HEALTH SERVICE JOURNAL hsj.co.uk

HSJ FINANCE

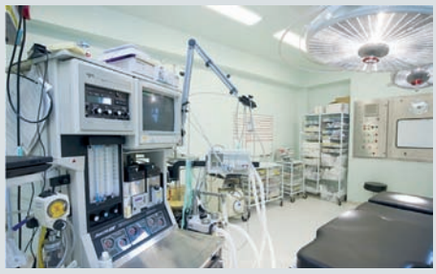
AN HSJ SUPPLEMENT/2 DECEMBER 2010

NO TIME LIKE THE PRESENT

WHY FINANCIAL SKILLS WILL BE IN HIGH DEMAND

CONTENTS

QUALITY



Successful service design has been shown to result from collaboration between clinical and financial staff so that the right arrangements can be put in place to achieve healthcare decisions

CONSORTIA

The emergence of GP commissioning groups as primary care trusts give way to consortia is a time for those with financial management expertise to consider their marketability. Page 4

OUTSOURCING

As the structure of the NHS changes, the opportunities for outsourced expertise will expand and financial services will be joined by a range of other functions. Page 7

INTERVIEW

The incoming and outgoing presidents of the Healthcare Financial Management Association are upbeat about the challenges facing the NHS – which can also be seen as opportunities. Page 8

Supplement editor
Alison Moore
Design Jennifer van Schoor

QUALITY

Understanding and shared decision making between clinicians and financial staff can help deliver a higher quality of service at lower cost, writes Ingrid Torjesen

TWO SIDES TO THE COIN

Great efforts have been made in recent years to encourage finance staff and clinicians to work more closely together – and for good reason.

"There is no point in managers and finance staff leading service redesign, and it is useless if the clinicians come along with a service redesign package that ignores the finance element," points out Audit Commission managing director health Andy McKeon. "The two clearly need to go together. It has to be the clinicians, who are actually going to deliver the service, leading it, but the clinicians need the right information and support and a collaborative approach with the finance staff."

Not only does a close working relationship between finance staff and clinicians help them understand each other, it also has practical benefits, Mr McKeon says. When clinicians hold the budget or have more influence over the money, they are able to do more with that money. When finance departments work more closely with clinicians and understand the clinical processes, they are able to orchestrate the finances by providing relevant figures and costing to help clinicians develop viable alternatives and make the right decisions about services. Then they can ensure that the right financial arrangements are in place for clinicians' decisions to be put into effect.

An excellent example of what a good relationship can achieve is the 2gether Foundation Trust for Gloucestershire, Mr McKeon says.

"They identified how they could make savings and they produced a completely redesigned service from this which was better for patients," he says.

Before the service reconfiguration, which won a Healthcare Financial Management Association efficiency award in 2008, there were three different commissioners of mental health and learning disability services in Gloucestershire, resulting in variable standards across the county.

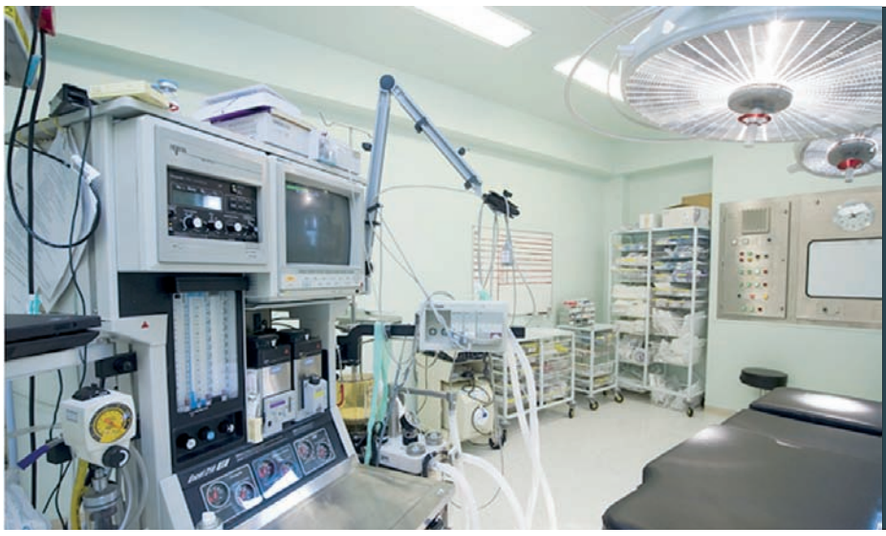
Andy McKeon, managing director health, Audit Commission

'It is useless if the clinicians come along with a service redesign package that ignores the finance element'

2gether director of finance and commerce Sandra Betney says: "We wanted to make sure we had an equitable service, make sure we complied with all the national guidelines and make ourselves more efficient at the same time."

