healthcare finance

December 2022 | Healthcare Financial Management Association

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Lee Bond

The NHS needs to show strength in numbers

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Julian Kelly calls for renewed push on productivity

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Transformation is how we end the cycle of firefighting

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News

Kelly calls for renewed push on productivity and corporate service costs

By Steve Brown

It has been a difficult year financially for the NHS, with both inflation and numbers of Covid-19 patients running well beyond the levels assumed in the original settlement. Systems had to deliver unheard-of efficiency savings of 5% on average to get close to their planned break-even position.

And next year looks set to be as difficult, with the significant levels of non-recurrent savings in this year's financial positions adding to next year's challenge.

But NHS chief financial officer Julian Kelly is adamant that there remain opportunities to improve efficiency, value and productivity, and he is looking to the finance profession to take the lead.

'Our priorities are going to have to be to: stabilise and improve emergency care; deal with backlogs, including the elective backlog and increased investment in mental health; and improve primary care access,' he told *Healthcare Finance* at the end of November.

> **"The conditions people are operating under are clearly not those we asked people to assume in their plans"**
> **Julian Kelly**

'And as finance teams, we have a job to explore how we recover productivity and take an honest assessment of where we are on some of the overhead costs and how we can work together to get better value out of our procurement.'

Mr Kelly acknowledged that 2022/23 has been harder than anybody had anticipated, both in the delivery of care and financially. 'The conditions people are operating under are clearly not those we asked people to assume in their plans,' he said.

Inflation, as measured by the retail price index (RPI), stood at less than 7% in October 2021. The latest figures put it at 14%. More pertinently, the much lower value GDP deflator – the government's preferred measure of inflation for public services, which many believe underestimates real public service inflation – has also increased significantly since the spending review settlement.

And Covid-19 has continued at much higher levels than expected – in July, close to 12% of beds were occupied by a Covid patient on a daily basis, with more Covid patients in hospital beds this summer than the previous two summers combined. And yet Covid funding was cut from £5.1bn in 2020/21 to £2.2bn in 2022/23.

'It is clearly far more challenging for the service than anyone expected,' says Mr Kelly.

Thirty-seven of the new integrated care boards submitted break-even plans for the year, with five boards starting the year with a forecast deficit with a combined value of £100m.

While many boards are reporting year-to-date deficits, most continue to forecast break-even for the full year.

And NHS England has brought in a formal protocol, setting out consequences and steps that must be followed if boards want to change their year-end forecast away from plan.

Mr Kelly said NHS England understands the difficulties systems face. For example, earlier in the year it added £1.5bn to system budgets to cover the impact of rising inflation since the spending review.

'Covid hospitalisations were higher this summer than the previous two combined. There are problems getting people out of hospital. And because sickness absence is higher, the ability to do things like get your temporary staffing costs down is much harder,' he said.

'We are keeping the position under constant review,' he added. 'I said we would cover the extra inflation pressures. So again, we're just keeping that under review.

JULIAN KELLY: THEODORE WOOD

This year's financial challenges also provide a difficult foundation going into 2023/24, compounded by the fact that a third of planned efficiency savings this year are non-recurrent, according to the National Audit Office. While NHS bodies always include a proportion of one-off savings in annual savings plans, these efficiencies all need to be made again next year before coping with new cost pressures.

However, what was looking particularly bleak next year has improved with the autumn statement. This increased NHS budgets by £3.3bn in each of the next two years compared with last year's spending review settlement.

Crucially, social care funding will also increase by £2.8bn and £4.7bn, with central government funding increasing by £1bn next year and £1.7bn in 2024/25 to get people out of hospital on time.

Mr Kelly had warned in a paper to NHS England's October board meeting that the service could face additional costs of £6bn to £7bn, the continued impact of this year's partially unfunded pay increase, continuing high inflation and new pay rises above the 2% that had been assumed in the spending review. But he suggested the £3.3bn did cover the 'baseline inflation pressures we have flagged'.

Mr Kelly also said that a lower inflation forecast from the Office for Budget Responsibility made about £1.5bn worth of difference to forecast cost pressures.

Some things will have to give. Some transformation programmes set out in the long-term plan will have to be phased in.

But within these parameters – the lower inflation forecast, pay contingency and phased investment – Mr Kelly said that what the

continued overleaf

continued from previous page

NHS received should be 'enough' for the core priorities and to help staff deliver the best possible care for patients.

Enough, but not easy. And systems will need to bear down on costs. 'We know that some of our corporate costs have grown due to Covid,' said Mr Kelly. NHS England guidance has already called for systems to develop plans for corporate services transformation and consolidation, where appropriate.

'And we know we can make savings through things like procurement,' he added. As systems grow the permanent workforce – and there were 130,000 vacancies at the last count – Mr Kelly said temporary staffing costs must reduce. And there has to be a real focus on hospital throughput.

The National Audit Office highlighted estimates that in 2021 the NHS was about 16% less productive than before the pandemic.

This is complicated to unpick. A large element of this is because of delayed discharge, and more activity doesn't necessarily mean better outcomes. It is, however, a high-level indicator that there is room for improvement.

'We do need to get back to some of the core disciplines and the core ways of working,' he said. The extra funding provides a big opportunity, especially with the increase in social care funding.

'People have done incredibly well this year,' he said. 'The NHS is already one of the most efficient health services in the world and I really want to thank finance staff for the work they are doing. In particular, I recognise that the work done in closing down clinical commissioning groups and standing up integrated care boards was phenomenally taxing.' But there is another big year ahead, and there continue to be big expectations on finance teams.

• *Julian Kelly will address the HFMA annual conference on Thursday 8 December.*

Financial pressures put prevention schemes at risk

By Steve Brown

Programmes tackling health inequalities and pursuing key priorities such as a greater emphasis on prevention and population health are most at risk from financial pressures next year, according to an HFMA survey of finance directors.

Finance directors in the survey said next year looked hugely difficult, rating the financial challenge between eight and 10, on a scale where one is achievable and 10 impossible.

However, the survey was conducted prior to chancellor Jeremy Hunt's autumn statement, in which he raised funding for the NHS for the next two years.

Emma Knowles, HFMA director of policy and communications (pictured), said finance directors welcomed the added funding for the NHS and social care. 'However, it doesn't directly address the current workforce crisis, nor is it sufficient to put in place longer term solutions for the continued financial sustainability of the NHS.'

Inflation – on goods and services and specifically on utility costs – was the concern raised by most directors. This was closely followed by temporary staff costs, partly being driven by staff absence as a result of higher than anticipated levels of Covid.

Directors also pointed to the underlying deficits they would carry into 2023/24 as a further cost pressure, with half of responding organisations reporting that 50% of this year's planned efficiencies were non-recurrent.

There were concerns about providers' ability to hit activity targets this year to reduce waiting times. Four out of five respondents thought they would not achieve this year's milestone.

But reducing the elective backlog remains the clear priority, with wider programmes such as health inequalities and prevention seen as most at risk from the continued financial pressures.

This is despite recognition that many of these initiatives – in particular those based around prevention or addressing the wider determinants of health – are part of the solution for delivering sustainable services in the long term.

Capital funding is another concern. More than 80% of respondents were slightly or not at all confident that the capital departmental expenditure limit would be sufficient to invest in transformation plans, with particular nervousness around digital and community diagnostic centres.

NHS England targets recovery

NHS England is forecasting a £270m overspend for 2022/23. However, while there is 'significant risk', particularly in system positions, it expects to break-even by year-end.

At month 6, the NHS was reporting a £482m overspend compared to plan, with systems overspent by £651m.

According to a finance paper presented to the NHS England board at the beginning of December, the forecast £270m overspend at year-end is actually £170m above plan, with five systems submitting deficit plans at the start of the year at a combined overspend of £100m.

According to the paper, the majority of systems are forecasting that overspends will be recovered in the latter part of the year, with all systems forecasting a combined overspend against plan of just £7m for the full year.

The possibility of flu and Covid hitting the NHS together during the winter is seen as a significant risk. There is also a question mark over the impact of additional inflation costs above the level reflected in plans.

On capital, providers had spent 27% of the capital departmental expenditure limit by the half-way point in the year, in line with performance in 2021/22. Based on provider reports at month 6, NHS England is forecasting spend to be £164m below the CDEL allocation for the year. NHS chief financial officer Julian Kelly said NHS England was seeking flexibility to carry this underspend forward to next year.

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Scheme offers better outcomes for families and cuts legal costs

By Steve Brown

A scheme that aims to speed up decision-making around clinical negligence claims for babies incurring severe brain injury has shown early signs of success – reducing the time taken to admit liability by five years and cutting defence legal costs.

NHS Resolution, which runs indemnity schemes for health services in England, introduced the early notification scheme five years ago. It requires trusts to report cases early where there is evidence of brain injury, which in many cases leads to cerebral palsy. The aim is to provide families with a faster, more caring response when a baby suffers severe harm.

Sangita Bodalia (pictured), NHS Resolution's head of legal for the early notification team, said: 'The purpose is to remould the traditional litigation process to deliver a more upstream approach to give better outcomes for families and faster learning for the health service.'

Under the traditional process, she adds, a family might first issue a complaint about the care received during delivery and then instruct solicitors, who would undertake a lengthy investigation looking at the medical records and involving clinical experts. This could take four to five years before a claim can be made and, at this point, NHS Resolution might start its own investigation, which could take a year or more. Often this means a child doesn't get a decision on liability until they are 10 or older.

The early notification scheme flips the process. 'What we try to do is have an early investigation – an early assessment of risk – without waiting for a family to go and instruct lawyers and issue a claim,' says Ms Bodalia.

'Then we try to give them enough information in a letter at the end of the investigation, which will clearly inform the family whether an admission of liability will be forthcoming based on the evidence we have.'

NHS Resolution reported on the first year

of the scheme in 2019. But a second report detailing progress since then suggests the scheme has had success in meeting its goals.

Although a more thorough evaluation of the scheme is planned for 2023, the report looked in detail at 20 of cases involving hypoxic brain injury, where the brain is starved of oxygen, often leading to a diagnosis of cerebral palsy.

Under the early notification scheme, it took on average of 18 months from birth to provide an admission of liability. This compares with an average time for non-early notification cases of nearly seven years. The reduction in time can reduce stress for the family and lead to earlier interim payments, until the full long-term care needs of the child can be determined.

The earlier investigation also helps clinical staff speak about the incident, give evidence and learn from the events.

There can even be costs savings, with the average defence legal costs for the early notification cohort reduced by around one third – from about £34,000 to less than £12,000.

Since the scheme started, NHS Resolution has identified more than 400 claims, some 75% of which include proactive early investigations.

The combined savings are not insignificant. However, the criteria have been tightened, following experience in the first couple of years, to be focused on claims that are most likely to lead to high-value financial compensation.

There is also the possibility that claimants' legal costs will be reduced. These costs are often paid by NHS Resolution when liability is admitted. According to Ms Bodalia, this will be considered when the scheme is evaluated.

However, she said, for claimant costs to significantly reduce this would depend on a change of mindset among some claimant lawyers, who may not be happy to wait for the NHS Resolution investigation to be concluded.

'We would argue that there is no need to incur these early investigation costs, but some claimant lawyers may still decide to go ahead, which is their prerogative,' she said.

NHS Resolution was encouraged by the way lawyers have responded, Ms Bodalia added. They could generally see the benefits for their clients and had been prepared to change how they worked in response.

The cost of clinical negligence claims overall rose again last year. Actual payments made by NHS Resolution from its clinical schemes such as the clinical negligence scheme for trusts (CNST) increased by nearly 9% to £2.4bn, up from £2.2bn in 2020/21.

Overall, the provisions for liabilities arising from claims rose by a staggering 55%, or £45.8bn, to nearly £129bn, although the vast majority (£42.6bn) was related to a change in the Treasury long-term discount rate.

The cost of CNST claims incurred as a result of incidents in 2021/22 was £13.3bn, up from £7.9bn – again with the discount rates being the main cause of the increase. However even without the discount rate change, the costs rose from £7.9bn to £8.7bn – a 10% increase.

Maternity cases continue to dominate the costs of clinical negligence in the NHS, with payments often needing to cover long-term care and support for the child's whole life.

Obstetrics in 2021/22 accounted for just 12% of all claims reported in the year – the same percentage as emergency medicines and orthopaedic surgery. But they accounted for 62% of the £6bn costs of those claims.

CONFERENCE STAGE IS SET

Lee Bond will become HFMA president during the association's annual conference, which runs in the week beginning 5 December, taking over from outgoing president Owen Harkin. The conference combines online sessions with the full face-to-face conference and also includes the HFMA annual general meeting and the 2022 HFMA Awards.

News review

Steve Brown looks at recent developments in healthcare finance

It has been a mad few months in Whitehall, with rapid changes in the key offices of prime minister, chancellor and health and social care secretary following the disastrous mini-Budget. The short-lived growth plan promised wide-ranging tax cuts funded by increased borrowing, causing mayhem in the financial markets and triggering a major reshuffle in the government's leadership team.

Kwasi Kwarteng resigned as chancellor after a little over a month in office and was replaced by Jeremy Hunt, who stepped down as chair of the Commons Health and Social Care Committee to become the Conservatives' fourth head of the Treasury in four months. Liz Truss (pictured) was soon to become the shortest-serving prime minister in Britain's history as she stepped down after just 44 days in office, with Rishi Sunak – one of those previous four chancellors – winning the ensuing Conservative leadership contest. Liz Coffey had been appointed health and social care secretary under Ms Truss, taking over the office from Steve Barclay, who had only been in the job since July. But she duly handed the office back to Steve Barclay as part of Mr Sunak's cabinet reshuffle.

LIZ TRUSS: SHUTTERSTOCK

New chancellor Mr Hunt presented a Budget in his autumn statement in November, insisting the government's priorities were 'stability, growth and public services'. The only main surviving proposal from the mini-Budget was the abolition of the health and social care levy. But there was financial support for key public services, including an extra £3.3bn in each of the next two years on top of last year's spending review settlement to help the NHS cope with inflationary pressures. The Health Foundation said the extra funding would mean the NHS budget increasing by 2% in real terms in each of the next two years, using the Treasury's preferred public services metric, the GDP deflator. The overall Department of Health and Social Care budget will increase by just 1.2% in real terms over the same period. This is below the average seen in the decade preceding the pandemic (2%), as well as the historic average of around 3.8%.

Local authorities will also see extra money for social care – £2.8bn next year and £4.7bn the year after – a combination of additional grant funding, council tax flexibilities and savings from the delayed Dilnot reforms. The reforms were due to cap lifetime care costs for an individual at £86,000 but will now not be implemented until October 2025. Nuffield Trust CEO Nigel Edwards said the delay would be a disappointment to families facing eye-watering costs for care. 'While the cap was never the silver bullet for reform, this delay risks losing the momentum that was growing towards real and long-awaited change to the sector,' he said. 'On top of this, delaying the policy of moving towards paying a fair cost to care organisations is missing an opportunity to develop a more sustainable market for care, and risks undoing the progress already made.'

The autumn statement finally saw the government commit to an independently verified workforce plan for the NHS. There have been growing calls to produce forecasts of the number of doctors, nurses and other healthcare professionals that will be needed in five, 10 and 15 years' time, taking account of improvements in retention and productivity. It was perhaps a predictable announcement as Mr Hunt had himself made the case for such a

The news in quotes

'Seeing your GP should not be as random as booking an Uber with a driver you're unlikely to see again.'

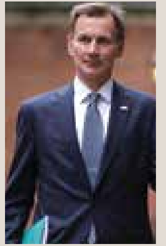
Health and Social Care Committee member Rachael Maskell on the importance of continuity of care

'Since 2015 we have lost the equivalent of more than 1,800 full-time, fully-qualified GPs in England, and the majority of these new recruits will take at least another three years to qualify.'

David Smith, chair of the BMA's GP trainees committee, says new trainees won't help in the short term

'[The autumn] statement offered short-term relief, especially compared with other public services. But the NHS is going to be treading water at best, as inflation bites and it faces rising pressures from an ageing population, pay, addressing the backlog, and ongoing Covid costs.'

Anita Charlesworth, director of the REAL Centre at the Health Foundation, puts the NHS settlement into context



'We want Scandinavian quality alongside Singaporean efficiency, better outcomes for citizens and better value for taxpayers. That does not mean asking people on the frontline, often exhausted and burned out, to work harder, which would not be fair. But it does mean asking challenging questions about how to reform all our public services for the better.'

Chancellor Jeremy Hunt calls on all public services to tackle waste and inefficiency

ZARA FARRAR / HM TREASURY

"The only surviving proposal from the mini-Budget was the abolition of the health and social care levy"

long-term workforce plan while chair of the Health and Social Care Committee. Saffron Cordery, interim chief executive of NHS Providers welcomed the commitment. 'We are pleased our voices have been heard,' she said. 'As a next step, it is essential that this assessment is published in full, with an explicit commitment to provide the necessary funding.'

