healthcare finance

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Reading between the lines

Statistical process control

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Concerns mount over health service recovery targets

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We need clearer rules to ease the planning round

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News

Warnings issued over recovery and finances

By Steve Brown

The NHS faces difficult service and financial challenges in 2023/24, with multiple warnings that the service will fall short of recovery targets within existing levels of funding.

The Institute for Government and accountancy body CIPFA's latest performance tracker said that 'by any reasonable measure, hospitals are in crisis'. It highlighted record levels of people waiting longer than four hours in accident and emergency departments last year and a waiting list of more than seven million.

It said the crisis had been driven by 'more than a decade of relative under-investment', which had led to 'too few, burnt-out staff working with too little, faulty or out-of-date equipment in buildings that are often unsuitable for a modern health service'. It rejected arguments that the critical state of the service was due to the pandemic or striking staff, although these had exacerbated underlying problems.

The report also singled out difficulties with discharging patients as a contributor to high bed occupancy and capacity issues. Some funding had been provided to address this, but its 'short term and haphazard nature makes it very difficult for the service to effectively plan and spend the money'.

The tracker looked across nine public services, also including social care, schools, police and prisons. It concluded: 'Performance in some services has got substantially worse over the last three years and reversing that will require considerable effort.

'As such, performance in these services is unlikely to return to pre-pandemic levels before the next election.'

The Institute for Fiscal Studies came to a similar gloomy conclusion that waiting lists were most likely going to 'flatline' this year. The research body's analysis suggested that the government target for a 30% increase in elective activity by 2024/25, compared with pre-pandemic levels, would require 'unprecedented double-digit growth' in treatment volumes over the next two years.

The 10.3% annual growth requirement compared with average annual growth of 2.9% in the five years prior to the pandemic. 'That would be more than three times the growth rate in the five years prior to Covid, and looks increasingly unreachable,' said Max Warner, IFS research economist and author of the report published to coincide with the one-year anniversary of the government's backlog recovery plan. 'As a result, it is likely that the waiting list will flatline rather than fall over the coming year.'

At the end of February, the Commons Public Accounts Committee also gave a negative assessment of progress to reduce waiting lists. It said the three-year recovery programme was already falling short.

> "[The NHS is in] full blown crisis... with all the metrics going in the wrong direction"
> **Dame Meg Hillier, PAC**

Cancer waiting times were at their worst recorded level and the NHS would not be able to meet its first 62-day cancer recovery target.

Dame Meg Hillier, the committee's chair, said the NHS was in 'full blown crisis', with 'all the metrics going in the wrong direction'.

'We do not expect the NHS to achieve the significant and ambitious targets of its current recovery plan, but it must now step up and show leadership for a realistic way forward, with targets that have patients seeing the real improvements,' she said.

The concerns are not confined to England. Audit Scotland has also called for full transparency on NHS recovery. The Scottish government's recovery plan was a 'high-level, top-down document' that did not contain the detailed actions that would allow progress to be accurately measured. And the financial watchdog said that growing financial pressures could limit investment in recovery and reform.

Lee Bond: calling for more flexibility

Outside Scotland, strikes over pay have exacerbated recovery efforts. The government in England has now offered to reopen discussions with all unions after previously rejecting claims for a higher pay increase in 2022/23. As *Healthcare Finance* went to press, there was no news of any revised pay offers.

Speaking ahead of the March Budget, the NHS Confederation's chief executive, Matthew Taylor, said the NHS was going through 'an extremely tough period'.

'It is in the government's hands to set out details of its long overdue workforce plan, to reach level ground with the trade unions, and ensure that its spring statement delivers – for the NHS and the communities it serves,' he added.

The HFMA also issued a statement in February on the current challenges facing the health service, which included 'significant financial pressures'. Integrated care systems are now expected to end the year with a £500m deficit, according to a paper at the NHS England February board meeting. And the HFMA said the current challenges were set to continue into the new financial year.

The association called for more flexibility for systems to deliver local solutions, with as much money as possible allocated to systems without being tied to specific uses. 'If we are clear on "what" the national priorities are, we need to allow local systems to develop the "how",' it said.

HFMA president Lee Bond (pictured) said that NHS systems would need to realise significant levels of cash-releasing efficiencies to balance plans in 2023/24.

'That would be hard enough on its own, but we need to do it while wrestling with major workforce challenges and creating headroom to transform services and pathways,' he said.

LEE BOND PHOTOGRAPH: THEODORE WOOD

One NHS Finance unveils flexible friend for recruitment and retention

By Steve Brown

Fully embracing flexible working within NHS finance can ensure that teams attract the widest pool of talent and improve retention levels.

There is increasing evidence that flexible working can be a real asset in recruiting and retaining the highest quality staff. But a new publication from the NHS Finance Academy, part of One NHS Finance, claims there are much wider benefits both to the individual and to teams and their organisations.

Changes to NHS terms and conditions in 2021 now give employees a contractual right to request flexible working from day one of employment. And the *NHS people plan* makes it clear that employers should be open to all clinical and non-clinical permanent positions being flexible.

But saying flexible working is an option is different to creating an environment and culture where anybody feels they can ask for a work pattern that better meets their needs. This is true across all functions, but in finance it means challenging preconceptions that some jobs can only be done on a full-time basis and by following a rigid timetable.

Month-end, annual accounts, costing, planning and contracting processes may all involve times when work is intense and has strict deadlines. But this does not necessarily mean that all staff have to be available at all the same times. Increasingly, this mindset and attitudes towards flexible working are changing.

David Cooper, deputy director of finance at Lewisham and Greenwich NHS Trust, commented: 'I think there has been a preconception that folk working on a flexible arrangement were being done a favour. And there was a feeling that there were lots of roles that you just couldn't do flexibly. You had to work all hours and be available all the time – that presenteeism attitude.'

> **"By opening up to flexible working, you are widening your talent pool"**
> **David Cooper, Lewisham and Greenwich NHS Trust**

Covid-19 has challenged this view, with whole finance teams working from home, often fulfilling roles that previously people thought you had to be on site for.

Although there remains value to working in teams in the same physical location, it is increasingly not being seen as essential all the time or for all roles.

There perhaps also needs to be recognition that flexible working will mean a whole range of different things to different people. It could mean starting earlier and/or finishing later. It could mean not working during school holidays. It could mean working four days a week or having an annualised hours contract.

Mr Cooper, who works flexibly himself (not working on Mondays), said that all sides can benefit from flexible working arrangements. Individuals can clearly match hours to other responsibilities – fitting work more easily around family or personal commitments or even around other interests and hobbies, improving wellbeing and relieving stress. But teams and employers benefit too.

There may be increased development opportunities across finance teams as other staff step in to provide cover. If different hours are being worked by different team members, the service may be able to provide support beyond the typical nine to five. It might mean the knowledge and ability to undertake a specific task are shared more widely across the team – reducing single points of failure and building resilience in the team.

Mr Cooper suggested that perhaps the biggest benefit to an employer was improvement in staff retention and giving the organisation the best chance of recruiting the best staff. 'By opening up to a flexible working approach, you are widening your talent pool,' he said. 'You are able to access more people, including those who wouldn't be able to work rigid hours.'

At Lewisham, the finance team has moved beyond a basic right to ask for flexible working. Recognising that some people might still feel that simply asking for a flexible arrangement could count against them, the finance department has made it clear that the answer to any flexible working arrangement is basically 'yes' and then the time is spent making it work.

Mr Cooper cited a recent case of an experienced, long-serving, full-time team member who requested to take the role forward as a job share. 'It took us a little while to find the other half, but we did find them and we've ended up with somebody who would never have applied to the full-time role,' he said.

'So now we have two people working part-time, giving us access to two people who work in slightly different ways, which gives us I think an enhanced service and better continuity.'

The trust has also made it clear that flexible working is not only available at certain levels. Mr Cooper's own flexible work pattern shows that flexibility can be offered even in senior roles.

And he lists numerous directors across London who are themselves working flexibly – dispelling the stereotypical image of finance director roles being accompanied by a disastrous work-life balance.

The One NHS Finance work, which Mr Cooper supported, grew out of its women in leadership finance group. One of its subgroups was looking at the issue of returning to work and flexible working. While its specific remit was to look at ways of reducing the imbalance between men and women in the most senior roles of NHS, it was realised that flexible working was something the whole finance function could benefit from, rather than just a section of it.

'I think a lot of people can see the benefit of flexible working,' said Mr Cooper. 'What the

continued on next page

NCC will go ahead at patient level despite technical staffing shortages

By Steve Brown

A national cost collection (NCC) will go ahead in 2023 and will be undertaken at the patient level, although the collection window will not open until mid-September, NHS England has confirmed.

A series of updates in January from the national costing team had thrown this year's collection into doubt, with NHS England saying it wasn't in a position to announce submission dates and that planning activity for the year's NCC had been paused. The updates referred to the 'resourcing of technical staff' as the key problem.

However, in a webinar attended by more than 300 costing practitioners and stakeholders this week, NHS England confirmed it had been given two very clear objectives – for the NCC to go ahead with a patient-level output and to identify a resolution to the resourcing issues.

Chris Walters (pictured), NHS England's director of pricing and costing, confirmed the NCC would be going ahead, although the collection window would not open until at least 18 September.

Staff shortages, particularly with data engineers, are behind the problems, driven in part by the merger of NHS Digital with NHS England, and this is requiring a 're-engineering' of the collection process.

'That re-engineering process has begun and will enable us to do a national cost collection at the patient level this year, but it won't be before September,' said Mr Walters. He added that work was ongoing to streamline the national cost collection and reduce the work involved for trusts in making a submission.

Streamlining the NCC would involve two strands of work – automation and revising the costing methodology.

'We had a successful pilot with our technology partners and Chelsea and Westminster NHS Foundation Trust,' he said. 'In the pilot, the collection window was reduced to under two weeks, which is much less than the three to four months you have reported to us that it can typically take to do the NCC.'

The next step would be to upscale this to a system level. Mr Walters said that North West London Integrated Care System had volunteered to be part of that process. The business case for investment in the pilot is currently being prepared.

'The second way to streamline the NCC is better aligning our approaches to costing at national level, as embodied in the *Approved costing guidance*, with the way you do costing locally,' he said. He added that proposals to streamline the approach had been approved internally within NHS England and the next step would be to pilot how that can happen in practice.

Deputy director of pricing and costing Helen Laing gave the webinar further details on the staffing shortages facing the central team. She said the team responsible for the NCC currently had a vacancy rate of 54%. And this increased to 70% when looking at team members needed for 'data onboarding'.

These were not roles that could be picked up by other members of the team. And this was in the overall context of NHS England needing to reduce in size by 30% to 40% by the end of 2023/24, with recruitment freezes and a voluntary redundancy scheme in place.

The *Approved costing guidance* is expected to be published in May with a new, more powerful and easier-to-use data validation tool due to be launched in April. The tool will be able to produce data quality reports, summary reports and patient-level files.

Costing practitioners were urged to start their NCC process as soon as the tools were released and not to wait for official confirmation of the submission date. The national team said the production of costing data in 2023 should be treated as 'business as usual' – with small year-on-year changes but 'not an overhaul'.

However, in questions, they accepted that there were a number of changes, although most of these had been well flagged and tested in an early implementation test collection towards the end of last year, details of which are available.

Team members suggested there were only minor changes from this to the full 2023 collection, with the exception of the removal of mental health clusters, which should represent a simplification.

Among the known changes is the removal of the NCC workbook with a number of services now due to be collected at patient level, including chemotherapy, palliative medicine, radiotherapy, rehabilitation, community maternity and renal.

A number of voluntary test currencies were also being introduced, including virtual wards, community and mental health.

The general response from practitioners on the webinar was that the level of changes was ambitious given the staffing pressures. And there was concern that the late submission would also mean late publication of patient-level cost data.

The 2021/22 publication has yet to be published – and the later the costing data is published, the less useful it is for supporting cost improvement and benchmarking.

from previous page

guide tries to do is to provide some tools and insight into how to make it work both for team members and team leaders.'

'I don't think it's a surprise to anyone that we have a diversity challenge across NHS finance,' he added. 'This means, not only are we excluding talented people from joining the team and developing their careers, we are also denying our stakeholders the best quality service we could offer. Flexible working creates a more equitable opportunity of success for people from all walks of life and, while not a silver bullet, must surely be a positive intervention we can all make to provide everyone with better opportunities to succeed.'

Mr Cooper's central argument is that flexible working is a recruitment and retention asset. However, he warned that not offering it – or not actively promoting it and developing the right culture – would increasingly undermine retention and limit new applications.

At the moment, actively promoting flexible working might make an organisation stand out from the crowd. But it will increasingly become the norm.

News review

Steve Brown looks at recent developments in healthcare finance

It has been a frantic start to the year for the NHS. Continued winter (or year-round) pressures have taken their toll. And finances are also under strain, with February's NHS England board hearing that integrated care systems expect to end the financial year with a combined £500m deficit. Meanwhile, NHS pay disputes rumbled on, with growing concern about their impact on the recovery programme. And the 2023/24 planning round kicked into overdrive with the release of the key planning and financial guidance.

NHS pay has stayed in the headlines throughout the end of 2022 into 2023. The English government's initial and sustained determination to stick to the pay review body recommendation of a 4.8% average increase for agenda for change staff looked increasingly unrealistic as Scotland produced first an enhanced offer for 2022/23 and then a further 'credible and serious' offer for 2023/24 (more below). While the English government has on other occasions chosen not to implement review body recommendations, on this occasion it insisted it could not meddle with the process and further increases were simply not affordable. The government's evidence to the pay review body ahead of the body's recommendations for 2023/24 said funding was only available for pay awards up to 3.5%. With multiple strike days looming, from nurses and ambulance staff to junior doctors, the government faced significant calls from bodies including the NHS Confederation and NHS Providers to return to the negotiation table. And finally, it agreed to do so, initially with the Royal College of Nursing, subsequently broadening this to all unions. As *Healthcare Finance* went to press, there was no news of a revised offer.

