healthcare finance

September 2022 | Healthcare Financial Management Association

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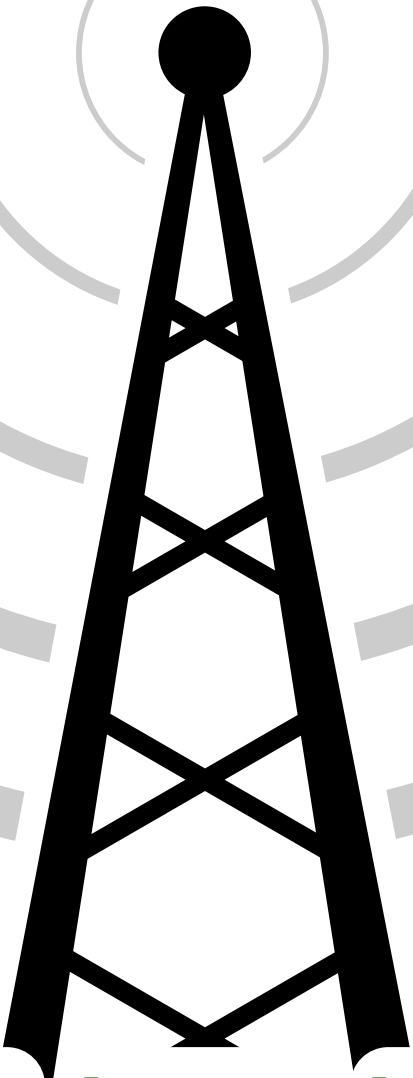
Remote monitoring

The growth of virtual wards



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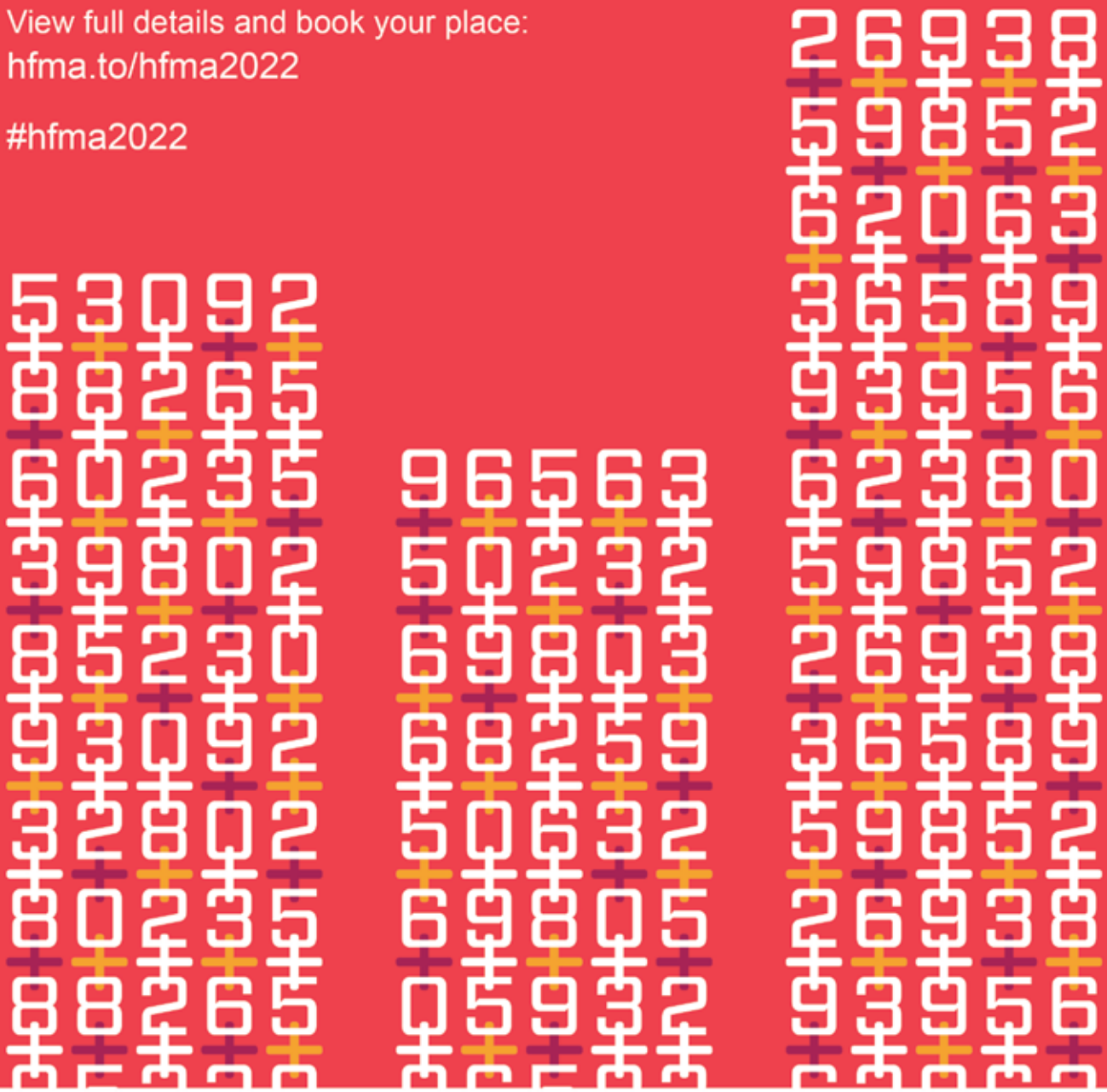

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Make Costing Matter

Realise the investment you've already made in your costing software

Every NHS trust is now mandated to take part in NHSI's national cost collection (NCC) and no doubt this year every NHS trust will submit a costing return. Some trusts may also produce quarterly costing reports.

However, for a depressing number of trusts producing the NCC return is where their costing journey will end. Costing is simply not being used in decision-making, whether that's in the finance department or at board level.

At LOGEX we think that using costing for decision-making purposes is a bit like trying to lose weight – it's clearly in everyone's top five priorities but people generally don't quite get around to it. Life just gets in the way.

Effectively trusts are spending money to produce information, but are not then acting on that information.

We get it, we see it year after year in trusts – tens of thousands of pounds spent on costing software and no value created.

We want to help which is why we are introducing our **Make Costing Matter** service.

This is a done-for-you service where we produce an actionable idea for you every month that we have hypothecated from your costing data. You can then present this idea to your board for immediate decision-making.

This idea will either save your trust money or it will improve patient care. Or we'll refund our fee.

Our Make Costing Matter service is being led by our colleague, Jason Dean.

Jason has recently re-joined our company after spending 13 years as the costing lead at Alder Hey Hospital.

In that time he won the HFMA costing award and impressed people both within his trust and at NHSi.

> Solving the problem highlighted by Jason saved winter this year"
>
> Mags Barnaby, Chief Operating Officer, Alder Hey Children's Hospital

> We are constantly using Alder Hey's patient-level costing information, and their governance processes, to show trusts what is possible with this critically important dataset"
>
> Winston Piddington, former NHSI Transformation Lead

Make Costing Matter is priced at £2,499 plus VAT per month. No tie in, cancel at any time. We use whatever costing software you have. We don't impact on your costing team. And if you feel what we've produced is not actionable we'll refund our fee. No quibble.

If you'd like to learn more how Jason could provide you with an actionable monthly insight (or your money back):

Email: jason.dean@logex.com

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News

UK PARLIAMENT

NHS urges Truss to tackle costs and staff shortages

By Seamus Ward

The new prime minister, Liz Truss (pictured), has an opportunity for a fresh start on the NHS, addressing short- and long-term issues, including funding, workforce, capital development and social care, NHS leaders have said.

Ms Truss said tackling the energy cost crisis is a priority. The scale of its impact on the NHS could be seen in a *British Medical Journal* report, which said trusts faced monthly energy costs this winter that are two or even three times higher than last year.

Most trusts contacted by the BMJ are expecting combined gas and electricity bills to double at least, although one trust has budgeted for a 214% increase in electricity and gas costs in 2022/23 – around £27m more than 2021/22.

In May, NHS England acknowledged the impact of rising inflation on the health service, and redirected some of its national budget to help the service cope with inflation that had arisen since planning assumptions were set in December 2021.

"Liz Truss has an opportunity to... take decisive action on the key challenges facing the NHS"
Saffron Cordery, NHS Providers

It allocated £1.5bn overall, with £485m earmarked for increased energy costs.

As *Healthcare Finance* went to press, the prime minister announced a two-year plan to cap domestic bills at an average of £2,500 a year. Public sector energy costs will also be limited at a rate equivalent to the domestic ceiling, initially for six months.

Saffron Cordery, interim chief executive of NHS Providers, said trusts would welcome the announcement. 'Urgent action was needed to address the soaring energy bills trusts and other public sector bodies are facing, and we are glad that a decision was finally made to protect public services from spiralling energy costs,' she said.

'However, trusts need more detail from the government about how the equivalent energy price guarantee will apply to them over the next six months.

'Without these measures, many trust leaders would have been hit by an exorbitant rise in energy costs, with no price cap available to them, with others being increasingly exposed as their current energy contracts expire.'

The domestic cap will provide some relief for staff and patients at a time of increasing financial hardship, she added.

Ms Truss named health as one of her three priorities, and new health and social care secretary Therese Coffey said she would focus on ABCD – ambulances, backlogs, care, and doctors and dentists. Later, Ms Coffey, who is also deputy prime minister, added that she was 'very conscious' of NHS staff shortages.

Ms Cordery said the NHS would expect Ms Truss to deliver on her commitment to make the health service one of her priorities.

'She now has an opportunity to lead a government that must take decisive action on the key challenges facing the NHS and social care, including severe staff shortages, treatment backlogs, NHS funding and social care reform, and support it to deliver,' Ms Cordery said.

NHS Providers pointed out that the impact of the rising energy costs was compounded by the 2022 pay award not being fully funded. Below-inflation pay awards, the cost of living crisis and ongoing concerns over pension taxation for senior staff had adversely affected NHS recruitment and retention. A fully funded long-term workforce plan was needed quickly.

The latest figures for the NHS in England show vacancies have risen to 132,000.

'Patients experience [workforce issues] daily,' Ms Cordery said. 'The elective waiting list now stands at 6.8 million alongside substantial care backlogs across mental health, primary care and community services. With severe pressures on ambulance services and urgent and emergency care, the winter ahead will be very challenging.'

Health initiatives must be underpinned by a long-term funded plan for social care, Ms Cordery said. During the Conservative leadership campaign, Ms Truss said she would transfer £10bn a year from the NHS to social care – funding currently generated by the health and social care levy, which she intends to scrap.

Launching the levy, the government has said it will move a greater proportion of the fund to social care over time, so it is unclear whether Ms Truss's statement is a continuation of government policy.

Ms Cordery said the government must meet its commitment to build 40 new hospitals by 2030, and take decisive action to improve the wider health estate. This will have an effect on patient safety and the productivity of services.

• *See Winter is coming, page 8*

HFMA statement: Queen Elizabeth II

The Healthcare Financial Management Association mourns the loss of Queen Elizabeth II (1926-2022).

The Queen was on the throne for virtually the whole of the HFMA's existence. In that time, through hundreds of royal visits and engagements she was steadfast in her support for the national health service. She opened many facilities and was patron of many health-related causes.

During the period of national mourning, the HFMA has limited its output, including delaying the receipt of this magazine, out of respect for her memory. We send our best wishes to her family and the millions of people grieving her loss both in the UK and around the world.

Mark Knight, HFMA chief executive

Quality link in payment system here to stay

By Steve Brown

NHS England remains committed to linking provider payments to quality, but recognises that the current mechanisms need further work.

An aligned payment and incentive (API) system was introduced in April, covering the vast majority of services commissioned from NHS providers. Under the new system, integrated care boards (or NHS England for many specialised services) agree a fixed payment with providers to deliver activity and objectives included within system-wide plans. This fixed payment includes funding to cover a target of 104% by value of 2019/20 elective activity.

In addition, a variable element further supports the elective recovery programme and adjusts the fixed payment depending on under- or over-performance compared with the 104% threshold.

There are further adjustments related to quality. First, commissioning bodies should include 1.25% of the value of each contract in the fixed payment based on delivery of agreed CQUIN (commissioning for quality and innovation) metrics. If providers fail to deliver the target, funding is withdrawn as part of the variable payment.

Similarly, the fixed payment should include funding to reflect the expected performance under the best practice tariff (BPT) scheme. If the volume of activity meeting BPT criteria differs from the expectation, then the fixed payment is reduced or increased based on the difference between the relevant BPT and the published unit prices.

Rob Unsworth, NHS England head of payment policy, said the service had largely welcomed the move to using a fixed payment to cover the majority of funding for providers.

With the fixed payment intended to reflect a realistic local cost of planned services, he said, the general view was that the system facilitated a population health approach and put the money into the right places.

However, he accepted there had been a more mixed response to the variable element.

This has been evident in the various engagement sessions the national body has undertaken around the new payment system. But it is also the focus for 30 formal variation requests from integrated care systems, predecessor clinical commissioning groups or NHS England specialised commissioning teams.

Some of these variation requests were looking to disapply API altogether, with systems that had already adopted local risk share arrangements seeing this as a backwards step towards a payment by results-style approach.

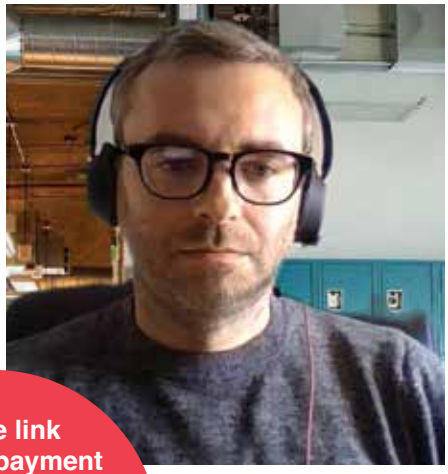
However, the bulk of the requests relate to the quality-related aspects of the variable payment.

Some argue that the value of the CQUIN payment (which reduced from 2.5% to 1.25% for 2019/20) is low, with the costs of compliance outstripping the rewards. Others argue that local quality priorities differ from those covered by the national CQUIN scheme.

There are similar arguments against the use of the 21 BPTs, which link enhanced payments to best practice care processes and are only relevant to acute providers. There is also a recognition that providers need to set up local data flows to monitor and report on achievement of BPTs.

Systems submitting variation requests would prefer to roll previous CQUIN and BPT payments into the fixed element and simply ignore any in-year transactions.

Mr Unsworth said NHS England had 'not quite got it right yet' on CQUIN and BPTs. 'But we retain the view that some link between payment and quality indicators that we think are valuable nationally is important, at least in the initial stages of the API model,' he said.



"Some link between payment and quality indicators is important, at least in the initial stages of the API model"
Rob Unsworth, NHS England

In part, this helps to mitigate any concern that 'block' contracts could lead to a reduction in quality as systems look to stay within budget.

In future, this might lead to a more detailed process around agreeing the level of BPT payment included in the fixed element, but dropping the in-year transactions. This could fit well with the planning cycle, with systems agreeing up front the investment and steps needed to deliver on prescribed quality goals.

The assessment of variation requests was ongoing as *Healthcare Finance* went to press, but is likely to be brought to a head after the summer, particularly as elective recovery fund adjustments are expected to start flowing from the third quarter of the year.

NHS England is continuing to engage on its proposals for the payment system in future years. Although formal consultation will take place in the autumn, the national body has already suggested that the payment scheme rules could be set for two years rather than one. There is an expectation that the variable element related to elective activity would continue to operate in a similar way.

However, NHS England is considering a possible move to using a 100% variable rate, meaning activity over or under whatever threshold is set would be paid or withdrawn at 100% of national unit prices, rather than the current 75% rate.

It is also considering the implications of removing the £30m threshold for contracts that cross system boundaries. While API applies to all arrangements between NHS organisations within a system, only system-to-system contracts above the £30m value are currently subject to API rules.

Quality links

The CQUIN (commissioning for quality and innovation) scheme was reinstated this year having been suspended for two years during the pandemic. The scheme aims to provide a financial incentive for providers to deliver quality improvement goals – with achievement of the targets collectively worth 1.25% of the fixed element of contract value under the aligned payment and incentive scheme. Different metrics have been published for services commissioned by integrated care boards and NHS England commissioned specialised services. Commissioners and providers are recommended to include no more than five indicators within a CQUIN scheme, with the financial value of each indicator equally weighted.

Audit Wales finds mixed picture for health boards

By Seamus Ward

The annual audit of the Welsh NHS has found positive and negative developments, with overall finances remaining largely unaffected by significant demand, but three of the seven health boards failing their financial duty to break-even.

Auditor general Adrian Crompton (pictured) said the position on break-even had improved. Cardiff and Vale University Health Board, which had been in breach of the duty in previous three-year periods, met the target of breaking even between 2019/20 and 2021/22.

