place

Value masterclass

28 February 2017, central London

This **'value in progress'** masterclass will focus on how to translate the theory of value-based healthcare into practice, and specifically **how to do this jointly as finance and clinical leaders.**

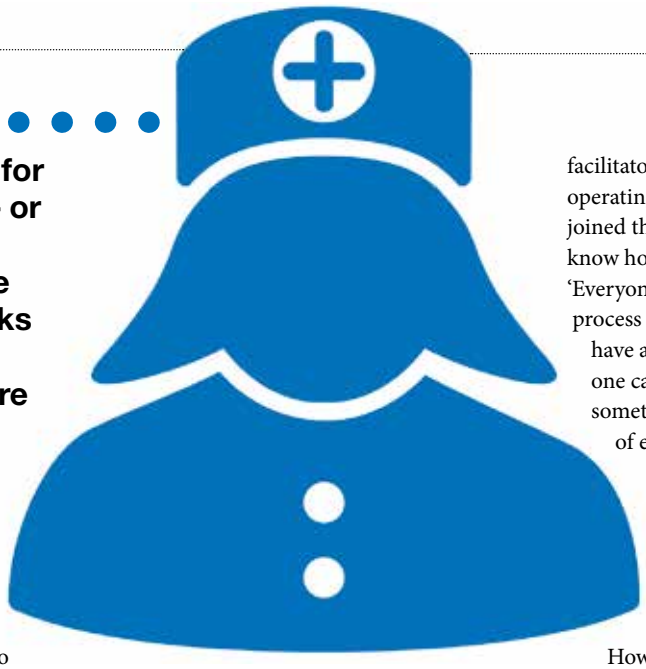
The programme will look at pilot projects, case studies and international practice where the value equation is starting to become a reality in healthcare.

Every HC4V Institute member is recommended to send **one finance leader representative and one clinical leader representative for free** in order to gain the most benefit from the day.

To book email jonathan.richards@hfma.org.uk

Further information on the value masterclass can be found at http://hfma.to/1j

HEALTHCARE COSTING FOR VALUE INSTITUTE



one to one

Improved arrangements for enhanced nursing care – or specialling – can deliver patient benefits and save money. Steve Brown looks at how two trusts have shown the value of a more structured approach

Lord Carter's preliminary report of NHS productivity identified specialling – or one-to-one nurse care – as an area where greater consistency could improve care and reduce costs. A number of NHS providers have started to realise these benefits, but there is significant scope to expand this best practice across the service.

There are definitely savings to be had – Lord Carter's report suggested that Salford Royal NHS Foundation Trust, which has pioneered some of the improvement work in this area, was anticipating trust-wide savings of more than £1m a year based on its results in the first few months operating a new system (see box page 25). But financial savings – many of which arise from reduced usage of bank or agency staff (where trusts continue to face extreme cost pressures) – are just part of the benefits package.

Improved specialling arrangements can also help deliver more consistent, patient-centred care and greater involvement of patients' relatives and carers, and provide nurses with more support to take key decisions about patients' requirements.

East Lancashire Hospitals NHS Trust is one trust to have made major progress following Salford's initial example. It was one of 12 providers to work with the former NHS Trust Development Authority to attempt to replicate Salford's work using a Lean management 90-day rapid improvement programme.

The hospital trust's quality improvement facilitator, Sonia Nosheen, says the trust was operating in the dark with specialling when it joined the TDA initiative. 'It was difficult to know how much we were spending,' she says. 'Everyone had a different opinion on how the process should work. And we didn't even have a clear definition about what one-to-one care meant across the organisation, sometimes confusing it with other forms of enhanced care such as cohorting.'

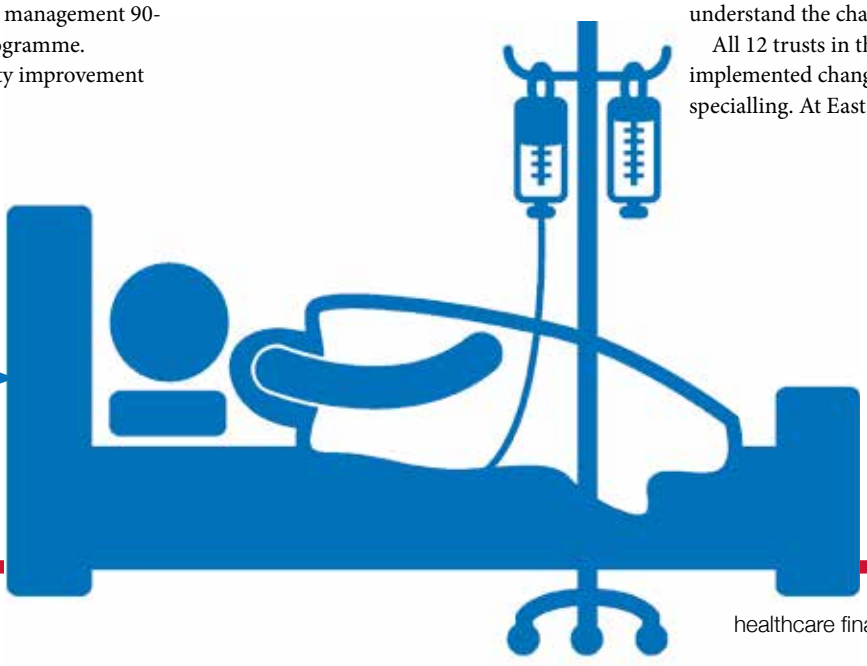
Although the trust only had a loose grasp on what it was currently spending on specialling, it recognised that costs were rising and that there was significant potential for improvement.