In Scotland, health secretary Humza Yousaf claimed the NHS pay deal in Scotland was the largest pay package in the history of the NHS. It would make Scottish agenda for change staff 'by far and away, the best paid anywhere in the UK', he said. The government had already offered an average increase of 7.5% for 2022/23 (with more than 11% for those on the lowest bands). In February it supplemented this with a further offer for 2023/24 averaging 6.5% plus a one-off non-consolidated payment ranging from £387 to £939. Over the two years, the deals would mean pay rises of between 5.4% and 19.26% – representing cash uplifts of between £3,753 and £6,506.

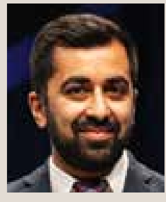
The Welsh government also made a final 2022/23 pay offer to NHS workers in a bid to end strikes. Under the offer, the government would supplement the £1,400 already awarded under pay review body recommendations with a further 3% increase – half of which would be consolidated into ongoing pay, with the other half as a one-off payment. The offer would be backdated to April 2022. Unite and GMB members in the Welsh Ambulance Service rejected the offer. In Northern Ireland, the offer implemented for 2022/23 reflects the same offer in England – a £1,400 increase for agenda for change staff and an uplift of 4.5% for salaried doctors and dentists.

NHS England released a swathe of planning documents for 2023/24 just before Christmas – a now almost traditional end-of-year release date. These included changes to the proposed aligned payment and incentive scheme, with all elective activity paid for at tariff prices rather than agreed activity levels being funded through the fixed element. The overall planning guidance set out the national objectives for the year, including a target for 76% of patients in accident and emergency to be seen within four hours by March 2024. Improvements are also required in

The news in quotes

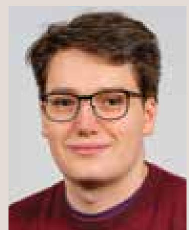
'The bed occupancy and discharge targets are challenging. But the blunt reality is that if social care markets continue to collapse in the way they have been, then some of the key targets outlined in the guidance won't be achievable.'
Matthew Taylor, the NHS Confederation's chief executive, gets real about planning objectives

'Money is tight but investment is needed in recovery. That means ministers have to prioritise which NHS aims can realistically be delivered. And they need to be more transparent about the progress they're making.'
Stephen Boyle, auditor general for Scotland, on the tough choices facing the government



SCOTTISH POLITICO

'This [pay deal] ensures that Scotland's NHS agenda for change staff are, by far and away, the best paid anywhere in the UK.'
Scottish health secretary Humza Yousaf shows the way towards ending strikes across the NHS



'To deliver on the headline ambition of increasing elective activity to 30% above pre-pandemic levels by 2024/25 would require unprecedented double-digit growth in treatment volumes over the next two years.'
Institute for Fiscal Studies' Max Warner on why waiting lists are likely to flatline over the coming year

SHUTTERSTOCK

category 2 ambulance response times, and providers have been asked to keep bed occupancy to no more than 92% to improve patient flow.

The government in England finally agreed to return to the negotiating table to discuss the NHS pay offer with unions

While pay in the NHS may have dominated headlines, there have also been calls to address pay levels in social care. The Association of Directors of Adult Social Services warned of worsening workforce shortages, with retailers paying considerably more than social care providers and those referred to social care often requiring greater input than in the past. A focus on hospital discharge had also led to people being discharged with higher levels of social need than they would have pre-Covid, the body said, calling for measures to be brought forward to address the situation in the March Budget.

Sir Chris Ham, co-chair of the NHS Assembly, called on the Department of Health and Social Care and NHS England to define what a high-performing integrated care system (ICS) looked like. He said the emphasis on transparency in the Hewitt review (looking at the oversight and governance of ICSs) suggested more attention would be given to publishing data on system performance. Sir Chris said publication of comparative information on performance could be a powerful driver for improvement as long as care was taken to select the right measures and take account of the different contexts in which ICSs are working.

The influential Institute for Fiscal Studies has said the ambition to increase NHS treatment volumes to 30% above pre-pandemic levels by 2024/25 was 'highly unlikely to be achieved.' In its report *One year on from the backlog recovery plan: what next for NHS waiting lists?* it said it expected waiting lists to flatline for the next year and gradually fall from the middle of 2024. It pointed out that between January and November 2022, the NHS actually treated fewer patients than in the same period in 2019, although there were encouraging signs of an uptick in numbers treated in November. However, it acknowledged that the NHS had come close to eliminating waits of more than two years and the target of eliminating 78-week waits by April 2023 remained within reach.

The NHS continues to deal with continuing pressures from the pandemic. However, in February, the Organisation for Economic Co-operation and Development (OECD) published a report that was focused on the next future health shock, whether it is another pandemic, an economic crisis or the effects of climate change. *Ready for the next crisis? Investing in health system resilience* said that systems had been underprepared, understaffed and suffering from underinvestment ahead of the Covid-19 pandemic. The report recommended an annual targeted investment of 1.4% of GDP across OECD countries relative to expenditure in 2019, with half of this used to bolster workforce.

Health ministers in Scotland need to prioritise which NHS aims can 'realistically be delivered', the country's auditor general has said. Stephen Boyle warned that some key targets – such as recruiting 800 GPs by 2027 – are unlikely to be met and workforce capacity remains the biggest threat to the NHS recovery plan. He added that the recovery plan does not allow for progress to be accurately measured and lacks robust modelling on demand and capacity. The report from Audit Scotland – *NHS in Scotland 2022* – said the Scottish government should be fully transparent on recovery progress and how long people have to wait for treatment.

from the hfma

Systems need to learn from each other and benchmark their activities, said Claire Wilson, introducing the HFMA's Integrated Care Board Finance Group. Ms Wilson, chair of the new group, is also director of finance at Cheshire and Merseyside Integrated Care Board. In a blog, she said system working depended on transparency, but there was room for much better sharing of information between the new systems.

At the end of 2022, Bill Shields left his position as chief finance officer of Bermuda Hospitals Board to take up the CFO role at Devon Integrated Care Board. Mr Shields spent more than five years in the territory, during which time he has kept readers informed and entertained with his experiences and exploits in a different healthcare system, albeit facing many similar problems to the NHS. He wrote his final blog in the series giving his final thoughts on the 'strangest role' he has ever had. The series of 26 blogs is available online.

Planning guidance, business rules, contracting arrangements and details of how the elective recovery fund will operate meant systems had everything by early February to finalise balanced plans for the year ahead. But Lee Outhwaite, HFMA vice president and South Yorkshire Integrated Care Board chief finance officer, was clear this year's planning round would be difficult. There were huge details to unpick, he said in a February blog, but perhaps the biggest issue would be balancing national and local priorities.

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

Comment

March 2023

Keep it simple

Clear rules on funding and allocation will make for an easier planning round

I did my first HFMA branch conference towards the end of February. The HFMA Eastern Branch had a great event, packed with a mix of technical and softer skills-type presentations.

The highlight for me was listening to an incredibly courageous lady who has battled with a disability for 52 years and is now at a place in her life where she doesn't care what others think.

She has reached a kind of inner peace that many of us strive for and has a work-life balance that seems out of reach to many of us – an inspiration to us all. So thank you to the HFMA's Hayley Ringrose!

The conference was full of discussion about the recent draft plan submissions and the various levels of deficit that each integrated care system plan appeared to be reporting at the time.

I was approached on more than one occasion and asked whether the HFMA was going to be saying anything at a national level about some of the more interesting policy directives that have materialised in this year's planning round.

The rules around the elective recovery fund came up a lot in conversation!

It would appear that no matter where you sit on this spectrum, whether you are a trust tasked with getting to 103% of 2019/20 activity or aiming for 113%, there is a particular reason for you to feel aggrieved.

I'm not sure what the right answer is to this, but it is clear that nothing will make everyone happy.

Is the solution to reinstate some arbitrary target that is equally applicable to everyone – a bit like telling us all to get to 76% with the emergency department standard or have no patients waiting longer than 65 weeks? Or should we continue with differential target baselines that don't, on

HFMA president Lee Bond

Planning and realism

Realistic assumptions needed ahead of challenging year

There are growing calls for UK governments to be more realistic in their assumptions over what can be delivered in health service recovery and transformation within available resources.

The NHS faces huge pressures, with a long list of missed targets and historically low performance metrics. As the Institute for Government and CIPFA said in February, 'by any reasonable metric, hospitals are in crisis' (*see page 3*). The only way you might argue with that statement is that it is not just hospitals that are in trouble, but most aspects of healthcare delivery.

There are some big forces at play driving this crisis. Historic underinvestment over the past decade, compared with long-run funding growth, has left its mark. And there is a major shortage of staff, which is linked to increasing pressure on the workforce, levels of pay, Brexit and lack of forward planning.

But these issues need to be acknowledged in assessing what realistically can be achieved in the coming years. A swathe of reports, including that from the Institute for Government, suggest that currently we are not getting this right.

According to the Public Accounts Committee, NHS England made unrealistic assumptions about the first year of recovery, including that there would be low levels of Covid-19 and minimal adverse effects from winter pressures. And Audit Scotland has called for 'full transparency' on Scottish NHS recovery.

Greater clarity on what is and isn't being achieved, and about realistic waiting times going forward, would help to manage public expectations.

We are now well into the 2023/24 planning round, with draft activity, workforce and finance plans having all been due for submission before the end of February.

At this more detailed level, there is also a

Healthcare Finance editor Steve Brown

“The complexity we’re wrestling with and the numerous ways the system rules are being interpreted are not helpful”

the face of it, seem terribly intuitive or logical in their creation?

I don’t envy the team at NHS England tasked with developing these financial systems, and I would never dream of telling them what to do. My only advice would be to make it simple.

The level of complexity we are wrestling with and the numerous ways that the system rules are being interpreted are not helpful.

I get the sense from talking to colleagues that we just want the rules to be clear and unambiguous, which is arguably something that we haven’t got quite right so far this year?

What is certain is that there is a lot of work needed to reduce deficits.

The question bothering me as a chief finance officer is what happens when we can’t get the numbers down any further?

At what point do we need to talk about what is actually deliverable, as a national health service, if we are to remain within this resource envelope?

That said, there is clearly more we can do, particularly on productivity, and all organisations must be looking to reduce unit costs over the coming period.

But it’s not just waiting lists and the ERF that are causing concern. Most systems are also wrestling with the challenges of urgent care and ever increasing lengths of stay in hospitals as out-of-hospital services continue to recover from the pandemic, the economic downturn, and even Brexit.

The push on virtual wards is a good example. These initiatives operate on a simple premise – care closer to home is safer and better for the patient and, in the long run, could be more cost effective too.

This is definitely a work in progress, and not without its challenges – working with stakeholder partners in a way that many of us haven’t done previously. And learning to be reliant on the system acting in concert is a real ask, especially with the workforce pressures that many of us are also trying to juggle on a daily basis.

The temptation to abandon initiatives such as these before they have time to mature and flourish is a real one. However, I think it is a temptation we need to resist as we try to change decades of consumer custom and practice through the use of technology and virtual medicine. These approaches offer real hope in terms of freeing up physical beds that will help with recovery.

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major need for realism. There is, as ever, real pressure on systems to deliver everything that is required of them within a balanced budget. And inevitably, there is a political angle. Governments are never keen on awarding extra funding without tying the growth to the delivery of additional activity or targets. However, the danger with this is that services’ underlying deficits never get addressed. The problem just gets carried forward.

It is completely legitimate for the centre to put downward pressure on systems to deliver value for money – really drive the push for efficiency and improved productivity. But this needs to stay within the bounds of realistic achievability. Otherwise, the NHS is just being set up to fail.

And the ability to plan for the long-term – move more into prevention, address health inequalities and really start to tackle local priorities – just goes out the window.

There appears to be a disconnect. NHS bodies report that inflation on goods and services continues to be well above the levels assumed in allocations. Yet they are expected to just absorb this additional cost pressure.

Everyone wants to improve waiting times, but workforce shortages make this difficult. Add in pressure to reduce temporary staffing costs – another laudable aim – while staying within overall balance, and it starts to look like a game of whack-a-mole – addressing one problem or requirement, only to see it jump up again somewhere else.

“It’s like a game of whack-a-mole – addressing one problem only to see it jump up somewhere else”

There is lots of good work going on. Systems are looking at upskilling and maximising the value of existing staff as a way of delivering services with real workforce shortage hot spots. And many areas remain determined to make progress on health inequalities and prevention, despite the major financial challenges.

But simply pretending the money is sufficient to do everything the service wants to do – provide rapid elective recovery, transform pathways, harness digital technologies, fix primary care, move more towards population health management and address health inequalities – will get the service nowhere. The danger is that whatever is achieved, come the end of the year, it will look like failure.

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FIRST STEPS

It has been a hard start to life for integrated care systems, with the NHS facing significant service and financial pressures. But while integrated care board chief finance officers see further challenges ahead, they also point to progress towards real system working

Integrated care systems (ICSs) have been born in hard times. As the Public Accounts Committee said in February, it is 'difficult to see how ICSs can fulfil their potential' until a number of longstanding challenges have been addressed – including the elective backlog, workforce vacancies, increasing demand, a crumbling estate and a difficult financial outlook.

The operational and financial context is undeniably difficult. But integrated care board (ICB) finance leaders can identify progress in the boards' first year (or nine months to be exact) of existence. *Healthcare Finance* spoke to three of them.

