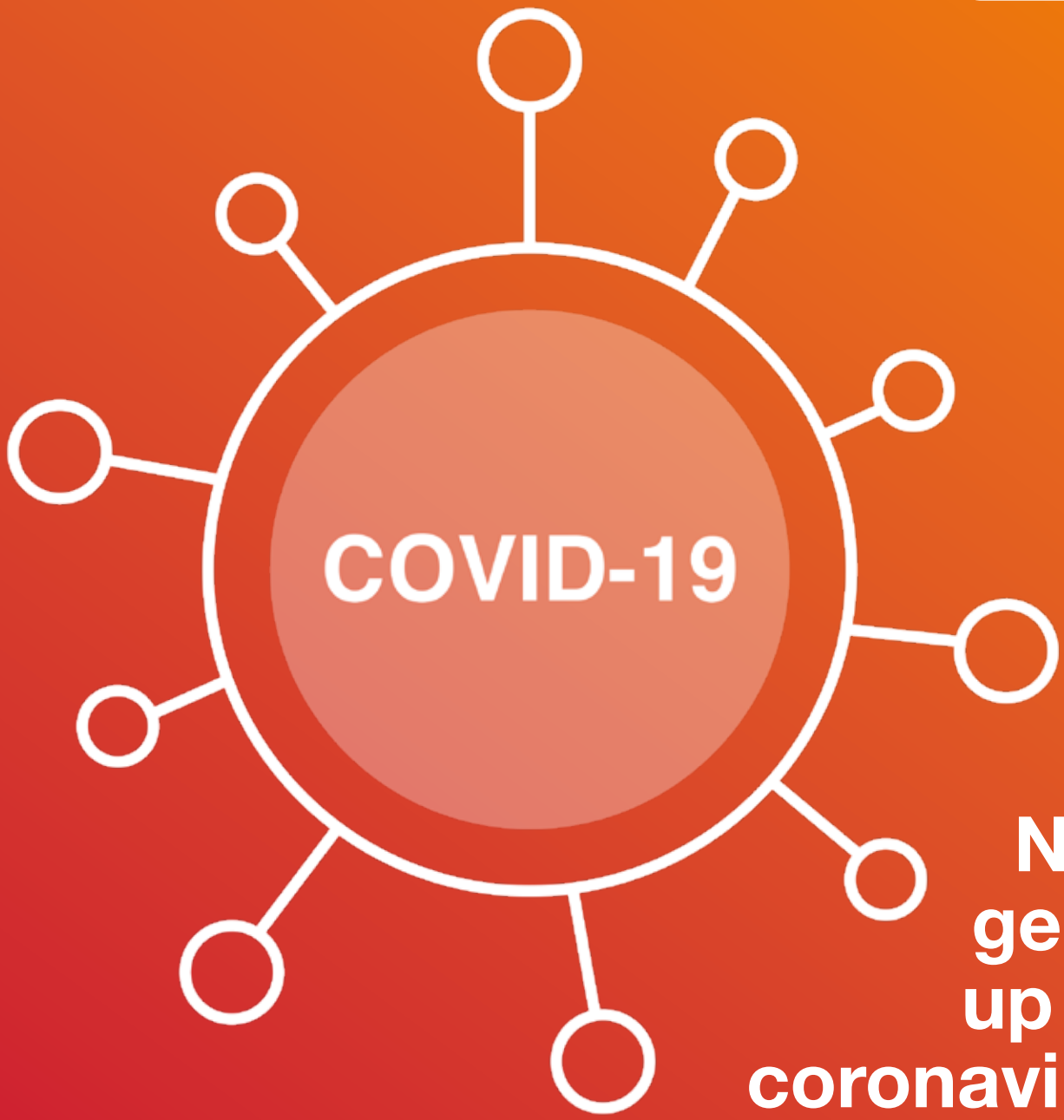
healthcare finance

April 2020 | Healthcare Financial Management Association

www.hfma.org.uk



NHS gears up for coronavirus

HFMA bitesize
CPD accredited online courses

hfma
Academy

Free bitesize courses coming soon!

The HFMA, in partnership with NHS England and NHS Improvement, will be providing all the courses below free of charge to all NHS staff in England.

- Ethical and professional considerations
- Board-level decision-making for value
- How the NHS is funded and structured
- Motivation and relationship management
- Managing conflict
- Influencing and negotiating
- Management and leadership
- Effective communication and presentation
- NHS charities
- Politics, policy and financial challenges
- The fundamentals of governance
- Risk management and governance
- Models of governance in the NHS
- Good governance
- Board assurance and working together
- Health economics
- Information systems in decision-making
- Integration in healthcare

Courses will be available for access through Electronic Staff Records (ESR) from early April 2020 and shortly after available for organisations learning management systems.

To find out more about each course visit **hfma.to/bitesize**.

For further details on how to access the courses please email **bitesize@hfma.org.uk**.

Managing editor
Mark Knight
0117 929 4789
mark.knight@hfma.org.uk

Editor
Steve Brown
015394 88630
steve.brown@hfma.org.uk

Associate editor
Seamus Ward
0113 2675855
seamus.ward@hfma.org.uk

Professional lives
Clare Macleod
0117 938 8358
clare.macleod@
hfma.org.uk

Advertising
Paul Momber
0117 938 8972
paul.momber@hfma.org.uk

Subscriptions and membership
James Fenwick
0117 938 8992
james.fenwick@hfma.org.uk

Production
Wheal Associates
020 8694 9412
kate@whealassociates.com

Printer
Severn Print

HFMA
1 Temple Way,
Bristol BS2 0BU

Executive team
Mark Knight
Chief executive
mark.knight@hfma.org.uk

Emma Knowles
Policy and research director
emma.knowles@hfma.og.uk

Alison Myles
Education director
alison.myles@hfma.org.uk

Ian Turner
Finance director
ian.turner@hfma.org.uk

ISSN 1472-3379

Contents

April 2020

News

Comment

Professional lives

Features

Supporting you through Covid-19

The HFMA is committed to supporting the healthcare finance community through the current Covid-19 pandemic. The Association has already begun to release work to support you in your role and help you to adjust to the new circumstances we are in. The HFMA will continue to keep you up to date on the latest news and support available, this will include:

- Briefings, summaries and responses
- News, articles and top stories
- Online events and webinars
- Podcasts

If you have any suggestions please get in touch, email: policy@hfma.org.uk

Visit hfma.to/covid19 and look out for the Friday signpost email for all the latest news from the Association on Covid-19

News

Finance rules simplified as service focuses on Covid-19 measures

By Seamus Ward

The NHS has welcomed measures that aim to reduce the burden on finance teams as the service focuses on treating patients with the Covid-19 coronavirus.

A temporary finance regime – that will operate for the first four months of the new financial year – was announced on 17 March. The operational and financial planning process for 2020/21 was suspended, as was the payment by results payment mechanism. Instead, commissioners and providers are required to agree block contracts covering the period from 1 April to 31 July.

Funding for providers will be based on a minimum guaranteed income, calculated by NHS England and NHS Improvement, with top-ups based on additional Covid-19-related expenditure.

To help reduce the burden on finance departments, the Treasury has agreed to defer implementation of IFRS 16 *Leases* until April 2021, while the deadline for final submission of annual reports and accounts has been delayed by almost a month.

NHS chief executive Simon Stevens (pictured) said there was no doubt the NHS would come under severe pressure as the outbreak intensifies over the coming days and weeks. The scale of the action being taken was bigger than anything in the service's history.

'I don't think in the history of the NHS there's been anything like it. The nearest parallel I can think of, certainly in terms of the fantastic work being done across London, is the way London hospitals and emergency services came together during the second world war.

'The reality is that is now playing out across all services across all parts of the country,' he told the NHS England and NHS Improvement board meeting in common on 26 March.

'This is a unique moment in the history of the NHS. Every country is being confronted with this and it is putting great pressure on our frontline staff, who have responded brilliantly.'

He added the pandemic was also driving a lot of changes that may turn out to be positive. Changes in the *NHS long-term plan*, such as fewer face-to-face outpatient and GP appointments through the greater use of video technology, were likely to happen more quickly.

"This is putting great pressure on our frontline staff, who have responded brilliantly"
Simon Stevens (main picture)

Senior trust finance staff described the decision to defer the implementation of IFRS 16 as 'sensible' and 'pragmatic'.

Trusts reported that they were urgently developing ways of tracking and collecting costs related to Covid-19.

Finance directors agreed with the need to maintain financial control and reporting so that, when the NHS returns to normal operation, they can account for their expenditure.

The HFMA has moved swiftly to support the finance community, publishing a number of guides and briefings, including on Covid-19 financial governance and a summary of the temporary financial regime.

King's Fund chief analyst Siva Anandaciva (inset) said: 'It's absolutely sensible to take measures that reduce routine burdens and transaction costs, and to preserve cashflow by, for example, moving to minimum income guarantees on account.

'The national bodies have acted quickly, which should be welcomed, so the NHS can focus on tackling Covid-19.'

He wondered if it would be sensible to extend the temporary finance regime until the end of the financial year, rather than trying to operate two systems in 2020/21.

Eleanor Roy, CIPFA health and social care policy manager, said the decision to delay the deadline for audited accounts and the temporary finance regime would give finance teams the flexibility they need to focus on supporting the frontline response.

'This will allow them to ensure that access to money is not obstructing or delaying the response to the outbreak, maintaining essential functions to support the front line, such as payroll and procurement,' she said.

Mr Anandaciva said there may be unexpected insights gained from the enforced break in the financial framework.

'It might highlight just how complex the financial architecture has become in recent years. It could also reveal to what extent this complicated basket of incentives is actually needed to improve clinical and financial management.'

He added that the temporary regime could accelerate some planned changes, such as the move from largely activity-based to blended payments. But he raised questions about whether existing financial targets – such as the pledge that every organisation will achieve balance by 2023/24 – could still be met.

He said: 'We shouldn't automatically assume that the old system, including the Financial Recovery Fund and contract sanctions, should be recreated after the NHS comes through Covid-19.'

NHS Providers has raised a number of issues relating to frontline care, including the need to test staff, allowing a swift return to work for those who are symptom-free but are isolating

continued overleaf

continued from previous page

Covid-19: finance rules simplified

because someone they live with is displaying symptoms.

The NHS has struggled to provide enough PPE (personal protective equipment) to frontline clinicians, although it is understood that the situation improved after 23 March, with the army drafted in to help with logistics.

The board meeting in common heard that supplies had now shifted to a push model – where the centre estimates NHS trust needs and delivers this to them, rather than waiting for the organisations to order supplies.

There has also been some confusion over the type of PPE needed. The board heard that the NHS guidance was in line with the World Health Organisation, but there were some differences. It was important staff were confident in the PPE they were using so the NHS guidance is being independently reviewed, with the outcome available very soon.

- The NHS England and NHS Improvement joint board heard that the number of trusts reporting a financial position worse than plan had halved compared with the same point in 2018/19.

Sunak tops up NHS funds

By Seamus Ward

Chancellor Rishi Sunak allocated an initial £2.9bn to help health and social care tackle the coronavirus outbreak as he promised the services he would give them 'whatever it takes'.

Delivering his first Budget in mid-March, Mr Sunak announced a £5bn Covid-19 fund for the NHS and other public services – almost £3bn will be allocated to health and social care. The Department of Health and Social Care said £1.6bn of the funding will go to local authorities, while £1.3bn will be given to the NHS.

'Whatever extra resources our NHS needs to cope with coronavirus – it will get. Whether it's research for a vaccine, recruiting thousands of returning staff, or supporting our brilliant doctors and nurses, whether its millions of pounds or billions of pounds, whatever it needs, whatever it costs, we stand behind our NHS,' Mr Sunak (pictured) told the Commons.

The local authority funding should be used to relieve pressure on all council services, including increasing support for the adult social care workforce and services for the most vulnerable.

The extra NHS funding is earmarked for enhancing hospital discharge processes – ensuring patients who no longer need urgent medical treatment can return home quickly and safely. The Department said this would help free

RISHI SUNAK: HM TREASURY

up 15,000 beds across England and give hospitals greater capacity to treat those needing urgent care, including patients with the coronavirus.

The Budget also saw an increase in NHS funding. Mr Sunak said that, in addition to the extra £33.9bn promised to NHS England in the five-year funding settlement (up to and including 2023/24), another £6bn would be allocated over this Parliament. He said that this would help meet Conservative manifesto promises, including the creation of 50 million more GP surgery appointments a year and more free hospital car parking.

Budget documents show a £1.1bn increase in the 2020/21 NHS England capital allocation compared with the spending review documents from last September (£8.2bn compared with £7.1bn) The Budget said 'operational capital' would rise by £683m to allow trusts to invest in estates maintenance and refurbishment.

Most NHS staff to avoid pension tax after Budget

A change in the tax regime will prevent senior clinicians and managers falling foul of pension tax rules.

The change – presented in the Budget – was widely welcomed by NHS leaders. They had expressed concern that senior doctors and nurses were refusing to take on extra shifts or leadership roles for fear of being hit with a large tax bill. This affected attempts to reduce waiting times, for example, or destabilised NHS clinical management.

Managers were also being hit with unexpected tax bills. But the government limited temporary measures to clinicians to ensure they did not turn down extra hours this winter.

