HFMA briefing

The future NHS financial regime in England: a discussion paper

June 2020

"As a group of finance professionals, I think we must lead the way – in our organisations, in our systems, and with our regulators. We all have to change. It is non-negotiable."

Caroline Clarke, HFMA president

Introduction

The Covid-19 pandemic has fundamentally changed the way in which the NHS operates and, for the first time since 1948, the service is presented with a chance to redesign the national health and care system from an almost blank sheet of paper. This opportunity must not be overlooked, and this is why the HFMA is asking for your views in this discussion paper about what the future NHS financial regime should look like in England.

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.

'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.'[1]

[1] HFMA and PwC, *Making money work in the health and care system,* June 2018

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.

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.

Closer to home, the NHS financial regime has been substantially changed 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'[2]. But what will the NHS financial regime look like in England when it returns to business as usual, whatever business as usual may look like after the pandemic?

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.

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; workforce; and the NHS finance function.

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[3] with senior figures from a range of organisations across the health and care system to gather their views on how their organisation has 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. And finally, a survey has been carried out to understand finance directors' views on what the NHS financial regime of the future should look like. 63 responses were received across all regions and sectors. Appendix 1 contains the summary data from the survey responses and relevant quotes are included throughout this briefing.

In order to fully reflect the views of the NHS finance community and key stakeholders, we need to hear your thoughts. Throughout this paper we ask a number of questions and these are drawn together in a short survey that you can find here. Please tell us what you think and share your ideas on the future of the NHS financial regime. The deadline for responses is Friday 24 July 2020. If you would like to discuss it with other members of the NHS finance community, we have set up a dedicated discussion board in the NHS Finance Forum on the HFMA website.

> "*Start with the principles of the reset and be bold. We will still be working with significantly constrained finances so we need a focus on paying for things that add value to the outcomes that the service can deliver. If we don't take the opportunity to reset the overall system properly, then we will drift back to pre Covid ways of working."*
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> ***Finance director, mental health and community provider***

[2] HM Government, *Budget speech 2020*, March 2020
[3] HFMA, *HFMAtalk,* 2020

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[4]. 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.

The impacts of the block contract arrangement run through this paper, providing areas of learning that can support the development of the future finance regime. 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."*
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> **Finance director, mental health provider**

The majority of respondents to the survey have assumed that the commissioner/ provider arrangements will remain, but some have questioned whether this has to be the case and if it represents the best use of resources. This split does not exist in the same way in the other home nations. The role of commissioners in the future English NHS is discussed in the next section as strategic commissioning and planning to meet population needs will remain important in any healthcare system. Over two thirds of finance directors responding to our survey believe that the post Covid-19 contracting arrangements should be on a block or aligned incentive[5] basis, where strategy is aligned across the system with incentives for providers to develop and improve services as well as

[4] NHS England and NHS Improvement, *Next steps on NHS response to Covid-19: Letter from Sir Simon Stevens and Amanda Pritchard*, March 2020
[5] HFMA, *How it works: the aligned incentive contract,* June 2020

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 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.

> *"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."*
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> **Finance director, integrated care provider**

There are already moves away from a case-based payment mechanism. For example, 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. Blended payments may be compatible with an aligned incentive approach, where they support the agreed objectives.

From the survey responses, there is no appetite for a cost per case contract model from any sector within the NHS, although a method is clearly needed to enable calculation of the correct baseline contract. Any 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[6]. 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.

Establishing the baseline for contracts going forward will be challenging. 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. In the short term, future contracting arrangements will have to recognise the potential surge in demand as services are re-established and the increased waiting lists that will need to be addressed. 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.

[6] HFMA, *Healthcare acute costing standards for England Recommendations,* October 2019

As 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[7]. 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

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

There was wide acknowledgment in the survey responses that 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.

Some respondents to the survey see this as an opportunity to review the local commissioner role and the purchaser/ provider split. 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

[7] BBC, *Bank of England warns of sharpest recession on record,* May 2020

shared decisions with providers on population health, service redesign and long-term plan implementation.'

The commissioning sector has already begun to reorganise with a number of CCG mergers taking place during 2019/20 and a significant number during the pandemic, coinciding with the start of the 2020/21 financial year on 1 April. These organisational changes happened with little fanfare or service disruption, showing that the strategic commissioning role currently being undertaken can continue to be carried out almost regardless of operational form, giving the opportunity to consider the most appropriate place for local commissioning to be carried out within a system. 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.

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 and out of area treatments. As new contracting models are developed, these areas must not be overlooked. There is also specialised commissioning to consider. 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.