Sarah Stansfield, Northamptonshire Integrated Care Board

Sarah Stansfield, chief finance officer at Northamptonshire Integrated Care Board, says one of the biggest achievements locally has been the way local partners have embraced a different way of working. 'We have been having broader conversations about things that previously only commissioners or providers talked about. Now we talk about them together.'

And it's not just talking – some of the progress is becoming tangible. Ms Stansfield points to a new care model piloted by the system's community stroke service, which captures exactly what system working should be about.

The model involves funding something in health that saves money in local government. 'We have just about got to grips with spending money in one area of health that saves money somewhere else in health,' she says. 'But we've now got something we think saves significant amounts of money in social care.'

The new allied health professional-led community stroke service has 'significantly improved care in the stroke pathway'. It has reduced length of stay and improved outcomes. Therapy and some mental health support (with physiotherapists trained in counselling) have been increased at the beginning of the pathway, just after discharge. This is reducing subsequent care needs in the community – in some cases eliminating the need for packages of social care altogether.

'The challenge now for the integrated care board is how to fund that beyond March,' says Ms Stansfield. 'Ideally, we would like to expand the service beyond the pilot area. And we are working through what the funding mechanism could look like.'

In many ways, Ms Stansfield says the achievements and challenges are tied up together, with the ability to fund and staff new ways of working an undeniable issue. However, she says, it is important to acknowledge that this year's progress has been gained through the commitment and efforts of frontline clinical staff.

Winter has been difficult and there is recognition from everyone that they would want to be providing better access and support to patients.

There is a danger that people will judge the performance of ICSs without due regard for the current NHS context – one defined by financial difficulties and workforce shortages. As Robert White, National Audit Office director of health value-for-money audit, said last October: 'It is going to take time for ICSs to show their worth.'

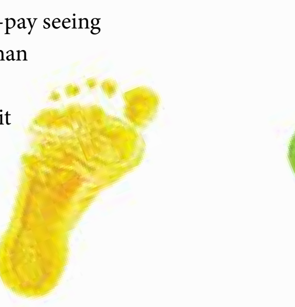
"We have to start investing in those areas we know give us some of the answers and accept that gives us a higher efficiency target across the rest of care"
Sarah Stansfield

But Ms Stansfield identifies a further risk if the agenda becomes too focused on cost-cutting and efficiency. 'We have sold a lot of people a vision about integrated care boards – about being new, innovative and exciting and doing things you couldn't do before,' she says. 'But if we say to these new leaders that they need to run their organisations for materially less and eliminate an underlying deficit, it is not as exciting and innovative as you might like.

'I genuinely think that one of the challenges for integrated care boards will be retaining the talent that they have managed quite successfully to recruit initially.'

For Northamptonshire, the financial reality is a forecast deficit for 2022/23 of £35m, rather than the planned break-even. Much of this is driven by pressures in providers, with pay costs increasing in part due to demand-led escalation and Covid sickness backfill, and non-pay seeing much higher levels of inflation than assumed in funding levels.

But the ICB has also taken a hit in prescribing and increased continuing healthcare (CHC) costs – a result of both the inflationary and demand pressures in this area. The ICB's CHC costs this year represent a material increase, but there are further concerns for next year.



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'So, looking at 2023/24, the letters I'm currently getting from our CHC providers are looking for between 8% and 15% in terms of inflation,' she says. 'And the settlement is funding me for 5.5%.'

Ms Stansfield acknowledges that the settlement for the NHS in 2023/24 is a good one – relative to the rest of the public sector. But it comes with a long list of performance targets, and high inflation has eaten into its purchasing power.

As with the rest of the country, workforce shortages are a major obstacle – making service delivery harder and more expensive, as the trust backfills with more expensive temporary staff.

Pay is an issue – the recent industrial action is clear evidence. For Northamptonshire, a particular challenge is being situated at the confluence of multiple motorways, which has led to the area being a logistics hub. 'We are surrounded by warehouses and the dispatch industry, including Amazon,' Ms Stansfield says. 'And you can earn materially more in an Amazon warehouse than you can in some of our crucial healthcare roles.'

A recent HFMA survey raised concerns that the initiatives most at risk from the current financial pressures were those related to prevention, health inequalities and population health management – despite two of the national goals for boards and their wider systems being improving population health and tackling health inequalities. The system's 10-year strategy – *Live your best life* – published in January, sets out 10 core ambitions, only one of which relates directly to health and social care. The rest reflect a determination to contribute towards tackling the wider determinants of health – giving children the best start in life and access to good education; supporting employment that keeps people out of poverty; and good housing.

But Ms Stansfield is clear that ICBs have to find a way to make progress on these wider ambitions. 'If we genuinely believe what we've written down, then we have to have a different conversation,' she says. 'We have to start investing in those areas that we know give us some of the answers and accept that that gives us a higher efficiency target across the rest of care.

'Otherwise, nothing is ever going to change. It would be a real shame if the core purposes of improving population health and addressing health inequalities were to suffer because we can't make the money work.'

She admits she has no magic solution to enabling investment in these areas. But it has to start with commitment. That means not cutting investment in the key enablers of digital and prevention – locally and nationally. And it means the NHS getting better at benefits realisation.

Lee Outhwaite, South Yorkshire Integrated Care Board

Finding the balance between the operational planning guidance's must-dos and the important local priorities is the key challenge for South Yorkshire Integrated Care Board, according to its chief finance officer, Lee Outhwaite.

The system has some stark challenges – shorter life expectancy than the English average, more years spent in poor health and 37% of its population living in the country's 20% most deprived areas. But it also has some major ambitions in its integrated care partnership (ICP) strategy, including accelerating the focus on prevention and reallocating resources to where they are most needed – tough ambitions in the face of the current financial context, unrelenting emergency demand and a national focus on reducing the elective backlog.

'There is real tension between the ambitious health and wellbeing strategies being developed by all the ICBs and the NHS-centric planning round, which is largely around doing more of the same faster,' says Mr Outhwaite. He admits that ICSs and ICBs have been introduced in a very difficult context. 'The challenge is to get into that positive space about trying to do different things.'

He also detects a different mindset around the system. 'This is a genuine partnership,' he says. 'The conversation is now about what you do about the problems rather than who owns them, which was sometimes a feature of the old system.' He warns that all systems need to guard against 'muscle memory' kicking in. Systems have huge and laudable local agendas, which will require doing things in different ways and spending money in different places. But alongside this they have a national requirement to deliver increased activity, which is directly linked to the funding they will receive. Not everything will be achievable while delivering a balanced budget.

"The conversation is now about what you do about the problems rather than who owns them"
Lee Outhwaite

'Trying to integrate care in the current financial context would test even the best international management teams and the trick will be not to default to old competitive behaviours,' he says.

Having said that, he recognises a different mindset across senior finance. 'There is a recognition that if one of us has got a financial problem, then we've all got a financial problem,' he says. 'It sounds like a little thing, but it is actually quite big, because that isn't how it has operated in the past. 'We need to test this in anger in the context of next year's plan, but it feels a little more collegiate and supportive.'

He adds that having a local authority director of adult social care as one of the ICB's place directors has really helped to strengthen engagement with local government.

He describes a recent health inequalities event, bringing together NHS providers with local government, public health and health and wellbeing boards. 'People were getting very animated, talking about doing things differently and getting into communities that are sometimes forgotten and the health benefit of doing that,' he says. 'There was some real energy in the room that I can't remember for quite a few years.' Backing this up with investment is the challenge.

Mr Outhwaite says the answer to making progress on the transformation agenda has to lie with 'tracking down the inefficiency in the incumbent spend'. 'That is what will give us the headroom to get into moving support upstream and dealing with previously unmet need,' he adds. 'Investing in prevention has to be a good idea, but the only thing that gives us permission to do that is stopping spending on the things we don't need to do right now.'

He is under no illusions about how difficult this will be. Finance reports to boards of providers and systems up and down the country are littered with examples of under-delivered efficiency programmes in a further year of Covid-19-disrupted care delivery.

Mr Outhwaite believes the real leaps forward in health outcomes and value for money will be in allocative efficiency – allocating resources to the programmes of care that maximise health. The spotlight is on the elective backlog, but should there be more focus on the waits for child

and adolescent mental health services assessments, he asks. And he has a similar question about speech and language assessments for pre-school age children. 'I think we have to stress test this new operating model to see if we can make that different partnership working deliver allocative efficiency in a different way,' he says. 'We are not going to get through this by all running faster on the spot anymore.'

Shared plans will be needed at place level that make the case for interventions in social and domiciliary care that release beds occupied by patients who are medically fit for discharge. 'We have to mobilise around the broader transformational change agenda and build some confidence in it,' he says.

Simply asking individual organisations to deliver their contribution to the efficiency target will not be enough. Instead the efficiencies will be delivered by working across organisations and optimising pathways.

What would success look like in a year's time? 'If we've taken two or three projects forward in each of the four places and they have begun to have an impact on clinical and cost-effectiveness in a small subset of areas and we've grown a bit of confidence that we can do multi-organisational change – if we've done that over the next year, I think that would be a fair achievement while working in a different way,' he says.

Sarah Truelove, Bristol, North Somerset and South Gloucestershire Integrated Care Board

For Bristol, North Somerset and South Gloucestershire, the creation of the integrated care board has felt more evolution than revolution.

It was not born out of the merger of numerous clinical commissioning groups and has not had the additional complication of pulling together multiple organisations. Even so, 2022/23 has brought considerable new demands – a first system capital prioritisation process, for example.

But perhaps the biggest change has been a state of mind. 'What we have really tried to get on top of is that we are planning for ourselves,' says Sarah Truelove, the board's chief finance officer. 'This is about our population and driving population health improvement and reducing health inequalities. We do need to respond to what NHS England asks for, but our primary focus has to be looking at our populations.'

She says this can be seen in the board's planning process, in which reducing health inequalities carries as much weight as more traditional performance metrics.

'There is as much focus on community services as there is on acute,' she says. 'There is still more to do, still more to improve. The integrated care partnership has only been in place a short amount of time and we have a strategy framework rather than a clear strategy at the moment. But it is good progress.'

The determination to address health inequalities means there has been a lot of preparatory work identifying better data sets to support better targeting of healthcare and improved decision-making around the needs of different population groups. That may not yet be visible to the population, but it is an essential foundation for focusing on improvement in population health, not just the delivery of healthcare.

Similarly, the system has established a GP collaborative board as part of developing a new relationship with primary care. This has helped create a powerful primary care voice as part of system discussions. And its involvement in prioritising capital spend has highlighted how the areas of greatest need in terms of estate are also the areas of highest inequality.

But there are also more tangible early developments. There's been an improvement in the learning disabilities services, with more physical health checks being undertaken. This may be a change in inputs at the moment, but the ICB anticipates it will lead to improved outcomes downstream. The changes have included service reviews to ensure that the particular needs of learning disability patients are being met – including when visiting accident and emergency departments.

Elective recovery remains important for the system, albeit challenging. Ms Truelove says that the system understood early on that the current year's 104% activity target, compared with pre-pandemic levels, was not achievable. 'But that doesn't mean we aren't trying to do as much as we can in terms of elective recovery,' she says. 'It is just recognising that we've got a heavy weighting on things like dental and ophthalmology, which had particular challenges during Covid and are taking a little longer to recover.'

> **"There is as much focus on community services as there is on acute. There is still more to do, still more to improve"**
> Sarah Truelove

There have been significant improvements in cancer waiting times and the system delivered the required reduction in long waiters, but it couldn't achieve the 104%. This year's target is more demanding in terms of a higher than average year-on-year increase in activity, but a lower absolute target of 103%.

Like other systems, Bristol, North Somerset and South Gloucestershire has faced major capacity and staffing challenges. But it also experienced some of the highest levels of patients in hospitals with no criteria to reside. With the end of the national discharge to assess funding, the system had developed its own business case for a continuing programme and was implementing this.

'It was really challenging because we wanted to increase home care capacity so we don't rely so much on community beds, but recruitment is very difficult in a very high employment area, with lots of competition from other employers,' she says.

However, the ICB worked with the care sector and with the Local Government Association to get a better understanding of current practice.

This revealed how cultural changes and better trust between clinicians and practitioners could enable the demand to be better met without a major increase in capacity.

It realised that there were more patients being

allocated to the P3 pathway (typically a care home) than seemed necessary. As Ms Truelove points out: 'Once they go into those beds, it can be harder for them to come back out and so they are more likely to end up in long-term care. It appeared that more people could be going to the P1 pathway, which is going home with home care support.'

Addressing this involved improving understanding among clinicians about the services delivered in the community and gaining confidence in those services.

The review also found that there was the possibility for a higher number of patients to be allocated to a P0 pathway rather than P1 – still being discharged home but just with informal input from support agencies and voluntary bodies.

These kind of changes can't be delivered overnight – or in just nine months. But over time, they do provide an opportunity to make much better use of existing capacity.

Ms Truelove acknowledges that the financial context is challenging. But she says that a strong directors of finance group in the system, with an agreed medium-term financial plan, is a real asset.

'We have an underlying deficit at the moment, but we've got a plan to address it and some short-term measures to break-even on our way to getting to recurrent break-even,' she says.

Break-even in the next two years is especially important as the writing-off of an historic clinical commissioning group deficit depends on it. Having to repay that former overspend would be a major blow for future system plans.

As for all systems, next year looks particularly difficult in terms of finances. Temporary staffing costs are another issue that the finance directors are grappling with. The work around discharge should enable providers to close escalation capacity, which will reduce some agency usage. But there are trickier problems around mental health nursing shortages. And with the local university reporting a 50% drop in intake for mental health nursing, there would appear to be no medium-term solution to filling the gap.

International recruitment will help but won't address the whole problem. Instead, Ms Truelove says, the system will need to explore the creation of alternative roles and ensure it is using existing staff in the best way. For example, it is looking at how specialling arrangements may be tying up mental health nurses unnecessarily.

