HFMA briefing
December 2020

The future NHS financial regime in England: recommendations

In June 2020, the HFMA published a discussion paper[1] which set out a number of areas where the association believed that beneficial changes could be made to the financial regime for the NHS in England, as a consequence of the Covid-19 pandemic. The discussion paper was supported by a survey to enable HFMA members and other interested parties to share their views on the proposals.

As the NHS begins to set out its intentions for its future form, this briefing builds on the discussion paper and makes a number of recommendations for change as the financial regime is developed for 2021/22 and beyond.

[1] HFMA, *The future NHS financial regime in England: a discussion paper,* June 2020

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Executive summary

The Covid-19 pandemic has presented an opportunity, possibly the first since the NHS was created in 1948, to revisit how the NHS operates as a national entity. The pandemic has dramatically changed the way in which healthcare is delivered, with a wide public acceptance of the use of digital methods which were unlikely to be embraced so whole heartedly in normal times.

And it is not just healthcare delivery that has radically changed as a consequence of the pandemic. The NHS financial regime has been substantially altered for the duration of the pandemic. The normal regime has been paused and much simplified payment mechanisms and contracts have been put in place. This has removed many financial barriers to co-operation and innovation and has demonstrated how organisations can work together when traditional areas of conflict are removed.

The NHS must not be allowed to slip back to how it was before Covid-19 without taking this opportunity to consider where beneficial changes could be made, learning from good practice across the country and seeking out ideas and innovations to meet the challenges of a 21st century health system. This must be done in the context of delivering a financially, and environmentally, sustainable health and care system.

The pre Covid-19 financial regime does not support the way in which organisations need to work now in order to combat the virus and prepare for future epidemics and pandemics, nor does it reflect the activity levels or demand that are anticipated. For the NHS and for the finance profession, this opportunity must be grasped with both hands. It is worth remembering that the *NHS long term plan* set out an ambitious programme for change:

'… the NHS and our partners will be moving to create integrated care systems everywhere by April 2021, building on the progress already made. Integrated care systems (ICSs) bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. They will have a key role in working with local authorities at 'place' level, and through ICSs, commissioners will make shared decisions with providers on population health, service redesign and long-term plan implementation.'

In addition, it was felt that primary legislation would be needed to deliver this new way of working and optimise the approach.

'An NHS Bill should be introduced in the next session of Parliament. Its purpose should be to free up different parts of the NHS to work together and with partners more easily. Once enacted, it would speed up implementation of the 10 year NHS long term plan.'[2]

Through working with our members, the HFMA is now in a position to make a number of recommendations to support the development of the future financial regime for the NHS in England. The service needs to build on what worked well, progress the beneficial changes that were already underway when the pandemic started, and develop new ways of working in those areas that need to change to support a greater focus on population health.

This paper sets out the areas where the HFMA believes that beneficial changes can be made to develop a financial regime suitable for a post-Covid NHS. It covers the NHS long term plan; system working; contracting arrangements; the capital regime; financial governance and business planning; procurement and workforce. While many of the temporary Covid-19 measures are not sustainable in the long term, there is much that can be learnt from the experiences during this time. The pandemic has presented the NHS with an opportunity to make changes and not go back to just doing everything the way that it has always been done.

[2] NHS, *The NHS's recommendations to Government and Parliament for an NHS Bill*, September 2019

Summary of recommendations

NHS long term plan

- NHS England and NHS Improvement should review the trajectories for achieving the ambitions in the *NHS long term plan* and amend them to reflect the new starting point of many organisations
- NHS England and NHS Improvement should seek to strengthen the ambitions relating to mental health, prevention and the reduction of health inequalities
- NHS England and NHS Improvement should give a clear prioritisation of services to enable organisations to allocate funds to support their populations, in a way that also contributes to national health objectives. This prioritisation should support organisations, through additional funding, to invest in areas which may not be financially sustainable in the long term but are essential to meet current needs due to the activity backlog and the requirement for social distancing.

System working

- Progress towards integrated care systems should be speeded up to build on advances made during the Covid-19 pandemic. More devolved decision making should be enabled at a local level.
- The commissioning function should focus on strategic commissioning in order to improve population health and to strengthen system working.
- Emergent integrated care partnerships should be encouraged to foster and continue new ways of working between primary, community, secondary and social care, to manage and own the risks of increased demand.
- Models should be developed that encourage and simplify provider collaboration, to ensure that the system working arrangements during Covid-19 do not unravel as they once again become voluntary.
- Local systems should take the opportunity of improved relationships and a new way of working, to clarify shared goals and determine each organisation's role in achieving them.
- Social care and the care home sector must have a stronger voice in system discussions, as their importance in supporting the NHS to operate effectively has become apparent during the pandemic, but they can struggle to be heard. This involvement must be supported by sufficient funding to back up the necessary actions.

Contracting arrangements

- Recognition of the different levels of maturity and development across sustainability and transformation partnerships (STPs) and ICSs is essential when designing and implementing new ways of exercising financial control and establishing new contracting arrangements. A 'one size fits all' approach will not be effective.
- When the business as usual financial regime is established, the emphasis should be on the transparency and understanding of the financial allocations to each STP or ICS.
- The new financial regime needs to encourage ownership of the finite financial resource by each system and each organisation within it.
- The principles of the local authority section 151 obligation for effective management of financial affairs, should be embedded at system level with the intention that service transformation is undertaken to provide healthcare within the allocated financial envelope.
- Any national contract model (which may be required based on relative STP or ICS maturity) should be on an aligned incentive basis. Preparations should be made for the new arrangements to take effect from 1 April 2021.

- While a detailed national tariff will no longer be needed to support the payment system, there will need to be a mechanism to reimburse systems for out of area treatments and specialist treatments, as well as appropriately funding the contributions of the independent and charitable sector. The current tariff arrangements are overly complex, and a streamlined tariff should be produced to support payments between systems and spot purchases.
- Any new payment system must support the collection of high-quality activity data and retain the granularity needed to support robust decision making.
- The financial processes around reimbursement of low value non-contract activity should be reviewed with the intention of making adjustments to host organisations through allocations rather than multiple invoices.

Costing and data

- There should be a review of the current national costing requirements for all sectors of the NHS. Robust costing information is essential and costing standards must follow the principles of being proportionate, achievable, deliver high quality comparable cost data, easy to understand and provide useful information for local and national use. The current arrangements fall short when assessed against these principles.
- Data collections should be reviewed to ensure that it is both possible to collect the information required and that it is useful locally and nationally. Collections should be clearly defined to ensure that the data is comparable, and the analysis should be made available to organisations to utilise in a timely fashion. Consideration must be given to the resource that is required to collect and return the data when compared with the value of the data to the NHS.

Capital regime

- Capital allocations must be published for several years ahead, be transparent and recognise the multi-year nature of many projects, including the impact of inflation. This requires the government to make multi-year capital allocations to the NHS. In addition, capital approval processes should build on the learning during the pandemic and remain streamlined and simple.

Financial governance and business planning

- Governance processes should be reviewed in light of the pandemic and only be continued where they add value to the organisation.
- National timescales and priorities should be aligned across health and social care to give local systems the opportunity to work together to develop robust plans to meet their population's health and care needs.

Introduction

The NHS was established in 1948 to deliver universal, comprehensive, and free healthcare to the population based on clinical need, not the ability to pay. This purpose continues to underpin the NHS that we know today but, over the last 72 years, the service has evolved to meet the changing needs and demands of the population. Organisational restructures, service redesigns and an expansion of what is possible due to medical research and developing technology has created an NHS which can be complex and difficult to change at a large scale.