The HFMA and others had called for a solution that treated all staff equally, pointing out that the tax rules were leading senior managers to reduce hours or seek early retirement. The Budget changes will apply to all staff, as well as high earners in the wider economy.

The pension tax rules affected those with a threshold income above £110,000 a year – this was the most that could be earned before potentially becoming liable for the tax. Those with an adjusted income – which includes threshold income plus their annual growth in pension savings – of more than £150,000 were liable for tax, with the tax-free allowance tapered as adjusted income increased.

But in the March Budget, chancellor Rishi Sunak raised both thresholds by £90,000, increasing the annual income allowance to £200,000 and the taper threshold to £240,000.

'Based on their vital work for the NHS, that will take around 98% of consultants and 96% of GPs out of the taper altogether,' the chancellor said.

NHS Employers chief executive Danny Mortimer (left) said the chancellor's announcement was a significant step in reforming pensions taxation. 'The overwhelming majority of NHS employees will no longer face the uncertainty and distress of the application of the annual allowance taper based on additional NHS earnings,' he said.

'Employers will hope this announcement reassures clinical colleagues so they can agree to undertake additional work without the perverse consequences that have resulted in recent years. The change in the taper will also benefit a wider range of employees, and this is also welcome.'

Clear access standards call

A clear, credible, fully funded implementation plan must accompany potential changes in NHS access standards, according to NHS Providers.

NHS England and NHS Improvement have been considering proposed amendments to urgent and emergency, elective and cancer standards and the addition of broader mental health access measures. But with the focus currently on tackling coronavirus, a final decision has been deferred until later this year.

Proposals for A&E signal a move away from the four-hour target to wider measures, including time to clinical assessment and the average waiting time.

An NHS Providers' report said each clinical area had its own operational issues to consider, such as workforce and IT.

Deputy chief executive Saffron Cordery said: 'There are a number of major operational factors that have to be taken into consideration and will need funding. These include changes to the workforce, which may include additional staff to collect and report on a wider range of standards, and crucially ensuring all trusts are supported to put the required digital capability in place.'

Additional Covid-19 coverage and support

March has seen the country's response to the Covid-19 pandemic ramp up with major restrictions placed on the public aimed at reducing pressure on NHS services. Critical care capacity remains the major pinch point for hospital services, with a new field hospital being set up in London to provide surge capacity and reports suggesting other sites are also being considered around the UK.

Personal protective equipment – and having sufficient quantity in the right places – continues to be a major concern. And there are growing calls for a much faster expansion of both case testing and antibody testing, with NHS staff being the key target.

A temporary finance regime has been introduced with the overarching principle that money should not be a barrier to the care of patients with Covid-19. ***Supporting the front line*** (*page 10*) explains the key features of this new regime and explores how finance is setting itself up for this key support role.

In ***A changed world*** (*page 10*) HFMA president Caroline Clarke reflects on how life has changed in such a short period of time and on the role of finance professionals in this uncertain period. And *Healthcare Finance* editor Steve Brown (***Keep the wheels moving***, *page 10*) underlines the message that the core finance task is to keep the money moving, while also ensuring financial control is maintained and that all spending can be properly accounted for.

Annual accounts still have to be delivered and a revised timetable acknowledges that some finance teams will need more time to achieve this, especially as the finance community is also likely to be operating with fewer staff as the virus spreads. In ***Accounts deadline pushed back*** (*page 21*), HFMA policy and technical manager Debbie Paterson runs through the key steps and deadlines for this year. And on page 22, we also highlight other technical changes aimed at reducing the burden on finance teams and spotlight new rapid guidelines from NICE to support the care of individuals with Covid-19.

HFMA policy and technical

The HFMA policy and technical team has already produced items to support finance practitioners as they gear up to new systems and ways of working. In March, it published a **summary of the coronavirus cost reimbursement guidance** as well as good practice tips for finance practitioners who are now working from home and on how to make the most of Microsoft Teams for meetings. A briefing also looks at **financial governance** issues that NHS bodies need to consider as a result of the Covid-19 changes.

All this material – and the HFMA's subsequent policy briefings related to Covid-19 – will be accessible by all finance practitioners.

As part of its newly launched **podcast HFMAtalk**, the association is also recording a series of podcasts capturing individual perspectives on how the service is meeting the Covid-19 challenge. The series will hear from people working in different regions, sectors and roles. Kicking this off is the first of a regular series from Sanjay Agrawal, HFMA trustee and a consultant in respiratory medicine and intensive care at University Hospitals of Leicester NHS Trust.

As well as continuing to provide further briefings for finance teams on Covid-19 related issues, the HFMA is looking to set up a **forum** to enable finance staff to network and stay in touch – particularly important as many will now be working from home. There are also plans to develop **regular webinars**.

- For all HFMA Covid-19-related material, visit **hfma.to/covid19**
- For the HFMAtalk podcast visit **hfma.to/hfmatalk**

People plan: nurse training must be fully funded

An influential MP has called for the government to ensure that the NHS people plan is fully funded and tackles nurse shortages, after the National Audit Office concluded the service does not have the nurses it needs, *writes Seamus Ward*.

Publication of the people plan has been postponed until later this year under emergency measures taken by the NHS to allow commissioners and providers to focus on delivering care to patients with the coronavirus, Covid-19. The plan is due to set out detail of workforce plans and meet the *NHS long-term plan* ambition of reducing the nursing vacancy rate to 5% by 2028.

An NAO report, *The NHS nursing workforce*, said the health service increased its nursing staff by 5% between 2010 and 2019.

But, between July and September 2019, trusts reported 43,500 full-time equivalent vacancies – the vacancy rate at the end of the period was 12%.

The report highlighted the failure of the government's plan to increase student nurse numbers by removing the nursing bursary in 2017 – with student numbers actually falling. There are now plans to reintroduce bursaries from September.

Commons Public Accounts Committee chair Meg Hillier (pictured) said the need for more nursing staff was being highlighted by the current pandemic.

'As the coronavirus spreads, the importance of the NHS and nurses who look after us becomes ever more apparent,' she said.

'There are 44,000 nursing vacancies. Plans to increase the numbers of nurses starting degrees have failed to meet expectations.

'It takes three to four years for policies to train new nurses to have an impact. The government's people plan must be fully funded and finally start to tackle the real reasons why there are not enough nurses.'

News review

Seamus Ward assesses the past month in healthcare finance

The last few weeks have seen a huge upheaval, with the world increasingly caught up in the grip of the coronavirus, Covid-19, pandemic. At the time of last month's issue, the NHS was looking forward to the new financial year, though the spectre of the virus was beginning to loom. Now, the normal progress of business has been dropped – in England, the operational planning process has been suspended, a temporary financial regime put in place and most non-urgent operations postponed. And all minds are turning to supporting patients with the virus and the clinicians who are treating them.

In this environment it's difficult to get beyond the daily prime ministerial briefings, the number of cases and, sadly, deaths. However, before governments and central bodies started to intervene in mid-March to better prepare the NHS, news not related to Covid-19 continued to flow.

Health Education England has responded to a 6% increase in applications for nursing degree courses by pledging to invest up to £10m in additional clinical placements in 2020/21. HEE's chief nurse Mark Radford said the funding would increase nursing capacity and build on the investment that enabled an extra 1,400 student nurses to start their training in September 2019. He told the chief nursing officer's summit in Birmingham that there would be further investment in learning disability nurse training, return to nursing programmes and supporting nursing associates and apprentices to train as registered nurses.

Local authorities' public health grant will total £3.279bn in 2020/21, the government has announced. In 2019/20, the grant was £3.134bn. A Department of Health and Social Care circular said the ring-fenced grant includes an adjustment to cover Agenda for Change pay costs . This is for eligible staff working in organisations commissioned by local authorities to deliver public health services. The circular also includes an outline of the allocations to be given to eligible local authorities. The NHS Confederation welcomed the news, but, with the announcement made just two weeks before the new financial year, it warned that there was little time to adjust plans.

Also in public health news, the Department of Health and Social Care is to give local authorities £16m in 2020/21 to provide the preventative HIV treatment PrEP. The drug will be available from local sexual health clinics and the funding will support the cost of delivering the service. The Department will cover the cost of the drug. The availability of PrEP is part of the government commitment to reach zero HIV transmissions by 2030.

Stephen Boyle (pictured) has been nominated by the Scottish Parliament to become the new auditor general for Scotland. Subject to the Queen's formal appointment, Mr Boyle will succeed current auditor general Caroline Gardner when her term finishes at the end of June. He is currently an audit director at Audit Scotland, where he leads on central government audit. Mr Boyle is also the appointed auditor of the Scottish Police Authority, the Scottish Public Pension Agency and Registers of Scotland.

The month in quotes

"In the midst of the outbreak, the importance of a well-resourced public health function has never been more evident. It will take time to establish what these allocations will mean for providers and commissioners of public health and community services, and whether the adjustment to cover estimated additional Agenda for Change pay rises for eligible staff will be sufficient.'

Andrew Ridley, chair of the Community Network, hosted by NHS Providers and the NHS Confederation, ponders the adequacy of public health funding

"We are focusing on a number of initiatives to boost nursing numbers in support of the government commitment to 50,000 nurses – in crucial areas including learning disability and district, and investing in supporting new routes into nursing and CPD, as well as encouraging nurses to return to practice.'

Health Education England chief nurse Mark Radford outlines plans to boost the nursing workforce

'The NHS is not some centralised command-and-control state like Bismarckian Germany. It's more like the Holy Roman Empire: a story of fragmentation, duplication and high levels of regional variation. There is no single national NHS back office.'

Health secretary Matt Hancock calls for greater national co-ordination and less duplication in the NHS

'This technology will help people access healthcare advice from their homes – particularly if they are self-isolating because of the virus – while helping the NHS cope with an increase in demand.'

Wales health minister Vaughan Gething hails faster roll-out of video health consultations as part of NHS Wales' Covid-19 response

SHUTTERSTOCK

The Welsh government has approved a faster implementation of video health consultations as part of its response to Covid-19

Fife Integration Joint Board – the body responsible for planning local health and social care services – is facing 'significant and ongoing financial problems, with recurring overspends', according to the Accounts Commission. It said the board had overspends in the past three financial years. The overspends had been covered by NHS Fife and Fife Council, the board's partners. In a report, the commission said ongoing financial pressures are likely to undermine the joint board's efforts to improve services. Although the board had made recent progress, the commission said significant short- and medium-term financial issues are likely to remain until transformation of services can be achieved.

Only a quarter of GPs are satisfied with the amount of time they have to spend with patients, according to the Health Foundation. Its study examined GP satisfaction across 11 high-income countries, and found that only GPs in France were less satisfied with practising medicine and only those in Sweden reported higher levels of stress. Six in 10 UK family doctors said their job was extremely or very stressful, while 49% plan to reduce their working hours in the next three years. The average length of a GP appointment in the UK is 11 minutes, compared with a 19-minute average across the 11 countries.

Putting the 'national' back into the national health service means taking a single platform approach in the way some services, such as the back office, are delivered, and having a consistent set of standards, according to health secretary Matt Hancock. He said the NHS was not a monolithic body, and there is no single NHS back office, for example. Trusts had their own systems for a range of non-clinical services, leading to duplication, and no national data architecture has been put in place. He added that better healthcare lies in the delivery of 'millions of incremental improvements'. However, such changes need strong accountability, the right data, funding and trust.

NHS productivity grew by 1.26% between 2016/17 and 2017/18, according to the University of York Centre for Health Economics. A report updating its examination of NHS productivity with 2017/18 data, said that since 2009/10, productivity had grown much faster than in the wider economy. It said that NHS outputs increased by 1.72% in 2017/18, adding about 0.35 percentage points to the cost-weighted growth rate.

Finally, there has been some speculation that the coronavirus pandemic response could lead to NHS services being transformed more quickly. The Welsh government said it had approved a faster implementation of video health consultations as part of its response to Covid-19. The government said that the new web-based platform would allow those in isolation to have face-to-face care and advice from their GP, while also helping relieve some of the pressure on the NHS. The service, which has been piloted at Aneurin Bevan University Health Board since 2018, is part of the government's £50m Digital Priorities Investment Fund.

hfma

from the hfma

With HFMA members focusing their efforts on helping the fight against coronavirus, Covid-19, the association is seeking to support them in several ways. HFMA director of policy and research Emma Knowles says these include producing a summary of the temporary finance regime for England; feeding back concerns and issues from frontline finance staff to colleagues in NHS England and NHS Improvement; and providing finance staff working from home with tips to help them remain productive and avoid feeling isolated. In a blog for the HFMA website, she adds that all association output related to Covid-19, including *Healthcare Finance* articles and policy and technical documents, are now freely available to all, not just HFMA members.

The operational and planning guidance for 2020/21 has been suspended at least until the end of July, but the NHS is committed to implementing personalised care – a pledge that is sure to be picked up once the NHS returns to normal operation. In a blog, Amanda Hughes looks at making a reality of the commitment to personalised care. Ms Hughes, NHS England and NHS Improvement senior finance, contracts and commissioning manager for the Personalised Care Group, says her group's *Finance, commissioning and contracting handbook* offers tips to commissioners to make it happen.

