healthcare finance

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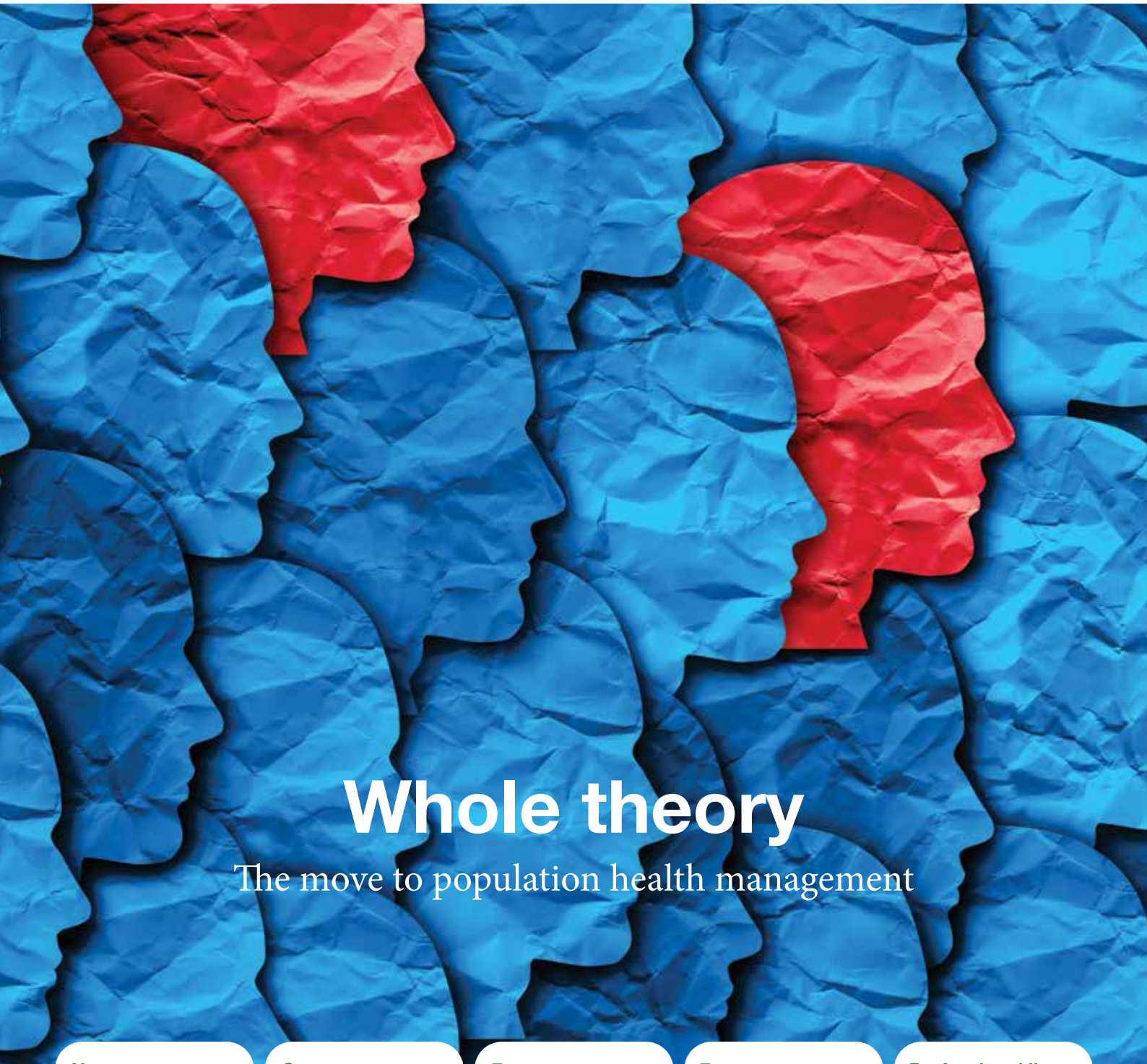

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How to catch up, accelerate and supercharge finance with software robots

The pandemic changed the NHS forever. The very same people, processes and expertise that helped it through are now in a precarious position. The system faces huge backlogs in care,[1] maintenance[2] and recruitment.[3]

The task of getting the service back on track is colossal and demands every tool in the box. Tools like artificial intelligence (AI) powered software automation. This is the technology that allows anyone today to configure software robots to emulate and integrate the actions of a human operating digital systems to undertake business processes.

Put simply, AI-enhanced robotic process automation (RPA) operates a computer, mouse and keyboard like a human – but virtually. It's like having a digital worker – allowing employees to focus on more important tasks.

Automation made a dramatic difference to healthcare when it really mattered in the last two years. Software robots kept staff on the front line instead of having them enter data, reduced waiting times by taking on admin tasks, recruited experts to fight the disease, and supported better procurement by balancing orders with supplies.

They also played a huge role in financial management – even before the pandemic. NHS Shared Business Services (SBS) used the UiPath end-to-end enterprise automation solution to automate hundreds of financial processes across activities such as reconciliations, cash flow, invoice payment, and debt collection. This saved resources to be ploughed back into reducing waiting lists and backlogs.[4]

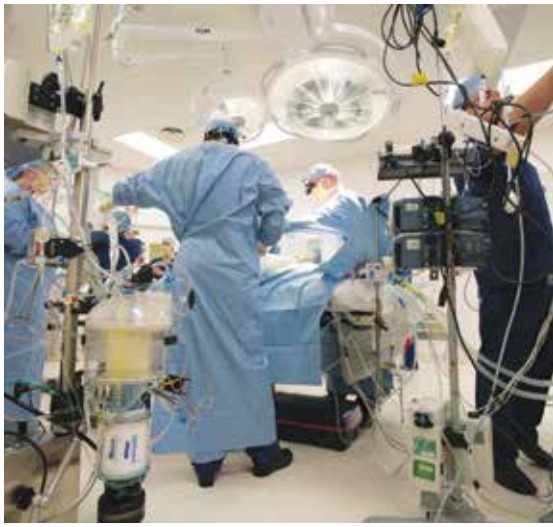
Reflecting on the use of automation, Stephen Sutcliffe, Director of Finance and Accounting at NHS SBS said: "We aim to be as efficient as possible in everything we do, and RPA has a significant role to play in this. It can carry out the mundane, repetitive tasks no one likes, while improving the accuracy and quality of financial processes. The exciting part is the time it frees to enable us to offer greater value to the NHS organisations that use our services."[5]

As Sutcliffe's experience shows, automation offers a chance for the NHS to create efficiencies as it works tirelessly to deal with backlogs. Finance departments are often one of the easiest places to start. This is because the administrative side of the role often entails routine and repetitive work that staff must complete at scale. For example, processing invoices. If handed to software robots, employees can focus on more valuable and rewarding work. If replicated throughout the whole NHS, the impact could be colossal. So much so, that in the future software robots could help the NHS go from catching up to accelerating and even supercharging – especially in finance departments.

To find out how UiPath can help you introduce software robots to the finance team, contact matt.hogarth@uipath.com or visit www.uipath.com.

1) BMA.org, NHS backlog data analysis. 2) kingsfund.org.uk, NHS funding: our position. 3) Personnel Today, Staff shortages undermine NHS backlog plans, employers claim, 8.2.22. 4) UiPath, Nursing healthcare back to health. 5) UiPath, Nursing healthcare back to health.

News



Providers raise concerns over revised marginal rate

By Steve Brown

The NHS will face higher deductions from commissioner payments than previously proposed if activity levels fall below target.

NHS England and NHS Improvement published changes to national tariff plans as part of a new consultation at the end of February. The original proposals included in December's consultation said that a new aligned payment and incentive approach would be introduced from April. This involves a fixed payment to fund an agreed level of activity plus a variable element, primarily to pay for additional activity above the agreed baseline or to withdraw funds for shortfalls in activity.

The initial consultation suggested that trusts over-performing against agreed elective activity levels should receive 75% of national or unit prices for additional work. But trusts that underperformed against the baseline would have faced deductions at a rate of 50%.

The new consultation harmonises the marginal rate at 75% for both additional payments and deductions. The change aligns the rates with those proposed for commissioning bodies as part of the elective recovery funding proposals. It argues that 75% is an appropriate rate as analysis of patient-level cost data shows that, on average, 25% of elective activity costs are fixed, with the remaining 75% relating to staffing and purely variable costs.

However, NHS Providers chief executive Chris Hopson said there were often good reasons for trusts missing stretch targets and there was concern this change would leave them underfunded compared with their significant fixed cost base.

"Reasons beyond a trust's control in 2022/23 could include the impact of current and future waves of Covid-19, pressures in urgent and emergency care, the impact of current workforce shortages, and pressures in social care, given their impact on bed capacity," he said. These factors were already constraining trusts with varying impact.

'It's right to set very stretching targets here,' he said. 'But it's also vital that any financial regime is appropriately flexible and recognises the legitimate variation that may occur. Otherwise trusts risk being driven into financial problems that will affect their ability to deliver safe and effective care.'

He added that significant care backlogs also existed in mental health and community services, which also needed funded plans.

Draft guidance was also released in February setting out the mechanism for additional elective recovery funding for 2022/23. The planning guidance for the year requires systems to deliver over 10% more elective activity than before the pandemic. This is measured in terms of completed referral-to-treatment pathways.

However, the guidance said that this target would be met with delivery of 104% of value-based activity – measured as 104% of the 2019/20 activity valued at healthcare resource group and treatment function code level using the 2022/23 tariff.

The difference between the 104% and 110% targets is primarily because a planned increase in pre-referral advice and guidance means more pathways will be completed in primary care. This is expected to contribute about six percentage points towards the completed pathways target. However, the contribution towards the value-based activity target is expected to be less than one percentage point, as the value of these pathways is significantly lower than the value of an average pathway.

"It's right to set stretching targets but also vital any financial regime recognises the legitimate variation that may occur"
Chris Hopson

Commissioners have been given additional elective funding to enable them to deliver the 104% value-based activity target across elective ordinary, day case, outpatient procedures and first and follow-up outpatient attendance activity.

This will be adjusted up or down by 75% of the tariff value if actual activity across the system is above or below this baseline value.

Any downwards adjustment will be by a maximum of 75% of the initial allocation from the £2.3bn national fund. This is known as the elective funding adjustment floor.

The elective recovery guidance underlines that providers will also earn or lose 75% of the difference in value for elective activity that differs from plan – with the consultation on the tariff specifically reissued to deliver alignment between the two sets of rules.

This means there is alignment between the way systems receive or lose elective recovery funding and how provider remuneration is adjusted to reflect activity differences.

Independent sector care will be treated differently, with additional activity paid at 100% of tariff rates both for activity directly commissioned by commissioners and activity subcontracted by NHS providers. This will depend on the system delivering over 104% of independent sector activity and 104% of elective activity overall. This will mean monitoring performance against baseline, through the secondary uses service data warehouse, broken down by provider activity, subcontracted activity and directly commissioned capacity.

Subcontracted activity is now being excluded from the aligned payment and incentive arrangements and will instead be subject to tariff prices. This addresses a concern, raised by the HFMA in its response to the original tariff consultation, that providers wanting to make extra use of the independent sector to make further progress with waiting lists would have faced being paid at 75% of tariff prices, but having to pay subcontractors 100% of the tariff.

Increasing focus on place as systems move towards formal start

By Steve Brown

Integrated care systems (ICSs) should devolve funding to place-based partnerships, with resources only being retained by the system when that is the agreed approach, according to a new report from the NHS Confederation.

In the report – *Governing the health and care system in England* – Chris Ham (pictured), King's Fund senior visiting fellow and former ICS chair, looked at how the central scrutiny of NHS performance can be reconciled with devolved decision-making.

He said that ICSs would need to rapidly develop new capabilities and the authorising environment that systems work in must change.

He argued that ICSs should be held to account for a small number of national priorities, but should also agree a small number of local priorities as part of a memorandum of understanding with regional offices. Both the national and local priorities should be expressed as 'whole system targets'. He called for the drawbacks of the current system – where wide-ranging targets are issued supported by copious amounts of guidance – to be recognised.

'Funding should be allocated to ICSs on a population basis and not tied to specific deliverables,' he said. 'In turn, ICSs should devolve funding to place-based partnerships with resources only being retained by the system when agreed by partners.'

These measures would allow those responsible for delivering care to decide how best to use resources to improve outcomes and also eliminate the work involved in bidding for funding.

"A legal duty to collaborate doesn't necessarily mean it will happen"

Sarah Scobie, Nuffield Trust

Decisions should be taken as locally as possible, he added, starting in teams and neighbourhoods, followed by places, system and the centre. And a 'regime of proportionate accountability' should be based on light-touch oversight of well-performing systems and rules-based intervention and support of other systems.

The government's February white paper on integration of health and social care – *Joining up care for people, places and populations* – also set out a clear direction of travel towards greater accountability at place level. All systems are expected to have governance arrangements for places set up by spring 2023. This will include having a single person responsible for delivering outcomes.

While places will be free to decide on an accountability model that works for them, the Department of Health and Social Care has outlined a place board model as one way of taking local decision-making forward.

Under this arrangement, the relevant local authority and the integrated care board (ICB) would delegate functions and budgets to the board. The paper also makes it clear the use of pooled or aligned budgets is expected to grow 'eventually covering much of funding for health and social care services at place level'. Revised guidance will be issued to simplify the creation of section 75 pooled budgets. And the better care fund, which is regarded as a success, will also play a role in supporting integration at place level.

However, while there is support for the introduction of systems and the important role that will be played by place-based partnerships, there are concerns about the proposed system architecture and the increasing central direction over structures.

Some finance leaders suggest the white paper has added complications and layers of bureaucracy rather than helping integration. While 2021's *Integrated care systems: design framework* promised flexibility for systems in governance and management arrangements to operate in a way that reflects local context, there are now growing signs of prescription.

There is an increasing focus on place. But some believe that the starting point should be deciding what can be done at system level and then asking if better value would be delivered by breaking it down to a more local level. The aims are to improve working between primary and secondary care and between health and social care, and to move towards prevention. And the focus should be on how providers organise themselves to achieve these aims.

The Health and Care Bill is currently at the report stage in the House of Lords and is expected to receive royal assent in time for implementation on 1 July, when the 42 new ICBs will be created. Allocations for new ICBs are being set on broadly the same basis as for clinical commissioning groups and will cover delegated commissioning functions.

Some ICBs will take on delegation for some primary care services in 2022/23, with all expecting to take these on in 2023/24.

Speaking at the Nuffield Trust summit at the beginning of March, the trust's deputy director of research, Sarah Scobie, said there were lessons to learn from earlier integration policies across the UK. The trust published a report in December exploring the impact of earlier integration policies.

'It was clear to us there has been an over-reliance on structural and organisational levers to drive integration and these are not enough on their own,' Ms Scobie said.

'A legal duty to collaborate doesn't necessarily mean it will happen in practice,' she added, identifying the different cultures of organisations and workforce issues as examples of other issues that need to be considered. 'We also found limited evidence that integrating finances have led to cost savings or more efficiency.'

She warned that initiatives often started off identifying integration in general as being a good thing for patients. But over time, these often ended up focused on narrow financial measures – for example, reducing emergency admissions to cut acute care costs.

• *ICB finance appointments, page 35*

NHS urged to consider rural funding needs

By Seamus Ward

Much of the coverage of the government's promise to level up has focused on the urban districts of northern England. But deprivation and health inequalities can be found in other areas, according to a cross-party Parliamentary group, which called for a greater focus on the health needs of rural and coastal communities, and the cost of providing services there.

An All-Party Parliamentary Group on Rural Health and Care report, published in February, said that health services in rural and coastal areas faced a number of challenges that, if not addressed, would move from urgent to critical.

The parliamentarians said health inequalities are often dispersed within rural settings, which tends to average out need when examined as part of funding allocation. Consequently, the costs of providing services are underestimated.

Populations temporarily swell in summer and at harvest times. Additionally, the group said, it is more difficult to provide care to dispersed communities, while the wider determinants of health, such as fit-for-purpose housing, and education and employment opportunities, can be lacking.