The Covid-19 pandemic has forced a pause in the small-scale developments and incremental changes. It has presented an opportunity, possibly the first since 1948, to revisit how the NHS operates as a national entity. The pandemic has dramatically changed the way in which healthcare is delivered, with a wide public acceptance of the use of digital methods which were unlikely to be embraced so whole heartedly in normal times.

Across the health and care system, new and innovative practice has emerged as organisations meet the challenge of a completely new disease. The United Kingdom is not alone in seeing a rapid and significant shift to digital consultations since the start of the pandemic, for example, similar stories are being shared worldwide and efforts to combat Covid-19 are being developed across the globe. This willingness to change must be capitalised on; health services, staff and patients are realising that things do not have to stay the same.

And it is not just healthcare delivery that has radically changed as a consequence of the pandemic. The NHS financial regime has been substantially altered for the duration of the pandemic, reflecting the government's commitment that *'whatever extra resources our NHS needs to cope with coronavirus – it will get'*[3]. The normal regime has been paused and much simplified payment mechanisms and contracts have been put in place. This has removed many financial barriers to co-operation and innovation and has demonstrated how organisations can work together when traditional areas of conflict are removed.

The NHS must not be allowed to slip back to how it was before Covid-19 without taking this opportunity to consider where beneficial changes could be made, learning from good practice across the country and seeking out ideas and innovations to meet the challenges of a 21st century health system. This must be done in the context of delivering a financially, and environmentally, sustainable health and care system.

The pre Covid-19 financial regime does not support the way in which organisations need to work now in order to combat the virus and prepare for future epidemics and pandemics, nor does it reflect the activity levels or demand that are anticipated. For the NHS and for the finance profession, this opportunity must be grasped with both hands.

In 2018, the HFMA worked with PwC to examine the way that the money flows around the NHS, and the behaviour that this enables or blocks[4].

'Together we have concluded that the current financial system needs to be overhauled if it is to support and enhance the journey that the NHS is on. Funding is currently too short term. It does not support the integration of health and care locally, nor does it drive a sharp focus on outcomes. There are limited incentives for providers to change their behaviour. There is an overwhelming consensus that the financial flows need to be redesigned if the aim of integrated care is to be achieved.

The way the NHS financial system currently works is simply not aligned with place or outcome-based care. Today the care system and the way that money moves around it is in a messy no-man's land with a chaotic and bewildering array of financial mechanisms in place.'

The time has come to make these changes and redesign the financial regime for the 21st century.

[3] HM Government, *Budget speech 2020*, March 2020
[4] HFMA and PwC, *Making money work in the health and care system,* June 2018

This paper sets out the areas where the HFMA believes that beneficial changes can be made to develop a financial regime suitable for a post-Covid NHS. It covers contracting arrangements; system working; the NHS long term plan; the capital regime; financial governance and business planning; procurement and workforce. While many of the temporary Covid-19 measures are not sustainable in the long term, there is much that can be learnt from the experiences during this time. The pandemic has presented the NHS with an opportunity to make changes and not go back to just doing everything the way that it has always been done.

The views expressed in this paper have been drawn from a number of sources in order to represent the opinions of our members. Throughout the pandemic, the HFMA has recorded a series of podcasts[5] with senior figures from a range of organisations across the health and care system to gather their views on how their organisations have approached the pandemic and what has been learnt from the experience. The monthly Healthcare Finance magazine has been reborn as a weekly update email that includes interviews with other members of the NHS finance community across several levels.

The HFMA's discussion paper in June set out a number of areas where we believed that beneficial changes could be made, building on a survey of finance directors in May 2020 that received 63 responses. During June and July, we asked for thoughts from our wider membership and other interested parties on the views that we shared, receiving a further 165 responses across all sectors and regions of the NHS in England.

As a result of this work, the HFMA is now in a position to make a number of recommendations to support the development of the future financial regime for the NHS in England. The service needs to build on what worked well, progress the beneficial changes that were already underway when the pandemic started, and develop new ways of working in those areas that need to change to support a greater focus on population health.

It is intended that this will continue to be a consultative process, with the finance function working as one to deliver better quality healthcare through effective use of resources.

[5] HFMA, *HFMAtalk,* 2020

NHS long term plan

Background

In January 2019, the *NHS long term plan* set out a series of ambitions to significantly change the way that the NHS operated. Just over a year later, Covid-19 wrought its own changes on the NHS, dramatically altering the way that services were delivered and reducing the capacity of organisations to deliver patient care in traditional ways. However, the health needs of the population remain, and many of the ambitions of the *NHS long term plan* are still relevant, although the trajectories to deliver them have fundamentally changed.

Many areas have seen swift and significant progress towards the achievement of certain aspects; the rapid rollout of digital and telephone consultations for primary care and outpatients, for example, has meant that this ambition is likely to be achieved much earlier than planned. Likewise, many areas have taken significant steps towards developing better system working as a consequence of the pandemic. Where the response to the pandemic has supported the *NHS long term plan* ambitions, this should be retained and built upon rather than returning to any pre-existing plans or trajectories.

Reviewing some of the ambitions and revising them as a consequence of learning during the pandemic could also support the NHS in addressing the waiting lists that have built up during this time. The use of technology to deliver outpatient appointments could be extended to allow more test results to be available online and easily shared between secondary and primary care, which would enable people to be seen in alternative settings. Similarly, an expansion of community diagnostics would allow people to be seen outside of hospital. All of this should be supported by greater use of electronic patient records so that the same information is available to all sectors in order to support patient care. Since rapid progress has been made as a consequence of the pandemic, this should be built on, and invested in, in order to further develop effective system working.

For example, the *NHS long term plan* states that *'in order to improve access to advice and care, it is intended that digitally-enabled primary and outpatient care will go mainstream across the NHS'* with full achievement by 2024. Progress in this area during Covid-19 has necessarily been rapid and, while there are some areas within the *NHS long term plan* which may still need work such as patient access to their records via the NHS app, and linked data across the NHS and local authorities; there is much to build on to achieve this aim sooner than planned.

> *"The ambitions are still relevant, but the scope and the priorities may need to shift. Digitisation has been kick-started as a result of the pandemic and this should be built upon."*
>
> **Commissioner**

However, Covid-19 also means that some ambitions will not be achieved in the timescales set out originally and trajectories will need to be revised. There needs to be a recognition that the operating environment for the NHS as it resets will be very different with financial pressures resulting from the ongoing demands of the virus.

> *"Some of the ambitions will probably now happen sooner, digital for instance, but there has to be a recognition that running NHS services for both Covid and non-Covid patients is more expensive. Therefore, funding that may have been available to transform services will undoubtedly not now be there. We have also lost precious time where colleagues have been fighting the pandemic and that needs to be recognised."*
>
> **Finance director, integrated care provider**

The impact of Covid-19 on other NHS services may mean that progress has been lost. Organisations may find that they are restarting from a worse position than they had achieved before the pandemic began. For example, much has been reported about the impact of Covid-19 on cancer screening programmes[6] meaning that the milestones set out to improve cancer diagnosis and treatment in the long term plan, may need to be revised to take account of the backlog of demand.

If some ambitions have been met sooner than expected and others have fallen behind, then it is necessary to reprioritise what is being asked of systems and organisations.

> *"The entire country is going to be in a state of recovery for some time and this will have significant impact on mental health services to ensure the necessary support and access is available for people"*
>
> **Finance director, integrated care provider**

Summary of survey responses

It is clear from the survey responses that the *NHS long term plan* ambitions are still supported but that there is a need to review how and when they can be achieved. In addition, three strong themes have emerged where there is support for the ambitions to be strengthened: mental health, prevention, and the reduction of health inequalities. All of these areas have been highlighted in the Covid-19 response and will need further investment to support people to manage their health needs and address rising demand at a time when treatment capacity is reduced.