What do HFMA members in Scotland want from their local branch, asks new Scotland Branch chair Craig Marriott (pictured). In a blog, he says that while the branch annual conference remains successful, the branch should do more throughout the year. He suggests the branch look at different types of events and alternatives to physical meetings. Committee members are considering options and local members are being urged to come forward with training needs and research requirements.

www.hfma.org.uk/news/blogs

Comment

April 2020

A changed world

Clinicians are the frontline of virus response, but there is a big ask of finance teams too

I nearly didn't write this month's column because, like most of you reading, I have been totally immersed in trying to prepare my organisation for the Covid pandemic. I also gave away my laptop today to someone who needs it more – not only are we facing shortages of personal protective equipment (PPE), but also laptops. And then my iPad froze in a really unexpected way, perhaps to remind me I really can't take anything for granted – as if I hadn't learned that lesson already.

HFMA president Caroline Clarke

So, I'm going to take the opportunity to reflect about how quickly life has changed, in such a short period of time, and to reflect upon the role of finance professionals in these times.

Just over a month ago, I was in Morocco for half-term. We knew there was a danger posed by the Covid-19 virus and travel might be curtailed.

I remember coming back to the UK and thinking how brilliant the NHS was because we had such a digital capability compared with the Moroccan system, which was largely paper-based.

At the start of March, my organisation started to realise the enormity of what could happen, but we hadn't really digested it.

That first week in March saw an awful lot of pennies dropping, and it hasn't really stopped since.

I do realise that we are in overdrive, planning for a pandemic and trying to stay a few days ahead of the curve. I also realise that London is seeing this happen earlier and more quickly than the rest of the country,

Keep the wheels moving

Money mustn't be an obstacle to frontline delivery

Healthcare Finance editor Steve Brown

Keep things simple and ensure that money is not a barrier to providing the best frontline response to Covid-19 coronavirus emergency. That is the overriding goal of the new 'temporary' financial regime put in place for the start of 2020/21.

This simplified framework will see the operational planning process replaced with a regime based on block contracts giving providers a guaranteed minimum level of income. All finance team efforts are to be directed towards supporting the frontline.

Other distractions have been removed – the IFRS 16 leasing standard has sensibly been deferred for another year – and timelines for accounts have been adjusted.

But there can be no doubt that the finance community still faces a huge agenda in supporting the coronavirus efforts – see HFMA president Caroline Clarke's comment above.

Cash will be absolutely vital so that hospitals can pay their staff and suppliers. There is a clear message that NHS providers should in fact be looking to significantly improve on existing payment performance for suppliers. Ensuring providers have two months' worth of funding by mid-April should support this aim. But finance teams will need to check that they can keep these functions running in the case of significant increases in staff absences.

Finance staff will also be busy ensuring that capital expenditure is enabled for equipment or modifications related to Covid-19 – the purchase of pods, medical equipment or works that will enable theatres or other areas to be put to different uses. This will be supported by rapid assessment of claims where needed by the centre.

Keep the wheels moving is the clear instruction. Ensure the money isn't an obstacle to the frontline response.

But while there is an emphasis on keeping the money flowing, there is also a clear message that financial control remains vital. Spending decisions have to be quick, but these still need to be taken within a robust financial governance framework.

The lack of plans for this period mean that there are no budgets against which performance can be compared.

But the calculations used to set commissioner funding and provider

"It's a time when the NHS will be at its best, in the worst circumstances. And finance will be at the heart of it"

who we hope will be able to learn from what's worked and what hasn't. And who hopefully won't see the sheer volumes of patients we are already seeing.

While the current ask of the NHS is operational and clinical, there has also been a huge demand on finance teams too. I've seen my chief finance officer, Peter Ridley, move mountains to get PPE, accommodation and new wards into the organisation. What he doesn't know about masks and fit testing isn't worth knowing.

He and I have spent hours bending every rule we know in order to get stuff done to give our patients the best possible care, and to keep our staff safe, and the results have been extraordinary.

I am in awe of some of the things he and the finance team have made happen, and I'm sure that many of you will be doing similar things to support your clinical colleagues.

We're now moving from that initial start-up phase, where everything seems reactive and one-off, to something that will hopefully feel a bit more systematic and sustainable.

The skills of the finance team in making that happen have been fundamental. And I don't think we've lost financial control – we have some clear governance and accountability. We know who's in charge of making decisions and who has the right of veto (if anyone).

Peter reminded me of the work we did under Future-Focused Finance around decision-making – I urge any of you in a leadership position to take a look at the Best Possible Value toolkit, which helps you do the right thing quickly.

This is a time of huge anxiety for all our staff, clinical and non-clinical. Everyone has loved ones and friends that they will be worried about. But it's also a time for us to do the right thing as NHS professionals.

It's a time when the NHS will be at its best, in the worst circumstances. And finance professionals will be at the heart of it, ensuring that we keep the show on the road and that we have a path to recovery.

Contact the president on president@hfma.org.uk

SHUTTERSTOCK

reimbursement will provide the basis of the financial monitoring framework – even recognising that costs are very likely to exceed the baseline assumptions.

The guidance stresses that all costs incurred in responding to the outbreak will also need to be recorded accurately and reported monthly. In part, this will help ensure providers receive adequate top-up funds to cover their exceptional costs.

"While there is an emphasis on keeping the money flowing, there is also a clear message that financial control remains vital"

However, the service will also have to give an account to Parliament about how the money was spent, why it was spent and that it was spent properly.

As finance staff themselves become ill and are forced to take time off work, finance directors will have to find ways to move staff around the team to keep the most essential activities working efficiently.

And there is also the likelihood of staff being asked to take on more general covering roles to support the frontline response.

No-one is in any doubt that the efforts to respond to the Covid-19 coronavirus are being led by the multidisciplinary frontline staff. But this is a team response, with back-office staff all having vital roles to play in what will be a sustained challenge.

Finance staff, with some important specific functions, are a major part of that team.

Supporting the front line

Clinicians and operational staff are leading the service's response to the coronavirus, but finance teams have a major supporting role to play. The finance regime has been temporarily simplified with the key principle that money should not be a barrier to the care of patients, as Steve Brown and Seamus Ward report

The coronavirus, Covid-19, has changed the world. The NHS is now largely geared to addressing this threat, changing the way care is delivered, how money flows through the system and how finance supports the care of patients. It's a fast-moving environment that saw a Budget, which set aside an initial £5bn for the NHS and other public services to respond to the coronavirus, overtaken by events.

NHS England and NHS Improvement have been quick to act – not only taking much-needed practical action to free up beds and increase the capacity to deliver oxygen to the bedside, but also in making wide-ranging changes to financial guidance that supports the NHS response to the virus.

The key message is that finance should not be a barrier to the care of patients with Covid-19. The finance regime has been simplified and greater certainty on the flow of money has been given to reduce the burden on trusts and help NHS organisations support the wider economy by paying suppliers promptly.

The operational planning guidance due to be implemented this month – which sought to speed up the pace of integration and reduce deficits – has been put on the back burner, with the Financial Recovery Fund and associated rules on eligibility suspended.

The Covid-19 guidance frees up managerial capacity. In the short term at least, leaders will not have to worry about implementing the *NHS people plan*, new standards for access to care or the *NHS long-term plan* implementation framework. All of these were due to be published in the coming weeks, but have now been deferred until later this year. The latter will not now be available until the autumn and it is recommended that local plans also be deferred until then.

The finance changes are temporary – initially applying from 1 April to 31 July. Over this four-month period, providers will receive a guaranteed minimum income, reflecting current costs. With the usual national tariff payment mechanism suspended during the period, trusts and commissioners should agree block contracts to provide this minimum monthly payment.

Provider costs

NHS England and NHS Improvement are to ensure all costs are covered while maintaining robust financial governance. Payments will be made 'on account', with top-ups available for any additional coronavirus-related work that has to be done.

The figures for the payment to be made from each clinical commissioning group to their providers have been calculated nationally, based on the average monthly expenditure implied by the month 9 agreement of balances exercise. This figure has been uplifted to account for inflation (pay rises and the clinical negligence scheme for trusts, CNST) and no efficiency factor has been applied. Clinical quality CQUIN payments are included, assuming 100% delivery.

Mental health trust uplifts will include an additional sum consistent with the amount needed to deliver the mental health investment standard.

The block contract for a provider's co-ordinating commissioner also includes a sum for non-contracted activity equivalent to the historical monthly average for this work. Trusts have been told to stop invoicing for this activity for the four months, but to continue recording non-contracted activity in SUS as normal.

As well as the minimum income that will flow through block contracts, providers will be able to claim monthly top-ups, depending on the additional cost of Covid-19 treatment. The guidance says these must reflect 'genuine and reasonable additional marginal costs due to Covid-19'. These costs could include:

- Evidenced increases in staffing costs, compared with the baseline period, that are associated with dealing with the increased total activity.

NHS England and NHS Improvement believe the funding providers receive through the block contracts plus top-ups should deliver a breakeven position in the four-month period

- Increases in temporary staffing to cover higher levels of sickness absence or to deal with other caring responsibilities (such as looking after family members)
- Payments to bank or sub-contractor staff to ensure all sickness absence is covered
- Additional costs of dealing with Covid-19 activity – for example, the costs of running NHS 111 assessment pods; increases in the volumes required or prices of equipment to deal with the response to the virus (where not offset by reductions elsewhere); extra costs of decontamination and transport for the ambulance service; higher testing volumes in acute-based laboratories; and community-based swabbing services.

The top-up claims should be made alongside regular monthly financial reports. NHS England and NHS Improvement believe the funding providers receive through the block contracts plus the top-ups should be enough to deliver a breakeven position in the four-month period. They add that this will be the basis for the monitoring of financial performance.

The first block contract payments from commissioners will be made on 1 April and 15 April, covering both April and May funding. Further payments will be made on 15 May and 15 June. The payment on 1 April will be for the amount already agreed between commissioners and providers. This means that by 15 April, providers will have two months' cash, allowing them to ramp up prompt payment of suppliers.

The guidance adds that prompt payments are vital to ensure that cashflow for NHS and non-NHS providers of goods and services does not become a barrier to the provision of services. The steps described in the guidance should mean that providers' requirement for interim working capital is minimal, though those that do need additional support should apply in the usual way.

Payments made by commissioners under block contracts should not be revised if there are shortfalls in normal contractual performance. NHS England and NHS Improvement note that most NHS providers are exempt from the majority of contract sanctions – but until further notice any remaining sanctions for all NHS providers are suspended.

Most of the guidance focuses on the first few months of the 2020/21 financial year, but it does recognise Covid-19 costs will have been incurred during 2019/20.

For acute and ambulance providers, there will be an initial payment on account for these costs, based on submissions received to date. Commissioners and acute, community and ambulance providers will receive a final payment based on the updated cost template.

Allocations

Commissioner allocations for 2020/21 will not be changed. However, NHS England and NHS Improvement say they will take into account a number of factors when assessing commissioner financial positions and affordability, such as the impact of block contracting. This includes the cost of removing the tariff efficiency factor and the benefit of excluding activity growth from block funding payments.

Commissioners and local authorities are being urged to pool budgets for community-based services – through the Better Care Fund

Finance function

The simplified temporary finance regime will have an obvious effect on the finance function. It shifts the emphasis on to simplicity and certainty with a focus on keeping the cash flowing and the key functions of paying staff and suppliers operating smoothly.

Finance staff have a major role in identifying additional costs incurred in organisations' response to the virus and will also have to maintain financial control while ensuring that purchases are made in a timely way to support services. The annual accounts also have to be completed, albeit to a revised timetable.

The centre recognises that while some teams are well placed to deliver the accounts, others will need the extra time. And as the virus continues to spread, finance departments are likely to have their own staffing problems due to illness, self-isolation or because staff are needed elsewhere to support other critical functions.

A number of burdens have already been lifted – and further requirements or deadlines could yet be relaxed.

The postponement of the implementation of the IFRS 16 leasing standard until April 2021/22 was one change that was widely welcomed.

Some finance directors said their staff were working well from home, with good access to finance systems, others said their access to technology was limited. Many finance staff have already been reallocated to different roles – one costing practitioner said he was supporting payment activities.

As *Healthcare Finance* went to press, an announcement was still awaited on the 2019/20 national cost collection and clarity was also being sought on the next steps in the Costing Transformation Programme.

NHS Shared Business Services, which provides finance and accounting, payroll and procurement services across the NHS said it was focused on ensuring cash was flowing around the system. With 15,000 invoices a day still paper-based, it said it was encouraging suppliers wherever possible to submit invoices electronically.

And with more than 65,000 retired doctors and nurses being asked to return to the NHS, SBS finance and accounting director Stephen Sutcliffe said getting all these new starters onto the system promptly would be a key challenge.

Staff remain a key issue. The Covid-19 crisis is taking place against a background of the NHS already facing high vacancies. And as demand increases, finance directors expected agency and locum costs to rise and were concerned that neighbouring NHS organisations could be left competing for staff and supplies.

On Twitter, former NHS chief executive David Nicholson (pictured) praised the efforts of 'wonderful people' in the NHS, but he was concerned that some agency locum junior doctors were costing £100 an hour.

The Department of Health and Social Care has sought to address these concerns, writing to staffing agencies with an appeal for them to work with NHS and social care providers to ensure agency staff are 'proportionately remunerated', placed efficiently, fully compliant with registration rules and aware of coronavirus guidance.