The allocation formula could be a mechanism to mitigate these costs. In 2018, the Nuffield Trust examined the impact of rurality and sparsity on the costs of delivering healthcare. This review looked at the key factors for calculating health allocations. It concluded that while population and demographic needs are key, a further adjustment could be made for the higher costs of running hospitals with 24-hour A&E departments in remote areas. In evidence to the inquiry, the Nuffield Trust said six rural hospitals carried a quarter of England's NHS funding deficit at the end of 2019/20.

The current funding formula for clinical commissioning groups has three adjustments for the costs of providing services in rural areas. These cover the extra cost of ambulance provision, an allowance for hospital remoteness, and an adjustment for supply-induced demand in urban areas to help ensure remote areas are not under-funded relative to need.

The NHS in Scotland and Wales have developed allocation formulae that adjust for the costs of providing services to remote areas.

In a note to NHS England on its recommendations for 2019/20 CCG target allocations, the Advisory Committee on Resource Allocation (ACRA) said it could find 'no nationally consistent evidence' that pointed to a need to make further changes to the ambulance and remote hospitals adjustments. But it backed the development of a community services formula to better recognise the needs in some rural and coastal areas.

The inquiry insisted ambulance and remote hospital adjustments were outweighed by costs due to market forces and health inequalities. In the total budget for core services these factors moved around £600m from predominantly rural areas to urban and less rural areas.

It made 12 recommendations, including setting up pilot sites to test integration of health and social care budgets in rural areas, measuring outcomes against that budget.

Miriam Deakin, director of policy and strategy at NHS Providers, said: 'Health inequalities are a priority focus for trusts, and a one-size-fits-all approach is not appropriate. This report highlights the unique factors impacting health outcomes in rural, remote and coastal communities, and the health inequalities challenge facing these communities differs from the challenge faced by more urban populations. Efforts to address health inequalities must take into account these differences in context.'

SHUTTERSTOCK

Isle of Wight challenges

Darren Cattell (pictured), chief executive and former finance director of Isle of Wight NHS Trust, gave evidence to the all-party group. The island trust faces operational and financial challenges as a result of its remoteness, he said. 'Health inequality is a big factor for us as we continue to improve services.'

During summer, tourism doubles the population. 'Even without the influx of tourists, we have enough people to demand a wide range of services. But if you compare that population with that of other small district general hospitals, our remoteness and size means it is a challenge to make sure services are clinically and financially sustainable.'

The trust provides acute, ambulance, mental health, learning disabilities and community services to a year-round population of about 142,000, which doubles in summer.

'We cope incredibly well. But it's a significant challenge in clinical and financial terms, particularly attracting and retaining a high-quality workforce. And while the lifestyle offered by island living will be attractive to some, others will prefer city life or working in a major teaching hospital,' Mr Cattell said.

Working with partners, the trust is mitigating the workforce issue, putting in place joint appointments, shared rotas and different ways of working, with less reliance on traditional medical roles. It is also recruiting at home and overseas, setting up apprenticeships and visiting schools.

Mr Cattell praised the NHS England and NHS Improvement South-east Regional Office and the Hampshire and Isle of Wight Integrated Care System for supporting the trust in identifying 'what we call the island structural deficit. This is two-thirds of the total trust deficit, and exists where costs exceed income where we provide sub-scale but necessary services for residents of and visitors to the island'.

The changes in the CCG target allocation formula have helped, and he welcomed ACRA's determination to introduce a community services formula to account for the added costs of rural and coastal provision.

'There will be a further move towards target in next year's allocation. It's a slower process than we'd like – that's not a criticism, but it's inevitable given the reality of the current economic situation.

'The report will prompt other organisations to dig deeper to understand the true drivers of deficits and to produce realistic plans to solve them.'

The trust is willing to support others by sharing its work, Mr Cattell said.

News review

Seamus Ward looks at recent developments in healthcare finance

It's been a tough winter for the NHS, and although demand was high, and providers felt the impact of staff absences due to the infectivity of the Omicron variant, it does not appear the service was overwhelmed. Restrictions are now being eased, with politicians declaring we must learn to live with Covid-19, but in England waiting lists stand at more than six million people.

Tough winters are par for the course in the NHS, and another regular feature of the healthcare year emerged – claim and counter-claim on pay awards. In evidence to the NHS pay review body, the Department of Health and Social Care called for Agenda for Change pay rises of no more than 3% in 2022/23 – a proposal that would 'go down like a lead balloon', according to Unison head of health Sara Gorton. The Department insisted the NHS budget was now set, and for it to remain balanced there had to be a trade-off between pay rises, tackling waiting lists and increasing staff numbers. It also called for pay restraint for doctors, dentists and senior managers, insisting hospital consultants should get no more than 2%. Multi-year deals are in place for other medical staff.

The Royal College of Nursing (RCN) warned of nurse shortages. Workforce shortfalls were affecting trusts' ability to provide safe and effective care before the pandemic – and the situation is now worse, it added. Immediate action to increase nursing supply is needed. The RCN said that, going into the pandemic, 73% of nurses surveyed believed staffing on their last shift was insufficient to meet patient needs. Patient care was compromised, according to 57%. The union added that one in five nurses are aged 56 or more, and will be due to retire in the next few years.

Councils are increasingly concerned that the costs of the government's adult social care reforms will exceed funding, according to the Local Government Association. The LGA said cost pressures will include the 'fair rate for care' that councils will pay providers. Without adequate funding some councils will struggle to balance their budgets, worsening existing pressures and risking the delivery of timely, quality care, the LGA said. In February, the Department confirmed an additional £1bn for 2022/23, including increases in core social care funding via £636m in social care grant. Public health funding will increase by 2.8% in cash terms, and the public health grant will be more than £3.4bn in 2022/23.

The power-sharing executive in Northern Ireland collapsed in February, so local health and personal social services will not receive the planned rise in funding from April, unless the executive is restored. The draft Budget had proposed a 10% real-terms uplift for health over three years, but this cannot happen without a first minister and deputy. Current year budgets will continue into 2022/23. Under devolution arrangements, other ministers can remain in place, but with limited powers. Finance minister Conor Murphy said his legal advice was that budgetary measures cannot be implemented without an executive. He added that the proposed shift to three-year planning could also not now be introduced.

An overview of NHS Scotland finances in 2020/21 said the Covid response significantly affected health boards' ability to make efficiency savings. Audit Scotland said several boards relied on government support and £102m was allocated to 14 NHS boards to achieve financial balance – this shortfall was recurring. Six boards with particularly challenging financial positions

The news in quotes

'This tight-fisted proposal falls well short of rising costs and staff hopes. It's barely half the rate of inflation, which is far from peaking and won't for many more months.'
Government pay proposals are unacceptable, says Unison head of health Sara Gorton

'On 1 April the health service will not be able to plan on a three-year basis, nor will it be equipped with additional resources to invest in waiting lists, cancer services and mental health. In these circumstances, rather than improving, the health service will decline.'
Northern Ireland finance minister Conor Murphy explains the consequences of the collapse of the local executive

'Electronic patient records are the essential prerequisite for a modern, digital NHS. Without them, we cannot achieve the full potential for reform.'
Sajid Javid wants to speed up adoption of EPRs

'The promises made by Greensill and the easy acceptance of these by the Department of Health and Social Care are reminiscent of the emperor's new clothes. That DHSC is now paying pharmacies more quickly itself begs the question why it ever engaged with supply chain finance in the first place.'
PAC chair Meg Hillier slams the Department's engagement with Greensill Capital

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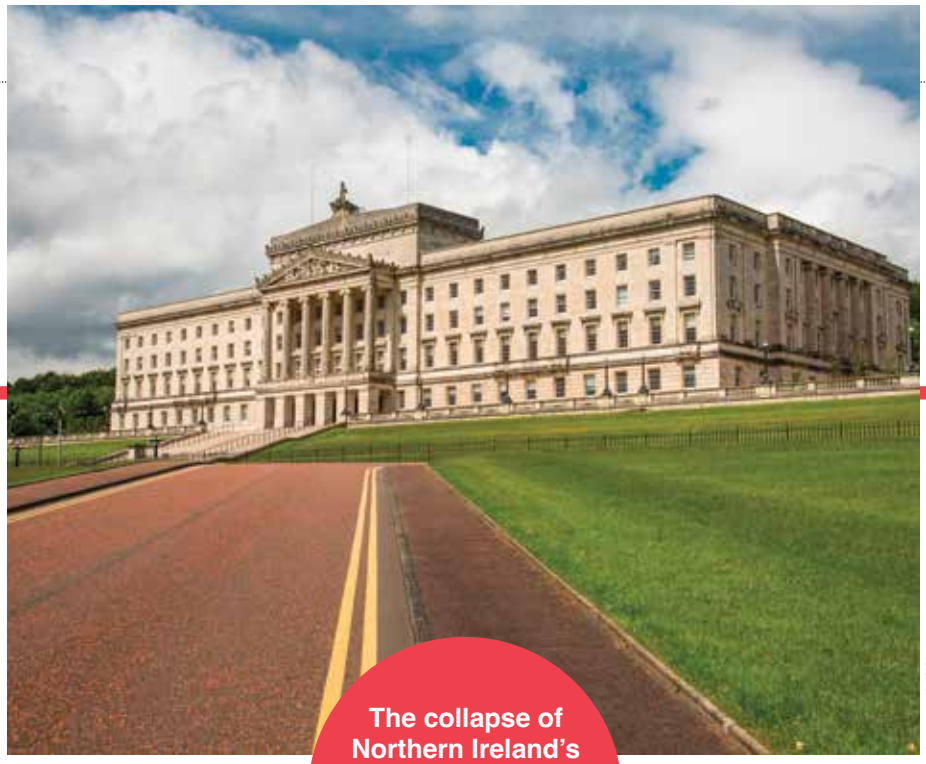

SHUTTERSTOCK

The collapse of Northern Ireland's power-sharing executive has stalled planned funding increases

are receiving additional support. The report added that the Scottish government must transform health and social care if it is to address the growing cost of the NHS and Covid recovery. The NHS was not financially sustainable before the pandemic, and Covid had increased those pressures.

The 2020/21 financial position of the NHS in England was outlined in the Department's annual reports. It said NHS commissioner and provider sectors ended the financial year with an underspend. This was due to the uncertainty around the Covid pandemic and a reduction in non-Covid activity as providers focused on their response to the virus. The annual report and accounts for 2020/21 noted a £3.5bn underspend in non-Covid budgets. Measures taken to support providers, including the temporary financial regime and write-off of historical deficits, had ensured the sector had a 'healthy' net surplus of £655m, the Department said. However, auditor general Gareth Davies qualified the financial statements for several reasons, including lack of evidence over the accruals balance (*see Technical, page 29*).

The government is to consult on capping legal costs in some clinical negligence cases in a move that it said could save the NHS £500m over 10 years. The proposal applies to lower value clinical negligence claims – typically between £1,001 and £25,000. Legal fees in these cases have been 'increasing and disproportionate', it said, while the National Audit Office has identified claimants' legal fees as a significant factor in the rising overall cost of clinical negligence. The consultation closes on 24 April.

Health secretary Sajid Javid set out his digital ambitions for the NHS, saying electronic patient records (EPRs) should be used in 90% of trusts by December 2023. Mr Javid said progress on EPRs had been 'undeniably brilliant' but inconsistent, with 20% of trusts having no EPR. There should also be a focus on social care, he said, but around 40% of providers had yet to adopt a digital social care record. Mr Javid hoped three-quarters of adults in England would be using the NHS app by March 2024.

Early payment schemes, promoted by former government adviser Lex Greensill's company, had no clear rationale, the Commons Public Accounts Committee said. The PAC looked at schemes with Greensill Capital, which included a pharmacy early payment scheme arranged with the Department of Health and Social Care, and a salary payment scheme with trusts. Mr Greensill told the government the former would save £100m a year, but the Department cannot provide evidence of benefits realised, the PAC said. Only 14% of pharmacies took up the scheme, compared with the anticipated 60%-80%. When Greensill Capital collapsed in 2021, no finance provider was willing to take on the scheme, and the government had to step in. The early salary scheme was marketed to trusts from 2019, but the PAC said government advice that trusts should avoid these sorts of schemes was not communicated until recently. A number of trusts took up the scheme, but they were now picking up the costs, the PAC added.

from the hfma

The HFMA's decision to give free membership to all finance staff in Agenda for Change bands 2 to 6 was highlighted in a recent blog from association chief executive Mark Knight. He says that the association is already seen as the voice of NHS finance, but the expansion will ensure it is representative of the whole function. 'We are determined to develop a membership that looks and feels like the wider finance community,' he adds.

Business assurance provider TIAA's digital assurance director, Pete Sheppard, examines the steps that NHS organisations should take to protect themselves from cyber attacks. Covid has heightened the risks. And remote working has created the perfect storm – potentially losing sight of exposure to cyber threats, as well as workers using unfamiliar technology, and challenges accessing IT support.

The announcement that integrated care boards (ICBs) in England will not now be formally launched until July will have created further uncertainty for some clinical commissioning group finance staff, says Debbie Paterson, the HFMA's policy and technical manager. It will mean two part-year sets of accounts must be prepared, but the association is helping staff navigate this complex process, she adds.

Staying with ICBs, HFMA policy and research manager Lisa Robertson uses her blog – *Everything in its place* – to ask what 'place' will look like and how these new bodies will operate.

See www.hfma.org.uk/news/blogs

Comment

March 2022

Twin challenges

The NHS faces a renewed push on efficiency and integration

The NHS is now at the stage of bringing the 2021/22 financial year to a close, while looking forward to the clear challenges that await us in 2022/23.

The financial challenge ahead will continue to be influenced by Covid as the pandemic moves towards being endemic. Covid hospitalisations are expected to reduce, although the pace of this reduction is likely to be patchy across the UK. However, it is clear that the virus will continue to have an impact on direct costs – as a result of personal protective equipment and testing – and on performance, as a result of changes to pathways and flow to facilitate infection prevention and control.

So it is essential that we work to understand additional Covid-19 costs and how to 'reset' the system. How do we deliver efficiencies in a system where costs have significantly and permanently changed? And how do we manage service expectations, as all nations will be subject to much tighter finances?

In early February, the Department of Health and Social Care published a white paper on the integration of health and social care in England. *Joining up care for people, places and populations* sets out a vision to join up planning, commissioning and delivery across health and adult social care.

Its focus is on integrated working at a place level to encourage local planning to prioritise outcomes for local people through solutions developed across organisational boundaries.

The paper recognises the need for effective, and different, leadership within and across organisations,

HFMA president Owen Harkin

Bringing in the new

A move to a new payment system must avoid an increase in bureaucracy

Ask most finance leaders about the old payment by results (PbR) system for paying providers for their activity and they will say 'good riddance'. But ask them about its replacement – the aligned payment and incentive (API) scheme – and you'll get a much more nuanced response.

Undoubtedly it is an improvement on PbR. For a start, it covers all healthcare activity, not just acute services. PbR's acute-only approach would be particularly incongruous in the context of attempting to encourage a more integrated approach to service delivery.

And the inclusion of a big fixed element in the new approach – set to cover the costs of a realistic and agreed level of activity for the year – gives far more confidence to commissioners and providers about their actual spend and income.

But it's not that straightforward. The NHS is moving from PbR to API via two years of a temporary financial regime, which has seen providers funded on a largely block contract basis during the service's Covid-19 response. For some finance professionals, the move to API now feels like a step backwards.

There is recognition that as the NHS moves into a new 'living with Covid' phase, aspects of the pre-Covid financial regime need to return. Pressure is needed in the system to drive efficiency savings and productivity improvements. However, these will be harder to deliver given the continuing pressures of working in a heightened infection control environment with an exhausted workforce.

There are concerns about the new payment approach. For community and mental health services, it may feel as though little has changed. They also face significant backlogs of care, with mental health services, perhaps in particular, facing a huge rise in demand as a result of Covid-19. But there is no variable element or elective recovery programme to support these non-acute services.

For them, it may feel as if PbR's focus on the acute sector has not broadened out much – although clearly the huge elective backlog does need to be addressed.

