stronger together

New HFMA president Sue Lorimer doesn't underestimate the challenge of transforming healthcare services, but she knows that organisations need to tackle the job together. She talks to Steve Brown

Building financial resilience within organisations and across health systems will require new models of care and new ways of working. According to Sue Lorimer, who became HFMA president at the end of 2014, NHS organisations and finance professionals can't do this alone. 'There is no other option,' she says. 'We need to work together.'

Ms Lorimer, business director north for the NHS Trust Development Authority, is so convinced about the need for partnership working that she has made it her theme for her year as president – 'Stronger together'.

With experience as a finance director in all the different provider types, Ms Lorimer understands the pressure facing provider colleagues. 'I'm not sure there has ever been this much pressure,' she says. 'I was a finance director in 2005/06, when the service last had major problems with deficits, but I don't recall the problems being of this magnitude.

'There wasn't the same pressure to maintain staffing levels and achieve access targets; you could react quicker and put a hold on vacancies or reduce capacity. There was also more ability for the centre to move money around. The problem is we have a whole combination of pressures now – the economic environment, five years of basically a 4% efficiency requirement (for providers) and a real focus on staffing levels.

'When nurse staffing is typically 25% of a trust's budget and there are fixed costs such as private finance initiative [PFI] unitary payments, that means trusts are trying to make their whole cost improvements on less than three-quarters of their budget. The pressure is massive.'

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Hit on all sides

She understands that provider finance directors feel 'hit on all sides' and accepts that commissioning finance directors 'don't feel any better', with budget reductions to create the better care fund and the costs of activity overtrading with providers – even at marginal rates.

And she is completely clear that the financial position is not the sole responsibility of finance professionals. Trust and clinical commissioning group boards have collective responsibility for living within their means and, more broadly, all clinicians and staff have a responsibility to be aware of the financial consequences of their decisions and actions. But she says that 'finance people have a tendency to feel a personal responsibility for the financial position'.

She believes part of the HFMA's success is that it brings finance managers together from all parts of the NHS. It is a finance family where members mix across provider and commissioner boundaries. As a professional group, it already knows that it is 'stronger together'.

'That helps us to focus on the bigger picture and see the challenges facing other parts of the system, rather than just our own immediate problems,' she says. And she believes this problem-sharing and big picture approach needs to be carried into local health economies. 'We are now working in a highly fragmented system and each part of that system has its own levers and objectives,' she says. 'It's not always obvious how we align those objectives to focus on the most important issue – high-quality care for patients that is financially sustainable.'

She is concerned that, while some health economies exhibit constructive relationships between commissioners and providers, in others too much time is spent 'fighting their own corners'. 'The system is spending money on staff to count and code activity and for other staff to check and challenge the counting and coding,' she says.

She acknowledges that proper coding by providers and getting paid the right amount for the treatment delivered is important, but if increasing income from coding is the core part of a provider's 'cost improvement plan', it is unlikely to help tackle the real requirement to improve overall efficiency. 'If you suck every penny out of your commissioner, where does that leave you?' she asks.

Similarly, commissioners challenging every line of activity and seeking to levy every penalty within the contract are missing the partnership point. Instead, there needs to be a balanced approach.

Referencing NHS Trust Development Authority finance director Bob Alexander's comments to the HFMA annual conference in December, she says NHS bodies have to avoid getting into an 'arms race' and stop playing games of 'who fails first'.

Her concern about over-zealous use of payment rules and penalties does not mean she is anti-tariff. 'If you don't have a tariff of some description, I'm not sure what else you put in its place. However, sticking rigidly to tariff does not support the need for healthcare to transform and there needs to be some generally accepted transitional arrangements when there are activity changes.'

She underlines the need for new payment approaches to support new


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ways of working, but believes the best health economies are already finding ways to do this. 'Partnership working is not the soft option. It's much easier to externalise all your problems and blame everything on the other side, whether you are a commissioner or a provider. It's much more difficult to find a joint solution you can sell within your own organisation.'

In some cases, this will mean providers giving up activities as alternative services are developed in different settings or at different points in the patient pathway. This runs against traditional growth strategies as a means of securing future organisational security.