Covid-19: other measures

The centre's response to Covid-19 has been wide-ranging:

- Freeing up the maximum possible inpatient and critical care capacity – 30,000 or more of the 100,000 general acute beds by postponing all non-urgent elective operations from 15 April for at least three months (earlier if necessary); discharging all inpatients medically fit to leave
- The Care Quality Commission announced it had stopped routine inspections, though it made clear that it could still use its powers in a limited number of cases where harm is evident
- To tackle shortages of PPE (personal protective equipment – such as masks and gowns), the Department of Health and Social Care ramped up deliveries to trusts, enlisting the army to help with deliveries
- The government passed the *Coronavirus Act* – temporary, emergency legislation that includes additional clinical negligence indemnity, allows the speedy registration of healthcare professionals and the suspension of pension rules that would block retired NHS Pension Scheme members from returning to work. There is a potential pool of 15,500 doctors and 50,000 nurses, midwives and nursing associates who have left the registers over the last three years
- A new sick note that can be obtained online, to reduce the pressure on GPs
- Measures to protect GP income, with practices paid on the assumption that they are performing at historical levels
- A deal was struck with independent hospital providers, buying up 8,000 beds across England, almost 1,200 more ventilators, more than 10,000 nurses, over 700 doctors and more than 8,000 other clinical staff.
- A temporary coronavirus hospital, which could hold up to 4,000 beds, at London's ExCel exhibition centre has been arranged. Media reports suggested further facilities in Birmingham, Manchester and Glasgow were also being considered.

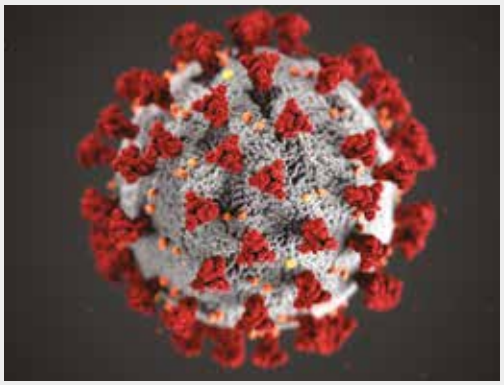


IMAGE: ACENTERS FOR DISEASE CONTROL AND PREVENTION/ALISSA ECKERT; DAN HIGGINS

or section 75 agreements. NHS England and NHS Improvement believe this will avoid the distraction of debates over which organisation is liable for the cost of a service.

The expected reductions in service development investment will also be considered when looking at commissioner finances. This will include the impact of funding transferred between commissioners to pay for the non-contracted element of the block contract, and the cost of additional service commitments, such as extra out-of-hours provision.

Transformation initiatives will be reviewed and, if deemed unable to proceed during the coronavirus emergency, the funding will be redistributed.

NHS England and NHS Improvement are also aware that some commissioners need additional funding to meet their expenditure. These organisations will be given a top-up payment, calculated broadly on the same basis as the FRF, to cover the shortfall.

Governance

While NHS England and NHS Improvement are keen to remove any barriers to treating patients with Covid-19, they also want to make sure organisations retain strong governance. The guidance stresses the need to maintain financial control and proper stewardship of public funds during the coming months.

As a matter of urgency, organisations should review their financial governance to ensure decisions to commit resources to tackling Covid-19 are robust. Staff absences could be significant and the resilience of finance and business functions – especially payroll, accounts payable and core reporting – should be tested, as should the strength of antifraud arrangements. Reasonable costs will be reimbursed, but this was not a signal that financial control was unnecessary during this period. Costs must be recorded as the NHS will have to account for its spending to the National Audit Office and Parliament, once the outbreak is over.

Normal financial arrangements are suspended, so no new revenue business investments should be entered into, unless related to Covid-19

Normal financial arrangements are suspended, so no new revenue business investments should be entered into, unless related to Covid-19 or if NHS England and NHS Improvement agree it is consistent with a previously agreed plan. Providers should agree an approach with the national bodies if costs have already been committed or a body has entered into a contract.

Indicative capital allocations for 2020/21 were due to be released shortly as *Healthcare Finance* went to press and the guidance acknowledges the importance of capital in the Covid-19 response. It will be required to modify theatres, for example, to extend the supply and delivery of oxygen, and to purchase ventilators.

While NHS England and NHS Improvement may bulk purchase some supplies, this will not always be practical or desirable.

Providers and commissioners can access capital needed for their Covid-19 response if the planned spending is clearly linked to Covid-19 care, and if the asset can be delivered or building work completed within the expected duration of the outbreak.

The guidance anticipates that most of the capital needed will be within the delegated limits for commissioners (£10m) and providers (£15m). Public dividend capital dividends will not be chargeable on capital funding related to Covid-19.

The NHS has taken swift action to ensure finance does not prevent services from treating patients with Covid-19, largely sweeping away a financial architecture that has built up over many years.

For now, the finance function focus has to be on helping clinicians get the best services to patients, but it must also cling to the ideal of strong governance and accountability.

For all HFMA materials relating to the Covid-19 pandemic, including a summary of the financial changes and financial governance considerations visit ***hfma.to/covid19***

civica

CP2: Clearly identifiable costs

Level 1 vs Level 2 compliance, why does it matter?

I'm sure you will have been aware of the upcoming changes to CP2 (Clearly Identifiable Costs) for the national cost collection this summer. But what do the changes mean and why do they matter? We have answered some of the questions we are commonly asked by our CostMaster customers.

What will the standard say?

The current draft standard has 2 levels of compliance with CP2.

Level 1 - the lower level of compliance which states the GL is mapped directly to the Collection Resources.

Level 2 - the higher level of compliance, where GL lines are mapped to the national costing ledger and on to local resources for more accurate and detailed costing allocation rules.

Why has it been added in?

Its introduction is to allow trusts and suppliers, who have not been able to fully comply up to this point, a lower level of compliance while the necessary work is completed to reach level 2.

Level 1 – An inferior methodology that involves aggregating costs at source which loses the detail of the GL for costing.

Level 2 – The default for all previous CTP collections. If your system hasn't been able to meet this standard in previous collections then you haven't been meeting the requirements of CTP.

What if I choose Level 1?

To put it simply, your NCC submission is more likely to be audited. Level 1 does not provide enough assurance that costs were in the correct starting position and labelled correctly, or were classified in a consistent way.

How does it impact my costing model?

This has a wider impact than just how your collection will be assessed by NHSI. An accurate costing model needs detailed costs as well as detailed data. Take CPF023 professional and technical staff as an example, you can't group Physiotherapists and Clinical Scientists together into one bucket and expect either to be allocated accurately.

How does it impact my reporting and analysis of costs?

When it comes to PLICS we need to think about the 'C' and the 'I'. You cannot fully understand the costing results if all the costs have simply been grouped at source in the way level 1 describes. Yes you can complete your collection, but the value beyond that is limited. Level 2 compliance provides the detail needed to understand the drivers of cost variation in clinical activity and means that the costing model can be a valued source of intelligence within the organisation on a day-to-day basis.

To find out how you can achieve level 2 compliance, contact us on **healthandcare@civica.co.uk**

CostMaster is fully level 2 compliant

Cycle of improvement

Five years ago, leading US healthcare provider Virginia Mason was brought in to pilot its continuous improvement programme in NHS hospitals, including Surrey and Sussex Healthcare NHS Trust. While it borrows well-known principles such as Lean, the programme amounts to a complete culture change – a shift in thinking that is benefiting Surrey and Sussex. Seamus Ward reports

A few years ago, healthcare providers around the world looked enviously at the quality, efficiency and value gains made in Japanese car factories. Many wondered how their virtuous cycle of continuous improvement could be adapted to healthcare. The Virginia Mason Institute in Seattle is a pioneer in this area, and its work is now being brought into the NHS in England, benefiting patients, staff and the taxpayer.

The NHS signed a five-year deal with Virginia Mason in 2015 to work with five trusts on implementing continuous improvements based on Lean principles (see box overleaf).

One of the trusts – Surrey and Sussex Healthcare NHS Trust (SaSH) – had a troubled recent history in terms of quality and finance. Paul Simpson, chief finance officer, explains that between 2007 and 2010, the trust had a recurrent deficit of around £25m – one of the largest deficits in England at the time. There were significant clinical problems and a high turnover in executive positions.

'When I joined [2007], I was the fourth finance director in a year, so the trust wasn't in a great place,' Mr Simpson says. 'We also had a number of quality problems, so it was not just about the money.'

An external clinical review in 2010 examined improvements in outcomes before a process of rebuilding the clinical structure of the trust. Building on this, the trust received a CQC rating of good in 2014. 'At that point, we were circling around financial balance and we looked at what we needed to do to take us further,' he adds.

The next step was applying to be part of the Virginia Mason programme. SaSH was successful, becoming one of the five trusts confirmed to take part in the five-year programme.

The trust's work with Virginia Mason has been named SaSH+, with a focus on the Japanese philosophy of Kaizen, or continuous improvement.

There is often some confusion between Kaizen and Lean, and in truth there are overlaps and similarities. Sometimes the terms are used interchangeably. Kaizen requires culture change. It is a mindset that seeks to eliminate waste and variation through focusing on good processes, data, teamwork and staff engagement. It often targets small changes, though not exclusively. Organisations that adopt Kaizen often use Lean tools, which systematically focus on the removal of waste and anything that does not add value.

Sue Jenkins, SaSH director of Kaizen, says the trust board saw the Virginia Mason programme as an opportunity to make further gains. The trust's previous work on safety, quality, patient experience and outcomes provided a platform for entering a programme of continuous improvement, she adds.

Mr Simpson says the NHS Trust Development Authority (TDA – one of NHS Improvement's predecessors) wanted to get five different trusts on the programme.

'SaSH was improving and the TDA wanted to see how we dealt with the Virginia Mason programme. The other trusts were all in different places and the idea was to see how the development and support from Virginia Mason would work in different situations.'

Training programme

The trust was admitted into the programme in late summer 2015. Ms Jenkins and a colleague – chosen by the trust board to oversee the work – visited Virginia Mason in October that year for their first training sessions.

The training is tough, with two modules over six weeks covering the concept of Lean and improvement methodologies. There are 12 assignments in the six-week period, and all must be passed before the candidate is certified. Not only did this accreditation give them the skills to set up and run the SaSH+ Kaizen programme office (KPO), but also to train and certify colleagues locally.

Ms Jenkins, who is now a Kaizen specialist following her training,

SHUTTERSTOCK

says: 'The training with Virginia Mason offers a teaching certification – my team and I are able to use that to help people become experts in the SaSH+ methodology.'

SaSH+ consists of three main components. These are:

- Trust-wide improvement schemes – there are six value streams, including diagnostic imaging, and the trust is planning to launch a further eight streams soon
- Building capacity and capability around improvement tools, including Lean for leaders. This is a year-long training programme that is optional for existing staff. However, it is a requirement for new staff in leadership roles who are expected to sign up within six months of joining the trust
- Genba walks for leaders – allowing them to see what's happening at the front line and give staff the opportunity to raise concerns or suggest improvements.

Value stream workshops

The value streams for the major projects are facilitated through five-day rapid process improvement workshops (RPIWs). These involve around 12 staff and three or four workshops are held each year per value stream.

The sessions begin with validating KPO data on areas such as activity that has been collected during a six-week observation period with the clinical team. They then go on to ask the staff to generate ideas for improvement. The metrics are examined 30, 60 and 90 days later to ensure that the project is delivering improvements.

The trust holds between 12 and 16 RPIWs a year, each one focused on a particular ward or department, with roll-out across the organisation. In the management of diarrhoea value stream, for example, there were six workshops, which came up with 21 improvement ideas that are being rolled out across the organisation.

Ms Jenkins says it is often the case that given the chance to shift their focus from getting the day-to-day job done – and given the permission to offer improvement ideas that can be tested – staff question and improve the basic elements of the processes they carry out each day.

For example, every patient was routinely sent for a blood test before a CT scan. The diagnostic imaging value stream saw an opportunity for better care, greater efficiency and potential savings.

"The RPIW was seen as an opportunity to reduce waste, make a positive impact on patients, improve referral times for CT scans and reduce haematology costs. It was win-win"
Sue Jenkins, SaSH

'The evidence from the RPIW was that we can reduce the number of blood tests by 75% – we have 38,000 CT outpatients a year,' Ms Jenkins said.

'The response was great, and it was seen as an opportunity to reduce waste, make a positive impact on patients, improve the referral times for CT scans and reduce haematology costs. It was win-win.'

She adds that the implementation is probably the trickiest part of the process, but the trust has done this well. 'Virginia Mason has been seeking our ideas on how to do the roll-out because we have tied the process into our governance, and it is signed off by our clinical effectiveness committee before it is rolled out.'

Mr Simpson acknowledges that implementing a roll-out is not always plain sailing. In one department that was not part of a value stream, the roll-out failed. He says this was due to some of the clinicians fearing change and how it would impact on their day-to-day work. The trust is now looking at other techniques to improve the department.

'The process is hard work and isn't always successful, but failure is recognised as an essential part of learning. It's about recognising the point at which the individuals involved are not going to do it.

'We operate a broad church. A lot of people talk about turnaround versus Kaizen and we are not saying that turnaround doesn't work.'

He adds that the Kaizen approach works, in general, at the trust, but others may find different approaches more beneficial.

The improvement workshops can mean taking staff away from their duties for five days, which potentially has an impact on frontline care. Mr Simpson says the trust has experienced issues with backfilling. The estates department, for example, argued that it could not release staff for the workshops as it could not afford to back fill.