Strikes have been called for 15 and 20 December in England, Wales and Northern Ireland after nurses rejected the government's pay offer of a £1,400 increase for most agenda for change (AFC) bands, with small extra increases for bands 6 to 7 – an increase in payroll costs of 4.75%. There were calls from the Royal College of Nursing for the government to return for proper negotiations to avert the action. Ambulance workers have also joined nurses by voting to strike. The GMB, Unison and Unite unions all announced ballot results, with strikes likely to be called before Christmas. Meanwhile, in Scotland unions halted industrial action after the Scottish government enhanced its pay offer for AFC staff. An offer averaging 7% had been on the table, but the government further increased this to 7.5%, with the added increase focused on bands 5 to 8A.

More than 4,000 would-be GPs have entered training this year, exceeding the 4,000 target for the second year running. In 2014, only 2,671 trainees entered training. Health Education England has been recruiting foundation year doctors, trust grade doctors and even consultants who want to retrain. In total, there were around 9,600 trainees in GP placements in September, according to NHS Digital figures. However, David Smith, chair of the BMA's GP trainees committee, said this should be seen in the context of the number of GPs leaving the service. 'There is no point having record numbers coming in the front door if huge numbers are still leaving through the back,' he said. 'We need to make the job safe and rewarding again.'

The Commons Health and Social Care Committee recommended a raft of changes to address the crisis in primary care services and protect patient safety. Its report - *The future of general practice* – highlighted the importance of patients seeing the same doctor regularly. To support this, it called for GP practices to be mandated to report on levels of continuity of care by 2024. Workforce shortfalls must also be tackled, which would support the reintroduction of personal lists, allocating patients to individual GPs. The committee said this should be in place by 2030. Stronger links between funding and deprivation should also be implemented by replacing the Carr-Hill allocation formula with a mechanism that gives greater weighting to more deprived areas, it added.

Failure to invest in capital projects will hinder efforts to reduce waiting lists and put patients at risk, the NHS Confederation has warned. It highlighted the low level of capital investment in the NHS compared with other health systems, the impact of inflation in the construction industry and the difficulties in accessing capital when it is available. Yet investment in the NHS can boost the regeneration of local areas as well as making it more efficient.

from the hfma

Covid-19 hit ethnic minority groups harder and affected their access to planned care. In an HFMA blog, the Nuffield Trust's Sarah Scobie said this inequality must be addressed as systems tackle elective backlogs. The trust has published research, calling for better quality ethnicity data and more work to understand ethnic variation in elective pathways.

Suffolk and North East Essex Integrated Care Board's Keith Wood set out a wish list for planning guidance. It called for realistic assumptions given the real rate of inflation of Covid activity and the reduced funding for costs relating to the virus. Simply asking for more activity for less money without a clear rationale could not be considered integrated, he argued.

Just because fraud is not being found in day-to-day activities does not mean it is not happening, according to NHS Counter Fraud Authority's Matthew Jordan-Boyd in a blog. Organisations are not doing enough to stop fraud and recover funds; NHS bodies must proactively look for fraud.

Integrated care systems are widely supported but have been introduced in a difficult environment and will need time to be able to show their value, said the National Audit Office's Robert White. One step that would help would be to ensure oversight arrangements are fully aligned with strategic objectives for integrated care systems, he said.

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

Comment

December 2022

Financial dilemma

Don't sacrifice transformation in the face of financial pressures

This year is difficult, next year will be even harder. That is the simple headline from the HFMA survey of NHS finance directors, published just ahead of this year's annual association conference.

On its own, that may not be very surprising – certainly not to a finance community that is already embroiled in delivering this year's financial position and nervously eyeing inflation and other cost pressures ahead of 2023/24. But the survey detail reveals some deeper concerns – particularly around how we continue to invest in transformational programmes (*see page 4*).

The autumn statement provided an important boost in NHS funding for the next two years above the spending review settlement.

And crucially, it also increased funding for social care, which it is hoped will help to improve NHS capacity as fit patients can be discharged more rapidly.

But the extra funds will not cover all the cost pressures facing the NHS.

We are already seeing the real impacts of more than 10% inflation in contracts for goods and services. And utility costs remain a major issue.

It is also not news to hear that workforce pressures are front and centre in finance directors' minds.

Temporary staffing costs are one part of this, as providers look to cover for high vacancies, which have worsened but pre-exist the pandemic, and also cover for Covid-driven staff absences.

Bearing down on these costs is as much about improving retention and recruitment as it is about agency caps and framework contracts.

And that is tied up with training the right numbers of healthcare professionals, and with staff satisfaction around terms, conditions and work-

HFMA president Lee Bond

The right numbers

The promised long-term workforce plan gives the NHS a shot at addressing staff vacancies

The autumn statement may well have provided the NHS with as good a deal as it was going to get. The economy is in poor condition and other public spending departments face a significant squeeze on their resources.

The £3.3bn increase in each of the next two years for the NHS at least addresses some of the service's concerns about inflation and potentially allows some headroom for pay rises above the 2% allowed for in the original spending review settlement.

The extra funding for social care, with some funds specifically focused on accelerating discharge of well patients from hospital, is also good news.

But no-one in the finance community believes next year will be easy financially – as the HFMA finance director survey has underlined. There are just so many things on the must-do list – the elective backlog, the need to expand mental health capacity, workforce problems in general, and the urgent requirement to improve access in general practice and ease GPs' burden.

As HFMA president Lee Bond says above, there is a concern that new programmes focused on prevention, health inequalities and population health could fall victim of the need to meet these pressures, while staying within budget. These initiatives are how the service will move to being sustainable, so it would be a false economy to cut them.

Perhaps the best news in the autumn statement was the commitment to an 'independently verified' long-term workforce plan. The government has long resisted this, despite a barrage of calls from every corner of the NHS. But, given that the new chancellor had himself called for such an assessment while chair of the Health and Social Care Committee, it was perhaps difficult to continue turning a deaf ear.

This, too, is all about the future and is an important development. Such an exercise a decade ago might have prevented the

Healthcare Finance editor Steve Brown

"Transformation is how we end the cycle of annual firefighting and move towards a sustainable NHS"

life balance – something the current industrial unrest suggests we haven't got right.

One less obvious concern is that finance directors have identified wider programmes – involving prevention, population health and tackling health inequalities – as being most at risk from financial pressures next year. (Investment in staff training, upskilling and development was also seen as at risk, which is not going to help those workforce pressures we were talking about.)

In some ways, this is completely understandable – although it reflects finance directors' views before the new funds were announced.

There is a huge focus on the elective backlog, a major need to meet a massive demand for mental health services, and an urgent requirement to support primary care.

How can NHS systems not meet the demand already at their front door?

But transformation is how we end the cycle of annual firefighting and move towards a sustainable NHS. Investing in prevention or adopting population health management approaches to tackle the wider determinants of health will have some quick wins, but they are mostly about reducing demand in future years and helping to deliver a healthier, more productive population.

Addressing health inequalities is the right thing to do. It may increase some activity in the short term, but it will lead to longer term savings as people are treated earlier. And it is a simple issue of equity.

This is one of the many challenges for finance teams working with their frontline teams – how do we get the balance between funding the demands of today and investing in the solutions that will move us towards the health service we need in the future?

The solutions will be found in working together as systems, looking at ways to optimise whole pathways of care to deliver the best outcomes for patients at the best value to the whole system.

The finance role will often be to identify how the costs and benefits can be equalised across all system partners. We need to be supported by the centre.

Capital, for example, in sufficient quantities and allocated in a timely way, will be vital to the whole agenda.

It will not be easy. But it is what we need to do.

• *See Numbers man, page 14*

Contact the president on president@hfma.org.uk

SHUTTERSTOCK

workforce crisis the NHS now finds itself in. It takes 10 years to train a GP from when they first go to university – longer for other specialties. So, boosting medical school places now won't help fill the more than 9,000 medical vacancies across England right now, according to recent statistics.

But it should mean the NHS of the future has a better chance of filling the medical positions it needs to run services.

That would have numerous consequences. With the right number of staff, the NHS should be able to maximise its capacity, improving flow and patient experience. It should reduce pressure on, and stress within, the current workforce. And it should reduce costs as reliance on the temporary staffing market reduces.

Of course, a workforce plan on its own won't achieve anything. It needs to be backed with funding and there needs to be a strategy to achieve whatever increase the report decides is needed. And with vacancy rates uneven across the country, thought will have to be given to how all areas can access the workforce they need.

But it is a good start. It would seem hard for a government to ignore the numbers produced by such an independent report – and it would certainly be held to account for refusing to back the findings with the required investment.

It won't solve the workforce crisis on its own. The NHS desperately needs to tackle issues around retaining staff. GPs, hospital doctors, nurses and other health professionals are all leaving the service in too high numbers.

"Perhaps the best news was the commitment to an 'independently verified' long-term workforce plan"

Improved retention, keeping those skills and getting the best value out of the investment in their training is all tied up with how staff are paid and valued in other ways. The current industrial unrest demonstrates that this balance is not right at the moment.

Better retention also means ensuring healthcare staff achieve a good work-life balance – something unachievable for many of them in recent years.

Beyond the NHS, social care needs its own long-term workforce plan and at some point the government will need to bite the bullet on improving social care staff pay to enable it to attract and retain this vital workforce.

The promised NHS long-term workforce plan is by no means the complete solution to current workforce challenges in health and social care. But it has at least moved the service one step in the right direction.

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.

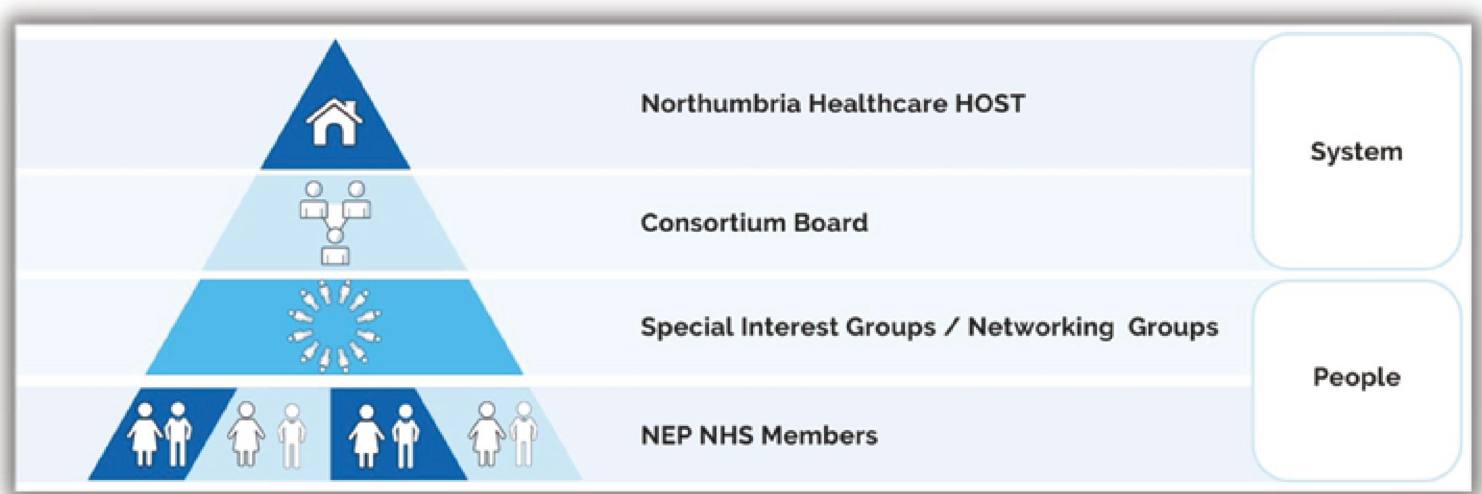
Sir James Mackey – Chief Executive Northumbria Healthcare & NHS England and NHS Improvement Elective Recovery Advisor

"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[illegible]'

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.'.*

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Numbers man

Finance teams will have a big part to play in the coming years as the NHS refocuses on finance and looks for more strength in numbers, new HFMA president Lee Bond tells Steve Brown

The NHS faces a difficult financial challenge this year, but, even with additional funding, 2023/24 looks even tougher. Lee Bond, the HFMA's new president, is concerned the NHS is not fully prepared for this step change in financial difficulty. He believes finance staff have a major role in raising awareness, helping clinical teams to prepare, and supporting those teams to drive as much value out of their budgets as possible.

The first two years of the Covid-19 pandemic saw a major change in focus in the NHS. There was a reduced focus on finance as NHS England put in place a temporary financial system that aimed to ensure money was not an obstacle to responding to the virus. Block contracts replaced activity-based arrangements, and providers received top-ups for the additional costs associated with the pandemic.

There was an understandable and correct focus on staff wellbeing as frontline services performed heroics in coping with long hours and the imposition of restrictive infection control measures. Talking to clinical teams about cost reduction or efficiency targets was not appropriate.

However, productivity and efficiency is very much back on the agenda, alongside the ever-present issues of quality and activity. Covid has not gone away, but the service is now living with the virus and the consequences of the past two years, particularly the significantly increased waiting lists and times. With this change has come a definite tightening of the purse-strings. This has coincided with eye-wateringly high inflation, driven at least in part by the war in Ukraine. Waiting lists are at an all-time high, staff shortages that existed before Covid have worsened, and underfunding of social care continues to have a crippling effect on the NHS in the form of unnecessarily occupied beds.

'The focus on the money is very definitely back,' says Mr Bond, chief finance officer at Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust. 'And I'm not sure the NHS is ready for it.'

'The finances are really tough,' he says. He suggests there is already a mismatch between funding and expectations, with this year's settlement representing a real-terms cut in funding.

'There needs to be a conversation about what the NHS can afford and what the public can expect from the NHS,' he says. Inflation hit 10% in September and Mr Bond says this is all too evident in the contract renewals in Humberside. 'We are seeing 10% to 20% higher costs for the same goods in some cases,' he says.

This inflation has a direct impact on trusts' non-pay spend, which is typically 30%-40% of provider costs. The other 60% is related to pay, which is also driving costs. This year's pay settlement, which was not fully funded in the settlement, added nearly 5% to the overall paybill.

Efficiency targets

So it is not surprising that the NHS is facing unprecedented efficiency targets this year. According to the National Audit Office, systems need to reduce spending by 5% to break-even – although this was more than 9% for some systems. For providers, the average efficiency needed to break-even is nearly 4% – although, again, the full range takes this to over 10%.

Mr Bond believes that many organisations will manage to get over the line this year – using a combination of non-recurrent savings and balance sheet flexibility.

However, these are non-recurrent fixes and 2023/24 is looking like a much more difficult proposition, even with the welcome additional funds announced in the autumn statement.

The additional pay and price inflation experienced in 2022/23 will carry on into next year. This year's pay deal generated £1.4bn of unfunded costs, which becomes a recurrent pressure in 2023/24 – before any further pay settlement is agreed. Similarly, the additional funding reallocated by NHS England to allow for higher inflation (compared with the levels assumed in the spending review) also becomes a first call on next year's budgets.

The extra £3.3bn for each of the next two years, unveiled in November's autumn statement, undeniably improves the situation. But it represents about half of the additional costs that NHS England estimated in October that the service could face next year, as a result of inflation and possible pay rises. However, the increased funding for social care should also have a positive impact helping to improve flow into and out of hospital.

Mr Bond says the challenge is across the whole service. It extends from the high-profile acute sector, with its unprecedented elective backlog, to community, ambulance and mental health services, through to primary care, where GPs are delivering more activity than before the pandemic, despite the numbers of GPs continuing to fall.

Presidential theme

The challenging financial position was very much in mind when Mr Bond set his theme for his year as HFMA president – *Strength in numbers*. In one respect, the theme is about re-asserting the importance of finance as a fundamental foundation stone for the NHS and about emphasising the role of finance staff in delivering effective and financially sustainable patient services.

Finance professionals will have to help clinical colleagues understand the financial reality – strengthen their understanding of the numbers and the importance of hitting financial targets. They will also have to support them in realising the most efficient use of resources to maximise what can be done for patients.

'By and large, outside the finance community, and for understandable reasons, the rest of the NHS has slipped out of worrying about the resources,' he says. 'But we need to get the genie back in the bottle.'

Many commentators believe the NHS may have what looks like an impossible financial task. But Mr Bond is clear that finance directors cannot simply pass this on to budget holders, imposing unrealistic efficiency targets. 'There is no point passing on something that

CHRIS TURNER/HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

is patently not doable,' he says. 'There's lots of research into how budgets are set that suggests if you set something that's quite clearly unachievable, you will have the wrong impact.'

There may be no easy solutions to the shortage of staff and funding, but Mr Bond is clear there are still opportunities to secure better value. Under the national tariff system and service line reporting, improving the financial position was often about growing income. Now it has to be about increasing value.