Ms Lorimer acknowledges that this is complex and difficult but that finance has a big part to play in making it happen. It can lead the way on ensuring discussions are open, honest and mature and come up with win-win solutions on contracting.

> **"I like having the ability to contribute to whole health system transformation, as well as working with individual organisations"**

Staffing is perhaps the most immediate challenge facing the service, particularly the rising costs of agency staff. The safe staffing agenda – with its roots in the Francis inquiry and the Keogh review of trusts with high mortality rates – is central to the delivery of high-quality care. But trusts must meet these demands in an affordable and sustainable way.

Ms Lorimer recognises that providers are struggling to fill nursing and medical positions and are being forced to use more expensive bank and agency staff to populate shifts and rotas. She says the service needs to share good practice in this area and optimise its rostering. An HFMA roundtable discussion in conjunction with Allocate Software was held in January to examine opportunities to do just this (see next issue).

She also says there is an overwhelming need to apply sound, business-like approaches and business cases to all staffing decisions. If budgets have been set on the basis of safe staffing ratios and signed off by the board and nursing director, people need to be held to account for those budgets. 'Establishments need to be based on evidence and then managed to budget,' she says.

She also suggests there should be a financial pay-off to ensuring good staffing levels, in addition to the prime motivation of improving care. 'Better staffed wards should mean a lower tolerance to things like pressure ulcers and should mean shorter length of stay,' she says.

The good news is that there are examples of health economies where organisations are already collaborating and starting to see results. 'In my patch, for example, the Mid Yorkshire economy is working together to provide more services out of hospital and to reconfigure hospital services across sites. They plan to reduce inpatient beds and eradicate the longstanding deficit that, at times, appeared an intractable problem.'

'It is not easy and people don't always agree,' says Ms Lorimer. 'But they are talking about the important issues in a positive way and they share one plan for the economy.' The trick now is to expand this approach across the whole service. 'However hard it seems, working together is the only way we will make some of these difficult changes and ensure services meet patient needs in a sustainable way.'

A finance journey

With 30 years' health service experience to date, Sue Lorimer has stayed close to the frontline of patient care, working across the full range of NHS providers.

Brought up in Liverpool, she left school at 16 to take a job at the city's Royal Insurance, drawn by the attraction of 'earning some money' rather than continuing to study. After a summer break in Norfolk, she decided to return to college to do an HND in business studies and then started to look for a job in Norwich.

Admitting she was 'always attracted to accountancy', an application to become a regional finance trainee started her on her NHS finance career. Although she wasn't accepted on to the scheme, she was made aware of the availability of finance jobs at Great Yarmouth and Waveney Health Authority, where she could pursue an accountancy qualification on day release.

She grabbed the chance and subsequently moved to a junior accountant role in Norwich Health Authority, working with hospitals that would become the Norfolk and Norwich Healthcare NHS Trust.

Three years after joining the NHS, in 1988, she qualified with CIMA.

A year outside the NHS at East Anglia Water was enough to convince her that her future lay in the health service, and the first wave of NHS trusts in the early 1990s gave her the opportunity. Her appointment as finance director of Norfolk Ambulance Service NHS Trust, aged 33, marked a rapid rise through finance.

Missing home, she returned to Liverpool in 1993, working first for the Mersey Ambulance Service NHS Trust and then Chester and Halton Community NHS Trust. This was followed by six years at cancer specialist trust Clatterbridge on the Wirral and a further two at mental health trust Cheshire and Wirral Partnership NHS Trust, where she oversaw the building of a new hospital.

Attracted by the opportunities of working in a new foundation trust, she joined Liverpool Women's NHS Foundation Trust in 2005 before making the short journey to Alder Hey Children's NHS Foundation Trust in early 2009. Here she helped prepare for the trust's new part-privately financed hospital, due to open this year.

Having worked in every type of provider, it was perhaps natural she would look to put this experience to good use. She joined the NHS Trust Development Authority as business director for the north of England, attracted by the role's variety. 'I like having the ability to contribute to whole health system transformation, as well as working with individual organisations,' she says. 'It has certainly given me a broader perspective on what the challenges are in the system.'