In conversation with: Professor Andy Hardy

Andy Hardy, CIPFA President and CEO of UHCW NHS Trust

CIPFA's new president and CEO of University Hospitals Coventry and Warwickshire (UHCW) assesses the impact of COVID and the continuing importance of lifelong learning.

Sarah Shreeves, CIPFA Head of Training, in conversation with Professor Andy Hardy.

Starting as a trainee accountant in the NHS, Andy progressed via roles in different parts of the NHS to become CFO of UHCW in 2004. After four years he became the deputy chief executive, before being appointed chief executive two years later. He is also the senior responsible officer for the Coventry and Warwickshire STP/ICS. Andy has been a CIPFA member since 1994.

Sarah: What have been the greatest challenges you've faced in your career and within the public finance sector as a whole?

Andy: It's difficult to think of anything before COVID! Without a doubt, it has been the biggest challenge. In some ways, it's one of my most fulfilling periods, and that often comes out of challenge.

As public sector finance professionals, we've been through incredibly tough times following the 2008 financial crisis. Whilst many in the public sector will look at the health sector with some envy as we were partially protected, austerity led to the need to make some tough decisions. There are lots of services we used to provide that we don't anymore. We want to provide the best for the populations we serve, and when you stop doing things, irrespective of what that decision is based on, it will hit someone who sees value in it.

Going forward, I think the government will want to invest in the public sector off the back of COVID, having seen the value of what it does as far as managing a crisis is concerned.

S: There are certainly going to have to be some difficult decisions to make about spending. What are your thoughts on the potential impacts of cuts to training budgets?

A: If anything, the COVID-19 pandemic has highlighted the importance of lifelong learning so that you're prepared for when change comes. What I've strongly observed during the pandemic is that those organisations and teams that succeeded were those who were able to learn and adapt quickly.

Lifelong learning plays into how you prepare for unprecedented situations. It's how you can be ready for change and keep on top of what's happening in the world around you. You don't become a qualified accountant and then stop there. You need to be looking at how you learn and develop, including softer skills such as leadership as well as financial skills. When you get into a crisis, you need to be able to adapt quickly. That is about learning both independently and from others.

S: So true. And, in your opinion, what are the skills that NHS finance professionals will need for the years ahead?

A: Well, I think that all finance professionals, whether they're working in the NHS or elsewhere, should continuously consider what stakeholders need from them, how this will impact on their job roles and therefore what skills they need to adopt or improve in order to 'future-proof' their organisation.

Central to that has to be the ability to gather and analyse data and turn it into information that informs business decisions. We are in a world that's awash with data, but we have to make it meaningful. We must be a lot more data aware – and digitally aware.

A few months ago, most people working in NHS finance would never have thought they could do most of their job from home. What does the new normal mean? Future professionals will absolutely have to go beyond the traditional skills of accountancy.

S: Is it difficult for NHS accountants to decide on CPD options that are right for them and their organisation? If recent times have taught us anything, it's that things change fast!

A: Yes, choosing appropriate CPD can be challenging, particularly when we don't know exactly what the future will look like and given that, more than ever, we need to ensure a good return on CPD investment. But what has happened this year won't be the last black swan event we face, and finance professionals in the NHS will need to be resilient to future disruption and change. Helping public finance professionals prepare for the future is core to CIPFA's mission and why I'm so proud to be President.

CIPFA has recently published 'Key Competencies for Public Sector Finance Professionals' which brings together the skills and knowledge required for a robust, resilient and ethical public finance profession, both now and in the future. While not everyone will require every competency in their career journey, it provides a valuable conversation starter. It is designed to help identify where an individual or a team's training needs may lie – whether that's technical accounting proficiency, increasing public value or leadership, influencing and negotiating.