There are other misgivings too. One of the main criticisms about PbR was the way it led to increased bureaucracy – a mini-industry in coding and counting and time spent challenging activity and the validity

Healthcare Finance editor Steve Brown

"Now is the time for the association to look to the future with a refresh of our strategy"

underpinned by clear accountability for delivery and financial responsibility.

The use of pooled and aligned budgets is expected to increase to facilitate integration across organisations.

This will be supported by investment and legislative change to encourage data sharing and shared digital approaches at system level.

There will also be greater flexibility in the sharing of the workforce and the transfer of staff between health and social care settings, with a focus on integrated workforce planning at a place level.

Each nation has taken a different approach to working more seamlessly across NHS settings and improving links with the social care sector.

There remain opportunities to learn from the different arrangements and the HFMA is planning to produce a short paper setting out how each of the four nations has approached integration across the NHS and social care.

The paper, which should be published in the early summer, will share learning and highlight the different methods employed.

The past two years have also created challenges for the association, particularly at the outset of the pandemic. These have now stabilised, thanks to the amazing work of our staff team and the support of branches. So now is the time for us to look to the future with a refresh of our strategy.

With this in mind, the trustees have agreed to look at our services and plans across a range of headings: membership; policy and research; education and training; and managing ourselves as a business.

We will particularly look at how the association can adapt its offering to meet the changing needs of our membership, following the provision of free membership to all band 2 to 6 finance staff from the beginning of 2022.

We are delighted with the response to date, with almost 1,200 new members as of February, and we are determined to meet the needs of our new members.

The refreshed strategy will be developed in the coming months, with publication planned for the summer.

Contact the president on president@hfma.org.uk

of payments. Most agree that the new API system will reduce these activities. But it won't do away with them.

There are significant counting implications connected to the elective recovery funding regime, details of which were published in draft form at the end of February (*see Providers raise underfunding concern, page 3*).

Commissioners will need to demonstrate system-wide any variations from the 104% value-based activity, compared with 2019/20 activity, on which their initial elective recovery allocations are based.

At provider level, this activity monitoring will be key to triggering the variable payments under the API – or identifying the level of clawback due to missing the activity baseline.

The centre has recognised that a marginal rate of 75% doesn't work for additional independent sector activity, as trusts would face full tariff prices. Paying 100% removes any disincentive. But this will mean detailed monitoring and reporting of this activity too.

"Coding, activity counting and costing all improved under PbR – but there are concerns that these gains could disappear in a change of system"

A balance needs to be struck. Coding, activity counting and costing all improved under PbR. And there have been concerns that the gains could disappear with a change of system. There is agreement that this should not be allowed to happen, given the importance of good activity and costing data to support population health management, whole pathway costing and transformation.

But the new payment approach needs to provide a mechanism that helps systems channel resources to where they are most needed and support discussions about how system priorities can be delivered within available funds. Rather than counting and challenging, it needs to leave time for finance staff to support operational colleagues with identifying options for improvement and understanding the financial implications of revised pathways.

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Our business

Addressing health inequalities, in general and as part of the elective recovery programme, is a priority for the NHS. Steve Brown talks to three finance directors about the role of finance in this agenda

It can be easy to see health inequalities as someone else's business, an issue for clinicians or public health specialists to address. But increasingly, the financial role in improving equity is being recognised.

'It is absolutely the business of the finance profession,' says Lee Outhwaite, finance director of Chesterfield Royal Hospital NHS Foundation Trust and of Derbyshire Community Health Services NHS Foundation Trust. 'It has got everything to do with how well we allocate resources – are we having the maximum impact we can with our spending and are we doing the right things?'

He is equally adamant that this is not simply a commissioning issue, but one that provider organisations have to be just as focused on. 'How do we ensure we've got good, equitable, fair access to our services?' he asks.

Mr Outhwaite says you don't have to look far to find evidence that things are not right currently. 'In the most deprived part of Derby city, a 49-year-old male can expect to have 1,000 more days of healthy life,' he says. 'Someone the same age living in the most affluent part of Derby can expect to live another 20 years of healthy life.' And the gap is even wider for women.

Every area would recognise statistics such as these, with often stark differences in life chances of people living short distances apart.

It is not just that people are noticing existing health inequalities, but that it's getting worse. In 2020, Michael Marmot published a follow-up to his landmark review of public health in England. He concluded that improvements in life expectancy, experienced from the beginning of the 20th century, had since 2011 'slowed dramatically, almost grinding to a halt'.

For part of the decade, life expectancy actually fell in the most deprived communities outside London for women and in some regions for men. And Professor Marmot noted that for men and women everywhere, the time spent in poor health was increasing.

Covid-19 has also thrown a spotlight on health inequalities, having a disproportionate impact on those living in areas of high deprivation, as well as on black, Asian and minority ethnic communities. Vaccination uptake, which feeds into Covid outcomes, was also slower and less comprehensive among different population groups.

'At the community trust, in almost everything we deliver, we observe differentially high access from the haves and lower access from the have-nots,' says Mr Outhwaite.

He argues that the service as a whole could get better outcomes if it reached out to more deprived and under-serviced communities.

'We are not trying to achieve equality, where everybody gets the same treatment and support,' he adds. 'We are looking for equity, which may mean allocating more to those who need it, proportionate to their circumstances.'

He admits it is 'exceptionally hard'. If the NHS is serious about narrowing the gap, it will need to start having conversations about areas that it can disinvest in – or not apply growth to – to enable increased investment in other areas.

Addressing the wider determinants of health is likely to deliver the biggest gains in levelling up health outcomes, he says. But the headroom to do this will only be created by improving integration between secondary and primary care services and between health and care services. More outreach by secondary care clinicians into primary care could eliminate waste and help avoid unnecessary admissions. And better social care could enable hospitals to move fit patients out of hospital quicker.

Waiting list analysis

One trust has highlighted the very real inequalities in access to care and shown that something can be done about. In March last year, Calderdale and Huddersfield NHS Foundation Trust analysed its waiting list, focusing on patients waiting for operations.

It found that patients from ethnic minority groups were waiting on average 15.2 weeks for a priority 2 operation – operations that should be performed within a month. This was 7.2 weeks longer than white patients.

By December the average for all patients was 4.4 weeks, with black, Asian and minority ethnic (BAME) patients actually waiting 0.2 weeks less than white patients.

Similarly, using a deprivation lens, patients from the most deprived areas in May were waiting on average 8.5 weeks longer for treatment than those from the most affluent areas. This improved by the end of the year, with the gap reducing to two weeks.

The study was instigated by the trust's then chief executive, Owen Williams, who also chairs NHS England's Health Inequalities Expert Advisory Group. Gary Boothby, the

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trust's finance director, says: 'The data is really powerful. When we saw it at the board, we were really surprised.'

Overlaying data about deprivation (using IMD – the index of multiple deprivation) and ethnicity was new for the trust. 'I don't believe we have anybody in our booking teams who decides to make somebody from a certain postcode or with a particular surname wait longer,' says Mr Boothby. 'I'm confident that is not happening. But it was quite clear patients from a BAME background or patients from areas with a lower IMD were waiting longer.'

The trust spent a lot of time trying to understand what was driving this. 'There are language barriers and a difference in the ability to manage the system,' Mr Boothby says. 'We've realised some IT systems aren't always that easy to navigate in terms of booking slots or accepting dates.' Communication difficulties can also lead to delays in pre-operative tests.

The trust recognised that people in lower paid employment may not have as much flexibility in getting time off for hospital appointments. It also acknowledged that there was less trust in health services among some communities, so the organisation had to think more about engaging with different people in different ways.

In response to the data analysis of its whole waiting list, the trust made several changes. First, it committed to prioritising patients with learning disabilities, having identified these people made up a disproportionately high number of its over 52-week waiters.

There were explanations for this – patients with learning disabilities may need more time on a list or require additional clinicians – but the trust recognised that this did not justify the longer waits.

More generally, in terms of deprivation and ethnicity, the trust has changed some of its communications – making letters easier to understand, for example – and the way it engages. But Mr Boothby says simply the process of making the organisation and staff aware of the problem has been the main contributor to improvement. Staff are more likely to enquire about what support might be needed to make an appointment, for example.

'If other organisations did the same analysis, they might be in the same position,' he says. 'The key to the improvement has been the data and the knowledge of problem. We haven't cracked it. We are still asking the questions and have a continuing workstream.' He urges all trusts to undertake the same type of analysis.

Views from the finance front line: (l-r) Gary Boothby, Usman Niazi and Lee Outhwaite

Usman Niazi, chief financial officer of South East London Clinical Commissioning Group, says addressing health inequalities is even more complex than looking at outcomes or access by different groupings. 'What surprised me in south-east London was the big disparity between and within ethnic groups,' he says. Outcome and access inequalities are much more stark for people from a black African or black Caribbean background than for other groups, for example.

Engagement issues

Poorer outcomes also have a financial impact, with evidence showing clearly that health inequalities in deprived communities lead to higher costs, particularly in acute settings. 'One reason is that these population groups often don't feel like they can use primary care and early intervention services, so they only present in crisis,' says Mr Niazi.

He says the quality of life experienced by these communities is not acceptable and there are opportunities to re-channel funding earlier in the pathway in ways that will improve outcomes. The Covid-19 vaccination programme has shown that trust is a key issue in vaccine uptake, with a better understanding of how to engage with different communities through community centres and religious facilities helping to improve jab rates.

'The thing that it really drew out was the power of hyper-local information and action at an almost street-by-street level,' Mr Niazi adds.

He says systems have the opportunity to use similar local data – analysing outcomes by lower layer super output areas (LSOAs) – to help meet needs in a more targeted way.

'The information we have allows us to accurately predict the number of people in an area with undiagnosed hypertension or diabetes [comparing known cases with expected cases], giving us the opportunity to outreach to them to help get them into some early action preventative programme.'

Mr Niazi stresses that the key is to provide 'actionable insight' rather than simply churning out volumes of data. 'I want to see one page that tells me the five things in these areas that teams should do now,' he says. The CCG has commissioned work to test this hypothesis, and quantify the costs of health inequalities in the south-east corner of the capital.

'As well as data, we also need to find more effective ways of serving deprived groups,' Mr Niazi says. 'For example, that means focusing on building strong, trusting relationships with people from deprived communities and delivering the sort of care people from these communities want to receive.' That might mean peer support in a mental health crisis rather than more traditional NHS services.

Identifying the cost of health inequalities nationally may help to make the case for action generally, but Mr Niazi wants something more specific. 'What do health inequalities mean in terms of how many times people come into hospital more than others, for what conditions, at what point in the journey and how do you stop it happening?' he says.

Making the financial case for addressing health inequalities will be crucial. 'We have to have evidence and an empirical base on which to make decisions,' he says. 'We need to quantify the cost of inequality, and the sets of interventions need to be backed up by a business case that shows the return on investment and timeframe.

'I don't buy that it will take two decades to deliver a payback. Everyone we stop from having a mental health crisis today, for example, potentially stops someone turning up in the emergency department.'

Mr Niazi says the system must collectively own the health inequalities agenda. It will need to get back to delivering efficiencies, confine waiting list spending to the elective recovery funds received and concentrate growth on investment in its shared priorities, with health inequalities at the top of the agenda.

'The ethical arguments for addressing health inequalities should be what drive us, but the financial case for doing so is also compelling and important to ensuring the sustainability of the programmes we need to put in place to reduce health inequalities,' he says.

NHS finance careers: make your career count

In the second of a series of CIPFA webinars, leading senior finance professionals at NHS England, Claire Gravil and Devasuda Anblagan, discuss their careers in the NHS, the training and development necessary to carry out their roles, and why being a finance professional in the healthcare sector is a challenging vocation – but also a rewarding and fulfilling one

Over the past two years, we've never been more aware of the need for the NHS to be fast-changing and flexible, responding to rapidly changing circumstances. And in many cases, that was as true of the finance function as with other specialisms within the UK's healthcare service. NHS finance professionals have had to rise to that challenge and, as well as having the technical qualities needed to ensure sound financial management within the organisation, have also had to be flexible and agile enough to adapt to different challenges and respond extremely quickly to new scenarios.

Here, Claire Gravil, Head of finance for Direct Commissioning/COVID vaccination programme for NHS England and NHS Improvement Northeast and Yorkshire region, talks with more recent graduate, Devasuda Anblagan, Senior Finance Manager at NHS England and NHS Improvement in the East of England, about switching careers in science for finance – and what they find uniquely rewarding about working for the NHS.

Claire Gravil (CG): What brought you into the NHS, and how did you get to where you are now?

Devasuda Anblagan (DA): I joined the NHS because I'm passionate about improving the health and quality of life of patients I serve. Previous to my finance role, I was an MRI physicist researching perinatal development and the aging brain. And, during my academic career, I saw the need to improve resource allocation models in the NHS and medical research by forecasting future healthcare pressures and taking action to address them now. This motivated me to join the NHS finance management training scheme in September 2017, so that I could better understand the current challenges and the future demand, and therefore influence the strategy development and implementation, and ultimately the interlinked funding allocation in medical research and the NHS.

Within the NHS graduate management training scheme, I had the opportunity to work on different placements, including three different NHS organisations – Cambridge University Hospital NHS Foundation Trust, Hertfordshire Community NHS Trust, as well as a system delivery unit of Cambridge and Peterborough STP. And I also had the opportunity to work with a consulting firm, PwC on projects in the ambulance service and at an acute trust.

On completion of my training scheme – around March 2020, just as the pandemic arrived – I joined NHS England and NHS Improvement as a finance manager, before being promoted to my current role. I've undertaken various placements in these organisations, giving me a broad range of experience to help me connect different areas of finance together. I've also gained insights into partnerships between the NHS local authorities and other organisations that take collectiveresponsibility for managing resources, delivering services based on NHS standards and improving the health of the local population.

That set me up for my current role where I'm responsible for looking after the public health and primary care funding for the Eastern region, covering business planning, development and project performance management for the regions, with a budget of around £400 million.

Claire, I know that you have a similar kind of experience as well...

(CG): When I went to university, I wasn't quite sure where I wanted to go in my career. I did a chemistry degree and then I worked at a chemical plant as a chemist for a couple years, which was very interesting – but it didn't feel quite right for me.

I love the medical world, particularly the NHS, and wanted to be part of it so I applied for the NHS finance graduate scheme and was successful. It was hard course, but it was also a brilliant scheme to be on. My first role was in Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust and I absolutely loved it – you feel you are part of something special. For example, when you're working on business cases to develop funding for something, you can just walk down the corridor and see it implemented. That aspect of the role is one of the fascinating and interesting parts about being an accountant in the NHS, seeing elements to that decision-making process, around patients. As a young accountant it really impacted on me – it made me realise it's not just about the money, it's about the wider concept.

I then took a break from the NHS for a couple years and went to local government at North East Lincolnshire Council. It was very different, but when it comes to your finance training, it was also familiar – because it's the same concepts and financial principles; everything was similar.

I returned to NHS England as assistant Head of Finance in primary care finance. The role then migrated into specialised commissioning, and I worked my way up to Head of Finance for specialised

commissioning and public health. I'm now working on the COVID vaccination programme as part of a secondment to support the national programme.

The insights you get from working in all the different roles provides so much experience – there are so many opportunities. Your accountancy training sets you up, but the world really is your oyster.

(DA): Our career journeys have been similar in some ways, from science to finance via the NHS Graduate Management Training scheme. I found the orientation part of the scheme really important in understanding how different functions operated and collaborated within the NHS, and how it's all interrelated. This really helped me to understand the vision, the values, the priorities, as well as the strategies of the organisations that I worked at. It helped me understand how different clinical and non-clinical departments collaborated to achieve the organisation's vision and provided insight into their working relationship with the finance department.

(CG): I did something very similar – it's important, moving into a career in finance or within the NHS, to understand how it all functions. You can do your job well but you need to ensure you have empathy, compassion and understanding for everybody you work with in the organisation across all parts – the NHS only functions because of everyone in it, whatever their role. The graduate scheme helped me appreciate that. Even now in my role, if I don't understand something, I'll go and see the process in action, I'll walk the floor and talk to the people involved.

Taking the CIPFA qualification was – and still is – an integral part of the NHS graduate scheme. It was challenging to work and study at the same time, but in hindsight, it was one of the best things the scheme did for me. I flourished through CIPFA. I loved the modules, I loved the structure to it and I loved how it was delivered, as well as the access to different people within CIPFA.