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 could 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

Questions:

- Do you believe that the purchaser/ provider split should be part of the future NHS financial regime?
- Where contracts are required do you agree that the aligned incentive approach should be the nationally agreed model?
- Do you have concerns about the burden of national data collection?
- Where should the strategic commissioning function sit within a local system/ ICS?
- Is there a need for a single ongoing strategic commissioning function for areas such as out of area treatments, primary care and continuing healthcare?

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. Over 50% of the respondents to the survey noted that system working had 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. Conversely, some trusts have highlighted that reacting to the pandemic has necessitated an inward focus to support staff and patient safety, pausing system working with partners. This may reflect areas where system working is less mature, and trust has not yet been fully established between partners.

"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 20 September 2020. 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.

"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 strategic public health data and clinical analysis."

Finance director, mental health and community provider

As the NHS resets, there is a desire to strengthen system working and formalise the role of sustainability and transformation partnerships (STPs) and ICSs. Indeed, this has already been recommended to the government by NHS England,

'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.'[8]

and this view is supported by a number of survey responses, with some appetite to give ICSs legal powers. This would mean that accountability for the use of resources and the provision of the correct services to meet the needs of the population, would sit at a local system level although this would require additional changes to the statutory requirements on the organisations that made up that system.

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. There is also a need to draw in more expertise from across the

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

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.

"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

As the NHS resets, it is essential that there is clarity on the role of local systems and organisations, with common aims and objectives set. This exercise is not only necessary in the development of aligned incentive contracts but is fundamental to the effective operation of a local health and care system. 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.

The pandemic has demonstrated the importance of the care home sector to the effectiveness of the health and care system and highlighted how it has often been overlooked in planning assumptions. A key lesson coming from the response to Covid-19 is that care homes need much greater involvement in system working.

Social care

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[9] 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. But a robust social care system is essential for the effectiveness of the NHS; recurrently funded capacity needs to increase. There may now be public support – indeed an expectation – for a change to the current arrangements. It is positive that relationships have improved for many areas during the pandemic but allowing the sector to remain fragile means that system working cannot rely on the support needed from social care. This will adversely impact patient care.

"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

While health and social care are joined up at government departmental level, the local experience is a much more separate approach with different regimes and statutory requirements on health and social care. It is well documented that this can make collaboration difficult. The Covid-19 pandemic has improved local relationships for many but 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

[9] HFMAtalk, *Covid-19: the local authority response*, May 2020

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.

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.

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.

Questions:

- How can social care and the care home sector be given a stronger voice in local systems?
- What is needed to enable closer working with those services that directly impact the wider determinants of health, such as housing?
- How can the voluntary and community sector be better supported to enable effective system working for the improvement of population health?
- Are there any barriers to system working that have not been considered in this paper?

NHS long term plan

The *NHS long term plan* was published in January 2019 and set out a series of ambitions to make significant changes to the way that the NHS operated. Covid-19 has, to some extent, turned these on their head but 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.

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."*
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> **Finance director, integrated care provider**

The impact of Covid-19 on other NHS services may mean that progress has been lost, for example performance against cancer standards is currently poor. Organisations may find that they are restarting from a worse position than they had achieved before the pandemic began.

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. Two strong themes are apparent in the survey responses when considering which of the ambitions should be prioritised. The first is mental health, recognising the impact that Covid-19 has had on both staff and the wider population.

> *"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"*
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> **Finance director, integrated care provider**

The second is prevention and supporting people to stay well or to self-manage, so as not to return to the activity levels seen before the pandemic.

> *"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."*
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> **Finance director, commissioner**

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

Questions:

- Which *NHS long term plan* ambitions need to be reviewed as a consequence of Covid-19?
- What new ambitions are required?

Capital regime

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.

The reformed approval arrangements already set out in the new capital guidance should support faster decision making, with system allocations being used to co-ordinate local projects effectively, although national pre-approval is once again needed for Covid-19 projects below £250,000.

"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

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.

Survey respondents have shown a cautious welcome to the allocation of capital to local systems as it should enable capital investment to be matched to system priorities, however there is concern that this may add an extra level of bureaucracy to the approvals process. 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.

> *"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."*
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> **Finance director, acute provider**

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.

Question:

- What is needed to make the system level capital allocation process work well?

Financial governance and business planning

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.

[10] DHSC, *Health infrastructure plan*, September 2019
[11] Public administration select committee, *Accounting for democracy revisited: the government response and proposed review (paragraph 29)*, June 2018

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.