"There needs to be a conversation about what the NHS can afford and what the public can expect from the NHS"
Lee Bond

Robust costing data will be vital. As Mr Bond points out: 'We need to be able to talk about the unit cost of production and how that splits between the costs of our inputs, the materials and labour, and the outputs we are getting as a result. Are costs driving our problems, or is it the productivity derived from our processes?'

He suggests that other countries, including the United States, have this information more readily available. 'We need finance teams producing good quality costing data that clinicians can use,' he says. 'And there should be more use of technology, such as the scan for safety barcoding initiative, so that we are really recording what people are doing and can cost it better. That way, we can have better, more productive dialogue with clinical teams over how to improve.'

He acknowledges major strides forward in costing in recent years with the adoption of patient-level costing (PLICS) systems and methodologies. But it has been a long, drawn-out process. Inconsistency of approach is still a problem and progress in using the data to identify opportunities for improvement has been slow.

There is a tendency for costing teams to be under-resourced and there remain major concerns about differences between local costing models and the detailed costing return required by NHS England. Costing practitioners and the HFMA, through its HFMA Healthcare Costing for Value Institute, have argued for a more streamlined methodology, more focused on providers' significant costs, that leaves teams with more time to actually use the data.

Agency staff

NHS England has again put a major focus on reducing agency staff costs. Having suspended its controls involving caps on rates and overall spending levels during the first years of Covid, it has now reintroduced agency spending ceilings at the system level.

Mr Bond is clear there are good reasons for the increased use of agency staff. Covid led to much higher staff absences – and this is still a pressure – and there remain significant levels of staff vacancies across nursing, medical and other staff.

But he believes there are opportunities to reimpose a bit more rigour back into the use of temporary staff. 'There's something about getting more organised and potentially we can do that on an integrated care system basis,' he says. For example, the Humber and North Yorkshire system is seeking to agree a single rate for consultants and junior doctors for doing extra work. This would reduce competition between

A head for heights

Lee Bond has worked in Hull as chief finance officer for 10 years and took on the additional lead finance role at Northern Lincolnshire and Goole NHS Foundation Trust in 2020.

He started in the NHS in 1993, fresh out of university. At his first organisation, Sheffield Children's Hospital, he undertook finance tasks including registering invoices, receipting goods and chasing debts. He stayed 13 years, gaining his CIMA qualification and becoming finance director in 2003 – his first director position.

'One of the real benefits of being in a small organisation was that you got to see all aspects of its operations,' he says. 'I wasn't lost within a division in a big hospital.' One of the biggest challenges he faced in those early years as a director of finance was providing the finance lead for the trust's successful foundation trust application – becoming the first children's hospital in the country to gain that status.

Following this, Mr Bond became finance director at Sherwood Forest Hospitals NHS Foundation Trust, with shorter stints at the East Midlands Strategic Health Authority and with the team at Central Manchester Hospitals, before he took the role in Hull.

Mr Bond also spent 18 months as the lead finance officer for the emerging Humber and North Yorkshire ICS. He says being chief finance officer for two trusts is fascinating. 'There are really good things on both sides – but also things that could be shared and improved – and I have great staff in both finance teams,' he says.

The trusts already share a chairman, chief finance officer and a newly appointed chief information officer and are engaging on a possible move to a formal group structure.

Out of work Mr Bond has an extreme way to relax – snowboarding in winter; downhill biking in the Alps in summer. His friends refer to him as 'admin' due to his tendency to fall off.

They've also had a go at parapenting (a cross between hang-gliding and parachuting) off mountains, white water rafting and canyoning. 'It all scares the hell out of me,' he says, 'but it stops me worrying about work.'

Mr Bond lives with his partner Joanne, who also works in the NHS, and they have four children between them.

trusts in the same system looking to make use of the same staff.

Mr Bond also thinks that finance and procurement can sharpen its performance when negotiating with the private sector on the costs of goods, even in the face of rampaging inflation. With such a difficult financial climate, finance professionals have to explore every opportunity to get the best value out of every pound spent.

But *Strength in numbers* also reflects the need for finance teams to work more collaboratively across the new integrated care systems. The new system-first focus means much closer working in terms of managing the system's financial position, not just those of the constituent organisations.

This will mean getting financial reporting right so that there is much greater transparency across systems about the positions and challenges facing different organisations. It will be about understanding the knock-on impacts of decisions taken in one organisation on the wider system. Payment approaches will need to support the wider system plan and prioritisation of scarce capital resources will be essential. And it will require teams to think about efficiency in terms of whole patient pathways, rather than just organisational productivity.

There will be a need for finance staff to increase support for population health management approaches and to put spending and costs alongside health inequality data.

Benchmarking and best practice

Mr Bond is also keen to see more benchmarking and sharing of good ideas and best practice within and between systems. He says there are significant differences in working practice between the two organisations he oversees. And the finance function, armed with data and evidence, has a big role in understanding these differences and reducing unnecessary and sometimes costly variation.

A further aspect of the HFMA president's theme for his year in office is about improving the representative nature of the HFMA – delivering more strength in depth. This means expanding membership overall and ensuring the membership is representative of the finance function.

The association has made a start on this under 2022 president Owen Hargreaves, opening up membership free to all finance staff in agenda for change bands 2 to 6. Already more than 3,000 finance staff have taken up this offer, expanding membership overall, changing the association's age profile and shoring up its future membership levels.

One NHS Finance is leading work to ensure the NHS finance function at the most senior levels is representative of the function as a whole. The HFMA supports this programme and will publish the latest version of its regular finance function census in the new year.

But the association also wants its own committees and special interest groups to reflect its and the finance family's make-up. The HFMA will actively look to increase opportunities for under-represented groups and will specifically target its resources to these areas, including providing bursaries for under-represented groups across its qualifications.

Mr Bond adds a final dimension to his strength in numbers theme. Given the significant financial pressures in the year ahead, finance individuals and teams will need to show great mental strength at times. He says they should take confidence from the robustness of the numbers backing their arguments.

However, he reminds finance professionals that they are not alone. As well as their wider finance teams, they also have a whole NHS finance family to lean on. Networking, sharing problems and solutions with colleagues at events and recognising the value of meeting people face-to-face occasionally, rather than everything being online, will be vital. Finance practitioners should also make themselves fully aware of the support available through coaching and mentoring via the association and One NHS Finance programmes.

Finance teams will inevitably be at the heart of the service and finance challenges in the years ahead. But there are also opportunities for finance professionals to help their organisations and systems to push forward on the efficiency and value agenda and a chance for the profession to show its strength.

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Automatic for the finance people

A spreadsheet-based automation tool aims to reduce the time it takes to fill in provider finance returns, freeing up finance staff for value-added tasks. Steve Brown reports

People are attracted to accountancy and working in NHS finance for lots of reasons. But it is fair to say that filling in regular finance returns and submitting them to the centre is not one of them.

NHS providers' provider finance returns (PFRs) may be essential if NHS England is to see how providers are performing against financial plans and to highlight where pressures are emerging – on staffing, for example. But they take considerable time to complete – time that could be better spent on analysis or supporting budget holders and clinical teams to add value to patient care. They are also vulnerable to human error – a lot of damage can be done with a simple cut and paste.

The *Becoming One NHS Finance* report, the output of a conversation with the NHS finance community commissioned by the Finance Leadership Council, made it clear. Finance staff wanted greater use of automation, leaving them with more time to analyse figures and use the data to drive improvement. The PFRs seemed a good place to start.

So this year, the One NHS Finance Finance Innovation Forum has been working with NHS England's returns team to see if this manual burden can be reduced with a simple and shareable Excel-based automated solution.

Edd Berry, director of finance innovation at Manchester University Hospitals NHS Trust and a member of the Finance Innovation Forum, says completing the returns can be a big burden, particularly when there are changes to the template and the data requested each month. For example, this year NHS England has added requests for information about providers' utility costs. The returns resemble a mini set of accounts including details of income, balance sheet and cash flow, with lots of additional detail required on aspects such as staffing and staffing costs.

They are typically made available by working day 1 of each month, with trusts having to make partial submission for their system on working day 6, based on a minimum data set. Then the full submission to NHS England is on working day 11. Some 25 tabs in the workbook require some degree of input – ranging from a few cells to hundreds of elements needing to be completed.

'In a big organisation, there will be a team of people involved in compiling the information. But in a smaller trust, it could be one person doing the whole return,' says Mr Berry.

Half a dozen people are involved for a few days each month in the Manchester trust, he says. The spreadsheets have been aligned with the planning template, so the monthly returns feel familiar, but it's still a lot of work, even when the details being requested haven't changed.

Different requirements

All organisations run different ledgers, which are set up to meet their local needs. For example, a ledger may be programmed to provide data at the level of detail that the board wants to see it, which may be a slightly different view than that required by NHS England.

A trust might identify all its nursing and midwifery costs by agenda for change bands, while NHS England only wants to see the costs split into substantive, bank and agency. Some ledgers may be able to provide this output, others would require a manual intervention.

Once the month-specific workbook is issued, a trust would typically need to convert it into a shared file to enable multiple people to access and work on it at the same time. It is pre-populated with a trust's

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planned figures and with numbers from previous returns; trusts then input their actual year-to-date figures and their full-year forecasts.

There are multiple worksheets. For example, one looks at staff cost detail. 'What you would normally do is pull off a trial balance from the ledger and it would hopefully be summarised at the NHS England category level correctly,' says Mr Berry. 'That can take some checking, especially if someone has created new codes and there is misalignment with the required categories. Then, basically, it is just a case of typing all those figures directly into the return, line by line.'

The problem is that the sheets can be huge. 'It's not a difficult process,' comments Mr Berry, 'it's just time-consuming – and there is a lot of scope for manual error and putting figures in the wrong boxes.'

"It is an automated filling-in process, not an automated submission. It doesn't submit the information without you looking at it first"
Edd Berry

The main benefit of automation, he says, is the time it can save. His trust switched to working day 1 reporting a couple of years ago. The thinking is that the sooner you know your position, the sooner you can do something about it. And, in a similar way, reducing the time spent on transactional processes, such as those involved with filling in the PFRs, frees up people to analyse the data and make decisions.

Rather than taking time to compile data for the centre showing, for example, a big variation against plan, finance staff could be spending their time understanding why there is the variation and putting mitigating actions in place. 'Anything that puts more time back into locally supporting the decision-making is a good thing,' says Mr Berry. 'Feeding the central beast is an essential part of what we do, but we need to do it as efficiently as possible.'

He recognises that some people are nervous about automation, in case they lose control of the numbers being reported. But he believes this is born of a misunderstanding of how automation works. 'You are actually making the system far more reliable,' he says. 'You design and build it and then thoroughly test it until you have an automated process that will always do exactly the same thing. It won't get disturbed when someone interrupts you and it will eliminate human errors.'

The automation process works on the basis of describing a standardised data set in the same way that data sets are produced for outpatient or accident and emergency activity. The idea is that all organisations can set up their ledger systems to output data in a set order. Depending on the ledger, it may be able to output data at the NHS England category summarised level or the trust may need to do a little local mapping.

This list would have three columns – subcode, main code and value – with the codes making it clear that this was, for example, the year-to-date costs for substantive registered nurses. With a list output in this format, all the trust finance manager has to do is cut and paste the long, three-column list into the provided spreadsheet tool and the tool then populates the rest of the workbook.

Use of the tool is completely voluntary. And while it does involve some initial set-up work with the ledger, that only needs to be done once. And trusts don't need to codify everything straightaway. They might start just with the income and expenditure and continue to do the balance sheet and cash manually. Or they might just start with staffing costs and then gradually improve their automation.

Steve Hubbard, deputy director of financial reporting at NHS England, says trusts do need to put a small amount of time into the tool up front. 'It will take perhaps four to five hours to set up,' he says. 'You have to invest that time. But then you have something that will save time on a monthly basis.' Feedback from NHS providers suggests that the tool is saving as much as five hours work each month.

But it has other benefits. Some trusts have reported that using the tool has prompted a wider review of the efficiency of their reporting processes. 'It can make everyone's process leaner,' says Mr Hubbard. 'And that can open up other doors.'

Claire Ridgway, senior financial reporting lead at NHS England, says there is a small increased admin burden for the central team. But this is minor compared with the benefit, even for an individual trust, and is incurred just once, rather than in every NHS provider finance team. She adds that the tool was designed by practitioners in frontline finance teams and then built by NHS England.

The tool did not start from scratch, but drew on existing local solutions already in use across a wide-ranging user group. However, she says that some local automation solutions still resulted in an Excel spreadsheet with data that needed to be copied over to the formal returns. The new tool takes the automation a step further.

Take-up rate

Up to 20% of NHS providers have started to use the tool to some extent and NHS England is keen to encourage other organisations to follow. It insists the sole motivation is to reduce the burden on finance practitioners. 'We've built the tool, but it has been designed by the service. In particular, it should help smaller providers to make their process more efficient and to free up their time,' says Ms Ridgway.

Mr Hubbard adds that the whole returns team has worked in frontline finance roles and has experience of the returns process. 'There is some benefit to NHS England,' he admits. 'If we've created more time for trust finance teams, the product we receive should have fewer queries or problems,' he says.

Back in Manchester, Mr Berry agrees that reducing the burden of form-filling should allow more time for checking figures before submissions. In the manual process, about 80% of the time is taken up actually filling in the return, he says, leaving just 20% of the time for checking. Automation should flip those numbers on their head.

'The point is that it is an automated filling-in process, not an automated submission,' says Mr Berry. 'It doesn't submit the information without you looking at it first. So, you can look for any variations or surprise changes.'

There is a clear direction of travel towards earlier financial reporting. Several organisations have moved towards adopting working day 1 reporting and more are showing interest. A recent One NHS Finance webinar on the topic attracted more than 150 delegates. It also seems likely that system working and reporting will push organisations to harmonise their reporting practices across systems. Systems are unlikely to want some organisations reporting the most recent month's figures while others are quoting the previous month or have reporting dictated by the slowest in the system.

Automating the PFR process clearly aligns with this move to faster reporting. But there are no current plans to bring the PFR timetable forward. For Mr Berry, the automation tool is a no-brainer. 'People manually typing in figures, and potentially not getting it right, is not adding value,' he says. 'The bit that adds value is the analysis of what the figures are saying.'

And the tool frees up finance managers up to do exactly that.

Integrating care: policy, principles and practice for places

Dr Eleanor Roy, CIPFA Health and Social Care Manager

Health and care integration is not a new phenomenon but has been a constant and significant policy theme for many years.

Over time, integration has moved from specific pilots and programmes, through voluntary partnerships with no formal accountabilities. The *Health and Care Act 2022* (the Act) put integrated care systems (ICSs) on a statutory footing, and provides a legislative framework that moves away from competition in the NHS and aims to better support collaboration and partnership working.

There has also been a widening of the scope of what integration is trying to achieve. From closer integration within the NHS and between the NHS and social care to a broader view including the wider determinants of health and wellbeing, to positively impact on population health with a focus on prevention and reducing health inequalities. This is reflected in the 'triple aim' in the Act.

While the Act established integrated care boards (ICBs) and integrated care partnerships (ICPs) on a statutory basis, it made no provision for local level: the place-based partnerships where health and care organisations, with understanding of their local area, come together to deliver services and solutions for residents.

In February 2022, the government published '*Health and social care integration: joining up care for people, places and populations*' which recognised place as the engine for delivery and reform and the need for formal place-based arrangements. However, it raised many challenges, including outcomes, accountability and finance at the level of place. These are key components of good public financial management, and critical elements for effective collaboration across organisations with such different systems and cultures.

CIPFA believes that for integration to be a success, a whole systems approach to public financial management is essential. This means understanding that outcomes can be improved by working across organisational boundaries, recognising the inter-dependence of services and the greater impact they can have through closer collaboration while working towards a shared vision.

Our recent publication, '*Integrating care: policy, principles and practice for places,*' aims to support such an approach. It provides an overview of the changes as a result of the Act and what integration is seeking to achieve. It considers the wider health and care landscape in the current climate and addresses the remaining challenges at place level. The publication, and the recommendations and case studies it contains, are intended to influence the development of further policy and guidance by central government, and to provide support for practitioners working at the local level.

To learn more: visit cipfa.org/services/integrating-care

Importance of place, partners and prevention

- The renewed focus on integration presents a new opportunity for partners across the health and care sector to work differently. Taking a place-based approach focused on the wider determinants of health and wellbeing, with an emphasis on prevention, could make a huge contribution to achieving the aims of integration and improving population health.
- Local government, both upper and lower tier councils, have a vital role to play in integrating health and care. They hold many of the levers that are key to influencing the social determinants of health and wellbeing, as well as a deep understanding of the places and neighbourhoods they serve.
- Achieving the vision for integrating health and care requires long-term commitment and certainty of funding. A twin-track approach is necessary to ensure that health and care services can deal with immediate pressures, as well as making the long-term preventative investments to ensure services are sustainable for future generations.