Betsi Cadwaladr, Swansea Bay and Hywel Dda university health boards failed to meet their break-even duty. Betsi Cadwaladr University Health Board has returned balanced positions in 2020/21 and 2021/22, with the help of significant Welsh government support.

However, the auditor general qualified his regularity opinion on the board's 2021/22 accounts because of the failure to break-even over three years, and because it incurred irregular expenditure by complying with a ministerial direction to fund clinicians' pension tax liabilities.

All health bodies, except the Welsh Ambulance Services NHS Trust, Health Education and Improvement Wales and Digital Health Care Wales, received a qualified opinion on the regularity of expenditure as a result of the ministerial direction.

Mr Crompton also issued a qualified true and fair opinion on Betsi Cadwaladr's accounts because he could not obtain sufficient evidence that some figures were accurately stated and accounted for in the correct accounting period.

Health and social services minister Eluned Morgan said: 'I am pleased at the progress made by Cardiff and Vale University Health Board in returning to in-year financial balance.

'The health board has met its three-year break-even duty for the first time since the implementation of the 2014 *NHS Finance (Wales) Act*. As announced by the former health minister, any historical deficits incurred will no longer be repayable.'

Overall, health boards delivered 121% of planned savings (nearly £115m) in 2021/22. However, a greater proportion of one-off savings were delivered than in recent years – 49% in 2021/22 compared with 32% in 2020/21.

The auditors said the NHS in Wales had received an unprecedented increase in funding in 2020/21 (a 14.3% real terms increase) to help the service cope with the Covid pandemic.

This was followed by a rise of £0.2bn in 2021/22 (2% in real terms). But despite

significant demand pressure due to Covid and backlog waiting lists, the in-year deficit across NHS Wales remained static at £47.4m compared with £47.9m in 2020/21. And the three-year cumulative overspend fell from £233m to £184m in 2021/22.

Mr Crompton said: 'NHS bodies have faced the challenge of using that money to both respond to immediate service pressures and to also start to recover and reshape services to tackle backlogs and new patterns of demand.

'The focus on recovery and remodelling must continue into the current year and beyond, but our data points to challenges with the workforce, as evidenced by a growing expenditure on agency staffing, and a need to develop a more strategic approach to service transformation.

'As the peak of additional Covid funding subsides, NHS bodies will need to use the reinstated medium-term planning process to set out a financially sustainable path to service recovery and modernisation.'

Review raises doubts over major health projects

The annual review of major government projects has flagged serious issues with some large Department of Health and Social Care programmes, including the new hospitals initiative.

The report, by the government's Infrastructure and Projects Authority (IPA), evaluates a project's likelihood of achieving its objectives on time and to budget.

Though the position on the programme to build 48 new hospitals by the end of the decade has improved, there are major issues. The IPA rated the programme amber after a red/amber rating last year (successful delivery in doubt).

The amber rating means successful delivery appears feasible, but significant issues require management attention. The category definition adds that issues appear resolvable and, if addressed promptly, should not present a cost or schedule overrun.

The assessment came after an NHS Providers survey of trusts involved in the new hospital programme warned that delays were pushing up costs. Half of trust leaders doubt they have enough funding to deliver their projects; almost two-fifths said schemes were behind schedule. Almost all trusts called on the government to confirm the funding for the programme beyond the current spending review period.

Interim chief executive of NHS Providers Saffron Cordery said: 'Trust leaders are deeply frustrated the benefits they expected to be able to deliver for patients and their communities are increasingly in doubt.'

The National Audit Office is to carry out a value-for-money review of the programme.

The assessment of the integrated single financial environment (ISFE) procurement was also amber, but it was red last year (successful delivery appears unachievable). The ISFE is a managed service that includes a financial and accounting system.

Around two years ago, the NHS in England explored the feasibility of procuring a combined ISFE and HR/payroll system, but this has been dropped in favour of separate procurements.

In August, the NHS Business Services Authority tendered for a £1.7bn workforce system including payroll, learning, talent management, total reward statements and workforce reporting. It is expected the workforce system will be implemented in August 2024.

The ISFE contract, provided by NHS Shared Business Services, was due to end in 2021 but was extended to 31 March 2024 to give time to procure a replacement.

News review

Seamus Ward looks at recent developments in healthcare finance

The NHS is facing another difficult winter, with overheads including energy bills on the rise, the need to make further in-roads into the waiting list backlog, the unknown quantity of Covid and the potential impact of another wave on services. The familiar problem of a shortfall in staff – and its associated costs in terms of temporary staff and potential reductions in capacity – will continue to frustrate efforts to provide the best possible service to patients.

There were signs the workforce situation was improving at the end of the previous quarter. Figures for the final quarter of the 2021/22 financial year showed a fall in full-time equivalent (FTE) vacancies to around 105,000 – although this could prove to be a blip. The latest data release from NHS Digital said overall NHS vacancies in England increased to more than 132,000 FTEs in the first quarter of 2022/23. Vacancies increased in all regions, and stand at 9.7% of the NHS workforce. The nursing vacancy rate is 11.8% of the total nursing workforce, and there are now nearly 47,000 nurse vacancies across England. Medical vacancies also climbed to more than 10,500.

MPs believe the NHS could boost staff numbers by extending flexible working arrangements to all staff in the next 12 months. This would give staff the same control over their working lives as temporary workers. In a report on workforce, the Commons Health and Social Care Committee said these flexibilities would help retain substantive workers, allowing them to choose working hours that better suited their lifestyles and responsibilities. It also called for a ban on newly qualified doctors taking full-time locum posts for their first two years, while all temporary staff should be given access to NHS training to improve their skills. With a wider skill set, temporary staff would be able to take on shifts previously unavailable to them due to lack of qualifications. The report also said the pension tax arrangements – said to be forcing senior doctors to refuse additional shifts, reduce their number of sessions or even consider retirement – were a 'national scandal'.

Staffing will be key to executing the NHS winter plan, which was revealed in August. It asks the NHS to increase capacity by the equivalent of at least 7,000 beds through a mix of new physical beds, virtual wards (see page 27) and improvements elsewhere in the pathway. Capacity will also be increased outside acute trusts. Accountability has been clarified, with integrated care boards responsible for initial problem-solving if providers fail to deliver their role in local plans, with intervention from NHS England regional teams as required. System performance will be assessed via six metrics – 111 call abandonment; mean 999 call answering times; category 2 ambulance response times; average hours lost to ambulance handover delays per day; acute type 1 bed occupancy; and the percentage of beds occupied by patients who no longer meet the criteria to reside.

The rising cost of living will affect the wider population, NHS leaders in England, Wales and Northern Ireland warned. The NHS Confederation said the increase in energy costs will drive more families into poverty, potentially leading to a public health emergency and increasing pressure on the NHS as more people fall sick. Deaths associated with cold homes – estimated at 10,000 a year – could rise. And increased demand for NHS services would

The news in quotes

'Nursing staff are burnt out and simply not valued by their employers and government. Ministers choosing to hold their pay well below inflation in a cost of living crisis is making more reconsider their future.'
Nurses must be paid more to improve recruitment and retention, says RCN general secretary and chief executive Pat Cullen

'Unless urgent action is taken by government, this will leave an indelible scar on local communities and cause a public health emergency.'
The NHS Confederation is in no doubt that the cost of living crisis will have a serious impact on health

'There is a clear benefit in reducing energy use and increasing efficiency in everything we do. To achieve the transformational change that is necessary, we need to establish a culture where resources are safeguarded and used responsibly.'
Scottish health secretary Humza Yousaf on plans for NHS eco-sustainability

'We now face the greatest workforce crisis in history in the NHS and in social care, with still no idea of the number of additional doctors, nurses and other professionals we actually need. This must be a top priority for the new prime minister.'
Commons Health and Social Care Committee chair Jeremy Hunt urges the new administration to address health and social care staffing shortfalls

SHUTTERSTOCK

The NHS Confederation said increased demand could strike just as the service faces the most difficult winter on record

strike just as the service faces what is likely to be the most difficult winter on record, the confederation added.

Regular asymptomatic Covid testing in England has been paused, including in hospitals and care homes. However, testing for individuals with symptoms, such as staff and immunocompromised patients, will continue. Asymptomatic testing will also continue for patients transferring from hospitals and the community into care homes and hospices. In Northern Ireland, free lateral flow tests (LFTs) are now limited to those eligible for Covid treatments and those working in health and social care. Though those with Covid symptoms are no longer advised to take an LFT, the Department of Health said it was essential they minimise contact with others.

The Welsh government is consulting on changes to legislation on social care and continuing NHS healthcare. The proposed changes would eliminate profit from the care of looked-after children, with an initial focus on the private provision of residential care, alongside independent sector foster care. Further proposals would enable access to direct payments for adults eligible for continuing NHS healthcare. Responses are requested by 7 November.

The new NHS Scotland five-year sustainability strategy targets five areas: buildings and land; travel; goods and services; care; and communities. The strategy is part of its aim to be a net-zero health service by 2040. It is estimated 80% of the nation's global climate emissions are linked to the production, consumption and waste of products and resources, so the strategy sets out plans to create a circular economy – extracting less and reusing more. In the goods and services theme, this will include phasing out use of the most damaging plastics and taking whole-life costs into account when grading tenders.

According to the Commons Public Accounts Committee, it is impossible to have confidence that the contracts awarded to Randox Laboratories for Covid testing and goods were awarded properly. In a report, the committee of MPs said there was 'woefully inadequate' record-keeping and a failure to report ministers' meetings with external parties or deal with potential conflicts of interest. Gaps in the audit trail made it impossible for the National Audit Office to provide positive assurance on the contracts in the normal manner. However, the company insisted it had provided value for money, adding the PAC report was flawed and was the subject of a legal complaint.

A record 77% of claims were resolved without court proceedings in 2021/22, NHS Resolution said. Its 2021/22 annual report and accounts said that the move away from court cases continued a year-on-year reduction in clinical negligence proceedings over the past five years and is consistent with its strategy. The number of resolved disputes increased, as has the value of claims settled – £2.5bn in 2021/22 compared with £2.3bn in 2020/21. Provisions increased from £85.2bn to £128.6bn, with more than £42bn of this uplift resulting from a change in the Treasury's long-term discount rates.

from the hfma

The new structures in England mean organisations are working together as whole systems to improve services to patients, says Paul Brown, Staffordshire and Stoke-on-Trent Integrated Care Board chief finance officer. But changes in culture and attitude will also be needed to deliver success. In a blog on the HFMA website, he says that as well as working collaboratively, organisations will share risk and design services across patient pathways. Integrated care board staff will need new skills and to develop new relationships.

Good Governance Institute senior consultant Joanna Watson says system working will mean changes in risk management for all NHS bodies working in integrated care systems, not just ICBs. System risk management must be put in place, with partners coming together to resolve issues. But it should be recognised that risks in one organisation could affect others in the local system, and may impact differentially. And maintaining board focus on key risks will be part of internal audit's role as system working develops, says Louise Cobain, MIAA executive director of assurance.

Other blogs over summer looked at costing. HFMA policy and research manager and costing lead Hayley Ringrose, for example, argues costing teams can do more to support transformation, but need time and support. And Jade Ackers, NHS England transformation programme director (digital productivity), describes three areas where the NHS can free up capacity and release time to care.

See www.hfma.org.uk/news/blogs

Comment

September 2022

Common challenges

Workforce remains a major challenge as the NHS looks to reduce waiting lists

It was my pleasure to represent the association at the US HFMA national conference in Denver in late June (pictured). I found it both educational and reassuring.

It is clear that the NHS operates a very different model to the American system. But we face the same challenges as we look to establish a stable and sustainable future.

Health leaders in the UK are faced with the challenge of maintaining our contract with the public. This means delivering healthcare freely at the point of need through the constrained universal state-funded system.

And this is in the context of needs having increased in recent years and inequalities exposed.

At the same time, our colleagues in the US face the challenge of reframing their system more around population health, moving away from the fee-for-service approach that has historically been the service's main source of revenue.

There is a lot of common ground that will need to be covered as the two services strive to achieve their goals. Both are looking to enhance integration and collaboration in service delivery and to transform care through digital technologies.

Developments in digital medicine, genomics, artificial intelligence and robotics have a huge potential to transform the delivery of healthcare.

I am delighted that the HFMA has been delivering a programme of work to increase awareness among NHS finance staff about digital healthcare technologies.

The aim is to enable finance teams to take an active role in supporting the use of these technologies to drive value and efficiency.

In July, the government announced the NHS pay settlement for 2022/23. In England, Wales and Northern Ireland, the £1,400 increase for agenda for change staff equates to a different percentage rise

HFMA president Owen Harkin

Winter is coming

With winter approaching, the government's new leadership team has urgent decisions to take on health and social care

Healthcare Finance editor Steve Brown

It is unfair to expect major new ideas or solutions to current NHS challenges to be announced in the first days of a new government. It is perhaps enough at this stage to acknowledge that new prime minister Liz Truss has at least set the NHS as one of her top three priorities.

No-one could argue with the to-do list set by new health and social care secretary Therese Coffey (pictured) – her slightly trite ABCD of ambulances, backlogs, care and doctors and dentists.

But the new government leadership team needs to quickly move beyond the simplistic and obvious if it is going to support an NHS that, according to the NHS Confederation, is in the 'most challenging state it has been in for decades'.

It may be early days for the new regime, but the Conservative government in general and its new leaders have in reality had plenty of thinking time to prepare a response.

The government – and the country – face a huge cost in paying for the much-trailed action on rising energy bills.

But the NHS will also need further funding both in the short and medium term. When has the NHS ever not needed more money?

The service faces immediate pressures that cannot be ignored. Some of these are in the form of its own direct energy costs. Some is the energy-cost induced inflation of goods and services. And some of it relates to other costs – the pay settlement that was not fully funded, for example.

The NHS Confederation estimates the service faces a real-terms cut in funding of between £4bn and £9.4bn, depending on

"The NHS operates a very different model to the American system. But we face the same challenges"

depending on banding.

But the pay review body said the pay settlement would increase the overall agenda for change pay bill by an average of 4.8%.

This settlement is, of course, significantly higher than the 3% anticipated when NHS budgets were set, with the result that the service is now required to make up the difference from existing budgets.

This will inevitably have an impact on the health service's ability to meet the needs of patients and government expectations. Given August's news that inflation had risen above 10% for the first time in 40 years, the NHS pay deal will feel to many like a real-terms pay cut.

While health and care staff are motivated by more than just pay, it is clear that this position will lead to unrest among staff, increasing the risk of further loss of staff to other sectors. It also increases the risk of industrial action as we approach what already promises to be an extremely challenging winter.

This challenge is, of course, further exacerbated in Northern Ireland given the lack of a functioning Assembly and executive to take the necessary funding decisions that will progress these issues.

While winter is always a busy period in the NHS, this year will be particularly challenging due to the sustained high demand for our services.

Reports suggest NHS emergency departments have had their busiest summer ever. This is already requiring the system to do everything possible to free up capacity to improve flow through hospitals, including improving timely discharge, strengthening social care and providing better support to community services.

These pressures are likely to further challenge our ability to meet the targets of the elective recovery programme, given the impact on workforce availability and the prevailing financial constraints across health and social care.

Contact the president on president@hfma.org.uk

which measure of inflation is used. This would be hard enough if the service was simply attempting to deliver the status quo. But, coming out of the Covid-19 pandemic, the service in fact faces major challenges, with some 6.8 million people now waiting for planned treatment.

Funding is also desperately needed for social care. Health and social care are inextricably linked, with insufficient social care capacity having a direct impact on the NHS in the form of delayed discharges and unnecessarily occupied beds.

The changes needed in social care are huge, including raising pay levels to make vital social care roles more attractive to existing and potential new care staff.

But the big decisions are not all about money and the expected emergency Budget in September. Workforce remains the stand-out issue across the whole health service.

Beyond the remaining threat of industrial action in response to this year's below-inflation pay deal, workforce will remain on the agenda for years, with solutions needing to be actioned now.

The NHS is currently carrying over 130,000 vacancies – although it is not clear that it could afford to fill all these positions. However, the consequence of those vacancies is under-staffing – heaping more pressure on already overworked staff – and overuse of expensive temporary staff solutions.

Given the time it takes to train doctors and nurses, the NHS needs to be planning now for its future requirements. And it needs to be doubling down on efforts to upskill existing staff and develop new roles to make best use of those staff. A long-term plan for workforce remains conspicuous by its absence.

Refreshing the whole estate – and the new hospital building programme – are also essential to delivering the right quantity and quality of care in the decades to come.

"Beyond the remaining threat of industrial action in response to this year's pay deal, workforce will remain on the agenda for years"

All of these are huge challenges. They will need considered, rather than knee-jerk, responses. But decisions also need to be taken quickly. Winter is coming. And although the service has already been experiencing winter-like demand, a flu season on top of any surge in Covid infections could place even more stress on services.