"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

Some organisations have introduced a 'buddying' system between executive directors and non-executives to give support to those areas where action has to be taken away from the normal approval cycle. This buddying also acts as a wellbeing support to help to ensure that senior leaders do not burn out during the crisis. Once again, there is good practice in evidence that should be retained as the NHS resets.

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.

"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

Questions:

- Have you made any permanent changes to your governance procedures as a consequence of the pandemic?
- How can the planning process be made more inclusive to consider the wider health and care sector?

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. Any future procurement organisation will need to reflect this.

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.

The speed of procurement and the necessity to make quick decisions during the pandemic has led to some concerns about increased incidences of fraud. However, over 86% of respondents stated that they had not needed to put any extra fraud prevention measures in place as existing practice was proving to be sufficiently robust. The rapid dissemination of fraud threats from the centre has been helpful in this regard.

"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

Questions:

- Where should procurement responsibility sit within the health and care system?
- Is there a role for a centralised procurement service?
- How can a 'mutual aid' approach be maintained?

Workforce

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. We are yet to see the final NHS people plan. 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[12].

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 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.

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

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.

Questions:

- Are you anticipating any future workforce capacity issues beyond those that you had prior to the pandemic?
- Are you reviewing staffing models to reflect new ways of working?

NHS finance function

The NHS finance function has worked hard to support the service throughout the pandemic. Many staff have been working remotely, developing innovative new ways of carrying out processes that were previously thought to be impossible away from the office. Some staff have remained on their sites, with some organisations operating a rota system so that all staff had the opportunity to work in both environments. Finance staff have been involved in many aspects of the work to address Covid-19, working with procurement functions, delivering PPE, supporting Covid-19 testing, and working at a system level to carry out scenario modelling. The flexibility and willingness of finance staff to turn their hand to whatever role is needed has been a really positive outcome of the pandemic and demonstrates to other staff groups that finance is not a remote function. The increased understanding of the service that they support will help to develop relationships between finance staff and clinicians, showing that they are working towards a common goal, that of improved patient care. Consideration should therefore be given to including experience of other parts of the organisation in the induction programme for finance staff. This is already part of the NHS graduate scheme, recognising that a broad knowledge of the NHS can support people to perform well in their eventual role and providing resilience across teams.

"Finance staff have worked more closely on the front line or in different areas and organisations which I believe will increase their understanding of the service."

Finance director, STP

Covid-19 hit the NHS at the same time as finance teams were beginning to prepare annual accounts. It is a credit to finance staff that the accounts have been completed and submitted on time, with many aspects being undertaken remotely. The same is true of the audit process which looks quite different for 2019/20 than in previous years, with auditors unable to work on site. Accounts deadlines have been slightly relaxed to recognise the unusual circumstances that they are being prepared under, and this has been beneficial. Grant Thornton has highlighted[13] that the NHS accounts deadlines are tighter than those for any other part of the public sector and indeed weekend working over the period is the norm for many finance teams. It has been suggested that there may not be a great benefit in these short deadlines and a more relaxed timetable could be maintained in future years, although

[13] HFMAtalk, *The 2019/20 audit process and the impact of Covid-19,* May 2020

any change in NHS deadlines could impact on other areas of the public sector due to auditor availability.

Working in different ways has highlighted, or created, a number of areas of good practice for the NHS finance function that should be retained. It has shown that remote working is possible with technology supporting virtual meetings, and a number of organisations are looking to retain that to some extent, supporting work life balance but also looking at the real office needs for the function. There has had to be a focus on the essential activities and many organisations have found that some things that have always been done are just not necessary. Processes have been streamlined as a result and communication has improved. Rather than isolating people, remote working has tended to encourage people to talk more, to share information and value the skills of their colleagues in meeting the needs of the NHS.

"This has proved that we don't need a traditional office-based model. The use of virtual arrangements has been really effective and has focused meetings. I would support far more remote working in the future."

Finance director, community services provider

"We would never have previously managed doing a complete year-end close down and set of annual accounts remotely, but it just shows what we can do!"

Finance director, acute, community and mental health provider

"We have been maintaining financial stewardship in an ever-changing environment whilst approving expenditure much faster than usual."

Finance director, commissioner

Questions:

- Do you have examples of good practice of how the finance function has operated during the pandemic that you would like to share?
- Has the pandemic highlighted any new training needs for people working in NHS finance teams?

Our views

Our views are set out below.