Between 2006 and 2008, adult services were completely redesigned, with traditional community mental health teams replaced by a more proactive service. The changes were clinically led, with management accountants assigned to each strategic service unit, so they were involved with all the unit business, not just financial aspects.

Ms Betney says: "I think that makes a huge difference to their understanding when it comes to something like how services are designed. It is their knowledge and understanding of how things work that



The Liverpool Women's Foundation Trust Hewitt Centre for Reproductive Medicine

'The Hewitt Centre came up with a very creative public private partnership... and it is now a very impressive unit'

has enabled them to play their part. I don't think you can just parachute somebody in and say your job is to be the finance support on this project if they haven't earned their spurs with the clinicians from an adding value point of view."

The new service has increased crisis resolution face to face contacts by 86 per cent and early intervention face to face contacts by 337 per cent, while costing 2gether 8 per cent less than the old service.

In 2006 Liverpool Women's Foundation Trust's Hewitt Centre for Reproductive Medicine had a £0.2m trading deficit, but by thinking strategically the organisation turned this around into a £1.2m surplus the following year.

Mr McKeon says: "Clinicians in their fertility clinic developed a business plan with the help of the finance staff, which helped them to adopt a more entrepreneurial approach – the kind that may be needed in the new environment – which enabled them to expand their service, increase their income and become more efficient."

Bottom up costing

Director of finance Vanessa Harris explains that finance staff looked at the service line position and did a bottom up costing.

"They came up with a very creative public private partnership which has allowed the organisation to invest a considerable amount of money into the capital side and it is now a very impressive unit," she says.

A new state of the art facility opened in October 2010, and patient numbers have increased dramatically through a wider NHS catchment area and business being won from the private sector.

Ms Harris says: "We share the costs across the public and private sector and that allows us to have a bigger staff base in total, which allows people to take forward their specialist areas of expertise."

HFMA president Paul Assinder says: "It is important that finance staff get the message that what we are doing in the next two or three years isn't just saving £20bn; we have got to do that while improving quality."

It will also mean transforming entire patient pathways to make them leaner, not just tweaking what happens in individual organisations, and he believes finance staff's analytic skills and ability to think in system terms give them a unique skill that will be "absolutely vital".

"They think how one link in the chain relates to the next one – and that is really beneficial," he says.

Mr McKeon says the immediate challenges for finance staff are to increase their understanding of clinical processes, so that they can better consider how they are financed; to further develop service line reporting and patient level costings at most trusts; and to narrow the gap between the financial information available to commissioners and what they actually require in order to commission effectively.

While clinicians recognise the need to do things differently and save money they rarely talk the business language, says Mr Assinder.

"There is an opportunity for the finance profession to be the interface between the clinical world and the policy makers because we do speak that business language," he says. "Finance staff have got a professional legitimacy that clinicians recognise. Clinicians recognise the sort of professional pain you have to go through to get the qualification and I think sometimes we don't exploit that enough.

"I think we can get an audience with clinicians whereas other management disciplines sometimes can't." ●

THE NEWHAM QUALITY SAFETY AND EFFICIENCY PROGRAMME

Eighteen months ago Newham University Hospital Trust was struggling to achieve its financial improvement targets. Director of finance and investment Ian O'Connor believed that if there was a greater focus on quality, where procedures were done safely and correctly first time around, financial improvements would follow.

He managed to persuade the board that he and the nursing director should step out of their day to day responsibilities for three or four months to head up a small team who would act like internal management consultants by visiting various departments to understand the work they did.

The first target was the operating theatre. They found patients admitted through accident and emergency had to wait an unnecessarily long time for procedures. They worked on ways to shorten this, so that patients could be treated more quickly and hospital length of stay could be reduced.