However, data issues added to the problem. Its e-rostering system at the time was set up in a way that, depending on what other data was being entered, it was not always possible to record enhanced care; and it was not possible to distinguish between, for example, one-to-one care and cohorting (patients requiring observation, often with a 1:4 ratio).

Even if it relied on its data as accurate, there were further difficulties in interpretation. Nurses had traditionally used gut instinct, informed by their experience, to identify patients who needed enhanced care. But this made it difficult to understand changes in the incidence of specialling over time. For example, the trust could see a major step change in use of specialling – but it was not clear what might be behind this.

There had been a couple of serious incidents around the time of the increase. But there was also new guidance on mental health enhanced care that could have influenced acute practice. The hike could equally have been influenced by changes in personnel or casemix. Without a consistent and robust process to put specialling in place, there was simply no way to understand the changes.

All 12 trusts in the TDA cohort implemented changes in their approach to specialling. At East Lancashire, the trust



SHUTTERSTOCK

Enhanced care risk assessment tool

Risk of falls	At risk of getting up unaided or trying to leave the ward	An episode of increasing confusion/delirium/dementia	Other clinical risks	Score	Level of observ'n	Menu of possible interventions
Patient not deemed as a falls risk as per initial falls risk assessment	Patient independently mobile around ward	No identified confusion or delirium	Clinically stable	No risk	Usual ward observ'n	• No need for further assessment unless condition deteriorates, or any change in clinical treatment plan
0	0	0	0		0	
Patient identified as being at risk of falls No history of actual inpatient falls	Patient at risk of getting up unaided or attempting to leave the ward	Mild to moderate confusion Patient requires regular reassurance and reorientation to ward area	Patient is at low risk of deterioration	**GREEN** Level 1 Some risk	Intermittent observ'n	• Additional family support, open visiting times • Review medications with doctor and pharmacist • Communicate and escalate at safety huddle • Maintain intentional rounding • Consider location of allocated bed
1	1	1	1		<4	
Patient identified as being at risk of falls with one or more of: • An actual fall has occurred • Patient is impulsive and/or non-compliant in using nurse call bell • GREEN level interventions have not made the patient safe	Patient is showing signs of attempting to stand unaided or to leave the ward	Moderate confusion Frequently agitated and restless or requires regular reassurance and reorientation to the ward environment At risk of pulling out device Unable to make needs known	Patient is acutely unwell with elevated EWS score and requires additional nursing care to maintain safety	**AMBER** Level 2 Moderate risk	Within eyesight	• Relocation of patient in area of high visibility • Cohorting of at risk patients - 1 staff member per bay • Request additional family support, open visiting times • Commence patient engagement activities • Consider DOLS application or MH assessment • Review medications with doctor and pharmacist • Consider bed/chair sensor alarm if patient appropriate
3	3	3	3		4-12	
Patient is identified at significant risk of falls with serious harm and one or more of the following is present: • All amber actions have been attempted but risk remains • An actual fall with harm has occurred	Patient is wandering and/or standing unaided and attempting to leave the ward	Severe confusion with regular episodes of agitation, violent behaviour and/or aggression towards staff, other patients or relatives	• Patient requires 1:1 care to maintain safety – severe alcohol withdrawal, risk of self-harm • Unstable MH patient needs continuous enhanced observation/ intervention	**RED** Level 3 High risk	Continuous observ'n	• Implement 1:1 asking family first if they can assist • If family unable to assist look at existing staffing levels • If staffing levels cannot be used escalate to matron • Consider DOLS application, MH assessment, safeguarding lead, MH liaison team or acute falls lead nurse review • Communicate and escalate at safety huddle • Commence patient engagement activities • Review medications with doctor and pharmacist
12	12	12	12		>12	

piloted changes on three wards covering older people, complex care and orthopaedics.

With the 90-day programme broken into three 30-day report back sections, the trust went through a number of plan-do-study-act cycles to improve different components of the overall process.

First it tackled its data problems, recognising that robust coding was essential to better management of enhanced care and to demonstrating the impact of changes. Its e-roster system, through which all requests for enhanced care are made, now enables all cases of enhanced care to be recorded and the different levels of care separately identified.

Its next step was to explore how it could involve relatives and carers more – both to understand better the quality of care for vulnerable patients and to explore how relatives could be more involved with care where they wanted to do so.

Ms Nosheen (pictured) said feedback to a survey underlined that relatives were often keen to be more involved and that this had benefits for patients and could reduce demands for enhanced care.

In order to take this forward, the trust worked with John's Campaign, which aims to give the carers of those living with dementia the right to stay with them in hospital.

'We want to give holistic care, but we want to work in partnership with the relatives and carers, so it is really important when a person comes in, and they are assessed by the nursing staff on the ward, that we get a history from the patient,' says Jarrod Walton-Pollard, director of nursing for the surgical division. 'This means we can understand their needs – do they want to spend more time with their loved one or have open visiting? Or perhaps they want to have a rota with all the family and carers so someone can be with them all the time.'

This has led to the development of material both to support nursing staff in discussing the option of family/carers providing informal one-to-one care and to help explain the options to relatives.

Implementing changes

Next on the 'to do' list was to provide more support to nursing staff on what was expected of them in one-to-one care. 'One-to-one care is also about engaging with patients and getting to know them as well as monitoring them,' says Ms Nosheen. 'This has therapeutic value.'

Nurses are now issued with nurse pocket cards detailing a set of rules to be observed during one-to-one care. Nurses are also required to log activities and this log is passed from one care giver to the next.

The final step was to put the whole triggering of enhanced care onto a more robust footing.