NHS long term plan

- The ambitions of the *NHS long term plan* and the trajectories for achievement must be reviewed to reflect the new starting point that many organisations are at.
- Funding should reflect the services that need to be delivered and consideration should be given to how services can effectively integrate with wider public sector provision to support the needs of the population. 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

- Progress towards integrated care systems should be speeded up and more devolved decision making enabled at a local level. The commissioning function should focus on strategic commissioning in order to improve population health and to strengthen system working. Local systems should take the opportunity to clarify shared goals and determine each organisation's role in achieving them.
- 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.

Future contracting model

- When the business as usual financial regime is established, any national contract model should be on an aligned incentive basis. The current block contract and top up arrangements should remain in place for the remainder of 2020/21 and 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.

Costing

- 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.

Social care

- 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 more 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.

Capital regime

- While the recent changes to the capital regime are welcomed, 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 would require 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.

NHS finance function

- NHS finance teams must take this opportunity to review processes and ensure that non-value-added activity is not reinstated. Agile working practices should be reviewed and maintained where appropriate.

Financial governance

- Governance processes should be reviewed in light of the pandemic and only be continued where they add value to the organisation and its assurance.

Question:

- Do you agree with our views?

  Please access our survey here to share your thoughts on our views and the other points raised in this paper. Thank you.

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.

Acknowledgements

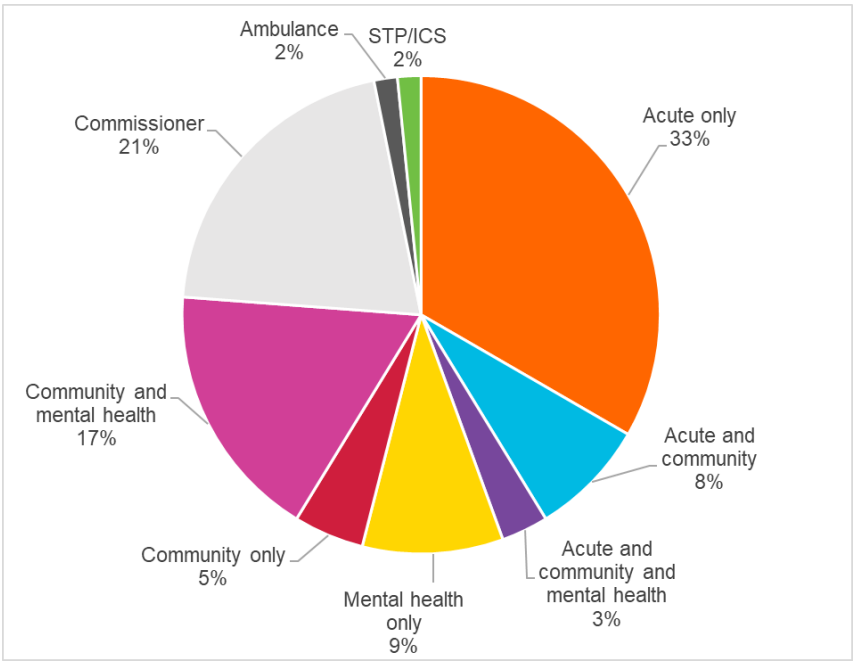
The HFMA is grateful to all those who have contributed to the association's work to support the finance community during the Covid-19 pandemic. All views and opinions expressed in interviews, blogs, podcasts and surveys have informed the development of this paper.

The author of this briefing was Sarah Day, HFMA policy and research manager, under the direction of Emma Knowles, director of policy and research.

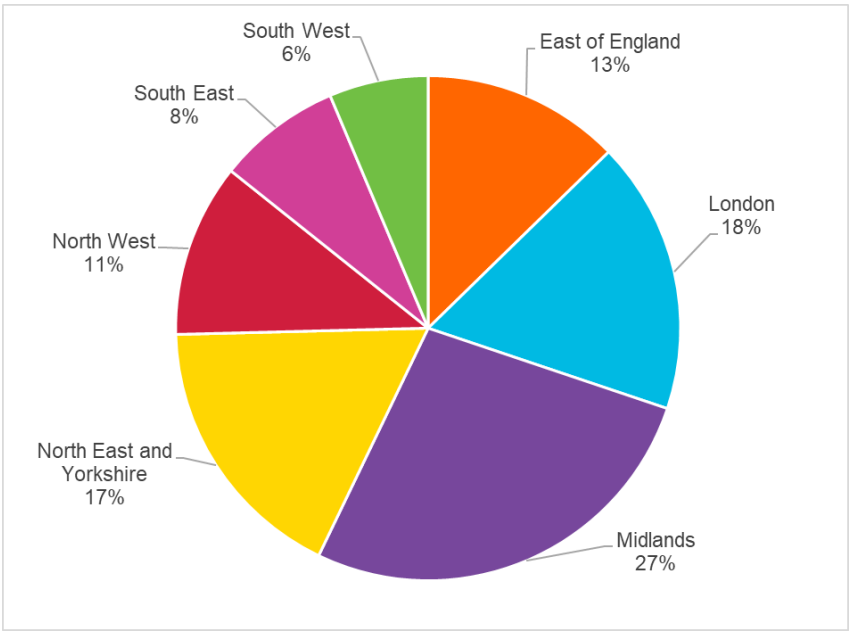
Appendix 1 – graphical analysis of survey responses