> *"Where people have stayed away from using the NHS for the right reasons (e.g. reduced inappropriate attendances), trying to ensure this continues – turning this into a focus on personalised health and prevention."*
>
> **Finance director, commissioner**

As ever, the achievement of the *NHS long term plan* is dependent upon having sufficient funding to invest in change. At a time when the NHS has a significant backlog of treatment needs to deliver in constrained estates due to social distancing requirements, freeing up funding to invest in other areas is a challenge. In addition, this now needs to be done in an environment where potentially financially unviable sites and services are required in order to address population health needs in a Covid-19 safe way.

> *"We need to take into account local delivery issues and the cost of this, particularly in rural areas where multiple sites are required without the activity levels to make them viable"*
>
> **NHS combined acute and community provider**

When resources are allocated it will be essential to take into account the shift in activity that is being seen in the NHS. With the issues around capacity to treat patients in acute settings, many more people are being supported in the community, by NHS organisations, primary care and local authorities. Funding allocations need to not only recognise that additional resource is needed but understand where that resource is within the system.

> *"We need to consider how costs will shift – so not just more funding but realignment"*
>
> **NHS mental health provider**

The reset NHS may also have need of new ambitions, particularly around resilience, pandemic preparation, the supply of personal protective equipment (PPE) and increased testing facilities. Improvements will be expected by a public inundated with news stories around staff safety and the response of the NHS. Whether or not the government formally recognises the work of health and

[6] Cancer Research UK, *Over 2 million people waiting for cancer screening, tests and treatments,* June 2020

care staff during the pandemic, there will be an expectation on the NHS as the employer to improve working conditions and address staff wellbeing.

Recommendations

- NHS England and NHS Improvement should review the trajectories for achieving the ambitions in the *NHS long term plan* and amend them to reflect the new starting point of many organisations.
- NHS England and NHS Improvement should seek to strengthen the ambitions relating to mental health, prevention and the reduction of health inequalities.
- NHS England and NHS Improvement should give a clear prioritisation of services to enable organisations to allocate funds to support their populations, in a way that also contributes to national health objectives. This prioritisation should support organisations, through additional funding, to invest in areas which may not be financially sustainable in the long term but are essential to meet current needs due to the activity backlog and the requirement for social distancing.
- Funding should reflect the services that need to be delivered and recognise where that resource is needed. Consideration should be given to how services can effectively integrate with wider public sector provision to support the needs of the population, maintaining the focus on population health. This should take account of the additional capacity that is required and the costs of running safe, non-Covid services that meet ongoing demand and enable the activity backlog to be addressed. There must be clear links between the requirements placed on local services and the level of funding allocated for delivery.

System working

Working across organisational boundaries has been an essential part of the response to Covid-19 and many are keen to retain this unexpected positive outcome from the pandemic. It has been noted that system working improved during the pandemic, with significant improvements in relationships between acute trusts, community services and social care; perhaps unsurprisingly given the focus of the response. Covid-19 has demonstrated what can be achieved when people are able to work across organisational boundaries but as also enabled an unexpected change in culture. For example, community services' organisations report having a much stronger voice in winter planning than ever before[7]. However, organisational behaviour tends to be driven by financial structures so the way that funding is distributed will have an impact on how the NHS operates; funding at a system level should enable organisations to work together more effectively.

"The NHS needs to build on the trust and mutual support it has developed across systems."

Finance director, acute provider

"We had very good system working to start off with, but it has got better. The main area of change has been improved engagement with the local authority on social care."

Finance director, mental health provider

It is acknowledged that system working is easier without financial constraints as many areas of dispute around financial responsibility are removed. Nevertheless, the speed of decision making, and its collective nature, bodes well for the future development of systems. In many cases, this has been supported by the acceleration of existing plans to share information across organisations, allowing data to be shared to identify vulnerable people and for patient care. However, the legal basis for the sharing of data only relates to information that is shared with the purpose of tackling Covid-19. It is a temporary measure under the *Health Service (Control of Patient Information) Regulations 2002* and is currently due to expire on 31 March 2021[8]. The joint working that this has allowed, and the co-ordinated support that it has enabled for vulnerable people, should be continued and steps must be taken to continue and expand the ability to share data across organisational boundaries.

As the NHS resets, there is a desire to strengthen system working and formalise the role of sustainability and transformation partnerships (STPs) and ICSs. This view is supported by a number of survey responses, with some appetite to give ICSs legal powers. Accountability for the use of resources and the provision of the correct services to meet the needs of the population, would therefore sit at a local system level.

This means that there continues to be a need to review legislation to enable systems to work more effectively and NHS England and NHS Improvement are consulting[9] on the changes needed to do this, across all aspects of the system architecture. While significant progress has been made to build relationships and trust across systems, there are financial and governance complexities which make system working difficult. At a strategic level, statutory requirements on the constituent bodies of a system will continue to cause conflict for boards who are legally required to act in the best interests of their organisation, rather than the wider system, should there be a conflict. NHS England and NHS Improvement have already recommended changes in this respect to the government,

'An NHS Bill should be introduced in the next session of Parliament. Its purpose should be to free up different parts of the NHS to work together and with partners more easily. Once enacted, it would speed up implementation of the 10 year NHS long term plan.'

[7] HFMA, *The impact of Covid-19 on the future delivery of NHS community services,* October 2020
[8] NHS Digital, *Control of patient information (COPI) notice,* August 2020
[9] NHS, *Integrating care*, November 2020

"Community discharges have been supported by the £3.2bn social care funding – we have seen people who have been waiting months for packages, discharged safely.
Managed risk taking and system risk stratification of vulnerable individuals has been incredible.
Weekly system gold command has enabled fast paced discussions and responses, supported by

"There needs to be more focus on groups of providers working together to improve care and improve value, and a contractual mechanism that supports this approach.'

Finance director, community services provider

"If a meeting of system leaders looks like a regional conference, then the system is far too large!"

Finance director, combined acute and community services provider

Many support the development of provider alliances, with appropriate decision making moving from commissioners to providers. Models that encourage and simplify provider collaboration are vital to retain the positive progress made during the pandemic, as some of these working arrangements once again become voluntary. Emerging integrated care partnerships should be encouraged, and new ways of working developed between primary, secondary, community and social care. Working across these traditional boundaries will enable these partnerships to manage the risks of increased demand and pathway changes. There is also a need to draw in more expertise from across the spectrum of health and care, such as primary care and social care, to better develop and align care pathways. However, concern remains about how the GP contract can fit with wider system working. Primary care is an essential part of the NHS and the GP contract will need to develop to ensure there is a sustainable primary care model which supports system working.

Throughout the work to support this briefing it has become clear that there is a need to simplify terminology and set out the current and future architecture of the NHS clearly; similar terms are used in different ways across the responses, reflecting the confusion felt on the ground when discussing local systems. There is also confusion around how NHS systems link with local authority and other public sector bodies who may have different geographical boundaries. This general uncertainty could lead to people disengaging with the process and a lack of clarity about where decisions should be made.

As the NHS resets, it is therefore essential that there is clarity on the role of local systems and organisations, with common aims and objectives set. This exercise is fundamental to the effective operation of a local health and care system. The success of the local health and care system response to the Covid-19 pandemic was, in large part, due to having clear and common priorities across all organisations both within, and outside of, the NHS. Being clear from the outset about what is expected and who is responsible will enable decisions to be made quickly and any disputes to be easily resolved. This is an area where the experiences of the past must inform future developments, learning from some of the initial problems in setting up STPs that are still influencing system behaviour now.