Restructurings are not the solution. The new system-based arrangement has to be given time to bed in. But perhaps most important will be a sense of realism.

There needs to be recognition of the resources the NHS needs to make progress and pragmatism about what can be achieved this year and next.

Inflection point

With the health service moving on from the pandemic, NHS Supply Chain is also looking to the future and how it can best serve its NHS customers, including mitigating rising costs and supporting cost improvements. Seamus Ward reports

SHUTTERSTOCK

Like the rest of the health service, the past two years have been difficult for NHS Supply Chain, with Covid-19 having a significant impact on its operation. But it is now looking to the immediate future, implementing a new strategy to meet its NHS customers' needs.

Colin McCready, chief finance officer of the NHS England-owned supplies and logistics organisation, believes it is time to review the direction of the business. 'Given the past two years, it's a really good time to treat this as a point of inflection and say: "Actually, what needs to change? How do we need to do things differently to deliver what our partners, our customers need from us going forward?"', he says.

As well as demand pressures, trusts must address backlog waiting lists, cope with inflation, and return to cost efficiency and productivity measures not seen since the beginning of the pandemic.

The new strategy will be key to addressing these pressures, as Supply Chain simplifies its processes and looks at what needs to change to deliver the needs of its partners and customers.

'Based on the key performance indicators, we are doing a good job around increasing our market share and delivering savings. That's really important, but the NHS has different priorities right now. The NHS and the world have changed, and we need to deliver a broader range of services and focus on what our customers need from us.

'We recognise that what we deliver is relatively simple, but we do it in a relatively quite complex way. We need to make ourselves easy to do business with. This is particularly important for customers because the more time they spend trying to work their way around our complexities, the less time they can devote to delivering frontline care.'

New market, new approach

Mr McCready adds that Supply Chain is planning for a more challenging market. 'We will go about things differently. It's not just about driving prices down, it's about looking for different solutions that will get better

Supplies support

With trusts seeking to exert more control over their spending in the wake of the pandemic, they will be offered new support on non-pay spend from NHS England's new central commercial function (CCF).

NHS England chief commercial officer Jacqui Rock (pictured) says the support will be underpinned by seven value-adding service offerings, which the CCF has developed with trust leaders, including chief finance officers and procurement leads.

The service offerings cover areas such as best practice technology and data, sustainability and innovation, and commercial strategies, including the use of category strategies – segmenting items into groups of similar types of products across the NHS, ensuring greater buying power, for example.

NHS providers' addressable spend on goods and services totals about £30bn, delivered by national-level NHS England and trust-level buying.

'It's really difficult to get efficiencies out of the supply chain when the NHS is spending billions of pounds in over 100 different ways,' Ms Rock says. 'This is where aspects of the CCF – for example, commercial strategies – will come into play. Trusts will still do the buying, but there will be collaboratively agreed category strategies in place, which will dictate how we buy and the routes to market. This will ensure we are all buying in a consistent way.'

Potential savings are significant. 'If the commercial and procurement community work towards the common objectives of the CCF, we could jointly expect to make a minimum of 5% reduction in the £30bn addressable spend over the next five years, which equates to approximately £1.5bn. This could go straight back into the NHS front line.

'By utilising category

outcomes. But we'll need to procure differently. We need to buy smart, we need to supply right, and we need to partner expertly.'

Data analysis will play a major role in the new Supply Chain operation, he continues.

'We collect a huge amount of data, but we don't extract enough value from it. We need to become much more data insight driven in our decision-making, in our interactions with the system, to help our customers to make better decisions, more informed decisions around what's likely to be happening and therefore where they can deliver savings, where they can do things differently.'

Tailoring its target operating model to deliver the new, broader, objectives will be the next step. Implementation is due to begin this autumn, with completion due by the end of 2025. The emphasis will be on simpler processes, collaboration and sharing information, as well as supporting trusts as they face the effects of inflation.

Streamlining priorities

Previously, Supply Chain had 11 category towers for goods and services, such as for infection control and wound care, large diagnostic capital equipment, and hotel services. These have been streamlined into eight categories, with three of these brought in-house, together with the expertise to buy the required products, in terms of quality and getting clinicians what they need.

'We're bringing in-house categories where we've got really strong market share, or we believe we're better placed to have the expertise and the knowledge in-house, and we can make efficiencies,' Mr McCready says. 'We are re-procuring the ones we want to outsource too.'

One of the three to be brought in-house – diagnostic and capital equipment – was moved in-house on 1 July, earlier than planned, to accelerate the implementation of the NHS Supply Chain operating model. This will enable greater control, to connect the activities around the sourcing of products with the needs of clinicians in this complex area, as well as improve opportunities to deliver more value to the NHS.

PPE role

Personal protective equipment (PPE) – which was set up as a standalone procurement function during the Covid-19 pandemic – will also be brought in-house.

Supply Chain is acting as agent for the Department of Health and Social Care on PPE until at least the end of the financial year. The Department owns the stock and, for now, PPE will remain free of charge. Distribution will continue to be based on the automatic replenishment model to acutes, with a portal for social and primary care.

E-commerce and the online catalogue must be simplified, making them 'as frictionless as possible', Mr McCready says.

'Any time spent at a trust level trying to navigate through our catalogue to buy the products they need is time wasted in terms of delivering healthcare. We need to automate as much as possible, use better inventory management, get better end-to-end visibility of what a trust has, so that some of that stuff can be ordered automatically without any human intervention.'

Logistics must become more agile, he adds, to support NHS at home,

strategies, the NHS will have the opportunity to leverage our collective buying power and shape the market.

'Category strategies will also open up opportunities for small and medium-sized enterprises. Our buying will allow for this critical innovative market to be able to bid for NHS spend, for innovation and longer-term relationships with suppliers.'

But will the initiative lead to a reduction in trust's flexibility to procure goods and services? Though some elements of the CCF's work are mandated – for example, governance and assurance – Ms Rock insists there will still be choice.

'This is about the NHS buying as a collective community with agreed routes to market, and flexibility and choice underpinned by a central service offering best practice and tools.'

The trusts will be part of those strategies. ''We are delivering the service offerings and strategies in partnership with the trusts. It's a central commercial function, but it's not centralised NHS buying.'

Ms Rock highlights how potential savings are being identified by bringing clinicians into the procurement process, examining clinical pathways.

Clinicians and procurement specialists are identifying opportunities for innovation and savings and eliminating wastage by reviewing products, their specification, price and how they are used. They are also seeing where price variation is unwarranted.

Technology, particularly to generate management information, will be a major part of the CCF's work. Atamis, a single source-to-contract platform being offered across the NHS, will help NHS organisations and the CCF to plan and undertake procurements consistently.

Ms Rock says: 'The insight it will give us collectively in terms

of our planned procurement activity and total contracted spend will be phenomenal.

'We are offering Atamis, at no cost, to everyone who buys in the NHS. Atamis will give us an accurate layout of the commercial landscape.

'This will give us a clear and transparent view of our commercial pipeline. The chief finance officers will want to see that data.

'We don't all buy in the same way. Trusts get different prices and different service level agreements for the same product or service. So, it's really going to be quite insightful when we combine this with visibility from the spend comparison service and the accounts payable data. This will allow us to understand which commercial categories we want to go after first, what's going to give us the biggest bang for our buck, and work together to ensure we enhance and reform the commercial landscape.'

Ms Rock adds: 'In trusts, most of the commercial procurement teams report to the finance function, so I want to see CFOs supporting the CCF ambition.

'Our digital and tech procurement will significantly accelerate digitally enabled care. The social value weighting will reduce health inequalities. We are working on reducing emissions, supplier innovation and reducing costs.

'These are all core offerings of the CCF and linked to better health and patient outcomes. This is why we are doing it.'

for example, by sending items out in smaller sizes. It could mean Supply Chain has more involvement in importing goods than in the past.

Mr McCready accepts that, in hindsight, Supply Chain has probably outsourced too much control and expertise over the past few years Bringing procurement of some goods and services back in-house will give it better control and agility, as well as supporting the move for greater visibility to inform better decision-making.

Value-based approach

Given the new focus on working more closely with NHS customers, greater transparency, streamlining processes and limiting rising costs, value-based procurement (VBP) will remain high in Supply Chain's collective thinking. This is about reducing total patient pathway costs, not just the cost of products.

'It's definitely required more so now than ever,' says Mr McCready. 'Cost savings aren't going to come from just squeezing suppliers on price. We need to think about this differently. It's just one of those things that you just need to really get stakeholder engagement on to make sure it really scales up quickly. But we are pursuing it, and it is something that our customers are really excited about.'

VBP is being tried out in nine sites in 2022/23, based around procurement of disposable infusion pumps, high-pressure needles and other items. Supply Chain is working with the National Institute for Health and Care Excellence and NHS England to understand which pathways to examine.

'We're also working to make sure that we've got quantifiable measures that we can use to say, "These are the savings that are going to deliver", so that we can help trusts with the short-term savings targets. And I think the best way we can do that is focus on productivity – the clear message from NHS at the HFMA summer conference was around increasing productivity.

'If we can give them tools and products that show something will increase productivity, and that it can be quantified, I think that will help get some of these things over the line a little bit quicker,' says Mr McCready.

Lengths of stay could be used as a standard measure of effectiveness, but this could be affected by many variables, including the ability of social, primary or community care to take patients well enough to leave hospital, he adds.

'There are dependencies that make it difficult. But I think when you look more holistically, when you look at productivity or capacity as a whole, then if you do enough VBP initiatives, you'll start to see savings coming through. You may not know which savings came from that, that and that, but on the whole you know you're delivering savings of X to the trust or to the system.'

Supply chain resilience is a global issue that the company must mitigate at local level.

'It's all about collaborating, sharing information, and working closely together so that we can predict where the challenges are coming. It's about working more closely with our suppliers to understand where they're having difficulties – if it's a manufacturing challenge or if it's a freight challenge, and how we can help.'

Cost increases

In some cases, mitigation might require an increase in costs. However, as Mr McCready explains: 'The key priority is to make sure that our trusts have the products they need to deliver the services they need when they need them.'

Supply Chain has established a resilience forum, where it meets

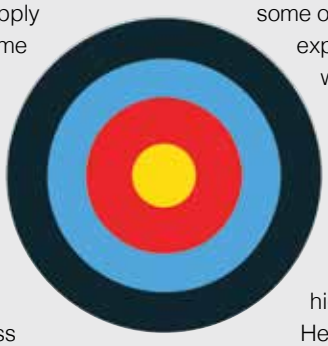
Savings target

Supply Chain was initially charged with delivering savings of £2.4bn to the NHS by the end of 2022/23 and to increase its market share to 80%. However, it has faced criticism over how it reported the savings made in the past.

Supply Chain reported savings from its category towers using the price at the start of the service providers' contract, compared with the current price.

For most, the baseline was May-July 2018. However, trusts report on a comparison of the current price with that one year earlier.

But these savings are now reported by Supply Chain in the same way that trusts report their savings.



NHS Supply Chain says it is on track to achieve the original business case target, based on the Treasury *Green book* savings methodology, of £2.4bn in the financial year 2022/23. However, it recognises that NHS trusts want it to focus on in-year, incremental revenue savings.

Mr McCready adds: 'We developed a self-serve portal in conjunction with nine pilot trusts that fits how they report on savings and gives them the key information they need. That was launched last year, and on that methodology, we've delivered over £90m of revenue savings last year.'

He is well aware that trusts are required to make challenging cost improvement programme (CIP) savings in 2022/23, and this year Supply Chain's savings target is over £100m. Frontline organisations in England have been given additional funding to help with rising inflation. Mr McCready says that finance directors will welcome the funding, but most will say a shortfall remains.

So, while revenue savings remain important, in the current environment mitigating price pressures is equally, if not more, important for its trust customers.

'We've given ourselves a target based on the price pressure we see coming through from suppliers – some of it known already, some of it we're expecting – where we can see that there could be well over £100m of price pressures, if not much higher than that.'

He says that some of the mitigation will be through seeking alternative products, negotiation with suppliers, or trying to delay higher prices.

'We've set ourselves a target to keep those price pressures down to below £50m, and around £40m is our stretch target for what we're trying to achieve.'

Supply Chain's market share in 2021/22 stood at 68% – its starting point had been 38% when the Department of Health and Social Care took over full responsibility for Supply Chain in 2019. Prior to this, it had been an outsourced contract with DHL The market share calculation excludes provision of PPE.

"The NHS and the world have changed, and we need to deliver a broader range of services"

Colin McCready, NHS Supply Chain

representatives from all regions every fortnight to share information on market insight – for example, on stock levels. This could lead to earlier intervention to manage demand or to seek alternatives.

Mr McCready believes this represents a significant change in the way Supply Chain works with trusts and NHS England. To support mitigation of potential shortages through finding alternative products, it has set up a clinically led forum to ensure that there is a list of clinically approved options.

'We do it once and then everybody has access to that information. So again, it's trying to collaborate across the piece, and doing things as efficiently as possible so that we don't have every single trust out there trying to find a suitable alternative for some product that is critical.'

The initiative has been well received, he says, and is an example of how Supply Chain is growing as an organisation.

Collaboration is also the watchword with the new NHS England central commercial function (*see Supplies support, page 10*). Led by chief commercial officer Jacqui Rock, the function will aim to drive a central commercial strategy, binding local, regional and national procurement communities, and leveraging the NHS collective buying power.

'We have good interaction with the commercial team,' Mr McCready says. 'Jacqui Rock sits on our board and we work closely with her. The central commercial function is going to be a really good initiative and we're going to play our part in that. It's going to help make sure that the whole piece is consistent and standardised, and delivers the most effective service.'

He continues: 'We will support it and feed into it, but we'll also share expertise with this central function, and also feed this out to regional and local level.

'I think it's critical that we all work together because we're all trying to deliver the same thing. It will clarify where responsibilities lie, and it will make it all more transparent and straightforward for everybody across the system to know how everything fits together.'

The NHS and the procurement landscape are changing, and NHS Supply Chain is primed to adapt.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Crest of a wave

Used properly, patient-level cost data should support service and financial improvement. One East Midlands trust has developed a programme that is doing just that, while gaining increasing support from its clinical specialties. Steve Brown reports

If you talk to NHS costing practitioners, they want to be working with clinical colleagues to use cost data to drive service and financial improvement – not filing more and more cost returns to feed central requirements. And that is exactly what is happening at Nottingham University Hospitals NHS Trust, where its WAVE programme has united clinicians, operational managers, service improvement and finance professionals to drive up value.

WAVE (working to achieve value and excellence) has been running for six years and is led by deputy programme director Richard Smith. Initially its focus was on cutting costs, but it has evolved over the years to look more at waste reduction and the development of efficient pathways.

And with this change has come a wave of enthusiasm from clinicians and service lines, who now see the programme as a way to tackle longstanding issues to improve experiences and outcomes for patients, while improving flow and increasing capacity.

Sophie Wilne is clinical director for the trust's Nottingham Children's Hospital, which runs 100 beds and cares for around 40,000 children each year. She says the programme is about working together and making the best use of people's time and skills.

'I'm also a full-time paediatric oncologist and all my heads of service at best probably have half a day to do their head of service roles,' she says. 'Some of the things we have achieved through the WAVE programme are things we've known intuitively make sense and we've been trying to do for years.

'But it's having the time to make a complete case. It's about having access to the data and putting it together in a way that the divisional leadership team and board can understand. And that is completely outside my skillset.'

Three phases

Specialties that sign up commit to a 17-week programme, which breaks into three distinct phases. The first phase – data cleansing – is led by the costing team and involves presenting all the available data back to a multidisciplinary team put forward by the specialty.

This will include patient-level cost, Getting It Right First Time and model health data, and effectively shows the speciality how the outside world sees its performance.

'It is an opportunity to challenge the data – if it doesn't look right, how do we need to change it?' says Scott Hodgson, the trust's head of clinical accounting and costing transformation.

It is also a chance for the specialty to tell the costing team the most useful way the data could be presented, leading to the development of bespoke service-specific dashboards.

In phase two – the sandpit, led by the service improvement leads in Mr Smith's team – the issues to be tackled are agreed and a long list of possible solutions developed.

Crucially, this seven-week section includes two 'confirm and challenge' sessions with the divisional leadership team to ensure it is on board and agrees with the direction of travel, and to prioritise the proposed solutions.

The end product is a shortlist of initiatives with a maximum of three or four. 'We know we can do three or four well,' says Mr Hodgson. However, the further priorities remain with the team for future implementation.

The final step, led by the trust programme management office (PMO), is focused on working up executionable plans of the prioritised projects. These are then presented at the third confirm and challenge session, this time with the executive team, to agree the plans and identify the resources needed to take them forward.