A survey of finance directors was carried out between 11 and 18 May asking for their views on changes to the NHS financial regime. 63 responses were received. Not all questions were answered by all respondents. This appendix displays the answers which were not free text.

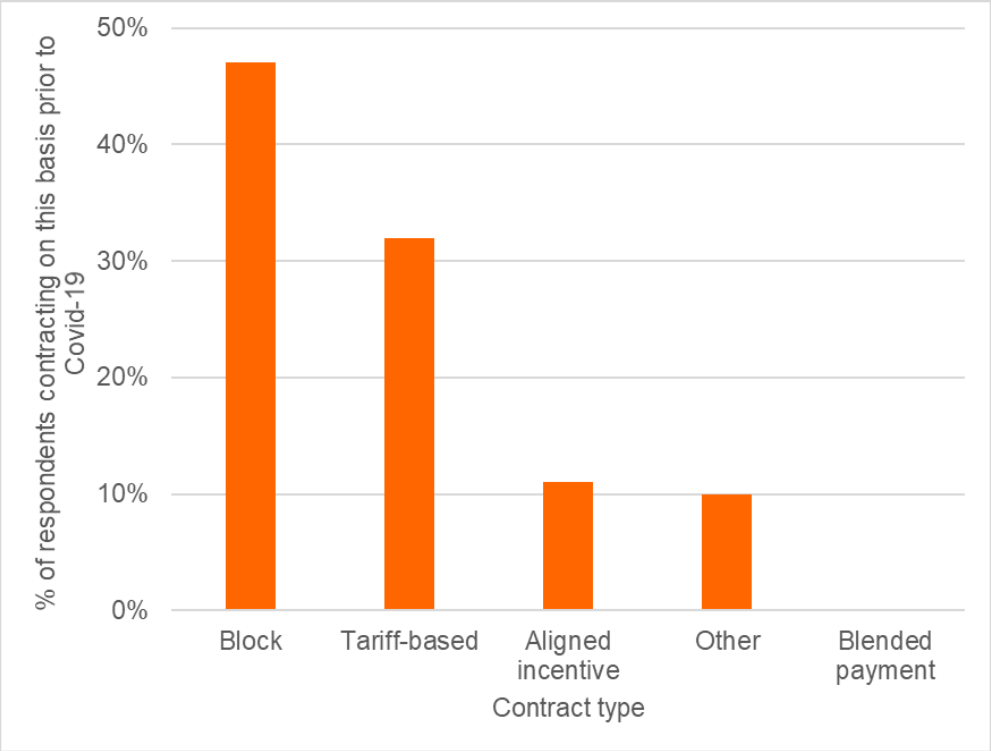
Response by sector



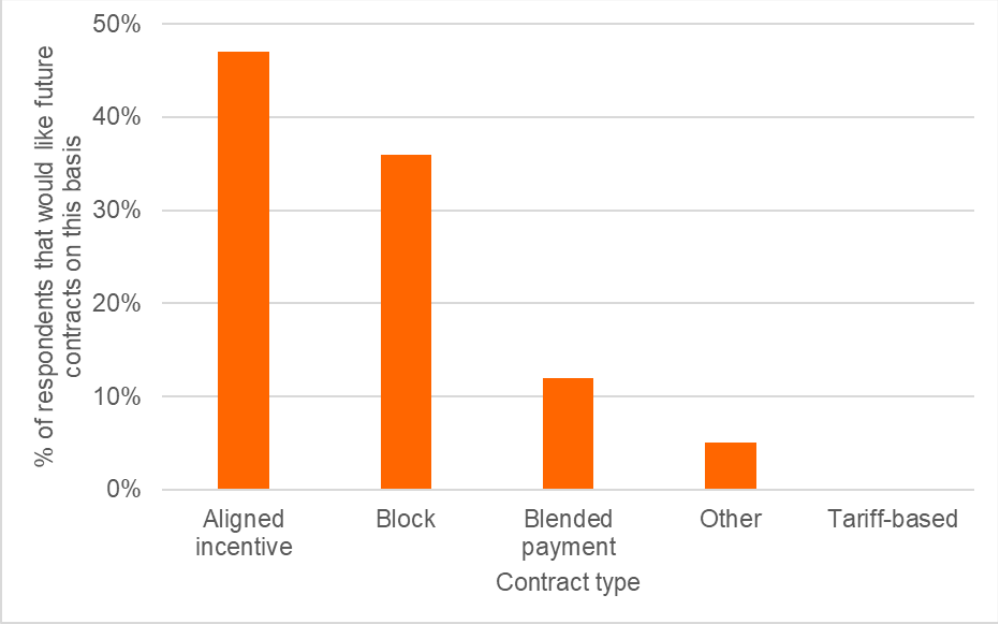
Response by region