For Bristol, North Somerset and South Gloucestershire, the biggest financial headache is the current level of inflation, which is significantly above the level allowed for in-system allocations.

Locally, the ICB has significant private finance initiative costs, which are linked to the retail price index, far higher than the GDP deflator used by the Treasury to allow for inflation in departmental settlements.

It is a key issue as it impacts directly on the savings the ICB must deliver to achieve break-even and on the investment it can make to meet local priorities.

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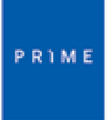

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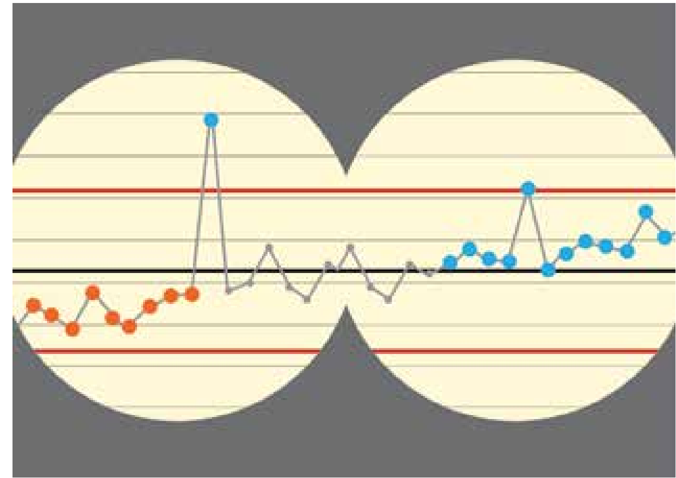
Statistical process control has a long history of improving efficiency and quality in manufacturing. In recent years, it has been widely adopted for performance reporting in the NHS. And now it has financial reporting clearly in its sights. Steve Brown reports

Reading between the lines



Something is happening to NHS finance board reports. Gone (well, going) are the detailed table and text heavy affairs with liberal use of RAG (red-amber-green) ratings to show performance. In their place is a new breed of reports, full of 'new' statistical process control charts.

In some cases, the change is dramatic. At Oxford University Hospitals NHS Foundation Trust, the first thing non-executives saw in their January finance report was a collection of five SPC charts showing the trend on monthly income over the past two and a half years (see below).

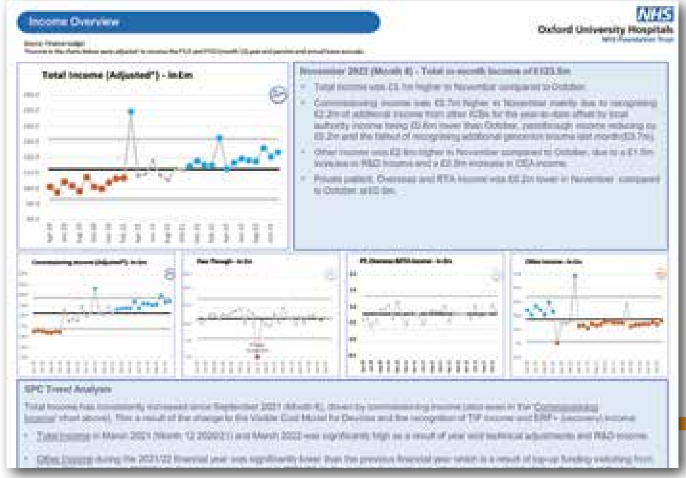
You can still clearly see how the income compares with the previous month, but you get the added information on the long-term trend and can see how this has varied over time compared with the average level of income, and where any major spikes or troughs have occurred.

Turn the page and you find SPC charts used to analyse the pay run rate. On the next page, nine SPC charts give a detailed breakdown of the spend on non-pay. And the appendices overflow with more of the same.

The charts are intuitively easy to understand and enable targets to be included, where these exist, as well as helping readers to understand the difference between normal variation and variation that they should be concerned about or that demonstrates improvement.

SPC pioneer

Kay Wiss, director of finance at Stockport NHS Foundation Trust, is one of the pioneers of using SPC charts to show financial performance. In 2018, after the trust was rated as requiring improvement by the Care Quality Commission, NHS England's Making Data Count team was dispatched to the trust as part of a wider support programme. Its focus was to improve the trust's integrated performance report as part of improving decision-making across the trust.



Exposed to some of the SPC training, Mrs Wiss – the 2022 HFMA Deputy Finance Director of the Year – decided the approach could be used in a different way – to help tell the story of the financial position. In particular, she wanted to use the SPC approach to throw a spotlight on the issue of workforce, and specifically the cost of temporary staffing.

The ability to see trends and whether variation is normal or something to be concerned about means the trust isn't wasting time worrying about things that don't need fixing and can concentrate on those that do (*see SPC advantage, page 19*). Instead of a narrow focus on this month versus last month or a one-time comparison with a target, the trust gets to see a bigger picture.

'The traditional approach to reporting staffing costs simply doesn't tell you what you need,' she says. Mrs Wiss started with six SPC charts, showing monthly spend and whole-time equivalents actually working broken down by permanent staff, bank staff and agency staff and going back 17 months. If the trust's aim of increasing permanent staff and reducing reliance on temporary staff was being achieved, this should be clearly visible in the whole-time equivalent charts. The spend charts would show if this was matched by the anticipated reduction in costs.

With further drilldowns into medical and nursing staff, the charts have also helped identify specific cost drivers. 'This allows us to focus on what we should be looking at, not looking at everything,' she adds.

January's report to the finance and performance committee, where SPC charts have been most used at the trust, continue to tell the story on temporary staffing. The charts show that, while permanent staffing levels are going up, bank and agency costs have not started to reduce.

This is the result of a combination of higher agency rates (particularly for medical staff), the need for extra staff while international recruits gain the objective structured clinical examination to demonstrate competence, and the need to staff escalation wards as a result of emergency demand and discharge hold-ups. But the charts have helped the trust gain a more nuanced understanding of staff costs and drivers.

Stockport has also started to use SPC charts at divisional performance meetings. 'These meetings look at quality, operational metrics, workforce and finance, so we replicated the workforce charts at that level

Controls assurance

Pennine Care NHS Foundation Trust is not currently using SPC charts in its board finance report. But it is pioneering their use in giving assurance about its financial processes and control mechanisms.

'When we started thinking about how to use SPC charts, we decided to anchor back to their core purpose. For us that was about looking at our financial processes, using the SPC charts to determine whether our processes are under control,' says Andrea Osborne, the trust's deputy director of finance. 'This took the trust in the direction of the financial controls report to its audit committee.

The report uses SPC charts in specific areas – showing performance against the better payment practice code (BPPC), aged debtors and creditors and procurement waivers. While the committee sees the cumulative performance on BPPC, as this is how the trust is monitored, the finance team also looks at monthly performance.

'That is what can give us the early warning sign,' she says. 'If your in-month performance is starting to vary, that's an indication that in a couple of months the change will impact on your cumulative performance.'

Response to the use of the charts has been positive. 'We've issued two reports into audit committee and they've gone down well. The non-executives like to see the trends in the data and they are starting to understand how to interpret the charts,' she says.

Each SPC chart is presented with accompanying numbers and narrative, and supplemented by detailed charts in the appendices.

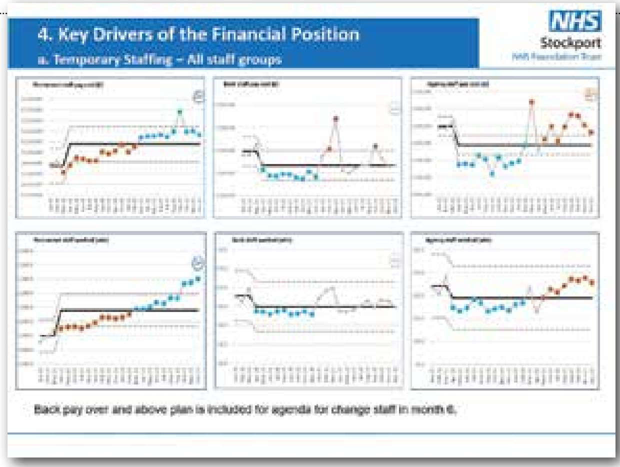
The trust is also expanding use of the charts in the finance team, particularly around pay and non-pay analysis. Ms Osborne says SPC charts are starting to help with month-end reporting. 'Sometimes it is about looking at the control limits to understand the level of variation,' she says, 'because that can signal issues with your processes that impact on the quality of your data.'

The charts also provide a handy way of checking for consistency in data flows. For example, the trust's workforce return and finance return are produced by different systems. 'One thing we've done is bring the data together using SPC. We can see trends and this is alerting us to possible issues,' says Ms Osborne. 'That's what SPC does – it prompts you to ask more questions – and that's helping us improve the quality of our financial reporting.'

too,' says Mrs Wiss. 'And this really does start to show what is driving a division's financial position. We've even used them at ward level and there are things that get highlighted that enable you to take prompt action,' she says.

In one example, the charts highlighted rising agency costs that were linked to sub-optimal rostering, which was quickly fixed with some additional training. According to Mrs Wiss, that made tens of thousands of pounds of difference in one month.

All finance staff are now trained in using SPC charts. But she says the charts are simple to produce and use. 'It is really easy and it's free, because the resources are all online. You can just have a go and you can't break anything.' Mrs Wiss has presented on the use of SPC in finance at HFMA and other events and is an ambassador for NHS England in



encouraging wider adoption. Her current focus is on spreading use of the charts across Greater Manchester, so that the whole system can start to explore trends on agency and bank staff and consider the potential for combined action where needed.

Finance focus

Stockport was relatively unique when it started to use SPC charts in finance reports. Nikki Greenwood, deputy director of intensive support at NHS England, says that 190 NHS bodies use SPC to report operational performance, but about 30 use them specifically for finance.

She believes SPC charts offer a way of improving clinicians and non-finance staff engagement with finance information. 'Often, with finance data, people don't think it is important to them or they just don't understand it,' she says. And that might mean they don't challenge the data because they don't want to be exposed for not understanding it.

'One of the beauties of SPC is that it is really simple and you can look at an SPC chart related to finance for anything and be able to say something about it,' she adds.

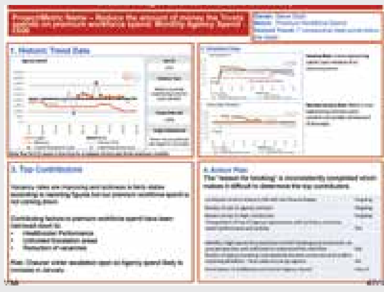
Not just about variation

Finance data doesn't always lend itself to the SPC approach, admits Steve Orpin (pictured), deputy chief executive and chief finance officer at Maidstone and Tunbridge Wells NHS Trust. 'When you think of board-level metrics, income and expenditure performance in a month, for example, that can vary wildly depending on what month of the year it is,' he says.

Things like cash and cost improvement programmes work on a 12-monthly cycle, he says, so the longitudinal analysis of SPC doesn't always fit.

But the trust is a big supporter of using SPC charts to report performance across all its strategic themes – patient access, clinical effectiveness, patient experience and financial sustainability. Non-executive directors have really bought into the use of the charts, which have been used extensively throughout the trust's integrated performance report since before the pandemic.

The trust has even introduced its own touches. It has added a red border to charts where an issue being monitored has been escalated as an area that needs to be looked at and introduced



Oxford University Hospitals has really taken the approach to heart. 'We started using SPC charts in the annexes of our board paper about a year ago,' says Jason Dorsett, chief finance officer. 'And we've taken ourselves and the board on a journey and progressively transitioned more and more data to being presented via SPC charts.'

The response was immediate and positive. 'Non-accountants find a graphical presentation of data easier to understand than a table and if you are trying to present data in a trend format, simply shifting from a table with rows of numbers to a chart makes a big difference. A non-executive without much extra training can understand a run chart.'

The charts also help to prevent inappropriate responses to normal variation. Yael Hunt, finance performance manager at the trust, and self-confessed SPC enthusiast, highlights how easy it is to read a chart. 'It was about six months before the board had any training,' she says. 'But we were still comfortable presenting the charts.'

The colour coding of special cause variation (as opposed to common cause or normal variation) is intuitive and people understand the concept of upper and lower process limits, even though they do not need to understand how they are calculated.

'Previously our board reports were full of financial tables with narratives that were really repetitive with lots of two-point comparisons, this month with last month. SPC gives you the whole story,' she says. 'It also gives you the ability to triangulate data.'

So, a human resources SPC chart might show sickness rates going up, with lots of orange dots (*see SPC advantage, page 19*). But a finance chart on temporary staffing will show the same story from a different angle, confirming the data and clearly showing cause and effect.

Similarly, the trust has been able to show the link between increased length of stay, the need for additional capacity and rising pay costs.

Mr Dorsett says automating the production of SPC charts within the Power BI reporting software has been a game-changer. While the Making Data Count templates are 'great', Mrs Hunt admits that producing lots of charts for the board report was a time-consuming exercise in cut and paste. Now it is a simple push of a button – with the required code again provided free to the organisation by NHS England.

"One of the beauties of SPC is it is really simple – you can look at an SPC chart related to finance for anything and be able to say something about it"
Nikki Greenwood, NHS England

Levels of analysis

Being able to produce analysis at different levels is another benefit. 'We were seeing rising pay in one area and we've been able to drill down into the data and show exactly which staff group is driving it and link the increase to additional sessions,' says Mrs Hunt. The presumption might have been that temporary staff costs were driving the increase, but the link to additional sessions simply wasn't visible in the high-level data.

'Fast forward a month and we had controls in place and were already mitigating what was going on,' she adds.

In another example, SPC analysis helped assess the appropriateness of introducing a winter incentive scheme to encourage further bank take-up.