Changing paths

Covid-19 has altered how many NHS services are delivered. A recent HFMA virtual roundtable discussed these new pathways, including how the service had introduced, virtually overnight, models proposed for years. Seamus Ward reports

Over the past nine months, the NHS has got used to a lot of change as Covid-19 has swept across the UK. A&E attendances dropped as patients decided against risking exposure, while outpatient and GP appointments moved to phone or video calls to protect patients and staff. Specialist services such as dialysis are increasingly provided in patients' home.

Covid has changed virtually every pathway, but with rising hope of a post-pandemic world, what now? Should the NHS retain and expand on these emerging pathways and how does it ensure the new models meet patients' needs and are cost-effective? These questions were examined in a recent HFMA Healthcare Costing for Value Institute virtual roundtable, sponsored by Baxter Healthcare Limited.

Chair John Graham, director of finance at Stockport NHS Foundation Trust, asked the roundtable about the impact of Covid on patient pathways. Participants agreed it had accelerated pathway changes, many of which the NHS had wanted to introduce for years, such as the move to digital outpatient appointments or shared patient records.

Nigel Foster, director of finance at Frimley Health NHS Foundation Trust, said: 'Many of the things that were changed we were probably already planning to do, but Covid has caused us to move much faster.'

The redesign of the trust's frailty service was one example, with the hospital consultants now working more as part of multidisciplinary community teams. 'The label of the provider really wasn't mattering in the way it used to. People were just working together in a community setting to support frail patients who, by and large, don't need to be in a hospital. You need to provide holistic care rather than siloed specialty care for them. Covid just reinforced that journey we were on,' he said.

There was a potential sting in the tail for acute trusts – reducing lower priority or unnecessary activity meant that in some areas it was hard to achieve last year's activity levels, on which service recovery targets are based.

Claire Wilson, chief finance officer at Wirral University Teaching Hospital NHS Foundation Trust, said the trust had moved much of its outpatient activity from face-to-face to virtual appointments. The trust had been trying for two years to develop its virtual outpatients programme, but progress was difficult until the pandemic. Over two weeks, more than 89% of its outpatient activity moved online, though she said clinical colleagues do not believe it is a full solution. Further work is needed to ensure that it is as efficient as possible.

'It's absolutely the right thing to do at the moment for patients who do not need to come into hospital,' said Ms Wilson.

'We need to do the benefits realisation work and ensure that savings are cash-releasing. The efficiencies are not generated automatically – clinical time for clinics is similar to before, but the savings are in areas such as medical records and estates, both of which need focused change programmes to release the savings.

'My feeling as a non-clinician is that there has been a fundamental shift in terms of virtual working, although it doesn't necessarily mean we won't bounce back to seeing people face-to-face.'

Covid has affected all care sectors. Rachna Chowla, GP in Southwark and joint director of clinical strategy, King's Health Partners in London, said ensuring care was available for all patients while meeting Covid restrictions during the first wave, has led to the current hybrid version of primary care.

In March/April, Covid led to the complete

HFMA ROUND TABLE

Participants

- **Rachna Chowla,** King's Health Partners
- **Ann Cole,** Baxter
- **John Connolly,** Royal Free London NHS FT
- **Alice Forkgen,** North West Boroughs Healthcare NHS FT
- **Nigel Foster,** Frimley Health NHS FT
- **Chair: John Graham,** Stockport NHS FT
- **Craig Mustoe,** Baxter
- **Michelle Pilling,** East Lancashire Clinical Commissioning Group
- **Sam Wilde,** Lincolnshire Community Health Services NHS Trust
- **Claire Wilson,** Wirral University Teaching Hospital NHS FT
- **Keith Wood,** Suffolk and North East Essex ICS

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reconfiguration of primary care from face-to-face consulting to mostly video or phone. And in some areas practices were zoned into 'hot' areas (for patients with suspected Covid) and 'cold' areas to look after, and protect, everyone else. In some localities, this translated to system level, with separate hot and cold clinics to serve their populations safely.