Salford had developed its own risk assessment checklist to support the specialling decision-making process.

Ailsa Brotherton, clinical quality director for the North at NHS Improvement, who led the TDA's support for trusts on specialling alongside nursing director Peter Blythin, says practices across the cohort of 12 trusts varied. Some had no risk assessment in place, and where they did exist there were differences in the quality and how they were used.

'Some were not very robust. They provided a simple checklist – had the patient had a fall for example – but gave no indication of what to do if they had,' she says.

Having looked at various risk assessments already in use, the cohort of trusts opted for one developed by University College London Hospitals NHS Foundation Trust, which incorporates a clear scoring mechanism that links to different levels of enhanced care.

'Nurses really liked the mechanism,' says Dr Brotherton. Not only did it help them make an important decision on the level of care needed, but it created an audit trail for the decision-making process.

East Lancashire was one of the trusts that did not have a pre-existing risk assessment in place and has adopted the UCLH template with a few minor tweaks to suit its local context. Patients are scored in four key areas:

- Risk of falls
- At risk of getting up unaided or attempting

Patient focus: key to Salford improvement

Salford Royal NHS Foundation Trust says improving care was the sole focus for changing arrangements around enhanced care at the trust – and this was at the heart of the programme's success.

However, there were significant financial savings from the outset and these have been sustained. The trust has rolled its revised practice out across its more than 40 wards and remains on target to realise the £1m of savings referred to in Lord Carter's preliminary report on productivity improvement in acute hospitals.

Peter Murphy (right), trust director of nursing, quality and governance, says there had been an increase in demand for one-to-one care across the trust before it introduced its new system. The trust had up to this point considered this issue from a professional point of view – how best could it manage the increase in activity? This had led to the use of a pooled team of nurses in its neurosciences area dedicated to enhanced care duties.

The catalyst for change came when the trust tackled the issue from the point of view of the patient. One elderly patient was admitted for pneumonia, but also had been newly diagnosed with the onset of dementia. He talked about 'feeling scared' to wake up and find a stranger by his bed. His wife talked about being parted from her husband for the first time in years, going home and crying, wondering why she couldn't be part of her husband's care.

'It was a lightbulb moment,' says Mr Murphy. 'You have to do what is right for the individual. Not how we want to professionally manage this situation, but how to approach it from a patient-centred point of view.'

The revised approach involved four key changes. The trust introduced a revised risk assessment process that provided a more rigorous basis for deciding when enhanced care was appropriate. It described different levels of increasing observation from co-locating patients in a bay, with a nurse or nurses looking after multiple patients, through to specialling. The risk assessment process produced scores that were linked to these different levels of observation.

It also introduced a requirement to talk to relatives or carers about how they might like to be involved in the care of the family member. And it added a requirement for a senior nurse to sign off any request for specialling.

Mr Murphy says that involving the family/carer with the care – referred to as triangulation of care – was the single most important change the trust made. He adds that the foundation for the programme's success and its sustainability was that the changes were staff-led. 'This was designed by staff and they are proud of the changes,' he says. 'When you own something, you are much more likely to practise it.'

Roll-out from the original four wards to the more than 40 across the trust was also relatively smooth and rapid. Link nurses from wards were trained in the elements of the change package. Within four weeks all departments then had to return a pledge card with signatures from staff indicating they had read and understood the principles of the change package.

Levels of one-to-one care are considered alongside other metrics at weekly ward-based dashboard meetings with ward managers. But to a large extent the new system has simply become normal working practice.

Mr Murphy says other trusts could benefit from taking a similar approach, although they would need to localise the process and ensure staff ownership of any changes. He also says that Salford is open to further refinements.

For example, the trust is using surveillance technology for some specific patient groups as a way to improve observation in certain circumstances. And it is keen to re-import any refinements to its process from other parts of the NHS.

In summary, he insists the changes are a no-brainer, delivering better care at lower cost. Indeed he says that savings started almost immediately with a significant fall in specialling budget before costs plateaued at a new lower level.

But he adds that the focus has to be on the care quality not the savings. 'During the change package and all the work we did, we anticipated savings would follow, but we never once talked about money. We simply focused on putting a patient-centred approach in place that did the right thing first time around for individual patients.'

to leave the ward
- Increasing confusion/delirium/dementia
- Other clinical risks.

Each patient is assigned to one of four levels in each of these areas – representing no risk (white, score 0), some risk (green, score 1), moderate risk (amber, score 3) and high risk (red, score 12). Once a patient is assessed, the individual scores are summed and the total indicates the level of observation needed.

This simple tool (left) includes prompts to help nurses assign patients to the relevant level in each risk area and also reminds nurses of possible interventions associated with each observation level. Risk assessments are carried out on all patients (aged 18 upwards) within 12 hours of admission to the ward. However, the trust has also put in a structure around reassessments. Its new standard operating procedures state that the level of enhanced care for any patient must be reviewed on an ongoing daily basis and reviewed at the start and finish of each shift by the nurse-in-charge. Decisions to discontinue enhanced care are documented in medical and nursing notes.

'When we asked trusts about their specialling policies we were sent lots of

Risk assessment scores for observations

0	Usual ward-based observation
<4	Intermittent observation
4-12	Within eyesight (relocation or cohorting)
>12	Continuous observation

information about how and when to start specialling, but very little on how to stop it,' says NHS Improvement's Dr Brotherton.

'In many cases, once specialling started, it never stopped until a patient was discharged. But patients' conditions and needs change and there are some potentially big wins here while still ensuring care meets patient needs.'