In outpatients the team found "a quirk" – only 80 per cent of the slots were being booked.

"Because we had clinical people on the team we were able to say actually that doesn't make huge amounts of sense," Mr O'Connor said. "We spent quite a lot of time working out what would it mean [to] our throughput if we booked in 100 per cent or 95 per cent of them."

The trust had expected to have to spend £2-3m to increase capacity to push up activity and deliver the 18-weeks target, but after analysing and improving the outpatient booking system, that investment was shown not to be needed.

Cue cards were used to ask clinical staff: "What do you do well?", so the idea could be replicated elsewhere, and "What would you like to see done better?".

One problem reported by on-call staff was a difficulty finding beds. Yet when the team analysed bed availability, it found that there always seemed to be some, but in the wrong place. Certain specialties are being relocated to a surgical centre, which is separate to the main hospital, to release beds.

The Quality Safety and Efficiency concept has been so successful that, having saved the organisation around £5m so far, it has now replaced the cost improvement programme.

"When we go into the business planning round for 2011-12 one of the things we will be asking people is: 'What are your plans to improve quality?' We will not be asking: 'How will you deliver against a 4-5 per cent or 10 per cent efficiency target?', but literally saying: 'How will you improve the patient lot in 2011-12?' and then do some work around qualifying what the impact of that would be," he says.

COMING TO TERMS

GP commissioning groups are going to need financial management expertise, whether inhouse or outsourced, and the roles and openings are worth thinking about right now

When the last primary care trust closes its doors and switches off the lights on 31 March 2013, a revolution in the NHS will have been completed. But with all those powers over commissioning, GP consortia will also inherit financial obligations.

Exactly which obligations go to consortia and which to the NHS commissioning board is not yet clear, and may only become clear as existing PCT functions are split between different bodies.

But consortia are likely to be responsible for the bulk of NHS monies – with up to 70 per cent of the budget passing through their hands. And they will have a duty to balance their books, with a need for proper accounts and auditing.

That in itself means that consortia are likely to need a finance director – the government guidance stipulates a chief financial officer. But they will also have contracts with provider organisations, bills to pay and to send out, and future plans to fund.

Help from financial professionals will be vital in doing this – but that does not mean consortia will be reinventing PCT finance departments. The shape of the financial expertise they will need – and who will provide it – is still very much up in the air.

And that is unsettling for many finance professionals working in PCTs at the moment. They will increasingly face a difficult decision – should they hang on and hope for a job in the new structure or should they try to get out now?

Chair of the Healthcare Financial Management Association's accounting and standards committee David Bacon says: "Existing relationships will be key to determining whether individuals in PCTs at the moment will find jobs in the new structure. I think that if there are tensions at the moment these tensions will either carry on or will need to be addressed."

That may spell bad news for finance staff in areas where the GP body and PCTs are at loggerheads: these consortia may be far more likely to look outside existing PCT staff for finance specialists in an attempt to break the mould.

But where relations are more cordial and there is mutual respect, consortia may be open to the idea of recruiting from PCT ranks. The question is then: what jobs will be on offer and to what extent will even these consortia be looking to outsource some financial functions?

Consortia will be strapped for cash from the start. They will be looking for efficiencies – and outsourcing or shared services will look attractive. If there are a small number of big consortia, they may be able to afford a financial team of their own; with large numbers of small consortia, even a finance director may be shared.

David Bacon, chair of the accounting and standards committee, HFMA

'If there are tensions at the moment, these tensions will either carry on or will need to be addressed'

Jobs up for grabs

But while consortia will need to have a chief financial officer – whether individually or shared – everything else is up for grabs. At the moment, it appears that as long as consortia meet their statutory obligations, they are free to get financial expertise and systems from wherever they like.

Knowledge of how the financial system works in the NHS may not be widespread among GPs and it may be a struggle to get them to agree investment in the financial function. And there could be compelling reasons not to want a large inhouse team doing both financial and management accountancy.

Shane Gordon, chief executive of Colchester Practice-Based Commissioning Group and an NHS Alliance spokesman, says the financial squeeze will mean consortia should only be doing things themselves where they add value. This may mean they look outside for services which can be done at a distance without loss of quality – and where there may be economies of scale if they are done across a wider area.