The move to remote consulting happened almost overnight. GPs were acutely aware they had to maintain high-quality care, but via remote consulting. GPs also knew they had a brief window, pre-peak of wave one, to optimise care for patients in the shielding/extremely vulnerable and high-risk groups. And they had to come up with guidance quickly to help clinicians safely triage, assess and manage patients with suspected Covid, remotely.

'It was a very uncertain time,' said Dr Chowla. 'We were seeing the birth of a new disease and, at the beginning, not really knowing what we were meant to do to look after our patients with suspected Covid, or how to organise ourselves to do so.

'Then lots of national groups started to put together Covid guidance and things quite quickly coalesced on a consensus of how best to assess and manage Covid patients.'

Mental healthcare providers have faced several challenges. Alice Forkgen, assistant director of contracting and transformation, North West Boroughs Healthcare NHS Foundation Trust, said the trust has been using video consultations to continue to provide services to patients. But it has also implemented enhanced physical health teams in its mental health wards to prevent patients having to go into acute settings.

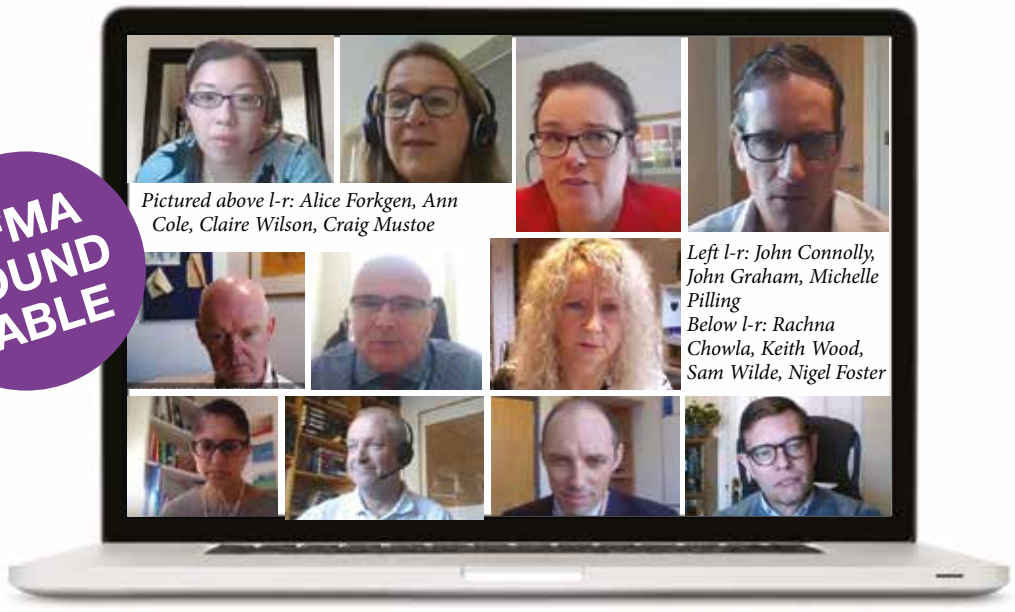
Mental health demands

Like all mental health providers, it is braced for a surge in activity, but this may have started already. 'Recently, I've noticed a massive increase in mental health bed usage – so much so that we've been required to use an additional 12 beds from the independent sector, which for us is half a ward, so it's a lot. I don't think we've understood the impact of Covid on people's mental health; [there's been] an increase in anxiety and depression in people, especially those with long-term conditions.

'We've always known mental health is closely linked to long-term conditions, so I guess that's something we will see more of in later stages.'

The trust also provides 0-19-year-old services, including school immunisation programmes. During the initial lockdown, schools were closed, and even now children can be hard to reach, leading to concerns about the backlog and long-term impact of not being immunised at the right time.