Mr Hodgson says the data cleanse can go one of two ways. The data presented leads the specialty team to the areas it wants to address. Or the specialty team highlights the areas where further data is needed to test out theories for changes it believes will transform performance. This was the case for the trust's

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"It is an opportunity to challenge the data – if it doesn't look right, how do we need to change it?"
Scott Hodgson

paediatric medicine specialty, which went through the WAVE programme at the end of 2021.

'We are the only children's hospital in the region that doesn't have a medical day care unit,' says Dr Wilne. 'We've needed it for a long time. But it costs money – you need to revamp an area and employ more staff.'

The pay-off is in quality of care, eliminating waits for a range of tests and treatments. But it can also take children out of inpatient beds – freeing up capacity and helping the trust with its elective recovery programme.

'This was a strong theory,' says Mr Hodgson. 'But what we were able to do was get a list of diagnosis codes that would be the kinds of cases going through a day case unit.

'And I built a dashboard showing where all the patients with these diagnosis codes were within the hospital – and they were effectively scattered across lots of different wards.

'We were then able to look at length of stay and the costs that could be avoided with same-day discharge, alongside reducing the risk associated with keeping children in hospital longer than necessary.'

The numbers were convincing, Mr Hodgson says, and this was only using an initial draft list of diagnoses. The full impact would be greater.

According to Mr Smith, previous business cases had failed to show how the clear patient benefits would ultimately cover the costs of implementation. 'When we first met the team, they were pessimistic any progress could be made,' he says. 'However, we love a challenge.'

The first issue to overcome was finding available space for the unit – made even more challenging by the Covid-19 pandemic and the need to find capacity to deal with the built-up backlogs. This involved some lateral thinking. Trust data showed that children who need an MRI under general anaesthetic had traditionally had all their pre-op assessment and preparation in the ambulatory care unit before being taken to the MRI scanner five floors away and then brought back to recover in ambulatory care.

Pathway change

So, a second project was initiated to revise the MRI pathway. This involved using a previously under-utilised dedicated play area located with a recently introduced interoperative MRI (iMRI) scanner. Everything from pre-op to recovery could be undertaken in one place now, reducing the time taken overall.

This pathway change reduced the need for the equivalent of 3.6 beds in the new medical day care unit, substantially reducing the space needed and associated costs, while enhancing patient satisfaction.

The third project supported by the WAVE programme was to improve the conversion rate of MRIs, where children needed a general anaesthetic. Benchmark data showed the level of general anaesthetic use in the trust was 36% higher than its peers.

'By the employment of an additional play specialist – funded by the trust's charity – we have significantly reduced the number of children requiring general anaesthesia before a scan,' says Mr Smith. This has significantly reduced clinical risk by cutting the time for a patient to have a scan from 32 weeks to six.

'Our conversion rate for general anaesthetic to awake scans is now really good,' says Dr Wilne. 'Our iMRI pathway parents like it. It's quick and efficient and it takes three or four children out of our ambulatory care unit each day, which means those spaces can be used for children needing day case surgery.'

Mr Smith says the changes are making real differences to people's lives, which is really rewarding. However, overall costs have also reduced as the need for general anaesthesia has also reduced. 'The savings will pay back the investment at least three times over,' he says.

The final proposal is for a six-chair medical day-case unit, smaller than originally proposed. Mr Smith says this will allow double the current medical activity due to demand and capacity planning, enabling the most efficient and effective use of the chairs throughout the day.

The trust has approved the capital spend needed for the project and it should be operational by the end of the year.

Dr Wilne says that in terms of revenue, the project will more than pay for itself with the growth in throughput. However, this is a bit more nuanced in a post payment by results world, where block contracts have effectively replaced activity-based payment.

Expanding on this, Mr Hodgson says the changes to the pathway will support the trust in meeting its elective activity targets (104% of 2019/20 levels). This will either help the trust avoid marginal rate repayments that kick in with underperformance or potentially increase elective recovery income if overall activity is above contracted levels.

'The money will come through eventually, although it may not be instant,' he adds.

Day case savings

Children that could be treated in a day case unit – often needing infusions or with food challenges – are currently admitted to one of the children's hospital's 10 inpatient wards. The proposal for the day-case unit involves capital spend of £524,000 and annual revenue costs of £338,000. However, the changes will not only improve patient experience and outcomes through reduced length of stay and shorter waits, but also lead to savings in the medical, surgical and MRI pathways.

The business case estimates the changes will free up surgical and medical beds, saving 14 beds a year – 11 for paediatric surgery and three for the children's hospital. This translates into a saving of £1.1m for paediatric surgery and nearly £300,000 for paediatric medicine. The reduced length of stay from having multiple children using the recliners each day will also contribute towards a 104% increase in the medical day-case procedures delivered, once predicted new demand is factored in.

The increase in activity will help to reduce referral to treatment times. There is also an expectation that the trust will be able to reduce costly waiting list initiatives. And the changes are expected to boost the capacity of ambulatory wards, which will increase the elective capacity for patients admitted for surgical day-case procedures, reducing the backlog of patients.

Risks will also reduce – for example, in terms of the potential harm to children from prolonged waiting for surgical procedures.

Dr Milne says some children could be in the unit for 20 minutes, while others could be there for three hours, depending on the test or treatment, which could include allergy or kidney function tests. Timetabling activity will be really important, she says, but she anticipates an average of three or four children in each chair every day, all of which takes pressure off inpatient beds.

The paediatric medicine programme has been quickly followed up by another programme for paediatric surgery. This was an opportunity to use the beds freed up by the new medical day care unit to increase surgical activity and bring waiting lists down.

Insourcing team

Here, the WAVE programme has been supporting the specialty to build a case to bring insourcing into the children's hospital to maximise its day case theatre activity.

Under insourcing, a trust subcontracts procedures to an outside body, which provides staff to deliver an end-to-end service using the trust's facilities. It is increasingly used as a way to get the best value out of NHS assets, where the NHS does not have the available staff to deliver the desired quantity of services itself. However, it is much more difficult for children's services as it requires staff with specific paediatric expertise.

In particular, the insourcing team was not able to supply sufficient paediatric nurses. So, the programme has helped to design a hybrid approach, where the trust supplies the nursing staff to support the broader theatre team provided by the insourcing service.

Insourcing offers a solution to a stretched paediatric workforce. 'One of our challenges has been the cancellation of lists, often at short notice, because of lack of availability predominantly of operating theatre practitioners (ODPs) and a little bit for paediatric anaesthesia staff,' says Dr Wilne. 'Doing this will maximise our efficiency.'

A typical arrangement for insourcing would be the insourcing team 'taking over' trust facilities at the weekend. But the use of trust nursing staff makes things far more complicated and sessions will actually run during the week.

'We've had to look at our starting position and current use of list space and work with the insourcing team to maximise what we can provide given the staffing constraints,' she adds. 'And WAVE has been very supportive of that.'

The case is not as straightforward to make as with the medical day care unit, in part because it is an expensive proposal.

'It is going to cost a lot of money,' says Dr Wilne, 'But we need to do it. And there's a huge quality issue here. Delayed procedures can have a massive developmental impact on children. You may need to do a procedure on a child with a cleft palette to support their speech development. If you miss that opportunity, that has an impact on the child for the rest of their life. Some interventions are time-critical.'

Clair Morley, deputy general manager for the children's hospital, says the use of trust nursing staff must fit with existing service delivery. It is proposed that insourcing is used on four concurrent days. But it is really about trying to work smarter. 'We will have two theatres running concurrently,' she says. 'The nursing staff are already down there looking after one theatre and these staff will also be available to support patients in the other theatre.'

Ms Morley says the proposal has been subject to a lot of scrutiny because it is a significant investment and will leave the specialty with a deficit.

Mr Hodgson says that while there has been support from senior decision-makers for the approach in the short term, they are keen to understand what a long-term solution might look like. 'They want to understand how we would bring this all back in-house at some point,' he says.

"We will have two theatres running concurrently... The aim is to keep our theatres running consistently"
Clair Morley

Ms Morley says she has been working with theatre and recovery teams to understand how this could be sustained going forward. However, the hope is that insourcing will have an immediate impact.

'The aim is to keep our theatres running consistently,' she says. 'Some 17% of our theatre lists have been taken down every week since October 2021 and that has a significant impact. That is just staff sickness and staff taking leave.'

The paediatric surgical WAVE has looked at other changes, including setting up an improved pre-operative service that will reduce surgical cancellations and adding to the number of surgical registrars to increase surgical activity.

Mr Hodgson says the programme is very popular with the trust leadership, who are keen to increase the number of WAVE programmes each year. Most importantly, it is popular with the specialties themselves.

One early success was with the trust's spinal surgery service – see the HFMA Healthcare Costing for Value Institute's case study, *Using PLICS to drive service improvement – Nottingham's WAVE programme*. And now the WAVE team has a waiting list of specialties wanting to be involved in a WAVE programme, rather than it being imposed on them.

In addition to this, the WAVE team has been asked to lead on the GIRFT high-volume, low-complexity initiative using the WAVE methodology and has already had some early successes using the WAVE approach.

Dr Wilne did not experience the earlier version of WAVE, but says it appeared to be more about scrutiny and finance and less about what the specialty wanted.

'The real transformation this time is that the clinical, managerial, service improvement and finance teams have come together,' she says. 'They asked about our problems and goals and how we are going to get there. They've not just thrown data at us and asked what we will do about it.

'Instead, we've taken the skills we all have in different areas and brought them together to make a case for things that have significantly, or will significantly, improve patient and family experiences. That's the change.'

For the costing team, and the WAVE team, this is the point of costing information: not producing it for the sake of it, but using it to inform service redesign and improvement.

Standard setters

Standardised finance systems could improve the quality of financial reporting across the NHS. Delegates at an HFMA roundtable, supported by NHS Shared Business Services, agreed that the time is right to make a change. Steve Brown reports

The Getting It Right First Time (GIRFT) programme has been addressing unwarranted variation in clinical care for years. Finance managers at a recent HFMA roundtable called for the same focus on standardisation to now be applied to NHS finance departments, systems and processes. And they identified the move to integrated care system working as the perfect opportunity to put this ambition into practice.

NHS finance is subject to some standardisation. Financial accounting standards mean there should be limited variation in year-end financial reporting. And clinical commissioning groups all used a common integrated single financial environment (ISFE) until they were abolished in July. This provided them with a common accounting platform with a single chart of accounts – and their successor integrated care boards continue using the same model.

However, outside the commissioning sector, NHS providers use a range of different systems and charts of account, often arguing that a unique local context demands flexibility that cannot be provided by common systems.

Attendees at the roundtable, held ahead of July's system start date, challenged this view and argued that the benefits of greater standardisation outweighed the downsides and challenges of implementation.

The roundtable was supported by NHS Shared Business Services, a joint venture between the Department of Health and Social Care and Sopra Steria. NHS SBS has delivered the ISFE since its inception in 2013 and will continue to do so until at least 2024. Arrangements beyond this date currently depend on a tender process.

The roundtable's first job was to agree what it meant by standardisation. Simon Currie, director of financial planning and delivery at NHS England, got the ball rolling. 'From a national perspective, when we collect data, it is really important that everybody interprets that in the same way,' he said. This wasn't always the case. 'This is about some basic aspects of our reporting – quite basic definitions of how we categorise things and how we add them together. But it also gets into some of the cleverer things that we might do, such as model hospital and NHS Rightcare.

'The more we can do in terms of having everybody report the same things in the same way, the better,' he said.

He recognised that the NHS was not 'one size fits all'. 'It is about striking a balance between people having the flexibility to do things differently locally because they face different circumstances and doing things differently just because that is the way they've always been done.'

HFMA ROUND TABLE

Adrian Snarr, then NHS England director of financial control, said the validity of local variation should be challenged. 'What we tend to do is to work with that local variation and then try to standardise it at a regional or national level, instead of going back to the root and standardising it at an organisational level,' he said.

'We've had a fixed chart of accounts for commissioners and, through lots of pain, we haven't flexed it. CCGs constantly came to us asking us to change the chart of accounts locally, but it doesn't work if you do that.'

Commissioning edge

This enabled the centre to get a good, consolidated position for the commissioning sector in a way that can't be produced across the provider sector because of the lack of standardisation. 'That really pays dividends in terms of consistency of reporting,' he said.

He encouraged providers to see the bigger picture as systems started to look at the possibility of system-wide standardisation.

At the time of the roundtable, Norfolk and Waveney Integrated Care

SHUTTERSTOCK

System was exploring the potential for standardisation of systems and reporting across all its component organisations.

Norfolk and Norwich University Hospitals NHS Foundation Trust deputy finance director Stephen Beeson said the aim was to drive efficiency and value. 'We do lots of things where we spend time trying to make it work and fit together so that we can report in a way that is useful,' he said. 'If we have got good systems, automation and standardised ways of doing and capturing things, then we should be able to use groupings and other mechanisms to do the individual bespoke bits of reporting that we need to do at a local level, while still being able to meet national requirements.

'So I don't see them as independent issues,' he added. 'It is very much about the sophistication of the business intelligence process that fits on the front end.'

Providers are often protective about their own chart of accounts, arguing that they need their own unique coding structure to be able to report accurately and manage their activities. But Mr Beeson rejected this. 'We need to be a bit more mature about accepting that sometimes things won't be perfect,' he said. 'If we have something that has a reasonable categorisation that allows us to compare locally and across our system regionally, it will help drive efficiency. It will make sure that all the GIRFT and benchmarking actually don't lead us to dead-ends.'

Wider benefits

Organisations spending time defending their data and the specific way they counted it did not contribute to delivering transformational change, Mr Beeson said. Norfolk's new standardised approach is expected to go live in October and he said there was agreement that it would deliver wider benefits.

Robert Forster, chief finance officer and deputy chief executive of Liverpool University Hospitals NHS Foundation Trust, has recently overseen the merger of two finance teams and ledgers as part of a major trust merger. Chairing the roundtable, he said Mr Beeson's comments would ring true across most organisations. 'The amount of time sometimes spent on proving that something doesn't mean what it actually says is surely wasted,' he said.

Some organisational barriers need to come down in favour of working as a single NHS, according to Stephen Sutcliffe, chief finance officer of NHS SBS. 'Are we spending time adding value to clinicians and patients and improving the use of taxpayers' money? Or are we spending a lot of time just moving the deckchairs about?' he asked.

He also challenged the view of standardisation as a compromise on quality. 'It is often seen as a route to the bottom and a negative concept,' he said. 'But I genuinely believe that standardisation is about best practice. You standardise at the best level and then help everybody to move up to that.'

He agreed that the chart of accounts question was something that could be addressed, especially given the power of technology and new reporting solutions. However, he said that while standardisation in general made a lot of sense, there would still be the need for flexibility to accommodate nuances in organisational type and specific circumstances. 'About 80%-90% is common to the whole NHS. We've not quite got the balance right at the moment,' he said. 'It feels more 50:50 than it does 80:20.'

Portsmouth Hospitals University NHS Trust has recently been through a process of challenging established working practices when it moved to working day one reporting in April 2021. While clearly a technical process, this was in fact more of a cultural challenge – with the finance team having to become more comfortable with a slightly higher level of assumptions.

Participants

- Stephen Beeson, Norfolk and Norwich University Hospitals NHS FT
- Simon Currie, NHS England
- Gerard Enright, Leeds and York Partnership NHS FT
- Rob Forster (chair), Liverpool University Hospitals NHS FT
- Kevin Nederpel, Portsmouth Hospitals University NHS Trust
- Chris Plant, Herefordshire and Worcestershire CCG
- Adrian Snarr, NHS England
- Stephen Sutcliffe, NHS Shared Business Services

> **"The amount of time sometimes spent on proving that something doesn't mean what it actually says is surely wasted"**
> **Rob Forster, Liverpool University Hospitals NHS FT**

Kevin Nederpel, the trust's deputy director of finance, was one part of the team overseeing the changes. He told the roundtable that there was an argument for just getting on with the standardisation process.

'The chart of accounts is a really basic thing to get right,' he said. 'But it is the hierarchy that sits above it that is almost as important. I find that I'm having conversations in my own team about which hierarchy is being used to service different audiences – fundamentally the underlying data is the same.'

But while this might be viewed as 'flexibility', in reality it involved the finance teams validating the numbers rather than acting on the intelligence. So, he suggested that a common chart of accounts should be a relatively easy hurdle to clear, with the business intelligence software that sits on top of it being the key to extracting information to support the management of the organisation.

'Fundamentally, the chart of accounts only provides information on what you have spent rather than why and what the drivers are. All provider organisations have moved beyond reporting on the chart of accounts when providing analysis to the organisation.'

He added that getting everyone reporting the same thing in the same way was vital to understanding broader variation.

'We talk about triangulation – about finance, activity and workforce,' he said. 'But we need to get this right for finance and be seen to have mastered it if we then want to ask clinicians and others to do the same thing for activity and workforce.' There was a feeling that standardisation should also move beyond finance to rostering and staff systems, given the level of spend on workforce.