It is widely recognised that there are many factors which contribute to an individual's health and wellbeing. As local systems develop, it is essential that they work closely with all facets of local government to include consideration of the wider determinants of health which could impact the effectiveness of the services being delivered. Working with public health colleagues and the wider public sector around housing and employment and all the wider determinants of health will support the drive to tackle health inequalities. This should be considered an essential part of local system working and the management of population health. The voluntary and community sector also has a key role to play in enabling systems to meet the needs of their population.

Role of commissioners

The block contract arrangements during Covid-19 have removed many of the traditional commissioner tasks from the system; contract monitoring and reporting are much reduced, and many transactional processes have disappeared, albeit temporarily. This has also had an impact on the corresponding provider finance teams. Some decisions that would usually be taken by clinical commissioning groups (CCGs) to meet local needs have been taken nationally in order to address the crisis in a consistent fashion across the whole country. Although these changes are short term, this provides an opportunity to look at what the role of a commissioner should be in the future financial regime.

> *"The role of a commissioner is to bring together partner organisations to set a shared vision and strategic direction, setting priority areas for improvement and removing barriers between organisations."*
>
> **Finance director, commissioner**

With a national move towards system working and co-operation, it is the right time to review the traditional purchaser / provider split which tends to foster competition and can cause unnecessary conflict. This corresponds with the intentions of the *NHS long term plan* which sets out the strategic role of the commissioner within an effective system:

'… the NHS and our partners will be moving to create integrated care systems everywhere by April 2021, building on the progress already made. Integrated care systems (ICSs) bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. They will have a key role in working with local authorities at 'place' level, and through ICSs, commissioners will make shared decisions with providers on population health, service redesign and long-term plan implementation.'

However, the split in functions has played an important role in improving data quality and providing scrutiny around care quality and patient safety. There is a need to not allow complacency to drift back into the provision of healthcare due to the lack of competition. Commissioners, in some form, have a duty to ensure that taxpayers' funds are spent well and that quality outcomes are achieved.

The strategic nature of commissioning remains important for ensuring that the full range of population health needs are met. The removal of focus on transactional processes has been welcomed by providers and commissioners alike, allowing a greater focus on the transformational work that can make a real difference to population health. As ICSs develop, the strategic commissioning function may form part of the overall system architecture if legislation allows, rather than a separate organisation within the system. This recognises the essential role of commissioners in ensuring that population health is effectively managed and provided for. The recently published contracts and payment guidance[10] for the remainder of 2020/21 appears to support this view by distributing funding via a lead CCG in each system.

In addition to strategic commissioning to improve population health, there are a number of other areas which require, potentially resource intensive, commissioner input for example primary care, commissioning of ambulance services, continuing healthcare (CHC) and out of area treatments, as well as specialised commissioning as it moves out to local systems. As new working models are developed, these areas must not be overlooked.

[10] NHS, *Contracts and payment guidance October 2020 – March 2021,* September 2020

However, there is again an opportunity to consider if these areas are being administered in the most effective way. Out of area treatments can create a high level of transactional tasks for example, and may be more effectively managed by reviewing CCG, or system, allocations to compensate host organisations rather than creating multiple recharges across the NHS. Primary care strategy should be considered at a system level through primary care networks to support local priorities, and CHC is already delivered in partnership with local authorities. A fresh look at how some of these areas are managed may support the move to system working in a local area.

"ICSs are key here, making sure that not only are resources allocated appropriately between sectors but also between geographical areas according to the needs of the population. We have become too focused on 'sectors' e.g. hitting the mental health investment standard, to the detriment of the needs of places or localities."

Finance director, combined acute and community services provider

Some of these activities may naturally fall into an aligned incentive arrangement across a system where a lead provider or provider alliance could take responsibility for one or more of these elements. Conflicts of interest must be effectively managed to ensure that all service providers, including NHS, independent and voluntary sector organisations are treated equally. The GP contract may need to be considered separately as it is negotiated nationally but administered locally. In the move to local system working, it must be noted that some areas may remain more appropriately negotiated or commissioned at a regional or national level. Where this is the case, local responsibilities must be clearly defined.

Work during the pandemic has highlighted an even broader role for local commissioners, developing relationships across the wider public sector and working with services such as the police and fire service to address population needs. Commissioners have a key role to play in supporting systems to operate effectively, delivering a strategic commissioning service for the full range of health and care services including primary care, hospices, and voluntary and community sector provision. Commissioners may also hold a system governance role, ensuring financial control and a neutral voice when considering the allocation of resources.

"Commissioners need to be strategic and focus on improving population health jointly with partners in councils, police, fire etc. Providers should be incentivised to work together to transform patient pathways, with the funding following in a way that reflects costs."

Finance director, community services provider

"Strategic commissioning is the direction of travel for the system and we need to ensure that commissioners understand what that entails and allow providers to make decisions."

Finance director, integrated care provider

Social care

Social care was fundamental to the response to Covid-19. The ability to quickly discharge people from hospital, where appropriate, freed up beds in anticipation of rising demand for acute care. Across England, NHS organisations have reported an improvement of relationships with their local authorities, as they all worked together towards the same aim. But the pandemic also highlighted the disparity in available support and access to supplies and equipment, with extra difficulties in procuring personal protective equipment (PPE) and accessing testing for social care and care home staff. Integrated working between health and social care at a local system level needs to be an equal partnership that considers the impact of decisions on all parties.

The health and care system should be treated as a whole even though they legally have to remain separate and each have their own expertise. Equal partnerships need to be supported by resources that enable both parties to contribute, be they financial resources or other assets such as workforce or estate. The continued underfunding of social care means that true system working cannot be achieved for the benefit of those who rely on the health and care system.

Prior to Covid-19 there was significant concern about the sustainability of social care, and this has only increased as a consequence of the pandemic. The additional funding has enabled delayed transfers of care to be almost eradicated across the country, but this funding is not recurrent and there are credible fears that normal working practices will resume when the money runs out. CIPFA believes[11] that there will be little appetite to tackle the long-term social care funding issues while the government deals with the impact of Covid-19 and Brexit.

"I sincerely hope they are given a realistic financial settlement that enables them to continue to develop the community infrastructure to support the vulnerable in our communities and to fund a better, more resilient, care sector – both care homes and domiciliary care."

Finance director, mental health and community provider

"Funding social care to facilitate discharge needs to be maintained even if this means funding coming out of the acute sector which should no longer be incurring the costs of delayed discharge."

Finance director, acute provider

Despite the belief that ICSs are whole health and care system bodies, many survey respondents highlighted that their local authorities were not actively involved in strategic population health discussions and just needed a place at the table to get that stronger voice. This could be because ICSs are seen as an NHS initiative and may not be given the necessary importance by local authority colleagues. However, the national planning and reporting demands on ICSs focus purely on health services and so do not need social care involvement to meet their requirements.

"Conversations within systems need to be less NHS centric and more about population health and care in its widest sense. This is sometimes difficult because of national NHS exercises which dominate the conversation"

Finance director, community provider

However, some areas are already working in a more holistic way with joint appointments across CCGs and councils; by its very nature, this means that boundaries are aligned, which makes working together far simpler. This also offers the opportunity for both NHS and local authority staff to better understand each other's culture, which could be further supported by enabling a rotation of staff through both sectors. The HFMA has issued guidance[12] for CFOs who hold joint posts.

Voluntary and community sector

The voluntary and community sector plays an essential role in supporting people and communities to stay well, promoting self-management and healthy lifestyles in many cases. This sector has been hit hard by Covid-19 and may struggle to deliver the same level of service that the NHS has been used to. Some of the funds raised for the NHS during the pandemic will be used by NHS Charities Together to support healthcare provision in the community to get back to 'normal' and this may include supporting some voluntary and community programmes. However, the public sector may find that extra support is needed in the interim for the cohorts of people normally served by charitable bodies, such as hospices or organisations which provide community mental health support.