(DA): CIPFA gave me a good understanding of public sector accounting and how different public sector bodies work together. The knowledge I gained from CIPFA training has been extremely valuable for the work that I do for financial management and reporting, as well as financial strategy. I still refer to my lecture notes from CIPFA strategy modules alongside the Green Book. When you do CIPFA, you learn that it's not just about the theory, it's how you can apply it, and that's been very beneficial.

(CG): So learning from your experience on the course, what advice would you give to CIPFA students now?

(DA): The most important advice I'd give is to take time to understand yourself and what is important in your life. Know what the purpose, values and goals are in your life – ask yourself questions about exactly what type of things you want from your work life. Once you get to know yourself and your priorities, you can then shortlist the ideal career for yourself. This way, you are more likely to enjoy and be satisfied with a career that meets all your needs, and it will continue to motivate you to progress further.

Also, I strongly believe that it's really important to have a network of support for your professional life as well as your personal life. I've been mentored by two female chief executives and it's been invaluable – it's shaping my finance career. They've challenged me to think outside the box and trust in my ability, and that has helped build my confidence.

Be proactive and identify who can support you in your career and reach out. CIPFA has the buddy scheme, mentoring and coaching. But also look for opportunities to give back when you can in your career.

(CG): When you're a student, you often feel like you're choosing a career and making decisions that are going to affect the rest of your life, so it can be quite pressured. But that world's changed a lot now. I'd say to students, although you will make some decisions at the beginning of your career, that doesn't define you – it doesn't mean you are going to be 'stuck' for the rest of your life.

Don't be afraid to make a decision based on what you want to do now. You're certainly not pigeonholing yourself into anything.

Career opportunities

Please find more details of CIPFA training courses by visiting: **www.cipfa.org/training**

Claire Gravil is Head of Finance for the COVID Vaccination Programme for the North East & Yorkshire Region, a very challenging role that she is still heavily working on and enjoying.

Devasuda Anblagan is a Senior Finance Manager in NHS England & NHS Improvement. She is currently in the East of England Direct Commissioning team, where she is responsible for business planning, development, and financial performance management for the region's Public Health and Primary Care.

Single focus

Working day 1 reporting can put an organisation on the front foot for performance and show it is serious about financial management, say its proponents. Steve Brown reports

It is pretty safe to say that Simon Worthington is a fan of working day 1 financial reporting. He was responsible for the introduction of such early reporting in the NHS almost 20 years ago, in a small primary care trust, and has more recently overseen its introduction in Bolton NHS Foundation Trust and in his current organisation, Leeds Teaching Hospitals NHS Trust. His case is simple. If you can report on day 1, why would you want to wait longer?

'What is the function of a budget report?' says the Leeds finance director. 'It is not to be a forensically accurate bank statement, down to the last penny. It is there to highlight if there are any material issues that management needs to take action on. And in that context, it is better to get it out quickly.'

There are other high-level benefits. With working day 1 reporting, everyone knows exactly when budget reports are issued and this helps to create a rhythm about the financial management cycle. And it sends a message that financial management – which has a key role to play in the delivery of good patient care – is taken seriously.

Mr Worthington says organisations must want to do it – not have it imposed on them. And teams need to be given the right environment to work out what is required to deliver it. The result is an organisation on the front foot in terms of its financial position, and a finance team that is more confident and able to start working earlier with operational teams to influence service and financial performance.

The practice is not widespread in the NHS, although it is believed that NHS England and NHS Improvement would be keen to see wider adoption as part of moves to faster reporting in general. Just over 10

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organisations across the English NHS currently report on working day 1, with most trusts – more than 70% of the total – reporting between working day 5 and working day 8. However, there are still examples of trusts taking 10 days or more to get financial reports out to executive teams and budget holders.

Jenny Ehrhardt (pictured below), group chief finance officer for Manchester University NHS Foundation Trust, previously served as deputy director of finance at Leeds and was involved with Leeds' working day 1 introduction back in 2017. She makes no bones about the fact that she took her inspiration for earlier reporting from the Leeds model, bringing in key people from the Leeds team to brief staff before going live in April 2020.

While the finance team also spoke to colleagues in Bolton, Leeds' experience was particularly relevant because of its comparable scale. The £2.4bn turnover trust with its headquarters in Manchester runs 10 separate hospitals and employs more than 28,000 staff, together providing hospital care to more than one million patients a year. It is also the single biggest provider of specialised services in England.

Ms Ehrhardt says that communication was vital. 'I started by talking to the chief executives of our hospitals, because they are our finance customers. And I knew that it was important for the non-finance community to see this as a positive.'

She admits that hospital finance directors were taken aback initially by the prospect of implementing the approach – mirroring her own immediate response back in Leeds. Concerns ranged from whether the timescales were achievable to availability of data and the accuracy of using estimates.

'But any accountant, whatever timeline they are working to, is doing estimates,' says Ms Ehrhardt. 'Whether they close on day 1 or day 21, there will be estimates in there. So actually, what we are asking people to do is still to make estimates, but just before the month-end.

'Actually, how much difference does it really make if you do it two days before the month-end or two days after? It is about the quality of the evidence you've got and the knowledge of the service.'

Accuracy concerns

Mr Worthington completely rejects concerns about accuracy. 'I think it is a non-argument. The accuracy objection only exists in people's minds. Since we introduced it at Leeds, I can't remember a single time, across all our board and clinical service unit reports, when we got something wrong due to working day 1. It has just not been an issue.'

Ms Ehrhardt adds that the move to earlier reporting is partially about finance managers building confidence.

Kevin Nederpel, deputy director of finance at Portsmouth Hospitals University NHS Trust – the latest trust to join the working day 1 fold – agrees. He says the biggest hurdle to overcome in their 2021 implementation was not technical, but a change of culture. 'The aim was to get things approximately right, rather than precisely wrong,' he says. 'Accountants want to get the perfect accrual, but close enough is good enough for day 1. It is a cultural shift we needed.'

Once accountants realise they are being trusted to provide their judgement in some area, he says the process can be quite empowering.

Exploding myths

All those who have implemented working day 1 reporting are keen to explode some myths. First and foremost, it does not mean doing seven days' work in a single 24 hours. In fact, it is not about producing reports faster. Instead, it involves shifting activities to the left on the timeline.

Before it moved to working day 1 reporting at the beginning of May 2021, Portsmouth reported on working day 7. Finance director Mark Orchard says: 'Within that, we spent about five days processing information and a couple of days deliberating on judgements that don't have a perfect answer.

'We've reworked some of the processes, and they've definitely got sharper, but by and large they still take four to five days – just shunted left in the timeline. But the biggest change is with validation, where we force ourselves through a very disciplined, structured process.'

Day 1 is now run with military precision, with all judgements made by the middle of the afternoon so that reports go out to budget holders at 5pm.

However, the process inevitably does rely on an element of estimates on both income and expenditure items, including high-spend areas such as drugs. Drugs is one of the key areas that all trusts highlight as a key area of focus. And finance teams are best placed to work out how to make those estimates. Portsmouth, for example, now processes its drugs spend for the month four days before the month-end – on working day -4. However, the trust is not cutting off expenditure at that point. It uses estimates for the missing days and is getting better and better at these estimates.

"I can't remember a single time, across all our board and clinical service unit reports, when we got something wrong due to working day 1"
Simon Worthington (above)

As a major tertiary provider, the Manchester trust uses a lot of high-cost drugs, so getting the numbers right on pharmacy costs was one of its main issues. 'The easy ones are those that are always a pass-through drug. So the flag in the pharmacy system identifies it as a pass-through drug,' says Ms Ehrhardt. 'Because the income and expenditure matches off for pass-through drugs at month-end, and the detailed reconciliation with commissioners comes much later, it isn't necessary to get perfection within the year. The much trickier ones are where it's a pass-through drug for condition A, but not for condition B and you only know once you link it to the patient.'

A further complication for Manchester was effectively having three pharmacy systems in place when it went live – a result of earlier mergers. The solution has been to use a three-month rolling average for drug costs, rather than trying to put actuals in.

'We've done this because of the complexity of our pharmacy systems and it is an area that we keep looking at,' says Ms Ehrhardt. 'Currently

Ending Change Paralysis in NHS Estates:

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"Revolutionary treatments, technological developments, leadership structures, different funding... one certainty in the NHS is constant change. But there is a critical area that has proved notoriously slow to evolve: estates. Get it right and trusts, GPs and care homes can adapt to meet the needs of today's and tomorrow's patients and visitors. Fail to take action and hospitals and surgeries will not be fit-for-purpose, continuing to deteriorate and damaging patient services and user confidence."

- Sir Robert Naylor

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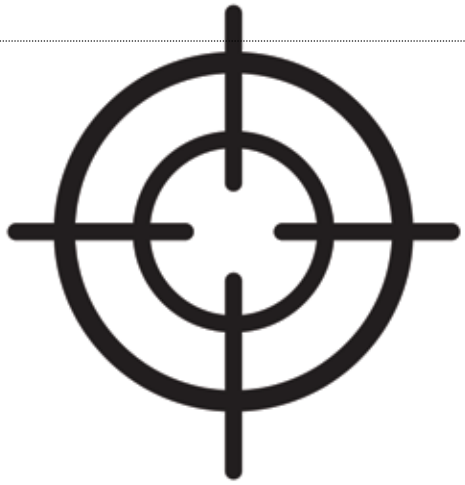


we don't think we have a better way of doing this, but we have a new electronic patient record and electronic medicines management system going live in September – so this will all get reviewed again.'

She says any variation between estimates and final actuals would get picked up in the following month's reporting. And material errors would be known about before operational managers submit their year-end forecasts, which are the basis for the trust's financial accountability framework.

However, she stresses the importance of accuracy in feeder systems. 'This can avoid, for example, the management accounts team spending time re-coding people from payroll,' she says. In fact, she believes that working day 1 has driven data quality improvements in feeder systems.

In all the trusts spoken to, accuracy simply has not been an issue. 'We thought we'd probably be working with about 80%-90% accuracy of our transactions,' says Portsmouth's assistant director of finance Steve Smith. 'In reality, we are much more accurate than that and I think we are 99% of where we were at before working day 1.

'People were really worried at the beginning – it was challenging their own predetermined view about what was necessary to deliver a financial position. But they moved very quickly round once they had tested it for themselves on their own terms.'

Outsourcing issues

Portsmouth has also demonstrated that outsourcing financial services and payroll is not an obstacle to day 1 reporting – another often quoted objection. The trust contracts for these services with NHS Shared Business Services.

For example, pay will form the main chunk of most services' expenditure. 'The main part of the payroll, we can't really estimate,' says Mr Smith. 'That is where the bulk of staff get paid. We have to have that as a hard piece of information and that flows in – it varies a little from month to month as to when we get the information and that puts a little tension into the system, but it is not an estimate.'

Learning points

A detailed timetable is key to successful delivery of working day 1 reporting, according to a case study of the Leeds implementation featured as part of the One NHS Finance innovations programme. The timetable should set out what needs to be done on each day up to month end close down and day 1 and this will need to be reviewed many times and become a live document.

The timetable also needs to be sensitive to holiday periods, recognising that day 1 will move back at Christmas and at the financial year-end.

Another learning point was the importance of keeping people informed – it is better to over-communicate to avoid confusion. Also, listening to budget managers can highlight information that doesn't add value and processes that can be streamlined.

• More information online at: **hfma.to/mar222**

Some estimates can be needed for weekly pay, for instance when there is a five-week month. But if there is any difference between the estimate and the actual, it is marginal compared with the overall paybill. This is also the case for supplemental pay, where people have missed the payroll run. The point being that the costs are not ignored, but estimated.

'We've been with SBS for 15 years and everything is provided based on the specification,' Mr Smith says. 'It can submit the payroll file up to the 28th of each month. If it provided information to us as late as it could, it would test our ability to do any final adjustments or controls around the process. But, in reality, the system works better than that and typically, they work within their specification.'

He adds: 'Because of the outsourced ledger, we can have a rush of transactions right at the death. But we don't leave it to chance. We run reports in the days leading up to day -1, so we are watching it all the time.' This can create risks if the team has posted creditors for things they didn't expect to be paid, but subsequently do get paid. However, there is a small window to do journals on working day 1.

Mr Smith says the experience of implementing working day 1 reporting contradicted his expectations. 'In reality, my preconceptions of what's involved and how complicated it was were shattered,' he says. 'You start thinking this is going to be hard and we are going to have to batter away at it, but it wasn't really like that.'

While he suggests the trust's finance team are still 'rookies' on day 1 reporting, it has gone through 11 months of a cycle.

'We've had challenges, but that doesn't detract from it being the right thing to do,' says Mr Smith. 'And it's taken us to a different place. It has invigorated the way the department functions, presented us with a fresh challenge and undoubtedly improved our understanding of what we do.'

Mr Orchard says the benefits are clear. 'I'm reporting to the trust leadership team a whole week earlier than I was before,' he says. 'I can be having conversations as early as 8.30am on day 2. That insight has put us on the front foot and given us the ability to take actions, where they are needed, that much earlier.'

Ahead of schedule

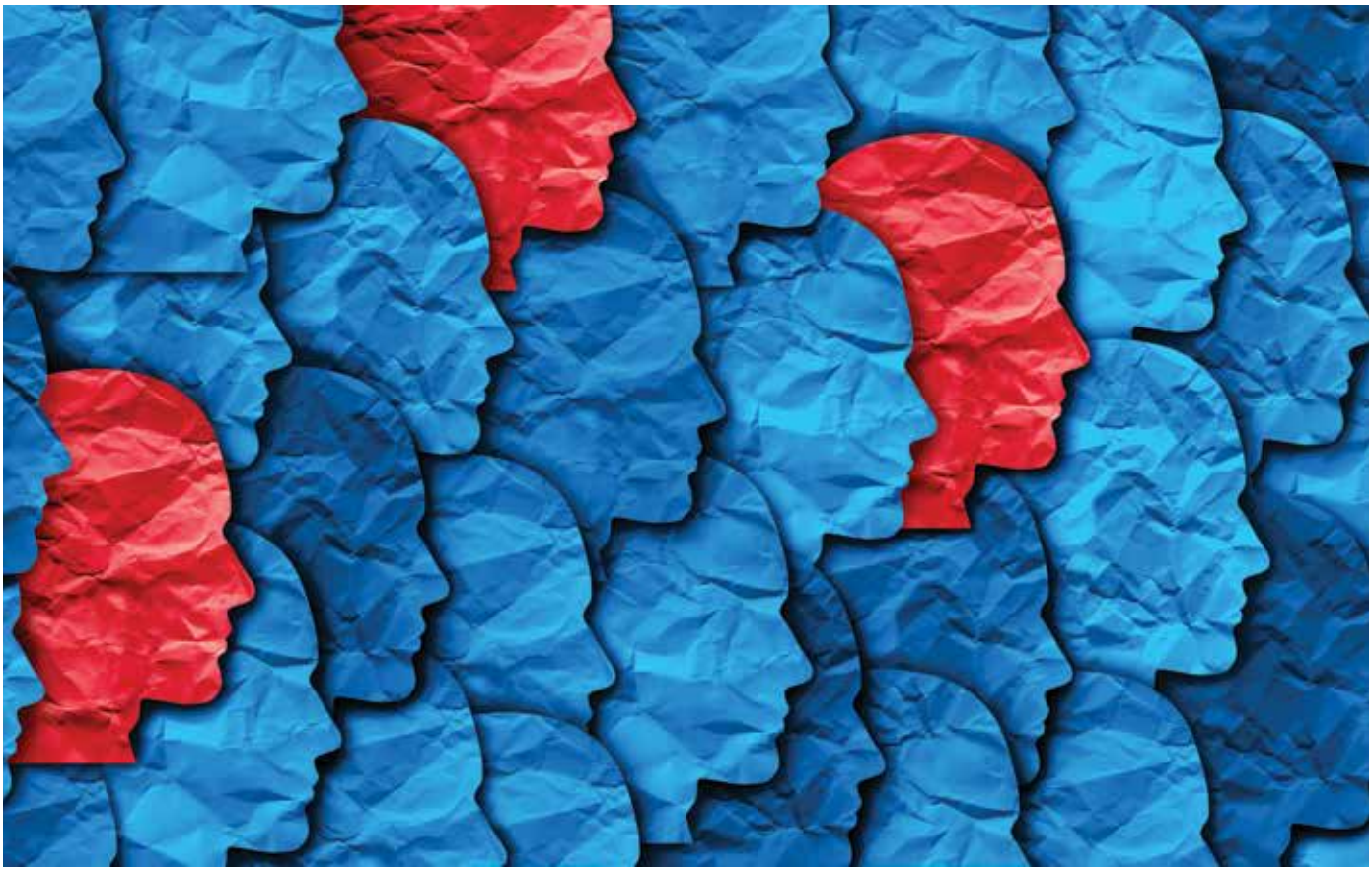
Ms Ehrhardt agrees, adding that discussion with executives and non-executives seems much more current. Even compared with organisations that are reporting around day 7, she suggests that she can typically be a week ahead in terms of insight.