East Lancashire showed a significant improvement in the three-month pilot period. Its aim for the project was to improve quality and patient experience and reduce the cost of bank and agency spend by 20%.

In fact agency/bank spend to support specialling reduced by nearly £19,000 or 68% compared with the previous three months' spend – more than three times the target reduction.

It is now rolling out the new process across the trust – which includes 50 wards. And it has also raised its ambitions, targeting a 50% reduction in the cost of agency and bank spend. If it achieves these savings across all its wards, it would be close to matching the £1m annual savings estimated as possible by Salford.

The roll-out involves raising awareness of the reasons for the programme and clear communication about progress. There is also a significant training agenda – both for substantive and temporary staff. This covers what is expected of staff when requesting or delivering enhanced care and talking to families and carers about the 'partnership in care' options.

Ms Nosheen believes the challenge is to ensure the new process is sustainable. As part of this, the trust is looking to use its internal nursing assessment programme to ensure the process is working and being adhered to. 'What made this work was that cost wasn't the driving force. Cost is important but the focus was on process and quality,' she says.

'However, what the pilot proved was that if we get the fundamentals of care, experience and quality right for our patients, then the costs move in the right direction.

'This has to be sustainable and spreading it across the organisation so that we have the same standard embedded as daily practice in all areas is the key to making this successful in the long term. This will not be an easy task and will take time,' she says.

'But we are confident that, having successfully tested the interventions in the pilot wards, we will be able to make it an organisation-wide success. This is helped by the aims of the programme strongly connecting to the values of our staff and organisation to provide safe, personal and effective care.'

Efficiency map

The HFMA and NHS Improvement have been working together to update and revise the NHS efficiency map. This interactive tool, due to be published soon, supports best practice in delivering cost improvement programmes. The map signposts existing tools and reference material, bringing links to wide-ranging material into a single place. It is split into three sections – enablers for efficiency; provider efficiency; and system efficiency – and also includes updated definitions for different types of efficiency improvement. Case studies of existing good practice in cost improvement – including the 'specialling' case study produced here – are being developed to accompany the map.

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Be prepared: it's not too soon to think about new accounting standards

Technical update

Given the extreme financial pressure on finance departments at the moment, it is probably good news that the next couple of years will be quiet from the perspective of new accounting standards, *writes Debbie Paterson.* However, it's not too early to be thinking about the new accounting standards that will be applicable in 2018/19.

In particular, the new revenue recognition standard is likely to require some work, as well as discussions with colleagues outside of the finance department.

IFRS 15 – *Revenue from contracts with customers* will replace the current standard, IAS 18. The Treasury is proposing that the standard will apply to all public sector bodies from 2018/19 without amendment or interpretation.

At first glance, the new standard seems fairly straightforward. It sets out a logical five-step approach to recognising income. However, the general consensus in the accountancy world is that it will take time and effort to implement, even if it does not change the eventual timing or amount of revenue recognised.

In the commercial sector, the focus is on industries such as telecommunications, where contracts involve the provision of goods and services for a single payment and it is difficult to match one to the other.

It would be easy to say that NHS contracts are annual contracts for the provision of services, where the services to be provided and the prices to be paid for them are well defined, so this standard won't make a difference.

That may well be the case for the contracts that are currently in place. However, by 2018/19, some of the new models of care currently being tested by vanguards may well be on stream.

Some of these will involve long-term contracts and include payments for pathways of care or capitated payments. Ideally, the accounting issues should be considered while contracts are drafted and developed.

The five step approach is as follows:

1. **Identify the contract(s) with a customer**
   This will include all NHS contracts as well as other contracts with third parties.

2. **Identify the performance obligations in the contract**
   This is what has to be done to earn the income. It could be the provision of a good or a service and it may take place at a point in time or over time. Each performance obligation needs to be distinct, which means that it could be delivered separately. One way to think about this is whether it would have to be re-done if the service provider was changed. So, would a pre-operative assessment be a separate performance obligation to the operation? If the assessment would need to be re-done if the provider was changed then it is not a separate obligation. There could be several performance obligations in a single contract so they all have to be identified.

3. **Determine the price of the transaction**
   This is likely to be the price set out in the contract, but it could be different if the contract includes a variable element or delivery of the contract takes place over time. For NHS bodies, sometimes the full price is contingent on the patient being discharged and not being re-admitted to hospital.

4. **Allocate the transaction price to the obligations in the contract**
   This could be complex where a price has to be allocated to different performance obligations. NHS tariffs may not necessarily map to separate performance obligations, particularly in tariffs for a pathway such as with maternity.

5. **Recognise revenue when (or as) performance obligations are satisfied.**

The new standard requires qualitative and quantitative information to be disclosed in the annual report and accounts – improving understanding of the nature, amount, timing and uncertainties of revenues and cashflows.

The standard requires revenue to be disaggregated and the Department of Health, in an August consultation, set out an example of likely requirements. This could involve a matrix with customers (clinical commissioning groups, local authorities, other) across the top and the types of services down the side (for example, elective, non-elective, A&E, mental health, community, private patient).

It is possible that the Department will mandate this disclosure. Although the information may fall out of current ledger analysis, in some cases new systems/ arrangements may be needed.

Information about performance obligations, transaction prices and any significant judgements in relation to revenue recognition will also have to be disclosed.

