The HFMA's response to the Public Accounts Committee's inquiry into NHS financial management and sustainability

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

Summary

This submission is based on the views of our members and draws on HFMA publications and research. Our key points are:

- the reasons for the financial difficulties that NHS bodies face are many and complex
- there are indications that the financial position in 2019/20 may be better than in 2018/19, but there was still a reliance on on-off savings rather than systemic cost reduction and efficiencies
- while capital to revenue transfers at the Department of Health and Social Care (DHSC) level will have had an impact on patient care, so would any alternative measure that would have had to be taken to ensure that the DHSC remained within its voted revenue resources

- the changes made to the NHS financial regime by the DHSC and NHS England and NHS Improvement in response to the Covid-19 pandemic have been timely and agile. There is an opportunity to retain and build on the positive changes that have been made. Therefore, looking at financial arrangements in place prior to 2018/19 should only be done to allow lessons to be learned
- work still needs to be done to understand and collect national data on the full costs of new ways of working
- the NHS does not work in a silo, so changes made to the NHS financial management arrangements need to be mirrored by changes to the social care system
- as the nation recovers from the immediate impact of the Covid-19 pandemic, the role of NHS bodies as anchor organisations in their local economies should not be underestimated.

Detailed response

Introduction

The NAO's report was published on 5 February 2020 and focused on the financial position of the NHS as at March 2019. The issues raised and recommendations made remain valid but need to be viewed in the light of the NHS's financial performance in 2019/20 as well as the current pandemic and the changes that the NHS has made in response.

The reasons for the lack of financial sustainability in the NHS are many and complex – including increasing demand for healthcare, an aging population, the impact of austerity on the wider public sector particularly local government, workforce shortages, the cost of policies such as the pension tax and apprenticeship levy, the unintended consequences of changes to the financial system such as marginal rate for emergency work and the sustainability recovery fund (STF), ongoing efficiency requirements in the tariff and so on. Financial sustainability is therefore not straightforward and cannot be considered in isolation without understanding the wider reasons underpinning the financial position.

Covid-19 was declared a pandemic by the World Health Organisation on 11 March 2020 and the Prime Minister announced that the UK would effectively go into lockdown on 23 March 2020. For the NHS, this means that most of the 2019/20 financial year was relatively unaffected by Covid-19. However, the pandemic has changed the NHS out of all recognition and has afforded it, and the government, a unique opportunity for widescale redesign including the financial regime.

The relatively unlimited level of resource that has been made available to the NHS by the government since the start of the pandemic cannot continue forever so a financial regime will need to be established to allow the NHS to operate within the available financial envelope. However, our members are welcoming this as an opportunity to learn from the work that has been done in a very short period of time and put in place a new, more flexible and responsive financial regime rather than simply returning to the previous arrangements. Also, it should be noted that any new financial plans will need to be based on best estimates of what business as usual will look like in the future.

2019/20 financial position

According to the financial report presented to the NHS England and NHS Improvement (NHSE&I) Board meeting in common on 26 March 2020[1], at month 10 (the end of January 2020), the commissioning sector was forecasting an underspend against plan of £374.1m at the year-end, while the provider sector was forecasting on overspend against plan of £523.0m. Overall, NHSE&I were forecasting 'that the NHS may end the year with an overspend of £149.0m (0.1%)'. The board report

[1] NHS England and NHS Improvement Board meetings held in common, *Month 10, 2019/20 finance report*, 26 March 2020

indicates that this is a better position than the same time in 2018/19. Only 63 trusts were forecasting a financial position worse than plan compared with 111 trusts at the same time in 2018/19.

This indicates that the financial performance[2] of the NHS was improving in 2019/20 compared to 2018/19 before the pandemic was declared. However, at month 6, 33 trusts were forecasting that they would end the year worse than plan compared to 87 at the same time in 2018/19 so the number of trusts forecasting that they would miss their planned position was increasing towards the end of the financial year.

NHSE&I's financial report does not provide any information on how this financial performance was achieved and how much meeting the year-end forecast relied on one-off savings. Throughout the year, our members have expressed concern about the achievability of cost improvement targets by the year-end. Until the 2019/20 annual report and accounts have been finalised, the overall financial performance of the NHS will not be known. However, NHS organisations' year-end financial positions should not be impacting by the pandemic as any Covid-19 related costs will be funded by NHS England and NHS Improvement.

Capital to revenue transfers

The Department of Health and Social Care (DHSC) is required by statute to contain expenditure within the resources voted to it. There are various measures used to assess whether this is the case, but the main metric is the requirement for capital expenditure in the year to be kept within the capital departmental resource limit (CDEL) and revenue expenditure within the revenue equivalent (RDEL).