She adds that, if others also move to working day 1 reporting, this could really help at the system level, enabling systems to quickly get to grips with emerging issues relating to revenue and capital envelopes.

The Leeds trust has reported surpluses for the past four years and was rated outstanding in its use of resources assessment by the Care Quality Commission in 2019.

While Mr Worthington does not credit working day 1 as the single reason for these successes, he is clear that earlier reporting is key to its wider financial improvement plan, *Finance: the Leeds way.*

He agrees with Ms Ehrhardt that there would be benefits nationally and at system level to wider reporting at day 1. But he believes the organisational mindset benefits and the ability to get an earlier start on course correction when needed are far bigger incentives. His challenge to other finance teams is simple: 'What are you waiting for?'



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The bigger picture

A recent HFMA roundtable, supported by Civica, discussed the challenges and opportunities in moving the NHS focus to whole populations and the role for finance. Steve Brown reports

HFMA ROUND TABLE

Improving population health – focusing on outcomes for entire populations and tailoring services to individual and group needs – is one of the core aims of integrated care systems. It means health services thinking about current and future health and care needs and working in partnership with other organisations to address the wider determinants of health. But, while there is considerable support for the population health management (PHM) approach, which relies on the analysis of wide-ranging datasets, there are considerable challenges to putting it into practice.

The HFMA organised a roundtable event in February, supported by global public sector software specialist Civica, to share current progress, identify solutions to common barriers, and discuss the specific role that finance professionals have to play in the population health agenda.

Getting started is one of the key issues with the move to population health. This was where Su Rollason, chief finance officer at University Hospitals Coventry and Warwickshire NHS Trust and former system finance lead for the Coventry and Warwickshire integrated care system, focused the roundtable's attention initially.

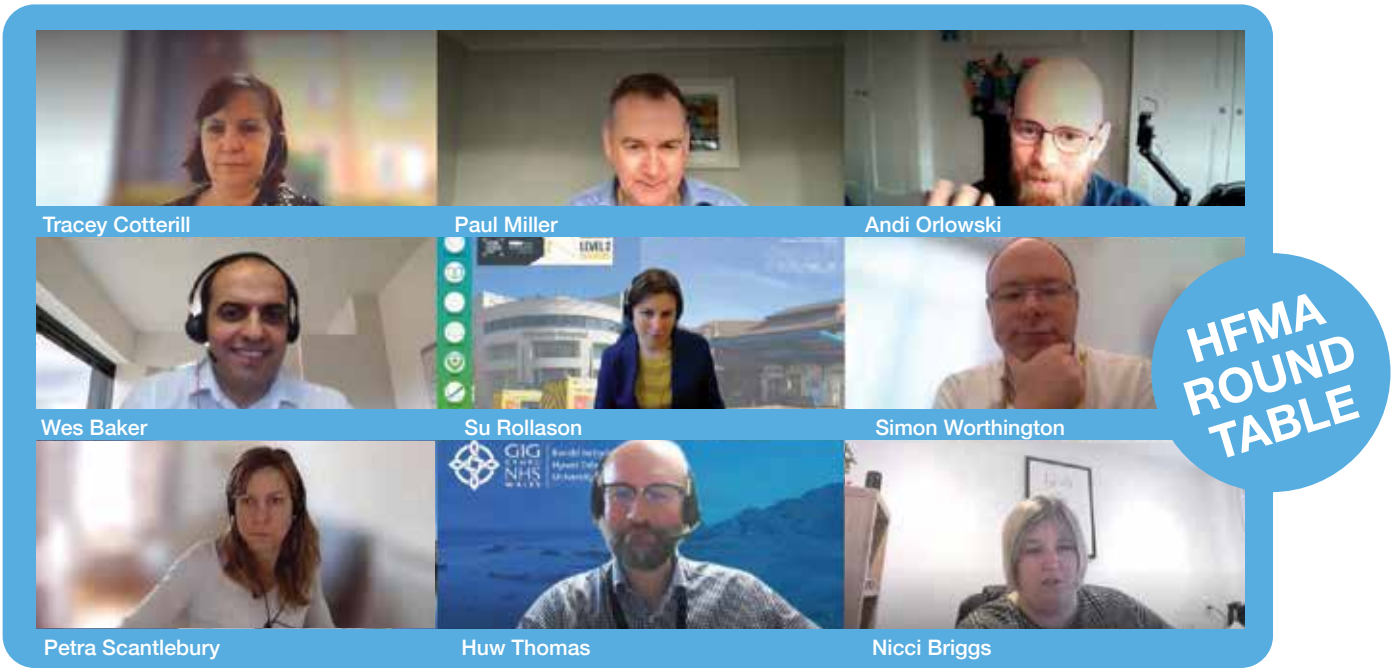
Wes Baker, director of strategic analytics, economic and population health management at Mersey Care NHS Foundation Trust, said the key decision locally was moving away from a pathway approach to one that looked at patients and service users more holistically.

For example, there was a 20-year life expectancy gap for mental health service users compared with non-mental health service users. These users were dying of physical health long-term conditions such as respiratory disease. And a pathway approach simply didn't address the issue of multi-morbidity.

So the trust had gone down the route of segmenting its population into groups with common healthcare needs and risk-stratifying these groups.

While the overall goal was to take a whole population view, initially trusts had to narrow their focus, said Mr Baker.

'We had to focus on two segments to be able to do something tangible on the ground,' he said. 'And this really started the conversation at a place level.'



The use of data to start conversations – and the fact that it was the conversations and not the data itself that led to change – was to become a common theme for the discussion.

Andi Orlowski, director of the internal NHS consultancy the Health Economics Unit, said one of the important aspects of segmentation models, such as Bridges to Health, was its focus on whole populations. This included healthy people today who may be sick tomorrow.

'We've captured data about activity that has already happened in great detail, but what about the well people?' he asked. 'The 45-year-old who hasn't seen their GP for a decade, but has been gaining weight over time, with a more stressful job and drinking more – how do we know more about them? That is what we mean by whole population. How can we predict who is going to be sick tomorrow?'

Nicci Briggs is director of finance of Leicestershire, Leicester and Rutland Clinical Commissioning Groups, which have recently implemented a primary care funding formula based on patient need, aiming to reduce health inequalities across the system.

The funding model is based on patient-level data and aims to better match primary care allocations with local health needs. However, the data was the starting point.

'We spent a couple of years improving the data that we did have in terms of population health and all its component parts,' she said.

'And we worked with Johns Hopkins on its Adjusted Clinical Group (ACG) system, which allows you to combine primary care, acute and public health data together and then identifies risks and tracks patients over a period of time – projecting forward rather than looking back,' she said. 'This allows you to cluster on morbidity rather than defined diseases, which is the way the health service works at the minute. In addition, our model incorporates list turnover, deprivation and communication issues, which can increase the amount of time you need for health appointments.'

Participants

- Wes Baker, Mersey Care NHS Foundation Trust
- Nicci Briggs, NHS Leicestershire, Leicester, and Rutland CCGs
- Paul Buss, Powys Teaching Health Board NHS Trust
- Tracey Cotterill, Civica
- Paul Miller, Salisbury NHS Foundation Trust
- Andi Orlowski, Health Economics Unit
- Su Rollason (chair), University Hospitals Coventry and Warwickshire NHS Trust
- Petra Scantlebury, Barking, Havering and Redbridge University Hospitals NHS Trust
- Huw Thomas, Hywel Dda University Health Board
- Simon Worthington, Leeds Teaching Hospitals NHS Trust

Data has also been the starting point for Barking, Havering and Redbridge University Hospitals NHS Trust. Petra Scantlebury, the trust's assistant director of finance for strategy and planning, said the North East London system had recently established a financial intelligence workstream to look at both allocative and technical efficiency.

'It has two key objectives – to build intelligence to inform the allocation of funding to maximise outcomes for our population,' she said. 'And once those resources are allocated, the aim is to understand how they are used and to inform improvement.'

Working in partnership is key to addressing the wider determinants of health according to Paul Miller, non-executive director of Salisbury NHS Foundation Trust. 'So a starter for 10 has to be to engage your local authorities around their joint strategic needs assessments,' he said. 'If we don't, we'll have a very irritated set of public health colleagues. It has to be about what adds value to the population, not just what adds value to the patient.'

Tracey Cotterill, a former NHS finance director and Civica's managing director of population health intelligence, said systems could also start by looking at who is missing from referrals and attendances, or showing up in a later stage of disease development.

'In one London system, analysis of the data identified that a significant proportion of cancers among the more deprived cohorts of their population were being diagnosed in the emergency department,' she said. 'We need to ask if we are seeing the proportions of people we'd expect to see in each category. And when

we are late with a diagnosis, what are the common denominators and how can we use that information to enable earlier diagnosis in those cohorts in future?'

HFMA ROUND TABLE

Huw Thomas, director of finance of Hywel Dda University Health Board, called for a focus on place. 'Understanding the characteristics of communities will be really important in this,' he said. 'We need to start broad and work down.' But he warned that this needed to go beyond postcode level. 'You ultimately have to take it down to households,' he said.

'In Hywel Dda, we have areas where the legacy of old, heavy industry remains; and then we have areas of remote rurality and the drivers of deprivation are very different.'

Health systems should also beware the 'tyranny of the average' – for example, pockets of deprivation are often found in rural areas, but can be more hidden than in urban areas.

Data played a part in understanding communities, but continuous engagement and conversations were also vital. Mr Thomas added that people would respond differently to different interventions. 'So, we need to think more creatively about targeting the individual drivers for people,' he said.

Mr Baker also reminded the roundtable that health bodies' workforces also provided a place to start. 'A third of our staff live in the most deprived communities,' he said. They will face many of the same access and lifestyle challenges as others in those areas. They also tended to have the highest sickness rates, so focusing on improving their health could have a double benefit.

Mr Orlowski suggested that impactability modelling could help with understanding who was most likely to respond to specific interventions.

'This is where primary care networks and people understanding their local populations, and staff, will make the real difference in picking the right intervention,' he said.

Finance data

Ms Rollason asked if areas had specifically used finance datasets as a starting point for improving population health.

Paul Buss, director of clinical strategy for Powys Teaching Health Board, said that he moved from a more traditional acute focused provider to a primary care, community, integrated provider, as it looked at things from a different, population perspective.

'Initially I looked at finance within primary care,' he said. 'If you delve into various levels of practice-based finance, at cluster finance level or practice level, or even dispensing logs at a local level, from a clinical perspective, you recognise clinical behaviours. And the variation evident across a region in the primary care finance data is of great interest.'

Dr Buss said the existing data sets were 'rich pickings'. 'But we've got to be prepared to have good data sharing agreements. And we've got to understand how we will look at that data, because someone with a secondary care view will see particular issues, while someone with a public health population lens will start to look at it from an allocative value perspective.'

Ms Scantlebury highlighted the significant amount of costing data in secondary care. 'So we know we are able to evaluate cost effectiveness,' she said. 'We can look at cost efficiency. But can we answer the question of whether or not the needs of our population have been met? The answer is probably not, because the main assessment criteria around population health management are more ethical than economic in nature. We need more information around reliable assessment of need than just the finance data sets.'

Simon Worthington, finance director of Leeds Teaching Hospitals NHS Trust, argued that there were opportunities to put a public health lens onto provider costing data.

The trust's costing team has developed a system combining its patient-level costing data with trust-collected comorbidity and lifestyle information (hfma.to/mar226). It has also pulled in index of multiple deprivation data from the Office for National Statistics.

'So, for instance, we've got analysis of where respiratory conditions are coming from and the extent of heating in houses in those

System opportunity

Closer system working may provide opportunities to focus on populations and whole patient pathways, rather than looking at the secondary care pathway in isolation from community or primary care services. Wales has been operating a planned integrated system structure for a number of years. 'One thing we've started to explore at the population level is how to take the allocation that is given to us and distil it down to sub-parts of the system – to the counties and clusters,' said Mr Thomas. 'We want to understand what those allocations look like versus the resources consumed at that level.'

He acknowledged that this had not yet led to much change. 'But it has helped us to understand what is driving our deficit and our financial challenges,' he said.

The health board has also looked at the patients consuming the highest level of resources to understand their journeys over the whole pathway and their lives outside of being a patient.

'We've also got 10 pathways where we are measuring patient reported outcome measures (PROMs) at scale,' he said. 'That is the other bit of the equation – the impactful bit of the equation that we've missed in the past. Bringing that in has been helpful. But one of the challenges that we've now got is comparing apples and pears across PROM measurements.

'So we are looking at how we can use datasets such as EQ5D to understand the impact we are having on quality adjusted life years. This will enable us to start to compare, at a population level, the impact of investment across conditions and up and down the pathway.

Dr Buss echoed Mr Thomas's comments about using the EQ5D. 'It is very easy to collect and it can be done by a GP, a nurse, even a carer – anyone with patient contact,' he said. 'If you collect it across a whole system, you will start to get trends about population health and wellbeing, mobility, anxiety, pain control – all in one simple validated metric.'

He added that there were many care models that had been shown to deliver value, by moving interactions from secondary care into community settings, for example. But he acknowledged that existing finance data sets only reveal a partial story. For example, investment in addressing adverse child events would certainly deliver societal benefits, which would be seen outside of health, in social care, education and crime or antisocial behaviour.

areas,' he said. 'And yes, you can see there are more people with respiratory conditions coming from areas where there is inadequate heating.'

While this may seem obvious, it helps to show the cost of treating the symptoms rather than the cause, and creates opportunities for discussion about what could be done to avoid the conditions developing in the first place.

'In the acute sector, if we have well-developed costing systems, there's a whole wealth of analysis and insight we can get.

'We can pick out frail patients or those consuming huge chunks of resource and start to discuss if there are better ways of managing those situations,' Mr Worthington added. 'That is really powerful and it is really engaging clinicians in my trust.'

Information governance (IG) is often raised as a concern for population health management with obstacles to be overcome in terms of data sharing. However, Mr Baker suggested that many of the problems were cultural. 'I don't think there is a major issue around information governance,' he said. 'Yes, we have to do the data protection impact assessments to get the data flowing. But the harder part is the culture – getting people to give you access to the data. They will put barriers up where they think there is an IG issue, when there isn't. So winning hearts and minds is key – demonstrate that everyone will benefit from this data. We'll take it, but we will give it back to you and it will enrich your job.

'I can do the legal side and show them the governance will be done properly, but the cultural part is harder. So perhaps there is a national role to engage with local authorities about why we need this intelligence.'

> **"We've got to be prepared to have good data sharing agreements. And we've got to understand how we will look at that data"**
>
> **Paul Buss**

Finance framework

The roundtable also discussed how a financial framework could support a new focus on population health. Ms Briggs said a step change in resource allocation was needed.

'All our long-term plans will talk about a left-shift and prevention, yet when you look at the financial history, you will see high growth in acute and below-inflation increases in community and primary care,' she said. 'So we put our stamp on a strategic vision, but what we do with the financial resources is the complete opposite, because we can't get out of that cycle.' She said the service needed to refocus on pathway costs.

'For example, we have found that our musculoskeletal pathway is our most expensive pathway, because it is largely in the acute sector,' she said.