Importance of a whole systems, outcomes-based approach

- A whole system, outcomes-based approach can highlight interdependencies between services and help foster a common vision and shared understanding between partners. Good public financial management requires making evidence-based decisions on the allocation of public money to outcomes and provide value for the public pound in place.
- Against the backdrop of wider policy reforms and huge pressures on the NHS and local government, a national outcomes framework could provide a single, coherent set of shared priorities across health and care. This should allow for autonomy with an emphasis on local priorities reflecting national outcomes – not national prescription driving local activity.

Importance of public financial management – putting the principles in place

- Governance, accountability and finance are key components of good PFM. Taking a one-size fits all approach to governance or focusing on pooling budgets alone does not account for the huger variation between places and their local circumstances.
- A principles-based framework for place that incorporates robust governance, accountability and finance arrangements would provide flexibility to allow for adaptation as places mature and evolve. Such a framework should be for local determination and aligned to the 'national ask.'
- Bringing together services to improve population health needs to be supported by long-term planning and removal of the barriers that prevent closer alignment of services. The finance profession is a critical enabler of closer integration, supporting long-term planning and closer alignment of services – enabling resources to move freely and empowering change.

A focus on place is vital if we are to make the most of the opportunities that integration provides and deliver the changes that will ultimately benefit the service user. The issues around integration are significant, but not insurmountable. CIPFA stands ready to support and empower local government and its NHS partners to find solutions to the financial, governance and place-based challenges around integration.

CIPFA's '*Integrating care: policy, principles and practice for places*' is available as a free download on the CIPFA website.

To learn more visit cipfa.org/services/integrating-care **call** 020 7543 5600

Stepping up

Four new chief finance officers, straight out of a One NHS Finance support programme, reflect on their journeys to the boardroom and how best to prepare. Steve Brown reports

It can be pretty intimidating stepping up to a first chief finance officer or finance director role. Getting used to the boardroom and other directors, leading a new finance team, being part of the community of wider NHS finance directors – there's a lot to take in.

However, help is at hand with a new One NHS Finance development programme aimed specifically at first-time-in-post chief finance officers. The programme builds on One NHS Finance's established talent pool, which is all about preparing senior finance managers and deputy directors for their first director-level position.

It aims to provide an instant network of other finance directors – all in the same position – and to provide a reminder of what chief executives, chairs, non-executives and finance teams all expect from their new financial lead. An initial cohort of 20 first-time-in-post chief finance officers recently attended the inaugural programme.

Peter Ridley, NHS England's deputy chief financial officer, operational finance, underlines the importance of the One NHS Finance programme. 'I remember my first chief finance officer job [at the Royal Surrey County Hospital NHS Foundation Trust] and how the step up felt,' he says. 'It could be lonely and isolating at times and it could feel as though everyone was looking to me for the answers.'

What really helped, he says, was having a network of others in the same position –people he could ask for advice, bounce ideas off or 'generally have a safe moan to'.

'The programme is great for building this network,' he says, adding that it felt like that bond was already growing in the first cohort.

'Spending time with the group was also really uplifting. It helped me to remember why we want to do these jobs, and how for most of us it's about a desire to make a difference – even more so than a deep desire to deliver a break-even position!'

He adds: 'The programme has so many benefits, in terms of mutual support, sharing ideas and working together on areas of common interest.'

Kris Mackenzie "Follow up on your contacts"

- **Position:** Group director of finance and digital
- **Trust:** Gateshead Health NHS FT
- **Start date:** Sept 2022

There are two categories of people: those who plan out their careers in meticulous detail; and those who don't. Kris Mackenzie puts herself in the second category. 'I try to do the best I can in a particular role and when I think I've taken it as far as I can, that's when I tend to lift my head up to see what is available,' she says.

Having said that, her career seems to have given her access to a text-book set of roles and development opportunities to prepare her for her first chief finance officer role – becoming group director of finance and digital at the Gateshead foundation trust in September.

Her 20 years in NHS finance started with the graduate training scheme, working in Wales. She then relocated back home to the North East of England, where she spent 10 years working in various roles for Newcastle upon Tyne Hospitals NHS Foundation Trust.

Ms Mackenzie also worked in regulation, as NHS Improvement's finance link for the patch, before moving to Gateshead four years ago. Her deputy finance director position even included a few months as acting finance director.

And in addition to the One NHS Finance first-time-in-post finance director programme and its national finance leaders talent pool, she has also completed the Nye Bevan Leadership Academy programme for aspiring executives.

Despite gaining her first chief finance officer position in an organisation she knows well, and which also knows her, she has tried to treat it as though she has just joined.

'I think it was important to reset myself as the director, so I've actually been spending quite a bit of time talking to people in the organisation in the same way I would if I was starting in a new trust,' she says. 'I am asking them their views on finance and digital. There is a danger that you think you know what the issues are, but you don't necessarily. That is how I will develop an action plan for myself.'

Having acted up to the finance director role previously, Ms Mackenzie has already worked with the executive team. 'But I am actually a member of the team now, so I need to reset those relationships too,' she says. 'It is good for the organisation to have some consistency. But I'm not the same person I was in the role before and I won't necessarily continue to do things the way that we've been doing them.'

She says the key thing she learnt in moving towards her first board role was the importance of networks and following up on contacts. She actively sought out senior people in NHS finance – directors who interviewed her for the talent pool and some who presented in the various programmes – to ask for advice and guidance.

'It was probably the first time I'd deliberately prepared for my next career step,' she says.

Ms Mackenzie believes there are still gaps in her skill set and experiences, but thinks some of this could be addressed with a coach or mentor – and that having a view from outside your own system can be helpful at times.

Chris Hearn “Remember: finance is a team game”

- **Position:** Chief financial officer
- **Trust:** Dorset County Hospital NHS FT
- **Start date:** Oct 2022

After four and a half years at Dorset Healthcare University NHS Foundation Trust – first as deputy finance director, then as director of operational finance, Chris Hearn was ready for his first board-level role. But with only three providers and one integrated care board in the county, and a young family making a local move imperative, he recognised he might need to bide his time.

‘I was just fortunate that around the time that I was starting to really stretch myself and actively participate in some of the leadership courses, such as the talent pool, the right opportunity arose at a local provider,’ he says.

He started at one of the county’s two acute providers, Dorset County Hospital NHS Foundation Trust, in October. His previous role at the system’s mental health and community services trust had involved lots of board-level interactions. But he recognises that this is different to the accountability and responsibility that goes with being a member of the executive team.

‘That is where the first-time-in-post programme has been really beneficial,’ he says. ‘What I was looking for support with was how to own those board interactions.’

Along with other participants, he points to the value in having NHS senior finance leaders in attendance – Peter Ridley and NHS England chief financial officer Julian Kelly were both in the room. But he says the wider programme looked beyond finance at what else finance directors needed to bring to the table.

‘What I thought was particularly helpful about the course was that it didn’t just have that straight finance focus,’ he says. ‘Coming up from a deputy role, which is what most people do in terms of getting their posts, I think the financial ability is just a given.

‘So hearing from chief executive officers and non-executive directors about their expectations of you and how you would work with them was really, really helpful,’ he says.

There was also a focus on some big ticket items for finance directors currently, including addressing health inequalities and ensuring that organisations practise equality, diversity and inclusion in everything they do.

What advice would he have for other aspirant finance directors? ‘First, make sure that you expose yourself to the board as much as possible,’ he says. ‘Have conversations with your chief executive, chair and non-executives.’ As well as being good preparation for the role itself, it will be good preparation for the interview process.

He also stresses the importance of networks – take opportunities to get involved with the broader finance community outside your organisation; it builds knowledge and reputation. Finally, he urges colleagues to make the most of available leadership development opportunities, whether from One NHS Finance, the HFMA or elsewhere.

Some may view the current economic climate as a difficult time to step into a first chief finance officer role, he says, but finance is a team game and this has been obvious in his first board meetings since joining the trust. ‘What’s clear and reassuring for me is that while you are the top-level finance person within the organisation, finance is a shared responsibility,’ he says. However, he adds, to make this work demands clear and open conversations so everyone can contribute to responses and solutions.

Aneel Pattni “Leave a legacy you can be proud of”

Aneel Pattni says a move to an executive board level post has been part of his career plan for some time. Having joined the NHS in 2009 at deputy level, at the Royal Free London NHS Foundation Trust, he spent time with Monitor and NHS London before joining Barts Health NHS Trust. But he always had one eye on what he might need to become a chief finance officer.

Barts Health encouraged and supported Mr Pattni to complete the Nye Bevan aspiring directors programme in 2017/18. Following the programme, he decided that, if he wanted to achieve his ambition, he would need to move organisation, which he did in 2019, joining Buckinghamshire Healthcare NHS Trust.

‘Barts was one of the largest NHS groups in the country,’ he says. ‘And my role in financial strategy and development was very focused on large capital investments, major projects and transformation.’ It didn’t allow him the full opportunity to demonstrate his ability to work at director level.

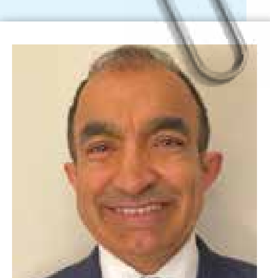
The role at Buckinghamshire – which is about a third of the size of Barts – offered a much broader span of duties and experience.

‘When I saw the ambulance trust role come up, it made absolute sense,’ he says. Mr Pattni was attracted to working in a different part of the health service and addressing a new set of issues, including the logistics of running an emergency fleet and call centres.

Working with the board – and being part of a unitary board while holding responsibility for finance and estates – is one of the big changes for new chief finance officers. And board exposure is something all deputies should be looking to get some experience of before stepping up, says Mr Pattni.

His role at Barts gave him plenty of exposure, albeit though the relatively narrow lens of capital and investment transactions. He deputised for the finance director in a more general way in Buckinghamshire.

He encourages others aspiring to work at board level to think about what they need to achieve their goals. ‘Focus on your personal development,’ he says. ‘But also ensure that the legacy you are leaving in your current organisation is one that you can be proud of.’ You need to be focused on what you have achieved for your patients, your organisation and your team, as well as what you have achieved personally, he adds.



- **Position:** Chief finance officer
- **Trust:** South Central Ambulance Service NHS FT
- **Start date:** Oct 2022

It is something he plans to put into action at South Central Ambulance Service. In the same way that he has benefited from the Nye Bevan programme and the One NHS Finance first-time-in-post programme, he wants to make sure there are development opportunities for the ambulance trust’s finance team.

Mr Pattni is full of praise for the first-time-in-post programme. Meeting the top team from NHS England in person was really helpful and a good way to feel part of the wider finance director family. He says the presentations were a good reminder of much that was covered in the Nye Bevan programme. But perhaps the biggest benefit was being able to create a network of other finance professionals also taking on their first executive roles. That would be invaluable, he says.

Tarryn Lake "Learn from the feedback"

- **Position:** Group director of finance and digital
- **Trust:** North East Ambulance Service NHS FT
- **Start date:** Nov 2022

The new group director of finance and digital at North East Ambulance Service (NEAS) NHS Foundation Trust, Tarryn Lake, says: 'Don't underestimate the interview. It is a lot of work going through the process for this type of role and you need to do your due diligence.'

The interviewers' focus will often be on softer skills, she says. 'It can be about your values, your leadership approach, how you fit with the organisation.' It should be two-way: you need to be comfortable the organisation will fit you too, she says. And for a first-time director, the strength and maturity of the finance team may be a factor.

For Ms Lake, preparing for an interview included a visit to the trust's emergency operations centre and talking to some of the executive and non-executive team.

She has been looking to step up to director of finance within her local area for a while and has taken advantage of many of the development programmes on offer – the Leadership Academy's Nye Bevan programme, the One NHS Finance talent pool and, recently, its first-time-in-post programme. Previously associate director of finance for Sunderland Clinical Commissioning Group, she moved to the North East and North Cumbria Integrated Care Board in July.

She had previously applied for other chief finance officer roles and saw these as good learning experiences. 'It is really important to get feedback,' she says. 'Learn from feedback and talk to people about what you could have done better, as well as your potential skills gaps.'

Ms Lake has a coach and a mentor, who helped her learn from each process and keep perspective on addressing her development needs. Having done various development programmes, Ms Lake says the final piece in the jigsaw was taking responsibility for non-finance functions during her time at Sunderland. She led on estates, sustainability and procurement and worked as part of the director team.

'It's a good experience to lead a function where you're not the expert,' she says. 'I was fortunate in doing this – I think it helped demonstrate, when I went for the NEAS job, that I had a broader experience and knowledge base.'

The opportunity to work within a director team environment was also invaluable and gave a good insight into effective collegial working.

Any practical experience is really helpful. While at Sunderland, Ms Lake also took on the role of finance director for the All Together Better out-of-hospital alliance bringing together commissioners and providers in Sunderland to improve health outcomes for the local population. She believes this helped build her leadership skills while demonstrating her readiness for the boardroom.

She is excited by the move to a completely new sector within the NHS, with the trust running patient transport services and 111 as well as the emergency ambulance service.

In her first weeks in post, says Ms Lake, she was in listening mode, getting to know the people and the business. But she says she has come into the role with a good idea of her priorities and an understanding of the pressures on all ambulance services. 'It has been humbling to observe how the clinical teams respond to these pressures and the focus that is being maintained across the whole organisation on doing the right thing for our patients,' she adds.

HFMA introductory guide to NHS finance

This comprehensive guide is a vital resource for anyone who wants to understand NHS finance and get the maximum value from NHS resources.

Visit hfma.to/nhsfinance to access the online document free

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Annual review 2021/22

A year of consolidation

President's and chief executive's report

The business plan for the year to 30 June 2022 was developed to achieve a year of consolidation following the reset required in the previous financial year as a result of the impact of the pandemic.

Listening to our members, it was clear the focus for the year should be one of maintaining and, where possible, increasing the volume of activities provided by the association to support the membership. At the same time, it was important to ensure the organisation was financially sustainable by making a small surplus to bring reserves further closer to the level they were pre-pandemic.

We are delighted to be able to say that both objectives were achieved. The volume of activity and support to members was greater than ever. Financially, the statutory accounts show a surplus of £290k for the year to 30 June 2022, bringing reserves up to a level of £4,244k.

We also reached a major milestone for the association in the year by purchasing a property in Bristol – HFMA House, 4 Broad Plain. It has been a long-standing objective to be able to move the head office in Bristol from rented accommodation into owned premises. In early 2022, this was achieved following the purchase and then sympathetic refurbishment of the grade 2 listed Georgian premises.

Another initiative this year was the offering of free HFMA membership for apprentices and those working in agenda for change bands 2 to 6. It has been very well received.

When we develop our business plan, we set key performance indicators in addition to finances, which we measure ourselves against each year. These show that, as at 30 June 2022, we had reached a record 20,653 members and supported them and others with for example: 335,131 hours of continuing professional development and the production of 53 policy briefings and publications. We also had an average of just over 100 students studying for our qualifications over the year.

We ask attendees and users of all our activities to give feedback. Over the last year we achieved an amazing 96% good or excellent on events and 94% from everyone undertaking our bitesize e-learning. We are very proud of this feedback.

During the year to 30 June 2022, we also continued to host, work alongside and support One NHS Finance with the delivery of its programme of work in England. This encompasses Future-Focused Finance, the National Finance Academy and the Finance Innovation Forum. We are proud to be a part of this exciting and developing set of programmes.

We also look to support other associations working alongside colleagues in the NHS. During the year we were proud and happy to start hosting the Healthcare Project and Change Management Association (HPCA). They have exciting plans to develop support for their members, which we are delighted to assist with.

With support from members, the association was also able to significantly increase the public benefit of its activities as evidenced by the levels of social media traffic and downloads of material over the last year. The overhaul and online relaunch of the *HFMA introductory guide to NHS finance* – which is available free of charge on the HFMA website – is one example of the public benefit provided during the year.

Our theme for the year fittingly has been Reimagining the future. This has been received well by our members and played well into the HFMA's next steps which were developed during the year as we worked on developing our new strategy for the three years to 30 June 2025 – *Picking up the pace*. This was launched in September.

The strategy re-emphasised the values of the association, which can be summarised as high-quality, fair, member-focused and accessible. It also set out the five strategic lenses through which its services will be developed. In pursuing our objectives, the association will ensure it: considers **equality, diversity and inclusion**; aligns its structures and services to reflect the **integration** agenda; **member services are personalised** through the use of digitalisation; supports and provides services that complement the **One NHS Finance** initiative; and considers **environmental sustainability** with all its activities.