The automation of chart production becomes particularly powerful for directorates, where a finance manager can drill down into income and expenditure below the overall trust level – providing SPC charts on different income, pay and non-pay categories for pharmacy, for example. 'This is such a valuable tool for a head of finance when in discussions with clinicians,' says Mrs Hunt. 'It is the other aspect of automation – making it accessible and really driving it deep in the use of day-to-day finance, not just reporting.'

Statistical process control won't replace all traditional ways of reporting financial data in the NHS (*see box below*). NHS finance still deals in absolutes in many areas. But trends and variation over time can provide a richer understanding of the financial position. And if you aren't already using SPC charts to enrich your financial reporting, it is likely you soon will be.

additional assurance icons to distinguish between a metric that is consistently passing or failing a target and one that is only just passing/failing.

The board receives a summary of financial targets, with SPC icons showing where variation is causing concern and targets being hit or missed. These cover the delivery of the financial plan, cash balance and capital spend. The trust has also been reporting against its target to reduce monthly agency spend – a target it has been consistently missing for more than six months.

But there is still a focus on the absolute financial position. 'Finance works in absolutes,' says Mr Orpin. Even if an SPC chart suggests an overspend is within the normal range of variation, the trust is managed on the basis of breaking even and might need to take action.

So Mr Orpin sees SPC as an adjunct to more traditional financial reporting to boards, providing additional insight rather than replacing it.

'But [SPC charts] can be really useful to share with service managers, operational managers and clinicians to show why you are concerned about something and how performance has changed over time compared with the mean and the target. They are a great communication tool, highlighting patterns over time really clearly,' he says.

Triangulation is a key benefit of the wide use of SPC charts – something brought into sharp focus in monthly 'visual management' meetings, where the executive team gets together to look at a display of all the key metrics.

'We can see our vacancy rates and staff turnover figures are improving. And we can see an improvement in falls, which we know is directly related to nurse staffing on wards. That's great. But we're not seeing a change in agency usage.'

What the trust has realised – and this has been helped by the visual presentation using SPC charts – is that some of the improvements will take a little time to have an impact on the metrics. Vacancies may be filled, but you may need to allow for different start dates or induction periods.

Mr Orpin says: 'That's a real-time conversation among all the executive team, driven by our use of SPC charts and our improvement methodology – and finance is a part of that.'

There is more use of SPC charts in the report to the finance performance committee, with a deeper drilldown into pay costs than in the board report.

'One of the areas we want to get into is showing forecasting in an SPC chart,' says Mr Orpin. He adds that because forecasts are clearly subjective, rather than actual hard figures, there is a question about whether showing them in an SPC chart is meaningful. The trust is also exploring how the use of SPC charts can help with planning for the new financial year.

HFMA annual conference 2023

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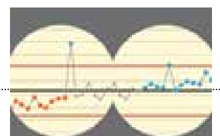
Super early booker available until 21 April

After the overwhelming success of last year's annual conference, in December 2023 we will come together again for the biggest and most prestigious event in the NHS finance calendar. For a limited time, we're offering a super early booker discount for all tickets.

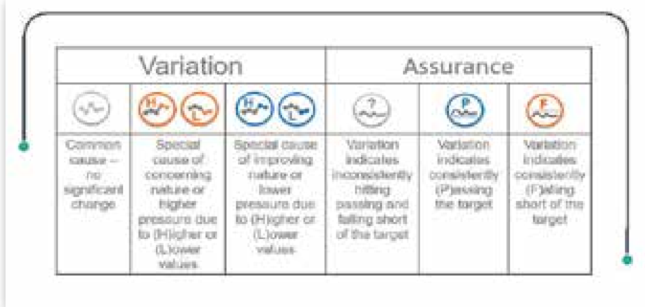
Super early booker available until **21 April** - don't miss out. Visit **hfma.to/hfma2023** and book now.



The SPC advantage

Traditional financial reporting tends to rely on comparing two points – the amount spent this month compared with the amount spent last month. Or it looks at the cumulative year-to-date performance against the target. But both approaches tell you nothing about trend or allow for natural variation.

Yet spotting trends over time can be important. Problems with the payment of suppliers, for example, can provide early warning signs of cashflow and liquidity difficulties.



Month-to-month changes could be the result of natural variation – so making alterations on the back of a 'dip' in performance would not necessarily be the right response.

And if you simply look at cumulative performance against a target, you might miss the fact that underachievement is due to earlier problems that have now been addressed.

This point-to-point analysis can be compounded by RAG (red-amber-green) ratings, which can set alarm bells ringing without due cause – triggering an unnecessary reaction to a variation within the range you expect to see. Instead, SPC charts show a time series of data with at least three reference lines – the average performance and an upper and lower control limit showing the boundaries of normal variation.

Within the limits

The limits are determined by the variability of the data, so that about 99% of data points fall between the limits. Neither the readers nor compilers of the chart have to understand how the limits are calculated; readers simply need to trust that they set the boundaries for normal variation and the freely available software provided by NHS England performs the calculation for chart compilers.

(For those of you who would like to know, NHS England's Making Data Count team teaches a type of SPC chart known as an XmR chart with the control limits 3σ (three sigma) away from the mean. Sigma is a type of standard deviation that takes into account the order of the data and is defined as the mean moving range divided by 1.128.)

In addition, a target line can be included if that is relevant.

The charts are intuitive. Readers can clearly see the trends and spot where performance has been outside of normal variation. There are also rules to help users understand when something unusual is happening. You generally have what is known in SPC circles as a special cause variation if:

- A data point is outside the process limits
- A run of (typically) six consecutive points are above/below the mean
- There are six consecutive points increasing or decreasing
- There are two out of three consecutive points close to the process limits.

"Spotting trends over time can be important – problems with the payment of suppliers can provide early warning signs of cashflow and liquidity difficulties"

Colour coding

Colour coding can highlight whether the special cause variation is of particular concern and needing action (orange) or if it suggests improvement (blue). Grey data indicates no significant change or common cause variation.

Annotations can also show where changes were introduced that could explain subsequent changes in data or add in supporting comments – although the Making Data Count team warns against spuddling (making a lot of fuss about trivial things as if they were important).

Things can happen or changes can be made to a process that lead to a step change in the data – and this may require the mean and the process limits to be recalculated.

However, this should be a measured decision based on the identified change being statistically significant, ideally resulting from a known cause, and confidence that the change has been embedded (perhaps with a run of at least 12 data points).

Use of icons

Icons can also be used in reports to give the reader a quick understanding of whether a variation is common cause (nothing to worry about) or special cause, with different symbols to indicate if the change reflects an improvement or a reduction in performance. Further icons can be used to show simply if a process is failing, capable or unreliable and if targets are being met.

The Making Data Count team has already supported 500 people across the NHS finance community through its *Step one for finance* training course (the team's more general training includes eight training steps), with sessions run quarterly.

There are also four innovations published using SPC for finance in the One NHS Finance innovation library. And a new mini guide to support the use of SPC in finance is due to be published in the coming weeks.

• For further information about statistical process control, visit the NHS England website – hfma.to/mar231 – or see the Making Data Count workspace on the Future NHS portal – future.nhs.uk/MDC

The Importance of Governance, The Very Essence of Collaboration

Christine Hall
Managing Director
NEP Shared System Group

Background

NEP is hosted by Northumbria Healthcare NHS Foundation Trust, and NEP Cloud is the solution which our unique NEP Consortium utilises across their finance and procurement functions.

NEP is an NHS wholly owned organisation which is not for profit enabling opportunities for our NHS colleagues to join our consortium through our governance arrangements.

We have a very robust Governance Structure supporting both the **'system'** and the **'people'** and forms the basis of what NEP is about and what our objectives are.

NEP is in its 21st year, and our Host Organisation has been supportive at every step of our Journey.

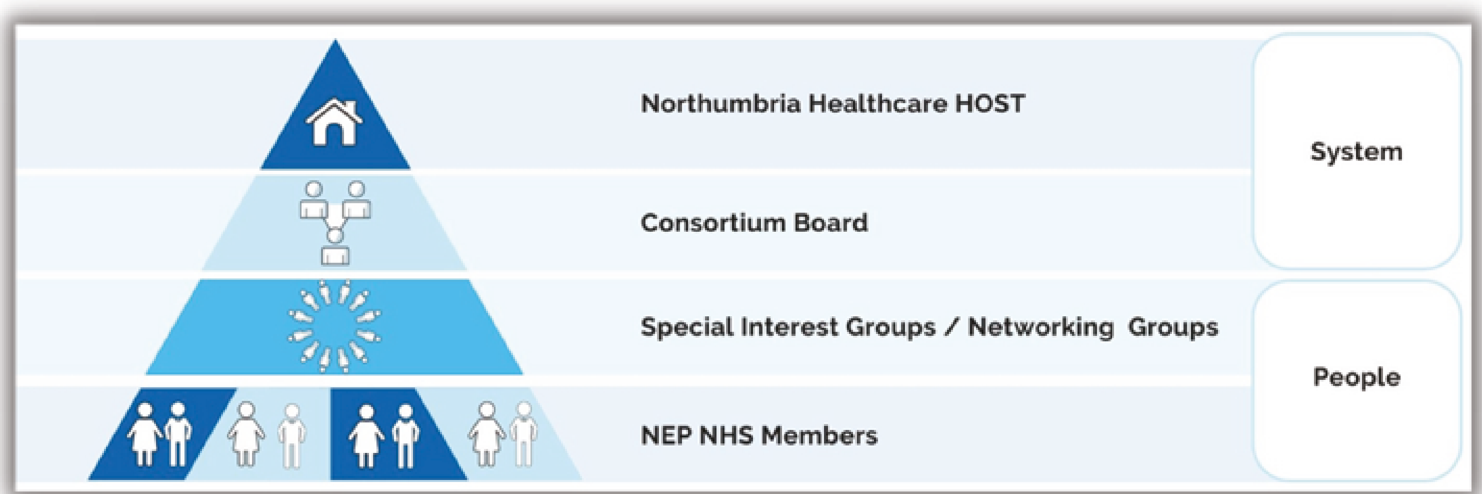
Sir James Mackey – Chief Executive Northumbria Healthcare & NHS England and NHS Improvement Elective Recovery Advisor

❝*The Trust has been with NEP since its inception and 21 years later we still believe in its ethos and proud to be Host.*

Ensuring we have strong and effective governance in place is absolutely essential, having the right people involved giving a high level of professional service, and having a level of confidence and openness between all stakeholders invested in the solution makes it the success it is today.❞

How does our Governance work?

NEP Governance is quite simply a robust structure that is in place to ensure that all members receive a specialist, professional and efficient service meeting the requirements of NEP Cloud and have the voice of our members. It brings transparency in terms of service levels delivered, financial sustainability and is seen to be responsive to both NHS requirements as well as external influences.



At the top of the NEP governance structure is our NEP Consortium Board, in which has delegated responsibility for the achievement of NEP's strategic and operational plans and objectives NEP Cloud (The System) for the benefit of all. They are the group of senior NEP Consortium members who have been voted into the role by the Consortium itself, and have the responsibility in how NEP Cloud system is run and developed.

As you can imagine, being on the NEP Consortium Board is not only an integral role but an important one. Hearing from some of our NEP Consortium members you can see first-hand their view on how important it is to be an active member of the NEP Consortium Board.

Martin Campbell-Smith says, *'To help develop and implement initiatives that benefit the NHS finance and wider communities. To have the change to work with colleagues across the NHS to shape and influence the direction of NEP and the development of NHS Finance for the future.A recent example of this is the NEP Annual Conference which provides all its members the opportunity to come together and share best practice'.*

Speaking to a long standing Consortium member who resides on the Board, Steven Kitching reports, *'Being part of an NHS Consortium is important not only to me, but to my organisation, which is why I joined the NEP Governance Board. It is also important that I act independently for the benefit of all Consortium members, and all decisions are taken with the consortium's interest at heart. There is definitely a distinction and is an important part of the governance arrangements to ensure all members benefit equally, regardless of their size.'*

It is pleasing to hear the feedback from one of our most recent members of the Board, Stuart Smith says: *'Putting it simply, our NEP Governance ensures appropriate processes/routes are followed for any developments or changes, well informed decision making and is transparency to all members'.* Stuart went on to say, *'any NHS Organisation clearly benefits from the strong governance arrangements and the assurance around networking, collaboration and sharing best practice are the key things.'*

Hearing what they have to say in terms of commitment you have to agree that there is a common theme, which is demonstrates how important it is in supporting all our members, members. Helen Lane reports: *'Our Governance allows excellent learning opportunities across organisations and supports continuous improvements and best practice. This is facilitated by the governance structure which includes Networking Forums, Customer Relationship Managers and the Annual Conference.'*

'The NEP Governance Arrangements ensures appropriate processes and routes are followed in terms of enhancements, changes and that there is well informed decision making and transparency to all members'

Our Special Interest Groups show where the governance supports the views and ideas of the 'people' allowing them to contribute in the shaping of the solution. Asking the views from some of our chairs from the Networking Groups, in how the governance supports our NEP Colleagues.

Tony Ulyett – Chair of our Chart of Accounts says: *'The NEP Governance Structure supports it members by providing the platform for organisations to raise suggestions not only for developments but requests for assistance, and support in issues. We receive regular updates and share good practices and ideas across the consortium.*

The Networking structure supports all groups and in terms of any new coding or reporting changes for national reporting, enables to be fast-tracked and implemented quickly for all. '

'As NEP Cloud is refreshed and updated every twelve weeks, system testing is rolled out to members, giving them the first-hand opportunity to check robustness and feedback any specific items and gives ownership back to our users. Overall, the structure offers the opportunity for organisations to participate in shaping the solution, raise issues and share ideas and practices in a partnership to benefit each and every member.'