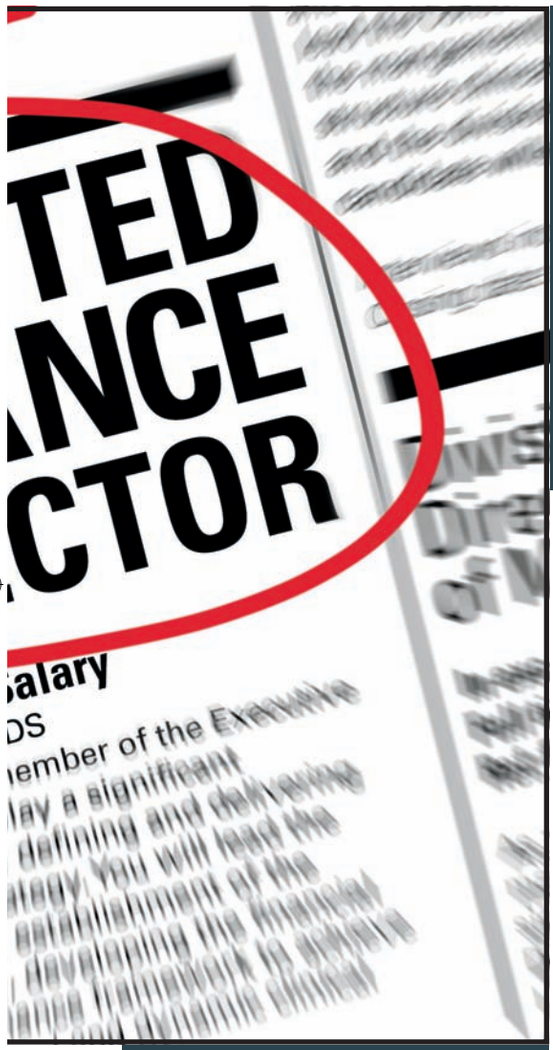
"We have to stick at doing only the stuff we add value to and look at putting out the other stuff," says Dr Gordon.

Transactional tasks are likely to be the first thing to go: PCTs and trusts across the country have been increasingly outsourcing this work to organisations such as NHS Shared Business Services or private companies. GP consortia – which won't have large payrolls without provider services – may have a lot less of this work than PCTs and little incentive to keep it inhouse.

Consultant and *HSJ* columnist Noel Plumridge points out that not only may the immediate cost of outsourcing be cheaper than employing staff inhouse, in the long term it may save money by taking people out of the public sector pension (as would outsourcing other finance functions to a private company).

Could this mean more radical measures – such as off shoring some work – might be considered? NHS Shared Business Services

WITH CONSORTIA



'It feels like quite a lonely job, compared with being a finance director of a trust'

Noel Plumridge, consultant and *HSJ* columnist

Shane Gordon, chief executive, Colchester Practice-Based Commissioning Group and NHS Alliance spokesman

'We are in a financial situation which is being underplayed by the media and politicians'

already carries out some work in India, with very strict data security.

"As long as you can assure yourself of the quality and robustness, I don't have any personal objection to doing it," says Dr Gordon. "We are in a financial situation which is being underplayed by the media and politicians. The seriousness of this means consortia should not be handcuffed over how they deliver these functions."

There will a financial accounting and treasury function for consortia – preparing "the books" and keeping the in-year records, and ensuring the organisation has enough money in the bank to meet the bills each month. Mr Plumridge suggests this might be a function best delivered inhouse.

There will be a need for some form of management accounting – a function which blurs to some extent with data analysis.

Dr Gordon argues that consortia will have an enormous need for high quality data which can be scrutinised and broken down. That will need to be done at a local level to ensure sensitivity and to encourage dialogue around the data and what it means.

"This is the lifeblood of what we are going to do," he says. "I don't think that we can do that at a great distance."

He suspects each consortium will need a small team of analysts to do this: some of the staff for this may be from a finance background, but not necessarily all. Crucial to this will be data about hospital admissions, procedures and appointments – the basis of what consortia will be asked to pay for and therefore important to get right.