[11] HFMAtalk, *Covid-19: the local authority response*, May 2020
[12] HFMA, *Guidance for chief financial officers working across health and local government,* February 2019

A key theme in the survey responses was that NHS bodies and ICSs need to recognise the expertise of the voluntary and community sector, involving relevant bodies in discussions at an early stage of any transformation project. However, learning to recognise the expertise can be a challenge so health staff need to be more actively involved in their local communities. Encouraging staff to volunteer as trustees for local charities or to donate time for specific projects, can allow NHS organisations to more fully understand the benefits that the sector can bring to the table. It will also develop an understanding of the costs of running third sector organisations which are often, wrongly, seen as cheaper resources.

"Excellent relationships have been established through Covid, and this greater recognition of the importance of charities and third sector providers must continue to be built on in the forthcoming period. It should be recognised that charities save the public sector finances a significant amount and that support is essential to reap these benefits."

Stakeholder

Voluntary and community organisations also need support to evaluate their services and measure outcomes, so that they are better able to describe what they offer. Support to gather and understand data would give the sector a powerful resource and enable them to contribute to local system service planning more fully. This work requires good, trusting local relationships, which comes back to engaging more fully with the wide range of organisations in a local community. This can be done through umbrella organisations that represent groups of charities and community bodies, to make it more straightforward.

"Always involve the relevant third sector organisation in any service re-design as an equal voice at the table"

Stakeholder

Wider determinants of health

Voluntary and community sector organisations often work with people to address the wider determinants of health, but to truly work as a system to address population health and wellbeing, ICSs need to engage further with local authorities, police and others. With public health under the auspices of local authorities, ensuring their inclusion on strategic ICS boards, can enable discussion to take place around action on the wider determinants of health with a direct link back into the council. However, for those areas with a two-tier system, it must be recognised that county councils and district councils hold different responsibilities in areas such as housing.

"The local authorities need to be a key player in all system discussions. Not only to cover social care but also so that the impacts from decisions in other areas, such as housing, can be considered by the whole system to highlight any potential risks."

Commissioner

"We need much closer working with local authorities. In my experience, this works best where healthcare providers and local authorities serve the same population. Too many distractions and delays are caused by a lack of coterminous boundaries."

NHS combined acute and community provider

There is a need to co-ordinate programmes across the broader public sector to ensure that bodies are working towards the same aims, rather than working against them. For example, local authority efforts to tackle homelessness will be most effective if supported by investment in NHS homelessness services. Public health initiatives to tackle gambling addiction are supported by NHS programmes within mental health for this area; these could be further supported by reviewing local licensing laws for gambling establishments.

The NHS cannot, and should not, take responsibility for the wider determinants of health but, through the system working models being developed, it can support local areas to work together to tackle some of the biggest causes of inequalities and poor health.

Recommendations

- Progress towards integrated care systems should be speeded up to build on advances made during the Covid-19 pandemic. More devolved decision making should be enabled at a local level.
- The commissioning function should focus on strategic commissioning in order to improve population health and to strengthen system working.
- Emergent integrated care partnerships should be encouraged to foster and continue new ways of working between primary, community, secondary and social care, to manage and own the risks of increased demand.
- Models should be developed that encourage and simplify provider collaboration, to ensure that the system working arrangements during Covid-19 do not unravel as they once again become voluntary.
- Local systems should take the opportunity of improved relationships and a new way of working, to clarify shared goals and determine each organisation's role in achieving them.
- Social care and the care home sector must have a stronger voice in system discussions, as their importance in supporting the NHS to operate effectively has become apparent during the pandemic, but they can struggle to be heard. This involvement must be supported by sufficient funding to back up the necessary actions.

Contracting arrangements

The most significant change to the financial regime in England during the Covid-19 pandemic was the immediate suspension of normal contracting arrangements in favour of block contracts across the whole system, with payment in advance to ensure that cash was able to flow as needed. This change was made in order to remove finance, and particularly cash flow, as a potential block to making the changes that were necessary in order to tackle the pandemic. While this was clearly a temporary measure, albeit a prolonged one with arrangements currently extended to 31 October 2020, the impact of this change has shown what can be achieved when the financial regime is simplified.

The current operating climate for the NHS is unlike any other time. As the pandemic took hold, all elective activity was cancelled and emergency attendances for non Covid-19 related reasons plummeted. In these unusual circumstances, a simplified finance regime was effective as it was supported by a top up arrangement to reimburse any extra expenditure due to the pandemic or loss of operating income. The block contract arrangements underlying the regime were based upon average monthly expenditure at month nine as the most recently agreed financial position[13]. While this figure took account of staffing models and normal running costs, it in no way reflected the reality of what the NHS was facing as Covid-19 took hold; the simplified block contract was only possible with the top up arrangement to supplement it.

While operating in an unconstrained financial regime makes many aspects of the NHS simpler, it is not sustainable nor desirable in the long term as it can lead to wasteful practices. But there is little desire to return to the financial regime of before. It is essential that this opportunity is fully utilised to reboot the NHS finance system in England. As a finance profession, we must consider how to make best use of the taxpayer's pound and question whether the current structure is the correct one for the future. We must build on what was working well before Covid-19, remove the artificial barriers and obstacles to change and apply the lessons that have been learnt through reacting to the pandemic.

Future contracting model

The current NHS structure is built upon a network of contracts between commissioning organisations and those who supply services. Prior to Covid-19 a number of different contracting payment models were in operation across the NHS, with some organisations operating several different arrangements for the separate parts of the business. It will be no surprise that, based on the survey results, acute trusts tended to hold some form of tariff-based contract, while community services and mental health trusts tended to be paid under a block arrangement, although there are obviously exceptions to this.

"Retaining the block is not the right longer-term option. Introducing a true aligned incentive contract is the best mechanism to get the system working together."

Finance director, mental health provider

Over two thirds of finance directors responding to our first survey believed that the post Covid-19 contracting arrangements should be on a block or aligned incentive[14] basis, where strategy is aligned across the system with incentives for providers to develop and improve services as well as meet access criteria. Aligned incentive contracts are becoming more common within the NHS and recognise that the limited resources available to a system have to be used in the most effective way. By aligning objectives and assigning a block value to them, with associated risk and gain share

"The aligned incentive contract is a broad description of a contracting model. There will still need to be a lot of work locally to determine how this is introduced and what risks are shared."

Finance director, community services provider

[13] NHS England and NHS Improvement, *Next steps on NHS response to Covid-19: Letter from Sir Simon Stevens and Amanda Pritchard*, March 2020
[14] HFMA, *An introduction to aligned incentive contracts,* June 2020

arrangements, NHS organisations have greater freedom to innovate as there is certainty over the provider income that will be received and the cost to the commissioner. This also enables system level management of the overall financial envelope and avoids creating an environment where organisations have competing priorities. However, good relationships across the system are essential for the success of this way of working. As new contracting arrangements are developed, with the associated financial control mechanisms, it must be possible to flex requirements to recognise the different levels of maturity and development across STPs and ICSs.

Future payment mechanisms

There were moves away from an activity-based payment mechanism prior to Covid-19. The introduction of blended payments in the 2019/20 national tariff payment system – which was to be developed further in 2020/21 had it not been for Covid-19 – encouraged a move to a blend of part fixed, part activity-based and part outcomes-based reimbursement for specific activity.