'And when you put a population health spin on it, it is largely the people in the affluent areas, so we are not even getting to the deprived areas. And we wouldn't understand this without pathway costing. We have a responsibility to start to collect and analyse data at a pathway level.'

HFMA ROUND TABLE

Mr Worthington agreed with the need to invest upstream of acute services. But he said this didn't often lead to reduced pressure on acute beds, given the levels of pent-up demand. And there could be difficulties with stranded capacity

'So we should start with the things that we know we can do – that fit more with our traditional approach and traditional financing arrangements,' he said. 'But it is through the data-sharing potential we have across systems that we can start to ask some really interesting questions at a whole system level.'

Mr Miller stressed again that the real value of data was to start conversations, particularly among clinicians. 'There are lots of financial datasets around and a wealth of information. But my experience has shown me that conversation is the powerful thing, not the data,' he said.

He mentioned the HFMA Healthcare Costing for Value Institute and Future-Focused Finance's Engagement Value Outcome (EVO – **hfma.to/mar227**) initiative to promote collaborative working between clinical and finance teams using patient-level cost (PLICS) data. He said that once clinicians and others started to understand the value of the patient data, it did lead to changes in behaviour. 'We might not need other data sets,' he said. 'But are we using the ones we've got well enough? By sharing the information we already have, and facilitating conversations with the people who really make a difference if they change their behaviour, we can make a difference.'

Ms Cotterill agreed that PLICS data was a good place to start 'for analysing what is being spent as a system, not just as a hospital'. The National Cost Collection programme already involves acute, mental health and ambulance service trusts and this year community providers will join the mandatory submission.

Civica offers a platform that will bring this data together along with public health data on issues such as air quality and housing. This type of holistic analysis would be vital for systems, she said.

She added that when individual organisations only looked at their own pathways, there was a danger that overall patient care wasn't optimised and patients could be bounced around the system, delivering sub-optimum outcomes and overall higher costs. 'It is about understanding the total cost of a pathway and the value that we are deriving from it.'

However, the sheer volume of data involved can be intimidating and it can be hard to know what questions to ask. 'So what we've tried to do is to collate the data in such a way that it presents insights rather than just giving data back,' she said, adding that the system used artificial intelligence and machine learning to hit upon this demographic insight.

Thank you to all HFMA corporate partners for their continued support

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and costs. 'This is what makes this so challenging to get off the ground. That is the real tension and the real debate we need to get into,' he said.

'We need to eliminate some of the waste in our existing systems to give us some discretionary money to channel into some of these longer term challenges.'

He suggested that an aligned incentive contract in Leeds had provided a mechanism to move towards changes in allocation. This committed to growth for the acute sector, recognising that demand would not turn off overnight. But it also delivered higher growth to other parts of the pathway.

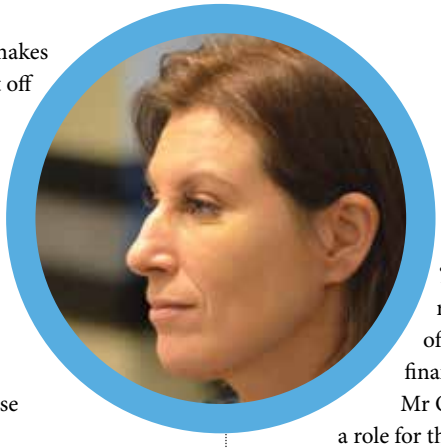
This gave a clear direction of travel, while providing the acute hospital with some financial security. It was then free to make pathway changes without losing funding, which was a characteristic of previous payment by results-type contracts.

'I'd encourage us not to come up with an overly complex payment system to support this agenda. Let's keep it simple,' he said.

'It's about aligning behaviours and incentives,' said Mr Miller. 'The biggest challenge in my hospital isn't money, it is a shortage of workforce. So on an individual care management level, anything that we can do to get the same or better outcomes through fewer interventions is great.'

But he said some key principles were needed about the financing of service change. So, a hospital shouldn't be left with stranded costs and be expected to eliminate them overnight.

'Variable costs should move with the service, but fixed and semi-fixed costs need to be managed over different time periods,' he said.



"Information governance isn't the barrier that people think it is. The data is there to influence and help change behaviours, so the key is engagement"
Su Rollason

'As a profession, it is our role to set up some rules of engagement around financing service change.'

Mr Orlowski said there was a role for the centre. 'If the NHS expects us to make these changes, you need to be given freedom from the very top,' he said. 'If they believe in us dealing with the wider determinants of health, which can take years if not decades to have an effect, they need to create a system that allows finance professionals to have these conversations and move money appropriately.'

Leap of faith

Ms Briggs called for a 'leap of faith' on making some of the changes and targeting the benefits. 'It is a bit like some of the digital work – you're not going to build a case for change based on our usual three- to five-year review of outcomes,' she said. 'We need to improve our measurement of outcomes and establish a baseline of our population health metrics.

'Then we can consider what we are trying to achieve and track that. Some of the population health outcomes won't be immediate, but you can track some of them.'

She suggested that tracking cancer screening numbers by deprivation areas, especially where English isn't the first language, could lead to a quick turnaround in those metrics.

Echoing Mr Miller's comments about workforce being the main challenge, Ms Cotterill said PLICS data could also provide a window on resource consumption as well as pounds spent. 'As a finance director, I can remember people coming to me for extra funding to meet service demand,' she said.

'But if you instead ask them to identify the clinicians they need, you can then prioritise against the resources actually available. Sometimes, no matter how much money is available, it just isn't possible to secure the resources.'

This could be really powerful at a system level. 'Maybe we need to think differently,' she said. 'Rather than moving the money around, we need to share the resources between us in a different way. And patient-level cost data can help you to see the resources, including staff numbers, being used in the total care of the patient.'

HFMA ROUND TABLE

In summing up the discussion, Ms Rollason said there was clearly a huge financial leadership role in moving towards a greater population health focus. 'But there is also a technical role. So it seems that the finance function is pretty central to this,' she said.

'We have lots of data, including some really rich costing data, and that will play a crucial part in informing decisions. And information governance maybe isn't the barrier that people think it is,' Ms Rollason added. 'The data is there to influence and help change behaviours, so the key is engagement – both at a leadership and at a clinical level.'

Liverpool's new dawn

Despite the pressures of Covid-19 and implementing a merger, Liverpool University Hospitals NHS Foundation Trust has been able to bring together finance, clinical and operational staff to revise many of its financial rules. Seamus Ward asks how it achieved the changes, which it believes other trusts could replicate

The impact of Covid on the NHS is well rehearsed, but its effects on NHS finance are not widely known. With a temporary finance regime in place, some processes wound down.

In the first lockdown, many finance managers focused on procuring personal protective equipment. Most worked from home, though others took to the front line to help out their clinical and operational colleagues in whatever way they could.

But despite the unprecedented time, relatively normal events took place, such as in Liverpool, where the two biggest providers had recently merged to form Liverpool University Hospitals NHS Foundation Trust (LUFT).

Aintree University Hospital NHS Foundation Trust and the Royal Liverpool and Broadgreen University Hospitals NHS Trust merged in October 2019 to form the new trust. Soon after, the body launched an overhaul of its financial governance.

As well as merging two ledgers, it rebooted its standing financial instructions (SFIs), budgeting, and business case processes, and revitalised its finance training for colleagues in the wider trust. The measures set the foundations for winning three categories in last year's HFMA Awards – Finance Team of the Year, the Governance Award, and the Havelock Training Award.

The trust's finance team is led by Rob Forster (pictured), deputy chief executive and chief finance officer. He joined the trust in April 2020, six months after the merger – just as the first wave of Covid was kicking in.

The merger was clinically led, but Mr Forster says that even though the organisations had been brought together, there was a wide acceptance in the new trust that there was much more to do to make it a success.

In finance, this meant bringing together the ledgers, and establishing a new single financial governance process.

Work had barely started when Covid 'came along and changed the world', Mr Forster says. 'But our role in finance was to continue our work in spite of Covid, so that when we came out of the pandemic we would be in a better position. We would be working in an organisation that had moved from two ledgers to one, for example.'

Revising the rulebook

SFIs were revised with help from internal and external auditors, and benchmarked against other major providers. The finished product is simpler and clearer, enabling quicker decision-making and resource allocation, and is presented in a user-friendly guide to help budget-holders.

'We had to identify our governance structures and in doing that took the opportunity to change the way we in finance were viewed within the organisation, using it as a catalyst for change,' says Mr Forster.

'Anyone who works in finance will know that SFIs are our rule book. They are how we govern

SHUTTERSTOCK

our finances. However, not everyone outside finance knows this, so we wanted to remind everyone what the rules and mechanisms are.'

In revising the budget process, Mr Forster says the trust worked with clinical and operational colleagues, devolving as much of its resource to the front line as possible. 'We are working with colleagues to build budgets, and they can see they are having an influence on the way we control our finances.

'SFIs are our rule book, but we look at them in conjunction with our business case process and it helps, most importantly, our budget-setting process. In doing that, we can explain that the finances are finite, but, as is often said, it's not the finance department that spends most of the money, it is clinicians.

'Our role is to help colleagues as part of (not separate to) the team, and make sure it is spent efficiently and effectively.'

The business case process was redesigned. 'If the SFIs set the rules, and the budget-setting says how you intend to spend it, the business case process is for when there is something outside of what you expected – how do you go about getting that assessed and approved?' he says. The new process facilitated controlled prioritisation of additional spending in-year, helping the trust deliver a small surplus in its first operating year.

He adds that the finance department wanted to bust the myth that finance was its domain alone. Finance managers spoke to departments about the allocation of responsibilities, and the rules that would accompany greater devolution.

'If you are going to commit to this, people recognise that you do need rules. SFIs should be understood and simple to use in a straightforward process. The business case process should be efficient and effective. Overall, we hope it's started to build the concept of Team LUFT, and to set us up for success as we step out of the pandemic.'

Mr Forster understands why some staff can be wary of the budgeting process, but adds: 'I get excited by it. It's a fantastic opportunity to understand your business, no matter which part of it you operate in.

'It's the one time of the year that you get to understand what you spent last year and what you expect to spend in the future. Not everyone has that excitement, so we need to explain why we are doing budgets.'

Key principles

To overhaul its budgeting process, the finance team worked with non-finance colleagues. Together, they set out four factors for implementing change:

- **Factual** Changes should be based on reliable information that is accurate and meaningful throughout the organisation
- **Transparent** The trust held check and challenge sessions at each stage of the budgeting process, to scrutinise how decisions were made, the cost of the policy, and cost improvements involved. This helped clinical, operational and finance staff to buy into proposals
- **Open and inclusive** Mr Forster says the finance team wanted to ensure all relevant staff received the information they needed to support decision-making. It could not be a case of finance making decisions and then telling others what would happen, he adds. Progress should be reported regularly
- **Realistic** 'We had to reflect on what could be achieved in the resources available,' Mr Forster says.

"We hope this has started to build the concept of Team LUFT, and to set us up for success as we step out of the pandemic"
Rob Forster, Liverpool University Hospitals NHS FT

Clinical engagement

Clinical-financial engagement is often tricky, so how was it achieved in a pandemic? The support of senior clinicians was key, he says. 'Engaging with clinicians was difficult in the pandemic because everyone's mindset, rightly, was on providing care to the patients we serve. Having said that, I think the clinicians and leaders in this organisation realised we had to get ourselves organised so that when we came out of the pandemic we'd be in a good position. We had to be flexible.'

Being flexible also meant working remotely and communicating through Microsoft Teams – a shift in working practice exemplified by the finance team, says Mr Forster. 'The finance team did exceptionally well and got straight into it, preparing the information that the clinicians needed.'

The trust's medical equipment committee, for example, which includes the medical director and deputy medical director, used the new governance processes and the information produced remotely by the finance team, to prioritise spending decisions, and match requirements with the trust's available resources.

Traditionally, a newly merged trust might choose one of its predecessor's SFIs, budgeting and business case processes. So why did Liverpool decide to take the seemingly more difficult route of giving the new organisation fresh financial governance policies?

'This was especially important as it was a merger not a takeover,' Mr Forster says. 'I also had this image of coming in afresh, with a fresh set of policies. We didn't want to miss the opportunity to create something that was of value to us and others in the NHS.'

The trust is happy to share its experiences and new financial governance measures with colleagues around the NHS.

'The catalyst for this was the merger and the arrival of a new CFO, but it doesn't need to be,' Mr Forster says. 'A review of governance can be a real spark for change for any organisation – and you can change the perception of finance along the way.'

Game changer

A novel game app helped win the trust one of its three HFMA awards in 2021. The app aims to bring finance and non-finance communities together to make the year-end accounting process less of a niche activity. Mr Forster says the app is an important element in its development of finance for non-finance staff. It had developed its training for non-finance managers, tapping into the local John Moores University MBA schemes, and Mr Forster hosts his own podcast, *The balance*. But the team wanted to innovate further.

He says: 'It's one thing working with colleagues to develop a set of rules and policies, but the app is recognition that in the organisation we have over 13,000 whole-time equivalent staff, and we need to take seriously our responsibility to help non-finance people deal with finance.'

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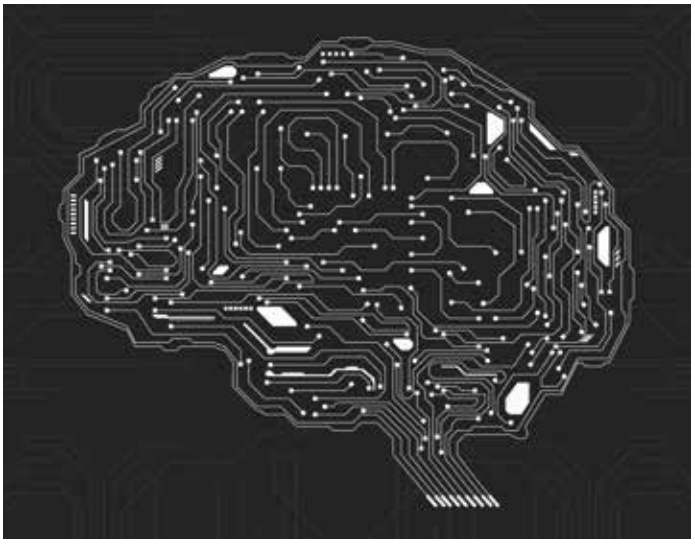

In the latest in our series on the HFMA programme, supported by Health Education England, that aims to increase finance mangers' awareness of driving up value and efficiency through digital transformation, Seamus Ward explores AI and robotics

Ask the average person in the street to explain artificial intelligence (AI) and robotics and most will have a view informed by the dystopian visions of science fiction films. For now, the promise – or threat, depending on your view – of near-sentient machines remains a pipe dream. Nevertheless, even in its relatively unsophisticated state, AI is all around us, from personal digital assistants such as Siri and Alexa to new technologies supporting clinicians in our hospitals.

Recent health secretaries in England and the *NHS long-term plan* have backed digital technologies as a means to improve services to patients, as well as promoting efficiency. So, it is unsurprising that NHS technology adoption has increased. The pace of change has quickened in the wake of the Covid-19 pandemic. And moves to integrate services have highlighted the potential benefits of analysing huge chunks of data and the need to be flexible in the delivery of services to patients.

The HFMA has a role through its *Delivering value with digital technologies* programme. Supported by Health Education England, it aims to increase NHS finance staff awareness of digital healthcare technologies, and enable finance to take an active role in supporting the use of digital technology to transform services and drive value and efficiency.

Before looking in detail at how AI and robotics are being used in the NHS, it is worth asking what they are. There is no universally agreed definition of AI, but it may help to think about what we understand to be AI – a computer that can choose the correct response to the data it is given, whether that be asking a digital personal assistant to tell you a joke or sifting through thousands of images to select those that show a suspected cancer.

AI is intrinsically linked with two further terms – data science and machine learning – and often AI is used in reference to all three. Data science is about the analysis of data, and the insights gained, while machine learning can be an engine to achieve both by performing tasks without being explicitly programmed to do so.

In clinical practice, robotics can refer to real robotic arms that assist surgeons in keyhole surgery. A surgeon controls the arms with the system seamlessly translating their hand, wrist and finger movements into precise movements of surgical instruments.