When asking for feedback from our Reporting Chair, Richard Kinsman says:

'The NEP Governance Framework works well, as it has the checks and balances, and more importantly engages and encourages developments. The Networking Groups are a great platform for sharing ideas and best practice. NEP Cloud reporting offers several different reporting solutions that when applied to the correct reporting task, delivers an output that can flex easily to both national and local needs. The reporting development, via the Reporting Group has delivered an extensive suite of standardised reports that cover all requirements of the finance and procurement business. The technical developments have been shared across the Consortium, which has help in the evolution of the overall NEP Reporting Strate

Christine concluded that our NEP Governance structure is there to ensure we act in the best interest of our clients ensuring the success of the Consortium as a whole, the input from our members ensures we have a continuous improvement strategy including the performance and stability of the solution. Overall, it gives assurance to all our members in that it reduces risk and our organisations have the confidence they are in a safe pair of hands.

To summarise, our governance colleagues intimate, *'NEP Governance is the bedrock of which our business is built on, giving assurance and support in the of making experts across both Finance and Procurement functions in terms of both system and people, enabling change to happen, collaboration and delivering on value and advocating shared knowledge and collective strength for the benefit of the NHS.'.*

FOR MORE INFORMATION PLEASE CONTACT;

Levelling up

The NHS has arguably always taken finance skills development seriously. But an accreditation programme helps to ensure continuous improvement and provides a kitemark that offers reassurance about the capability of the finance team

Most people recognise the benefits of skills development. Better skilled staff will be better equipped to face new challenges and adapt to new practices. Good development makes an organisation more attractive as an employer and, if people are getting the right development to enhance their career prospects, retention rates should also improve.

But beyond word of mouth and interview promises, how can you demonstrate that an organisation is really serious about development? Accreditation, that's how.

The Towards Excellence programme, run by One NHS Finance, began life back in 1998, when it was introduced by finance directors in the North West and overseen by the North West Finance Staff Development Group.

The aim is to recognise good practice in finance skills development and it is awarded at three levels, from level 1 (good practice), through level 2 (high performance) to level 3 (leading edge). Accreditation at each level lasts three years and it would typically take three years to move up the three levels.

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As of January, there are 178 organisations with accreditation at one of the three levels. The One NHS Finance development strategy sets a target of having all NHS finance teams accredited to at least level 1 by 2026.

Given the accreditation programme is open to all NHS finance organisations – including regional and national teams, community interest companies, NHS audit agencies and shared services operation – it is not clear how many organisations still need to embark on their accreditation journey. However, there are 72 providers and 20 integrated care boards yet to achieve their first accreditation milestone.

Some ICBs were quick off the mark after their creation last July. In Greater Manchester, for example, all the predecessor clinical commissioning groups made a concerted effort to gain accreditation ahead of the ICB going live, enabling the board to quickly demonstrate level 1 accreditation.

Of the 178 accredited bodies, 34 are now at level 2, with just 18 being able to claim that they are leading edge in terms of skills development.

Gaining level 1, in most regions, involves self-assessment against published criteria in six standards covering: infrastructure; personal development; professional development; workforce and career planning; corporate financial competence; and business controls and policy.

The requirements included within the criteria get more detailed and representative of higher performance as organisations progress up the levels.

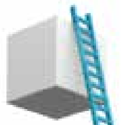
Levels 2 and 3 require external assessment, with assessors recruited from across the NHS, and level 3 organisations are required to put forward an assessor for the national programme.

One NHS Finance claims that the benefits are wide ranging, helping to create a development culture that is underpinned by a competence-based approach. It helps to

ensure that the finance function is constantly developing, adding or improving skills that can help steer their organisations to higher levels of performance.

And it highlights the fact that the chief finance officer is serious about staff development and about the financial competence of their organisation.

These benefits are echoed by those organisations at all levels in the accreditation process, many of which suggest there are additional benefits in improving recruitment and retention and encouraging a sense of pride among finance team members.



Level 1: University Hospitals Dorset NHS Foundation Trust

Applying and successfully achieving level 1 accreditation has helped University Hospitals Dorset NHS Foundation Trust (UHD) to further establish its staff development culture following a merger of two trusts.

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust merged in October 2020. This happened during an already difficult time, with the whole NHS in the first year of the Covid-19 pandemic.

According to the Dorset trust's associate director of finance, Chris Hickson, the accreditation process was particularly helpful in building on the culture for the new trust finance team. 'It really helped us to establish the UHD way,' he said.

In part, the accreditation proforma provided a checklist to ensure the trust had the core infrastructure in place to deliver staff development across its unified team. Much of it was already there, adopted from the previous teams' arrangements.

As a first step, the trust ensured the new organisation was registered with all the relevant accountancy bodies for continuing professional development – a step Mr Hickson encourages others thinking of embarking on the accreditation journey to sort out early on. UHD then proceeded to ensure it could evidence all the other criteria.

Mr Hickson says there was a noticeable increase in enthusiasm from staff in the 75-strong team about personal and professional development.

'There was an uptick in staff resuming their qualifications or studies and the process led to a lot more people being engaged in various networks,' he adds.

The level 1 criteria require the trust to

"There was an uptick in staff resuming their studies and the process led to a lot more people being engaged in various networks"
Chris Hickson

have staff members involved in various ambassadorial roles – for example, as a Future-Focused Finance value maker, a health and wellbeing champion or a finance and clinical educator. The trust has now easily exceeded the minimum requirements.

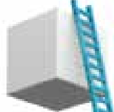
Level 1 also puts a focus on finance function diversity, expecting a trust to move towards a finance team make-up that mirrors its local population. In Dorset, the finance department has adopted the One NHS Finance equality, diversity and inclusion (EDI) action plan, overseen by an EDI steering group, which links in with the wider trust. Mr Hickson says this group has been highly successful and has further helped to establish the team culture.

The criteria also look for evidence of collaborative teamwork among clinicians and non-finance staff – something the trust could ably demonstrate given its deputy chief medical officer Ruth Williamson (pictured above with Mr Hickson) was named the 2022 HFMA Working with Finance – Clinician of the Year. The evidence-based approach of the assessment is also helpful in reinforcing credibility with clinicians.

The trust is the first provider in its system to gain accreditation and one of only 13 organisations in the South West out of a total 30 organisations. But Mr Hickson is clear that level 1 is a starting point.

'I feel we have a lot of the building blocks in place for level 2 and we are keen to start working towards that,' he says.

He admits that the process takes time, but insists it is time well spent, with the robustness of the process making the award valuable.



Level 2: Norfolk and Suffolk NHS Foundation Trust

Norfolk and Suffolk NHS Foundation Trust's finance team gained its level 2 Towards Excellence accreditation at the start of this year, following a December submission. Jodi Martin, senior strategic finance manager at the trust, says achieving the required level was a great feeling. But the real benefit has been the way that preparing for accreditation has fostered a culture around continual improvement.

'It is not just a tick-box exercise,' she says. 'The accreditation programme gives you a reason to ensure you are doing things that you should be doing anyway. But we don't just stop when it's done. It has made us think about how we can continually improve.'

Ms Martin led the accreditation programme at Norfolk and Suffolk and is also an assessor for the programme nationally. However, she says the trick to gaining accreditation is getting other members of the finance team involved.

Assigning other people to oversee specific criteria and gather the necessary evidence not only spreads the workload, but it also encourages engagement in the process.

'The more people who are involved, the more input you get from the grass roots,' she says, helping to raise awareness of the accreditation programme overall and what the organisation does to support development.

Moving from level 1, which is self-assessed, to the peer-reviewed level 2 is a significant step up. One NHS Finance describes it as moving from good practice to a high level of performance. For example, at level 1, organisations are required to demonstrate that all finance staff have up-to-date job descriptions, agreed objectives and personal development plans (PDPs).

But at level 2, objectives have to be reviewed and set at least annually and PDPs must be actively managed, with all staff having six-monthly reviews. While level 1 requires a finance skills development strategy and action plan, at level 2 organisations must also produce an annual finance skills development report.

One of the areas needing most effort at Norfolk and Suffolk in pushing for level 2 related to finance staff development. It has made a difference by taking a much more active, hands-on approach to development compared with level 1. Previously, an email might have been sent to all staff making them aware of development opportunities. But this didn't mean these opportunities were taken up, either because they didn't see the email or felt they were too busy. Now, managers actively

suggest training that they think would be relevant to team members.

Ms Martin says the accreditation process has helped bring the team together – particularly useful with everyone still mostly working from home after Covid-driven changes. She identifies pride among team members about having achieved the level 2 award, and says it is something other organisations are aware of. All seven organisations in the local system are at least level 1, with two now at level 2 and a further organisation submitting in April.

'It has to help with recruitment and retention,' she says, providing evidence to support an organisation's promises of offering career development opportunities.

"We don't just stop when it's done. It has made us think about how we can continually improve"
Jodi Martin

Since Covid, assessments have moved online. An element of the assessment involves a percentage of the finance team having a group session with the assessor. Staff are encouraged to be completely open with the assessor, and Ms Martin says that, even with her experience as an assessor herself, she was nervous about the group session. However, the feedback from the team was really positive.

The assessment typically takes roughly two months – from first meeting the assessor to the final report being submitted to the trust for comment. The process involves a review of the evidence by the assessor or assessors, an evidence review meeting, then a meeting with the chief finance officer and the group session.

The trust is now eyeing level 3, after the required two-year gap after gaining level 2. But that doesn't mean two years of inactivity. Ms Martin underlines her point about continual improvement and suggests that the level 3 proforma effectively provides a route map to gaining the higher level.

To evidence some of the criteria needed in two years' time will need earlier action. If staff at all levels of the organisation are not involved with the Skills Development Network or One NHS Finance – one of the criteria for level 3 – then that will need to be fixed, for example.

There is no doubt, however, that level 3 is the next step. The trust is convinced of the benefits of gaining accreditation and is determined to keep making progress.

Level 3: Royal Papworth Hospital NHS Foundation Trust

Achieving level 3 in the Towards Excellence accreditation programme is not the end point in staff development. What it does do is encourage and embed the right culture to ensure that improvement is self-sustaining.

That's the view of finance leaders at the Royal Papworth Hospital NHS Foundation Trust, which gained its level 3 accreditation in January – the highest level available under the programme. 'We don't consider you need a level 4, because level 3 provides evidence that you have embedded a culture of continuous staff development,' says Sarah Brisbane, the trust's head of commissioning and income. 'Level 3 is not the end of the road, but is a springboard to go on to even better things.'

The trust began its accreditation journey in 2019, when it gained level 1 accreditation, achieving its level 2 in September 2021 and its level 3 15 months later. 'It does take time, there's no doubting that,' Mrs Brisbane continues. 'But it isn't onerous if you plan well.'

The keys to success are a committed team of individuals to spread the load, as well as senior commitment to support and challenge – in this case, deputy chief executive and chief finance officer Tim Glenn.

Mrs Brisbane adds that the big step up was achieving level 2. Level 3 is more about demonstrating that the approach to staff development is fully embedded and consistently applied in the way the finance department operates.

Once delivered, the benefits are huge – for individual team members, the team as a whole, the organisation and, arguably, the wider finance function. For a start, the finance team saw accreditation as a badge of quality and a source of pride.

'Papworth has a reputation as a hospital that is innovative and right at the cutting edge of clinical care, which is reflected in the outcomes we achieve,' says Mr Glenn. 'And it is reflected in our Care Quality Commission rating, which is outstanding across all five domains.'

Mr Glenn says finance and support services play an important part in delivering these standards. He liked the idea of something visible that showed the rest of the hospital the high standards adhered to by the finance team. He suggests that is exactly what the accreditation programme does.

'If you are good at training people, you tend to attract the talent that wants to be trained. If you attract the right people with the right motivation and they grow and develop with you, that is how you get success,' he says.

'It also provides us with assurance that we are working to best practice,' says Mrs Brisbane, 'and striving to have an environment of excellence.'

She says the accreditation process has helped the finance team better understand what can be done. It is all too easy to sit back, especially when times are so busy, and think that you are doing everything right for the team. 'But some of the accreditation criteria make you realise there is more you could do,' she adds.

Getting accredited has been popular with the finance team. The finance department comes out top in the trust's staff survey results, and Mr Glenn is convinced this is linked to the quality of service provided – happier and more motivated staff get better results.

Retention is good, but when staff do move on for promotions elsewhere, that is also seen as a positive outcome linked to the development provided. Mr Glenn says it is interesting how often candidates in job interviews mention the accreditation as part of the attraction of joining the trust.

Even if the accreditation process is a little time-consuming, Mr Glenn believes not focusing on development also puts a drain on resources. 'Really there is no alternative. Not developing people also creates work,' he says. 'If people keep leaving the hospital, you have to keep recruiting and spending time in interviews. Having the right development culture is about channelling energy into something that is positive. It is just a decision as to where you want to put that energy.'

Mrs Brisbane believes once you start looking, there are lots of ways to improve an organisation's development opportunities and resources. As an assessor for the wider programme, she has a great insight into good practice. 'One of my pieces of advice to any organisation looking to pursue accreditation is to get a team member to become an assessor,' she says. 'As well as the networking, you pick up amazing ideas from other organisations. We've shared a lot of what we do – our skills matrix is a good example – but we've had lots of ideas coming the other way too.'

"The programme gives us assurance we are working to best practice to have an environment of excellence"
Sarah Brisbane

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professional lives
Events, people and support for finance practitioners

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Leasing standard is key change for 2022/23, but other issues may have an impact

Technical

This is the year that right of use assets and their associated lease liabilities finally hit NHS balance sheets. Implementing financial reporting standard IFRS 16 is likely to be the biggest challenge for this financial year-end, *writes Debbie Paterson*.