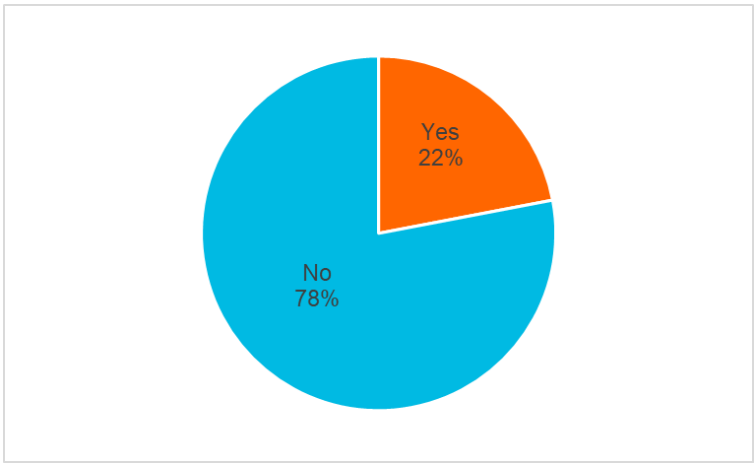
Prior to Covid-19, what type of contract did you operate under with your main commissioner(s) / agree with your main provider(s)?



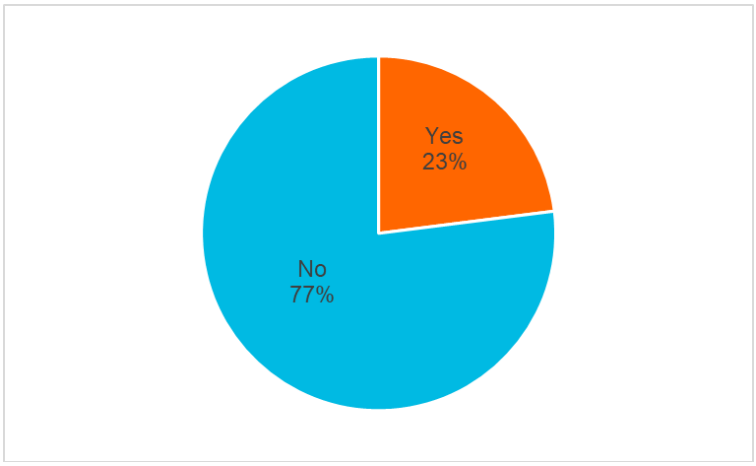
What contracting arrangements should be in place beyond 2020/21?



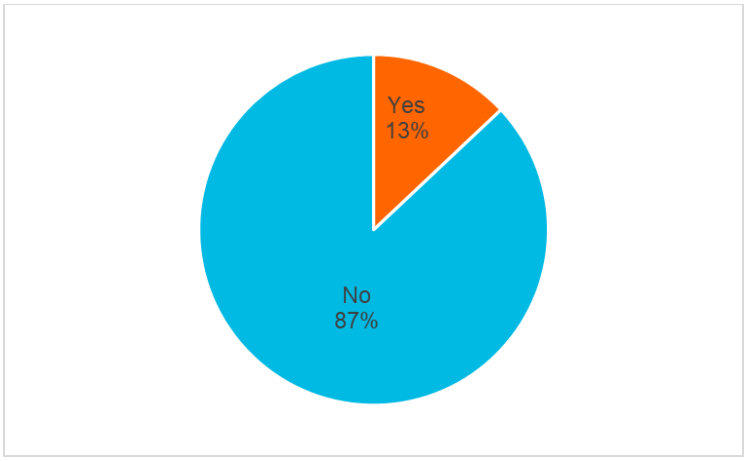
Have you made any permanent changes to your governance procedures as a consequence of the pandemic?