'I think there has to be some accountability and divisions need to think about how they will back fill,' he says.

Ms Jenkins adds: 'We have never had to cancel a workshop because the right people were not in the room, even during the junior doctor strikes. It is seen as important and continues to be a priority for the organisation.'

Mr Simpson continues: 'We employ clinicians who bring substantial expertise with them and we need to allow them the time to do this and then harvest their contributions.

'It's been tough – as it has been for hospitals everywhere. Our A&E attendances increased by 10% in the last 12 months. There are a few financial issues, but we are helping staff to feel supported and enable them to contribute to managing these issues.'

"The Lean for leaders course is very hard work – the drop-out rate is about 20% – but it's intended to reach the greatest number of staff"
Paul Simpson, SaSH

Releasing time and costs

Departments have been able to release time by applying the SaSH+ principles – 7.5 hours of clinical time per week for cardiac clinical nurse specialists, for example, by revising their administration procedures.

As well as releasing time, SaSH+ has helped avoid costs. In one case, while waiting for funding to procure a new electronic patient record system, the trust looked into optimising the effectiveness of the medical records department. The initial outcome suggested that six new staff members would be required – although according to the records team, only three new staff were needed.

Having personally completed the Lean for leaders course, Mr Simpson says: 'It's very hard work and the drop-out rate is about 20%, but it's intended to reach the greatest number of staff.'

Around 200 SaSH staff have passed the programme and a further 100 are currently taking the course.

An orthopaedic consultant who took the course used a Virginia Mason technique called 'rooming in' to re-examine the flow of patients in his hand clinic. He realised he was doing a lot of the admin for each new patient and as a result was seeing 12 patients in each clinic.

Now, a physiotherapist sees the patient, takes their history and presents that to the consultant, who decides on the best course of action. The number of patients seen in a clinic has now increased from 12 to 25.

The Genba walks are a vital part of the executive team's work, Mr Simpson says. 'We talk to staff about what they are doing; giving the executive team more contact with the front line, concentrating on what matters and what's going on in the organisation.'

Ms Jenkins adds: 'SaSH+ is a management system with a quality improvement model that allows all staff to practise Kaizen continuous improvement. We are building capacity and capability. Lean for leaders is one example of this and is probably the most successful partner package that came from Virginia Mason.'

She insists that SaSH+ and its embedded Lean principles are not just for senior managers, but for all levels of the workforce.

A variety of training programmes are offered, including half-day taster sessions, where some of the basic principles of Lean are taught, to one-day and more advanced programmes. This gives staff the appropriate level of skills to bring about continuous improvement in their working spaces and practices. 'We have tried to develop our education offer so all staff can access the right type of training and apply what they have learnt,' Ms Jenkins adds.

Staff often tackle the issue of cupboard space, both in terms of fitting in supplies and how they are organised so they can be found quickly – which can be time-critical – once they have been on a SaSH+ course.

Mr Simpson says it is important that training and rapid process improvement workshops are not top-down events.

'We have found that the sessions create time for individuals to form their own networks, speak the same language and see the changes being made. It's all coming from staff themselves and that's the key thing. I can think of examples of things that didn't work when they were rolled out because there's a risk of the NHS telling people that they have to get on and do it, because that doesn't always work.'

Trust ratings

Mr Simpson believes that the success of SaSH+ can be demonstrated in the trust's national staff survey results, where it was rated one of the best in the country among comparable acute trusts. Some 65% said that the trust had a positive safety culture and, with a total of 99% of nursing posts filled, agency nursing costs have been minimised.

'The language is really important here,' he says. 'It's been demonstrated that when an organisation talks about waste, it covers a range of things – not just money, but how long it takes to do something; is it necessary; and are there steps or processes that you are duplicating elsewhere?'

Clinicians and managers must ensure they are speaking the same language when they are speaking about internal matters or across systems, he adds.

The five trusts working with Virginia Mason must share their learning as part of their involvement in the programme. The Surrey and Sussex trust holds quarterly open days for other organisations and is helping local health bodies to improve.

It has also been enlisted to help develop the national improvement framework and is anxious that continuous improvement methodology

becomes one of the framework's key elements.

Mr Simpson says that it's difficult to share the trust's improvements simply by speaking about them – other bodies need to be involved in the work to truly understand it.

He adds: 'You also need time. There's a view that we can make changes immediately, but if you are going to transform the NHS, you have to understand that it takes time. And you have to understand the opportunities and get people at every level to change how they do things. However, the rewards are substantial.'

The potential benefits are underlined in the trust's latest CQC assessment (January 2019), which moved the trust from good to outstanding for quality and use of resources.

'I don't think we would have achieved that without the SaSH+ process,' he says. 'It's difficult to connect the SaSH+ work with money – we had a £13.6m surplus in 2017/18, with the PSF, a surplus of £11.6m in 2018/19 and are on target to deliver a £7m surplus this year.'

The trust has low reference costs and among the lowest cost per weighted activity unit for an acute trust. Though a number of factors affect these figures, Mr Simpson believes SaSH+ has played a significant role. 'SaSH+ has helped to turn us from good to outstanding.'

What is Kaizen?

Virginia Mason has been following the concept of Kaizen, or continuous improvement, since the turn of this century and has used it to become one of the top providers in the United States.

Kaizen is about changing culture over time and moving the current provision to an ideal state.

First, a baseline must be set by identifying what needs to be done to perform a specific task. Is a process currently being undertaken necessary?

It then requires two further questions – how should the work be done and how long should it take?

Once an improvement has been made, the new standard forms the baseline for further levels of improvement – this way, continuous improvement can be delivered.

These questions can be answered in rapid process improvement workshops, using the experiences of frontline staff to identify waste and better ways of doing things.

Language is important and waste reduction tends to strike a chord with frontline staff.

'You don't come at it from the point of view of reducing costs or becoming more efficient. That doesn't work with clinicians or 99% of staff,' says SaSH director of Kaizen Sue Jenkins.

Instead, you must use data to demonstrate to clinicians how the service is operating day-to-day.

'When staff come together, they can talk about the things that are going wrong or what demand is looking like or interactions with other parts of the trust,' says Ms Jenkins. 'Another key principle is respect for people – both patients and staff.'

Other improvement methods are used across the NHS, including Six Sigma, which uses a framework and statistical tools to understand and reduce variation.

Both Kaizen and Six Sigma are often combined with Lean techniques to deliver improvements.

In 2018, the NHS announced that a further seven trusts would be taking part in a three-year Lean programme that builds on the partnership with Virginia Mason, and other health service programmes, such as those in Western Sussex Hospitals and Royal Bolton Hospitals trusts.

All acute trusts are now calculating the costs of their activities at the patient level. And there are also a number of mental health and community providers that have switched to this more granular level of costing. However, this just gets providers to the starting line – the point of having patient-level cost (PLICS) data is to use it to inform decisions about clinical practices and to drive improvement.

This is where the Engagement Value Outcome framework – or EVO for short – comes in. Developed by the HFMA's Healthcare Costing for Value Institute with Future-Focused Finance, EVO helps trusts to put PLICS data to work with the ultimate aim of its use being business as usual, just part of how services are managed.

There is broad agreement – in theory at least – that patient-level cost data can inform service improvement, but how do you put this into practice and make it part of business as usual. Steve Brown reports on a programme that aims to help providers do exactly that

It does this by providing a trained facilitator to run a number of workshops with multidisciplinary teams made up of clinicians, service managers, finance and informatics staff working in and supporting specific specialties and services.

Four trusts – two acute, one mental health and a community services provider – last year piloted the approach, each running the process in three separate service areas.

The results and feedback from those

pilots are being published in four separate case study briefings. Two are available now (Gloucestershire Health and Care NHS Foundation Trust and North Staffordshire Combined Healthcare NHS Trust), while two further studies (University Hospitals Birmingham NHS Foundation Trust and Great Western NHS Foundation Trust) are due to be published shortly.

The four trusts had different starting positions and different contexts, but there were some common themes in their assessment of the programme. All reported that the EVO work helped strengthen working relationships between clinicians and finance staff – a major result in itself, providing a robust platform for further work.

And there were numerous comments about clinicians starting to understand what all the fuss is about – how patient-level information and costing data can really provide them with a useful window on their work and help them to understand variation and address it where necessary.

"The biggest thing about EVO was getting everybody committed to being around the table for two hours … that is so much productive time"
Jenny Richards, Gloucestershire Health and Care NHS FT

'The biggest thing about EVO for us was the discipline it affords in terms of getting everybody committed to being around that table for two hours in three separate slots,' says Jenny Richards, senior planning and costing manager at Gloucestershire Health and Care NHS Foundation Trust, one of the pilot sites.

'That is so much productive time and the amount of benefit you can glean from that skillset around the table has moved us forward hugely. That's not just in our understanding of the data but also our relationships across the clinical and non-clinical borders.'

Commitment pays off

She is clear about the commitment needed. There is a lot of work involved in supporting the process – especially for the costing and informatics teams in getting the data together for each session. Trusts embarking on the EVO framework themselves need to ensure they have resource put aside to cover this.

But she says the effort has been worth it. The trust is currently rolling out some of the improvements identified during the sessions and is now embarking on its first mental health service area, running the process solo without external EVO support.

That is the aim of the programme – to help trusts kick-start the process of using PLICS data to understand current practice and identify opportunities for improvement.

SHUTTERSTOCK

Gloucestershire Health and Care is no stranger to patient-level costing or to clinical engagement. The winners of the 2019 HFMA Costing Award, the trust has a track record of developing costing and working closely with clinicians to refine the quality and accuracy of its data. Even so, Mrs Richards says EVO moves them to the next stage.

'We all believe in the data, but to get to the real nugget of clinical variation, do we have enough insight in the data? And if we don't, can we get it?'

The trust explored three areas – allied health professionals, diabetes and wound care. Work on allied health professionals built on an earlier project in the Cheltenham locality (one of five areas covered by the trust). This had attempted to improve recognised data issues in therapy and district nursing services.

It led to more detailed recording of activities. For example, therapists had typically logged contacts with patients simply as physiotherapy or occupational therapy. But a new template was introduced that enabled therapists to provide details around the specific interventions delivered.

'EVO gave us protected time to properly analyse what that data was showing us,' says Mrs Richards. 'And because we had the right people in the room, we got way more out of it than we would have without EVO.'

The EVO group also further refined the data that was being collected, getting rid of a catch-all 'long-term conditions' category and forcing practitioners to provide a more precise description of the activity.

Other trusts undertaking the EVO programme should expect to find that sometimes they don't have the data at the right level of detail to help them uncover value.

But there are still insights that can be gained with the available data. Identifying the data you need – and having everyone bought into fixing it – is a successful outcome in its own right.

Arguably, the most progress the trust made was in diabetes, where the data clearly demonstrated that diabetes patients' dependence on other services, such as district nursing, tissue services and podiatry, was as much as six times greater than non-diabetic patients. However, diabetic patients who had previously received a structured education programme that helped them to take control of their diabetes made far less use of these services.

Patients aged 45 to 64 not receiving the education programme cost 50% more on average than those with the education – 30% more for those aged 64 or over. The expansion of the education programme offers the potential to reduce demand for other services and, on the back of the EVO analysis, a business case is now being produced to do exactly that.

Staffordshire progress

North Staffordshire Combined Healthcare NHS Trust is one of the main providers of mental health, social care and learning disability services in the West Midlands. It is one of only two specialist mental health trusts in the country to be rated 'outstanding' by the Care Quality Commission. And in March, a report from the CQC applauded the trust for the way it had sustained its improvement trajectory.

The trust started implementing PLICS in 2015 and now has a well-established system in place (winning the HFMA Costing Award in 2016). It has developed a standard PLICS dashboard and the costing team has its own Activity Information Dashboard (AID). This enables the team to present data in a user-friendly way, tailored to the needs of services.

While the trust had already started rolling out the use of PLICS, EVO was seen as a good way to encourage trust-wide interest in PLICS.

One of the areas chosen for the programme was crisis care, and the first workshop demonstrated how specific patient costs could be extracted and used alongside activity metrics to highlight variations.

The EVO group – made up of costing, finance and performance staff as well as the acute and urgent care directorate's service manager and modern matron – decided

to explore three areas. These included: the home treatment team; the access team; and e-rostering.

The home treatment team helps avoid admission to inpatient wards. But it also works with people in hospital as they prepare for discharge and then supports them as they make the transition back into the community.

"There's the importance of conversation. How many times do we have a strict agenda in meetings, which means you don't get conversation?"
Clara Day, University Hospitals Birmingham NHS FT

In particular, the group wanted to test out the impact a home treatment intervention during a ward admission had on the length of inpatient stay. The PLICS analysis in fact showed that the overall average lengths of stay and costs for people was similar for people with and without a home treatment episode (not including the costs of the home treatment intervention).

The group discussed this apparent lack of impact. Some of the patients may not have been suitable for home treatment, it suggested, such as someone with relationship problems or someone admitted from a care home.

There could also be a cohort of patients in the data who had a number of readmissions and may not have received a home treatment intervention for each admission. However, regular readmissions could indicate that the pathway isn't working as well as it could.

A review of an individual pathway for a patient with a pattern of admissions and discharges led to a conclusion that the patient may have been discharged too early, with a lack of input from the care co-ordinator. Looking at an individual's pathway through AID was seen as a great way to visualise the care given and to start to understand if a pathway is working.