> *"The movement away from a case-based system has enabled us to swiftly develop new pathways and ways of working that previously would have taken significant time to implement, if at all."*
>
> **Finance director, integrated care provider**

NHS England and NHS Improvement are already taking the opportunity of the temporary pause to standard finance arrangements, to introduce a blended payment approach for all secondary care across acute (including specialised commissioning), community and mental health provision in 2021/22 for contracts over £10m. The engagement process recently undertaken[15] demonstrates the complexity of attempting to implement a significant change across the whole service without disrupting the provision of care. However, the opportunity is there to make this change and the proposals recognise the importance of developing a payment model that works for a local system, albeit within national guidelines. It is evident at this early stage that there continues to be a conflict between encouraging local autonomy and retaining levers at a national level to influence behaviour. The principles of the blended payment model are sound and will be refined to work in practice through this engagement period and the trajectory for full implementation over the coming years. It is essential that any new payment approach supports organisations to continue to collect the activity data that is needed to support good decision making. Blended payments are compatible with an aligned incentive approach, assuming that there is local discretion over the variable element of the payment to incentivise activity that supports local priorities.

The NHS finance profession has been pushing for a change to low value non-contract activity (out of area treatment) reimbursement for some time. With the proposed wholesale change to the payment system, the time is right to review whether the system of raising and paying multiple small value invoices between NHS organisations, is an efficient use of NHS resources. It is understood that this is an area for future national consultation.

Establishing the baseline for contracts going forward will be challenging and, for 2021/22, NHS England and NHS Improvement suggest that values are based on the block payments made in 2020/21. While this risks embedding any allocation errors made during the initial rapid response, it no longer makes sense to base activity estimates on previous years as delivering care in an era where Covid-19 has to be considered will not be the same as that which went before. The rapid move to virtual and telephone consultations suggests that care will be delivered very differently in the future and, for face-to-face contacts, Covid-19 will impact how and where that care is given.

Beyond 2021/22 it is expected that local costing data will be used to agree the fixed element of the blended payment contract. In reality, the NHS will probably see a hybrid calculation model as detailed costing information is not routinely collected across all sectors or services at this time.

[15] NHS, *2021/22 tariff engagement*, October 2020

The move to blended payments will not cover independent sector activity and may, or may not, cover activity under contracts of less than £10m. In addition, less mature systems may have need of national support in determining contract values or resolving disputes. It is therefore necessary that a streamlined national tariff continues to be available to support this work.

In the short term, future contracting arrangements will also have to recognise the potential surge in demand as services are re-established and the increased waiting lists that will need to be addressed. The elective incentive scheme set out in the phase 3 guidance[16] goes some way to addressing this but does not recognise the hidden waiting lists in mental health and community services. Consideration must also be given to supporting organisations to prepare for future Covid-19 surges or other potential pandemics, although this preparation may be best placed at a system level.

System allocations must be transparent and clear. Local systems must take ownership of the funding envelope for their services, with a similar level of responsibility as that set out in law for local authorities under a section 151 obligation. Working together as a system, with clear priorities underpinned by a strong financial framework that can be attributed to the necessary activities, is essential for the NHS to create a financially sustainable future.

When the country emerges from the immediate needs of the Covid-19 pandemic, finances will once again become constrained. These constraints could be significant with the Bank of England warning of the sharpest recession for 300 years[17]. The focus on efficiency in the NHS will increase and expectations are likely to be high around the efficiencies that can be achieved through changing working practices. While there is much to be learnt about economies of scale from the experiences during the pandemic, caution must be applied to what is achievable as significant investment will be needed in order to establish a health service that can deal with an ever present virus threat. However, revitalising cost improvement/ waste reduction programmes and focusing on value are essential, to ensure that resources are being used well and effectively. Potentially there is now more scope to make radical changes through these programmes which impact across a system, rather than just a single organisation. Developing a national contracting model that boosts system working, such as an aligned incentive contract, would support such measures.

"We need to move to a population health related payment system and aligned incentive is best placed to support that approach."

Finance director, commissioner

"The finance regime should stimulate better system working and ultimately lead to improvements in patient quality of care and clinical effectiveness. We need to have a very clear narrative of how any future finance regime does this."

Finance director, integrated care provider

Recommendations

- Recognition of the different levels of maturity and development across sustainability and transformation partnerships (STPs) and ICSs is essential when designing and implementing new ways of exercising financial control and establishing new contracting arrangements. A 'one size fits all' approach will not be effective.
- When the business as usual financial regime is established, the emphasis should be on the transparency and understanding of the financial allocations to each STP or ICS.
- The new financial regime needs to encourage ownership of the finite financial resource by each system and each organisation within it.
- The principles of the local authority section 151 obligation for effective management of financial affairs, should be embedded at system level with the intention that service transformation is undertaken to provide healthcare within the allocated financial envelope.

[16] NHS, *Contracts and payment guidance October 2020 – March 2021*, September 2020
[17] BBC, *Bank of England warns of sharpest recession on record,* May 2020

- Any national contract model (which may be required based on relative STP or ICS maturity) should be on an aligned incentive basis. Preparations should be made for the new arrangements to take effect from 1 April 2021.
- While a detailed national tariff will no longer be needed to support the payment system, there will need to be a mechanism to reimburse systems for out of area treatments and specialist treatments, as well as appropriately funding the contributions of the independent and charitable sector. The current tariff arrangements are overly complex, and a streamlined tariff should be produced to support payments between systems and spot purchases.
- Any new payment system must support the collection of high-quality activity data and retain the granularity needed to support robust decision making.
- The financial processes around reimbursement of low value non-contract activity should be reviewed with the intention of making adjustments to host organisations through allocations rather than multiple invoices.

Costing and data

Any blended payment, block or aligned incentive arrangement must be underpinned by robust cost information in order to be able to vary the contract year on year for changes in activity or service developments, and fully understand the cost of these. The HFMA is a supporter of the current programme to introduce patient-level costing using a consistent methodology across the NHS in England. However, the HFMA has previously raised concerns about the national costing standards set by NHS England and NHS Improvement and recommended that they should be proportionate, achievable, deliver high quality comparable cost data, be easy to understand and provide useful information for local and national use[18]. Although there have been some small changes to the costing standards, the fundamental changes required have not been made which means that the burden of producing cost data has not diminished.

It will also be essential that any future contracting arrangement enables organisations and systems to retain the richness of activity data that the case-based system allows. Good activity data across the whole health and care system will support systems to plan for their populations, particularly addressing health inequalities with local authority colleagues. Data collections must form part of any contract model, recognising that sectors such as mental health and community services have work to do to reach the level of granularity of data in acute trusts. As the future regime is developed, consideration must be given to the data that supports systems to operate effectively, developing national collections on this basis to ensure that the data asked for is useful both locally and nationally. This is an opportunity to review the burden of data collection as a whole rather than on a piecemeal basis as new requirements for information are created.

"Costing should support understanding of use of resources and delivery of outcomes and not just be an exercise in itself."

Finance director, mental health provider

"There are several requirements in the new national cost collection standards that are practically impossible to deliver, or which do not work in practice."

NHS combined acute and community provider

Robust costing relies on high quality activity data but there are concerns about the burden of national data collection. There is wide recognition that data collection and analysis is essential for decision making. However, there appears to be significant duplication in what is requested both regionally and nationally, which then requires additional resource to reconcile the slightly different requests. The apparent lack of co-ordination between teams at regional and national level when asking for data, seems to be a cause of frustration for many. On top of these requests, local collections between providers and commissioners are also required as part of the contract monitoring process. One survey respondent highlighted that, in any given month, over 6,000 items of data were submitted to 13 different bodies, with few of them used for any significant purpose.

Finance staff fully support the need to collect data but there needs to be clear value to doing so. Ideally, data should be collected once and used many times. Data collections need to be continually reviewed to ensure that they remain relevant and retired quickly when they cease to be useful. There is a wealth of information in the NHS across a multitude of systems, however there are still a number of areas where data collection, and data quality, require improvement. A focus on a smaller

"Consistency is a key factor. Submitting data is meaningless when it can't be compared as all submissions are using different methods.