Mr Forster agreed that the business intelligence side of things was important. 'It feels like we don't always make the most of the data we have,' he said. 'There is a big drive in my organisation towards making data count and the use of statistical process control charts to identify unwarranted variation. I'm not sure finance is at the front of the curve on that, despite banging the drum loudly for our colleagues to address it in their areas.'

Inevitable change

NHS providers may have resisted standardisation in financial systems, but there are forces that are likely to push them more in this direction. The movement of software providers to cloud-based solutions and the provision of software as a service (SAAS) is a good example. Under SAAS, software is accessed online via a subscription, rather than being bought and installed on individual computers.

Mr Beeson said the industry's move to SAAS and the NHS adoption of it were inevitable. 'Pretending we can do it another way is probably quite naïve,' he said. 'We simply need to accept it and move on.'

Mr Snarr agreed this was the clear direction of travel and the NHS could not swim against the tide for finance or other core systems. 'The ability to customise those cloud-based platforms is severely limited, so by default we will have to get used to a level of standardisation,' he said.

The reward would be potentially having the whole NHS on a 'near identical platform'. And he reinforced the importance of business intelligence solutions outside of the core system to slice the data in ways needed for local management. 'I think it might give us the opportunity to drive standardisation,' said Mr Snarr, 'but also offer the bespoke functionality around reporting. So you'll get the best of both worlds.'

Mr Sutcliffe said that maintenance and support for existing non-cloud legacy systems would also be reduced or withdrawn. 'But with SAAS, you'll get regular updates, as you do with Apple software, for example,' he said. 'There are benefits the large enterprise resource planning providers bring, such as Oracle and SAP. They can deliver continual improvements in functionality month by month, quarter by quarter. So, we shouldn't see it as a constraint.'

An additional benefit would be that standard technology should encourage standard processes. Mr Sutcliffe said this would help finance professionals to move more easily between organisations, reducing familiarisation times and training requirements when people take on new jobs.

Mr Nederpel said NHS organisations should ask themselves why they weren't using the same solutions as commercial organisations for core activities such as general ledgers, accounts payable and accounts receivable. This would allow them to focus on areas where the NHS is genuinely different – patient-level costing and capital accounting, say. 'Standard practice and standardisation of how you process invoices and report the general ledger should be fairly easy,' he suggested.

Convince or compel?

Mr Forster asked whether the move to greater standardisation should be achieved by convincing or compelling people. Despite general encouragement to increase the use of technology and standardise the accounts set-up, there had been minimal response.

However, he recognised finance teams were under a lot of pressure to deliver other priorities. And cost and the time needed to implement more standardised systems were both legitimate considerations.

Mr Snarr pointed out that a mandated system was in place for commissioners. 'We've discussed at various points throughout the past years as to whether we should mandate it for providers,' he said. 'But we've always decided against it for two reasons. First, there is the foundation trust regime, so you can't mandate it for them. And mandating doesn't tend to get the right buy-in.'

He suggested a cultural mind shift was needed to do some of this work, and ordering people to do it doesn't start from the right place. He again highlighted the work in Norfolk and Waveney as a template for greater standardisation at system level. 'I suspect they didn't all start in the same place but they've quite quickly developed a consensus,' he added.

HFMA ROUND TABLE

With partner organisations thinking through what system working really entails, Mr Snarr suggested that system mandation might not be necessary – they could work it out for themselves.

However, he accepted there was a danger that the NHS would end up with 42 different systems doing something different rather than a standardised approach across the whole service.

Gerard Enright, financial controller at Leeds and York Partnership NHS Foundation Trust, agreed that the messaging was very important. 'It is about getting everybody to commit to standardisation or to using the same tools,' he said. 'Using terminology like "mandating" just sends the wrong message.

'It's a balancing act. Perhaps getting standardisation at ICS level is a good first step.' He added that Norfolk and Waveney's experience and feedback later in the year could help others to follow their lead.

Chris Plant, deputy chief finance officer at Herefordshire and Worcestershire Clinical Commissioning Group, said that before July's move to system working, there had been benefits to using a mandated

chart of accounts across all commissioners. 'We merged CCGs about two years ago and it made the process a lot easier, because obviously we were all starting from the same base,' he said. 'There were slight nuances, where things were done slightly differently, but on the whole, everything aligned – so standardisation across commissioners did make things easier.'

Consolidated reporting

Mr Plant said the system had also been thinking through how consolidated reports could be produced across all partner organisations. Commissioners had been used to creating a 'non-ISFE' report, with soft intelligence and narrative added to the figures. An early ICS reporting tool had looked to bring this together with provider finance returns.

It had not been without its difficulties. With commissioners reporting by working day 7 and providers working to day 11, the consolidation meant bringing provider reporting forward. 'This was a mandated approach, but it caused real problems in some of our providers because their internal systems weren't set up to do that,' he said. 'So there are issues that we could hit upon along that journey.'

Mr Nederpel said moving the reporting day shouldn't be a barrier. While earlier reporting required work and preparation, the systems themselves weren't an obstacle – it was more of a mindset change that was needed.

Mr Beeson said that it was important not to get 'hung up' on systems in initial discussions. In Norfolk and Waveney, the starting point was on the principle of a standardised approach. The upfront focus had been on the basic chart of accounts and ensuring the business intelligence systems were capable of doing the integrated care board reporting, even if the system did end up aligning to the same system and transactional services delivery.

He said there should also be recognition that some organisations were operating legacy systems and did not pay very much for them. So, change would come at a cost for some.

Mr Currie said cost concerns had also had an impact on the development of a reporting structure for ICBs and changes to the reporting cycle. The reality is that systems are in different positions in terms of their ability to deliver consolidated information across providers and commissioners. So a balance has had to be struck that falls short of what some systems are capable of delivering.

Suggestions to bring forward reporting deadlines, building on the move by some organisations to working day 1 reporting, were also met with concerns from some trusts that this would involve significant investment, which is difficult in the current climate.

HFMA ROUND TABLE

Mr Currie echoed earlier concerns that in the absence of a higher bar for unified financial reporting by systems, 42 different approaches could emerge.

'Then we'd end up in a place that isn't vastly different to where we are now, but in some ways even more entrenched because it's all devised at system level,' he said. He also rejected mandating a standard system at the outset. But he suggested that once most systems had moved to a standard approach, mandation might have a role in getting the final few organisations on board.

Mr Enright called for clarity to be provided to the finance community about why changes were being made, whether they were to reporting deadlines or standardisation of what is reported. 'We need to keep an eye on what we are trying to achieve,' he said, adding that budget holders and users of information should be on board as much as the finance team making the changes.

"Standardisation is about best practice. You standardise at the best level and then help everybody to move up to that"
Stephen Sutcliffe, NHS SBS

However, the roundtable agreed that the move to system working provided a unique window to make progress with standardisation.

'I hope we haven't missed the boat,' said Mr Nederpel, 'because this is the perfect opportunity to take this forward.'

However, he said it wouldn't happen automatically and finance leaders must champion the required changes in their own systems.

There was recognition that the finance function, like the rest of the NHS workforce, was exhausted after two years of the pandemic. Nevertheless, the service would benefit from a clearly stated goal of delivering standardisation – even if this was over a number of years – and a road map of how to get there.

In summary, Mr Forster acknowledged that there would be a range of views on standardisation around the country, but the roundtable participants were unanimous in backing the ambition.

He repeated that there was in any case an inevitability about it, with the move towards the delivery of software as a service. A common chart of accounts could be a first step, with recognition that business intelligence software was how organisations actually produced information for management and system reporting.

Mr Forster highlighted broad agreement that mandating greater standardisation was unlikely to produce the right level of buy-in. And overall he said there was an opportunity, with the introduction of new integrated care systems for the service to make a one-time change that delivered better foundations in terms of financial reporting.

While there was a recognition that finance teams were already under pressure, there was also a need for the finance profession to take a lead role in this agenda. Not only is it key to introducing new financial systems and processes, it also needs to set an example for other disciplines where the elimination of variation is also needed.

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GOING DUTCH

The Dutch healthcare system provides broadly universal health services, but underpinned by an insurance funding model. However, a recent HFMA study tour found there were approaches that could have some application in the NHS. Steve Brown reports

It can be hard to draw comparisons from different health systems even when they face very similar challenges. But recent delegates on an HFMA study tour to the Netherlands saw benefits in how the Dutch health services have clarity over who delivers what services and the transparency around healthcare costs.

The tour, supported by LOGEX Healthcare Analytics, gave a number of finance leaders and a chief medical officer a whistlestop tour of two leading teaching hospitals in the Netherlands. It also provided some time out of the office to reflect on different approaches to healthcare delivery and whether innovative practices could be relevant to the NHS.

The two hospitals visited – Amsterdam University Medical Centers and Radboud University Medical Centre in Nijmegen – are specialist tertiary centres that undertake significant amounts of research and provide training for healthcare professionals. Both boast impressive, modern facilities.

Tour delegates were struck by the clear demarcation between different parts of the health service. Both hospitals focus solely on complex tertiary care, research and teaching. Very strict gatekeeping, starting in primary care, aims to keep less complex activity in general hospitals, with referrals needed for patients to access each sector.

'There is real clarity in the Dutch system about what tier a healthcare organisation is working in,' said Lee Outhwaite, chief finance officer at South Yorkshire Integrated Care Board. 'There is a clear-cut tertiary centre, secondary, community and primary care.'

This clear separation of roles was significant in the country's response to Covid. Paul Antunes-Goncalves, acting director of finance at Nottingham University Hospitals NHS Trust, stressed the point. 'The impact of Covid in the Netherlands system, particularly in the specialist teaching hospitals, was a lot lower in terms of productivity,' he said. In the NHS, with specialist hospitals undertaking more general healthcare, Covid was more disruptive.

Kiran Patel, chief medical officer at University Hospitals Coventry and Warwickshire NHS Trust, described the Dutch system as having more focus and being 'more ruthless' in defining boundaries. 'Focus in the sense that each organisation knows exactly what its business is and it doesn't venture beyond that,' he said.

Professor Patel highlighted the benefits of the Amsterdam hospital's complete attention on tertiary care, teaching and research. 'It accepts that it needs to devolve lower levels of acuity of care into the district general hospital setting or into the primary care setting and perhaps we don't do that as well in the NHS in England,' he said. 'We are not clear about where our boundaries of responsibility and accountability lie, we often absorb everything and that's often because patients come where the lightbulbs are on.'

However, UK delegates on the tour wondered whether the clearer separation between parts of the system might in some cases inhibit attempts to integrate services around patients and across organisational boundaries. Mr Antunes-Goncalves suggested that a tiered system, as exists in the Netherlands, would need very good communication channels to support integration.

> **"Each organisation knows exactly what its business is and it doesn't venture beyond that"**
> **Kiran Patel, University Hospitals Coventry and Warwickshire NHST**

In practice, Holland operates a hub structure where general hospitals form a network around each teaching hospital, with regular dialogue and team meetings to discuss cases.

Prevention incentives

He also wondered how the Dutch system incentivised investment in prevention, given funding was linked to the delivery of activities and not to population wellbeing as a whole. However, according to the European Health Observatory, the Netherlands actually has among the highest levels of spending on prevention in the European Union.

The Dutch system continues to use a tariff-based payment system for hospital care, based on diagnosis-related groupings (DRGs). In part, the English NHS has moved away from its tariff system because of concerns that it incentivises increased activity in secondary care and does not support a pathway view of the best place to deliver care. Earlier intervention or prevention may offer the better solution to improved outcomes and cost, rather than increasing secondary care capacity or improving hospital productivity.

Mr Antunes-Goncalves acknowledged both the hospitals visited were focusing on aspects of prevention. But it was not clear that the financial reimbursement mechanism directly supported it. 'I wonder how the insurance market is going to have to adapt for the move to prevention,' he said. This was particularly challenging given the workforce shortages that faced all health systems and the potential reduced mobility of staff in the more clearly demarcated Dutch system.

Huw Thomas, chief finance officer of Hywel Dda University Health Board, said all systems were looking for ways to take a more holistic view of patient care. 'In Wales, we have a population health system, and we are responsible for the population as a whole, not just treating people when they are unwell,' he said. 'That bringing together of public health, prevention and delivery of healthcare I think gives a very different model.'

Healthcare in the Netherlands uses a different funding mechanism to the NHS. In the NHS, healthcare is basically delivered by public organisations, funded by the government. The Netherlands also provides largely universal health coverage underpinned by an insurance model. A social health insurance system covers core services, with all residents required to purchase insurance policies covering a defined benefits package set by the government. Insurers are required to accept all applicants and then contract with not-for-profit providers for the delivery of services. There are separate funding arrangements for long-term care and for social care, with municipalities having a bigger role.

There is also an element of cost sharing with patients through an excess (or deductible) of around £325 per year.

The contracting framework appears complex, with insurers negotiating most rates with providers, some tariffs set nationally and add-on payments direct from government.

However, delegates on the study tour mostly liked the way patients were informed of the costs of care even though costs were largely covered by the insurance companies.

Robbie Chapman, deputy chief financial officer at Wirral University Teaching Hospital NHS Foundation Trust, said the cost visibility helped with the engagement of the population.

'People understand [the costs of services] through their insurance premiums and the excess they pay for initial treatment – and that can incentivise better behaviours and prevent people from presenting with issues that they don't need to see doctors for,' he said.

Dominic Thornton, deputy director of finance at Nottingham University Hospitals NHS Trust, also highlighted the fact that patients receive a receipt for the full costs of treatment, though the bulk of the costs are met from insurance. 'Healthcare that is free at the point of delivery in the UK can create the possibility that people feel entitled to it and don't always take responsibility for it,' he said.

While the public are generally very supportive and appreciative of the NHS, a better understanding of the costs of care could reinforce calls to access care in the most appropriate setting.

Insurance model concerns

Some delegates wondered if the insurance model – with the ability to top up core policies for additional coverage and the use of excess payments – might exacerbate inequalities.

University Hospitals Coventry and Warwickshire NHS Trust chief finance officer Su Rollason said she continued to have concerns about insurance-based systems.

'There are potential benefits to having a tightly defined minimum package of care, but it really depends on the depth of that package,' she said. 'If some aspects of care are covered by paying a higher premium, there is the danger of an inequitable situation, which could make the difference to being able to get back to work or look after your family.'

Brian Shipley, deputy chief finance officer of Northern Lincolnshire and Goole NHS Foundation Trust said the tour had also highlighted cultural differences and different attitudes to healthcare in the two countries.

'In the Netherlands, there is a cap on the level of care [determined by the government-set defined benefits covered in the mandatory insurance package],' he said. 'That just does not happen in the UK, where it is a tap that just keeps running.'

Returning to the subject of tertiary hospitals, Mr Shipley backed the idea of specialist centres of excellence. This can make the best use of scarce staffing resources and ensure clinicians see the right number of cases to keep their skills sharp. But it was not the solution for all types of care and there could be other issues that could be taken into account, such as ease of access. 'Trying to get everyone to specialise in certain things … might mean patients having to travel further in many cases, and that is difficult culturally in the UK.'

Overall, participants hailed the study tour a success and a valuable experience.

Mr Thomas, summed it up. 'The fundamental conundrum affecting all developed countries is how we continue to provide health and care with good outcomes to an ageing population with constraints in our workforce,' he said. 'How we all respond to that will be different, and in those differences exists a rich learning opportunity for us all.'

Smart buildings

Radboud UMC is one of the largest hospitals in the Netherlands, providing tertiary care for people living in the east of the country. Located in Nijmegen, the specialist centre handles more than 22,000 admissions a year and treats some 180,000 patients. It also majors in research and, at any one time, is training more than 3,000 students.

In July, it opened its new main building. More compact and flexible, this reduces the hospital's environmental footprint, with single rooms giving patients greater privacy and the use of smart technology providing benefits for patients and staff.

The entire campus now takes up 20% less space and makes more intensive use of its estate, although there are plenty of green spaces outside for patients and visitors to use whenever possible. The new building also makes extensive use of smart technology. Patients can use a tablet to digitally control the curtains, temperature and position of the bed. Other smart features include special 'care' telephones, digital door signs and intelligent care and call systems for the patient and care provider. Alarms and calls are immediately directed to the right care provider.

Sustainability was an important aspect of the design, with glass facades, floors and roofs extra insulated to achieve the lowest possible energy consumption. Sustainable power is provided by solar cells and wind turbines and thermal storage helps to regulate the hospital temperature. Taken together, the measures have earned the hospital an excellent rating under the BREEAM sustainability assessment scheme.