Overall, the group agreed to review communication between the home treatment team and wards and ensure patients completed or updated risk assessments before discharge. There was also a commitment to explore how effective home treatment was for people readmitted to a ward.

Before the EVO pilot, the trust was not collecting information on inpatient dependency and the group were keen to see if the new e-rostering system could be used to record staffing levels needed for each patient on a ward. Seven dependency measures were used, ranging from general observations up to a single patient needing three staff to care for them, and a census was carried out three times a day on the pilot ward.

Analysis showed that actual staff hours on the ward (for older adults with organic diagnosis and complex needs) were consistently lower than the numbers calculated using the dependency census data.

The data will inform discussions with commissioners, alongside other benchmarking data (showing the wards' below average bed day costs), and the outcomes of safer staffing reviews. One clinical director said that 'without information like this, complexity and acuity are just words in a sentence'.

Overall, the directorate clinicians involved in the EVO pilot were very positive about the skills of the costing team and the tools they use to present data. They particularly highlighted the visual presentation of the patient pathways, clearly demonstrating the complexity and, occasionally unco-ordinated nature of pathways for individual patients.

Birmingham merger

University Hospitals Birmingham NHS Foundation Trust was one of the acute pilots on the EVO programme, with a focus on dermatology, trauma and orthopaedics and vascular surgery. Its 2018 merger with Heart of England NHS Foundation means that the trust now has five major hospital sites – including the Queen Elizabeth Hospital; Heartlands; Good Hope; Solihull; and the Birmingham Chest Clinic.

This merger has already prompted a major review of clinical services to streamline and consolidate activities and address unwarranted variation. Participation in EVO was a way of supporting this process.

Clara Day, nephrology consultant and associate medical director of finance at the trust, told the HFMA annual conference in December that there were four lessons from the trust's experience with EVO. 'Don't underestimate the importance of proper time – that's external project, executive-sponsored, three-line whip time – people have to attend,' she said. 'Second, the data used in improvement is not the same as data used in research, but it is good enough.'

She said this was a particular aspect with which clinicians needed to be comfortable, although she warned that data needed to be presented in ways that clinicians found easy to process. Pictures not pivot tables, she suggested. Clinicians involved in the project at UHB now characterised the patient-level approach as providing information rather than just data.

'Number three is the importance of conversation,' Dr Day added. 'How many times do we have a strict agenda in meetings, which means you don't get conversation and dialogue?'

Finally, she said, the information and insight had to lead to action. 'Data shows you where the variation is, but you've got to put it into business as usual and translate it into transformed healthcare.'

The EVO has had successes at all four of the pilot sites. Perhaps its biggest achievement is in strengthening relationships between clinicians and their finance and informatics colleagues.

Even where good relationships already existed, it has brought the communities closer together and the protected time in each other's company has enabled real discussions to take place. The detailed data provides opportunities to back best guesses about causes and impacts of different activities with hard fact. Or in cases where the data is not detailed enough to do this, it provides a clear indicator of what data would be necessary to deliver that insight.

A second wave of the EVO programme is currently being planned, taking on board lessons learnt from the pilot programme. The start date for this is uncertain, given the extreme challenges facing the NHS as a result of the Covid-19 coronavirus pandemic. However, the results so far suggest that EVO offers a practical way to get trusts using patient-level cost data to inform service improvement and to put the theory of value-based healthcare into practice.

For a summary of the EVO pilot and cases studies on the pilot sites go to hfma.to/evo

hfma
professional lives
Events, people and support for finance practitioners

Accounts deadline pushed back in response to Covid-19 pressure on NHS

Technical

Usually, at this time of year, this piece would set out the key issues when preparing the annual report and accounts and most of these would be known in advance. This year is different and the mechanics of preparing the annual report and accounts has become a key consideration, *writes Debbie Paterson*.

NHS England and NHS Improvement have issued an amended timetable for the submission and audit of the accounts and have signposted where more guidance is being prepared.

All provider and clinical commissioning group draft accounts are now due for submission on 27 April, two weeks later than usual, but this can be extended to 11 May by providers if they wish. This recognises that some NHS bodies are keen to get on with the process, but others are going to struggle where they have fewer staff available and where home working is less easy.

Those providers that elect to use the later deadline will still need to provide agreement of balances information on 27 April. Equally, those providers submitting their draft accounts on the earlier date will have to provide updated agreement of balances on 11 May.

Therefore, providers will need to decide the deadlines they will work to.

For everyone, the audited accounts are now due to be submitted to NHS England or NHS Improvement on 25 June.

The annual accounts will have to be IFRS-compliant, so will need to include all of the necessary disclosures. This may feel like overkill in the current circumstances, but most of the information in the notes will be needed to prepare the primary statements.

For example, it would be impossible to determine a closing balance for provisions without understanding the movements in-year in terms of the provisions that have been discharged, new liabilities and changes due to discounting. Having said that, NHS bodies should consider materiality at all stages in the preparation of the accounts and may decide to exclude detail in notes that are usually completed as a matter of course.

SHUTTERSTOCK

These might include the financial instruments notes, details of all related party transactions, intangible assets and pooled budgets. But each NHS body will need to make this decision based on its own circumstances.

Early discussions with auditors in relation to materiality would be helpful. This is perhaps particularly the case in relation to the perennial problem of whether the fact that the submission schedules must be consistent with the accounts actually means that they should be the same.

In terms of the annual report, including the remuneration report, the guidance is still being developed. Again, the focus will need to be on what is important. It is hard to remember that there was a time before Covid-19. However, annual reports will have to cover the full financial year, focusing on what is really important in terms of strategic or critical decisions and performance issues.

Most of this information should be available in the board papers and board discussions. A good place to start is probably the annual governance statement, then moving on to the performance statement.

The preparation of the quality accounts by providers is a statutory requirement, so it is difficult to amend. However, NHS England and NHS Improvement have announced that there will be no audit work required on quality accounts. Foundation trusts are encouraged to include the additional quality report information in their quality accounts. It is not expected that the statutory deadline of 30 June will be strictly enforced.

Debbie Paterson is HFMA policy and technical manager

Technical review

Further Covid-19 technical developments

Technical

In response to the extra pressure on the NHS due to Covid-19, the Treasury and the Financial Reporting Advisory Board have decided that implementation of **IFRS 16** in the public sector will be deferred for a further year to 2021/22. NHS England and NHS Improvement said that work already completed by organisations on the new international financial reporting standard on leasing will be of value in bringing leased assets on to the statement of financial position a year later than expected. However, the note to the 2019/20 accounts in relation to standards issued but not adopted will still have to be completed based on the work done to date. hfma.to/hfa1

A new briefing from the HFMA examines the **financial governance** considerations arising from the Covid-19 pandemic. For example, in terms of schemes of delegation and standing financial instructions, it considers the actions needed on authorised signatories, access to procedure notes and business continuity plans. It suggests the delegated limits that need to be considered most urgently. It also discusses the importance of setting up unique Covid-19 cost centres and budget codes and the level of detail that will be required. hfma.to/hfa2

The extension of the off-payroll working rules for intermediaries to the private sector that was due to happen from 6 April 2020 has been deferred to 2021. The **off-payroll changes** to processes for public sector bodies that resulted from this extension have also been deferred. hfma.to/hfa4

The Government Equalities Office and the Equality and Human Rights Commission have suspended enforcement of this year's gender pay gap reporting deadline. In 2018, it became mandatory for all public sector employers with more than 250 employees to measure and publish their

gender pay gap information on the government website and their own. Last year there was 100% compliance from all organisations including the NHS. NHS bodies would also normally be required to include a link in their annual report staff report to where the trust's gender pay gap information can be found on the internet. hfma.to/hfa3

Auditors will conduct their annual accounts work remotely this year. With this presenting challenges for **auditor verification of inventory**, providers with material inventory balances have been asked to work with their auditors to provide alternative sources of assurance wherever possible. However guidance says that these steps should be proportionate. A 'limitation of scope' in the audit report may be necessary in some circumstances though it is hoped this could be avoided for most. This would be a qualified auditor opinion, modified only to reflect the auditor has been unable, at the time of the audit, to obtain sufficient and appropriate evidence on inventory. The remainder of the opinion would be unchanged and confirm the appropriate completion of the audit. hfma.to/hfa5

GP practices in 2020/21 will continue to be paid at rates that assume they would have continued to perform at the same levels from the beginning of the outbreak as they have done previously, including for the purposes of the quality and outcomes framework, directed enhanced services and local enhanced services. QOF calculations for 2019/20 were due to be made as usual, as QOF activity was largely complete by early March. However, the impact of Covid-19 work would be investigated and a one-off adjustment made for practices earning less in 2019/20 than 2018/19 as a result of the virus-related activities. hfma.to/hfa6

NICE guidance to support virus response

Technical: NICE

NICE is supporting both the NHS and social care to respond quickly to the challenges of the coronavirus pandemic, *writes Gary Shield*. It has brought together information at www.nice.org.uk/covid-19.

Part of the response has been to develop rapid guidelines on the care of people with suspected and confirmed Covid-19 and in patients without Covid-19. The guidelines aim to maximise patient safety while protecting staff from infection and making the best use of resources.

A guideline on critical care (hfma.to/critical) covers: admission to hospital; admission to critical care; starting, reviewing and stopping critical care; clinical decision making; and service organisation. It stresses that all patients on admission to hospital should continue to be assessed for frailty using the clinical frailty scale.

For patients with confirmed Covid-19, the guideline says decisions about admission to critical care should be made on the basis of medical benefit, taking into account the likelihood that the person will recover to an outcome that is acceptable to them. Two further guidelines cover kidney dialysis (hfma.to/kidney) and systemic anticancer treatments (hfma.to/anticancer).

The guidelines have been developed in collaboration with NHS England and NHS Improvement and a cross-speciality clinical group, supported by the specialist societies and royal colleges. NICE is using a different approach to normal to develop these quickly (hfma.to/rapid). In addition, rapid evidence reviews will look at whether certain medicines may increase the severity or length of Covid-19 illness.

Initially the body is reviewing:

- Ibuprofen and other non-steroidal anti-inflammatory drugs used to reduce temperature and ease flu-like symptoms
- Angiotensin converting enzyme (ACE) inhibitors used to treat high blood pressure or heart failure.

NICE will also be working with the Medicines and Healthcare Products Regulatory Agency to facilitate rapid review of information and advice on the safety and efficacy of treatments for Covid-19.

Gary Shield is resource impact assessment manager at NICE

NHS in numbers

A closer look at the data behind NHS finance

Capital and the NHS estate

Further information

ERIC return 2018 **hfma.to/hfa7**
NAO capital report **hfma.to/hfa8**
Transforming imaging report **hfma.to/hfa9**
Budget 2020 **hfma.to/hfa10**

Technical

Old age is the primary reason why the NHS needs to invest in its secondary care estate. The *NHS long-term plan* acknowledges that 'some of the estate is old and would not meet the demands of a modern health service even if upgraded'.

According to NHS Digital's estates return information collection (ERIC) for 2018, NHS trusts have a total of 9,312 sites, including 233 general acute hospitals, 49 specialist acute hospitals, 103 mixed service hospitals and 658 mental health sites. A further 5,660 sites are classed as 'non-inpatient' and there are 2,084 support facilities

The National Audit Office says that 14% of the estate predates the formation of the NHS and some hospital buildings date back to the Victorian times.

In some cases, facilities need to be improved or maintained, while elsewhere new buildings and equipment are needed.

According to NHS Digital, the backlog maintenance work to restore buildings to an appropriate standard would cost £6.5bn – with £3.4bn of this relating to high or significant risk backlog. High-risk backlog maintenance (£1.1bn) grew by 139% between 2014/15 and 2018/19.

NHS providers' annual assessment of their need for capital investment was on average £1.1bn higher than their spending limit in the three years up to and including 2018/19.

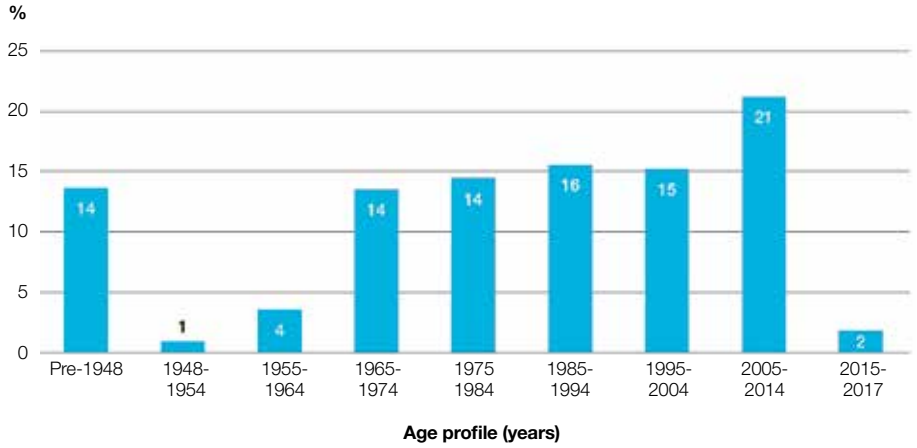
Despite this, the Department of Health and Social Care transferred £4.3bn from capital to revenue spending between 2014/15 and 2018/19 to help cope with day-to-day financial pressures in the NHS. A further £500m was planned for transfer in 2019/20, before the practice was brought to a halt.