Local systems should be able to feed into national data requirement discussions to ensure that the data being received can be used nationally and locally without causing additional burden on providers and systems."

Commissioner

[18] HFMA, *Healthcare acute costing standards for England recommendations,* October 2019

number of data collections will enable staff to both improve data quality and work with clinicians to interpret the data for the benefit of patients through service improvement.

Recommendations

- There should be a review of the current national costing requirements for all sectors of the NHS. Robust costing information is essential and costing standards must follow the principles of being proportionate, achievable, deliver high quality comparable cost data, easy to understand and provide useful information for local and national use. The current arrangements fall short when assessed against these principles.
- Data collections should be reviewed to ensure that it is both possible to collect the information required and that it is useful locally and nationally. Collections should be clearly defined to ensure that the data is comparable, and the analysis should be made available to organisations to utilise in a timely fashion. Consideration must be given to the resource that is required to collect and return the data when compared with the value of the data to the NHS.

Capital regime

Background

Capital during Covid-19

In order to meet the demands of Covid-19, a simplified national capital approval process was initially put in place which gave confidence that costs incurred would be reimbursed. The speeding up of governance processes and the ability to make swift decisions at a local level, enabled systems and organisations to invest in equipment and building alterations to address the pandemic. This was an extraordinary situation and, as the NHS emerges from it, lessons can be learnt about the capital allocation and approval process. As for the wider financial regime, an opportunity has been presented to review the capital process, despite the changes already introduced from 1 April 2020 to develop system capital allocations.

Local autonomy to agree capital spend for Covid-19 below £250,000 was effective and simplified the investment decisions needed, with retrospective national approval. The streamlined approval process for larger sums should be maintained, accepting that the speed of turnaround will slow as the crisis eases. One of the frustrations frequently expressed is the speed at which applications for financing for capital projects were dealt with under the old regime. The uncertainty about when funding would be available made planning capital projects almost impossible, impacting on the ability of NHS bodies to provide accurate capital forecasts. Multi-year capital allocations are needed to enable effective planning of capital projects, with flexibility to manage the investment across year end boundaries.

> *"Key enablers for capital spend during Covid-19 were clear rules and simple approval processes with a clear and quick timeline."*
>
> **Finance director, mental health provider**

Health infrastructure plan

The schemes in the *Health infrastructure plan* are large and, by their very nature, will take many years from the announcement to the opening of the new/ refurbished building. For example, the STP wave 1 schemes announced in 2017 have yet to reach the full business case approval stage and are still a way away from starting to be built. The cost of the schemes increases with inflation over this time, as the project moves from initial vision to reality. These additional costs are not included in the funding announced at the start and therefore need to be funded by the bodies themselves which usually means making compromises to their plans or spending less elsewhere. Such high profile projects should be tracked from the initial announcement to the opening of the facility (as recommended by the Public Administration and Constitutional Affairs Committee in its report *Accounting for democracy revisited*[11]) so that there is complete transparency about the delivery of these high profile projects as well as an understanding of how the cost of such projects changes over time. This will allow vital lessons to be learned by NHS bodies as they develop business cases for future projects.

Current national guidance and regulatory context

The reforms already announced to the capital regime that allocate capital to systems, should support faster decision making and allow investment to be matched to system priorities. However, there is concern that backlog maintenance and a political focus on building hospitals will limit the spending decisions that local systems can make. IFRS16 may also have an impact as leases charged against capital allocations will further reduce the funding available.

Future capital regime

As the NHS resets to a new way of delivering care, further Covid-19 capital investment will be needed to ensure that sites are able to deliver appropriate social distancing, particularly where a patient's Covid-19 status is unknown. Existing capital investment projects may need to be reviewed to ensure that they are fit for purpose in an NHS which is operating in a very different environment to that in place when the original business case was written.

"We require multi-year capital allocations so that systems can properly plan their investment priorities. We also need more of the capital budget to be devolved to system level so we can plan for service development, in addition to urgent backlog maintenance."

Finance director, community services provider

"We need a strong prioritisation process both regionally and nationally. The benefit of the current situation is that we all knew and agreed the priority so there was no 'case of need' or discussion internally or externally about what was important. Once a priority is agreed, trusts need a secure cash supply over multi-year and given freedom to get on with the programme."

Finance director, acute provider

There is a fear that the demands of the acute sector to address backlog maintenance and the development of the large schemes announced in the *Health infrastructure plan*[10] will mean that mental health and community providers will struggle to access the capital that they need to support the transformation of services. Transparency of the allocation process will be essential.

Recommendations

- Capital allocations must be published for several years ahead, be transparent and recognise the multi-year nature of many projects, including the impact of inflation. This requires the government to make multi-year capital allocations to the NHS.
- Capital approval processes should build on the learning during the pandemic and remain streamlined and simple.

Financial governance and business planning

Financial governance

Remote working, social distancing and staff sickness have all had an impact on working practices during the pandemic, but good financial governance appears to have been maintained throughout.

Decisions have had to be made quickly and, in some cases, this has meant that decisions have been made by those organisations who are directly involved in the implementation and delivery of care rather than going through what could be lengthy approval processes prior to Covid-19. Checks and balances are still required but the necessary delegation of decision making to appropriate levels in organisations has demonstrated that not everything needs board or central approval to be effective. While these changes were born out of necessity, it is important that the good practice that has been established is allowed to continue, with serious consideration given to whether previous processes need to be reinstated or not.

Governance appears to have remained robust but, with greater use of virtual meetings, discussions have had to be clearly focused in order to make, or approve, the decisions necessary. This has also been seen in board papers which have been reduced in length to focus on the key issues. While some elements will need to be reinstated, this is an opportunity to review what the information is used for and the level of detail required.

Organisations have also noted a reduction in waste as a consequence of new working practices, with documents distributed and approved via email rather than in hard copy. However, there is some concern that the drive to streamline meetings and reduce time spent online has reduced the quality of discussions and led to some issues not being given the time that they deserved for full consideration. It is therefore vital that all aspects of process change are considered prior to making any permanent changes.

"Some decision-making processes and revisions to financial delegations are time limited but may be implemented permanently following an assessment.

Some aspects of governance and the way we have changed executive structures will be permanent, for example how we have established multi-disciplinary teams."

Finance director, commissioner

Business planning

The improved system working has also had an impact on business planning with some areas sharing more data about social care, care home occupancy and putting a stronger focus onto understanding activity outside of the acute trusts. This has supported discharge planning in many areas and should be retained as systems work to better understand the needs of their population. However, as ICSs develop and have greater local authority involvement, consideration must be given to how local accountability is managed. A local system that just adds in all existing boards and scrutiny processes will be unwieldy and ineffective, unable to react in a timely fashion to the changes that are needed. Governance must be proportionate and appropriate, which will require both structural change to current processes and cultural adjustment to accept them.

"While we continue to have an ICS with no legal powers, so the accountability is sitting with commissioning and provider organisations, there is a danger of complex governance webs being created as boards understandably need to discharge their responsibilities."

Finance director, community services provider

The reaction to Covid-19 has required organisations to work together to plan their response, considering a number of factors across a range of public services. However, to do this successfully on an ongoing basis, a more inclusive planning process is required to consider the wider health and care sector. This needs to be driven from the top of the health and care system, aligning timescales and priorities so that local NHS organisations and social care were able to work together. However, good local relationships are vital to enable this to happen at a place and system level, so that plans are not just paying lip service to working together.

"The recent planning guidance in the phase 3 letter is predominantly health based. Whilst we continue to drive planning through the NHS only route, and manage performance of systems through the NHS lens, we will not get inclusive plans."