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Virtual reality

Virtual wards are seen as one way of supporting NHS recovery and plans are being developed across the UK. In the latest in our series supporting the HFMA delivering value with digital technologies programme, Seamus Ward asks how they should be implemented

Often ideas that have been circulating for a while finally suit the needs of the times. Virtual wards are one example. The notion of caring for and monitoring patients out of hospital, potentially supported by the rapidly expanding mobile or wearable electronic medical devices industry, has been around a while. But it began to be adopted more widely due to the need to get appropriate patients out of hospital or keep them out of hospital during Covid. And now, as the NHS seeks to free up hospital beds to make post-Covid recovery a reality, virtual wards are being expanded further.

The NHS at home programme aims to support the national expansion of virtual wards, based on evidence that 16% of admissions could be supported through a virtual ward. The ambition is for integrated care systems to achieve 21 virtual ward 'beds' per 100,000 population by October 2022, rising to 40-50 beds by December 2023. In England that's up to 25,000 virtual beds by the end of next year.

Virtual wards already exist, but the phrase has become a catch-all term for many types of service delivered at home. It can include integrated care in the community, case management delivered by district nurses, remote monitoring of one or two symptoms – a model that has sprung from the Covid pandemic – and post-discharge care.

Experts believe NHS clinicians and managers must ensure virtual wards are not seen as a separate service, but part of existing pathways. Microsoft chief clinical information officer Umang Patel says virtual wards need to have the same structure as bricks and mortar wards and common characteristics including:

- An easy-to-follow **admission process** to admit patients remotely
- A **call-bell system** – ensuring patients can call for help via a video conferencing and messaging app
- **Regular observations** – remote monitoring allows clinicians to keep an eye on each patient's vital statistics
- **Tests conducted by patients** – which can be uploaded remotely under guidance from clinicians where required
- Instructions and prompts to patients on which **medicines** to take and when – patients should be able to confirm via the system that medicines have been taken
- Ward rounds via **video conferencing**
- **Board rounds** to allow a virtual ward team to review their patients using a remote whiteboard and productivity tools
- A **streamlined escalation process** to move patients to a physical hospital if their condition deteriorates
- Engaging the patient's **support network** by extending communication to friends and family and formal carer

SHUTTERSTOCK

"The MDT team wraps around the patient at a time of crisis to monitor, stabilise and optimise them and re-establish their independence"
Anjula Mehta, Swansea Bay UHB

- A **discharge process** for patients to leave their virtual ward.

There is an assumption that virtual care equals cheaper care, but those who have set up the systems insist that this is not necessarily the case. A wide range of professional staff must be engaged to ensure patients are adequately supported to get the best possible outcomes.

On a more macro level, former NHS England director of strategy Robert Harris has questioned the economics of virtual wards. The 2022/23 planning guidance set out funding of £200m in 2022/23 and £250m the following year. Per bed, this means funding of between £7,100 and £9,000 in 2022/23. Assuming a 90% bed occupancy rate, this is about £22 per bed per day, he says, less than 10% of the normal inpatient bed cost.

If staffing accounts for around 80% of bed costs – whether in hospital or a virtual bed – the available funding is the equivalent of a few minutes of clinical time per day, he argues. But this does not include the cost of medication administration, software and monitoring equipment. It is difficult to see how this adds up without more funding, he insists.

An Institute of Health and Social Care Management roundtable on virtual wards earlier this year heard that as digital devices develop, there will be greater opportunities to introduce technology – in the use of wearables, for example. But staff will be needed to monitor, analyse and respond to the data produced.

Workforce impact

Potentially the biggest cost is workforce. But Alison Leary, chair of healthcare and workforce modelling at London South Bank University, says NHS England has launched virtual wards without first carrying out a workforce impact assessment.

'There is a perception that if something works well in a pilot you don't evaluate to find out why it worked well in that place,' she says.

Workforce is critical to success, but she adds: 'I have never seen a workforce impact assessment in the NHS, so you end up with copies of the original that probably don't function as well. And instead of being resourced adequately, the community services have to find staff from the community workforce.'

Yet, virtual wards are having an impact on workforce. 'When we started to do modelling on virtual wards, we found that district nurses are working on a lot of new services, not just virtual wards. A lot of these use technology, and this is increasing their workload. You can't just provide the technology – [the results] need interpretation,' says Professor Leary.

'Virtual wards are not a bad idea; in some places, it works really well. But you must understand why it works well and recreate it properly. There isn't the capacity in the community to keep absorbing ideas. Community teams are having to do virtual wards and other things as well as their normal caseload. It's papering over the cracks. We don't have enough acute beds. We have beds in the community, but we need to staff them properly.'

NHS England guidance says virtual wards should be delivered by a multidisciplinary team (MDT), led by a consultant practitioner or suitably trained GP. Its guidance includes six illustrations of staffing models, and staff numbers vary depending on the amount of face-to-face care needed. For example, one 50-bed service operating 24/7 has 54.7 whole-time equivalents (WTEs). Led by community matrons, staffing is provided by a mix of registered nurses and healthcare assistants, with specialist support from consultant (1.7 WTEs) and pharmacists (three WTEs).

A different virtual ward for patients with respiratory and cardiac issues – providing a mostly remote monitoring service, eight hours a day – has 9.7 WTEs covering 100 beds and is staffed largely by nurses and healthcare assistants.

Professor Leary agrees a multidisciplinary approach, coupled with an evidence base, is the best approach when setting up a local virtual ward programme. 'The most common model seems to be a lead physician who wants to run a virtual ward, supported by two or three health professionals,' she adds. 'But the current NHS model is a healthcare professional working with some unregistered staff. They are expected to provide the same level of care as in hospital, but they cannot provide it.'

She adds that virtual ward services are usually open 8am to 8pm, leaving other parts of the system, including out-of-hours GPs, A&E, 111 and community nursing teams, to pick up added patient demand.

Anjula Mehta is a GP and associate medical director overseeing the roll-out of virtual wards at Swansea Bay University Health Board – a programme that brings together an MDT from all sectors of health and care to look after those living with frailty, the elderly and those with complex health and social care needs.

She says the health board saw the introduction of virtual wards as a transformational project with the sole purpose to improve patient care. 'We wanted to create the opportunity for our patients to be cared for in their own homes when clinically appropriate. Frail elderly patients shouldn't be admitted to hospitals unnecessarily and put at risk of infections and deconditioning.'

The programme is about improved patient care and the ability to intervene before the patient reaches crisis point. This can be related to a deterioration in the patient's health status, resulting in an inability or reduction of independent living, often leading to hospital admissions.

'The virtual ward multidisciplinary team wraps around the patient at a time of crisis to monitor, stabilise and optimise them and re-establish their independence and ability to live safely in their own home. The team provides individualised and targeted care to this vulnerable patient cohort to help manage exacerbations of complex chronic conditions, such as heart failure or diabetes, to ensure patients get back to their independence and a good quality of living,' she adds.

Dr Mehta says the virtual ward service model is 'bespoke for Swansea Bay', developed after identifying gaps in wraparound community services. 'It is vital that virtual wards deliver an integrated service with direct links and referral pathways from primary care, community services and secondary care to ensure all patients can be referred to this service when needed,' she says.

The virtual ward MDTs include a hospital consultant geriatrician, a GP, nursing, pharmacy and therapies professionals. For the patient, this provides a link from hospital to home – these professionals could be looking after them on a hospital ward, but instead provide the care in the patient's own environment. This input may be needed to avoid hospital admissions or facilitate earlier safe discharges from hospital.

Members of the virtual ward teams visit patients to

undertake comprehensive assessments to identify their health and social needs. Bespoke care plans are then agreed with patients and their carers, and implemented by the virtual ward team. Weekly ward rounds are attended by virtual ward MDT staff, health board community services, social care and third sector agencies.

Dedicated virtual ward staff provide an in-reach service in front door services such as emergency departments and acute medical assessment units, identifying patients who could be looked after in the community by virtual ward teams to avoid unnecessary admissions.

Direct referrals into the virtual wards are not limited to secondary care, but taken from all parts of the system, including GPs, community services and care homes. Dr Mehta says: 'We are trying to avoid admissions, and trying to take patients out of hospital, helping to facilitate safe discharge and reducing lengths of stay, but the main aim is to improve patient outcomes and patient experience.'

The team is now exploring earlier discharges for patients after hip operations, enabling rehabilitation and recovery at home.

Swansea roll-out

Since August 2021, Swansea Bay has set up four virtual wards, each covering a population of about 50,000 and capable of looking after 30 patients. The health board has invested £2.4m in the programme, which is to be rolled out this month to the board's remaining four clusters.

Investment has included medical equipment, digital systems and staff. Each MDT includes consultant geriatrician and GP sessions, a full-time occupational therapist, half a pharmacist's time (full-time shared between two virtual wards), full-time nurse manager, assistant practitioners and admin support. Other staff attached to the wards include clinical nurse specialists for chronic conditions management, social workers, district nurses and wider community teams.

The MDT is a key element of the effectiveness of the virtual wards, adds Dr Mehta. 'I am particularly proud of the integration and the clinical discussions between secondary, primary and community services, which bring people together around the patient.'

The health board has identified key performance indicators in return for its investment and to ensure improved patient outcomes, including reducing emergency admissions and length of hospital stay, in addition to optimisation of individual care.

Phase 1 of the initiative has shown an 11% reduction in emergency admissions of patients over 65 years in the four virtual ward clusters. In non-virtual ward clusters, this cohort saw only a 3% reduction. 'This shows the concept of a virtual ward service is working for our patient population and we are proud of what this programme has achieved to date for our patients and their families,' Dr Mehta adds.

Looking at the roll-out in England, Professor Leary says the proposed expansion of virtual wards may best suit single conditions, looking after patients with no comorbidities. 'Where virtual wards are replacing acute beds, that's probably where a lot of the stress we are seeing comes from. It's not possible to provide the same level of care remotely. People who are in hospital need nursing care – they need constant monitoring, watching for signs of deterioration.

'In virtual wards they will need that care, but it isn't there. Social care cannot provide nursing care – social care is for patients who are stable. So there's a big risk there, as is the burden on families and carers.

'It seems to work well where a clinical nurse specialist looks after patients with a specific condition in the community – cancer, heart failure or kidney disease. The patients are familiar with their condition and know the signs of deterioration, so the nurse specialist can help them manage the condition in conjunction with the patients. The virtual environment works for them, and it has avoided a huge amount of admissions. That environment seems to have the most potential.'

But a review of Covid virtual wards has provided little evidence they can decrease acute admissions, she adds. And evidence of benefits tends to focus on bed days saved, rather than clinical outcomes for patients. Indeed, guidelines for early monitoring and evaluation appear to focus on their impact on the use of hospital beds, workforce and technology, as well as utilisation of virtual beds.

Virtual ward's time has come, but those who have implemented them insist that, done properly, they are not a cheap alternative to hospital care. Staffing is another issue, but, if addressed, virtual wards could offer a way to increase the NHS's capacity to tackle the waiting list backlog.

• *See Delivering value with digital technologies:* www.hfma.to/sep2210

Covid support

A small study of the virtual ward in Croydon found benefits to patients and the NHS. Croydon Health Services NHS Trust runs a multidisciplinary virtual ward, set up in 2019 to provide integrated care through its rapid response team. The evaluation examined the impact on a cohort of 250 patients admitted to the ward, who tended to be older (60% over 60) and admitted due to Covid. They spent an average of nine days on the ward.

One or two team members of the rapid response team are allocated to monitor the virtual ward from 8am to 8pm, seven days a week. The virtual ward is supported by two consultant physicians with a specialism in geriatrics and a respiratory consultant.

Only 4% of patients declined to use the health monitoring technology, and they reported the service gave them the same standard of care as in hospital.

A&E attendances were similar to a control group of other patients under the care of the rapid response team, and while phone contacts were higher than in the control group, home visits were lower in the virtual ward cohort.

Almost two-thirds remained at home for monitoring for the duration of their stay on the virtual ward, while 20% were admitted to hospital. Post-discharge from the virtual ward, readmissions and hospital admissions were 12% and 9%, respectively.

The estimated cost saving compared with the control group was £742 per patient.

The trust is now working with colleagues across south-west London to scale up delivery of the programme, aiming to achieve the national ambition of 40–50 virtual wards per 100,000 people by December 2023.

Picking up the pace

The HFMA's strategy for 2022 to 2025 is a bold, ambitious vision for the association over the next three years, as chief executive Mark Knight explains

Back in 2019, when we started work on the new HFMA strategy, the world felt like a completely different place. At first, I felt it would be very much 'business as usual'. However, in the wake of the global pandemic, I think it is fair to say that the priorities for the association have shifted.

Then again, in one sense the new strategy for 2022 to 2025 – *Picking up the pace* – is in some ways still very much 'business as usual'. The HFMA will not be venturing into new business areas. Finance remains our core focus.

To quote the best-selling management book by Tom Peters and Robert Waterman, *In search of excellence*, we are very much 'sticking to the knitting'.

The more radical aspect is the direction of travel for our key business lines and there are five lenses, through which the new strategy can be viewed. This is where our strategy becomes bold and exciting.

1. EDI focus

The first of these lenses will involve looking at everything with equality, diversity and inclusion (EDI) in mind. We have already made a good start down this road, with our new offer of free membership for bands 2 to 6. That offer was born out of the knowledge that we were too old, too white, too senior and too male.

Early evidence suggests that we have made a start to redress the balance, although detailed research will be undertaken to bolster that claim.

This, however, is merely the start. We would like to create a large, inclusive mass movement of finance professionals working in the NHS. But we want that movement to be representative of the service as a whole and the populations we serve.

That means that all our efforts in the next strategy period will be devoted to putting the EDI agenda front and centre in all our work.

It means targeting our services and our investment to under-represented groups, while also looking at how we can help the service redress long-term structural inequalities.

2. Integration

The second lens we are looking through in the strategy period is the theme of integration. Colleagues in Wales, Scotland and Northern Ireland are already ahead of the English in the way the health services are structured for more joined up working.

Our intention is to reflect the new integration agenda in our own structures and services. That means looking at issues along pathways and across organisational divides, rather than, for example, having narrow focus groups.

Our policy work will similarly take this integrated approach as, increasingly, challenges showing up in the acute sector are better addressed in the community or even with social care.

Integration is a good example of how different UK nations have pursued the same goals in different ways and we remain committed to our devolved nations work and to develop special opportunities for members outside England.

"Integration is a good example of how different UK nations have pursued the same goals in different ways and we remain committed to our devolved nations work"
Mark Knight

3. Member services

The third lens focuses on our desire to modernise and develop our member services. The HFMA trustees have signed off significant investments in a new website and a new e-learning platform to support our future ambitions. Those projects will come on stream next year, helping us to continue to deliver quality member services.

We will also maintain our extensive programme of policy and technical research work – the lifeblood of the association. Members can continue to expect to receive up-to-date and relevant guidance and support across financial management, reporting and governance.

4. One NHS Finance

The fourth thing you will see in our strategy is our unwavering commitment to the One NHS Finance initiative. The HFMA was one of the founding organisations of the original Future-Focused Finance in 2014 and we have continued to be the prime partner of the initiative since its inception.

Our new strategy commits us to supporting ONF in its future activities. We see the enormous benefit of working collaboratively with ONF, as it looks to deliver a distinct and vibrant range of services that complement those of the association.

5. Sustainability

The final lens of the strategy is our active commitment to environment sustainability. For the last few years, the association's Environmental Sustainability Special Interest Group has brought together finance managers who recognise the importance of this agenda and the role finance has to play in it. But beyond policy work, the association is committed to reducing its own carbon footprint – you will see real changes in how we work and run events.

So, far from 'business as usual', the association's strategy fills me with excitement. It has been devised with major input from trustees and members and I think there is something in it that will resonate with every member. Our firm plan is to create a wide, big, friendly association. Our clear aim is to build on our solid foundations and, in delivering our strategy, I am convinced you will see the association really begin to 'pick up the pace'.

Picking up the pace

The HFMA's 2022 to 2025 strategy

The HFMA's mission

To represent and support health and social care finance professionals through the influencing of health and social care policy, promoting best practice and providing high quality continuing professional development (CPD) and education.

The HFMA's vision

Better quality health and social care through effective use of resources.

Objectives

- To provide excellent member networks and services
- To continue to be the influential voice of healthcare finance, facilitating change through leading edge policy and technical work
- To create relevant and accessible development and qualification opportunities
- To manage ourselves effectively as a business

Strategic lenses

1. Equality, diversity and inclusivity are to the front and centre of our strategy
2. The external environment of the NHS, in terms of health and social care integration and change, shapes our services
3. Our members will be provided with a personalised service, enabled by technology
4. We will continue to support members to improve their skills, knowledge and career development, by working in partnership with One NHS Finance and other NHS initiatives
5. We will aim to reduce our impact on the environment through the HFMA's own activities and in the NHS via our Environmental Sustainability Special Interest Group

The HFMA's values

High-quality: we aim for excellence, continuous improvement, innovation and professionalism in all of our work

Fair: we strive to do the right thing and be honest, open and independent

Member-focused: we aspire to put members at the heart of everything we do

Accessible: we aim to be friendly, caring, inclusive, supportive and collaborative

The 10-year view

The HFMA continues to be regarded as the leading professional body for healthcare financial management in the United Kingdom. It supports its members to develop their professional competence, while working with the NHS at all levels to enable effective financial management to support the delivery of health and social care.