Debbie Paterson is a technical editor with the HFMA

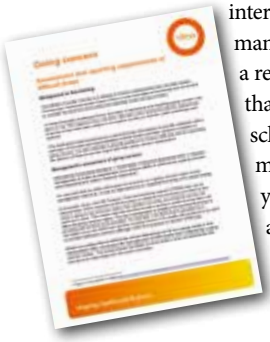
"The general consensus in the accountancy world is that it will take time and effort to implement"

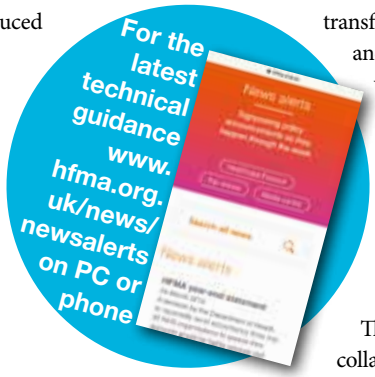
Technical review

The past month's key technical developments

Technical roundup

The HFMA's Provider Faculty has produced a briefing to summarise the roles and responsibilities of NHS bodies and their auditors in assessing and reporting an organisation's ability to continue as a going concern. While it is unlikely that an NHS body will be determined not to be a going concern, this interpretation does not exempt management from undertaking a review. The briefing underlines that the review should be scheduled into audit committee meetings in the final half of the financial year, with the assessment also on the agenda of at least the final full board meeting. Members of the Provider Faculty can download a copy of the briefing from www.hfma.org.uk within the faculty resources section.





The HFMA has called for phased implementation of proposed changes to salary sacrifice schemes that would make certain benefits-in-kind subject to income tax and class 1A employer national insurance. The association said it was concerned that changes could make some existing arrangements unaffordable for the individuals involved, while leaving schemes could incur a charge. 'Our members would strongly support phased implementation of any changes so that agreements that are already in place are not affected,' it said in a response to the consultation, which closed during October. The association said the proposed changes would have varying impacts depending on the scheme types. However, the biggest costs would arise for car parking and IT equipment/white goods and mobile phone schemes. (See *Healthcare Finance,* October 2016, page 25)

The Department of Health issued further information on the agreement of balances during October. This includes an update on the month six exercise, including information for providers on sustainability and transformation fund payments. The high-level annual report and accounts plan timetable has been issued, together with the agreement of balances timetables for quarters three and four.

NHS Improvement has issued guidance on the options for structuring foundation groups, including the implications for finance. Foundation groups go further than informal agreements, such as buddying, but stop short of merger or acquisition. They are currently being piloted as part of the acute care collaboration across 13 vanguards. The guidance looks at risk sharing and roles under three structures – corporate joint ventures, contractual joint ventures and the committee in common model. The corporate joint venture model is currently limited to foundation groups that only involve foundation trusts. Foundation trusts and NHS trusts have no powers to set up legally binding joint committees, but they can both delegate to committees in common. Both types of provider can enter into contractual joint ventures that are legally binding – with current examples including pathology service joint ventures.

The HFMA has published a briefing reminding NHS charities in England and Wales that they must meet the 'public benefit requirement' at all times. If this is not the case, the organisation is not a charity, it says. The briefing also looks at key issues that apply to NHS charities in particular – covered in the Charity Commission's NHS charities guidance. For example, it examines the conditions that need to apply for charitable funds to be used on services that are usually funded by the public sector. The briefing also includes an example of how one charitable fund approaches decision making in each of these areas. For example, where an NHS charity is funding a capital item, it should check the trust can fund running costs.

Lung cancer treatment is new fund first

NICE update

Lung cancer is a condition in which tumours develop in the lungs, *writes Nicola Bodey.* For people with locally advanced or metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive non-small-cell lung cancer that has progressed after a first-line tyrosine kinase inhibitor (TKI), the treatment option would be platinum-doublet chemotherapy.

In a technical appraisal (TA416), NICE has now recommended osimertinib for use within the Cancer Drugs Fund (CDF) for treating these cases.

Under the new CDF arrangements, cancer drugs that receive a draft positive NICE recommendation will immediately be funded by NHS England. Osimertinib is the first drug to benefit from the new arrangements.

The resource impact will be covered by the CDF budget. NHS England and AstraZeneca have agreed a commercial access agreement that makes osimertinib available to the NHS at a reduced cost. The financial terms of the agreement are commercial in confidence.

It is estimated that around 380 people, whose cancer has the T790M mutation and whose disease has progressed after first-line treatment with an EGFR tyrosine kinase inhibitor, may be eligible for osimertinib.

It is estimated that around 300 people in England have osimertinib each year based on the company's market share estimates.

The average treatment duration is reported to be 16.2 months.

Osimertinib is associated with fewer visits to hospital because it is better tolerated than other treatments, such as platinum-doublet

Diary

November

10 I HC4V: technical costing update, London
11 B Northern Branch: annual conference, Durham
14 B Eastern Branch: national tariff, Newmarket
15 F Provider Finance: digital health and technology directors' forum, London
16 F Commissioning Finance: forum, venue tbc
17 B West Midlands Branch: AGM, Birmingham
17 B North West Branch: annual quiz, Manchester
21 B North West Branch: AGM, Liverpool
23 B MH Finance: directors' forum, London
24 N Audit conference, London
24 B South Central Branch: technical update, Newbury
29 B Eastern Branch: accounting standards, Newmarket

December

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

January

12 F Provider Finance: directors' forum
17 F Annual chairs conference, London
18 F Commissioning Finance: financial recovery forum
19 I HC4V: NHS costing – regional network and training event, south
24 F CEO forum, London
25 N Pre-accounts planning, Leeds
26-27 B Yorkshire and Humber Branch: conference, Broughton
26 N Pre-accounts planning, London
27 B Kent, Surrey and Sussex Branch: student conference, Maidstone
30 B Eastern Branch: introduction to NHS finance, Fulbourn

February

7 F MH Finance: mental health costing forum
9 F Chair, Non-executive and Lay Member: forum, Rochester Row
17 B London Branch: student conference, Rochester Row
28 I Value masterclass

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

key B Branch N National F Faculty I Institute

chemotherapy, and is given as an oral tablet whereas other options need attendance at hospital for intravenous infusions.