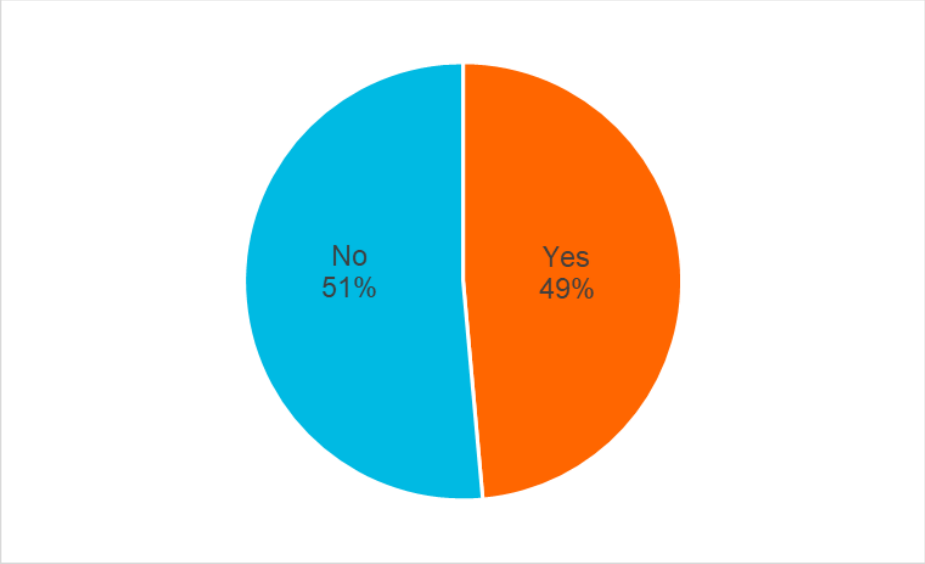
Have permanent changes been made to local procurement processes as a consequence of Covid-19?



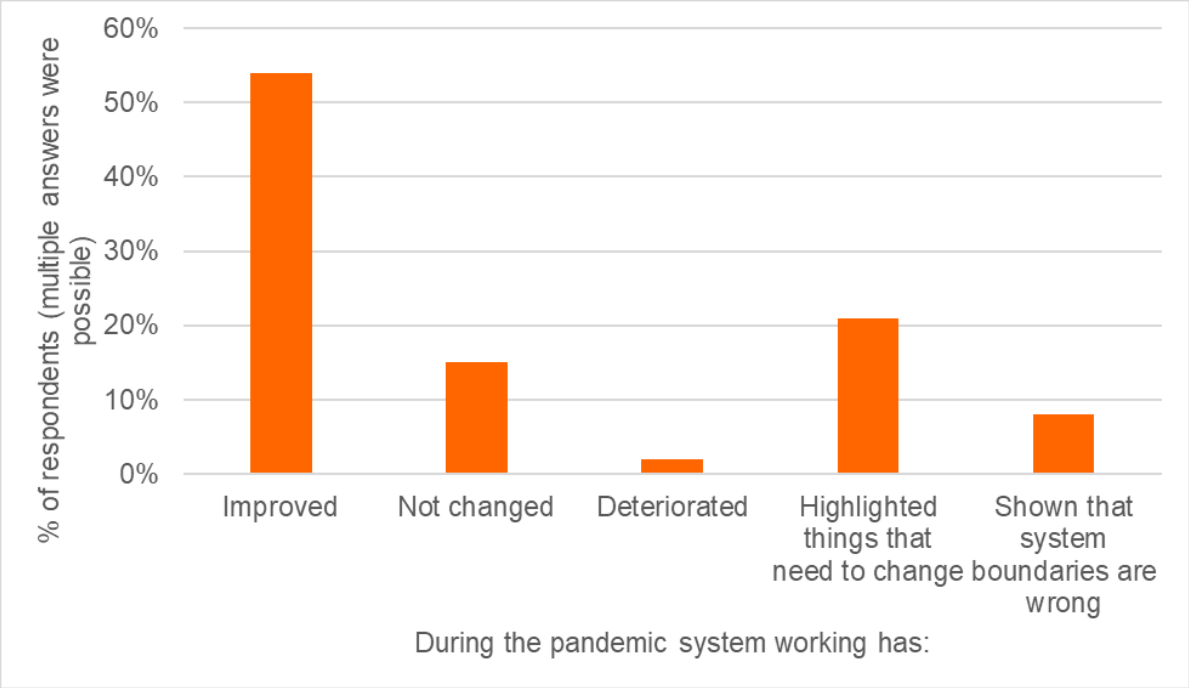
Are changes needed to fraud prevention arrangements to address any changes to procurement processes?