The strategy also sets out the four overarching objectives that the association will be working to deliver over the three years to 30 June 2025. They are to:

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

We would like to take this opportunity to thank our friends on the corporate partner programme, who provide us with valuable resources without which we would not be able to run our central infrastructure. They, along with all our commercial supporters, continue to be very supportive in these challenging times, for which we are very grateful.

At the HFMA we will continue to work hard to support our members as the NHS settles into the integrated structures. These have been in place for some time in the devolved nations, but are new to England. And there is still much to do to deliver real integrated care that delivers the best possible care for patients. We will also continue to work hard to help ensure that we keep the best of what we've learnt over the last two years.

Thank you for reading this annual review. As always, please do not hesitate to contact us with any comments or thoughts and our best wishes to you all.

Owen Harkin, president

Mark Knight, chief executive

2021/22 in numbers

335,131
total hours of CPD

193,541
visits to the HFMA website

20,533
members

2,917
new members working in bands 2 to 6

£290k
surplus for the year

53
new policy and technical briefings

17
Hub events

6
Institute events

6
policy responses to consultation papers issued

5
national events

1
new headquarters building purchased and redeveloped

Our finances

The 2021/22 annual accounts show that the year was financially very positive for the association. The surplus for the year of £290k has enabled the association to go some way in replenishing its reserves following the impact of the pandemic in previous years. Further surpluses are required to get back to the level held pre-pandemic. However, at £4,244k our reserves are at a comfortable level.

Our intermediate bitesize and short courses continue to be popular. **There are now over 70 courses, 34 of which are available for NHS staff to access free of charge** on the electronic staff record (ESR). In total 49,600 courses have been undertaken since March 2020, providing almost 325,000 hours of CPD.

Our networks and events

The 2021/22 year was one of transition for our networks and events as we navigated our way out of the pandemic and we delivered a full programme of events for our members. The Healthcare Costing for Value Institute and the HFMA Hub both grew their membership and their activities have provided tangible benefits for partners.

We were fortunate that we were able to hold our flagship event, the HFMA annual conference, as a face-to-face event in London and also online in December 2021. Over 550 delegates attended in person and over 2,000 took part online. While still social distancing, those attending appreciated the opportunity to meet with colleagues and renew acquaintances. The programme of speakers was wide ranging and highlights included broadcaster Emily Maitlis talking about her many encounters with world leaders, and rugby player Jonny Wilkinson CBE, who shared his experiences of dealing with anxiety.

The majority of the HFMA's other national events were held virtually. Highlights were:

the pre-accounts planning events held in January, which helped over 400 finance staff prepare for the 2021/22 year-end

the Healthcare Costing for Value Institute's international value symposium, which focused on person centred healthcare and population heath with speakers from Brazil, New Zealand and the United States. The costing revolution summit was also launched, which proved to be popular with institute members

the charitable funds conference held in partnership with NHS Charities Together, which provided 140 delegates with insights into the latest thinking on the financial aspects of managing NHS charities.

Our learning and development offerings

The HFMA's qualifications launched in the autumn of 2017 – firstly with the diploma in healthcare business and finance followed by the diploma in primary care management in early 2018. To date more than 600 learners have studied for an HFMA qualification.

2021/22 proved challenging for the NHS and our learners, with many struggling to find the time to study when their day jobs were so demanding. Nevertheless, during 2021/22 we had an average of 50 learners studying with us at any one time. While supporting our current learners, we have taken steps to expand our education portfolio. We completed a project with NHS England to develop an intermediate level bitesize course on personalised healthcare budgets. We are also in the middle of a project with Health Education England to develop several courses on digital health transformation.

During 2021/22 we reviewed our education offering to ensure that what we deliver meets the current and future needs of our learners and equips staff to operate in a system-wide environment. Several changes have been made as a result and these will be rolled out during 2022/23.

The HFMA continued to support the skills development networks in the South West, South Central and West Midlands regions. In total, 252 events were held providing 7,057 hours of CPD. We also launched the South West Digital Health and Care Skills Development Network.

Our membership

On 1 January 2022 we offered free membership to all finance staff working in agenda for change bands 2 to 6 or equivalent. This initiative has been well received and at 30 June 2022, the association had 2,917 new members working in these bands. Our membership direct scheme – where organisations can sign up the whole of their finance department for HFMA membership – also proved popular, with 11 organisations taking part in the scheme. These changes to our membership mean that the association's membership is more representative of the NHS finance function than ever before. Our total membership at the end of 2021/22 was 20,533, an increase of 18% on 2020/21.

Our policy and technical work

We continued our work to influence national finance and governance policy and provide technical support to members. During 2021/22 the HFMA's policy and technical team produced 53 new briefings, updated a further 15 and submitted six responses to consultation papers issued by stakeholders. We continued to update our range of guidance maps, aimed at helping finance staff to easily find support.

Our briefings covered a range of subjects aimed at supporting members as they go about their work. The topics covered included: health inequalities; the external audit market; costing and value; and environmental sustainability, as well as our usual suite of year-end outputs.

We produced a range of outputs to support members with the closedown of clinical commissioning groups and the creation of integrated care boards and system working. We were commissioned by Health Education England to undertake a range of activities to support the delivering value with digital initiative, encompassing a range of briefings, case studies, webinars and events all aimed at getting finance staff up to speed with the digital agenda. We also produced a range of briefings and tools to support NHS finance staff with the financial sustainability challenge facing their organisations.

We continued to provide members with the latest news via our Healthcare Finance outputs – weekly via the website and email and quarterly via the Healthcare Finance magazine.

A big success was the publication of the fully updated online version of the **HFMA Introductory guide to NHS finance.** The guide is free to access and, by the end of 2021/22, it had been viewed over 6,000 times.

Overall, **3,509 delegates attended an HFMA national event in 2021/22**, providing 12,665 hours of continuing professional development (CPD).

Our branches

Our 13 branches are the lifeblood of the HFMA. They all provide excellent training and development programmes as well as access to local networking opportunities. Listed below are just some of the fantastic activities our branches delivered for members in 2021/22.

The **HFMA Eastern Branch** hosted a two-day hybrid conference with 361 delegates. It organised 10 lunch and learn sessions, an accounting standards update and an introduction to NHS finance.

The **HFMA East Midlands Branch** hosted its annual conference with 49 delegates. It also organised a team building event, which was fully booked and gave an opportunity for 72 of their members to work together.

The **HFMA Kent, Surrey and Sussex Branch** held its mini summer conference with 39 delegates and a hybrid annual conference with 180 delegates. It also hosted a social evening at the races and an introduction to NHS finance event, as well as many others.

The **HFMA London Branch** held a one-day online conference with 104 delegates. It also held a VAT level 1 briefing for 15 delegates and held a lunch and learn with 25 members benefiting from the event.

The **HFMA Northern Branch** ran a very successful annual branch conference with over 300 delegates.

The **HFMA North West Branch** held its two-day face-to-face annual conference with 127 delegates.

The **HFMA Northern Ireland Branch** hosted an event on self-care and tools to drive improvement, which proved very successful and was well attended.

The **HFMA Scotland Branch** hosted a two-day online conference, which was attended by 250 delegates who participated in both a Strava challenge and a quiz. The branch also hosted a meeting of Scotland's finance directors.

The **HFMA South Central Branch** hosted a one-day conference with 203 delegates and a very successful women in leadership event.

The **HFMA South West Branch** hosted a two-day online conference with 326 delegates. It also organised 11 lunch and learn events, which provided an opportunity for 136 members to have valuable learning opportunities.

The **HFMA Wales Branch** hosted a three-day online conference with 280 delegates.

The **HFMA West Midlands Branch** hosted a one-day online conference with 218 delegates, as well as a two-day face-to-face conference, which had 256 attendees. It also continued to host the regional director of finance and senior leader meetings.

The **HFMA Yorkshire and Humber Branch** hosted a two-day annual conference with 125 delegates.

Our future

During 2021/22 we worked on the association's strategy for 2022 to 2025: *Picking up the pace*. The strategy represents a clear post Covid-19 vision for the HFMA. During the period 2020 to 2022, the HFMA survived by reducing its costs and reorganising its services. The strategy builds on the innovation of that period. It sees the association develop its services through five strategic lenses – each influencing the strategic objectives and how they are achieved:

Equality, diversity and inclusivity are to the front and centre of our strategy.

The external environment of the NHS, in terms of health and social care integration and change, shapes our services.

Our members will be provided with a personalised service, enabled by technology.

We will continue to support members to improve their skills, knowledge and career development, by working in partnership with One NHS Finance and other NHS initiatives.

We will aim to reduce our impact on the environment through the HFMA's own activities and in the NHS via our Environmental Sustainability Special Interest Group.

You can read our new strategy here: hfma.to/annualreview

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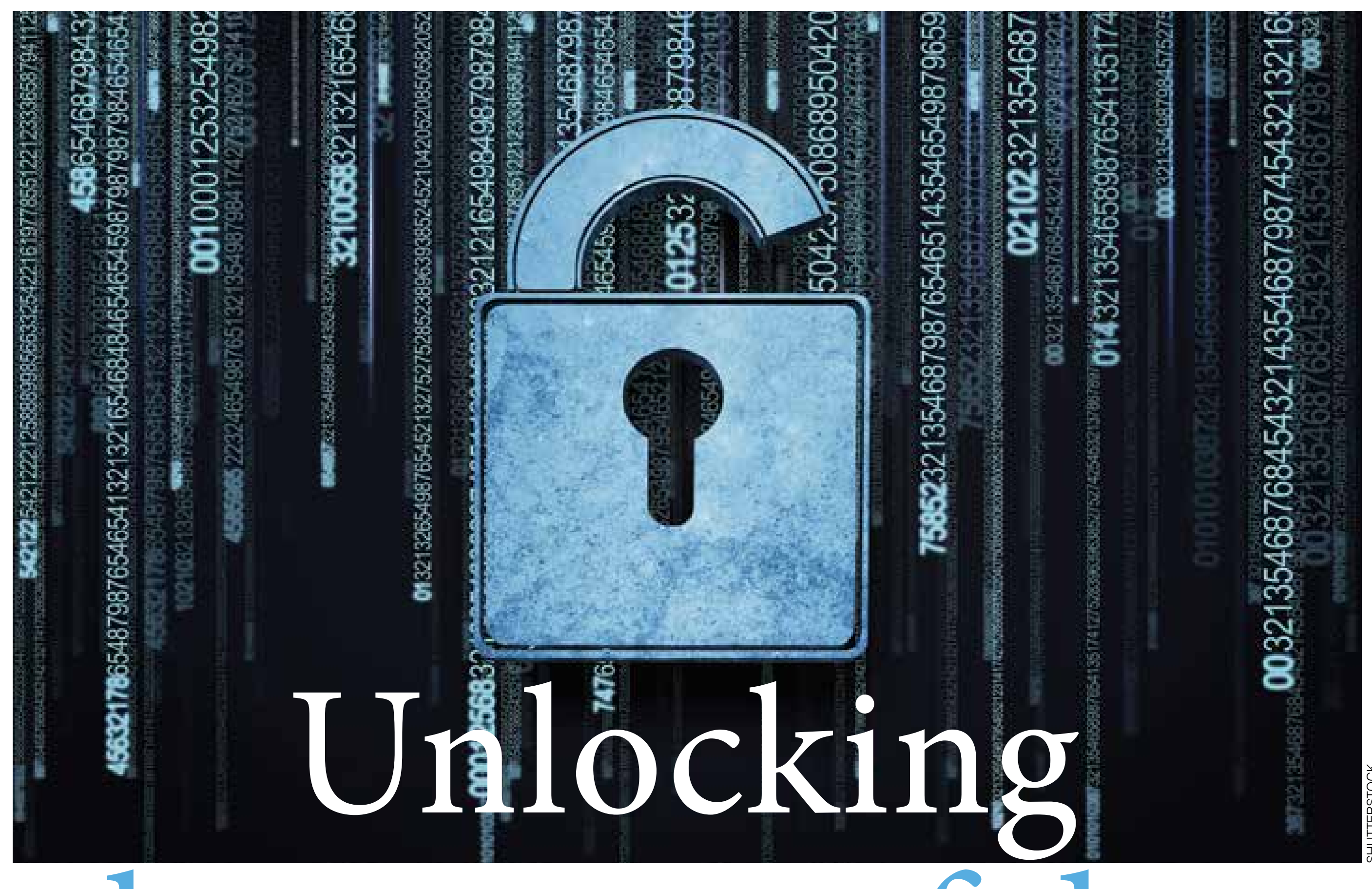

SHUTTERSTOCK

Unlocking the power of data

The NHS is data rich, but it needs to be analysed, communicated and acted upon if the service is to extract its full value – as delegates at an HFMA roundtable, supported by OpusVL, heard recently. Sarah Day reports

HFMA ROUND TABLE

In April 2022, the Goldacre review highlighted that the NHS already has some of the most powerful health data in the world. This is not surprising, given almost every interaction with the health service leaves a digital trace from diagnosis, through treatments and tests and even outcomes. And these exist for almost every citizen in the country. But simply having the data is not enough.

'This raw information has phenomenal potential,' the review said. 'Data can drive research. It can be used to discover which treatments work best, in which patients, and which have side effects. It can be used to help monitor and improve the quality, safety and efficiency of health services. It can be used to drive innovation across the life sciences sector.

'But raw data is not powerful on its own. It must be shaped, checked, and curated into shape. It must be housed and managed securely. It must be analysed. And then it must be communicated and acted upon.'

The challenge of unlocking the power of this data for the NHS was the question set for a roundtable held by the HFMA in November, supported by open source software and technology company OpusVL.

The first topic up for discussion was the sheer volume of data available. Every interaction with the NHS generates information about condition, treatment, age, gender, ethnicity and where somebody lives. There may be data about comorbidities, living arrangements, a person's occupation and so on. For those wanting to understand their populations, there appear to be infinite possibilities to learn about who seeks care, why, where from, how they access it, where they access it, and on and on.

Jaime Diack, head of finance systems and process redesign at Pennine Care NHS Foundation Trust, described it as being 'data giddy'. 'We are all trying to look at data, but we are all looking at it through our own lenses,' she said. 'We spend our time reconciling other people's analyses and wondering why there are differences.'

The level of reconciliation is not surprising when you consider the number of datasets that are created to meet a plethora of local and national needs to understand particular aspects of care.

Rony Arafin, head of analytics at NHS England, said that this process of reconciling different datasets is challenging. If all organisations drew on the same granular data, reconciliation wouldn't be necessary.

"Wherever you are in the NHS, hug your data engineer – because they can help you with this"
Andi Orlowski

'If we want to develop real intelligence from data, I think it has to be from completeness of patient level data,' he said. 'Then you can slice it in different ways. We don't fully appreciate the importance of individual data and, in many cases, we try to build datasets at a stage up, without even thinking about where the patient level data is getting collected.'

Michelle Skillings, head of performance at Somerset Integrated Care Board, agreed. 'We are now flooded with information across the NHS, but there is a lot of duplication across the various reporting resources. At times, I am unclear as to which is the best resource to be using, given that different reporting criteria may be used in different outputs.'

This proliferation, and confusion, of data can also be created by the multitude of systems that gather it. With more than 300 different systems collecting patient level data at Leeds Teaching Hospitals NHS Trust, Joe Selfridge, information manager for patient level costing, emphasised that automation of data processing can be important to deal with the volume of information.

Sarah McQuarry, finance systems and costing accountant at University Hospitals Plymouth NHS Trust, agreed, with around 130 systems in her organisation. 'The trouble is we get a lot of contradictions in the data across a patient pathway,' she said.

However, Mr Arafin said that even a single, patient-level dataset will never be perfect as data is collected about people with real life difficulties and circumstances that may not easily fit a dataset. 'We have to understand that we will always have data quality issues, we're never going to be able to solve that,' he said. 'But with what we do have, how do we provide better intelligence?'

Regardless of the number of datasets, there is still room for misinterpretation of the information if communication about the data is unclear. Ms Skillings highlighted: 'It's really important that we're all using the same language, because you could be talking about a metric or a piece of data in one way to one analyst within the region or nationally, but there can be different interpretations. Potentially you could be getting two or three different answers.'

Stuart Mackintosh, founder and chief executive officer of OpusVL, said that we need to take a step back and ask ourselves what we are trying to achieve with data. If that cannot be defined, then 'we'll end up being busy doing all sorts of fun things with technology,' he said, 'but will we actually solve the problem that we are here to achieve?'. 'It's about the human intelligence and how we have the computers working for us, to be the tool to do the work,' he added.