View our full strategy at **hfma.to/strategy**

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Academy

Developing healthcare leaders of the future

HFMA qualifications in healthcare business and finance

The HFMA's unique qualifications in healthcare business and finance provide a dedicated online programme to support current and aspiring healthcare leaders to fulfil their potential. The HFMA diploma qualifications provide the pathway to achieve an executive MBA with the University of Northampton.

Our qualifications are aimed at individuals working within finance, general management, clinical and medical leadership, and primary care including practice management. Our study cohorts bring together learners working in different roles across health systems, with a supportive and collaborative approach.

Applications are open for the October 2022 intake - will you be joining us in the Autumn?

Get full details online

hfma.to/qualifications

0117 457 3242

qualification.enquiry@hfma.org.uk

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professional lives
Events, people and support for finance practitioners

Private finance liability revaluation and ICB reporting on FRAB agenda

Technical

The Financial Reporting Advisory Board (FRAB) two-day meeting in June – **hfma.to/sep229** – included two agenda items of interest to NHS bodies, *writes Debbie Paterson*. First, the Treasury is still developing practical guidance on the application of international financial reporting standard IFRS 16 to private finance initiatives.

While developing that guidance, the Treasury has identified an issue concerning the timing and approach to revaluing the liability, to include changes that have taken place to date.

It is recommending that PFI liabilities should be revalued at 1 April 2022 for indexation changes that have taken place until that date using a cumulative catch-up approach. Until the guidance or FRAB minutes are issued, we will not know whether FRAB agreed with this recommendation. But NHS bodies with PFIs should be aware of the current thinking.

The second issue is the Department of Health and Social Care will update the *Group accounting manual 2022/23* (GAM) using the frequently asked questions process to take account of the impact of the *Health and Care Act 2022*. Having said that, the Department expects that the new act will have a limited impact on the financial reporting guidance included in the GAM.

However, the act does include new reporting requirements that will be included in the guidance on the annual report. For example, the act requires integrated care boards to detail the amount of their expenditure that relates to mental health services and the proportion of expenditure that this represents.

Looking further ahead, the Treasury is conducting a thematic review on the valuation of non-investment assets such as property, plant, equipment and intangible assets. The review is considering the costs and benefits of the current requirements and whether there is an alternative to the current accounting policy to hold non-financial assets at valuation.

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The preliminary findings are that the anticipated benefits and uses for the current regime have not been realised in practice and the scope for using the current data is limited.

The paper does not explicitly say what those anticipated benefits were. But when the move to resource accounting was being developed by the UK government in the 1990s and in the early 2000s, it was expected that reflecting the value of assets in the accounts would result in a clearer understanding of the cost of capital.

Accounts preparers have highlighted the time and expense incurred by engaging third parties to provide valuation services as well as the time and effort put into auditing these valuations.

Discussion with stakeholders indicates that this burden is not uniform across government, and larger central government departments have a relatively smooth valuation process.

Stakeholders have noted that the evolution of the audit regime and audit practice may be driving the increased burden rather than the requirement to revalue assets.

The paper notes that the issue seems to be more acute in the local government sector – the NHS was not mentioned, but it is likely that NHS bodies encounter the same issues as their local government colleagues.

Alternatives have been identified and discussed as part of the initial evaluation, which was undertaken by Deloitte:

- The historical/deemed cost model in accordance with IFRS
- The revaluation model for all non-investment assets in accordance with IFRS (including IFRS 13)
- A differential regime with a historical/deemed cost model for certain categories of assets such as specialised assets, and a revaluation model for non-specialised assets
- A periodic reset of historic/deemed cost – reset carrying values to current value every five years (but no annual requirement to hold at valuation).

None of these options are without drawbacks, so other alternatives will be considered in the next stage of the review. This will include further consideration of how the differential approach could be applied and what criteria could be used to segment different types of asset. This next stage is likely to include data collection by the Treasury from government departments and local authorities.

Finally, *IFRS 17 Insurance contracts* remains on FRAB's agenda, although there was only a verbal update at the June meeting.

At its March meeting, FRAB agreed with the Treasury's proposal to defer the mandatory adoption of the standard to 2025/26. The Treasury continues to consider what adaptations and amendments will need to be made to the standard before it is applied in the public sector.

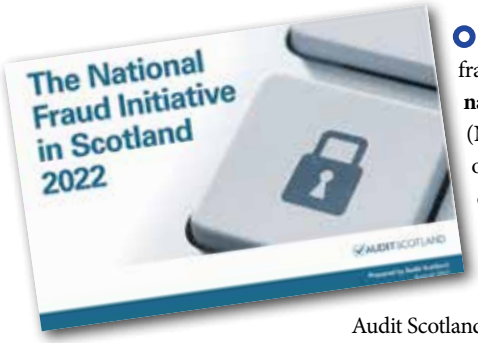
Debbie Paterson is HFMA senior technical manager

Technical review

Recent technical developments

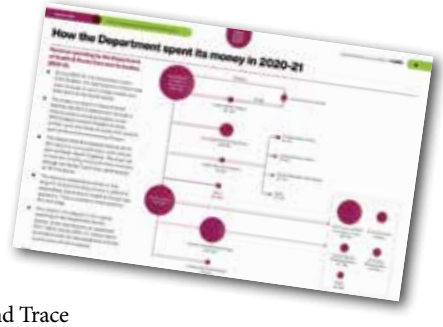
Technical

The **Charity Commission** consulted over the summer on a new approach to the annual return that charities are required to submit, including a new set of questions to obtain additional data. The HFMA has made a number of suggestions. It agreed with a proposal to increase flexibility in the return, but was unsure about the impact of questions in the consultation, spanning a range of areas, including financial governance, charity operations and structure, and employees and volunteers. **hfma.to/sep223**



Nearly £15m of public sector fraud was detected by the 2020/21 **national fraud initiative** (NFI) exercise in Scotland. The outcomes identified by the exercise, which involved 132 Scottish bodies including NHS organisations, were £0.4m lower than two years ago. Audit Scotland said this could be as a result of stronger internal controls in public bodies, the omission of some key datasets this time around or because staff had less time to commit to the programme during the pandemic. Outcomes include the overall amounts of fraud, overpayments and an estimate of future losses prevented. **hfma.to/sep224**

Almost a quarter of the Department of Health and Social Care's spending in 2020/21 was related to Covid-19, according to a **National Audit Office review of the Department**. This included:



- £13.5bn for NHS Test and Trace
- £13.1bn on the procurement and supply of personal protective equipment
- £16.3bn on the NHS Covid response
- £3.6bn on other Covid-related activities.

In total, the Department spent £193.4bn during the year, with £146bn accounted for by NHS England. Some £6.5bn was passed to local authorities, both directly and via Public Health England – although this does not include funding channelled through the better care fund, which is administered by NHS England. The £4.4bn spent by Health Education England included:

- £2.1bn on postgraduate training
- £0.9bn on undergraduate training
- £0.7bn on clinical education and training.

The report also highlights the most significant challenges facing the NHS, which include: workforce shortages and strain; digitising the NHS; and restructuring related to the Health and Care Act. **hfma.to/sep225**

The HFMA VAT Committee has published a document on issues to consider when **reclaiming VAT on contracted-out services** (COS) heading 71 (welfare services). The heading covers services including staff support, staff counselling, and care, treatment or instruction to improve physical or mental wellbeing. The committee discussed two issues at recent meetings – the meaning of the statement on supplies to prison inmates and hospital inpatients, and contract novation by care homes. It identifies questions and concerns, and aims to raise the profile of the issues. **hfma.to/sep226**

The Department of Health and Social Care has confirmed that NHS Resolution will operate the **Existing Liabilities Scheme for General Practice** (ELSGP) on a permanent basis. The arm's-length body already operates the Clinical Negligence Scheme for General Practice (CNSGP). Both schemes were launched in April 2019, with NHS Resolution running the ELSGP on an interim basis. Historical clinical negligence claims made against general practice staff come under the scope of the ELSGP, while the CNSGP covers liabilities incurred from 1 April 2019. A Department statement said: 'The economies of scale associated with operating multiple schemes support our assessment that NHS Resolution's management of the two GP indemnity schemes will deliver efficiency and value for money.' **hfma.to/sep227**

NHS England published guidance in August to support the collection of **patient-level costs** for a group of further services. Until now, chemotherapy, radiotherapy, renal dialysis, specialist rehabilitation, specialist palliative care and community midwifery have been collected at average cost per unit in the national cost collection workbook. However, as part of the costing transformation programme, a pilot is being run this year to test the collection of these services at patient level. The guidance, published on the NHS England costing team's open learning platform, said that data from the collection will only be used to review the collection structure and make improvements for future years. It will not be used to develop pricing or currencies.

The **NHS oversight framework** has been updated to reflect the formal launch of integrated care boards (ICBs) on 1 July. The amended framework has six themes, one of which relates to finance and use of resources. There are four metrics in the finance theme, and two apply to both ICBs and provider trusts – financial efficiency (variance from the efficiency plan) and financial stability (variance from break-even). Systems will also be assessed against the mental health investment standard and agency spending. Based on assessment against metrics in all six themes, ICBs and trusts will be put into one of four segments, reflecting the level of support they need. They will range from segment 1 (no specific need) to segment 4 (mandated intensive support). System agency ceilings have been set for agency spending based on the spending levels included in provider financial planning returns for the year. **hfma.to/sep228**

hfma Academy

HFMA bitesize

Introduction to digital transformation

Explore what digital technology is and how it can transform healthcare services.

This course looks at the concept of digital transformation, digital technologies, the challenges and the benefits of implementing successful change. It also explores how by focusing on value, patients and the wider NHS can benefit from digital transformation. This course has been produced in partnership with Health Education England and is available free to all NHS staff.

Find out more

View full details online at **hfma.to/bitesize** or, to contact our team and book a demo, email **bitesize@hfma.org.uk** or call **0117 938 8350**

Bursaries support diversity agenda

For more information, visit www.hfma.org.uk/qualifications

Training

The HFMA has announced a new bursary scheme to support its qualifications, with priority given to NHS employees from under-represented groups and more junior staff.

The newly reformatted advanced qualifications are being relaunched in October, bringing together the former advanced diploma in healthcare business and finance and the diploma in advanced primary care management in a combined programme. Choice of modules will determine the specific diploma awarded.

The association also delivers intermediate level qualifications, particularly relevant to agenda for change bands 2 to 6 staff. Many of the modules are free to study via the HFMA bitesize route, with courses available through the electronic staff record system. However, the cost of the final assessment – leading to an intermediate diploma – has been identified as an obstacle for some learners.

Both the advanced and intermediate schemes will be eligible for the new pilot bursary scheme, with 20 bursaries up for grabs in time for October's advanced qualification intake. The bursary will cover 75% of the cost of the qualifications.

'There have been two barriers inhibiting people signing up for the advanced qualifications programme – the time it takes to complete and the cost,' said Emily Osgood, head of the HFMA Academy. 'The review of the qualification, which now only involves the completion of two modules, rather than the previous three, addresses the time issue. And the new bursaries should make the qualifications even more accessible.'

One NHS Finance has highlighted that the NHS finance function, at its most senior levels, does not reflect the populations it serves and has committed to improving this position. So the HFMA bursaries will be targeted at people at all stages of their careers from these under-represented groups.

The association's qualifications programme has benefited from NHS England-funded bursaries, but this funding ended in 2021.

The HFMA is keen to support the development of a more diverse finance function and is working with One NHS Finance's National Finance Academy, which has developed an equality, diversity and inclusion action plan. Supporting the development of staff at all points in their careers is recognised as vital to the creation of a more diverse group of senior finance leaders.

The bursary programme is particularly focused on supporting women, those from different ethnic groups, people with a disability or those from the LGBTQ community.

The revised advanced qualifications now

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have two intakes a year – October and March. A diploma (60 credits) is awarded for completing two HFMA advanced modules, each worth 30 credits. The completion of two diplomas would entitle the learner to move on to an MBA, run by the University of Northampton. Qualified accountants wanting to take the MBA route can be eligible for exemption from one of the diplomas.

The course usually costs £2,200 plus VAT – the bursary could save individuals or their organisations £1,650. About 600 people have started to study on the HFMA advanced qualifications programme, with 300 already achieving a masters-level diploma.

Learners on the advanced programme complete two of seven modules on: making finance work in the NHS; managing the healthcare business; supporting quality care with patient-level costing; personal effectiveness and leadership; tools to support decision-making; creating and delivering value in UK healthcare: and NHS law, policy and governance in primary care.

Talent pool seeking 2023 cohort

One NHS Finance

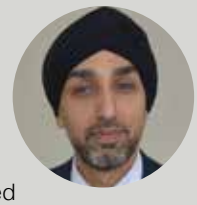
The National Finance Academy's finance leaders talent pool provides development and support to deputy directors (or equivalent), enabling them to step up to board-level positions in the near future.

The two-year programme provides access to a peer support network made up of deputy finance directors from all types of NHS organisations across the country, along with development events, masterclasses, coaching and action learning sets.

Its aim is to help build a diverse pool of talent that improves the number and quality of applicants for finance leadership roles that also reflect the populations served by the NHS.

Since its launch in 2017, there have been 68 participants, with 40 of those securing chief finance officer roles or other promotions since graduating.

Selection onto the talent pool is through a competitive application and interview process designed to reflect board-level CFO application procedures.



The National Finance Academy is hosting an online launch event on 14 September for a new cohort. Previous interview panel members will share advice on what is looked for in the application form and a subsequent interview.

Hardev Virdee (pictured), chair of the National Finance Academy, and group chief finance officer at Barts Health NHS Trust, said: 'I am delighted at the success rate of the pool with two of the recent 2022 cohort having already secured CFO positions, proving what a great programme this is in developing our CFO pipeline.'

Applications for the next cohort open on 19 September. Find full information about the talent pool and how to apply on the One NHS Finance website – **hfma.to/sep222**

Diary

For more information, please email events@hfma.org.uk

key (B) Branch (N) National (I) Institute (H) Hub (W) Webinar

September

15 (H) Introduction to NHS finance for chairs, non-executives and lay members, London
15 (B) Eastern, West Midlands, East Midlands, and Kent, Surrey and Sussex: joint student conference 2022
16 (B) South Central: annual conference
20 (I) Introduction to NHS costing
21 (H) Setting priorities for ICBs
21 (B) Eastern: lunch and learn – specialised commissioning
22 (B) London: annual conference
22 (B) Wales and South West: VAT level 1 – VAT refresher
22 (B) KSS: commercial acumen for NHS professionals
29 (H) Mental health conference
29 (B) Scotland: breakfast session – IFRS16 leases
30 (B) Northern: Self-management and leadership

October

04 (I) International value symposium
06 (H) Sustainability in the health service – one year from COP26
10 (N) Financial sustainability – getting on the front foot for 2023/24
12 (N) NHS charitable funds – finance and governance
13-14 (B) Cymru/Wales, ACCA Cymru: annual conference
13-14 (B) Kent, Surrey and Sussex: annual conference
19 (B) Eastern: lunch and learn, with NHS Supply Chain
20 (H) Estates and facilities forum, London
20-21 (B) South West: annual conference, Bristol
25 (B) Northern Ireland: annual conference
26 (B) Wales and South West: VAT level 2 – VAT in the NHS (intermediate)
27-28 (B) Scotland: annual conference

November

02 (H) NHS leadership and CEO forum, London
06 (H) Delivering value and efficiencies, London
08 (H) Delivering value and efficiencies
10 (B) East Midlands: annual conference
16 (I) Costing revolution summit

December

05-09 (N) Annual conference, London and online

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Events in focus

International value symposium 2022
4 October, online

As the NHS switches its focus back to ensuring it receives value for the money it spends, the international value symposium is a timely event. During the day, there will be sessions on international and UK examples of value-based healthcare (VBHC) in practice, encouraging broader thinking on the quality of patient care, the effective allocation of resources to a population base, and how data can be used to show cost and patient outcomes accurately.

Relevant to clinical and financial colleagues, the symposium will feature a range of speakers, including Wes Baker (pictured), director of strategic analytics, economics and population health management at Mersey Care NHS Foundation Trust. VBHC Center Europe chair Fred van Eenennaam will provide insights on the practical implementation of VBHC, while Petri Kivinen will look at value at a system level in Finland.

Up to four free places are on offer for organisations that are members of the HFMA Healthcare Costing for Value Institute, with rates for additional places, HFMA Hub partners and others also available.