HFMA ROUND TABLE



Pictured above l-r: Alice Forkgen, Ann Cole, Claire Wilson, Craig Mustoe

Left l-r: John Connolly, John Graham, Michelle Pilling
Below l-r: Rachna Chowla, Keith Wood, Sam Wilde, Nigel Foster

Many participants spoke of offering more care at home. Ann Cole, national evolving health manager at Baxter, said the company had developed homecare models to enable patients to manage their own condition.

'Patients are being trained to use the technologies to deliver their own dialysis, or to administer their own IV antibiotics,' she said. 'A number of these pathways have been advocated for many years, particularly the use of home dialysis. There are 20-plus years of Nice guidance or technology assessments.

'There are guidelines from professional bodies and patient bodies, yet we haven't seen any particular change to the overall prevalence of home dialysis. However, the Covid data shows significant disparity in infection and mortality rates that positively favour home therapies. We've seen an acceleration and uptake of this pathway, which enables social distancing, allowing patients to avoid multiple clinic visits per week and hospital transport, as they conduct their treatment in their own home. Remote patient management allows healthcare professionals to securely view individuals' recently completed treatment and act on information as required.

> **"There has been a fundamental shift in terms of virtual working, though it doesn't necessarily mean we won't bounce back to seeing people face-to-face"**
> **Claire Wilson**

'We saw huge change in the way services were configured, but also in the relationship between the NHS and industry – collaborating in a different way as partners to deliver these patient services; seeing pathways in totality rather than discreet episodes of care; and using data to inform care pathway transformation.'

Tackling inequalities

Covid has highlighted existing inequalities in access and outcomes, particularly for black, Asian and minority ethnic groups. John Connolly, group director clinical pathways at the Royal Free London NHS Foundation Trust, said this was the most important impact of the pandemic. 'That really focused us as an organisation.'

Performance metrics offered a way into tackling inequalities. The Royal Free had completed research showing people in communities facing inequalities are more likely to fail to attend outpatient appointments and more likely to attend A&E and have unscheduled care, he added.

'By factoring in addressing the vulnerable patients in our communities, we can improve performance. The way out of our performance challenge is to address those inequalities and rethink our pathways in response to that.'

Dr Connolly pointed to the overwhelming economic argument for addressing health inequalities. 'We need to change our mindset so we factor in the consequences of change before we make changes. We need to use data around inequalities to inform how we make changes rather than look at the impact after we've made the change.'

He added that while changes were necessary in the immediate response to Covid, there was a need to think about the long-term impact and to engage with local people on this.

'I have a deep concern about unidentified harm. A lot of our patients did not come to hospital and are still not coming. It's impossible to understand what's underneath the iceberg of unmet need – we really need to push on with pathway redesign to anticipate that. The question is what pathways have changed – I think every one has changed in some way.'

Michelle Pilling, deputy chair of East Lancashire Clinical Commissioning Group, said developments such as virtual clinics can benefit patients and systems. But she worried about vulnerable and older people, or those without access to smartphones or the internet, who the NHS risked leaving behind.

'Rapid discharge of patients can create problems of its own, as we have witnessed in care homes or in relation to continuing healthcare assessments, particularly around funding. Similarly, it has the knock-on effect of applying further pressure on different parts of the system such as primary care, for example.

'I want to ensure that, as we have these conversations, it is not just about finance. Efficiencies in hospitals can lead to bigger inefficiencies out in the community.

'And let's not lose sight of the human costs of this pandemic. To ensure we are designing quality pathways, we need to build patient experience back in, and quickly, alongside impartial lay oversight of the system changes that have taken place.'

Good-quality tools must be used to understand the impact of inequalities on care, she added. 'If we don't, all we're doing is shifting the problem down the road.'

Inequality can be created by language and cultural barriers. Sam Wilde, director of finance and business intelligence, Lincolnshire Community Health Services NHS Trust, described how it had addressed these obstacles.

'Some parts of our county have significant Eastern European populations, many of whom work in food processing. For a variety of reasons, they don't always access the healthcare services available. Some don't speak English, and many haven't experience of a healthcare system like the NHS. We've been sending staff into the food processing plants to speak to these people to explain what's on offer and how to access it. That has shown some real benefits.'