Participants

- Jade Ackers, NHS England
- Rony Arafin, NHS England/Association of Professional Healthcare Analysts
- Nicci Briggs, Cambridgeshire and Peterborough Integrated Care Board
- Jaime Diack, Pennine Care NHS Foundation Trust
- Peter Fry, Somerset NHS Foundation Trust
- John Graham (chair), Tameside and Glossop Integrated Care Foundation Trust and Stockport NHS Foundation Trust
- Stuart Mackintosh, OpusVL
- Sarah McQuarry, University Hospitals Plymouth NHS Trust
- Andi Orlowski, Health Economics Unit
- Duncan Orme, Nottingham University Hospitals NHS Trust
- Joe Selfridge, Leeds Teaching Hospitals NHS Trust
- Michelle Skillings, Somerset Integrated Care Board

Maximising the data

The clear message from the early discussion at the roundtable was that it is all about maximising the data that you have and making sense of it, for a clear purpose.

HFMA ROUND TABLE

Andi Orlowski, director of the Health Economics Unit, highlighted that there are 13,000 analysts, or data engineers, in the NHS to help create the architecture and data structures to help solve problems.

'There may be a lot of different questions and a lot of different datasets, but this group is dedicated to helping

build, extract and create files that can be interrogated,' he said. 'Wherever you are in the NHS, hug your data engineer because they can help you with this.'

Automation of data analysis

The volume of data generated in some cases means that automation of the analytical process can be essential to generate timely information. Mr Selfridge explained that automating the process had taken the Leeds trust's data processing time down from four months to four days. 'Get the information quickly and the organisation can use it,' he said. 'If it is four months old, it's out of date and nobody is interested anymore.'

Information can only be powerful if it is timely, but the desire to make it perfect can mean that it becomes too old to be useful.

'We can all be guilty of striving for perfection when it comes to data,' said John Graham, chief finance officer at Tameside and Glossop Integrated Care NHS Foundation Trust and Stockport NHS Foundation Trust and the roundtable's chair.

Jade Ackers, programme director for digital productivity at NHS England, flagged up that there are many good examples of robotic process automation across the NHS, many of which are captured within her team's evidence-based library. She highlighted opportunities across every integrated care system to look at how the automation of repetitive, rules-based processes can support every level of business across the health and care system. 'The potential benefits are phenomenal. They far outweigh the cost of implementation and offer sustainable benefits going forwards,' she said. 'These benefits include freeing up staff time to focus on higher value activities, improving data quality and decision-making, and improved staff and patient experience. This not only supports the organisation's development, but can also make the role more appealing for staff, which is important given the competitive digital and data analytics industry.'

HFMA ROUND TABLE

Local versus national data

There is always a balance to be struck between collecting the data required for national reporting requirements and the data useful for local decision-making. While it can feel preferable to focus on local data analysis, the importance of a national picture should not be overlooked.

As Mrs Diack pointed out: 'What we miss by looking at local data is how to shape the NHS as a whole going forwards. I recognise there are local issues to tackle, but we need to streamline and make our services more efficient. It's by looking at the national picture that we will do that.'

National data shares the common challenges of timeliness and quality, but this is intensified when drawing together multiple returns from across the health sector. As a consequence, national data can often feel clunky, said Peter Fry, head of income and costing at Somerset NHS Foundation Trust. 'Local nuance in data is important. NHS England pre-populates templates with data, but then we spend a lot of time picking it apart and trying to work out how it has been developed. I get nervous when NHS England builds a dashboard as it is often based on old data.'

However, Mr Fry acknowledged that there is a role for national analysis and the sharing of best practice across systems, when it comes to understanding and benchmarking data.

Mrs Ackers wanted to see a centralised, national knowledge hub, where people could share their experience in this area – including successes, key learnings and challenges – to enable the national teams to collate and curate best practice guidance and tools. She recognised that there are so many different networks and communities of practice across the NHS that it can be difficult to know where to look. So her team is working to consolidate and streamline these.

What is data imputation?

Data sets are often incomplete, which can lead to misleading answers when the data is analysed, as the missing data may introduce, or hide, a bias in the information. Data imputation is the process of substituting missing values with an estimated value, based on other data that is available.

For example, data imputation may be undertaken if a provider fails to submit data on one occasion in a regular data collection process. Excluding the provider from subsequent reports could skew the data to show a drop in activity that has not occurred. Data imputation techniques can be used to create expected values for the missing data, taking into account any known external factors that may have affected the activities of the provider over that time period.

A number of data imputation techniques can be used. In simple terms, these include repeating existing data, comparing with data from a similar organisation or substituting missing data with the mean value of the other data.

Scope of data

The NHS holds a wealth of data for more than 65 million people, but the data is not evenly distributed. While it can sometimes feel like there is too much information, there are some areas of the NHS that do not have the same richness of data.

'We need to be really careful about what we're not collecting,' said Mrs Diack, referring to an ongoing lack of information about mental health activity. 'There's a real issue about parity of esteem within mental health. We don't have a national currency and we find that it's very difficult to compare and benchmark data with other trusts. Where does that leave mental health patients? With such a gap in data, there is a real risk that we will miss something when we are talking about health inequalities, as we only focus on the data that we are collecting.'

She added: 'We need to be really careful about using the term "data rich", because it can suggest that we have got enough – and we really don't in some areas.'

Mr Orlowski agreed. 'There are groups in our populations that are over-represented in the data that we collect and how we collect it,' he said. 'Our algorithms, and the work we build from it, are therefore biased in favour of those populations.'

He highlighted that this is where the skills of a professional analyst come into play. 'A good professional analyst is aware of these biases and understands that they have to be taken into account, otherwise they will further inequalities.'

Data does not always have to be at a patient level to be useful, said Nicci Briggs, chief financial officer of Cambridgeshire and Peterborough

"The potential benefits are phenomenal. They far outweigh the cost of implementation and offer sustainable benefits"
Jade Ackers

Integrated Care Board. 'Sometimes it is as simple as a map of where the areas of deprivation are, overlaid with the facilities that we've got,' she said. 'You can start to map where the problems are, and it can be linked to levels of access. We forget facilities as a dataset.'

Duncan Orme, acting chief financial officer at Nottingham University Hospitals NHS Trust, shared an example of how this approach had highlighted an issue in Nottinghamshire.

'Prostate cancer was being picked up at an earlier stage in the more affluent zones and was costing less to treat,' he said. 'In the less affluent zones, it was often being picked up in the emergency department at a much later stage, and therefore had a far greater cost to the taxpayer and, more importantly, with a more significant treatment (and potentially less favourable outcome) for the patient.'

Mr Orme suggested that it is not just about understanding the physical assets, but also the knowledge assets. 'It's the way that we need to work with our communities to help them to understand the health challenges that they face,' he said.

Analytical workforce

So there is a lot of data available, a need to understand what is missing, and a requirement to identify the biases and omissions. This means it is essential that those analysing the data for future use have the necessary skills to do it well.

'You need to have confidence in the people who are serving the data,' acknowledged Mr Arafin, who is also chief executive of the Association of Professional Healthcare Analysts (AphA).

However, until recently there was no competency framework to describe how to start a career in data and analytics, and the skills that would be needed to become a chief data analytics officer. Such a framework has now been developed by the association working with NHS England.

"Get the information quickly and the organisation can use it – if it's four months old, it's out of date"
Joe Selfridge

Yet there remains a concern that there is no consistent level of expertise between data analytics teams, with a recent AphA survey showing that more than half of analysts do not receive continuous professional development within their organisations.

The ability to network and share knowledge is important in developing skills and competencies. Mrs Diack suggested that integrated care boards could have a role to play here in recognising data professionals and creating forums where they can bounce ideas around and get peer support. While accreditation can be useful, having a space for discussion can allow people to learn from one another and maximises the benefits of diversity.

This theme was picked up by Mr Orme, who described the importance of involving clinical staff in the use of data and their role in advocating for the benefits of robust data analysis.

He pointed to the possibilities of predictive analytics for managing patient flow and understanding how long people may need to stay in hospital. 'If you can predict how many patients you will have coming in, then you can schedule patients with greater confidence,' he said.

The role of the data analyst can be powerful, said Mr Orlowski. 'You allow people like me to guide hundreds of millions of pounds worth of decisions,' he said. 'What assurance do you have that the data and analytics that you're using to make decisions is appropriate for you?'

Opus's Mr Mackintosh questioned how easily that credibility could be achieved. 'It's difficult,' he said. 'It's a relatively new industry in the grand scheme of things and it's changing a lot, so it is hard to work out the ongoing relevance of a set of skills to a set of problems.'

Ms Briggs highlighted that a certain level of expertise is expected in finance roles and that credibility should be brought to the data analytics role, supporting Mr Orlowski's view that professional registration needs to be in place for analysts.

However, she also wondered if there comes a point at which the NHS needs to recognise that it does not have the necessary expertise to undertake some of these data functions. 'Do we need to build our own or do we need to have really strong relationships with organisations that are much better than us at it?' she asked.

Working together

Throughout the roundtable discussion, delegates raised the issue of working in silos. The power of working together to share information was widely acknowledged, and the benefits were clearly demonstrated in a number of cases.

'We built up such strong links through the costing team being sat with informatics colleagues,' said Ms McQuarry, relating her experiences at the Plymouth trust prior to the pandemic. 'We could learn about their tools and what they had to offer, and they could learn what we were using the data for.'

This view was shared by Somerset NHS Foundation Trust's Mr Fry. 'Costing teams are typically the ones that straddle finance and information, and there are definitely opportunities to cross-pollinate and learn from the respective teams in both technical and strategic senses,' he said.

'Even in an integrated organisation like Somerset, the corporate teams are also often siloed into sectors such as acute and mental health. Costing data can bring together an integrated pathway perspective that isn't readily available elsewhere.'

This is the approach taken in Leeds. 'We are one big team,' said Mr Selfridge. 'It's not just about having everyone in the same room for a meeting once a week; we do it every single day. That's how you untap the power of data and get people engaged.'

Engagement on the role of data analysts is essential across the whole organisation, not just with the finance team. Mr Graham challenged delegates to think about their own roles in supporting their organisations to engage more fully with the analytical profession.

'We have to build those relationships and put some effort in,' he said. 'None of us works in isolation and we need that support to understand the data.' He added that it would also be important to develop career paths for data analysts.

Throughout the discussion, it became clear that the power of data is not realised by developing newer and fancier IT systems – the systems are already in place.

Nor is it about collecting more data, although there are obviously some sectors where that would help, such as mental health. It is much more about the analytical workforce – fully utilising their skills, working with them to understand what the data shows, and supporting them as a profession to develop and be recognised.

As Mr Arafin put it: 'It is untapping the power of analytical professionals that will really serve the purpose of how the use of data is maximised in the NHS.'

• *Sarah Day is a senior policy manager at the HFMA*

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MANCHESTER EVENING NEWS

There were 12,699 of lost hours in August – equivalent to the whole of Lancashire and Cumbria having no ambulances for nearly six days

Lost hours

Ambulances stuck outside hospitals waiting to hand over patients reflect wider pressures in the urgent and emergency care sector, according to one ambulance trust finance director. Steve Brown reports

Hospital handover delays are the single biggest problem facing ambulance services. They have a direct impact on patients, delaying assessment or treatment. But they also have a knock-on effect on ambulance services' ability to respond to further emergency calls.

Carolyn Wood, finance director at the North West Ambulance Service (NWAS), one of 10 ambulance trusts in England, says: 'Delayed hospital handovers started increasing at the back end of summer last year and they have been on a steady upward trajectory since then.'

The big worry is how this could worsen over winter. Trusts measure handover performance against a target of 15 minutes, with a further 15 minutes for crews to be back on the road. In the North West, the average overall turnaround time was 43 minutes and 33 seconds in August, mostly tied up in patient handover. The total time taken above the 30-minute handover target was 12,699 hours in August, equivalent to the whole of Lancashire and Cumbria having no ambulances for nearly six days.

As well as the number of patients waiting outside A&E trending upwards for the past year, there have been more extreme waits across the UK, with reports of crews spending whole shifts waiting to hand over a patient.

Ms Wood says NWAS has certainly seen an increase in longer waits. More than 7,000 attendances had a turnaround time of over one hour, with 679 taking more than three hours.

'It's really frustrating for the patients. It's frustrating for the crews. It's frustrating for the A&Es,' she says. 'People didn't train to go and stand in a corridor waiting to hand over a patient; they trained to be out on the road. And that's why staff are getting really frustrated.'

The causes are well understood. Demand for A&E services remains high. Flow in hospitals is impaired by patients blocking beds, while they wait for social care support to be organised in the community to allow them to be discharged. That means A&Es can't get patients admitted, leaving emergency departments overcrowded and staff unable to take on new admissions.

There are also staffing pressures across the whole NHS, with Covid-19-related absences compounding the problems with record levels of vacancies. 'What we're seeing are the symptoms of a very overstretched urgent and emergency care system right across the whole system,' Ms Wood says.

Problems start in primary care with demand up and GP numbers down, piling pressure on 111 services, and then on 999 services. Meanwhile, social care faces its own capacity

challenges. Ambulance handovers are just where the pressure is bulging out. There is no obvious single solution; it will take action on multiple fronts. The reintroduced £500m adult social care discharge fund will help get medically fit patients out of hospital and back into the community faster. Plans to extend bed capacity – for example, through increased use of virtual wards – will also help.

Ambulance services are also playing their part. 'As a service, we are trying to reduce the number of people we are taking to A&E,' says Ms Wood. 'Over the past few years, that has gradually decreased. We are now transferring on average about 1,300 fewer patients per week across our different hospitals and sites compared with 2019.' This is done by increasing the amount of hear-and-treat and see-and-treat responses, alongside the more traditional see-and-convey activity.

Alternative options

Accessing an alternative crisis service in the community can really help take the pressure off A&E. But it relies on those services being available and, crucially, ambulance services knowing about them and able to access them.

Ms Wood says it is about doing what is best for the patient and working as systems. 'A see-and-treat response can take longer than a traditional conveyance directly to A&E,' she says. So it still ties up staff and vehicle resources. But it may provide the best option from both a patient and system perspective.

The handover delays have an impact on broader ambulance response times. Ambulance trusts are measured against four main response targets for different types of call. For a category 1 call – defined as life-threatening – an ambulance is supposed to arrive on scene in an average of seven minutes. And 90% of those calls should be responded to within 15 minutes. The comparable standards for category 2 calls (emergency) are an average response of 18 minutes and 90% of responses within 40 minutes.

"We are now transferring about 1,300 fewer patients per week across our different sites compared with 2019"
Carolyn Wood, NWAS

But ambulance services across the country are struggling to hit these targets. None of the targets were met for England as a whole in September. The mean response time for a category 1 call was two minutes and 19 seconds above the seven-minute target. And the target for 90% of calls to be responded to within 15 minutes was also missed, with a 90th centile time of 16 minutes 38 seconds.

Compared with the national average, the North West did relatively well, but still missed all the targets apart from the 90% target for category 1 calls. Its mean response time for a category 1 call was eight minutes 43 seconds.

Analysis from the Health Foundation makes a direct link between handover delays and response times. Even small increases in handover time can have a major impact on the number of calls a trust can respond to per hour. It said tackling ambulance performance would need an increase in hospital capacity and out-of-hospital care, as well as more ambulance staff. All of this will require further investment in the NHS and social care and a comprehensive, funded workforce plan.

There is also a financial consequence to the delayed handovers but, unlike the acute sector, service pressure can't always be easily spotted in the financial position. The trust does incur higher costs through increased overtime payments. And it can access third-party crewed ambulance supply (from organisations such as St John Ambulance) to increase the number of ambulances on the streets, although their responses are limited to lower acuity calls.

'However there's only so much [staff and third-party supply] can do in terms of filling that gap,' says Ms Wood. 'So we get to the point where we are saturated in what we can physically do. We don't necessarily see the impact in the finances, but we do see it in a performance deterioration. We see it in complaints increasing. We see it in hospital handovers.'

Ambulance trusts face their own unique financial pressures. This year's pay deal in England provides a flat £1,400 for all agenda for change (AFC) staff, which translates into increases of 9.3% for the lowest paid down to just 1.5% for those on the highest bands.

Acute trusts face an estimated 5% increase in their pay bill, a combination of the AFC increases and the 4.5% doctors' pay rise. But ambulance trusts tend to have far more staff on lower AFC bands and so face a higher percentage increase in pay costs overall.