People whose lung cancer is treated with osimertinib have a very high response rate to treatment compared with platinum-doublet chemotherapy and this could improve quality of life.

This technology is commissioned by NHS England. Providers are NHS hospital trusts.

Nicola Bodey is a senior business analyst with NICE

Events in focus

Integration summit: finance and governance for effective health and care integration

9 February 2017, London

Funding health and social care over the next decade is a key concern for commissioners, providers and service users. As financial, demographic and service pressures facing the NHS and local government intensify, the need for integrated care to improve people's experience of health and care, the outcomes achieved and the efficient use of resources will only grow. The pooling of resources across health and social care boundaries is an important ingredient of effective integrated care. The National Audit Office has highlighted the main risks and challenges as the system changes radically. The Department of Health and Department for Communities and Local Government expect local efficiency initiatives, service transformation and the Better Care Fund to help local government manage financial and service delivery pressures. This one-day summit, jointly organised by HFMA and CIPFA, will bring together finance leaders across local government and health to explore the challenges facing their organisations as they seek to work together to deliver better outcomes.

- *The programme will be available soon. To register your interest please email camilla.godfrey@hfma.org.uk*

Step up programme

November/December

Though Shahana Khan's term as president is drawing to an end, events to support her theme, *Step up*, are going from strength-to-strength. While there are two national one-day events this month to help senior finance managers develop their leadership and management skills, branches continue to host events locally. Local workshops focus on giving finance staff the personal and professional resilience needed as the NHS faces one of the most testing times in its history.

In November and December nine local events have been scheduled, most as mixed doubles – two half-day workshops on the same day. Sessions include *Evidence-based persuasion* and *Coaching people out of their comfort zone*.

While the former aims to help managers draw on their analytical abilities and offers insights from business psychology, the latter helps managers nudge team members to take more responsibility and extend their influence. Others look at negotiation, team resilience and sustaining high levels of performance.

There is also a one-day workshop on 15 November, hosted by the West Midlands Branch, entitled *Management in a day*.

System thinking

Association view from Mark Knight, HFMA chief executive

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

My HFMA

A big thank you to all those who have submitted their returns to our latest bi-annual NHS financial temperature check. It should be a real talking point at the annual conference in December as we consider the financial future of the NHS. It assesses finance directors' views at a key time, having just submitted system-wide sustainability and transformation plans and with providers having received their control totals for the next two years.

The line-up for the conference is almost complete, with a great mix of NHS speakers and Britain's most successful Paralympian, Dame Sarah Storey (left), closing it. Indeed, we are all proud of our own Paralympian James Blackwell, HFMA's head of finance skills development and one of the GB football team.

The conference comes at the end of a long autumn of events, conferences and workshops. We've no shortage of delegates for these events and this is down to the efforts my colleagues put into developing such successful events.

A very real feeling of isolation is felt by many at this time, so the opportunity the association provides for finance professionals to get together for mutual support and to share views, challenges and solutions remains highly valued. This is true for both national and branch events – our president's *Step up* series has been provided across branches specifically for HFMA members.

Out of all the programmes, one that stands out for me is our recent Healthcare Costing for Value Institute's international symposium in October (see page 19). The symposium focused on how we can share good practices from all over the world and I think it greatly benefited all the NHS organisations whose representatives attended.

Delivering value is surely at the heart of the current challenge and assessing value needs a forensic understanding of how we deliver services. That means granular and robust data with cost data absolutely at the centre.

HFMA chief executive Mark Knight

I'm particularly pleased we are working with NHS Improvement's costing team to develop appropriate messaging and learning around costing. We strongly urge organisations to join the institute so we can develop these services. This applies on both the commissioning and provider sides of the NHS.

Many of you in England have been involved in the development of sustainability and transformation plans. I know this has been an intensive process as you've tried to shoehorn everything into the resources available.

One option is creating accountable care organisations serving whole populations. This is an emerging international response to current pressures facing all healthcare systems. We start from different positions, but we have much in common. To me, the US appears ahead in data informatics, although the NHS has more mature relationships between commissioners and providers. But both systems are exploring and moving towards capitation-based payment systems – rather than fee for service – to provide the financial foundations for these arrangements.

To support these developments, we are keen for our faculties to work together more closely. Our next commissioning and provider annual events will run with overlapping programmes, which will enable us to explore real cross-system working. In all we do, we look for your support and I am always grateful for the help you provide to deliver our busy agenda. You don't just join – you join in!

Member news

Dawn Scrafield is the new vice chair of the Eastern Branch. Laura Rawlings takes over from Jenny Davis as treasurer.

HFMA management accountant Sarah Karabulut has raised £425 for Breast Cancer Care doing a tandem skydive. 'The skydive is something I'd wanted to do for a while and I'm pleased I have done it raising money for charity,' she said.

The HFMA East Midlands branch hosted its first awards ceremony at the East Midlands annual conference to recognise local achievements, hard work and commitment from the region in six categories. Manjit Pharm (below) from Leicestershire Partnership NHS Trust was named Unsung Finance Hero. The finance team at Chesterfield Royal Hospital won Team of the Year. Scott Jarvis, director of operational finance at Derby Teaching Hospitals NHS FT, was rewarded for his leadership contribution. Zoe Jeffery, finance officer at East Midlands Ambulance Services NHS Trust, was named Student of the Year. The Innovation Award went to the procurement and supplies team at University Hospitals of Leicester Trust, while John Wells, senior project accountant at Nottingham University Hospitals NHS Trust, received special recognition for his contribution to the NHS.