However, as the preparations have been going on in earnest for around five years, it should be a challenge that finance teams and their auditors are prepared for. There is no more guidance expected, although NHS England will be adding more validation checks to the month 12 trust accounts consolidation (TAC) forms.

There are no other major changes to financial reporting requirements this year. Having said that, a year-end frequently asked questions is still expected on the *Group accounting manual* – so there may be some changes still to come.

However, there are three other issues that could impact on the year-end.

First is the *Health and Care Act 2022*. Clinical commissioning groups (CCGs) and integrated care boards (ICBs) will be preparing part-year accounts. Some CCG accounts were completed last summer, but the audits will mostly take place during this spring and summer. This will mean that ICB finance teams will be dealing with two audits simultaneously, with the additional workload that entails. It'll be important to get the accounts signed off in the right order.

The act has introduced new requirements for ICBs' and provider bodies' annual reports. In particular, these relate to how they have exercised their functions in accordance with joint forward plans and capital plans, as well as inequalities information. ICBs must also report their mental health spend as a proportion of their total spend.

Although there is no requirement, yet, to formally report the financial position of ICBs and their related NHS provider bodies – the year-end position will be assessed on a system-wide basis. This year, NHS bodies should ensure that their closedown timetable is in line with the other organisations in their system. They may also want to discuss the impact that year-end adjustments will have on the wider system.

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The second area relates to qualifications issued by the comptroller and auditor general (C&AG) in respect of the Department of Health and Social Care annual report and accounts 2021/22 and the NHS England consolidated annual report and accounts 2021/22. Some of these issues will impact on 2022/23. There is concern about the timely finalisation of NHS bodies' accounts and the completion of local audits. The issues with the audit market are well known and are outside of the control of any one NHS body.

However, it remains important that NHS bodies engage with their auditors early and ensure that the draft annual report and accounts and supporting working papers have been subject to internal quality assurance processes.

The C&AG is concerned that the reorganisation on 1 July 2022 will impact on timeliness again in 2022/23.

There are still residual issues relating to stocks of personal protective equipment (PPE) purchased centrally by the Department. Also, 19 providers received a limitation of scope qualification in relation to material inventory balances at the end of 2020/21.

While stock is unlikely to be a key issue this year, this is a useful reminder of the importance of good stock-taking processes and the involvement of the auditor in those stock-takes.

The C&AG also remains concerned about the level of accruals in the year-end balances. Although the uncertainties and errors were not material at 31 March 2022, this is still an area of audit interest. The annual leave accrual is likely to be of particular interest as human resource policies around carry forward of annual leave return to pre-pandemic arrangements.

Both provisions and accruals will be subject to audit scrutiny due to the level of judgement and estimate involved in determining year-end balances. Provider bodies should remember that provisions only have an impact on the Department's resource departmental expenditure limit (RDEL) when the provisions are discharged. To allow the Department and NHS England to manage the year-end position, it is important that provisions do not change between month 11 and month 12.

Finally, as reported in December's *Healthcare Finance* (*page 41*) – there are changes to auditing standards. Auditors will be focusing on fraud and risk – this means that they are likely to want to understand the systems that NHS bodies use to produce their accounts, including arrangements for establishing accruals and provisions, as well as other areas of judgement such as deferred income and income in advance.

Debbie Paterson is the HFMA's senior technical manager

Technical review

Recent technical developments

Technical

NHS England has published statutory guidance about when and how it would intervene in how much capital a foundation trust was spending. Last year's *Health and Care Act 2022* introduced a new power for NHS England to intervene if a foundation trust was planning to spend money that was not affordable within integrated care systems capital limits or allocated capital through national programmes. In practice, foundation trusts will be given **notional capital resource limits**, notified through the monthly provider finance return. Spending against this notional limit will inform NHS England's assessment of whether a formal limit is needed. In reality, informal limits already exist as foundation trusts have to agree spending levels within their system's capital envelope. However, an order under the act is intended as a final resort and the limit on capital spending would remain in place for single financial years.
hfma.to/mar2310

The Department of Health and Social Care has published a routine update on the financial assistance that can be given to foundation and NHS trusts, including **revenue and capital cash support**. Revenue cash support generally takes the form of public dividend capital (PDC), with no set repayment schedule, but with trusts paying a dividend on the support provided. Capital expenditure must be affordable within the capital departmental expenditure limit and prioritised within the system allocation. If a provider considers it has insufficient cash to finance the expenditure, it can apply to NHS England with any cash made available as PDC. The guidance covers how to request assistance, the criteria used to determine whether to grant it and the terms and conditions which may be applicable.
hfma.to/mar2311

Suppliers entering into new contracts for goods, services and works of more than £5m a year with NHS organisations after April will need to publish a **carbon reduction plan**. The new requirement is born out of the NHS's net zero ambition and suppliers are encouraged to set their own net zero target of 2045. The new rule is in addition to the inclusion of a minimum 10% weighting on net zero and social value in evaluating bids as part of NHS procurement. The 10% requirement came into force last year.
hfma.to/mar2312

NHS England has issued guidance on **capital investment and property business case approval** for trusts. It is aimed at allowing trusts to manage their own capital investment, up to an agreed limit, while governance and assurance is in place, and reflecting the need to prioritise good value-for-money investments within the capital departmental expenditure limit. The guidance – *Capital investment and property business case approval guidance for NHS trusts and foundation trusts* – sets the delegated limit for trusts and foundation trusts in financial distress at £25m. This is an increase in the £15m delegated limit set in previous guidance dating back to 2016. Foundation trusts not in financial distress have been set a delegated limit of £50m. For self-financed digital capital schemes, the limits for trusts or foundation trusts in financial distress are £25m in capital cost or £30m in total whole-life costs. The limits are £30m in both cases for foundation trusts not in financial distress.
hfma.to/mar2313

The elective recovery funding in 2023/24 aims to support the delivery of 107% of 2019/20 activity, valued using 2023/24 national unit prices. However, integrated care boards have been set differential targets – ranging from 103% to 114% – to reflect their starting positions in terms of **elective recovery**. At the national level, just 98% of value weighted elective activity was delivered in the first half of 2022/23, compared with a target for the year of 104%. Commissioners delivering the lowest value weighted elective activity in 2022/23 may have lower absolute targets for the new year, but will need to improve by more than the national average. Providers will be paid using the aligned payment and incentive providers approach, involving fixed and variable elements. In a change from 2022/23, all elective activity will be paid for as part of the variable element at full national unit prices, adjusted for the market forces factor. This will cover all elective ordinary and day cases, outpatient procedures and first attendances, chemotherapy and unbundled diagnostic imaging and nuclear medicine activity.
hfma.to/2314

The **elective recovery fund** (ERF) is arguably the most complex element of the funding and payment arrangements for 2023/24 – aiming to drive recovery performance across England. A webinar held by NHS England prompted a large number of questions and the national body added a dedicated ERF section to its frequently asked questions for this year's planning round. The questions and responses cover a range of topics including how ERF funding has been calculated and the services that are in and out of scope. The additional guidance is available on the Future NHS platform (requires log-in), which also includes an updated version of the provider-commissioner ERF targets and baselines.
hfma.to/mar2315

A new tool to help boards assess how initiatives **impact on health inequalities** has been developed by the NHS Confederation. The tool and associated scorecard build on the five national priorities for tackling health inequalities and the key lines of enquiry used by the Care Quality Commission to look at the well-led domain.
hfma.to/mar2316

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The new pathways to qualified success

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Bands 2 to 6 finance staff are being offered a new intermediate qualification pathway, while senior leaders can join a fast-track to an MBA, under new programmes being offered by the HFMA.

The association last year opened up free membership to finance staff working at agenda for changes bands 2 to 6. And it is keen to expand the support for this important section of the finance community.

The intermediate pathway will allow relevant finance staff to study for a level 4 certificate. The association is effectively offering a bursary for up to 100 finance staff to study the *How finance works in the NHS* module completely free of charge.

The programme will involve self-study and will be supported by tutor Andy Ray, who will deliver four live tutorial sessions across the 16-week schedule.

Those who successfully complete the module will have the opportunity to move on to continue their studies, with a further two self-study-only modules resulting in a level 4 diploma. This could then lead to the opportunity to sign up for the HFMA's masters-level qualifications.

The module starts on 20 April and the HFMA estimates that completion of the module requires six hours of study per week.

A new executive pathway has also been launched, which provides a fast-track route to an MBA.

Access to the MBA in healthcare business and finance, which is provided by the University of Northampton, usually requires the acquisition of 120 credits. These can be gained by completing two HFMA advanced diplomas, each worth 60 credits and each involving the completion of two modules.

Qualified accountants with more than two years' experience in healthcare can already gain exemption from one diploma.

However, the new executive programme targets very senior finance managers, at bands 8d and above, who can demonstrate a high level of prior experiential learning.

Successful applicants for the programme will gain a further exemption from one module and so be able to study just the *Creating and delivering value in healthcare* module, which will be delivered over a shorter timescale.

Instead of the normal 17-week timetable, the module will run over 12 weeks and give quicker access to the MBA programme.

This will enable a suitably qualified candidate to gain the MBA in just over a year,

something that may be attractive to senior finance leaders with significant pressure and commitments in their day jobs.

Letsie Tilley (pictured), a former NHS finance director and an HFMA masters-level tutor, believes the fast-track approach will suit those in a hurry to progress their careers.

'To succeed and fully reap the benefits of this more intensive approach, you need to be willing to put in the necessary time and effort,' she says. 'This programme has been specially designed to accelerate the pace of your professional development by helping you to acquire and assimilate knowledge to enhance your work life. This will provide you with the potential to climb more rapidly up your career ladder and, if you choose, to advance in a slightly different direction.'

The programme will include a face-to-face introductory session in London, including a presentation from a senior NHS leader and a site visit.

One NHS Finance has offered to fund 10 places on the initial pilot programme. In future, the programme will cost £1,650.

National equality, diversity and inclusion action plan update

The NHS finance community has been working hard since the launch of the national *NHS finance equality, diversity, and inclusion action plan* in November 2021, supporting progress in improving equality, diversity and inclusion (EDI). After a national review by the Finance Leadership Council, the plan has been updated with refreshed actions for the next 12 months.

The updated actions were developed based on feedback from finance staff across the regions, particularly members of the regional inclusion and diversity ambassador networks and sponsee networks. These groups have been instrumental in driving the success of the plan so far, and their efforts are greatly appreciated.

The updated document includes a foreword outlining the changes made and a new colour-coded action list that shows what has been completed, what has changed and what has been added. Some actions have remained in place, particularly those focused on engagement and leadership support. The plan forms a five-year strategy based on data from the 2019 finance workforce census, which is due to be refreshed this coming spring.

In addition to the EDI update, there are several resources that may help organisations and teams, including a resource on flexible working (*see page 4 and* **hfma.to/mar234**) and three resources focused on parental leave (**hfma.to/mar238**).

The NHS finance community is committed to creating a more inclusive and diverse workplace, and these developments are key steps towards achieving this goal.

- **The updated plan can be found at hfma.to/mar237**

Diary

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

B Branch N National I Institute H Hub W Webinar

March

14 I Value masterclass, online
14 B East Midlands: workforce productivity and efficiency, online
14 B South Central: lunch and learn – SPC charts introduction, online
15 B Eastern: lunch and learn – innovations in cancer and other treatment, and managing the financial implications, online
16 H Audit conference, London
16 B West Midlands: workforce productivity and efficiency, online
17 B Scotland: NHS Lothian – the rise of the 'bots' and the automation of administrative tasks, online
21 B London: regional workforce event – senior finance leaders, online

April

12 I Costing conference

May

17 H Accounting together, London
17 B Eastern: lunch and learn – career story, online
18 N Financial sustainability – four nations, online

June

08 B West Midlands: annual conference, Birmingham
15-16 B North West: annual conference, Chester
20-22 N HFMA members' summer series, online
23 B Northern: annual conference, Gosforth

September

14 B South Central: annual conference
14 H NHS finance for chairs, non-executives and lay members, London
19-20 B South West: annual conference, Exeter
21 I Introduction to NHS costing, online
21-22 B Yorkshire and Humber: annual conference
28-29 B Wales: annual conference, TBC

October

3 H Mental health conference, London
10 I International value symposium, online

December

4-8 N HFMA annual conference, London

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Yorkshire and Humber laura.hill36@nhs.net

Events in focus

Accounting together
17 May, London

Are you a management accountant looking to connect with colleagues from across the NHS? Have you ever wondered what your impact is and how your financial reporting feeds into the bigger picture?

This new event aims to answer these questions. The association is busy reviewing suggestions for the face-to-face event and putting together the programme. However, a number of topics are likely to be covered, including:

- Best practice in reporting and engaging with non-finance budget holders
- Looking beyond income and expenditure
- Doing more with less: transformation initiatives
- The importance of the balance sheet
- Ethics.

For more information, please visit hfma.to/mar236 or contact events@hfma.org.uk

Costing conference
12 April, London

The annual Healthcare Costing for Value Institute costing conference provides the NHS with the latest developments and guidance in NHS costing, as well as increasing awareness of the collaborative approach needed to truly harness the power of data. The event will include the usual national update from NHS England's costing team, which is overseeing a busy period for costing.

There are moves to reduce the burden on costing practitioners and simplify the costing methodology, freeing up practitioners' time to support the local use of cost data to drive improvement. However, the year started with uncertainty over the timing for this year's collection, with technical resourcing issues at NHS England and NHS Digital (see page 5).

This year the conference will be hearing from both Warrington and Halton Hospitals NHS Foundation Trust and Barts Health NHS Trust on their work to build engagement and drive improvement. There will also be a session from Mersey Care NHS Foundation Trust looking at investing resources wisely within a health system and how cost data can support system decision-making.