Even though demand for capital outstrips supply, the Department has underspent against its capital departmental expenditure limit (CDEL) by a total of £2.7bn since 2010/11.

The big underspends came in the years before the transfers to the revenue budget became a regular feature. But there have continued to be small underspends subsequently – and a more significant £360m in 2017/18.

Age of the NHS estate by gross internal area

14% of the estate dates from before the formation of the NHS and 46% was more than 33 years old



Notes
1. Totals may not sum due to rounding
2. Age of the estate data last reported for 2016-17

Source: National Audit Office analysis of NHS Digital Estates Return Information Collection (ERIC) data 2016-17

These underspends can be a result of delays in capital programmes, meaning funds do not need to be drawn down, some of which could be due to concerns about the revenue consequences of capital spending.

There have been moves to increase the levels of capital available to the health service over the past year. Last summer, there was a flurry of announcements. A £1bn increase in CDEL was provided to support 2019/20 capital spending plans. A further £850m would support the upgrade of 20 hospitals over the coming years. There was also £250m to fund artificial intelligence investment over three years.

A further £200m for diagnostics, delivered over two years, would help to modernise CT, MRI and X-ray equipment. NHS England and NHS Improvement say this will help to address the fact that 14% of CT and 34% of MRI scanners are 10 years old or more.

This was followed up by the unveiling of the Health Infrastructure Plan, which promises to fund 40 hospital building projects over the next decade. Six new large hospitals were awarded £2.7bn in the first wave – although the funds will flow as required over the coming years.

A further 21 schemes – accounting for the remaining 34 hospital projects – were given a share in £100m seed funding to support the development of business cases.

The funding for these various programmes will be needed at different points over the coming years. The long-term capital settlement this summer will be important in setting out future capital spending limits, which will crucially start to clarify how much funding will be available outside these existing commitments for more general capital projects.

The 2020 Budget in March actually set a CDEL of £8.2bn for 2020/21 – an increase of £1.1bn on 2019/20 – although this was before financial commitments were made to support the Covid-19 outbreak. Within this total, just £100m is there to support the HIP, with projects only just beginning. The increase also includes a £683m increase for operational capital investment.

Graduation success

News and views from the HFMA Academy

Pictured top to bottom: Julia McLarty, Steven Heppinstall and May Ng

Training

Finance and clinical staff were among the first six graduates from the BPP university MBA in healthcare finance, having followed the pathway provided by the HFMA level 7 advanced higher diploma.

May Ng became the first clinician to achieve the MBA, gaining a merit in the process. Dr Ng is an honorary associate professor, a consultant paediatric endocrinologist and associate medical director at Southport and Ormskirk NHS Trust.

No stranger to qualification – this is her fifth degree – Dr Ng says the business and finance qualifications were crucial to supporting her role as a clinical manager. 'Most clinical managers are full-time clinicians and we don't have the foundation or training in management and finance,' she says. Even the language used in management meetings can put up barriers.

'Thanks to the qualification, I am more confident and able to lead as a senior clinical manager,' she says. 'I feel better able to inform my executives and be a bridge in driving improvements. I would have struggled without this background.'

She believes more should be done to encourage or support clinicians to undertake this sort of training. 'If you want to talk about NHS value in healthcare, efficiency and sustainability, you need clinicians in the room with managers, but they do not routinely have the background knowledge in finance and management to enable them to be fully informed,' she says. Her MBA healthcare consultancy project looked at this important issue of improving engagement between clinicians and managers.

Julia McLarty, head of redevelopment finance at the Royal National Orthopaedic Hospital NHS Trust, was one of the successful students, tracing her involvement in the HFMA qualification back to its first pilot programme in 2017.

The MBA, which she passed with distinction, has been demanding but well worth the effort. However, she says aspects of the HFMA advanced higher diploma and the BPP MBA programme for the final year have already helped in her day job. 'The value module as part of the diploma provided me with a bit of a lightbulb moment, and really changed the way I think about the finance role in putting the patient first,' she says. 'And the MBA programme, which was more corporate-focused, gave me some insight into strategic management that helped me to feed positively into my trust's own strategy.'

Overall, she says, the qualification has given her more structured knowledge about, and a theoretical base for, her role in the NHS.

Ms McLarty sees a difference between the diploma studies, which were well supported by tutorials and online activities, and the more independent study demanded by the final year. She highlights the support of the HFMA Policy and Research Committee as crucial in delivering the final year healthcare consultancy project.

She aims to share the findings of her own project – exploring engagement by finance practitioners with the HFMA London Branch and Future-Focused Finance – with the two finance networks. She has emerged with some interesting insights into the levels of engagement of younger and more senior finance staff.

Finally, **Steven Heppinstall**, associate director of finance at Derbyshire Support and Facilities Services – part of Chesterfield Royal Hospital NHS Foundation Trust – believes the value aspects of the diploma and MBA programme, in which he gained a distinction, have been particularly helpful to his full-time role. 'The biggest thing is a wider appreciation for how healthcare is structured, how it fits into the overall economy and how things work in other countries and regions,' he says.

'The focus on value has really hit home for me. It is really relevant to system working – it comes up so much in system meetings – and having studied that puts me in a really good place.'

FFF launches health and wellbeing charter

Future focused finance

When we are busy and facing challenges, it can be easy to forget to look after ourselves and our fellow team members. In the current NHS climate, more so than ever before, the health and wellbeing of staff is so important and something that must be protected.

Reviews such as the *Boorman Review* in 2008 focused attention on staff health and wellbeing. Personal resilience and the wellbeing of employees are now recognised as being of great importance in developing and maintaining a high-performing team.

Future-Focused Finance has carried out research into the different health and wellbeing initiatives being delivered locally by NHS teams across the country. It has taken some of this best practice to create a new charter that aims to inspire others to do the same.

Some ideas include: healthy lunchtime activities, such as wellbeing walks; events and training; and simple gestures of support and encouragement.

These aim to help build both personal and team resilience. The charter includes a pledge that people can sign up to if they are interested in championing this area of work at their organisation.

Health and wellbeing champions will form a new network of individuals that FFF will work with to share good practice and learning across the regions, and to also help with ongoing research into future resilience-proofing the workforce for the undeniable changes on the horizon for NHS finance.

• View the charter on the FFF website at **www.futurefocusedfinance.nhs.uk/wellbeing**

Diary

May

5 (H) Provider Finance: forum, implementing NHS strategy, online

7 (B) South West and South Central: developing talent conference **POSTPONED**

19 (H) Chair, Non-executive Director and Lay Member: forum, the role of non-executive leadership in system working, online

June

3 (H) Chair, Non-executive Director and Lay Member: forum, introduction to NHS finance, online

4 (N) Taking pride in our future: forum, online

17 (B) Kent, Surrey and Sussex: mini summer conference **POSTPONED**

July

2-3 (N) HFMA summer conference, Hilton Birmingham Metropole – **POSTPONED**

7 (B) South Central: VAT Level 1

November

9 (I) Costing conference, Victoria Park Plaza, London

For more information on any of these events please email events@hfma.org.uk

key (B) Branch (N) National (I) Institute (H) Hub

HFMA Hub

The *NHS long-term plan* stipulates that every organisation in England will need to be part of an integrated care system by 2021. The transition to system-wide working presents enormous opportunities and challenges for health and social care leaders as they work towards a unified system that is patient focused.

The HFMA's longstanding partner programme and faculty offering has evolved into the HFMA Hub to mirror current system working across the NHS.

HFMA faculties will continue as networks within the hub and will retain their identify and the strong communities each area has built.

In addition to their networks, hub partner organisations will have the added benefit of access to the rest of the programme and the opportunity to engage with other organisations and other colleagues, sectors and networks both nationally and in their local health economies. This should support an increased focus on system-level working.

Events in focus

Costing conference
9 November, London

The HFMA Healthcare Costing for Value Institute's annual costing conference was due to take place on 8 April, but has been moved to 9 November 2020 in response to the situation around novel coronavirus (Covid-19), and to ensure the health and wellbeing of our members and attendees.

The annual costing conference provides the NHS with the latest developments and guidance in NHS costing. It also aims to increase awareness of the collaborative approach needed to harness the power of data.

The day will include interactive workshops, case study examples, policy updates and the chance to network with more than 200 colleagues.

This is a must-attend conference for those looking for support to meet costing requirements. The day is aimed at healthcare costing professionals and those not in a costing role but with an interest in the costing agenda.

It is intended that sessions planned for April will run in November, with speakers including Matthew Cripps (pictured), NHS England and NHS Improvement director of sustainable healthcare, together with members of the national organisations' costing team and frontline practitioners.

• **To book a place, email kirsty.whittaker@hfma.org.uk**

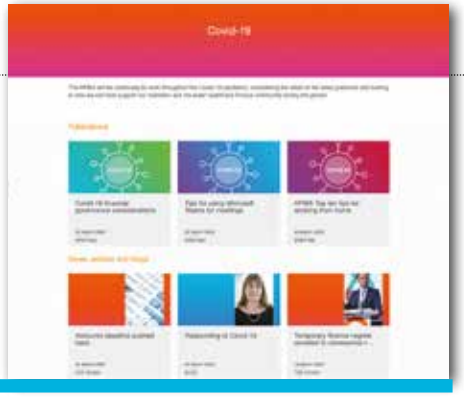
HFMA annual conference
9-11 December, London

The *NHS long-term plan* reset the direction of healthcare delivery in England, with the aim of moving towards even greater integration. Though the response to Covid-19 is taking up most of the service's operational and finance capacity currently, collaborative working remains a target for the NHS across the UK. This year's annual conference will focus on 2020 HFMA president Caroline Clarke's theme, *Taking pride in our future* – looking at how the finance function will develop and innovate through system working in the coming years.

Celebrate the HFMA's 70th birthday with us as we not only look to the future, but reflect on the history of the HFMA and the NHS. The annual conference is a fantastic opportunity to meet with colleagues, hear from sector leaders, recognise outstanding work within the service and gain accredited CPD.

The conference also includes one of the highlights of the healthcare finance year – the HFMA annual awards, celebrating the best in NHS finance.

• **To book a place, email josie.baskerville@hfma.org.uk**



Vital support

Association view from Mark Knight, HFMA chief executive

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

My HFMA

History will remember 2020 for one thing – the Covid-19 pandemic and the biggest public health emergency in modern times. The effects will be long lasting on our economy and on people's lives. Beyond the direct consequences in terms of deaths and illness, there may well be a sizeable indirect impact, with mental health a concern as a result of isolation and staying at home.

At this point, the focus is on the here and now and how we can all play our part in flattening the peak to protect the most vulnerable in society and reduce the burden on our health services.

Frontline health and care staff have already displayed amazing commitment, bravery and determination in these early days and the pressure will increase in the coming weeks. They deserve the public's thanks and support.

Our own NHS finance community has its own important part to play in ensuring the frontline can stay focused on the safe delivery of care.

The overriding goal of changes to the finance regime is to ensure money is not a barrier to the care that must be delivered, and finance teams will have a leading role in putting this principle into action. At its most basic, staff and suppliers have to be paid, but accounts must be finalised and core governance arrangements observed too. The HFMA will play its part in supporting finance teams during this challenging period. My colleagues in the HFMA policy team, led by Emma Knowles, have set to work developing a whole range of initiatives. Her recent blog (hfma.to/c19response) explains the initial proposals in more detail.

Our aim is to provide as much support as possible. Of particular note are plans to launch a message board for finance staff so you can share experiences and pass on useful tips. We are also exploring a programme of webinars.

In addition, all the HFMA's outputs related to Covid-19 (hfma.to/covid19) will be freely available to all NHS finance staff, not just HFMA members. This includes policy and technical publications and news content. The policy team will be focusing on work that supports practitioners in the current situation.

HFMA chief executive Mark Knight

I wanted to draw your attention to two things you might consider. First, we hope by December this outbreak will be over and the HFMA annual conference will be able to proceed. We will certainly have a lot to reflect on and we hope to see you there.

Second, the free bitesize programmes will shortly be available on the electronic staff record system. There are 60 hours free online. If you would like this material available on your own system, please drop me a note with your learning management system's contact name at chiefexec@hfma.org.uk.

The HFMA office in Bristol and the Rochester Row facilities are now both closed. Not surprisingly, all our staff are working from home and all meetings have moved online.

At the HFMA, we are aware of the hard work undertaken by all NHS staff – on the frontline and in support services – at all times.

However, we recognise that the current pressure is unprecedented in modern times. We thank you for your commitment and effort. Stay safe and make sure you follow the government's guidance. We look forward to normality –whenever that may be!

Member news

Kim Li (pictured), director of finance at South Warwickshire NHS Foundation Trust, has joined the HFMA Board of Trustees. She is an active member of the West Midlands Branch and a past branch chair.

On Saturday 29 February the HFMA **Northern Branch** entered a team into the Mad March Mare, Northumberland's new 10k multi-terrain obstacle course. The event includes 25 gruelling obstacles, designed to push even the most determined challenger to the limit. The team (pictured) raised over £1,200 for local charities, the Children's Heart Unit Fund at Newcastle Hospitals and SHINE, which helps support people who use Cumbria, Northumberland Tyne and Wear mental health services.