Looking to the future, the panel said the outcome of the spending review would be pivotal to post-Covid pathway development.

Keith Wood, senior finance manager at Suffolk and North East Essex Integrated Care System, said the service was at a critical point. 'Ultimately, the NHS pound can only be spent once. There is a very real risk that if the settlement isn't appropriate then instead of addressing those factors upstream that are going to lessen the flood, we will be too busy dealing with the tsunami coming through. All the resource will be committed to that, and that would be counterproductive.'

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>
> **John Connolly**

Block contracts were the best way to manage financial flows in this new environment. 'As a system for more than three years we have entirely run on blocks. It works because it focuses the mind on managing the costs and prioritisation of resource rather than growing the income.'

Voluntary effort

One of the most effective moves locally was putting funding into the voluntary sector, he said. 'It has achieved great things, including matched funding being put into the charitable sector. We all know the charitable and voluntary sector tends to deliver a lot more bang for the buck. But, unfortunately it comes back to the point that if push comes to shove and we are squeezed, we're going to have to look after those resources and services for which we are directly accountable, and that's massively counterproductive.'

A separate allocation to the voluntary sector would pay back many times.

Sam Wilde highlighted two key questions regarding finances: how much money would be made available and how would the financial framework operate?

'In simple terms, the NHS has pretty much had a year off from efficiency requirements in 2020/21. Will there be an expectation that this will need to be caught up, and if so, over what period? If we do try and catch up, and over a very short period, there is a significant risk we will end up doing some things that will be detrimental in the long term,' he said.

Chair John Graham spoke about the challenges of managing the estate during the pandemic. Like many others, his trust has established a hot and cold split in its emergency department, but it also needed to manage the use of the rest of its estate to prevent and control infections.

'We have all been doing dynamic risk assessments, which I know clinical colleagues probably do on a daily basis, but there are so many decisions being made and so many variables,' added Mr Graham.

Mrs Wilson said there will be ongoing costs from Covid in the new financial year, and for a number of years. Measures taken in hospital to control infection could affect productivity. It was vital systems understood their recurrent run-rate going into the new financial year and the impact of Covid. They must also understand non-recurrent costs such as social distancing premiums and the costs of dealing with the backlog activity.

There will be an efficiency requirement in 2021/22, but finance teams must think about how they can engage with clinicians exhausted by Covid, she added. Focusing on waste reduction could be the answer.

Before Covid, the NHS had been planning to shift from being a treatment service to a self-care and prevention service. But Nigel Foster said Covid had 'moved the dial' back to being a reactive service. The NHS had a huge backlog of patients and a hidden demand of patients who had not yet presented for treatment.

'There is a risk that all our resources will be focused on dealing with the backlog, rather than moving the dial back,' he said. 'We've got to get ahead of the game here as we plan for the year or two ahead. How do we as a health and care system put enough resources into the bits that will keep our heads above water? Is it about prevention? Is it about self-care? Is it about identifying the patients who are at risk of deteriorating before they have deteriorated? It's going to be really important to ensure we ring-fence enough resource, planning and headspace for that piece of work.'

Craig Mustoe, Baxter's market access manager, said the NHS had wanted to change pathways for some time. 'I'm hearing Covid-19 has resulted in some positive change, but it hasn't solved all the problems.

'We can't just make changes all the time with the pandemic as the stimulus because it won't always be there. So what can we do to make sure that considered change can take place in an accelerated way, but also specifically facing the new challenges so we don't revert back to trying to solve the old problems because we no longer have that stimulus in place?'

Despite the difficulties, Covid-19 has also quickened the pace of pathway reform. And, though the threat of the pandemic and questions over funding remain, the NHS is turning its collective mind to how best to harness the positive changes made to improve services and enhance the patient experience.

HFMA ROUND TABLE