- **For more information hfma.to/mar235 or contact institute@hfma.org.uk**

Three into one

Association view from Mark Knight, HFMA chief executive

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

As we approach the financial year-end, I'm conscious that members are working extremely hard to balance the books while planning for the new year. It's even more difficult this year and that has led to the association becoming increasingly vocal in highlighting the current service and financial pressures.

Our programme of work, led by Emma Knowles, continues. Her team recently gave evidence to the Hewitt review of integrated care systems – a clear sign that our voice and expertise are valued in helping to shape policy.

The HFMA is made up of several distinct parts, which many confuse with each other. Let's call the first part 'HFMA personal'. This is the part of the association that is accessed via the membership fee, which ordinary members pay unless they are bands 2 to 6. Your personal membership subscription brings you this very good magazine quarterly and a regular newsletter weekly, as well as policy outputs offered in a 'members only' section of the website. This is a comprehensive resource available to members at the touch of a button.

In addition, the branch network is member driven and central to our activities locally. A range of professional committees rely on membership and branch involvement. To be on these committees, you have to be a member of the association unless you are a guest. There are also member special interest groups, such as the Charitable Funds Group. These are very much part of our personal member area.

The next part of the association is 'HFMA organisational'. This part trades with your employers and creates a financial relationship with HFMA. You can access a range of services if your organisation has paid the association for them – a wide portfolio from the Healthcare Costing for Value Institute, the Hub, e-learning, the annual conference, paid events (such as pre-accounts planning) and all the Skills Development Network and HFMA Academy activities.

Perhaps slightly confusingly, there are committees in this space too, such as the costing committees and the Mental Health Steering Group. Here membership is based on whether your organisation has paid its Hub subscription rather than through personal contributions. Being a personal member is desirable, but in this case it isn't compulsory.

HFMA chief executive Mark Knight

The final part I want to highlight is 'HFMA public' – the association's role in representing the profession and demonstrating public benefit. The latter is crucial because all UK charities must benefit the public to maintain their charitable status. We also have a wider role in communicating messages about the value of healthcare to society. Some of our recent reports have been very powerful.

There are significant crossovers between the different parts of the association. For example, 'membership direct' is a scheme organisations can access, which bulk buys personal HFMA memberships for a discount. Equally, the qualification, which is an individual initiative, is part of 'personal HFMA' but is often paid for by the employer.

Whatever part of the HFMA you access, there are lots of ways you can engage with our activities – so why not get involved?

SHUTTERSTOCK

Member news

The HFMA Eastern Branch announced its 2023 regional awards at its branch conference in February. **Rebekah Grainger**, financial performance reporting manager, Cambridge University Hospitals NHS FT, was named Eastern Student of the Year (pictured top with branch chair Dawn Scrafield and HFMA president Lee Bond). Other winners included:

- Outstanding Contribution: **Sarah Brisbane**, Royal Papworth Hospital NHS FT
- Champion of Diversity: **Team Access Accountancy**
- Finance Team of the Year: **East Suffolk and North Essex NHS FT** (pictured above)

- Team Player of the Year: **Alan Dawson**, Norfolk Community Health and Care NHST
- Innovation: **Declan Nugent** and **Carol Roberts**, NHS England/PrescQipp.

Full details at **hfma.to/mar239**

Meanwhile, the HFMA North West Branch has set up a new branch shadow committee, made up of band 2 to 6 members. The group will help to develop local events and support a specific programme at branch annual conference. Members include:

- Ellie Lawson (MIAA)
- Nabila Parveen (East Lancashire Hospitals)
- Shaun Weaver (Greater Manchester ICB locality team)
- Harry Vlasman (Liverpool Heart and Chest Hospital)
- Charlotte Cain (MIAA)
- Bharvi Unadkat (Bolton NHS FT)
- Michaela Jones (Liverpool Heart and Chest Hospital).

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

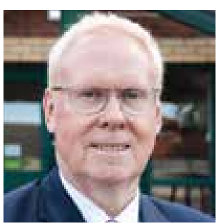
Appointments

Paul Matthew (pictured) is due to join Nottingham University Hospitals NHS Trust in May as chief finance officer, succeeding Duncan Orme, who is retiring from the trust. Mr Matthew, brings more than 20 years of NHS experience to the trust, having started his career as a national graduate trainee. He will be moving to Nottingham University Hospitals NHS Trust from United Lincolnshire Hospitals NHS Trust, where he has worked for the past five years and currently serves as director of finance and digital.

Jenny Hannon (pictured) has returned to Liverpool Women's NHS Foundation Trust as chief finance officer and director of strategy and partnerships. She moves from Lancashire and South Cumbria NHS Foundation Trust, where she was chief finance officer. Ms Hannon was previously at Liverpool Women's NHS Foundation Trust between 2012 and 2021, holding the position of director of finance. She also has experience in the private sector in the UK, and is on the board of trustees at social enterprise PSS.

West Yorkshire Association of Acute Trusts has appointed Ben Roberts as associate director of finance, succeeding Kim Gay, who retired in 2022. Mr Roberts worked at Leeds Teaching Hospitals as assistant director of finance before moving to the West Yorkshire organisation in January. He has more than 16 years of NHS experience, having started on the NHS graduate scheme, and now serves on the HFMA Digital Council.

Chesterfield Royal Hospital NHS Foundation Trust has formally appointed Steve Heppinstall (pictured) as director of finance and contracting. He has held the position on an interim basis since May 2022. Mr Heppinstall has spent more than 20 years working in the NHS. He joined Chesterfield in 2014, having started his career in Wakefield and Doncaster. He also completed an MBA in healthcare finance at BPP university through the HFMA qualifications pathway in 2020.



David Flory (pictured) has recently been appointed chair at Liverpool University Hospitals NHS Foundation Trust, taking up the post from the end of February. Mr Flory is also chair of NHS Lancashire and South Cumbria Integrated Care Board. He has more than 22 years of board-level experience, primarily across NHS organisations, including six years as deputy chief executive/director general in the Department of Health, responsible for NHS finances and performance. He was awarded a CBE in 2009.

NHS England London has appointed Hannah Witty (pictured) as London regional director of finance in January 2023. Ms Witty has since February 2020 served as chief financial officer at Central and North West London NHS Foundation Trust. She has been succeeded there by Tom Shearer, who moves from his role as site chief finance officer for St George's University Hospitals NHS Foundation Trust (*see Shearer keen to take new challenge, page 32*).

Steve Wilson (pictured), treasurer at the Greater Manchester Combined Authority, has taken a non-executive director role at Lancashire and South Cumbria NHS Foundation Trust. Mr Wilson brings more than 27 years of NHS experience to the trust, having started his career on the North West graduate financial management training scheme in 1996.

Atkinson to lead HFMA student body

Dily Atkinson, deputy finance manager for the medicine division at Mid Yorkshire Hospitals NHS Trust, has just become chair of the HFMA Student Committee – its first chair to be drawn from the membership.

The committee was set up to support finance practitioners working towards finance qualifications at CCAB (or equivalent) or technician level. She is well placed to lead the group as chair of the Yorkshire and Humber Branch's Student Committee and a student herself. But with her final ACCA strategic professional level exam early in March, her student status may not be for much longer.

Ms Atkinson says the committee aims to bring student representatives together from all the HFMA branches, primarily the chairs of each branch's own student committee, where these exist. The committee is about sharing intelligence about support and events that work well in different parts of the country and spreading good practice. 'But there is also a role in helping the association to understand students' needs and improve the support for members of finance departments below the professional qualified level,' she says.

The association last year opened up free membership to all finance staff working in roles at agenda for change bands 2 to 6. This has led to an influx of new members with now more than 3,800 members across these bands.

The committee hopes to support the association in identifying the support needs of these new members, she adds, raising awareness of how the NHS operates and helping them to further their careers.

Ms Atkinson says chairing the branch committee and now the national group is development in itself. 'It really helps to build your network and gives you good experience of chairing meetings,' she says, urging others to get involved in their own local committees.

If successful in her final exams, she plans to continue to chair the HFMA Student Committee for a while to ensure the group, set up last year to align with the association's new membership offer, has some stability as it looks to represent HFMA students working in NHS finance.

Alexander Webb, a finance graduate management trainee at Portsmouth Hospitals NHS Trust, is vice-chair.

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

"I think there is a real opportunity to enhance the use of performance metrics to drive improved productivity and benefit patients within the resources we have"
Tom Shearer, Central and North West London NHS Foundation Trust

Shearer keen to take up new challenge

On the move

Tom Shearer says he feels ready to take on a full chief finance officer role at mental health and community services provider Central and North West London NHS Foundation Trust, having spent several years at a deputy level and experiencing parts of the lead finance role.

Mr Shearer is currently site chief finance officer for St George's University Hospitals NHS Foundation Trust, which now operates as a hospital group with Epsom and St Helier University Hospitals NHS Trust.

The group is led by a single group executive team, including group chief finance officer Andrew Grimshaw.

Mr Shearer has spent eight years with St George's, which has included more than four as deputy chief finance officer and a six-month period acting up into the top finance role. However, he believes it is now the right time to take the next step.

The move will mean working with a new, smaller finance team, taking on ultimate accountability for finances with the board, and operating in a new sector and integrated care system.

'Having been in a big teaching hospital for eight years, I was really drawn to the mental health and community sector and experiencing that wider part of the system,' he says.

A graduate of the national NHS graduate management training scheme, Mr Shearer has spent the majority of his NHS career in the provider sector, with a short stint on the graduate scheme at the former Mid Essex Primary Care Trust. With the exception of specialist provider Moorfields, these provider organisations have delivered acute or combined acute and community services.

He recognises that there are significant financial challenges across the whole of the NHS, but points out that there are some specific issues for non-acute services. 'Mental health demands are growing and there is increasing pressure on community care to relieve more of the pressure on acute services and facilitate flow through the whole system,' he says.

As with the wider NHS, mental health and community services face their own workforce pressures, particularly with mental health nurses and practitioners.

These pressures are not as visible in the financial positions of mental health trusts as they are in acute providers. However, Mr Shearer suggests the pressures are just as real, with agency staffing costs a key area for cost increases.

Mr Shearer's new role, which he starts in the middle of March, will also include responsibility for business intelligence and information.

'This represents an area of opportunity for mental health and community providers,' he says. 'There are certain metrics within the acute sector that are shared nationally, well-developed and well-used in organisations. I think there is a real opportunity to enhance the use of performance metrics to drive improved productivity and benefit patients within the resources we have.

'This was definitely another attraction to the role – the ability to look not just at financial efficiency and the money side of things, but also to support the development of business intelligence within the mental health and community sectors,' he adds.

He also acknowledges that all finance director roles now come with a system angle as well as the organisational focus.

'There is a real need for systems to work closer together to release productivity and improve patient experience – making sure that we use the whole system capacity in the right way and are only doing things once, in the right place and the right environment.'

Mr Shearer has also been supporting One NHS Finance to develop a pilot programme to bring school leavers from lower socio-economic backgrounds into year-long placements in trusts in London. It is a subject he is passionate about and will continue to support the programme from his new role.

A huge fan of the existing graduate programme, he is keen for this to be supplemented with a scheme giving school leavers access to NHS finance careers.

'There are some fantastic ad hoc apprenticeships that organisations have established, but if the graduate schemes take 200 people a year, why don't we have a national programme that takes 200 school leavers as well?' he asks.

Mr Shearer says the make-up of finance departments does not always reflect its local community. Targeting specific groups at school leaving age could help to address this, bringing in people from more diverse backgrounds.

The plan this year is to run a pilot scheme with six people given paid placements on a 12-month programme, experiencing different roles across the finance department.

'I hope we can roll it out nationally,' says Mr Shearer. 'I know there are other integrated care systems that are watching on keenly.

'And, ideally, we'd end up with something similar to the graduate scheme bringing in 200 or 300 school leavers, helping to address both the skill shortage within the NHS and the diversity imbalance.'

Mr Shearer has personally been involved in school visits and wants to raise awareness of NHS finance as a career option. He credits a sixth form job as a ward assistant at Addenbrooke's as part of his motivation for his own career.

But he says that for many school leavers, pursuing finance in the context of the NHS would simply not be on their radars.

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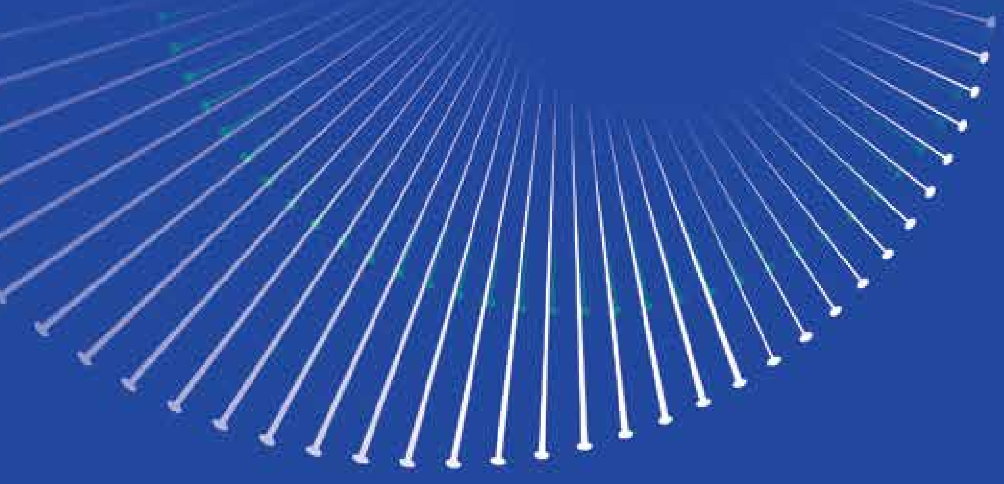

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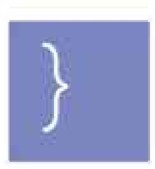

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