Finance director, community services provider

Working together to produce population health and care plans will be more complex than just producing an NHS plan, therefore publication of guidance, timescales and submission dates would have to reflect this; credible plans cannot be produced with just a few weeks turnaround. Longer term certainty on funding for all sectors would also enable better, joint plans to be created as the need to react and fire fight due to funding constraints, would be reduced.

"We have done a significant amount of modelling with the local council and would look to maintain links to their data cell going forward."

Finance director, acute provider

However, even without central change, ICSs offer the opportunity to make the planning process more inclusive through agreeing system priorities with local partners. Some areas are already working in this way.

Recommendations

- Governance processes should be reviewed in light of the pandemic and only be continued where they add value to the organisation.
- National timescales and priorities should be aligned across health and social care to give local systems the opportunity to work together to develop robust plans to meet their population's health and care needs.

Procurement

Procurement processes, and the speed thereof, have been at the forefront of media reporting about the pandemic response. The lack of PPE and the issues around procuring sufficient supplies in a timely manner have brought the NHS procurement function into the spotlight. There has also been debate about whether procurement is best organised at a local or national level. The NHS and social care response to the Covid-19 pandemic illustrated why strong local, national and international supply chains are required for many goods.

Survey responses have broadly shown a split between acute trusts who would like more local control over procurement and other, usually smaller, organisations who have appreciated the support of the national response. Across all sectors there is support for system-based procurement hubs, using the scale of the system as purchasing power, while retaining local control over provision. During the pandemic, many systems have worked on a mutual aid basis, moving stock between organisations to where it is needed. This flexibility of provision is appreciated at a local level, although may complicate stock accounting issues.

"NHS Supply Chain and NHSX have been good in really difficult circumstances and we will continue to use NHS Supply Chain in higher volumes post pandemic."

Finance director, mental health provider

"There is merit in procuring across more than one organisation, but it has to be a regional group that is employed by local trusts and is trusted by the organisations. We can't delegate this function to a national or regional arms-length body – it is too important for that."

Finance director, acute provider

The pandemic has accelerated joint procurement arrangements in many areas and has also enabled relationships to be developed between trusts to support this. Some organisations have seen a willingness among clinical staff to be less directive about the brand of item that is purchased, in order to exploit efficiencies of bulk purchase.

"Learning can be taken from the Covid-19 pandemic, where national and local procurement arrangements have been improved. There needs to be national buying power but the freedom for local purchasing to take place where it better supports the system."

Commissioner

There continues to be support for centralised, national procurement, recognising the need to leverage the purchasing power of the NHS to obtain economies of scale. A national procurement function can also provide a number of services that minimise risk to individual organisations through clinically assuring products and ensuring that suppliers are legitimate. However there remains a need for local flexibility, with the Covid-19 pandemic highlighting the importance of being able to procure locally for urgent or specific requirements. The majority of survey respondents who mentioned the need for local flexibility, envisaged this being at a regional or ICS level to still retain some, albeit smaller, economies of scale and consistency of supply.

"We need to set up simple national arrangements building on the 'towers' and develop at scale local sub-arrangements – bigger than current trusts and breaking through the commissioner / provider split."

Finance director, acute and community provider

Workforce

Background

The NHS workforce has received an outpouring of appreciation and support from the public during the course of the pandemic. Numbers of clinical staff have been swelled by people coming out of retirement and final year students joining the workforce. Many staff have undertaken new roles whether that be elective care nurses redeployed to ICU or finance staff distributing PPE. However, as the system resets, the workforce issues of before will return and may even be exacerbated by changes in demand and a necessity to change ways of working. Anecdotal evidence suggests that the exposure to new areas of work, and the cross-skilling that has occurred, has had a positive effect for many and could support staff retention through enabling people to move within the NHS.

Two areas are expected to cause issues immediately. Staff have been working at a high intensity for a prolonged period. Leave has not been taken and, as the pandemic eases, staff will be taking time off or experiencing periods of sickness as they recover from the demands of treating Covid-19. There is also a fear that more staff will choose to take early retirement as a consequence of the pandemic. In addition, the impact of Brexit on the recruitment and retention of overseas staff, is as yet unknown. Currently, around 153,000 staff are from overseas, with 65,000 from EU countries[19].

The demand on mental health services as the NHS and the country recover from Covid-19 is expected to significantly increase. This will be difficult to meet with the ongoing shortage of mental health staff, whose numbers may be further reduced because of the reasons previously stated.

"There will be exhaustion of key staff groups as we move through the year, leading to a lack of capacity in the winter."

Finance director, acute provider

"The backlog resulting from low referrals and face-to-face contacts during the incident means that we know we have significant work to catch up on."

Finance director, mental health and community provider

Delivering services in a new way to address social distancing requirements and Covid-19 status is likely to increase the overall staffing numbers needed as it will not be possible for staff to care for the same number of patients. The expectation that Covid-19 will be ongoing also means that critical care staff ratios need to be reviewed to deal with future cases of the virus.

As new staffing models are considered and areas of concern identified, community services must not be overlooked. With acute trusts reorganising service delivery there is likely to be an impact on community services if, for example, patients are discharged more quickly after their treatment. The consequences for those who have had Covid-19 and recovered are as yet unknown - there may be a need for increased specialist rehabilitation and support in the community.

Working practices

The pandemic has shown that it is possible for many staff to work differently. The massive increase in the use of digital outpatient appointments has shown that it is possible to assess and review many patients remotely, avoiding the need for travel and the risk of using waiting rooms while Covid-19 is still active. However, digital outpatient appointments are not quicker. The same amount of preparation is required by the consultant or registrar for the appointment with patient facing time remaining at a similar level to an in-person appointment. While there are many benefits of digital outpatients for both the patient and the NHS, it must not be considered as a quicker or cheaper option. There is some thought that this approach may change the overall skill mix of staff required

[19] House of Commons library, *NHS staff from overseas: statistics*, July 2019

and reduce the levels of administrative staff required to support busy clinics. Care must be taken not to reduce staffing levels in this area too quickly as an administrative burden will remain for digital outpatients and a virtual clinic will not be appropriate for all patients.

Remote working has also come to the fore during Covid-19. Dispersed teams sometimes working in different places have shown what is possible; teams are still able to keep in touch and deliver the service required while working away from the office. That said, the value of face to face contact has been noted with many staff keen to get back to seeing colleagues and the informal communication and support that the work environment brings. But remote working has shown that it is not always necessary to travel to a meeting, discussions can be just as effective through a video conference and often more focused, reducing meeting time as well as travel time. For multi-site trusts this could have a significant and positive impact on working practices.

The NHS people plan, *We are the NHS: people plan for 2020/21 – action for us all*[20], was published shortly after the survey closed that informed this paper. It recognised many of these issues and set out some steps to begin to address them but was necessarily constrained in its ambitions by the uncertainty around longer term funding for workforce issues in the NHS and Health Education England. The recent government spending review[21] identified additional funding to support training and workforce retention in 2021/22.

[20] NHS, *We are the NHS: People Plan for 2020/21 – action for us all*, July 2020
[21] HM Treasury, *Spending review 2020,* November 2020

Conclusion

This paper has set out the areas where the HFMA believes that the NHS in England can make beneficial changes to the financial regime. While many of these changes will be enacted at a local level, it is essential that they are supported by clear national messaging and a willingness to keep arrangements simple and effective.

It is recognised that the NHS, and the country, are currently living in unusual times and that the national financial arrangements reflect this – doing things differently is much easier with the relaxation of financial constraints. However, we must grasp this opportunity to make the changes that have been talked about for many years, building on what we know works well and removing those elements that no longer support the system working that the NHS aspires to. In the past the NHS has created stepping-stones to gradually move to a new way of doing things but now it has a chance to take a single leap.

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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.

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