• Contact institute@hfma.org.uk for further details

Estates and facilities forum
20 October 2022, 110 Rochester Row, London

SHUTTERSTOCK

With capital limited, backlog maintenance rising and the need to expand service capacity, this is a vital time for finance and estates staff to come together to discuss the challenges they face. This year, the estates and facilities management forum will return to being a fully face-to-face event. It will have sessions focused on achieving net-zero carbon, workforce retention, and tangible examples of construction and estates strategy.

Time will be allocated for audience-led discussions to share best practice, real-world solutions and collective experience.

The forum is aimed at directors and deputy directors of finance and estates, as well as any senior finance staff who have an interest in or responsibility for estates management.

• For further information or to book, contact events@hfma.org.uk – the event is free to attend for HFMA Hub partners, with two places on offer per partner organisation

Inclusive agenda


SHUTTERSTOCK

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 everyone who came to the HFMA's summer conference, followed by a fantastic key supporters dinner at the Science Museum in the July heat.

At an excellent evening celebrating the 70th anniversary of the association (two years late due to Covid), we honoured key contributors and awarded honorary fellowships to those stepping back from frontline HFMA service.

These are small tokens of appreciation to members, some of whom have given a career-long commitment to the HFMA – though they all say the association has been an invaluable resource in their career.

As you may be aware, we opened up free membership of the association to agenda for change bands 2 to 6 at the December annual general meeting. I wrote at the time that our purpose was to become more diverse, younger and broadly focused on more than the most senior roles in NHS finance. We have not had time to evaluate that aim conclusively, but we appear to be making good progress.

One thing I know for sure is that we have reached our other stated aim – to match the number of bands 2 to 6 to the current 'paying' membership. In fact, we've exceeded that goal.

Another change we've made came as a result of someone stopping me at the West Midlands Branch conference in June and asking why we excluded apprentices. The short answer is we don't. We currently have 56 in membership and we're looking for more, so please pass on the member link to your apprentices. Our trustees want to create a big, inclusive movement, so the more bands 2 to 6 we can reach, the better.

Our thoughts are on our extensive events programme. There are a few hub face-to-face events, but many are still online following extensive consultation with each group. As you are all aware, Covid is very much still with us so we're being characteristically cautious and hoping to do more face-to-face early in 2023.


HFMA chief executive Mark Knight

One event that is now firmly hybrid is, of course, our annual conference and we will be running that as usual in December. The main brochure for the event will be out soon and provides the last opportunity to book. I hope you'll be able to join us in person or take part in the online event. Look out for announcements of speakers soon.

All in all, the HFMA looks in good shape for the future. I'm pleased to say that 110 Rochester Row, our London venue and meeting rooms, is back up fully running and the team there are doing an excellent job.

We have also settled into our new office in Bristol. So if you come to the city and are curious to see it, it's less than 10 minutes' walk from Temple Meads station.

We have just revealed our key objectives for the next three years (see page 30). We continue to be focused on meeting the needs of members. If you would like to be more involved, why not reach out to your branch or get in touch with us.

Member news

The **Yorkshire and Humber Branch** has changed its committee structure, with chair **Nigel Booth** stepping down. He was awarded an HFMA gold key contributor award this summer for his longstanding support for the branch. **Emma Sayner** has taken over as branch chair, with **Cathy Kennedy** moving from president to deputy chair.

Kent, Surrey and Sussex (KSS) Branch has extended huge thanks to branch secretary **Gill Jacobs**, who is standing down after many years on the committee. She was recently awarded an honorary fellowship of the association and, in 2021, a gold key contributor award for her commitment to the branch and the HFMA.

The **Northern Branch** football team (pictured) made it to the quarter finals of the Newcastle Charity Football five-a-side tournament organised by Sellick Partnership in July. The event raised £1,000 for local charity If U Care Share, which supports prevention, intervention and those bereaved by suicide. The team said it was fantastic to be a mixed-gender squad in this year's competition, promoting inclusion in NHS finance and football.

Retired KSS committee member and prostate cancer survivor **John Hasson** has completed a charity triathlon, and is hoping for members' support. Supported by friends and family, he completed the Salty Seadog triathlon in Bournemouth – his first triathlon – and is fundraising for Prostate Cancer UK, Olive Tree Cancer Support Centre, and Guide Dogs UK. **hfma.to/sep221**

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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

Appointments

Joseph Fifer (pictured), the HFMA's US president and chief executive, is to retire next June. During Mr Fifer's tenure, which began in June 2012, the association's membership has grown from 37,000 to more than 89,000. He extended educational and membership benefits to finance teams in a range of healthcare organisations, and oversaw the introduction of international membership. 'I'm very grateful for the opportunity to serve healthcare finance leaders during a time of transformational change in the industry,' he said. 'I've been fortunate to work with some of the brightest and most dedicated people in this field. I look forward to advancing our strategic priorities and planning for a seamless transition.'

Integrated care boards continued to recruit chief finance officers over the summer, and almost all ICBs have now made substantive appointments. Recent appointments include:

- **Madi Parmar** at Coventry and Warwickshire Integrated Care Board. She joins the ICB from University Hospitals Birmingham NHS Foundation Trust, where she was deputy chief finance officer.
- **Howard Martin** at Suffolk and North East Essex Integrated Care Board. He is due to start in November, moving from Norfolk and Waveney Integrated Care Board, where he is director of population health management. Previously, he was deputy chief financial officer at the clinical commissioning groups in Norfolk and Waveney.
- **Bill Shields** (pictured) at Devon Integrated Care Board. He is due to join later this year; **John Dowell** will continue to act on an interim basis.

Tameside and Glossop Integrated Care NHS Foundation Trust has named **John Graham** as its executive chief finance officer. He joins the trust from Stockport NHS Foundation Trust, where he was executive director of finance and deputy chief executive. In addition, the trust has appointed **Asif Umarji** director of finance.

Gateshead Health NHS Foundation Trust has appointed **Kris Mackenzie** (pictured) group director of finance and digital. She was the trust's operational director of finance and has worked at Gateshead Health since 2018. She succeeds **Jackie Bilcliff**, who is moving to Newcastle upon Tyne Hospitals NHS Foundation Trust (see overleaf).

The Princess Alexandra Hospital NHS Trust has appointed **Tom Burton** as its finance director. He joined the trust in May as interim finance director. Previously, he was on a seconded role as the strategic planning director for the East of England Ambulance Service NHS Trust and, before that, served as operational director of finance for the regional NHS England and NHS Improvement team.

Samanthi Gibbens has become interim chief finance officer at East London NHS Foundation Trust. She joined the trust in April, but rapidly moved to interim CFO after **Steven Course** became director of finance of Norfolk and Waveney Integrated Care Board. Prior to joining East London, Ms Gibbens held assistant finance director roles at Whittington Health NHS Trust and Camden and Islington NHS Foundation Trust.

Mersey Care NHS Foundation Trust has appointed **Rob Collins** executive director of finance. He has held senior finance roles across Cheshire and Merseyside and joined the trust in 2018 as chief finance officer. He succeeds **Neil Smith**, who has relinquished his finance director duties but remains deputy chief executive for non-clinical services.

Mid and South Essex NHS Foundation Trust has recruited **Nina van Markwijk** (pictured) as its finance director – efficiency portfolio. She joins the trust from Barnet, Enfield and Haringey Mental Health NHS Trust, where she worked for nine years, initially as head of strategic finance and then deputy director of finance.

Rebecca Mae-Rose has become deputy finance manager at East and North Hertfordshire NHS Trust, moving from Mid and South Essex University Hospitals Group. She also took part in the One NHS Finance sponsorship programme (*see Healthcare Finance, June 2022, page 34*).

MIAA's Connor retires

MIAA managing director Steve Connor (pictured) has retired after 32 years at the internal audit provider.

Previously MIAA's commercial director and deputy managing director, he took the MD position in April 2019. He led the organisation through the pandemic, helping clients by voluntarily redeploying MIAA staff to non-clinical roles and supporting them with changes in government guidance.

Rather than internal audit only, MIAA now offers anti-fraud, technology risk, healthcare quality and advisory services to the police, fire services, local government and voluntary sector. It has led the medicines optimisation programme in Cheshire and Merseyside.

Mr Connor helped set up MIAA's advisory service, MIAA Solutions. 'Leading MIAA has been an honour and a privilege,' he said. 'MIAA is now one of the largest providers of assurance and anti-fraud services in the UK. I've loved every minute.'

Awarded an HFMA honorary fellowship this summer, he has been a valued member of the association's Governance and Audit Committee since 2009.

'I have benefited significantly from being an HFMA member – access to the wide range of publications and insights it produces, attendance at conferences and other events, supporting working groups and the extensive professional network it has helped me to establish.'

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

"The past couple of years have been the best of my career. I have loved working with the neighbouring trust directors of finance on developing integrated care"
Angela Dragone, Newcastle upon Tyne Hospitals NHS Foundation Trust

Dragone retires after 36-year career in NHS

On the move

Newcastle upon Tyne Hospitals NHS Foundation Trust finance director Angela Dragone has retired after 36 years' NHS service in the north-east of England and nationally.

Ms Dragone retired at the end of July, having joined the NHS in 1986 as a regional trainee in South Tees. 'A brilliant place to work,' she says.

Four years later, she moved to the community and mental health trust in Durham, before joining the Freeman Hospital in Newcastle in 1996. Now part of Newcastle upon Tyne Hospitals, the trust has grown from a turnover of £250m to its current £1.3bn.

'I probably always had an interest in medicine and public services, but I was never clever enough to master chemistry,' Ms Dragone says. 'I took a degree in social policy at Newcastle University, writing my dissertation on Italian mental health reforms. This sparked a real interest. It was an interest in medicine and policymaking that has stayed with me.'

She admits she chose the NHS as a student because she thought of the service as 'people who had nice values', but her memory is hazier on why she chose finance.

Nevertheless, her NHS finance career has been a successful one, and has included more than 25 years in senior leadership.

During her time, she has served as a CIPFA project examiner. 'Doing this, I really did get interested in watching people grow and develop into professionals, and work hard to become better accountants.'

She has also worked on the national stage, chairing the Shelford Group's finance directors committee for the past couple of years.

She describes the influential nature of colleagues on the committee with characteristic modesty. 'Some of these directors of finance were just amazing. I also got to deal with policymakers from the King's Fund, the Treasury and the Department of Health central team.'

While the Shelford work was exciting, she admits: 'I much preferred to work locally.' Indeed, the local aspect of working over recent years, as trusts and commissioners pulled together to deliver services to patients during the Covid pandemic, is one of the highlights of her years in the NHS.

'The past couple of years have been the best of my career. I have loved working with the neighbouring trust directors of finance on developing integrated care. We have been pulling together with no road map and no rules for the first time. It was all about how we should work together. It was a real team effort.

'They are all local directors of finance who will have worked in foundation trusts and been encouraged to be competitors in the past. But we worked together closely and helped each other through. I think we became good friends as well as colleagues.'

She cites other highlights. 'I quite liked the foundation trust regime,' she says, adding that it has allowed finance leaders to be more entrepreneurial. 'As accountants, we are naturally risk-averse, but the foundation trust regime gave us a chance to be a bit more commercial in our approach. It gave new freedoms to colleagues at Newcastle – doctors innovating and developing services that they might never have been given the chance to do.'

Moving up to a board-level post was exciting, Ms Dragone says. 'As an accountant on the executive team, you have to find your place. I was lucky to be part of an executive team that is focused on patients and clinical outcomes – there is no doubt about what the direction is for the organisation.

'My job was to make possible all the ideas they had. They drive the quality of patient services; they come up with the innovations; I need to try to make the money work.'

She also enjoyed meeting celebrities during the course of her work, including the frontman of The Who, Roger Daltrey, in his role as honorary patron of the Teenage Cancer Trust.

And she has a cherished memory of former Newcastle and England captain Alan Shearer signing her son's Sunderland shirt – a huge deal, given the rivalry between the two teams.

Ms Dragone says the lifetime achievement award presented to her recently by the HFMA Northern Branch was 'unexpected, but a lovely way to end my career'. She adds: 'I don't feel it is something I deserved as an individual because it's my whole team who does my job for me.

'The HFMA is a great organisation because it brings together people who want to take responsibility for their own development.'

She has some tips for newly appointed and aspirant finance directors. The first is to work hard – a trait she learned from her parents and grandparents, who owned an ice-cream shop.

'It's a hard slog to get to a director's post, so you need to have a strong work ethic. My dad always said that if you have a job you love then you'll never work another day.

'I found that job. Every day is challenging, but I never had a day when I felt I didn't want to get up for work in the morning. The thing that helped the most was my interest in medicine and policymaking – without that, it would be hard to be an accountant in the NHS. It helps you make the right decisions.'

Now retired, Ms Dragone plans to spend time in Italy, catching up with her family and 'sitting in an olive grove with a glass of Merlot'.

Jackie Bilcliff, deputy chief executive and group director of finance and digital at Gateshead Health NHS Foundation Trust, will succeed Ms Dragone as chief finance officer.

'I am really pleased to pass on my fantastic team to Jackie,' Ms Dragone says. 'I know that together they will do a brilliant job.'

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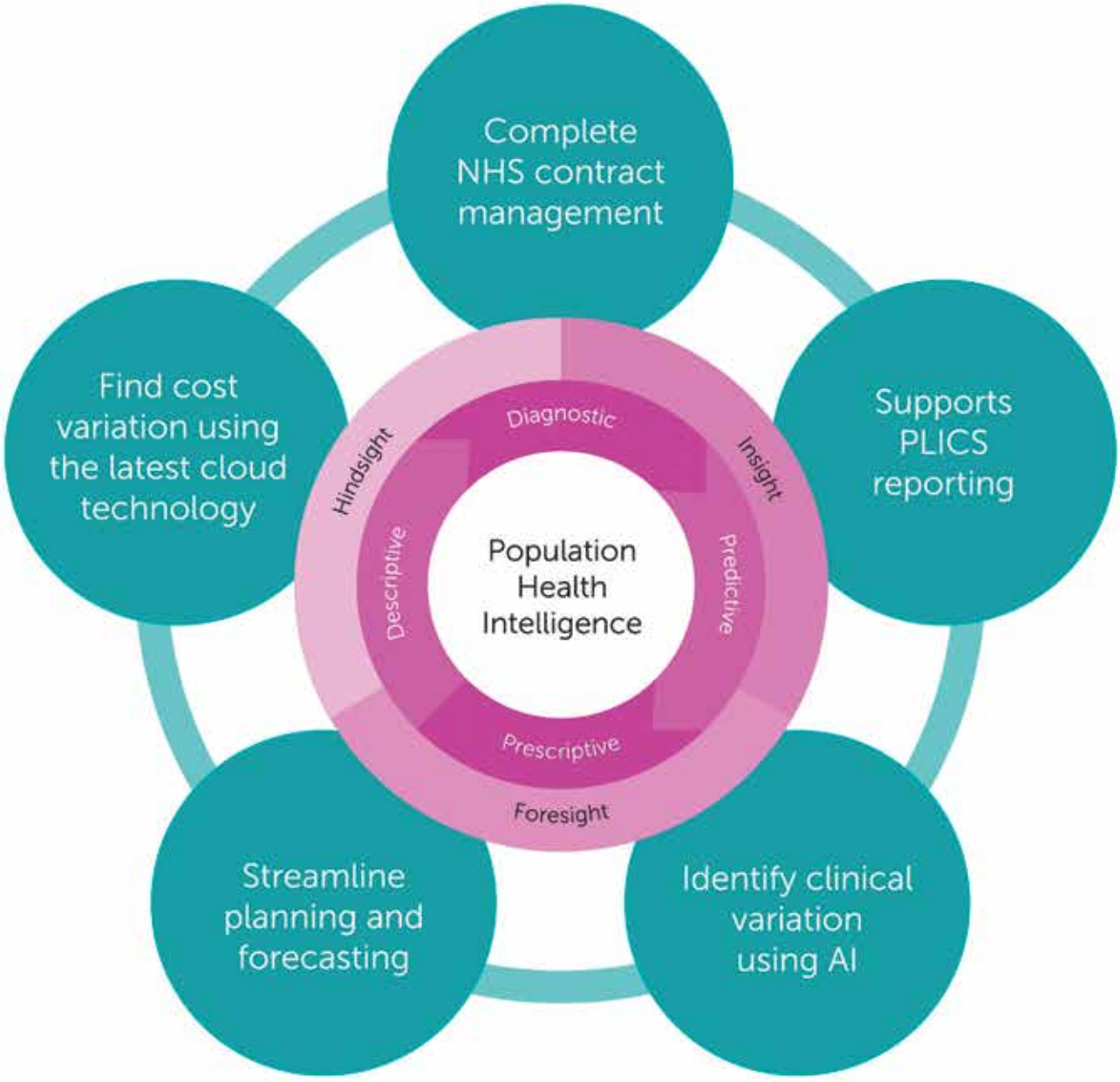

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