This data is also likely to be an important tool in performance managing GP practices: differing rates of referrals and prescribing between practices are two areas where attention is likely to focus. Will finance staff play a part in presenting the results of this analysis to overspending practices? Will GPs at the top of consortia be happy to have these discussions with their peers?

The "enforcer" role may be a vital one – raising all practices to the standards of the best will help deliver the savings needed – but does not sound a particularly enjoyable one.

Accountability still vague

But are there risks in having such a small financial team? Mr Plumridge points out that consortia will be responsible for a massive amount of money – if there are as few as 100 consortia, then the average will be an astounding £800m. Even with 500 consortia – a number many consider not feasible on cost grounds – they would control an average of £160m. Accountability will be important but arrangements for this are pretty vague.

Working in a small team will be different from the experience of many finance staff.

"It feels like quite a lonely job, compared with being the finance director of a trust," says Mr Plumridge.

He adds that maintaining professional standards can be more difficult in smaller organisations. There will be questions about training, career progression, and mentoring and raising concerns. And how will practical issues such as the separation of powers (such as ordering and authorising payment, for example) be addressed in a smaller organisation?

Although the lack of other jobs is likely to mean that there will be plenty of applicants it may be that over time these jobs attract a different type of person from those working in a larger organisation. In many cases, their closest working relationships will be with GPs and they may have to accept working in professional isolation for much of the time.

More immediately, Mr Bacon says there is a lot to be done over the next 18 months to ensure the financial situation of PCTs is maintained and secured. GPs will increasingly need to be drawn into this, as they will inherit whatever state the PCT is in at the end of 2012-13. ●

PUSHING OUT THE BOUNDARIES

Changes to the structure of the NHS are likely to mean more input is opened up to outsourcers and financial support is likely to be joined by a raft of other services

Many areas of the NHS have been protected from the cold winds of outsourcing over the last decade. But this may no longer be so.

The changes to the structure of the NHS – including the abolition of primary care trusts and the advent of GP consortia – offer opportunities for outsourcing companies. Kingsley Manning, business development manager for health at support provider Tribal, said recently that "the general view is that this is not a trivial opportunity". Other outsourcing companies are also effusive about opportunities in the NHS, with many highlighting commissioning support to consortia, along with back office functions.

But much will depend on how many consortia are formed and how much they pool functions. Very small contracts may not be attractive to the big players.

ALAMY

Short term hiatus

"They are going to feel it's difficult because they don't like dealing with smaller and smaller bodies," says National Outsourcing Association chair Martyn Hart. The costs of establishing the contract may be the same as with bigger organisations but potential profits will be less. He believes there could be opportunities for smaller local firms in some areas – such as IT and finance – if consortia decide to go it alone.

However, in the short term there may be a hiatus as primary care trusts pass over the reins to consortia. Outsourcing company Capita has seen enquiries from PCTs fall off this year but is interested in offering services to GP consortia as they emerge. Healthcare division managing director Beverley Bryant believes some form of shared services will be important if they are to operate at such low management costs. But what is on offer from outsourcers could go far beyond finance, to include commissioning support, informatics and management development.

Trusts and new community service providers will also face pressure to contain management costs and will be looking for ways to reduce transactional costs through economies of scale.

But this enthusiasm has to be laced with caution; the public sector will be short of money and will be looking for significant savings if it outsources work.

Some organisations – such as NHS Shared Business Services – are achieving large savings through economies of scale. More than 30 per cent of NHS organisations work with NHS SBS – a joint venture between the Department of Health and Steria. It offers a raft of services, including invoice payment, payroll and employee benefit and lease management. But it is also interested in taking on family health services and in offering a best practice consultancy.

'What is on offer from outsourcers could go far beyond finance, to include management development'

So what does that amount to for an individual organisation? NHS SBS says it offers operational efficiencies and savings of between 20 and 40 per cent, and aims to save the NHS £250m over 10 years. As well as sites in the UK, it sends some work to India for processing – one of the few examples of off shoring in the NHS.

But organisations are looking for enormous savings; Ms Bryant says that outsourcing finance functions alone may not be a big enough package. Capita is developing a more radical scheme which would allow acute trusts to outsource a vast array of back office functions – from HR to managing outpatient appointments. The work involved would amount to tens of millions of pounds a year for large trusts.