Capital is another challenge. The Carter review of productivity in ambulance services in 2018 highlighted that five years was the optimum length of time to keep an ambulance on the road, with annual maintenance costs rising significantly after this point. But for

NWAS in numbers

Workforce: 6,700 staff, roughly split into 4,500 for the 999 service, 800 for PTS and 600 for 111, with 800 in corporate and other functions

Areas covered: 5,400 square miles across three main areas – Cheshire and Merseyside; Cumbria and Lancashire; and Greater Manchester. This covers big inner cities such as Liverpool and Manchester; smaller cities such as Preston and Lancaster; and real rural areas such as the Lake District that have major vehicle access challenges

Number of sites: 100+

Budget (2021/22): £460m, broken into income of £360m (patient emergency services); £44m (patient transport services); and £32m (111). Other income amounts to just over £22m

Activity (2021/22)
999: more than 1.8 million calls and 1.1 million incidents
See-and-convey: 679,000, of which 598,000 to A&E
See-and-treat: 343,000
Hear-and-treat: 107,000
PTS: 1.2 million conveyances
111: 2.7 million-plus calls offered

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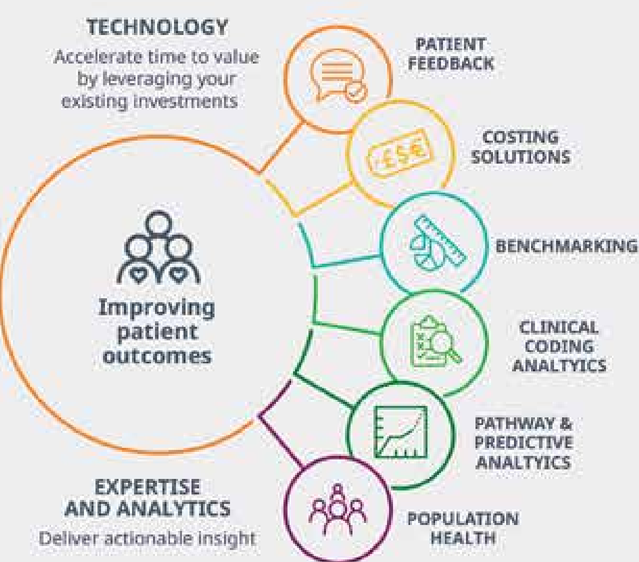

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most ambulance trusts, available capital will not stretch to delivering this refresh rate.

In the North West, a seven-year vehicle life is the target. With more than 500 ambulances in its fleet, the trust needs to replace about 70 ambulances a year. A dedicated national capital pot to help reduce the age of the ambulance fleet and increase numbers was announced in the planning guidance, but this provides just £20m a year across 10 trusts for the next three years. And at £125,000 for a converted van ambulance, the trust's share of this only covers 15 to 20 ambulances.

This year, the trust's capital allocation stretches to about £20m and half of this will go on fleet replacement, with the remainder covering backlog maintenance and developments across its 100 or so sites.

Another Carter recommendation was to reduce the number of sites used by ambulance trusts, building bigger stations where appropriate and consolidating the number of control centres. This would improve efficiency and effectiveness, particularly in urban areas. But this kind of development – and productivity improvement – remains off the agenda in the current environment of scarce capital funding.

Income issues

Ambulance trusts' income is largely fixed. Back in the days of payment by results, there had been moves to link payment to a currency based on hear-and-treat, see-and-treat and see-and-convey. But this was overtaken by wider events and the move away from the activity-based payment by results approach for acute providers. Patient transport services may have been on a cost and volume basis pre-Covid, but all contracts moved to a block basis as part of the temporary financial regime introduced for the pandemic. In the North West, there has been no return to cost and volume as yet.

However, there are discussions under way within the sector about how the variable element in the new aligned payment and incentive system could be used to reflect increased activity or incentivise performance in key areas, but this will not be concluded for the next planning round.

'One idea is you could have a fixed element for core activity and then a flexible element that starts to pick up the increased activity or reflect where handover delays increase beyond the planned level,' says Ms Wood.

Much like the wider NHS, many ambulance trusts think they will hit their financial targets this year. But next year looks much more challenging. They carry a lot of non-recurrent savings into the new year and inflation continues to soar. And the cost-of-living crisis will continue to keep demand for pay increases above the level assumed in current allocations. Industrial action remains a real threat.

But the real consequences of this continued extreme pressure on ambulance services is likely to be most evident in performance, response times and patient experience, and not in the financial reports.

PTS, 111 and staffing pressures

Patient emergency services (PES) are only one aspect – albeit the biggest – of ambulance services. Many ambulance trusts also run patient transport services (PTS) and 111 services. In the North West, of the trust's £460m income, about £360m relates to PES. But it earns a further £44m for PTS and £32m for 111 activities, with a small amount of other income on top.

PTS should be a lot more predictable than emergency services but it has its own pressures. It supports individuals to attend either regular appointments such as dialysis or cancer care, where they have a medical need that prevents them from using their own transport. During the pandemic, PTS fell below the baseline level included within the contract – almost 25% less in the last contract year. However, delivery involved more resources and higher cost.

In part this reflected infection control measures, which effectively required people to be transported individually rather than in groups. While Covid rules have been relaxed, activity continues to be below the baseline, although it is gradually increasing. However, NWAS continues to experience high levels of patients who meet the criteria for single occupancy transport and is exploring the possible reasons behind this cost driver.

In contrast, calls to the trust-run 111 service were 40% above pre-Covid levels last year, partly a result of the NHS-wide 111 first programme to reduce pressure on A&E departments. The call demand is not covered by the funding included in the contract, yet the trust also faces significant staffing pressures.

All ambulance trusts report challenges with recruitment and retention in all parts of their service. There is a shortage of paramedics with the potential for the increased recruitment of paramedics by primary care networks to exacerbate the situation. And, after an increase in recruitment during the first part of the pandemic for its 111 and PTS services, recruitment is again more challenging.

Junior call handlers in the 111 service or drivers for PTS services could earn similar money in hospitality or retail.

The trust has taken a number of steps, improving fair access to annual leave, trying to improve the rostering of people in teams, and introducing a retention premium as a short-term measure. But Ms Wood says the trust is also keen for the ambulance service to be seen as providing careers not just jobs.

'A lot of people who start within PTS on a vehicle, quite often go through the training to become a technician, then paramedic,' says NWAS finance director Carolyn Wood. 'And there are examples of people who start in 999 call-handling moving into a dispatching role -- allocating a vehicle to a job and moving the resources around. And, again, from there they might actually go on the road as a technician or paramedic.'

So a role in 111 is not just a short-term call centre job detached from the rest of the business, but entry into a much broader organisation. A single triage system across the 999 and 111 services helps improve flexibility and movement across the trust. 'We want the trust to be seen as offering a career, not just a job,' she says. 'It should be seen as an organisation for life.'

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Revised auditing standards will mean more questions for NHS finance teams

Technical

The HFMA year-end survey painted a picture of a difficult year-end for 2021/22 and there are indications that 2022/23 will be no easier, *writes Debbie Paterson.*

There are well known challenges. The IFRS 16 leasing standard is finally adopted. The implications of the *Health and Care Act 2022* mean multiple sets of part-year accounts for commissioning organisations. And, finally, NHS bodies that employ staff who are members of a local government pension scheme have struggled to get the information they need to finalise their accounts, even now.

There will, no doubt, be other unexpected issues that arise between now and next summer. However, there is one other area of change that finance teams need to be aware of. Two UK international auditing standards (ISAs) have been substantially revised and come into force for audits of accounts for periods beginning on or after 15 December 2021. For NHS bodies, this is the 2022/23 annual accounts and, although auditors will be most affected, NHS finance teams will feel the impact as well.

Part of the reason for the changes is to enhance auditors' professional scepticism. The standards now make explicit reference to auditors 'not being biased' towards obtaining corroborative audit evidence. In addition they should also not exclude contradictory evidence.

While the changes reflect best practice that may already be in place, there is no doubt that NHS bodies will face more questions from their auditors, particularly to understand the basis for estimates and judgements and evidence to support decisions made by finance teams.

ISA 315 – *Identifying and assessing the risks of material misstatement* – revisions are designed to drive a more robust and consistent risk identification and assessment. The standard

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(**hfma.to/dec2216**) introduces five new inherent risk factors, a spectrum of risk and the requirement to assess inherent and control risks separately. It also includes a number of new requirements related to understanding and assessing risk.

These include the new requirement for the auditor to consider all the audit evidence they have gathered from performing risk assessment procedures to determine whether they have sufficient understanding of the risks of material misstatement. This assessment should include all evidence including any that is contradictory.

This may change the type of work the auditors undertake and may mean that some of this work is done earlier in the audit, as the risk assessment process informs the design of audit procedures.

ISA 315 also requires auditors to understand NHS bodies' use of IT, the related risks and the system of internal control addressing those risks. This may mean there will be extra audit work on IT systems and direct and indirect controls.

The second revised standard is ISA 240 – *The auditor's responsibilities relating to fraud in an audit of financial statements* (**hfma.to/dec2217**) The amendments clarify that the evaluation of whether a fraud is material should consider qualitative as well as quantitative factors. It also emphasises the role of the auditor to obtain reasonable assurance about whether the accounts are free from material misstatement due to fraud.

The standards require auditors to investigate inconsistent responses to their inquiries as well as those that appear implausible.

There are also new requirements to make inquiries of those who deal with fraud raised by employees or other parties. This is to determine whether the engagement team requires specialised skills or knowledge to investigate further if there is cause to believe that a record or document may not be authentic.

Finally, a revised version of ISA 220 – *Quality management for an audit of financial statements* – comes into force for audits of accounts of periods starting on or after 15 December 2022. For NHS bodies, this is 2023/24. But early adoption of the standard is allowed, so audit firms may decide to adopt it early or at least start to change procedures in readiness for adoption.

This standard assigns some audit procedures and actions directly to the engagement lead. The increased involvement of the most senior member of the audit team could change audit procedures and will increase review time.

It is essential that auditors and finance teams liaise early in the audit planning process to understand the impact of the new requirements.

Debbie Paterson is the HFMA's senior technical manager

Technical review

Recent technical developments

Technical

NHS England has been running an initiative to understand more about the differences between local cost models and the methodology required for the **national cost collection**. The aim is to identify opportunities to reduce the burden on costing teams. Costing practitioners have for a long time called for a simpler approach, focused on providers' main material costs. They argue that they don't use all the very granular detail locally and that the time taken to compile costs reduces the time available to use the data to drive improvement. During September, NHS England asked trusts to submit details of the data fields they have available to support cost allocation and to list the cost pools used in their local model. It has followed this up in November with a wider-ranging survey on local costing approaches, with two separate versions: one for acute, mental health and community trusts; and one for ambulance trusts. The surveys are open until 6 January.
hfma.to/dec226; hfma.to/dec227

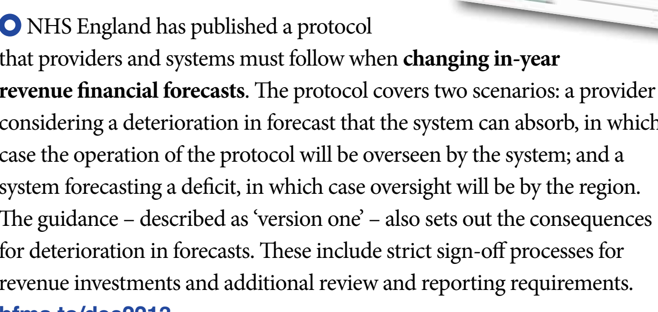
NHS England has issued an updated ***Code of governance for provider trusts*** covering both NHS trusts and foundation trusts. The code was last updated in 2014 and the new code reflects the significant changes in NHS structures and policy since then. It remains based on the *UK corporate governance code* (and in particular the 2018 version of the code). Compliance with the provisions in the code are on a 'comply or explain' basis. The code covers five main areas: board leadership and purpose; division of responsibilities; composition, succession and evaluation; audit, risk and internal control; and remuneration. NHS England has also published *Guidance on good governance and collaboration* and *Addendum to your statutory duties – reference guide for NHS foundation trust governors*. All three of the documents were consulted on this year and the government has also published its response to the consultations.
hfma.to/dec228

The effect of **blended payments** on hospitals' tendency to admit patients from accident and emergency departments is likely to vary by trust and region, according to a University of York study. The researchers at the university's Centre for Health Economics said the payment reform would change incentives for hospitals and implies a lower return on admission of patients. They added that their results indicated that payment reform alone is likely to have only a modest impact on hospital admissions. However, they also insisted that it was too early to draw robust conclusions on the impact of blended payments and highlighted that they had considered only one element of the emergency care system.
hfma.to/dec229

NHS England has published a framework setting out how it will operate in the new health service structure created by the *Health and Care Act 2022*. The **operating framework** describes the roles of NHS England, integrated care boards and NHS providers. NHS England said the document demonstrated how accountabilities and responsibilities will be allocated to improve health and care, maximising taxpayer value for money.
hfma.to/dec2210

The Department of Health and Social Care clarified elements of its ***Group accounting manual 2022 to 2023*** in October after a consultation on the document ended. In its response to the consultation, the Department replied to views on leasing standard IFRS 16, changes to the manual stemming from implementation of the *Health and Care Act 2022* and some other minimal changes. The Department has made the guidance more explicit in some areas, though in others it has noted comments, but not changed the draft, to avoid being overly prescriptive. **hfma.to/dec2211**

The HFMA has published a briefing on **accounting for digital technologies**. It said this is a complex area and it is not always clear if the NHS body is purchasing an asset or a service. In accounting, the former would be treated as capital expenditure, while the latter is revenue or both. The briefing sets out questions to help decide the appropriate accounting treatment, and looks at the role of NHS finance teams, management and auditors.
hfma.to/dec2212



NHS England has published a protocol that providers and systems must follow when **changing in-year revenue financial forecasts**. The protocol covers two scenarios: a provider considering a deterioration in forecast that the system can absorb, in which case the operation of the protocol will be overseen by the system; and a system forecasting a deficit, in which case oversight will be by the region. The guidance – described as 'version one' – also sets out the consequences for deterioration in forecasts. These include strict sign-off processes for revenue investments and additional review and reporting requirements.
hfma.to/dec2213

Draft NHS enforcement guidance sets out how NHS England intends to exercise its **enforcement powers for integrated care boards and providers**. The guidance explains when NHS England may decide to take action and what action it can take. It also covers how NHS England will decide what sanctions to impose and the high-level processes it will follow when taking enforcement action. A consultation on the revised enforcement guidance was due to close in early December.
hfma.to/dec2214

A new **environmental sustainability guidance map** from the HFMA brings together the key guidance, tools and examples to support the NHS in meeting its commitments to environmental sustainability and the net-zero targets. Aimed at boards, finance teams and their clinical collegues, the map is split into three sections: strategic framework; enabling environmental sustainability; and specific examples. It will be updated as new guidance is produced.
hfma.to/dec2215

Developing healthcare leaders of the future

HFMA qualifications in healthcare business and finance

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

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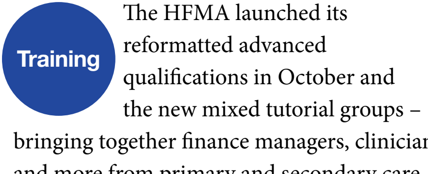

The HFMA launched its reformatted advanced qualifications in October and the new mixed tutorial groups – bringing together finance managers, clinicians and more from primary and secondary care – are already proving popular.

Iain Crossley (pictured), a tutor for the *Making finance work in the NHS* module, says the mix of sector backgrounds of students creates robust discussion and an opportunity to challenge misconceptions about how things work in different parts of the NHS. 'We often get into the territory of myths and misunderstandings. It's really helpful to see things from a different perspective,' he says.

Until this year, the HFMA had run separate study programmes for its diploma in healthcare business and finance and its diploma in advanced primary care management. But from October the programmes have been brought together. Students still work towards one qualification or the other, with the specific qualification determined by the combination of modules studied. However, students on both qualifications study together for modules common to both programmes.

This has brought a new dimension to the weekly tutorials, says Mr Crossley, who wrote the module and previously taught on the primary care qualification. 'We typically see finance managers, budget holders and clinicians from trusts and integrated care boards on the business and finance programme and GPs and practice managers on the primary care module. By learning together, we get some interesting views and it really helps everyone to see the whole NHS from a different angle.'

Mr Crossley says the masters-level course goes beyond explaining how the NHS works. Instead, it encourages students who are already working in the NHS and familiar with many of its systems to think about how it could work better. 'For example, we don't just explain how the allocation process works – the basics of how you give money out across the country in a fair and equitable way,' he says. 'But we also challenge if this process delivers what it is supposed to. And how do you make the process work for integrated care?'

About two-thirds of the 25 students on the current intake for this module being taught by Mr Crossley are pursuing the healthcare business and finance route.

'The mix exposes that what is clear and obvious in one sector is often seen completely differently elsewhere,' he says. 'In primary care, the focus financially is about income. They have a completely different approach to the idea of budgeting.'

The course also gets into emotive topics such as the pros and cons of funding capital in the NHS with public or private finance. Each week's 90-minute tutorial is popular and lively as a result.

The *Making finance work in the NHS* module is estimated to involve some 200 hours of study over 17 weeks from start to final assessment, including 10 weeks of teaching. Successful completion of the masters-level module is worth 30 academic credits. To achieve a full advanced diploma requires the completion of two modules. *Making finance work in the NHS* is mandatory for the healthcare business and finance qualification. For the primary care qualification, students must complete an NHS law, policy and governance module.