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This form of keyhole surgery can lead to reduced lengths of stay, less pain for the patient, fewer complications and faster recovery times (*see box, Robotic precision, overleaf*).

In the NHS, funding for AI projects has often come from the National Institute for Health Research and NHSX, now part of NHS England.

According to an HEE roadmap on the use of AI in the NHS, published last month, diagnostic technology such as imaging, pathology and endoscopy is the most common use of AI in healthcare. This was followed by automation or service efficiency.

In addition, HEE estimated that 56 AI technologies will undergo a large-scale deployment within a year, with 77% of these technologies used in secondary care, 23% in primary care and 7% in community care.

A total of 155 workforce groups across 67 clinical areas were identified to be using AI technologies, mostly in clinical radiology and general practice as well as non-clinical administrative staff.

Cancer care

The diagnosis and treatment of cancer is a major area for the application of AI in the NHS. The Royal Surrey NHS Foundation Trust, for example, is using AI in radiotherapy to target the tumours of patients with cervical cancer – a UK first. Using data from daily CT scans, the AI delivers prescription doses precisely to limit side-effects and damage to healthy tissue.

Last year, the trust was one of a group of bodies that won government funding to trial the use of AI in the diagnosis of breast cancer. Previous work had trained an algorithm to identify cancers, and the trial's aims include determining the accuracy and fairness of the AI model.

Doctors at Addenbrooke's Hospital in Cambridge are using an open source AI toolkit created by Microsoft Research to support diagnosis and speed up treatment. Funding for a range of projects at the hospital was provided by NHSX, including differentiating between cancerous and healthy tissue.

Sam Godfrey, senior research information manager at Cancer Research UK, says AI offers huge potential in cancer care, particularly diagnostics, where early diagnosis can increase survival rates.

'In the NHS, every cancer scan is assessed by two specialists,' he explains. 'If you could replace one with AI, then you would double capacity immediately.'

There are other promising areas, including using AI in treatment planning, giving oncologists more time face-to-face with patients.

Dr Godfrey believes that AI could be a useful tool for most cancers – Cancer Research UK is supporting a range of research projects that

involve AI. However, he adds: 'High-quality research is needed to explore whether we should always use it, and when best to use it. We don't want to take out the human element.'

AI is not just a useful tool for cancer diagnosis and treatment. Moorfields Eye Hospital NHS Foundation Trust and the University College London Institute of Ophthalmology, in conjunction with several other bodies, are exploring the use of AI to detect diabetic retinopathy.

Impact on diabetes

Adnan Tufail (pictured), consultant ophthalmologist at Moorfields and the Institute of Ophthalmology, points out that diabetes is an increasing public health problem, especially among Asian and black African-Caribbean groups.

Diabetes-related costs to the NHS totalled £10bn in 2010/11, with 80% being spent on complications. Averting complications offers huge potential savings by reducing morbidity and mortality, Dr Tufail believes.

"Some AI algorithms for diabetic screening, if implemented, would save the NHS over £10m a year"
Adnan Tufail, Moorfields

He says the early detection of diabetic retinopathy – which is the leading cause of blindness in the working population – through annual retina screening and grading of retinal photographs is key to avoiding sight loss. The NHS currently carries out more than 2.2 million screening episodes a year through its diabetic eye screening programme, but it is time- and labour-intensive, and costly, requiring humans to grade around 11 million retinal images annually.

'There is an urgent need to reduce the workload on human graders, who are difficult to recruit and retain,' Dr Tufail says. 'Automated retinal image analysis systems (ARIAS) are AI algorithms that could safely triage sight-threatening diabetic retinopathy from those at low risk. Furthermore, they can grade a retinal image within seconds.'

However, he cites a concern: the algorithms are often developed largely using white and younger individuals, leading to higher rates of ungradable images in scans of those from minority ethnic groups.

Dr Tufail says the data generated from the assessment of available algorithms will support the commissioning of AI for diabetic screening, while live implementation will help iron out technical issues.

He adds: 'Previous work from our group showed that certain AI systems were at least as good as human-trained graders at detecting diabetic eye disease on retinal colour photos, and specific enough to be cost saving to the NHS if implemented.

'Previous studies by our group, with the London School of Economics, have shown that some AI algorithms for diabetic screening, if implemented, would save the NHS over £10m a year. With the current generation of ARIAS being tested, the cost saving is likely to be more.'

The AI could be rolled out across the NHS. 'In diabetic screening alone, this live implementation study should pave the way for the commissioning and deployment of approved AI systems for the 2.2 million diabetics that need annual eye checks,' he says. 'Other screening programmes such as mammography could benefit from the methodology in this study, both for testing AI systems and monitoring them after mass deployment to ensure trustworthy AI for all.'

The NHS is only just beginning to use AI, but it shows promise as a tool to speed up diagnosis and care. If this potential can be harnessed, it will be good news for patients and service efficiency.

Robotic precision

A state-of-the-art robotic surgery system is helping cancer patients across Lincolnshire to get faster access to less invasive cancer treatments.

The robotic-assisted surgery system (pictured blow) was used at United Lincolnshire Hospitals NHS Trust (ULHT) for the first time in February as part of the treatment of a patient with prostate cancer. The trust says its £3.2m investment will offer more choice for urology and colorectal cancer patients as they undergo treatment.

Previously, patients had to travel outside the county for robotic surgery, explains consultant urologist Aris Alevizopoulos, who is based at Lincoln County Hospital. He has been performing robot-assisted procedures for cancer patients at Leicester General Hospital, as part of the East Mercia Urology Alliance with ULHT and University Hospitals of Leicester NHS Trust.

'Having our own robotic-assisted surgery system in Lincolnshire will allow us to offer cancer surgery in a timely manner, and much closer to home for patients who would otherwise have been waiting up to three or four months for their procedure.

'This robotic system upskills the operating surgeon and allows an advanced minimally invasive approach, which comes with a reduced risk of surgical complications, meaning those having surgery will be expected to go home earlier and have a faster recovery.'

The trust says the new system also supports its longer-term vision for improvements.

Paul Matthew, director of finance and digital, adds: 'This is an exciting opportunity to further develop the services for people in Lincolnshire. Not only are we supporting greater choice in the available treatments, we hope to make significant reductions in waiting times for those in need of our care.'

• *To find out more about Delivering value with digital technologies – the HFMA programme supported by Health Education England – please visit* **hfma.to/mof**

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professional lives
Events, people and support for finance practitioners

Financial reporting: not many changes but another difficult year

Technical

Most of the changes to financial reporting requirements for 2021/22 relate to the annual report rather than the annual accounts. However, it is likely that the preparation and the audit of the accounts will not be any easier than last year, *writes Debbie Paterson.*

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First, the annual report. This is not usually the finance team's domain, but it is important that those responsible are fully briefed about the changes.

In 2019/20 and 2020/21, because of Covid-19, NHS bodies were allowed to omit the performance report. However, this dispensation has been removed this year, so a full performance report is again required.

Because it has to include trend information, it may be that additional data will need to be collected so the trends can be reported from pre-pandemic years to 2021/22.

There is no requirement for NHS foundation trusts to produce a quality report, but all NHS providers are still required to prepare a quality account. Although the quality account does not need to be included in the annual report, all providers are required to include performance against quality improvement priorities and pertinent indicators in their performance report.

In the remuneration report, the fair pay disclosures have changed. The method for calculating the disclosures has changed and now the 25th and 75th percentiles for both the remuneration and the salary ratio need to be reported alongside the median.

Prior period comparatives are not required, but are considered best practice.

There are no new accounting requirements this year. Having said that, the standards issued but not adopted disclosure should reflect the work that has been done to date to assess the impact of the implementation of new leasing standard IFRS 16 from 1 April 2022.

The information submitted to NHS England and NHS Improvement in January, as well as the planning submissions, should be used as the basis for that disclosure.

It is likely that two areas of the accounts will attract additional attention for 2021/22.

Regulators as well as auditors will be focusing their attention on accruals and provisions this year. The comptroller and auditor general's report on the Department of Health and Social Care's annual report and accounts for 2020/21 (**hfma.to/mar2216**) raised concerns about the increasing levels of accruals in the accounts and the level of accruals error in the accounts.

Put simply, there is concern that estimates and judgements are erring on the generous side. Although the 2020/21 accounts were not qualified because of the errors, for 2021/22 the level of carried forward unadjusted error means that there will be less headroom for further unadjusted errors this year.

The Financial Reporting Council (FRC) reported on the inspection findings into the quality of local audits (**hfma.to/mar2217**) in October. The areas requiring action by some of the audit firms included strengthening the audit testing of expenditure. When this is linked to the findings on accruals and the wider pressure on auditors to challenge management's judgements and estimates (**hfma.to/mar2218**), it is inevitable that there will be a focus on accruals and the judgements and estimates that support them.

This is likely to have an impact on work on the agreement of balances, particularly mismatches resulting from year-end.

The second area of focus is losses and special payments – and in particular, special severance payments. This also arises from the auditor general's report on the Department's annual report and accounts – in this case a qualified regularity opinion.

This was due to the failure of a clinical commissioning group to seek Treasury approval for a special severance payment made to a senior manager and to disclose the payment in the losses and special payments note.

All special severance payments, which are those outside of the contractual amounts, must be approved by the Treasury in advance of being discussed and agreed with the individual concerned. All severance payments should be disclosed as exit packages and special severance payments disclosed as a special payment.

Debbie Paterson is the HFMA's policy and technical manager

Technical review

Recent technical developments

Technical

A consultation on the 2022/23 national tariff payment system has proposed revising the **variable element deduction** for elective activity below the agreed baseline (104% of 2019/20 activity). Initially, NHS England and NHS Improvement set the deduction at 50%, but have now proposed 75%, bringing it in line with guidance on elective recovery. The amendments also address concerns that NHS providers subcontracting additional activity to the independent sector could have to pay 100% of tariff, but only be paid at 75%. The consultation documents propose excluding subcontracted activity from aligned payment and incentive arrangements, with payments to subcontractors made outside of tariff rules. The consultation closes on 25 March.
hfma.to/mar228

NHS England and NHS Improvement have proposed removing the requirement to sign up to a **system collaboration and financial management agreement** (SCFMA). They said this would reflect the tariff arrangements for 2022/23, and the duty of integrated care boards (ICBs) and partner trusts to work together to deliver system financial balance. The change was proposed in a consultation on the new standard contract. A model SCFMA will still be available for systems that wish to adopt it. There are other changes in the draft contract to reflect new or updated national policies, such as wider zero tolerance standards, and smaller changes, such as the removal of separate arrangements for the local incentive scheme, which the national bodies believe is now redundant.
hfma.to/mar229

The planned **provider selection regime** will not begin until after ICBs are formed, the Department of Health and Social Care said. ICBs are due to launch formally in July. The news comes as the Department opened a supplementary consultation on the regime, which will give commissioners greater flexibility when arranging services. The Department wants to check with the service that its proposals will achieve its ambitions, including making integration and collaboration easier. The regime would remove mandatory competition, though it will remain an option. Existing services could continue where they work well and there is no value for patients, taxpayers and local people in seeking an alternative provider. The new regime would not apply to the procurement of goods and pharmaceuticals.
hfma.to/mar2210

Guidance has been issued on the **commissioning for quality and innovation** (CQUIN) financial incentive scheme, which is set to be reintroduced in 2022/23. The scheme was suspended in 2020/21 and 2021/22 due to the introduction of a simpler financial regime as the NHS focused on responding to Covid-19. However, it is being reintroduced as part of the new aligned payment and incentive (API) contracting arrangements – CQUIN payments will be made under the fixed element of API contracts, with adjustments possible (for underperformance, for example) under the variable element. The value of CQUIN is 1.25% of the fixed element of payment, which can only be earned under the five most important indicators in each contract.
hfma.to/mar2211

The HFMA has updated its briefing that aims to support members as **clinical commissioning groups** close down and integrated care boards are established. The document *Provisions and accruals: the impact of the Health and Care Bill on CCGs*, which was initially published in draft form, has been reissued following a review by members. Overall, three documents have been published to assist a smooth transition between organisations, ensuring that legacy issues are captured and managed.
hfma.to/mar2212

Changes in **member contributions** to the NHS Pension Scheme have been postponed until 1 October. The Department of Health and Social Care hopes the six-month delay will mitigate the pressure on take-home pay from 1 April, when the cost of utilities and other goods and services are due to rise. The delayed measures include a shift in the basis of the calculation of contribution rates. For employed staff, this will move from notional whole-time equivalent pensionable earnings to their actual annual rate of pensionable pay. The Department believes this is fairer to part-time staff. Tiering of contributions based on earning bands will remain, but the number of tiers and the gradient between tiers will be reduced. As a result of the overall changes, contribution rates will decrease for part-time staff and higher earners.
hfma.to/mar2213

NHS Pension Scheme **employer contribution rates** will remain unchanged in 2022/23, and employers will continue to be supported to make these contributions. NHS England and NHS Improvement have confirmed the employer rate will remain at 20.6% of pensionable pay, with an additional administration levy of 0.08% in 2022/23. Central funds will cover 6.3%, with employers contributing 14.38% of pensionable pay. Employer contributions increased from 14.3% to 20.6% in April 2019, but, under transitional arrangements, central support was introduced in 2019/20 and each of the subsequent years to ensure financial stability.
hfma.to/mar2214

The Department of Health and Social Care has issued an updated version of its ***Group accounting manual 2021 to 2022***, which details changes made to the document for this year. The changes include revised fair pay disclosures, expanded guidance on the applicability of *Managing public money* to all Department group bodies, and clearer guidance for NHS trusts on performance reporting and incorporating performance against national quality indicators.
hfma.to/mar2215

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Personalised care unwrapped

For more information, visit www.hfma.org.uk/qualifications

Training

With the NHS promising to make personalised care business as usual across the health and care system, the HFMA has released five bitesize online courses freely available to NHS staff to explain the approach.

The *NHS long-term plan* committed to delivering more personalised care, giving people more choice and control over care. The aim is for the NHS personalised care model to reach 2.5 million people by 2023/24, doubling this by 2028/29.

A comprehensive model, co-produced with a range of stakeholders, identifies six components of personalised care:

- Shared decision making
- Personalised care and support planning
- Enabling choice
- Social prescribing and community-based support
- Supported self-management
- Personal health budgets.

The model describes how the whole population will be supported to manage their physical and mental health and wellbeing through shared decision-making, social prescribing and choice, for example with maternity, elective and end-of-life care.

The 30% of the population with long-term health conditions will be targeted using proactive case finding and given personalised care and support planning. They will be supported to self-manage where possible and given access to health coaching and peer support. The 5% of the population with the most complex needs will also receive support from multidisciplinary teams using personal health and integrated personal budgets.

Under the plans, primary care networks will be a key delivery mechanism, with social prescribing and shared decision-making to be mainstreamed in primary care

The HFMA bitesize courses are all delivered online – the five new courses mean 34 free courses are now available across the NHS. To date, these courses – which typically take between three and 10 hours to complete, depending on the level of the course – have been accessed more than 36,000 times since they were launched in March 2020.

The five personalised care courses (see box) provide an introduction to the aims of personalised care and the context provided by the *NHS long-term plan,* while also drilling into more detailed aspects.

NHS England and NHS Improvement supported the production of the new courses, building on joint work to promote the personalised care agenda. Hugh Groves (pictured), finance lead for NHS personalised care at NHS England and NHS Improvement, said that, while personalised care has been around for a while, the launch of the *Universal personalised care* delivery plan in 2019 has given the approach new momentum.

'The aim is to improve everyone's understanding of the potential financial and non-financial benefits of the personalised care approach,' he said. 'The bitesize suite of courses provide good information on the concepts and benefits of the approach. And, while they are targeted at finance, commissioning and contracting staff, they also have real value for clinicians and other managers working across integrated care systems, clinical commissioning groups, trusts, primary care networks, social care and the voluntary sector.'

The courses – which take about six hours to complete – complement the existing bitesize short course on personal health budgets.