This model is similar to what Capita does for some local authorities – where it offers care centre support, for example – and foundation trusts, where it handles membership.

"We are already talking to a number of trusts," says Ms Bryant. "It will give the big savings they are looking for. The only way this will succeed is if we do it in partnership with the hospitals and clinicians and they buy into the efficiencies you need to make."

Capita has already seen its NHS business grow rapidly in the last two years and now supplies services to more than 300 NHS organisations.

With some of the big US healthcare companies increasingly interested in the UK market, and numerous pressures on the health service to cut its management costs, it is unlikely to be alone in the battle for NHS business. ●

INTERVIEW

MANAGING TO FACE THE MUSIC

The incoming and outgoing presidents of the Healthcare Financial Management Association talk about fighting the gloom and supporting members in tough times

It is a tough time to work in NHS finance, with many unable to foresee what the future holds for them. But the message from the incoming president of the Healthcare Financial Management Association is not "we're doomed" but "don't panic".

Royal Devon and Exeter Foundation Trust finance and business development director Suzanne Tracey says the skills of financial management, governance and decision-making continue to be needed.

"There's a danger that people can start to get sidetracked by this level of uncertainty," she says. "The challenge for financial staff is almost to keep on with business as usual while also supporting the massive change we are going through."

The need to reduce costs would be there even if the radical reforms for NHS structure were not, she says.

New HFMA services

The HFMA has revised its services to members and put some of its reserves into a support service for finance staff, due to be launched next week. Ms Tracey describes this as a suite of services which will help members take control of their own careers.

This will include tailored support for those whose jobs are likely to change – or disappear – as the structural changes to primary care trusts, strategic health authorities and also the Audit Commission start to bite. Initiatives will include workshops, mentoring and help with CV writing and presentations.

Ms Tracey says the aim is to provide these services either free of charge or at a heavily subsidised rate. The HFMA is hoping for some money from the Department of Health to support the scheme but has also put a "reasonable amount" of its own reserves into the services, she says.

"It's a recognition the HFMA is there to service our members. We want to use the resources we have for their benefit."

Pilots have been running during November and services will be available more widely from the New Year.

Ms Tracey is hopeful some of the uncertainties for HFMA members will diminish as more details emerge of the reforms – although the HFMA will be trying to influence these details, a point also made by outgoing president Paul Assinder, who is finance director of the Dudley Group of Hospitals Foundation Trust.

He says: "Our job is to turn the policies of ministers into hard plans. We have to be clear about what it takes to achieve that. We have to be honest about what we can achieve and what the timescale to do that is, and what resources are needed.

For finance staff in PCTs, the future is particularly hard to predict. Outsourcing is certainly an option which many GP commissioning consortia may explore, but Ms Tracey suggests finance professionals within PCTs might look at setting up social enterprises to provide services to a number of GP consortia.

She points out: "We are still talking about the management of massive amounts of public money. That money will still need good financial management and robust governance and people will still need to be paid and invoices processed."

Familiar faces

Mr Assinder argues that PCT finance teams will be in a good position when GP consortia are established. They will be familiar faces to many GPs, they will have knowledge of NHS finance and they will speak the NHS language.

But their colleagues in hospital trusts also face their own challenges in coping with increased demand within limited financial resources. Here, the relationship between doctors and other healthcare professionals and managers is important.

"Finance professionals have a privileged position viz-a-viz clinicians," says Mr Assinder. "There is some mutual respect for accountancy qualifications. We empathise with each other because we have struggled through professional exams."

"The most successful organisations are those with strong partnerships between clinicians and managers," says Ms Tracey. "I hope the traditional view of us as bean counters is dead and buried. That is not what makes the job interesting – it is about being enablers."

Looking back on his year in office, Mr Assinder – president for the HFMA's 60th year – highlights meeting former president Bob Hindle, who attended the first ever HFMA meeting in 1949, the opportunities to learn about other similar organisations and the challenges they face. Whereas at one time the UK looked to the US, increasingly healthcare finance professionals in the US are interested in what the NHS is doing. Mr Assinder praises the fellowship, professionalism and good humour of his colleagues.

As he hands over the reins to Ms Tracey, those attributes will be needed as finance staff contemplate the task ahead. ●

Suzanne Tracey

Paul Assinder