A team of HFMA staff hope to donate one of their working days to charity in the near future. They have arranged to spend a hands-on day at Holly Hedge Animal Sanctuary in Bristol, with a date to be finalised once the coronavirus restrictions have been lifted.

HFMA trustees Lee Outhwaite, director of finance and contracting at Chesterfield Royal Hospital NHS Foundation Trust, and Sanjay Agrawal, consultant in respiratory medicine and critical care at the University Hospitals of Leicester NHS Trust, share their insights into the importance of collaborative working between finance and clinical staff in this month's HFMAtalk podcast. See www.hfma.org.uk/news/hfmatalk-podcast

Member benefits

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

Network focus

My HFMA

Payment Systems and Specialised Services

The NHS response to Covid-19 has seen the usual payment by results tariff payment architecture suspended, with block contracts put in place for at least the first four months of the new financial year, *writes HFMA policy and research manager Andrew Monahan* (pictured). This is a sensible step in enabling organisations to free up time and devote the maximum operational effort to Covid-19 readiness and response.

But beyond the current crisis, the approach to payment will be a key component in the move to system working. The HFMA Payment Systems and Specialised Services Special Interest Group aims to provide an important finance voice in funding flows development.

Meeting three times a year, the group consists of finance professionals responsible for income or contracting from providers and commissioners, as well as representatives from NHS England and NHS Improvement, NHS Digital and NHS Specialised Services. The group aims to provide a platform for discussion on the national payment system and specialised service-related issues in England.

The meetings are an opportunity for sharing and testing ideas, most commonly from the national bodies, and to hear updates on plans such as establishing a new payment mechanism for adult critical care or chemotherapy drugs. Members – best placed to provide feedback on how theoretical changes will play out in practice – provide instant feedback on ideas.

Covid-19 permitting, later this year we expect to discuss options for new arrangements for CNST contributions. With the current funding mechanism based largely on averages across the sector and 60% of a trust's CNST costs based on historic claims, a trust with high historic claims may not get enough funding via the national tariff.

We also hope to continue to link with counterparts responsible for costing to understand how patient-level data will support future payment mechanisms.

The blended payment approach has been described as a stepping stone from episodic payment to a mechanism better reflecting system working. With little clear definition on what that may be, the HFMA is planning a future briefing looking at system plans and the key aspects required from payment structures. We will also keep a close eye on whether any of the measures put in place to ease the pressure from Covid-19 can be used long term.

branch contacts

Eastern kate.tolworthy@hfma.org.uk
East Midlands joanne.kinsey1@nhs.net
Kent, Surrey and Sussex elizabeth.taylor29@nhs.net
London amy.morgan@hfma.org.uk
Northern Ireland kim.ferguson@northerntrust.hscni.net
Northern catherine.grant2@nhs.net
North West sara.braidwood@hfma.org.uk
Scotland fleur.sylvester@hfma.org.uk
South West amy.morgan@hfma.org.uk
South Central georgia.purnell@hfma.org.uk
Wales charlie.dolan@hfma.org.uk
West Midlands jessica.balfour@hfma.org.uk
Yorkshire and Humber khushnu.mehta@hdft.nhs.uk

Appointments

Carol Potter (pictured) has taken up the post of interim chief executive at NHS Fife. She was previously deputy chief executive and director of finance at the organisation. NHS Fife chair Tricia Marwick said: 'Carol has already shown her professionalism and dedication and she is much respected through the organisation. I look forward to working with her as the interim chief executive in the period ahead.' Ms Potter's move comes after **Paul Hawkins** left NHS Fife to take over as chief executive of NHS Highland, after nearly five years as NHS Fife chief executive.

Katherine Archer (pictured) has taken up a new position as head of financial performance at Oxford University Hospitals NHS Foundation Trust. Ms Archer previously served as senior finance business partner at the trust. She has worked there since 2017.

Robin Andrews has started a new position as director of finance (operations) at Betsi Cadwaladr University Health Board. Mr Andrews was previously working as interim deputy chief financial officer at Horsham and Mid Sussex Clinical Commissioning Group.

Shropshire, Telford and Wrekin clinical commissioning groups have appointed **Claire Skidmore** executive director of finance. She previously held the position of chief finance officer at Shropshire Clinical Commissioning Group.

Colin McCready has joined Supply Chain Co-ordination Limited (SCCL) – the management function of NHS Supply Chain – as chief financial officer. Mr McCready, who will also be appointed a company director of SCCL, has moved to the supply body from NHS Professionals, where he was chief financial officer and, most recently, interim chief executive. He has held senior finance appointments at public sector outsourcer Serco and professional services provider Control Risks. He has a history of driving transformational change and improving business operational performance across diverse environments.

The London Audit Consortium, which is hosted by Barts NHS Trust, has named **Michael Townsend** (pictured) as its new managing director. Mr Townsend was due to leave consultancy TIAA at the end of March to take up the new role. The change means he will be standing down from his position as a member of the HFMA Kent, Surrey and Sussex Branch committee.

Get in touch
Have you moved job or been promoted? Do you have other news to share with fellow members? Send the details to seamus.ward@hfma.org.uk

"I wanted to be a CFO at an acute trust as I enjoy working with clinicians and understand the needs of patients within an acute setting"
Bimal Patel, North Middlesex University Hospital NHS Trust

Patel makes move into London director role

On the move

It's never easy coming into a substantive finance director role for the first time and Bimal Patel describes his first few weeks as chief finance officer at North Middlesex University Hospital NHS Trust as a baptism of fire. It has been dominated by the health service response to the coronavirus, Covid-19, but he is well prepared through 20 years of NHS finance experience and a strong support network.

In the six months immediately before his appointment at North Middlesex, Mr Patel was acting chief financial officer at London North West University Healthcare NHS Trust. He spent more than four years in senior finance positions at the trust, including as deputy director of finance and finance director, and has been enrolled in national programmes aimed at developing the next group of NHS executives.

'The transition has been good for me, as the last six months at London North West has given me experience of being a CFO in an organisation that's quite challenged, both operationally and financially. Despite that, it was an excellent way of seeing community and acute services working together within a complex STP.

'I had a great desire to be a CFO in the NHS. It's something I always wanted to do, and my career progression has been about getting to that point. More than anything else, I wanted to be a CFO at an acute trust as I enjoy working with clinicians and understand the needs of patients within an acute setting.'

He adds: 'North Middlesex is the right size for my first CFO role and the executive team have been great in my first few weeks during a difficult time globally. I was so impressed that the trust had a forward view for its population and am looking forward to inputting into the trust's clinical strategy.'

Mr Patel has benefited from having a coach and mentors across London, singling out the support he has received from CFOs he has worked with before, as well as new CFOs and those at NHS England and NHS Improvement.

'You need people around you to shape you and see how you are doing. When preparing for the interview for this job, I made sure I spoke to the right people; talked through what I am about, what the trust wanted from me and what I wanted from the organisation.'

He was also on the aspiring finance leaders' scheme, which was a national talent pool, and, before that, the Nye Bevan programme. While these were both beneficial, they are very different programmes, he says. The Nye Bevan scheme is geared to helping anyone who is hoping to move to an executive role, not just in finance, and to work on a board.

'On the aspiring finance directors' programme, you can build a strong network in your area of expertise. These two programmes reinforced my belief that I wanted to be a CFO. The job at North Middlesex came along, and I knew it was the right move for me.'

Covid-19 will take up a lot of operational and executive time in the coming months, but Mr Patel also maintains a focus on other issues. As with many London trusts, North Middlesex faces financial and operational challenges.

He says the executive team is strong and determined to tackle these issues, and to turn a Care Quality Commission rating of 'requires improvement' to 'good'.

Mr Patel's portfolio is not limited to finance – he also heads work on IT, informatics and performance. 'That additional learning for me is really good. I have a solid team behind me that I am looking forward to working with,' he says.

The Middlesex trust is a global digital exemplar fast-follower and he is focused on delivering the programme, as well as helping ensure the trust's response to Covid-19 meets patient and staff needs.

'We want to balance finance and operational challenges and address the ever-increasing non-elective demand,' he says.

This may require difficult decisions – on staffing, productivity or throughput, for example – but Mr Patel is looking forward to the challenge of transformation and working at a system level.

He highlights the fact that elective patients who have procedures postponed in the next few months will still need the work to be done when the coronavirus pressure recedes. 'We will have to get the IT and information to the right place to help clinicians make sound decisions and work as efficiently as we can,' he says.

Thank you to all HFMA corporate partners for their continued support

hfma

3M

PRIME

GETINGE

Liaison Group

IMS Health & Quintiles are now IQVIA

fleet SOLUTIONS

selenity expenses

GENMED MANAGED SERVICES

NHS Supply Chain

litmus

DXC.technology

Grant Thornton

Johnson & Johnson MEDICAL DEVICES COMPANIES

NHS Shared Business Services

Baxter

B BRAUN SHARING EXPERTISE

STORZ KARL STORZ — ENDOSKOPE

PA

PROCHAINMATRIX

civica

NHS

CIPFA The Chartered Institute of Public Finance & Accountancy

Meridian Productivity

hfma Corporate Partner

For more information about becoming a corporate partner, please contact Paul Momber
E paul.momber@hfma.org.uk T 0117 938 8972

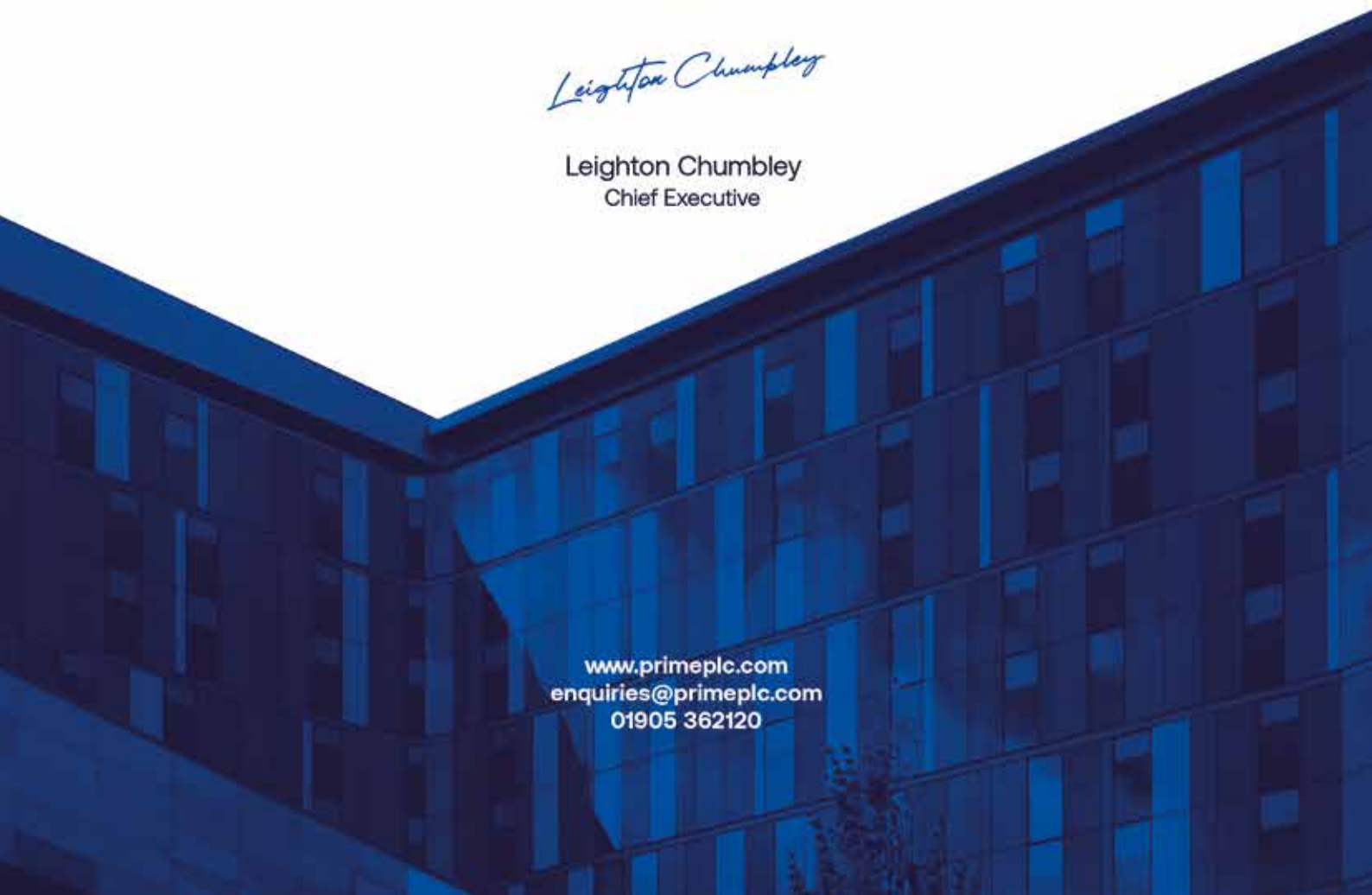
PRIME

"Amidst this crisis, we continue to support our colleagues and partners across health and care to find the solutions to immediate and long term challenges in their estate. So whether you need support now, or for when you have the moment to look ahead again, we're here."

Developing space for change in health and care.

Leighton Chumbley

Leighton Chumbley
Chief Executive



www.primeplc.com
enquiries@primeplc.com
01905 362120