Students for both qualifications can choose their extra modules from the following: *Tools to support decision-making; Creating and delivering value in healthcare; Supporting quality care through patient-level costing; Personal effectiveness and leadership*; and *Managing the healthcare business.*

EVO gets open-source reboot

The EVO – engagement, value, outcome – framework is being developed for NHS trusts to facilitate the involvement of multi-disciplinary teams in the understanding and local use of patient-level information and costs (PLICS). Using this information, teams can evidence the relationship between existing improvement cycles and value in healthcare.

Programmes using this data are well documented – in clinical practice groups at the Royal Free London NHS Foundation Trust (**hfma.to/dec223**), the wave programme at Nottingham University Hospitals NHS Trust (**hfma.to/dec222**) and the waste reduction programme at Leeds Teaching Hospitals NHS Trust.

The initial and continued development of the EVO framework was inspired by these implementations, with the ultimate aim being to improve clinical efficiency and productivity to achieve the best outcome for the patient. The EVO pilot, initially developed by the HFMA Healthcare Costing for Value Institute and Future-Focused Finance, took place in 2019 with four trusts, covering acute, mental health and community services. The case studies from the pilot sites are available online (**hfma.to/dec221**).

Since the pilot, EVO has been significantly developed. The Finance Innovation Forum and Future-Focused Finance, together with a large number of NHS teams, healthcare associations and subject matter experts, have collaborated to launch an open-source model of the EVO framework in 2023.

EVO 1.0 promotes collaborative working between clinical and finance teams and their collective understanding of PLICS data, providing the NHS with a process to ensure resources are used in the most effective way possible to provide high-quality care to patients.

Diary

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

B Branch N National I Institute H Hub W Webinar

January

12 B Eastern: introduction to NHS finance
13 H Health and wellbeing conference
17 H Chief finance officer and director forum, London
17 B South Central: lunch and learn – SPC charts introduction
18 B Eastern: lunch and learn – where might a career in NHS finance take you?
19 I Introduction to NHS costing
25-26 N Pre-accounts planning
25 B Wales: VAT level 3 – strategic workshop
25 B South West: VAT level 3 – strategic workshop
25 B Wales: members Christmas lunch

February

01 I Costing together, London
07 H Integrated care summit
10 B KSS: introduction to NHS finance
12 H Delivering value with digital technologies, London
20 B Eastern: HFMA, Skills Development Network and One NHS Finance annual conference, Wyboston Lakes

March

07-08 H HFMA 24-hour NHS leadership forum, London
09 H Chairs' conference, London
14 I Value masterclass, online
16 H Audit conference, London

April

12 I Costing conference

June

08 B West Midlands: annual conference, Birmingham
15-16 B North West: annual conference, Chester
23 B Northern: annual conference, Gosforth

September

14 B South Central: annual conference
19-20 B South West: annual conference, Exeter
21-22 B Yorkshire and Humber: annual conference, Forest Pines
28-29 B Wales: annual conference, TBC

October

12 B London: annual conference
19-20 B KSS: annual conference
26-27 B Scotland: annual conference

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Events in focus

Costing conference 2023
12 April, London, face-to-face

Bookings are open for the 2023 HFMA Healthcare Costing for Value Institute costing conference. The 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 day includes interactive workshops, case study examples and policy updates and provides an opportunity to network with like-minded colleagues and discuss key costing issues.

With significant inflationary and financial pressures, reducing costs and improving value are high on every system's to-do list. Robust costing data – and local approaches to use the data to drive improvement – will be vital to this agenda. There are also moves to reduce the burden on costing practitioners to free up more time to work with colleagues to realise this improvement.

This year the event will be taking place in London, with two free places available to all institute member organisations.

- **Visit www.hfma.to/dec225 for more details**

Delivering value with digital technologies
22 February, face-to-face

This conference, in its second year, will give a platform to those organisations that have made progress in rolling out digital technologies to transform the delivery of care and improve value.

Delegates will hear real-life examples of local initiatives that have been successful in using technologies, such as digital medicine, genomics, artificial intelligence and robotics, as well as hearing from NHS leaders about the policy framework and central support available.

They will have the opportunity to discuss how these technologies can help the NHS address some of its key challenges, including patient engagement, access and health inequalities.

Confirmed speakers include Nicci Briggs (pictured), chair of the HFMA Digital Council and chief financial officer of Cambridgeshire and Peterborough Integrated Care Board, and Sonia Patel, system chief information officer and director of levelling up at NHS England.

- **Visit hfma.to/dec225 for more details**

Handing on the baton

Association view from Mark Knight, HFMA chief executive

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

One of the joys of the HFMA is working with great leaders, and 2022 president Owen Harkin has been no exception. His theme, *Reimagining the future,* has given us a chance to fully explore living with Covid-19.

Owen (pictured with trustees and HFMA staff at a recent board meeting at Stormont) has been an outstanding president. He was vice president for an unprecedented – and turbulent – three years. I valued his wisdom and counsel throughout that period and his contributions to our agenda were significant.

This was on top of him being a busy deputy chief executive and chief finance officer in a system quite different from England. Despite his distance from mainland Britain, Owen has been ever-present at branch conferences, whether face-to-face or virtual. So a big thank you to Owen. We benefit from his wisdom on the HFMA board for a few more years yet.

So, on to our next leader, Lee Bond. It's been great getting to know Lee over the past few years. His call to arms with *Strength in numbers* will no doubt resonate with the finance function as we face the coming year.

I have just returned, with Lee and Bill Gregory, from representing the association at the Australian HFMA annual conference. In one session, as we listened to chief finance officers from across Australia, the facilitator noted down the many pressures on leaders. I commented that, other than the acronyms and accents, I could have been in a meeting with chief finance officers anywhere in the UK. The problems are largely the same.

Okay, Australia takes rurality to the extreme, and is about 30 times the size of the UK. And it does have a private sector that seems to run alongside the public offering much more visibly than our own. But other than that, its challenges are around balancing the books, access to capital, capacity and workforce.

HFMA chief executive Mark Knight

It was great to spend time with our Australian colleagues and encouraging them. Now that our relationship is fully re-established, we have a few ideas for sharing best practice across our two organisations.

By the time you read this magazine, the annual conference will be upon us – and it looks like it will be a big one. We are close to capacity and that's great because it shows the association is alive and well.

As we go into 2023, with all that's going on politically, and amid the economic challenges we face as a country, we need each other. We need to come together and associate. There are many learning and networking opportunities available throughout the HFMA and some new ones will be announced at the conference.

But what about you? Is there anything you'd like to do in our vast structure of boards, committees, branches and education offerings? There may be a 'you sized' opportunity within either the HFMA or One NHS Finance. So don't just join; join in.

Have a great festive period and tremendous 2023. We look forward to seeing you then!

Member news

Kent, Surrey and Sussex HFMA Branch announced the winners of its awards at its conference in October:

- Overcoming Adversity – NHS Kent and Medway
- Innovation – East Kent Hospitals University NHS Foundation Trust
- Finance Team of the Year – Sussex Community NHS Foundation Trust
- Outstanding Contribution – Zach Minter, Surrey and Sussex Healthcare NHS Trust.

In addition, Gill Jacobs (pictured above left with branch chair Sheila Stenson), on her retirement, was presented with the Exceptional Commitment and Longevity Award for her

contributions between 2008 and 2022. Ms Jacobs was branch secretary for 14 years. She also received a national HFMA key contributor award and was made an honorary fellow.

During its conference, the Kent, Surrey and Sussex Branch also raised £1,300 for charity Turning Tides, which focuses on ending local homelessness.

Two appointments have been announced in HFMA branches over recent weeks:

- Shekh Motin, director of operational finance at London North West University Healthcare NHS Trust – vice-chair of the London Branch
- Mike Clements, director of finance at Royal Berkshire NHS Trust – treasurer, South Central Branch.

The East Midlands Branch has named Zoya Gina (pictured) as its Student of the Year. Ms Gina, who works at Leicestershire Partnership NHS Trust, was selected because of her 'determination and can-do attitude', support for her trust and success in her studies.

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Member benefits

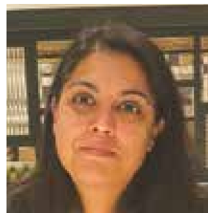
Membership benefits include a subscription to *Healthcare Finance* and full access to the HFMA news alert service. Our membership rate is £65, with reductions for more junior staff and retired members. For more information, go to www.hfma.org.uk or email membership@hfma.org.uk

Appointments

Amy Whittaker (pictured) has been named chief finance officer at The Mid Yorkshire Hospitals NHS Trust. She joined the trust in September, having served as director of finance at Airedale NHS Foundation Trust. Ms Whittaker succeeds **Jane Hazelgrave**, who is now the director of finance and investment at Humber and North Yorkshire Integrated Care Board.

Solent NHS Trust has appointed **Nikki Burnett** as chief financial officer and director of estates. Ms Burnett joined the trust in August, after working as deputy chief financial offer at NHS Portsmouth Clinical Commissioning Group. She has more than 14 years experience working in the NHS.

James Drury has taken over as interim chief financial officer at Queen Victoria Hospital NHS Foundation Trust, having joined the trust in August. He has more than 15 years' experience as an NHS finance director.



West London NHS Trust has appointed **Manpareet Hothi Dhaliwal** (pictured) as deputy director of finance. Ms Dhaliwal, who brings to the trust more than 16 years of NHS experience, took up the role in June having worked as associate director of finance and contracts. She succeeds **Jo Smith**, who has retired.

Helen Dempsey has been appointed director of planning at Staffordshire and Stoke-on-Trent Integrated Care Board. Ms Dempsey joined the ICB in August, having previously worked at Staffordshire and Stoke-on-Trent Clinical Commissioning Group as deputy director of finance - sustainability and transformation.

Paul Ronald is the new interim director of finance and estates at Hertfordshire Partnership University NHS Foundation Trust. Winner of the HFMA Deputy Director of Finance Award in 2013, Mr Ronald has been working at the trust for more than 10 years.

Ken Jones (pictured) has been appointed director of delivery for solutions at internal audit provider MIAA, succeeding **Keith Bowman**, who has become director of solutions. Mr Jones was previously associate director of financial control and assurance at Alder Hey NHS Foundation Trust. **Gayle Wells** also joined MIAA in November as director of operations. She moves from Mersey Care NHS Foundation Trust, where she was strategic head of finance. She is also vice chair of the HFMA North West Branch.

A further three finance managers have taken up their first chief finance officer position. **Chris Hearn** is the new chief financial officer at Dorset County Hospital NHS Foundation Trust, moving from Dorset Healthcare University NHS Foundation Trust, where he was director of operational finance. **Aneel Pattni** has joined South Central Ambulance Service NHS Foundation Trust as chief finance officer. He was previously deputy chief finance officer at Buckinghamshire Healthcare NHS Trust. Meanwhile, North East Ambulance Service NHS Foundation Trust has appointed **Tarryn Lake** as group director of finance and digital. She was previously associate director of finance at NHS Sunderland Clinical Commissioning Group, moving to North East and North Cumbria Integrated Care Board in July. (*See Stepping up, page 22*)

Adrian Snarr joined South West Yorkshire Partnership NHS Foundation Trust in August as director of finance, estates and resources, having previously served as director of financial control at NHS England.

Day eyes frontline return

Sarah Day, senior policy manager at the HFMA, says she is excited about the prospect of moving back to frontline finance as she takes up her new role as director of operational finance at Dorset Healthcare University NHS Foundation Trust. The new job starts in January.

'I've loved my five years at the HFMA,' she says. 'The association gives you such a broad perspective and contact with people working at a senior level. It has really helped my confidence.

'I've spent a lot of time researching and writing about the things people are doing in the NHS – there are some really great things happening,' she added. 'And I'm excited about being part of that. I am particularly interested in the whole health inequalities agenda and how changing something that might seem minor can make a big difference to somebody's life.'

Dorset Healthcare provides community and mental health services across Bournemouth, Poole and Dorset and has recently announced plans to appoint a joint chief executive and chair with acute provider Dorset County Hospital NHS Foundation Trust – part of a joint leadership model.

Ms Day started her career as a structural design engineer, designing military helicopters at manufacturer Westland, but retrained as an accountant before joining the NHS. She has worked in finance in community services and at a commissioning support unit.

Her most recent role within the NHS was at NHS England, where she was senior strategic financial lead for personalised care. She remains committed to this approach to care delivery, believing it can ensure NHS resources are used in a way that has a meaningful impact on service users and patients.

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

"We all face the same issues and challenges – even if the stunning location makes it look more dramatic"
Heledd Cooper, NHS Highland

Cooper takes the high road for new role

On the move

Changing your job can be stressful at the best of times. But factor in a major relocation – from North Wales to the far north of Scotland – and a change of health system to boot and things get pretty life-changing. That's exactly what Heledd Cooper did this summer, moving from her North Wales home and Liverpool job to take up the position of finance director in NHS Highland.

Ms Cooper said she and her husband, both outdoor enthusiasts, had holidayed in the Highlands – driving up in their motorhome – and had the 'could we live here?' conversation. But it got no further than holiday imaginings, until the health board role was advertised and the possibility became real.

'The truth was that it was an opportunity for us personally and me professionally,' she said. Having started the role in August, Ms Cooper moved into her new home in November.

It is a significant change of environment – just an hour from the spectacular Cairngorm mountains as well as the inner islands. But she says that professionally there are many aspects of the way health and care services are structured that are relatively familiar, having spent several years working the Betsi Cadwaladr University Health Board in North Wales.

Both Wales and Scotland have been operating single system structures for several years, bringing together commissioning and provision and looking to integrate health and social care services more closely.

In many ways, this puts Wales and Scotland (and Northern Ireland with its health and social care trusts) ahead of England, which has only more recently been moving towards integrated care systems.

'Scotland is more similar to Wales than England,' says Ms Cooper. This is not just in terms of integration, but size and how the systems are politically driven. But while Scotland has made progress with the integration of health and care services, she says there is more work to do in establishing the National Care Service.

Ms Cooper has worked in England, starting out in 2001 on the national financial management training scheme in the South West of England, before taking roles in providers and commissioning bodies and holding senior financial leadership positions in the North West Strategic Health Authority as well as NHS England.

She moved to Betsi Cadwaladr as area chief finance officer in 2015 before taking her first board-level executive director of finance role with Liverpool-based Primary Care 24 in 2018.

She says the not-for-profit social enterprise, which delivered exclusively NHS contracts, was a great place to cut her boardroom teeth and to learn about board level leadership.

'It was a big learning curve,' she recalls, 'but they supported me through it and that has prepared me well and made me stronger coming into this role.'

The whole of the NHS faces financial challenges currently. And this is certainly the case for NHS Highland. As of November, it was forecasting a £40m deficit against a planned overspend of £16m. It is being asked to recover its position by the year-end. And Ms Cooper says that next year looks even more difficult – a message that is being echoed by finance directors across the UK.

'Even if we can get to £16m this year, that is based on £30m of non-recurrent actions,' she says, giving a difficult starting point for 2023/24.

> "Long-term sustainability is what we have to focus on – and that can be a difficult balance when you are focused on the in-year deficit position"

There are heightened challenges for the Highlands in terms of geography and access to staff, affecting the delivery of both health and social care provision.

But Ms Cooper says there is a bigger challenge. 'Long-term sustainability is what we really have to focus on,' she says. 'And that can be a difficult balance when you are focused on the in-year deficit position.'

However, she says, one of the things that attracted her to the health board was its openness about the journey it had been on, the road ahead in terms of transformation and its determination to find new ways of working.

There are also some structural arrangements that are unique to the Highlands. Most health boards have set up formal integrated joint boards (IJBs) with local authorities to coordinate health and social care services.

Highland Health Board has such a board, but just for part of its area – Argyll and Bute. For the rest of its area, Highlands has a partnership agreement with the Highland Council. The council effectively contracts with the health board for the provision of adult social services. In addition, there is a counter deal for children's health services.

Ms Cooper says the relationship with the council is arguably the biggest change she faces. 'But it is all about relationships,' she says. And this is the same for health and care services across the whole UK.

'We all face the same issues and the same challenges,' she says. 'We are all looking at ways to get activity up post-Covid, to increase community services, embrace digital and care at home opportunities, support faster discharge from hospital and have the right level of care home provision so that patients receive the best outcomes.

'That hasn't changed, even if the stunning location makes it look more dramatic!'

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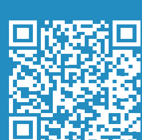
Rebuilding the NHS clinical estate from concept to completion.

Darwin Group are the experts in modern methods of construction working **exclusively in healthcare**. By owning every step of the process, our in-house specialists are supporting the NHS to increase clinical capacity and create a healthcare estate that is truly fit for the future.



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