There is a mechanism for agreeing capital to revenue transfers with HM Treasury which allows the DHSC to move available resource from capital to revenue. Based on our analysis of the DHSC's annual report and accounts for the past five years (**table 1**), without the capital to revenue transfers the RDEL would have been exceeded every year except 2018/19.

In order to achieve financial balance in those years without a capital to revenue transfer, the DHSC would have had to ensure that other measures were taken that would, no doubt, have had an immediate impact on patient care. However, over the medium to longer term a lack of investment in infrastructure will also have an impact.

In our opinion, while in-year transfers from capital to revenue since 2015 will be having an impact on patient care and the state of the NHS estate now, these issues should only be looked at in the context of learning lessons for future arrangements. One of these lessons will be that capital investment cannot be deferred for short-term benefit without having a longer-term impact and that capital is an area that the NHS needs to invest in going forward.

[2] The financial performance reported by NHSE&I includes the financial support provided to NHS bodies in the form of commissioner sustainability fund (CSF), provider sustainability fund (PSF), financial recovery fund (FRF) and marginal rate for emergency tariff (MRET)

Table 1: the impact on CDEL and RDEL of capital to revenue transfers

	RDEL	CDEL	Capital to revenue transfer	RDEL excluding transfer from capital	CDEL prior to transfer to revenue
	£bn	£bn	£bn	£bn	£bn
2018/19					
Budget	125.92	5.98	0.50	125.42	6.48
Outturn	125.28	5.94		125.28	5.94
Under/(over) spend	0.64	0.04		0.14	0.54
2017/18					
Budget	121.34	5.60	1.00	120.34	6.60
Outturn	120.65	5.24		120.65	5.24
Under/(over) spend	0.69	0.36		(0.31)	1.36
2016/17					
Budget	117.59	4.62	1.20	116.39	5.82
Outturn	117.03	4.56		117.03	4.56
Under/(over) spend	0.56	0.06		(0.64)	1.26
2015/16					
Budget	114.52	3.69	0.95	113.57	4.64
Outturn	114.73	3.63		114.73	3.63
Under/(over) spend	(0.21)	0.06		(1.16)	1.01
2014/15					
Budget	110.56	4.01	0.64	109.92	4.65
Outturn	110.55	3.95		110.55	3.95
Under/(over) spend	0.00	0.06		(0.64)	0.70

Looking ahead

We suggest that little is to be gained from revisiting old arguments and decisions that were made for the best of reasons at the time. There needs to be a focus on the new arrangements. Since the start of the pandemic the financial teams in the DHSC and NHS England and NHS Improvement have demonstrated agile decision-making and approval processes. Our members have welcomed the steps taken by national bodies to speedily streamline the financial regime and reduce bureaucracy.

They have particularly welcomed the increase in communications from the financial leadership team at NHSE&I to finance directors, that provide updates on new arrangements as well as an explanation of why those particular arrangements have been put in place.

Resource constraints are inevitable and therefore governance arrangements are required to ensure that the constraints are met, especially in a group made up of over 600 bodies such as the DHSC. However, this is an opportunity to keep the best of the new arrangements that have been put in place and remove the unhelpful elements of the old regime.

Understanding the new normal

It will be important to retain a degree of flexibility around financial allocations in the short term, at least. Even though the first peak of Covid-19 cases has passed, the new levels of demand for health and social care are unknown – the public responded to the plea to 'protect the NHS' to such an extent that there is now a concern that those who should have sought medical advice have not done so. The impact of the deferral of elective work, as well as the impact of the pandemic and the consequential lockdown on the mental health of the nation, are also unknown. Any allocation of resources will need to be flexible to reflect changes to demand as well as new ways of working.

The speed at which virtual clinics have been established has been astonishing and, where appropriate, these should be continued. However, the cost of providing clinics virtually rather than on a hospital site is not yet clear. There may be an assumption that virtual clinics are less costly but that needs to be tested – for clinicians, the time spent with patients face-to-face over a computer and the preparation for these appointments, may be longer than in a clinic. The costs of IT and the infrastructure to support virtual systems on an on-going basis will need to be assessed. For example, during the pandemic, we are all willing to accept internet connections that are not quite stable and lower broadband speeds – this is less likely to be the case as remote working becomes the new normal.

Equally, the ability of some administrative staff to work from home has been welcomed as it reduces travel costs and time. In the short term, the provision of remote clinics and the ability for staff to work from home will not reduce estates costs as more space rather than less will be required to provide healthcare safely while meeting distancing requirements.