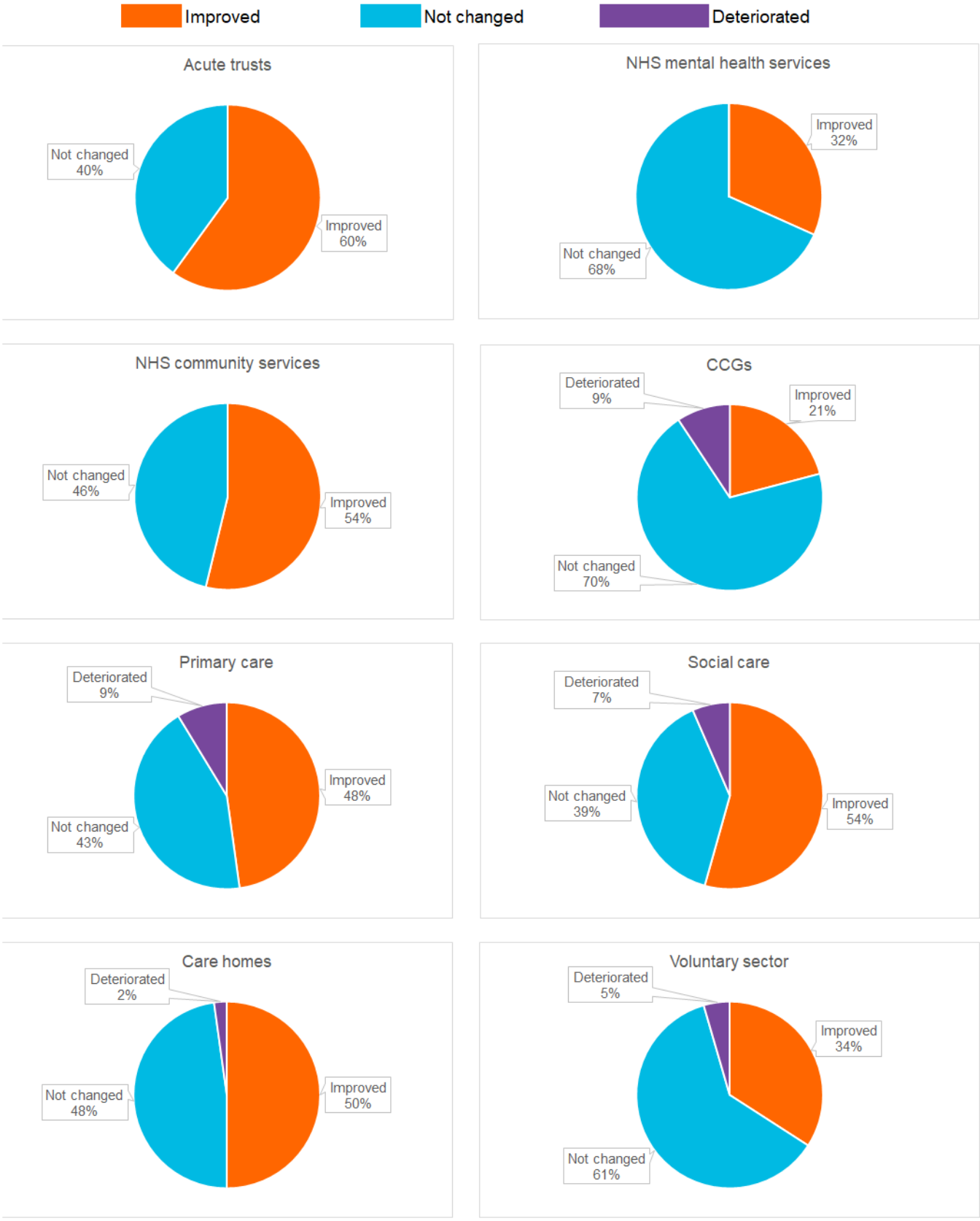
Are you anticipating any future workforce capacity issues beyond those that you had prior to the pandemic?



During the pandemic, system working has:



During the pandemic, how have local relationships changed with:



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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