'The devil is in the data' was the topic of the first tweet chat hosted by an HFMA network, the Healthcare Costing for Value Institute, with WeFinance. It was open to members and non-members and facilitated by Ben Roberts, Bolton NHS FT, and Gayle Wells, Mersey Care NHS FT. Go to #WeFinance on Twitter to find out what was said during the chat.

Member benefits

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

Branch focus

My HFMA

Wales
Dramatic support

How often do finance professionals get to explore their hidden acting talent? As part of the personal impact courses run by the Welsh Branch in conjunction with the Royal Academy of Dramatic Art, members had a chance to get away from the spreadsheets and learn more about getting noticed on entering a room, how to come across with gravitas, kudos and confidence and tell their story in a compelling way.

This was one of the many training and networking opportunities in the branch's calendar, the highlight of which is the annual conference. The aim is to support its new motto: 'We are the community of healthcare finance colleagues who support and help each other with networking and development opportunities throughout our careers; and through that raise the profile of our profession as a whole.'

This year the theme of the conference was 'Step change'. The title pulled in the national *Step up* theme, recognising the changes facing the NHS finance function, and included taster mentoring and executive coaching sessions.

'The theme reflected the requirement for us to consider the step changes that have happened in our landscape; with a new Assembly government in place alongside the fallout of the referendum to leave the European Union,' said branch chair Huw Thomas (pictured).

Some 220 delegates from all over Wales came together to take part in a series of interactive workshops and hear from keynote speakers, including Dr Andrew Goodall, NHS Wales director general of health and social services; Jessica Blair from the Institute of Welsh Affairs, who spoke about the implications of the changes in the political landscape; Sir Muir Gray, director of Better Value Healthcare; and Anita Charlesworth, from the Health Foundation.

'The thing that stuck with me was the importance of us as a finance community to engage with the value agenda. As savings become more challenging, value is a far more engaging concept to discuss with clinicians, building on Wales' policy framework on prudent healthcare and the wellbeing of future generations,' said Mr Thomas.

• To get involved with your branch go to www.hfma.org.uk/our-networks/branches

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West Midlands clare.macleod@hfma.org.uk
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Appointments

Jon Sargeant (pictured) has become director of finance at Doncaster and Bassetlaw Hospitals NHS Foundation Trust. He was director of finance at Burton Hospitals NHS Foundation Trust and has more than 25 years of experience, working exclusively within the health service. Starting as a financial trainee at Heartlands Hospital in 1989, Mr Sargeant has held a number of board-level posts, most notably as director of finance at Epsom and St Helier University Hospitals NHS Trust. He led a number of reconfiguration projects at the London-based trust, before moving to Burton Hospitals NHS FT in 2013.

Dorset Healthcare University NHS Foundation Trust has appointed **Matthew Metcalfe** director of finance and strategic development. He was previously interim director of finance at Homerton University Hospital NHS Trust. Jackie Chai has been appointed deputy director of finance at the Dorset foundation trust. She was previously associate director of finance and performance management at the organisation and acted as director of finance before Mr Metcalfe was appointed.

Stuart Diggles (pictured) has taken on the role of interim director of finance at Gloucestershire Hospitals NHS Foundation Trust. His previous roles include interim director of finance at Barnsley Hospital NHS Foundation Trust. The appointment follows the departure of Helen Simpson.

Ailsa Bawn, deputy director of finance at North Middlesex University Hospital NHS Trust, has taken the role of acting director of finance at the organisation. The move follows the departure of Martin Armstrong who was appointed in 2009.

Herts Valleys Clinical Commissioning Group has named **Caroline Hall** chief finance officer, succeeding **Alan Warren**, who has retired after over 40 years in the NHS. Mr Warren had been a board-level director for more than 20 years.

NHS Improvement has appointed **Simon Worthington** (pictured) financial improvement director for Maidstone and Tunbridge Wells NHS Trust. He will be the trust's primary day-to-day contact for special measures. He will oversee, on behalf of NHS Improvement, the actions the trust is taking to develop its financial recovery plan and reduce its financial deficit. Mr Worthington's role is part time and he'll continue to be deputy chief executive and director of finance at Bolton NHS FT, where he supports a similar financial turnaround. He was the HFMA's Finance Director of the Year in 2015.

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

"There's an opportunity for us to do things differently; to think about how we get extra investment into the right places and to find new solutions to problems like the scarcity of capital funding"
Steve Wilson, Greater Manchester Health and Social Care Partnership

Wilson's devolution role

On the move

When Steve Wilson is asked why he applied for the job of leading the finance function in the ground-breaking Greater Manchester Health and Social Care Partnership, he simply responds: why wouldn't he want to be part of something so exciting happening in the NHS on his own doorstep?

'It's a fantastic opportunity to be part of something that's doing things differently and taking a population-based approach to the delivery of health and social care,' he says.

Mr Wilson has been appointed executive lead – finance and investment – at Greater Manchester Health and Social Care Partnership, moving from NHS England, where he was director of financial control.

'I am a Manchester resident and have worked on the patch before, so I have a strong local network. It's a great place to work and, having been part of some of the devolution work in my role at NHS England, it was something I really wanted to be part of.'

He adds that the 'ambition that's at the heart of sustainability and transformation plans is writ large in Manchester'. Health and social care organisations in Greater Manchester have a history of working together, giving it a head start on integration. But now it must take this to the next level, especially in taking a place-based approach to services, he says.