It will be important that the new arrangements are properly costed. This will not only include the innovations discussed above, but also the costs of providing healthcare in Covid-19 ('hot') and non-Covid-19 ('cold') areas. Patients may have to be assumed to be Covid-19 positive until tested so additional tests and personal protective equipment will be required. There will be additional costs as well as inefficiencies associated with enabling patients, staff and visitors to move around healthcare facilities while maintaining social distancing. We are aware that many NHS staff with responsibility for costing were moved to other duties during the early days of the pandemic and could not access either the software they needed or the clinical colleagues they needed to speak to so it will be some time before the costs are fully known and understood.

The wider economy and systems

NHS bodies do not work in silos - for example, its reliance on the social care sector has never been more apparent than when patients were urgently discharged into care homes to clear hospitals to focus on the treatment of Covid-19 patients. This interdependence with the wider public sector needs to be reflected in the arrangements put in place going forward.

Prior to the Covid-19 pandemic, the *NHS long term plan* already set out proposals to integrate the provision of primary and specialist care, physical and mental health services, and health with social care[3].

[3] NHS, *NHS long term plan* (page 10), January 2019

Changes made to the financial regime of the NHS will not be effective without equivalent adjustments to the social care system and its funding arrangements, otherwise the levels of delayed transfers of care will increase again and the default will revert back to going to hospital rather than a more appropriate care setting. The new arrangements to treat people in the community and keep people at home or in care homes need to be continued and developed but this will require an understanding of the costs as well as equitable allocation of resources. The same is true for the mental health sector.

NHS bodies need to be allowed some time to understand what further changes need to be made to ensure that finite resources can be used to achieve value for money in the provision of health and social care. To understand what this means, a full and frank discussion between government, government departments and regulators, NHS bodies and the public is required to determine what the health and social care system can and cannot provide going forward.

On a more practical level, robust financial management and governance at a system level will need to put in place. The production of single, consolidated financial reports for sustainability and transformation partnerships/ integrated care systems will be an important part of the governance and financial management of the new systems.

Beyond the health and social care system, NHS bodies will also have a role to play in supporting the local economies in which they work – as anchor organisations providing employment themselves but also in the wider supply chain around them. The role that NHS bodies can play in the regeneration of both local and the wider economy needs to be considered alongside any changes to the financial regime.

Lack of cash, both for working capital and capital investment, has been a concern for NHS provider bodies for some time now and the block contract arrangements have been welcomed as they have injected cash into the provider sector quickly at a time when suppliers needed financial support. The transfer of interim loans to public dividend capital has also been welcomed to reduce the administrative burden of managing rolling loans, but it does not inject any new cash into the provider sector and will continue to be a cost to those NHS bodies whose financial position has resulted in them being in a negative cash position. Going forward, it will remain important for suppliers that the NHS continues to pay on time as the economy starts to recover so any new financial arrangements must take cash flow into account as well as resource allocation.

Value for money

As financial resources once again become limited, an arrangement for fair and equitable resource distribution needs to be put in place. The NHS contracting and tariff arrangements in England are complicated and administratively burdensome. Every alternative payment system has its pros and cons. Prior to the pandemic, there was a move to blended contracts or aligned incentive arrangements. Payment by results will only truly work where demand can be managed and where all services provided can be paid for. On the other hand, block contracts are a blunt tool that do not include any incentive for carrying out additional activity.

As NHS organisations transition to providing elective care again, they will need to restart their cost improvement/ waste reduction programmes. While this is good practice to ensure that the best value for money is obtained, in recent years these programmes have been required to deliver cost savings to enable NHS bodies to remain within their control totals. It is not yet clear whether now is the time to restart these programmes. This is particularly difficult given that most of the cost of service delivery is staff costs – is now the time to reduce NHS staff numbers? It will also be very difficult to put in place any programmes to manage demand, as demand is likely to be very different post-pandemic. It is not yet clear what on-going care those patients who have recovered from the virus will need or what wider health issues the population at large will present with as a result of staying away from hospitals during the period of lock-down.

Opportunity to reset

We suggest that rather looking to the past, the Committee should take this opportunity to ask the DHSC and NHSE&I officials about their proposals for a new financial regime for the NHS. In particular how they will address the problems identified with the previous financial arrangements, while building on the progress that has been made to the way that healthcare services have been delivered and the changes that the public have made to their use of healthcare services.

All of this must be done while addressing the unknown impact that the pandemic will have on future work in terms of addressing the backlog of electives, the impact of people staying away from hospital, mental health impact and the impact on emergency departments when social distancing is relaxed.

This response should be read in conjunction with our response to the Public Accounts Committee's call for evidence on capital expenditure in the NHS[4].

[4] Public Accounts Committee, *Capital expenditure in the NHS*, May 2020