Bitesize personalised care courses

- **Personalised care: the key to change**
- **Components of personalised care**
- **The commissioning cycle**
- **Introduction to co-production and personalised care**
- **Evaluating personalised care approaches**

Sharing problems and inspiring innovation

One NHS Finance

The Finance Innovation Forum – one of the three One NHS Finance (ONF) programmes – is a mechanism to transparently collect, validate, reward, and share NHS finance innovations across organisations in a structured and accessible way.

Since its launch in September, the forum has received great interest and after a four-week submission window and a month of peer review, it has presented 21 NHS finance innovations. This first cohort includes one example from every region. They can be read in full at **hfma.to/mar223**

ONF believes these innovations highlight local ingenuity. And by giving this best practice a national platform, it hopes to inspire other teams and organisations to share their improvements and learn from others.

The month-long Cohort 2 application window closed on 14 February. The 14 submissions received are being reviewed by the 60-strong peer review team, and the successful innovations published in April. Cohort 3 opens on 25 April.

In calling for submissions, the forum says: 'If you work for NHS finance and have worked as an individual or as a team to execute an idea which addresses a specific challenge and delivers better value to an organisation, and this has already been implemented or is currently live (in active use) then you should submit an application now.'

The Finance Innovation Forum will also launch its software skills for finance staff event series in April. This aims to shorten the time spent on manual and repetitive tasks.

• Find out more and register interest at hfma.to/mar224

Diary

Most events continue to be delivered online

March

08 (H) NHS leadership and chief executive network forum, London
10 (I) Value masterclass
10 (W) Year-end 2021/22 accounting and auditing issues
16 (H) Audit conference, London
16 (B) Eastern: lunch and learn – introducing the NHS social value assessment tool

April

07 (H) Annual chairs' conference 2022, London
13 (I) Costing conference 2022, hybrid
16 (H) Audit conference, London

May

05 (H) Health inequalities and population health management
16 (B) South Central: lunch and learn, NHS finance job applications and interviews – how to ace your next job
17 (N) Delivering value with digital technologies
16 (B) Kent, Surrey and Sussex: real talk conversations that save lives
24 (B) Northern: CV writing and interview skills
27 (B) Northern: boosting up – boosting your personal resilience

June

09-10 (B) West Midlands: annual conference, Birmingham
13-15 (N) Summer conference
16 (B) Eastern: lunch and learn – top tips for delivering a green NHS
16-17 (B) North West: annual conference, Chester
17 (B) Northern: annual conference, Durham
23-24 (B) Yorkshire and Humber: annual conference, Scunthorpe
24 (B) Northern: energising your time – the art of stress-free personal effectiveness

July

13 (B) Northern: interviewing skills
29 (B) Northern: does it make the boat go faster – unleashing creativity and Innovation

August

26 (B) Northern: taking back the remote control – the art of effective self-leadership

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

key: (B) Branch (N) National (I) Institute (H) Hub (W) Webinar

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Events in focus

Audit conference
16 March, online

Aimed at audit committee chairs and members, this one-day event will provide both practical guidance and a useful forum for discussion.

In the opening address, National Audit Office director of health Robert White (pictured) will look at the auditor's value for money programme and highlight key messages from the 2020/21 accounts, including spending on the NHS Covid response. NAO audit manager Suzy Smith will set out updates to local audit guidance. Other sessions will focus on environmental sustainability reporting, responding to cyber fraud, and integrated care system governance. NHS England and NHS Improvement director of financial control Adrian Snarr will also give a national update.

The event is free to attend for HFMA Hub partners, with up to four free places per partner. Additional places are available for a fee, and non-member rates are also offered.

• For further information or to book a place, email laurence.sampson@hfma.org.uk

Costing conference
13 April, hybrid

NHS costing professionals and those with an interest in the costing agenda will have a chance to meet face-to-face at the HFMA Healthcare Costing for Value Institute's annual costing conference. This is a hybrid event, allowing delegates to meet in person at the association's conference centre in London. The event will also be streamed live via the association's virtual event platform, so it will be possible to watch online.

The conference will hear discussions on the latest developments and guidance in NHS costing, as well as a focus on increasing awareness of the collaborative approach needed to harness the power of data.

The day includes interactive workshops, case study examples, and policy updates. Speakers from NHS England and NHS Improvement include director of pricing and costing Chris Walters (pictured) and Helen Laing, the deputy director of costing, who will give an overview of the latest national policy updates and the proposed future direction.

The event is free to all institute member organisations, with two face-to-face places and up to four online tickets per organisation. Additional and non-member rates are also available.

• For further information or to book a place, visit hfma.to/mar225

Get back

Association view from Mark Knight, HFMA chief executive

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

My HFMA

In January, I wrote a blog introducing the association's new free membership offer to bands 2 to 6 staff. Nearly 1,200 finance staff have taken up the offer. That means we only have 2,200 to go to meet my own target of doubling our membership. I'd like to give a big shout out to one organisation in the south, which enrolled 124 staff into membership with a dedicated campaign to enlist as many in that group as they could.

So how do we develop a range of services to cater for this group? I'd love to hear from any of our new members.

I shared the issue of band 2 to 6 engagement with our branch chairs a few weeks ago and they are involved in meeting those needs. The branch committee members are an amazing group who have kept the HFMA on the road locally over the past two years.

I recently attended the Eastern Branch conference, the first branch conference of 2022. Apart from the usual Covid restrictions, it felt very much like life coming back to normal.

What is the 'new normal'? How will the business of the association be transacted in future? Here's where we are with our thinking.

Virtual meetings and webinars will continue to play a role, but our view is that to justify travelling to an event or a meeting in the future it will need to be 'important enough'.

There are benefits to getting on a train to go to an event miles away. The most obvious is meeting informally with colleagues and being able to look them in the eye away from the pressures of work. The annual conference falls immediately into that category (advance tickets currently out), though it also does well online and enables far wider participation from the broader finance family.

But something extra happens when people come together to create and develop. Watching the Beatles documentary *Get back* showed them developing their legendary songs in the studio. While we cannot all be 'fab four'-like in our creativity, we should not underestimate what we can achieve in the company of others.

HFMA chief executive Mark Knight

Many of our committees will probably continue virtually, but we hope to get them into London occasionally.

However, it will need to be 'important enough', so we're thinking of what else we can co-locate alongside such in-person meetings.

There are a few events that are vital to the service, but may not be 'important enough' to justify travelling. Pre-accounts planning is a business-like event and a vital part of the pre-accounts calendar. But it will probably remain a virtual event.

However, you can't run a confidential meeting online and panel discussions do not work as well as those held in a room. So for future hybrid events, there may be 'chunks' excluded from the online offering, with only those in the room able to benefit.

What we do know is that we are starting a gradual return to running live events. And we recognise that we need to find the right balance to meet members' needs. I am certain the association's business is 'important enough' for you occasionally to travel to a location. We are, of course, very grateful for all your support as we move forward to 're-imagine the future'.

Member news

Finance staff in Agenda for Change bands 2 to 6 are eligible for free membership of the HFMA. President Owen Harkin said the members will be able to vote at the AGM, participate in branches, access information and briefings on the HFMA website, and receive *Healthcare Finance weekly*. They will also be able to buy a subscription to *Healthcare Finance*. For details see **www.hfma.org.uk**

The HFMA annual general meeting in December voted in favour of freezing the annual subscription rate for members above band 6 at £65, with a £5 reduction if paid by direct debit. Rates for other members will also remain the same. The AGM also heard:

- Lee Bond is a vice-president of the HFMA for his third year; Claire Wilson is the other vice-president (year one)
- Dawn Scrafield and Richard McCallum have been appointed trustees for their first three-year period
- Peter Ridley has been co-opted for his first three-year period as a trustee
- James Rimmer has come to the end of his maximum term as a trustee; Sandra Easton has stepped down.

National committee and group chairs were also appointed:

- Claire Yarwood, Systems Finance Leads Group
- Sam Wilde, Healthcare in the Community Group
- Nicky Lloyd, Governance and Audit Committee
- Nicci Briggs, Digital Council.

Craig Peacock has received the 2021 Sue Rosson Award from the North West Branch. The prize, awarded in memory of NHS finance training scheme graduate Sue Rosson, who died in 1995, is awarded to a student or recently qualified finance staff member who has contributed over and above their role.

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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

Appointments

Two NHS leaders with a background in finance were awarded OBEs in the new year honours list. **Alan Brace** (pictured left), who stepped down as director of finance for health and social care in the Welsh government last summer after almost five years in post, was awarded the honour for services to the NHS and the Covid-19 response in Wales. Mr Brace has held a number of high-profile finance and general management roles in NHS Wales. Meanwhile, **Kevin McGee** (pictured right), chief executive of Lancashire Teaching Hospitals NHS Foundation Trust, was awarded an OBE for services to the NHS. Mr McGee held finance director posts in the North West of England during the 1990s and 2000s, before moving into general management.

NHS Education for Scotland (NES) has appointed **Jim Boyle** (pictured) director of finance. Mr Boyle worked for Stirling Council, where he has been chief finance officer for the past 10 years. He has served as chair of the Scottish local government directors of finance group, and led the group's education portfolio for the past five years. He said: 'I am absolutely delighted to be joining NHS Education for Scotland as director of finance. I have long been aware of the vital role that NES plays in training Scotland's health and care workforce and in ensuring that those skills keep pace with the evolving needs of our country. I am also aware of NES's pivotal role in delivering digital services to support that workforce and in helping to reshape other areas of our health and care services. I am looking forward to being part of that journey.'

NHS Greater Glasgow and Clyde director of finance **Mark White** has been appointed chief financial officer at the University of Aberdeen. Mr White, who has been the health board's finance director since 2015, is expected to take up his new post in May. Before joining the NHS, he was a director in PwC's risk assurance practice.

The St George's, Epsom and St Helier Hospitals Group has appointed a new senior leadership team, formed following the decision for St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust to operate as a group. The trusts remain separate. The team includes **Andrew Grimshaw** as group chief finance officer. He joined the St George's trust as chief financial officer in 2017, and was also the trust's deputy chief executive. There are two deputy chief finance officers – **Tom Shearer** at St George's and **Carol McLaughlin** at Epsom and St Helier.

Pippa Moger has been named chief finance officer as part of the new single leadership team at Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust. With more than 19 years' experience in NHS finance, 12 at deputy and director level, Ms Moger has worked in regulator, commissioning and provider sectors. She joined Somerset Partnership NHS Foundation Trust in June 2013 as director of finance and business development. In October 2017, she became finance director of Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust, before the two merged to form Somerset NHS Foundation Trust in April 2020.

Paul Goodfield (pictured) is to retire at the end of the month after 43 years in NHS finance, including 30 as an HFMA member. He said: 'It's been a great journey and very enjoyable professional career supported by the HFMA. Personal highlights have been USA/UK exchange programme in 1999/2000, working on the accounting and audit committees and pre-accounts planning workshops and other HFMA activities.' He enjoyed 'giving something back to NHS finance' through the Future-Focused Finance value-maker and finance and clinical educator roles, as well as supporting the graduate training scheme, mentoring and tutoring through the HFMA Academy. 'I hope to continue to be active in retirement through voluntary roles and interests. Having competed my 12th London Marathon last year, there may be a few more races left in me yet, including the Great North Run in September.'

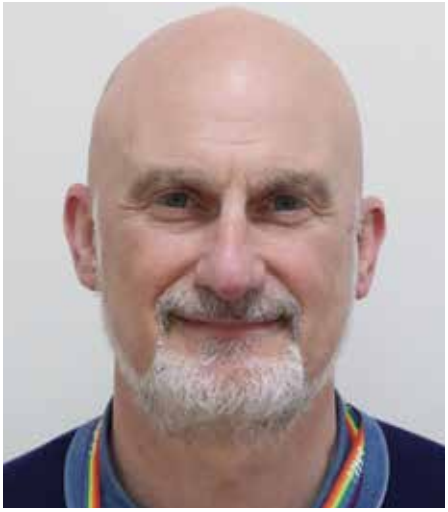
ICB finance appointments

With the formal launch of integrated care boards due in July, the new integrated bodies have started to appoint chief finance officers. As *Healthcare Finance* went to press, only a handful had been confirmed, and with the setting up of the bodies still undergoing Parliamentary approval, these are all designate appointments.

- **Northamptonshire Integrated Care Board has named Sarah Stansfield (pictured) as chief finance officer. She is currently director of outcome-based contracting and deputy chief executive at Northamptonshire Clinical Commissioning Group, and was previously executive director of finance at Gloucestershire Hospitals NHS Foundation Trust.**
- **Zoe Pietrzak has been appointed director of finance at Suffolk and North East Essex ICB. She has been director of operational finance and deputy regional director of finance at NHS England (East of England) for two years.**
- **Jonathan Webb has been appointed director of finance at the West Yorkshire ICB. He is currently chief finance officer and deputy chief officer at Wakefield CCG, where he has worked since May 2018.**
- **Claire Wilson, currently chief finance officer at Wirral University Teaching Hospital NHS Foundation Trust, has been appointed director of finance at Cheshire and Merseyside ICB. She has held roles at local, regional and national level, and is an HFMA vice president.**
- **Surrey Heartlands ICB has named Matthew Knight as chief finance officer. He is currently chief finance officer at Surrey Heartlands Clinical Commissioning Group.**

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

"We have a range of challenges in many, many directions – it's really about finding ways to mobilise and engage our brilliant people in picking a way through"
James Duncan, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust



Duncan steps up into chief executive role

On the move

James Duncan took over as chief executive of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust in February. The trust's former executive director of finance and deputy chief executive says he is honoured to be appointed: 'It was a role I had to go for. I've worked with this organisation and its predecessors for 21 years and it is in my blood.

'The past two years have been difficult for all, but the commitment, values and effort of everyone have shone through. It's time to get our heads up and create a sense of opportunity and hope. I'm really looking forward to working with our great staff, partners and, most importantly, the people and communities we serve.'

Mr Duncan knows the job, having acted up as chief executive on several occasions, but he acknowledges the challenge of the new role.

'I've been deputy chief executive for most of my time here, and have acted up into the chief executive role, so I have some insight,' he says. 'And I really don't see the director of finance role as pigeon-holed into focusing on professional lines; it should always be focused on quality of care and making the money work for people, not the other way round.

'Of course, there's a big difference between that and the CEO role. The big difference is the range of issues you are working on, as well as the absolute imperative of relationship building in multiple directions. It all comes down to human relations, trust and belief.'

Mr Duncan has worked in the NHS for his whole career and succeeds John Lawlor, who has retired after 37 years in the service. He started on the NHS graduate training scheme in 1992, taking on his first finance director role eight years later, and has worked exclusively in the mental health and disability field.

In addition to acting chief executive, he has held executive responsibilities for human resources, IT, estates and facilities, commercial and business development and transformation. He has been involved in national development of mental health payment systems for mental health, and is deputy chair of the HFMA's Mental Health Finance Steering Group.

As he takes over as chief executive at one of the largest mental health and disability trusts in England, the NHS faces multiple challenges – Covid recovery and the additional demands it has created, a new system-based landscape, concerns over workforce and funding, and the need to make more savings.

Asked what this means for the trust, Mr Duncan replies: 'The biggest challenge is in getting ourselves on the front foot. We have a range of challenges in many, many directions – but it is our role collectively to find a way to develop the best services, support and care for the people and communities we serve. So it's really about finding ways to mobilise and engage our brilliant people in picking a way through.

'We need to look outside the organisation and work alongside our partners and with our local communities. We must listen and learn from the experiences of those who work with us, whether that's staff, service users, carers or partners.

'As long as we recognise and understand our current position, are open and honest about our abilities and capacity, work within our constraints while innovating, learning and testing, we will deliver as well as anyone.'

Mr Duncan says his immediate focus is on the wellbeing of existing trust staff, who, like all in the NHS, have endured a difficult two years.

'I want to give our people a chance to breathe, to stabilise next year and not over-promise on delivery,' he says. 'At the same time, we must look to our long-term future by setting out our principles, hopes and ambitions, creating space in which our people can flourish, and developing great partnerships with all those we work with.

'There are huge opportunities – made more possible by the shift to integrated care systems, and away from the competition model – to radically change our collective models of care and support for the better, in a really inclusive way. It's not a short-term fix, but if we can set ourselves up right, we can really start making inroads into a journey that will shape us over the years ahead.'

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