'In Greater Manchester, we have 10 localities and we are looking at each as a single place – social care, commissioners, providers as a totality, rather than focusing on the financial challenges of individual organisations.'

Mr Wilson believes providing financial leadership across the Greater Manchester area is one of his key challenges. A finance leadership group, drawing chief finance officers from across health and social care organisations, is helping to provide this.

He acknowledges he is on a steep learning curve regarding local authority finance, but representatives on the finance leadership group are helping him get up to speed.

Financial leadership will mean ensuring finance staff are ready to fulfil their central role in 'making things happen in Greater Manchester'. Its strategic plan, *Taking charge*, sets out a financial gap of £2bn by 2021 across health and social care. This hammers home the need to rethink how services are provided and to make the best use of the £450m of transformation funding devolved to Greater Manchester.

'There's an opportunity for us to do things differently; to think about how we get extra investment into the right places and to find new solutions to problems like the scarcity of capital funding. The key thing will be to have robust financial plans behind the strategic plan.'

As well as the job of bridging the financial gap, Mr Wilson is responsible for the estates function and for one of the partnership's five transformation themes. His team is focusing on standardising clinical support and back-office services.

It's a high-profile role, both within the NHS, where STPs will be following Greater Manchester's progress closely, and nationally, where the city region is a test bed for devolution. However, Mr Wilson does not see the learning as going in one direction. Though keen to share Greater Manchester's experience, he wants to hear best practice from across the country.

He is a staunch supporter of the HFMA and intends to continue his membership of the association's Policy and Research Committee and Commissioning Finance Faculty technical issues group.

'They are useful forums to update people on what's happening in Greater Manchester, but also to find out what's going on elsewhere in the country,' says Mr Wilson.

Yarwood becomes value maker SRO

Future focused finance

Claire Yarwood, director of finance at Tameside Hospital NHS Foundation Trust, is the new Future-Focused Finance senior responsible officer for value makers.

Having worked in the Greater Manchester health economy for 30 years, she has a passion for the development of finance staff skills.

On accepting the role, which she will perform alongside her Tameside post, she said: 'I am looking forward to working with the value makers, who champion and spread the message of Future-Focused Finance in their organisations and throughout their health communities. Their passion for making a difference is truly infectious.'

Mrs Yarwood believes the value maker role is key to spreading the FFF message of 'Making people count', ensuring NHS finance staff have access to the relevant skills, methods and opportunities to influence decision-making in support of the provision of high quality patient services.

In one of her first acts as SRO, she launched a value maker application process that allows individuals to apply at any time of the year. She also introduced a value maker charter outlining what is expected of value makers and how the role benefits the individual and their organisation.

A relaunch event will be held this month, at which Mrs Yarwood will meet new and established value makers and hear how FFF can improve the support it provides.

'I look forward to supporting value makers to develop in that role and to recruiting more value makers so we can achieve our vision of having at least one value maker in every NHS organisation,' she added.

If you would like to find out more about the value maker role and how you can get involved, please visit the website at **www.futurefocusedfinance.nhs.uk**

HFMA
AWARDS 2016

HFMA Awards 2016 shortlist announced!

Accounts Team of the Year

Leeds Teaching Hospitals NHS Trust
NHS Hull Clinical Commissioning Group
Salford Royal NHS Foundation Trust
Wrightington, Wigan and Leigh NHS Foundation Trust

Costing Award Sponsored by CACI

Cwm Taf University Health Board
North Staffordshire Combined Healthcare NHS Trust
North Tees and Hartlepool NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust

Deputy Finance Director of the Year

Aideen Tucker, Devon Partnership NHS Trust
Diane Morrison, Salford Royal NHS Foundation Trust
Sharon Murphy, Leicestershire Partnership NHS Trust
Sheila Stenson, Maidstone and Tunbridge Wells NHS Trust

Havelock Training Award

Bolton NHS Foundation Trust
East Kent Hospitals University NHS Foundation Trust
London Ambulance Service NHS Trust
London Skills Development Network
Stockport NHS Foundation Trust

Innovation Award Sponsored by Clares

Lancashire Teaching Hospitals NHS Foundation Trust
Midlands and Lancashire Commissioning Support Unit
NHS Bolton CCG / Bolton NHS Foundation Trust
Salford Royal NHS Foundation Trust

Finance Director of the Year Sponsored by hcr

Annette Walker, NHS Bolton Clinical Commissioning Group
Carl Usher, Midlands and Lancashire Commissioning Support Unit
Claire Skidmore, NHS Wolverhampton Clinical Commissioning Group
Paul Brickwood, NHS Knowsley, St Helens and Halton clinical commissioning groups

Governance Award

Lancashire Teaching Hospitals NHS Foundation Trust
NHS Bolton CCG / Bolton NHS Foundation Trust
Salford Royal NHS Foundation Trust
NHS Mid Essex Clinical Commissioning Group

Working with Finance – Clinician of the Year

Anwar Zaman, Nottingham University Hospitals NHS Trust
Claire Mason, Salford Royal NHS Foundation Trust
Deborah Sanders, Royal Free London NHS Foundation Trust
Tara Kearney, Salford Royal NHS Foundation Trust

FFF Award

Ben Roberts, Bolton NHS Foundation Trust
Beth Pidduck, Midlands and Lancashire Commissioning Support Unit
Mark Songhurst, Leeds Teaching Hospital NHS Trust

The winners will be announced at HFMA's annual conference in December.

For more information on booking onto the conference, please visit hfma.to/hfma2016

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

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